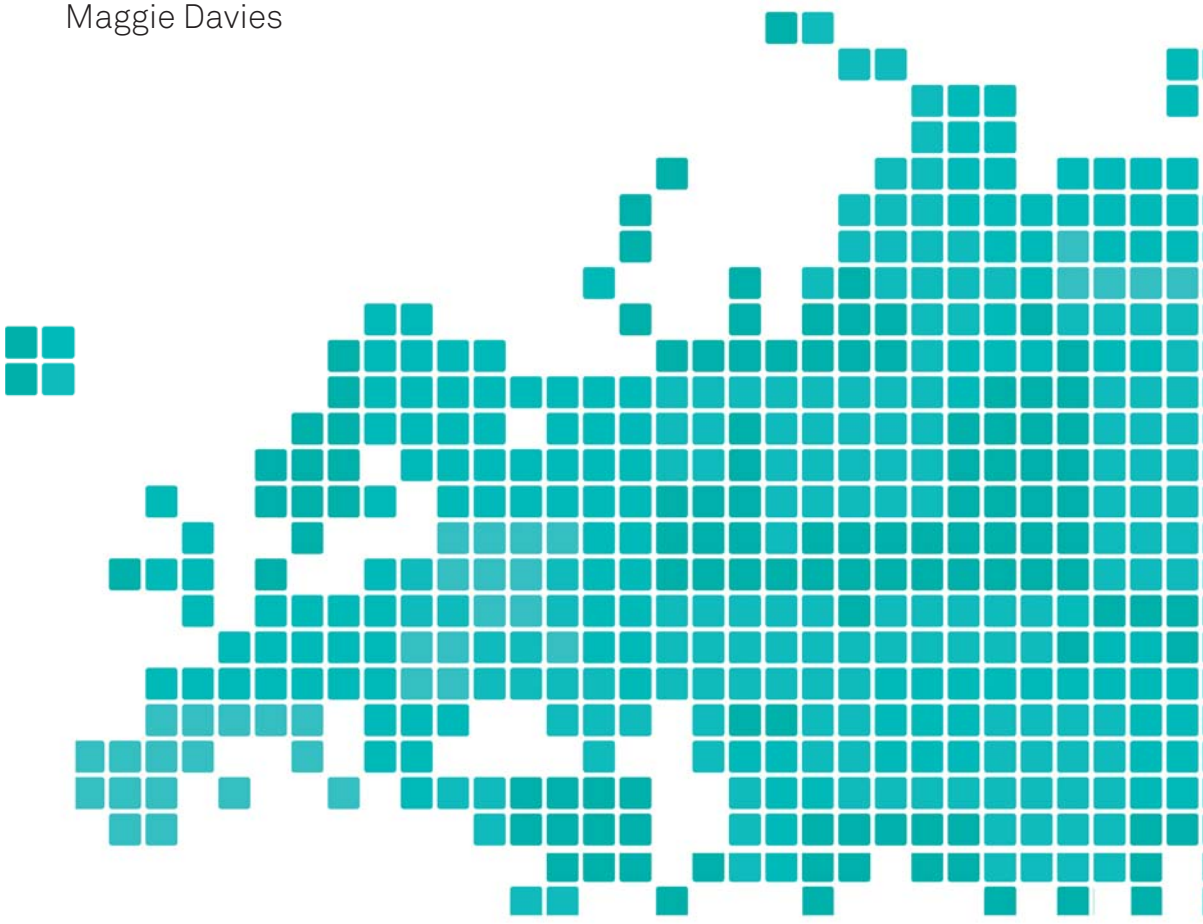
Intersectoral Governance for Health in All Policies

26
Observatory Studies Series

Structures, actions and experiences

Edited by
David V. McQueen
Matthias Wismar
Vivian Lin
Catherine M. Jones
Maggie Davies



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European Observatory on Health Systems and Policies

Intersectoral Governance for Health in All Policies

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health systems in Europe. It brings together a wide range of policy-makers, academics and practitioners to analyse trends in health reform, drawing on experience from across Europe to illuminate policy issues.

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Foreword

Since the arrival of the new millennium, the field of health promotion has added many emerging areas related to health to its field of interest and action.

Many of these areas were, of course, anticipated in the Ottawa Charter on Health Promotion; nonetheless there has been an explosion of interest in three critical areas in recent years, namely on the social determinants of health, governance, and Health in All Policies, and more specifically "the translation of Health in All Policies from a policy principle into a policy practice". Now we have a new and significant book that addresses these three areas in a most exciting way.

The International Union for Health Promotion and Education (IUHPE) acknowledges that many of the solutions to the most pressing health issues reside outside the health sector. It is therefore imperative to facilitate governance practices that enable improved work across sectors in government, the nongovernment sector, academic institutions and the private sector, at all territorial levels.

During the course of many discussions among health promoters it became clear that we lacked a solid understanding of the mechanisms that made possible the development of Health in All Policies. We knew that some European countries were clearly taking the lead in developing a Health-in-All-Policies approach and we observed that they often had a strong focus on issues such as equity, social justice and the reduction of the impact of poverty – all of which were key social dimensions related to the production of ill health. However we did not have a clear understanding of what went on in the world of governance within these countries that resulted in successfully creating a Health-in-All-Policies framework. This book aids greatly in more fully understanding the processes that lead to health in policies, while recognizing the need to further debate and research "to document the experience, assess the evidence and compare the effectiveness of different governance structures in producing action on social determinants of health, and ultimately on population health outcomes". By digging more deeply into the day-to-day work of governance, more of the internal processes are revealed.

In this time of turbulence in Europe, in which the basic concepts of equity and solidarity are challenged, health promotion has a particularly important role to play in encouraging and supporting further intersectoral discussions, knowledge exchange and development of guidance to achieve truly intersectoral "joint action" between researchers, practitioners and policy-makers.

The IUHPE is proud to have been highly associated with the development of this book. Obviously the involvement of IUHPE leadership in the editing and writing of this manuscript has led to the kind of new insights into governance contained within. In addition it has been a pleasure for the IUHPE to work closely with the European Observatory on Health Systems and Policies in planning meetings and teleconferences and in general assisting in the day-to-day efforts required to produce this publication. We look forward to the impact of the fruits of these joint efforts.

Marie-Claude Lamarre
Executive Director, International Union for Health Promotion and Education

Foreword

Health 2020 is the new health policy framework of the WHO European Region. The policy aims at significantly improving the health and well-being of populations, reducing health inequalities, strengthening public health and ensuring sustainable people-centred health systems. Health 2020 is for the whole of government and the whole of society. It envisages actions and outcomes well beyond the boundaries of the health sector and beyond the remit of the ministry of health. Health 2020 therefore proposes reaching out and working together with other ministries, departments, sectors, organizations, stakeholders and civil society organizations. Health 2020 also proposes reaching out to, and working together with, citizens, patients and consumers, providing more opportunities for empowerment.

Progress towards all these goals will be achieved by policy action in four areas: investing in health through a life-course approach and empowering citizens; tackling Europe's major disease burdens of noncommunicable and communicable diseases; strengthening people-centred health systems and public health capacities, including preparedness and response capacity for dealing with emergencies; and creating supportive environments and resilient communities.

This volume presents in a practical way an analysis of how to reach out and work together. It focuses and gives clear advice on intersectoral governance structures that can facilitate intersectoral action. It is hoped that the volume will help WHO Member States assess and revise their practices of intersectoral collaboration, and inspire new ways of reaching out and working together. We also hope that it will encourage the exchange of good practices between countries.

The book was developed in parallel with Health 2020 and it has continuously informed the technical consultations with Member States and experts that have taken place over the last two years. It comes as part of a package of studies that has provided scientific background to the development of Health 2020, including a study on governance for health in the 21st century and a review of social determinants and the health divide, both of which also provide examples on how to implement whole-of-society and whole-of-government approaches.

I am therefore pleased to present this volume on intersectoral action for Health in All Policies on the occasion of the sixty-second session of the WHO Regional Committee for Europe in Malta.

Zsuzsanna Jakab
Regional Director, WHO Regional Office for Europe

Acknowledgements

The idea for this book was inspired by the promotion of Health in All Policies (HiAP) as a main theme of the Finnish Presidency of the Council of the European Union in 2006 and the subsequent ministerial summit on the same topic in 2007 in Rome. We, the editors, are grateful for all the concrete support and encouragement we received from these important events.

Over the course of the project we benefited substantially from comments received at meetings, workshops and conferences where we presented our project. This includes the conference on HiAP in 2010 in Adelaide and our symposium at IUHPE's world conference in 2010 in Geneva.

We are also most grateful for the opportunity to attend a succession of meetings, workshops and conferences supporting the development of Health 2020, the new policy framework for the WHO European Region. This includes the conference held in November 2011 in Jerusalem, where we presented some of our preliminary results.

Agis Tsouros and Roberto Bertollini of the WHO Regional Office for Europe hosted a workshop in late summer 2011 to discuss with WHO colleagues the preliminary results of our study and to provide additional input from their vast experience and expertise. Agis Tsouros was also instrumental in connecting the book project with the development of Health 2020.

We are also grateful to Ilona Kickbusch (Switzerland), Vesna-Kerstin Petric (Slovenia), Bosse Pettersson (Sweden), Graham Robertson (Scotland, United Kingdom), Lea den Broeder (Netherlands) and Maris Jesse (Estonia) for their participation in the exchange of ideas. We are most grateful to the reviewers of the manuscript for the book, Horst Noack (Austria) and Marilyn Wise (Australia). Laura Schang, Maria Teresa Marchetti and Burcu Tigli provided invaluable services in supporting the commissioning and editing of the chapters and mini case studies. A very special thanks goes to Louise St.-Pierre (Canada) who contributed substantially to the conceptual discussion among editors.

We gratefully acknowledge the generous support provided by the United Kingdom Department of Health from the inception of the project.

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List of abbreviations

AIDS	acquired immune deficiency syndrome
CDC	Centers for Disease Control and Prevention
CIB	International Council for Research and Innovation in Building and Construction
CNSP	Comité national de santé publique
CSDH	Commission on Social Determinants of Health
DEFRA	Department for Environment, Food and Rural Affairs
DG	[EU] Directorate General
DG Sanco	[EU] Directorate General for Health and Consumers
DH	Department of Health
DHS	Department of Human Services
EEA	European Economic Area
EPHA	European Public Health Alliance
EU	European Union
FCTC	Framework Convention on Tobacco Control
GP	general practitioner
HFSS	high in fat, salt or sugar
HiAP	Health in All Policies
HIV	human immunodeficiency virus
HPB	Health Promotion Board
HSC	Health Select Committee
IPHC	Intersectoral Public Health Committee
IUHPE	International Union for Health Promotion and Education
MACHC	Mid-America Coalition on Health Care
MAFF	Ministry of Agriculture, Fisheries and Food
MDG	Millennium Development Goal
MP	member of parliament
MSAH	Ministry of Social Affairs and Health
NAO	National Audit Office
NCD	noncommunicable disease
NGO	nongovernmental organization
NHS	National Health Service
ODPHP	Office of Disease Prevention and Health Promotion
PAC	Public Accounts Committee
PPP	public-private partnership
SASP	South Australia's Strategic Plan
SDoH	social determinants of health

SGC	Strategic Growth Council
SOG	senior officials groups
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
UV	ultraviolet radiation
vCJD	variant Creutzfeldt-Jakob disease
WHO	World Health Organization

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Part I
Policy Issues and Research Results

Chapter 1

Introduction: Health in All Policies, the social determinants of health and governance

David V McQueen, Matthias Wismar, Vivian Lin and Catherine M Jones

Introduction

A number of major health policy developments internationally call attention to the emerging policy practice of "Health in All Policies" (HiAP). To begin with, the Millennium Development Goals (MDGs) have been in the background of much of the global efforts on health. However, initially they were not as explicitly directed at the broad causes of poor health as many in the public health sector wished. That has now changed markedly with recent United Nations activities, culminating in the United Nations General Assembly (UNGA) resolutions of September 2011. This activity put the three concepts of HiAP, the social determinants of health (SDoH) and governance front and centre, with particular emphasis on the global impact of noncommunicable diseases (NCDs). Secondly, the Finnish European Union (EU) Council Presidency in 2006 (Ståhl et al., 2006), the Rome Declaration on HiAP in 2007,[1] followed by the Adelaide Statement on HiAP (2010), with its emphasis on "moving towards a shared governance for health and well-being", clearly brought the role of governance into the picture. Thirdly, the work of the World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) and the release of the final report, *Closing the gap in a generation: health equity through action on the social determinants of health*, enhanced a long history of concern with the sociocultural factors underlying health and illness and revealed in all clarity

1 The EU Ministerial Conference on "Health in All Policies: Achievements and Challenges" took place on 18 December 2007 in Rome and was attended by health ministerial delegations of the 27 EU Member States.

the need to address issues such as equity and social justice (CSDH, 2008). The recent Rio Political Declaration on Social Determinants of Health (WHO, 2011), adopted during the World Conference on Social Determinants of Health in October 2011, continues to highlight the importance of the work of global institutions to address HiAP, social determinants of health and governance. This book in particular echoes and supports themes of the upcoming WHO health policy for Europe, the European Health 2020 policy framework, underscoring the importance of SDoH, HiAP and intersectoral governance (WHO Regional Office for Europe, 2012). These policy developments set the background for the issues to be addressed in this book.

This Introduction places the collective effort in this book into the context of the integration of three major concepts, SDoH, HiAP and governance, which together make this work unique. The integration of these three concepts stemmed from initial editorial discussions on the conceptual aspects of HiAP and emphasized how the SDoH and HiAP ideas help explain the role of governance in health.

Any insight into the relationships between and among the three core concepts would require a considerable narrative to illustrate each concept and their interrelationships. That is why we ultimately chose to see intersectorality as a mechanism or action component operating in the three concepts. Governance is the verb concept among the three and takes us to a concept that manipulates the other two. However, many of the published explanations of the concept of governance were passive or structural rather than active: that is, they generally described what agencies/government bodies were making decisions on governance rather than how the agencies were making those decisions. This book is concerned with both structures, such as committees or institutional structures, and agency, in the sense of actors and their actions.

Core concepts

Let us now turn to a brief examination of the three concepts. The purpose here is not to repeat the definition of each of these concepts: the glossary for this book (see Table 1.2) and many other sources give excellent characterizations of these concepts, such as the insights from the report of the WHO Commission on the Social Determinants of Health and the extensive supporting documentation. We will seek some common understanding of each of the concepts by addressing their theoretical, implicit and explicit underpinnings for the purpose of establishing the foundations for this book. We will also use the history of public health to illustrate the concepts.

Leadership of the Ukrainian Ministry of Finance: tax increases on tobacco products

Kristina Mauer-Stender

In just over two years, from September 2008 to January 2011, the excise tax on tobacco products in Ukraine increased more than sevenfold. The average price increased threefold for filter cigarettes and fourfold for non-filter cigarettes. Budget revenues from tobacco excise taxes increased from 2.5 billion Hrv in 2007 to 13 billion Hrv in 2010, or threefold in real terms. At the same time, sales of cigarettes decreased by more than 20% in two years. According to the State Statistics Committee, the daily smoking prevalence for the adult population was 24.0% in 2010, compared with 27.5% in 2008. This means that within two years, daily smoking prevalence decreased by 3.5 percentage points, or by 13%.

This progress would not have been possible without the intersectoral involvement and commitment of the Ministry of Finance of Ukraine. In 2008, the Prime Minister led a tax increase strategy on tobacco products, justified by the urgent need for additional revenue to relieve the consequences of flooding in the country. In March 2009, tobacco taxes were increased. In February 2010, a new President was elected in Ukraine and a new Government was appointed. Additional revenues were needed and this time the Ministry of Finance, taking the lead, proposed a bill for a continuous tax increase.

The strong position and leadership of the Ministry of Finance in recent years has been the main factor for the continuous tax increases on tobacco products in Ukraine. While increasing budgetary revenues, there has also been a clear gain for health.

Source: unpublished case studies being prepared for a series on the implementation of the WHO FCTC in the European Region. The WHO Regional Office for Europe series "Tobacco Control in Practice" will focus on the art of the possible. More information is available at http://www.euro.who.int/en/what-we-do/health-topics/disease-prevention/tobacco/publications/2012/tobacco-control-in-practice.

The domain of HiAP can be seen from a historical perspective as part of a theory base rooted in a public health associated with power, politics and social movements. Its European theoretical underpinnings are found in the nineteenth-century writings of thinkers such as Engels, Virchow and Durkheim. Virchow, in particular, emphasized the political nature of many of the actions that needed to be taken to address population health. These visionaries reasoned that the public's health was determined by large social processes and cultural adaptations to an increasingly urbanized and industrialized society. As medicine and public health embraced the more disease-oriented, infection theory-based, individual-centred, biomedical view during most of the 20th century, these sociotheoretical approaches tended to be less regarded. Towards the close of the 20th century, the individualistic hygiene approach to public health was increasingly challenged by the new form of post-industrial society. Once again, the theoretical challenge

and logic of causality in producing health became important. Thus, HiAP may be seen as the inheritor of the broader public health tradition.

In addition, two critical aspects of current thinking inform the rationale for HiAP: the ideas 1) that sociocultural factors define the prerequisites for health and limit peoples' choices in changing to so-called healthier behaviours, and 2) that diseases are exacerbated and differentially distributed in direct relationship to inequities in society. HiAP is a response to this renewed critical thinking and it is often manifested through governance. By definition, and in most advanced economies, governance takes place across all sectors of society, with government (central, regional and local) taking responsibility for many aspects of society ranging from the mundane (sewers, transportation, housing, energy, commerce) to the humane (education, the arts, sports). The underlying social theory is that these sectors of society and their attendant systems of governance play a role in the health of the population. Thus they comprise the institutions for action in the HiAP approach. The tools of action are those available to governance, namely persuasion, regulation, law and legislation. The tools are carried out by the appropriate agencies of government. Thus the concept of HiAP has emerged over time not just as a principle but as a form of policy practice.

The ideas behind the epidemiological concept of SDoH are highly influenced by the historical changes alluded to in the previous paragraph. However, the concept of "social determinants of health", while appearing very general, has some obvious theoretical underpinnings as well as some critical assumptions about agency and causation. To begin with, the concept is highly rooted in an epidemiological epistemology. The notion implies that there is a very strong, one-way causal relationship between social determinants and health. Since the underlying epistemology is based on a medical perspective, it also strongly implies that this is regarded as a relationship between causation and observed diseases or medically defined conditions. Given the power of the underlying medical orientation of SDoH, it is instructive to examine each of the verbal, English language, components of the concept in more detail.

The word "social" has multiple meanings in English, but the general meaning broadly implied is that of human society and the interactions of individuals and groups in the welfare of the whole society. However, epidemiological discourse throughout much of the 20th century tended to discuss this in terms of behavioural risk factors for disease. That is probably a closer notion to what is underpinning much of the recent literature on SDoH, because in much of that literature the "social" meaning relates to the notion of rank or status of individual members of society. Hence one sees the strong emphasis on notions of class and class gradient in the SDoH concept that are more individually derived.

The word "determinants" is especially important as used in the current conceptualization of SDoH. In the philosophy of science that deals with causality, this word would be seen as a most powerful word, meaning a very high degree of direct, scientifically based causality. It is doubtful that the underlying epidemiological evidence could support such a strict, high level of determination and the word "factor" is probably the appropriate operable word because it implies an active contribution of an element to a complex outcome. However, words have many roles and from the standpoint of advocacy of a position, the word "determinants" is probably more satisfactory than the more obscure "factors". Perhaps it is because of this that the SDoH concept links so well with HiAP. Further, the strength of the word "determinants" may be more arguable and defensible in governance.

The word "of" strengthens further the causality argument. This is in contrast to choosing the word "in", which implies a more diffuse, correlative causality argument. It is instructive to note that a social scientist would likely argue for the notion of social factors "in" health because of the diffuse and probably multidirectional causality that is being explained. However, this terminology is coming out of a medical model and not a social model of health.

Finally, the word "health" should be briefly examined with regard to SDoH, partly because we have the issue of whether the word means the same as or is just something similar to the use of the same word in HiAP. An in-depth reading of the extant literature on SDoH reveals that its focus is much more on disease than on health. Countless examples of disease and illness, particularly chronic diseases and NCDs, are cited in the extant literature. At best, health is often discussed and defined in terms of life expectancy. It is not the place here to go into the considerable discussion about what is health, a discussion that has enveloped the field of health promotion for decades, but rather to accept that the notion of health put forward in the SDoH approach is largely a "free of disease" approach to the notion of health and remains fairly biomedical.

A central notion in the current SDoH discussion is the existence of a "gradient", that the variation in health outcomes can be represented graphically by a slope. The notion is simply that within countries there are observed disparities in health, generally related to some notion of social class; similarly, between nations there are observed differences. For example, there is a cumulative literature showing that within highly economically developed countries there are wide differences in health outcomes in relation to class status. These differences are most profoundly illustrated by the differences between the United States of America and other, highly developed European, countries. Efforts to explain why there are such profound differences have not yielded any conclusive answer, but raised much speculation. A clear question for this book is what is the role, if any, of HiAP in these gradient differences.

The concept of governance is old, but the concern with it as a focus area of public health is not. The examination of underlying meanings in our concepts of HiAP and SDoH are critical to understanding why we have argued that governance is so important in attaining a healthier world. Primarily through governance, agents of government, civil society and nongovernmental organizations (NGOs) argue for the importance of health in framing the success of their endeavours. As many have argued, health becomes a metaphor for the success of the state with respect to those governed. A critical aspect of both HiAP and SDoH is that they place "health" as the major criterion for conducting successful operation of the state and they do it explicitly.

Implicitly, health has always been an underlying factor in governance. The reconstruction of Paris under Napoleon III is illustrative. When Baron Haussmann set out to "straighten" the streets of Paris and create the great boulevards of today, the rationale may have been largely the defence of the monarchy, but the outcome was the clearance of bad housing, reduction of pollution and greatly improved sanitation for the Parisians. It was, from another perspective, a major effort to address the social determinants of health by changing the social and physical landscape. That this was carried out as an act of governance is without doubt, even if it was a monarchical government. One can see countless similar examples in many movements that combined governance and civil society to address large-scale urban infrastructure, most notably the creation in most Western cities, particularly in America, of vast and extraordinary park systems. The ethos may have been to create places of beauty and leisure, but this is easily translated into today's notions of healthy cities. Most of these and other efforts to improve the commons were the result of governance actions and it is the process of these actions that is revelatory and leads to the topic areas presented in this publication.

The concept of governance acknowledges the earlier public health history that state action matters – be it clearing of marshlands or building of sewers in Rome, or quarantine as a measure to prevent and control plague, or regulations governing public health and safety to reduce injury and disease related to occupational health and safety. HiAP also builds on the health promotion experiences that underpin the first of the five action areas named in the Ottawa Charter (WHO, 1986) – "build healthy public policy".

The notion of government responsibility has been central to the public health effort, with government playing a leadership and a stewardship role in the "organized effort" by society to protect and promote health and prevent illness and injury. Even in contemporary economic thinking that underpins much of public administration around the world, public health is seen as a public good, and government intervention in health-related projects may be viewed by some

as a possible step to correct market failure. The coercive powers of government have been core to the health protection effort, while the redistributive powers of government have been critical for redressing health and social inequities.

In the late 20th century and leading into this century there has been a shift in the discourse on public policy, from government to governance. This reflects a number of shifts in philosophical outlook as well as changes in society. The advent of managerialism and neo-liberalism in government – for example, "steering, not rowing", "letting managers manage", purchaser/provider separation, focus on results, etc. – has led to a shift to deregulation, small government, output/outcome-based funding, performance-based evaluation. The ideological shift towards the market also allows government to devolve political and financial risks, by adopting contract management (rather than service delivery) as the core business of government. At the same time, social movements have called for greater participation, transparency and accountability in policy decision-making. Among many there is a recognition that the increased complexities in society and economy require a greater collective capacity (involving civil society and the private sector) to get things done, rather than solely relying on the power and resources of government.

Governance, however, remains an evolving concept and practice, and there are multiple definitions. The World Bank sees it as the manner in which power is exercised in the management of a country's economic and social resources (World Bank, 1992). Academics have adopted a more abstract approach but variously concerned with both structure and action – as actions and means to promote collective action and deliver collective solutions, or as self-organizing, interorganizational networks that are interdependent. The process orientation is reflected in more post-modernist theories as well – governance being the process of continuing interaction between participants inside and outside the formal structures of government, bringing to bear a diversity of frameworks through which matters are seen to need attention and responses evaluated (Colebatch, 2002), or more simply as ways of managing the course of events in a complex social system (Burris, Drahos & Shearing, 2005).

Regardless of the precise definition, Stoker (1998) suggests there are some key features:

- institutions and actors within and beyond government;
- self-governing network of actors;
- balance of rights and responsibilities for all participants in the process;
- power dependence between institutions, with business rules defined for relationship management;

- capacity to get things done is not dependent on hierarchical control;
- a shift occurs from authoritative direction by government (to a subordinate bureaucracy) to negotiation among stakeholders.

For this book, with governance seen as the verb for acting on social determinants and achieving HiAP, our approach to governance sees essentially two dimensions: 1) the structures that bring actors together and 2) the actions flowing from their mutual engagement and deliberations (i.e., the agreement to frame policies in a particular manner, the decision to adopt particular policies, use particular policy instruments to effect implementation, etc.). Our focus is both on the inner workings of government – across sectors, and across political and bureaucratic levels of policy-making – and on the engagement that government has with civil society and the private sector. Table 1.1 outlines the analytical framework that underpins the organization of the book. We see government as the centre of the governance system for HiAP, but we recognize the diverse voices that are part of policy decision-making.

HiAP is still a work-in-progress occurring in different national, cultural, economic and public administration contexts. The chapters in this book report on and analyse our experiences to date, as the beginnings of a cross-national learning process – in order to answer such questions as: how do we effectively put together institutions and decision-making processes to shape public policy and optimize the social determinants of health? How do we array state, civil society and economic actors in order to contribute to health improvement that is sustained and equitable?

Public policy is an iterative process that is historically layered and path-dependent, but always characterized by competing interests within and outside government. Governance structures mediate in this process, allowing for creative spaces and policy openings to shift the structural influences on health of the community.

Part II discusses some of the novel and varied ways in which HiAP is gaining traction with policy-makers and governments, as well as some of the challenges encountered.

Methods

To achieve the book's objective, the study employed multiple methods, corresponding to four phases. Firstly, the exploratory work was developed through discussions with international experts for the clarification of the fundamental conceptual issues. This phase of expert consultation resulted in the initial draft of the framework and the study proposal and outline. The authors

Table 1.1 *Analytical framework for intersectoral governance*

		Governance actions								
		Evidence support	Setting goals & targets	Coordination	Advocacy	Monitoring & evaluation	Policy guidance	Financial support	Providing legal mandate	Implementation & management
Intersectoral governance structures	Ministerial linkages									
	Cabinet committees and secretaries									
	Public health ministers									
	Parliamentary committees									
	Interdepartmental committees and units									
	Mega-ministries and mergers									
	Joint budgeting									
	Delegated financing									
	Public engagement									
	Stakeholder engagement									
	Industry engagement									

were then identified via contacts in the global professional expert network of the International Union for Health Promotion and Education (IUHPE), the network of policy experts in the European Observatory's policy dialogue work, and through the use of a snowball technique.

Secondly, an authors' workshop was held in Brussels in June 2010 to gather all of the contributors and additional stakeholders, partner and experts to discuss the study's methodological issues and the challenges and opportunities related to the diverse cultural and political contexts of the authors and the case studies. Based on the reflection of all the authors on their cases and their critical perspectives on the use of the proposed framework, the editors and other partners then modified and finalized the framework, with consensus on its validity as an analytical tool, agreement on a glossary of terms,[2] and

2 The authors' workshop highlighted the importance of defining a set of terms that authors could use for positioning their work. The glossary of terms was proposed and sent to all contributors as a starting point for their work, to create a common ground upon which critical perspectives and alternative definitions could be proposed. It was not the aim of the editors to impose standard, consensus-based definitions, but to give authors an anchor in relation to which they could situate their chapters. The glossary of terms as sent to authors is included as Table 1.2.

identification of further mini case studies that would be used to supplement the case studies.

Table 1.2 *Glossary of terms of the study's key concepts*

Effectiveness	An intersectoral governance structure is effective to the extent that it contributes to integrating health in other policies. Effectiveness should therefore be delineated from "lip-service" or post-decision justification. Effectiveness would include intersectoral action that has made a difference in the end-point.
End-point	The end-points of intersectoral actions aim to effect changes in other policies, such as changing the justification, the evidence base, the contents, its financing and implementation or legal basis for these policies such that they have a positive influence on health or determinants of health. The changes of the determinants or population health are not considered as the end-points since this would entail an analysis of the interventions taken.
Governance	Governance is the system of decision-making whereby directions are set, authority is exercised, and events are monitored and managed. Governments that recognize the complexity of social and economic factors will govern through engagement with market and civil society actors in policy development and implementation. Governance may include action that goes well beyond government by delegating policy formulation and policy implementation or parts of it to stakeholders or stakeholder organizations. In essence governance is about power relationships.
Health in All Policies	Health in All Policies is the policy practice of including, integrating or internalizing health in other policies that shape or influence the SDoH. These determinants include transport, housing, tax and agricultural policies, to name a select few. Health in All Policies is more concerned with the "big issues" and less with individual programmes or projects. Depending on the institutional context of a country, these policies may be found at the national, regional, local level or dispersed in multilevel governance systems. HiAP is a policy practice adopted by leaders and policy-makers to integrate consideration of health, well-being and equity during the development, implementation and evaluation of policies. This policy practice "requires a new form of governance where there is joined-up leadership within governments, across all sectors and between levels of government" (Adelaide Statement, 2010).
Health sector	For the purpose of the study, "health sector" is defined as all organizations, stakeholders and procedures in the remit of the minister responsible for health, which includes the ministry and other related statutory organizations. What is considered as the health sector may therefore be different from country to country. The term "health sector" is different from "health system", since the latter is based on an abstract model of functions and goals.
Health system	Health systems are composed of functions (governance, financing, resource generation, delivery) contributing to the achievement of goals (population health, equity, fairness, non-medical expectations of citizens and patients). A health system consists of all the organizations, institutions, resources and people whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver health services; it includes intersectoral action by health staff. (WHO, 2007).

Table 1.2 *(contd)*

Intersectoral governance structures	These are structures that exist to facilitate the collaboration between different ministries, departments or sectors. Intersectoral structures are "tangible" or "visible" in terms of leaving a trace in the organigram or prescribing distinct entities or procedures inside government and administration. Intersectoral governance structures are in this respect different from collaboration based merely on personal relations. Intersectoral structures can be owned or co-owned by the ministry responsible for health or by the whole government. Also included are other ministries' intersectoral governance structures to the extent they are accessible to the ministry of health.
Intersectoral governance actions	These are actions facilitated by intersectoral governance structures that aim to align other governance policies with health objectives. Examples of different intersectoral governance actions include evidence support, setting objectives, goals and targets, coordination, advocacy, monitoring and evaluation, policy guidance, financial support, providing legal mandates, implementation and management. They therefore range from rather "soft" to "hard" interventions and cover all stages of the policy cycle.

The third phase involved authors drafting their chapters and calls for mini case studies. Authors were asked to review both published literature reviews as well as national and international examples from "grey" literature, including government and nongovernmental publications and reports, and other sources where documentation of experiences could be collected. Mini case studies were submitted via a question-led template covering the background (when? why? who?), what problems it aimed to address, how the structure involved sectors other than health, how it contributed to action, and what the conditions were of its success or setbacks. Concurrently, the partners and the editors were engaging in a consultation and dissemination phase, sharing information about the study and its analytical framework in international meetings and conferences to collect feedback and other suggestions and to make connections with relevant work being undertaken elsewhere.

The fourth phase involved the internal and external review of the chapters and incorporation of the mini case studies. Two external reviewers were invited to read the entire publication and provide comments according to three criteria: 1) methodological/scientific rigour (with respect to content on the policy context, the analytical perspective, and the governance action), 2) validity of recommendations, and 3) meaningfulness to policy-makers. All of the reviews were discussed by all of the editors to ensure coherent scrutiny of the entire publication.

Analytical framework

The analytical framework reflects the structure of the publication. Eleven intersectoral governance structures were identified as mechanisms with capacity

to facilitate nine governance actions. The use of governance structures as an analytical category is based on existing conceptual work that distinguishes substantive from procedural policy instruments (Howlett, 2005) and that proposes a classification of governance tools including structures, process, frameworks and mandates (St. Pierre, 2009).

The governance actions establish end-points for the assessment of the effectiveness of governance structures. The identification and definition of governance action for this study was, in part, influenced by the WHO Health Systems Framework (WHO, 2000), in that it aims to link health system governance to health system objectives. Similarly, the intersectoral governance actions are proposed as a link between intersectoral governance and the objective of HiAP. In this vein, the actions are seen as an (intermediary) end-point. The general policy research on intersectoral governance suggests that its aim (or end-point) is to sensitize, to produce and share expertise, and to learn continuously (Bourgault, Dupuis & Turgeon, 2008). The definition of governance actions is also closely related to the idea of the policy cycle (Howlett, Ramesh & Perl, 2009). Table 1.3 provides an overview of how the governance actions were defined for this study. The ordering of the governance actions can be seen as corresponding to various parts of the policy cycle, albeit recognizing the iterative and recursive nature of the cycle.

Organization of the publication

The book is organized into two sections. Part I (comprising Chapters 1 and 2) explores the rationale and theory for intersectoral governance and summarizes the cross-analysis of the evidence produced by the case studies in Part II on how governance structures facilitate governance actions. The chapters in Part II provide detailed discussion illustrations and case studies of the structures in action, with analysis of the necessary conditions for effectiveness and barriers encountered.

The nine case study chapters cover a range of examples from the WHO European Region, North America and Australia. In addition, several mini case studies are included throughout the book to supplement the main chapters with further examples from different contexts and countries. Both the chapters and the mini case studies present and examine an array of examples from national and subnational levels, and some international examples are also provided from the European Union, the United Nations and WHO.

Each of the chapters in Part II presents a definition of the governance structure addressed, a description of the governance action facilitated, a discussion of

Table 1.3 *Definition of the nine governance actions in the conceptual framework*

Evidence support	The key factor for evidence support as an action is the co-production of evidence, and the notion of "shared" evidence. It implies a sense of agreement upon acceptability of the evidence produced and gathered by all parties involved.
Setting goals and targets	The action of setting goals and targets is about reaching multisectoral agreement on desired public policy outcomes, goals and targets. This agreement can then be translated into each sector having more specific targets that contribute to the whole, and may lead to the development of more specific plans and strategies to achieve goals and targets.
Coordination	Coordination refers to mutual adjustment in agreed fields of action. The focus on action in coordination is specifically intended to improve synergies between sectors, reduce fragmentation of action, and decrease duplication. Coordination, with an action focus, refers to efforts to organize and coordinate action and goes beyond communication and information exchange.
Advocacy	Advocacy as an action has two potential foci. First, it may aim to promote a shift in attitudes, culture and the social, political or physical environment. Second, it may aim to support or stimulate legal or legislative change. Broadly, advocacy actions can relate to awareness-raising or agenda-setting for government policies, laws and regulations.
Monitoring and evaluation	Monitoring and evaluation is a governance action to measure progress on the SDoH. This may be done through agreed indicators and knowledge management arrangements, or take the shape of evaluation reports.
Policy guidance	Policy guidance as an action includes policy orientation or recommendations that are made with other sectors, including health. The governance action here refers to the fact that direction is provided to guide what should be done in terms of joined-up policies, including in a national plan or policy strategy, etc. It is distinguished from implementation support in that it focuses on the "what" of policy recommendations rather than guidance on the "how" of policy implementation.
Financial support	Financial support involves the mobilization of specific funds. Financial support refers to the action of allocation, pooling and disbursement of funds to finance intersectoral action and joint programmes for health.
Providing legal mandate	The provision of a legal mandate is a governance action that reflects high-level support for action on the SDoH. As a governance action, it supports HiAP by providing a mandate for aligning different sectors to implement or adopt HiAP.
Implementation and management	Implementation and management are situated at the end of the spectrum of governance actions as they refer to the action-oriented implementation of proposals resulting from the other actions and the administration, oversight and management of those activities related to HiAP implementation.

effectiveness and a proposed set of lessons learned and conditions supporting or challenging effectiveness of governance structures to trigger action. Most chapters contain a couple of mini case studies presented in boxes, in which a short description of a governance structure and a rapid appraisal of how it facilitates action are provided. They are incorporated into the authors' arguments

in the individual chapters to support or provide alternative examples. The mini case studies serve the purpose of expanding the country coverage to be more inclusive of a variety of the 53 Member States of the WHO European Region.

Key points of the chapters

Many argue that HiAP has to occur through action at the highest levels, particularly if all of government is to be engaged. A powerful government structure for this is found at the ministerial level, in the "cabinet". Chapter 3, by Owen Metcalfe and Teresa Lavin, provides critical insights into this level of action. While cabinet committees and secretariats may not exist in all government structures, they remain a common feature of most western-style democracies. To a great extent, as the authors point out, committees at this level appear to the outside world as a "black box" and rarely have any identifiable papers related to their work. As historians know, many relevant documents may ultimately be seen, but generally years, if not decades, after the principals are deceased. Therefore, perhaps because of the secrecy involved, robust contemporary evidence for the effectiveness of cabinet-level action on HiAP is lacking. Until such evidence is forthcoming the pundits may consider looking elsewhere. If secrecy is characteristic of cabinet-level decision-making, almost the opposite is true of the parliamentary (or congressional) level. The sheer bulk of parliamentary proceedings, reports and other documents represents the other extreme in seeking evidence of action on HiAP. Simply put, there is too much information. In Chapter 4, Ray Earwicker explores this situation deftly in his case for parliamentary scrutiny. His example of the use of select committees helps to tease out some of the complexity in understanding how decisions relative to HiAP are made. In this chapter, Earwicker weaves together the scrutiny process with the discussions of the Wanless and Marmot findings and illustrates how this process ties into the issues on the SDoH.

While cabinets and parliaments represent the political, elected, aspect of government, there remains the often enormous underlying structure of government bureaucracy, consisting of agencies, bureaus, departments and sections; in short, the day-to-day work of governance performed by legions of civil servants. This area of governance is taken up in Chapter 5 by Scott Greer, which examines the role of interdepartmental action as seen through committees and special units. There is a rich history in public health of such interdepartmental structures and their influence. However, as is pointed out, in general such committees operate only in one area of government, that is in one ministry of government. Fortunately, counter examples are given. In general there is some compelling evidence that these created structures do

work and provide a strong potential structure for action on HiAP. Scott Greer, in Chapter 6, takes up the rather uncommon phenomenon of mergers and mega-ministries. This structural change does affect the whole of government, the political, the ministerial and the government bureaucratic staff. In many cases, the effect may be to combine staff that heretofore had no simple mechanism that allowed the affected sectors to work together. The chapter addresses the strengths and weaknesses of this structural change, but also illustrates that to date there appears little evidence of the value of such structural change.

Following the budget is a key indication of what actions will be taken by government. This is examined in David McDaid's Chapter 7 on joint budgeting. In theory it is assumed that joint budgeting is a logical approach to intersectoral action. However, as McDaid points out, joint budgeting has many forms and many consequences. The case for the particular context of any governance structure is well made. Chapter 8 by Laura Schang and Vivian Lin explores the budgeting process in further detail, examining delegated financing. This involves, in many cases, delegating funding to external agencies (statutory authorities) in some type of synergistic relationship. Nonetheless, such entities allow governments to establish a mechanism for the release of funds that otherwise would often be tied to legislative categorical budgeting. While the examples provided represent the common patterns of such funding that are found in western Europe and Australia, the strengths and weaknesses of such arrangements are discussed, as well as the lessons learned.

In recent times the importance of civil society in the public health dialogue has been championed. How the public can be involved in creating governance for HiAP is taken up in Chapter 9 by François-Pierre Gauvin. The extent to which governance reflects public desires and the interrelationship between these two bodies is most complex. However, the dimensions of direct pubic engagement with government is illustrated well by the United States of America's Healthy People initiative. Nonetheless, the author points out many of the difficulties to attributing the outcome of such efforts to the will of the public. Clearly this is an area for greater evidential understanding. Chapter 10, by Helmut Brand and Kai Michelsen, explores another dimension of civil society's role in HiAP and governance. Health conferences are characterized as a structural mechanism based on the voluntary participation of representatives from the government, the health system and citizens. Their goal is to deal with target groups, areas or problems which need to produce recommendations related to health. The authors illustrate a number of critical aspects that arise in using health conferences. It remains to explore the evidence of the effectiveness of such conferences and networks in relation to HiAP. Monika Kosińska and Leonardo Palumbo, in Chapter 11 on industry engagement, explore the

emerging world of public-private partnerships (PPPs). While it is often asserted that HiAP needs to integrate the private sector into the governance process, there is relatively little agreement on how, or even if, this should be undertaken. The authors reveal the changing landscape in this area and the role of agencies in facilitating this activity as a governance issue.

Limitations

We acknowledge a set of limitations of this study. While this chapter presents the arguments for the study's focus on governance and its focus relating structures to actions, governance is not the only factor influencing action in or on HiAP. Governmental structures, processes and systems that have shaped the conceptualization of the practice of HiAP may relate to various models of democratic and bureaucratic organization, which in turn reflect culture and history.

The conceptual framework is also a limitation, as the list of governance structures is not exhaustive but a starting point based on the literature, and reflects the practice of HiAP that is still evolving. Nonetheless, the aim of this study to break them down into discrete, manageable units was a decision to support a more in-depth analysis of the analytical and policy perspective for each structure. The omission of two of the structures for analysis is noted. The original chapters on public health ministers and ministerial linkages were not completed as planned, and mini case studies were prepared instead as an example. However, while the study maintains the importance of public health ministers and ministerial linkages as governance structures, they have been left out of the analysis given the paucity of material on this structure in comparison to the others included in the study.

Similar to the categorization of the governance structures, the list of governance actions is neither exhaustive nor representative of a commonly accepted list of categories. We recognize that those included in the framework for this study could be further broken down into more, or collapsed into fewer. The categories of actions were recognized by authors and editors as being distinct enough to be assigned to a set of concrete activities under those actions. It is recognized that there is still some overlap amongst categories of actions, which poses a challenge for the specific identification of actions facilitated by structures, as well as challenges regarding the definitions of those actions.

Although levels of governance structures were proposed as an organizational tool for the publication, the analysis of the relationship between structures and actions is open for future inquiry, to examine how structures and actions at various levels interact with other levels from a more macro perspective.

Finally, the limitations of the publication are established by the methodology, the available literature, the conceptual ambiguities and the country coverage. Although a plurality of methods was employed, the book is neither a complete mapping nor a thorough analysis of governance structures or the evolving practice of HiAP. Much of the literature on examples does not necessarily highlight the governance aspects. The conceptual and definitional diversity in how governance structures and actions are treated across the chapters illustrates the lack of consensus on some fundamental concepts and the influence of context in this process. Finally, the country coverage has been limited, but the attempt to include numerous case studies has proved useful to provide a more equitable representation of examples that may not have been documented to date.

Conclusion

As a concept, Health in All Policies continues to gain momentum. A lack of evidence has not stopped policy-makers and governments experimenting with intersectoral governance structures as a means to support the policy strategy of HiAP. The challenge for the future development and critical analysis of this practice is to document the experience, assess the evidence, and compare the effectiveness of different governance structures in producing action on SDoH, and ultimately on population health outcomes.

This publication suggests one possible analytical framework to support the organization of documentation of these experiences and a research agenda. It is our intention that the publication will, on the one hand, provide examples that demonstrate the potential of this framework in eliciting a discussion of the role of governance structures in the achievement and support of HiAP, and on the other, initiate a debate on how the framework may be modified and adapted in order to support further research. It is our desire that the overall objective of this publication has been fulfilled by demonstrating how governance structures are currently being experimented with and how the analyses of these experiences with the use of this framework can promote a more structured approach by policy-makers seeking various mechanisms and methods to address HiAP through governance.

We believe that the distinctive characteristic of this monograph, which sets it apart from many others on governance, is that we illustrate, through theory and practical examples, how governance decision-making actually takes place through its structures. What is revealed is a complicated, perhaps even complex, interplay between structure and agency that allows for the concept of HiAP to emerge. It is not a pretty or easy story to understand, but for anyone who has

worked in government as a member of staff or manager, many of the insights in the chapters, coupled with the case studies, will ring true. It will also leave the reader with an idea of the challenges for further research and discussions in this pivotal area of public health.

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Chapter 2

Synthesizing the evidence: how governance structures can trigger governance actions to support Health in All Policies

Vivian Lin, Catherine M Jones, Anneliese Synnot and Matthias Wismar

Introduction

Health in All Policies (HiAP) is a policy principle to improve population health, addressing factors that reside outside the health system and in policy sectors other than health (Sihto, Ollila & Koivusalo, 2006). HiAP is a new and evolving practice (Kickbusch, 2010; Puska & Ståhl, 2010), building on earlier practices of intersectoral collaboration and healthy public policy, but focused on action in the policy sphere in a more systemic manner rather than applied to single health issues. HiAP has become increasingly important as governments come to recognize the achievement of health and well-being goals, such as the MDGs and Health 2020, requiring a whole-of-government approach. The contribution of this publication is to demonstrate through practical examples the translation of HiAP from a policy principle into a policy practice.

The evidence to support HiAP is often scarce, preliminary or anecdotal. Nevertheless, policy-makers are experimenting with a range of mechanisms to influence health policy and health in other policies. The present study was developed to advance knowledge on how to effect HiAP through intersectoral governance with the objective to help health policy-makers who are building

bridges between different ministries and sectors to take governance action. The chapters present literature and case studies that illuminate how this policy practice is being undertaken within existing or emerging structures that are conducive to its experimentation.

The Adelaide Statement on Health in All Policies (2010) outlines the HiAP approach and identifies the role for the health sector as "creating regular platforms for dialogue and problem solving with other sectors" for joint policy innovation and cross-sector initiatives. As discussed in Chapter 1, governance provides the mechanism for action, through HiAP, on the SDoH. There is a growing literature on governance tools, structures and processes from the study of what governments do when they engage in intersectoral collaboration and dialogue. This body of knowledge examines country experience or focuses on individual tools and structures (Shankardass et al., 2011; Gilson et al., 2007; Ritsatakis & Järvisalo, 2006; St. Pierre, 2009; Wise, 2007; WHO, 1986). The present study builds on this work by using an analytical framework that proposes a relationship between intersectoral governance structures and governance actions (see Table 1.1). By addressing the two dimensions together, the framework both profiles each structure and links it to the action(s) it facilitates (see Table 1.3 for definitions of the governance actions). This framework serves as the conceptual basis for analysing the examples showcased in this publication.

This chapter presents a synthesis of the analyses presented in this publication on how governance structures can stimulate action to facilitate HiAP. A comparison of how the governance structures act as mechanisms across each of the nine governance actions is provided. These actions reflect what was in the case study, rather than the theoretical possibilities offered by the structure. Commonalities and differences in the conditions for effectiveness of the governance structures are discussed. Finally, the practical issues identified in the lessons learned from these examples are summarized. These may be useful considerations for policy-makers to reflect upon when considering available mechanisms to facilitate HiAP, such as the context, the level of political engagement and the policy cycle.

Identification of governance structures

Governance, by definition, involves multiple actors at multiple levels of government. The examples presented in this publication address intersectoral governance arrangements at the government, political and bureaucratic levels; from the level of perspective on funding and financing arrangements; and from the level of engagement beyond government and how governance structures including nongovernment actors contribute to action. The key features and trends identified in the case studies are summarized below.

Ministerial linkages are generally seen as a prerequisite for intersectoral governance action on HiAP. The term frequently refers to working together at the cabinet level, through a variety of structures and processes, and is often used synonymously with "joined-up" government, a "whole-of-government approach" and "horizontal management". It is an emerging development as governments attempt to adopt more coordinated approaches to address persistent and intractable social, economic and environmental problems. It can encompass how members and sectors of government work together at different levels (from national to local), and it can either focus on horizontal collaboration across government within a level or also between them. Ministerial linkages can vary in intensity and duration, as they encompass activity beyond the regular joint decision-making at cabinet level. They can comprise all, or a select number of, ministers and may be based on common objectives of action protocols that focus on a single policy issue or the entire portfolio of the government. Leadership may reside either with the prime minister or another minister. Empirical evidence on ministerial linkages is limited, often because of the difficulty of documenting and researching confidential political processes. This chapter will offer three mini case studies to illustrate some early understandings of how joined-up governments might work in relation to HiAP.

Cabinet committees allow ministers to engage with policy issues of cross-departmental significance and offer a mechanism for ministers to work with outside interests. **Cabinet secretariats** coordinate and facilitate collective decision-making on behalf of all government ministers and directorates to ensure that proper and timely collective consideration of policy is carried out before decisions are taken. While some governments may use more informal mechanisms to facilitate cross-departmental engagement, cabinet committees are recognized for being able to facilitate dialogue and reach agreement on shared policy issues. Based on a scan of cabinet committees and secretariats in Ireland, Scotland, Wales, New Zealand and Australia, Chapter 3 suggests that examples of cabinet committees with an express mandate for health are rare. More commonly, the health minister is a member of a committee, in policy areas such as economic renewal, social inclusion, domestic policy and climate change. Owing to the confidential nature of cabinet committees, the evidence to support their ability to influence governance actions for HiAP is necessarily limited to anecdotes. However, as the highest decision-making body of government, cabinet committees have the potential to make or break HiAP.

While not usually associated with promoting intersectoral governance, parliaments can contribute to HiAP through the formation of **parliamentary committees**. Chapter 4 considers the role of the parliamentary scrutiny process by the United Kingdom House of Commons Health (Select) Committee into

health inequalities. The United Kingdom example suggests that parliamentary committees can have an influence on ministers by raising the profile of a cross-departmental health issue and making recommendations. All-party parliamentary committees encourage a more consensual approach, can enhance the potential influence of findings and can support the longevity of an issue as a political priority despite a change of government.

Interdepartmental committees and units operate at the bureaucratic level and aim to re-orient ministries around a shared priority. Both interdepartmental committees and units are comprised of civil servants; however, committees can include political appointees and units can include those outside of government. The appeal of such committees and units is that they provide a unique forum for problem solving and debate, which in turn lowers implementation costs by involving affected departments in the decision-making. As outlined in Chapter 5, the relevance and roles of an interdepartmental committee or unit are highly dependent on context; in particular the relative political importance of an issue and the level of agreement there is between departments about the issue.

The ultimate aim of bureaucratic reorganizations in the form of departmental/ministry **mergers and mega-ministries** is to improve the ability to mobilize internal resources for health. However, the uncertain payoffs and high costs of such reorganizations mean they require careful consideration. There are few examples of mega-ministries (where entire ministries are merged); it is more common to merge units and shift portfolios to align policy areas. The literature presented in Chapter 6 proposes four mechanisms of reorganization that can support governance action in particular by putting bureaucracy in the service of a strategy to facilitate HiAP.

While Chapter 7 introduces five approaches to **joint budgeting**, all involve some kind of pooling of financial resources. This becomes a particularly attractive proposition within the context of engaging action for health in departments which do not have a dedicated budget for cross-cutting health issues. Chapter 7 outlines examples of joint budgeting, mandatory or voluntary in nature, being used in a range of different countries and contexts. Many joint budgeting initiatives to date have focused on addressing the needs of easily identifiable population groups. Evidence on the effect of joint budgeting on health outcomes is equivocal and mostly related to use of joint budgets for service provision; however, there is evidence to support their ability to help overcome narrow sectoral interests and support the establishment of partnerships.

Whereas joint budgeting is an example of intersectoral funding, **delegated financing** is an example of financing beyond government, usually secured by legislation and distributed to a semi-autonomous statutory body. As the

examples in Chapter 8 illustrate, delegated financing can facilitate HiAP by co-financing arrangements for health and providing funds for intersectoral programmes and projects. Delegated financing, in particular, relies heavily on a comprehensive health promotion infrastructure to stimulate intersectoral action.

While the term **public engagement** is poorly understood and articulated, it has become an increasingly favoured intersectoral activity to promote HiAP. Chapter 9 proposes a conceptual framework to analyse two examples from Canada and the United States. The contributions of this research is that it breaks down the concept of public engagement into five dimensions that allow for a more critical understanding of the controversial use of the term for this governance structure. While it is often used against a backdrop of dissatisfaction at traditional policy-making, particularly in some of the complex public health debates, there is limited empirical evidence to support its use. This chapter supports a better understanding of the forms that public engagement can take and how that may relate to action on HiAP.

Stakeholder engagement is a collaborative governance action initiated by public agencies or institutions that formally includes non-state actors directly in decision-making. Through the example of health conferences in the German state of North Rhine–Westphalia presented in Chapter 10, the practical considerations and potential positive outcomes are suggested via an analysis of these conferences as collaborative governance networks. While stakeholder engagement offers the opportunity for cross-sectoral policy-making, the topics selected for discussion are often of regional and local significance.

Industry engagement, in the form of public-private partnerships (PPPs) in health, is a relatively new and somewhat contested governance mechanism; nevertheless, the establishment of PPPs as non-state actors who combine industry, government and civil society interests are increasingly common. Chapter 11 draws on the EU Platform for Action on Diet, Physical Activity and Health as an example of how PPPs are being used as a policy tool for governance. The chapter refers to two main models in the literature that characterize current practice and the establishment of PPPs as governance structures that create relationships between industry and the public sector. PPPs often develop to meet a particular health challenge and generally seek to improve some aspect of health infrastructure. The chapter raises a number of issues that merge issues of governance action on HiAP with the governance challenges for PPPs themselves.

This publication does not suggest that the intergovernance structures identified and presented here are all necessarily new configurations within government

or institutions. However, while many of the governance structures discussed in the publication are not new concepts, it is the way in which they are being used to facilitate the policy practice of HiAP that is innovative and promising. **Parliamentary committees** of inquiry in the United Kingdom introduced departmental scrutiny after it was recognized that there was an imbalance of power between the executive and Parliament. Thus, parliamentary committees are emerging as a part of parliamentary procedures and processes, recognized as structures equipped with power and resources to look beyond the relevant health departments to explore health inequalities and assert influence in intersectoral governance actions. Similarly, **cabinet committees and secretariats** and **interdepartmental committees and units** are not new governance mechanisms in public health. However, cabinet committees are increasingly being replaced with more informal means of interdepartmental communication. Interdepartmental units and committees remain in high use by governments to facilitate intersectoral governance, though they are rarely visible to the outsider. Mergers of ministries into **mega-ministries** remain more popular in theory than in practice, and there is an inadequate evidence base for this kind of reorganization. Although smaller moves of units or policy areas merging into other units or ministries are common, they are rarely employed as an intersectoral governance mechanism, other than in Australia.

Joint budgeting has historically been neglected as a governance structure in light of the customary approach to working in vertical silos and guarding fiscal territories. There has been increasing experimentation with joint budgeting, particularly in the United Kingdom and Sweden, with increasing focus on evaluating its success. **Delegated financing** is a relatively new development in relation to the use of "sin tax" to create statutory authorities to fund health promotion and preventive health programmes. Following the Framework Convention on Tobacco Control, an increasing number of countries can be expected to increase tobacco tax and to delegate the expenditure of these additional funds to bodies outside the ministry of health.

Deliberative democracy and multistakeholder engagement are all evolving concepts and practices in public policy. The challenge is to have a continuous process of engagement, rather than one-off events for consultation. **Public engagement** has been highlighted in successive health promotion charters and is increasingly being perceived as an essential ingredient in successful intersectoral governance initiatives for health to account for lay knowledge and the public's voice on needs, values and preferences. **Stakeholder engagement** has been gaining momentum in Germany in the form of health conferences since the 1980s, being enshrined in law in North Rhine–Westphalia in 1997. Of all the governance structures, **industry engagement** is perhaps the newest

concept, but with the rapid growth of PPPs for vertical health programmes, there has been global support for it, being endorsed in the Bangkok Charter (WHO, 2005) and the recognition of PPPs by the United Nations.

Addressing the governance actions

The logic behind this publication is that population health improvement is produced by governance action on SDoH, which are in turn produced through intersectoral governance structures.

The governance actions facilitated by each governance structure as covered in the case study chapters are presented in Table 1.3.

The governance actions seen through these structures, as described in the case studies, offer some pointers about what structures might be useful, or effective, in leading to which types of actions. To complement the visual representation of this analysis in Table 2.1, a more detailed discussion of the types of governance structures that trigger each one of the nine governance actions is outlined below, pointing to specific examples offered in the chapters in Part II.

Evidence Support

The example of the United Kingdom Health Select Committee (HSC) into health inequalities shows that **parliamentary committees** can contribute to evidence support. Parliamentary inquiries call for and collate anecdotal and expert evidence on a health issue, and can question the evidence base and methodology used in government programmes. A unique aspect of the evidence support facilitated by parliamentary committees is the variety of sources of evidence, including both written and oral evidence, as collected in the 11 expert witness sessions preceding the HSC report. In the case of the Australian Auditor-General's report (mini case study in Chapter 4), the evidence also included perspectives from local government communities and Aboriginal community organizations. The approach of the HSC across parties encouraged a more consensus-based approach to evidence that can influence wider support for a broader approach to action through intersectoral policy. Evidence support is also a function that is fulfilled by **interdepartmental committees and units**, though more commonly by a unit than a committee. According to a literature review presented in Chapter 5, these functions can include collecting existing information, commissioning or performing research, engaging in public debates or informing ministers. Interdepartmental units can contribute to all four of these functions by serving as a forum for aggregating information and evidence. The mini case study in Chapter 5 from Slovakia provides an example

Table 2.1 *Overview of how intersectoral governance structures may address governance action to support Health in All Policies*

			Governance actions								
			Evidence support	**Setting goals & targets**	**Coordination**	**Advocacy**	**Monitoring & evaluation**	**Policy guidance**	**Financial support**	**Providing legal mandate**	**Implementation & management**
Intersectoral governance structures	*Government level*	Cabinet committees and secretariats		√	√	√					
	Parliament level	Parliamentary committees	√			√	√	√		√	
	Bureaucratic level/ (civil service)	Interdepartmental committees and units	√		√	√	√	√			√
		Mega-ministries and mergers			√						√
	Managing funding arrangements	Joint budgeting			√				√		√
		Delegated financing			√	√			√	√	√
	Engagement beyond government	Public engagement	√	√		√		√			
		Stakeholder engagement				√		√	√	√	
		Industry engagement			√				√		

of how the interdepartmental committee on road traffic safety contributes to the function of gathering evidence in addition to its coordination role. Finally, according to the literature review for Chapter 9, the experiential knowledge of citizens, as generated by **public engagement**, is considered a legitimate kind of evidence that can help to find innovative solutions to collective problems. The conceptual framework proposed in Chapter 9 underlines that challenges to the use of evidence generated by public engagement are highlighted in the level of the decision proximity and the degree of inclusiveness and structuring of the public involvement. The evidence support may remain symbolic, as it is difficult to synthesize such a variety of contributions.

Setting goals and targets

Joined-up government, in its various forms, can potentially support action to jointly define and agree on goals and targets, and this kind of action may be seen in the resulting "package deals" emerging from policy bargaining on

indicators and monitoring. Setting goals and targets is considered an essential component of a **cabinet committee** meeting. According to the analysis in Chapter 3 of cabinet committees from four jurisdictions, the very purpose of cabinet committees is integrally linked to the establishment of and agreement on goals and targets. Specifically, they allow for the prioritization of goals and targets. In the mini case study from the South Australian experience in Chapter 3, the Executive Committee of the Cabinet provides an opportunity to explore the interrelated connections between the targets of South Australia's Strategic Plan (SASP) with regard to HiAP. Based on the literature review for Chapter 9, a common outcome of **public engagement** is to reach agreement on, or to identify, goals and targets for a particular health issue. This action depends on the timing of the public involvement in the policy cycle and the level of involvement, as shown by the examples of the Strategic Meeting on Health in Canada and Healthy People 2020 in the United States. Public engagement can create an opportunity for citizens to contribute to the setting of goals and targets and provide a mechanism for their voices as important stakeholders to be included in the finalization of goals and targets.

Coordination

From the experiences and analyses presented in this volume, coordination emerges as the most frequently cited governance action common to a majority of the governance structures. High-level government agreements that underpin joined-up government can decrease fragmentation and duplication of actions to support increased synergy across ministries through coordination of practical arrangements. The signature of a Memorandum of Understanding between five ministries in Albania to establish a high-level coordination mechanism for the national Food and Nutrition Action Plan, presented in the following mini case study, shows how ministerial linkages can support coordination as an intersectoral governance action.

Cabinet committees allow for better cross-sectoral coordination of planning, and may be particularly effective in facilitating coordination across "social" departments such as health and education, and in building cooperation on difficult and complex policy issues of high political importance. According to the anecdotal evidence in Chapter 3, they are also promising mechanisms to work on problems that are challenging cross-departmental problems, such as homelessness and disability. The same chapter's case study from South Australia points to the capacity of cabinet committees to support joint reflection on policy and work collaboratively to identify issues and coordinate decisions. According to the framework presented in Chapter 5 for understanding intersectoral governance problems in light of different types of coordination

Joined-up government: the Food and Nutrition Action Plan in Albania

Trudy Wijnhoven and Ehadu Mersini

Five ministries in Albania formally agreed in June 2010 to take joint intersectoral action to improve the nutritional situation of the Albanian population. Through a signed Memorandum of Understanding on Malnutrition, the Ministry of Health, the Ministry of Agriculture, Food and Consumer Protection, the Ministry of Education and Science, the Ministry of Labour, Social Assistance and Equal Opportunities and the Ministry of Finance committed themselves to take joint, intersectoral action to improve the nutritional status of the Albanian population to reach the MDGs, to establish a national, sustainable, coordinating mechanism at the highest level of decision-making with the participation of the signatory parties and to work jointly in drafting and implementing a national intersectoral Food and Nutrition Action Plan. The Ministry of Health led the preparation and consensus agreement of the Memorandum of Understanding by organizing meetings with representatives from the other ministries bilaterally and in group meetings to discuss drafts of the Memorandum, the nutrition problems to be tackled and the possible solutions. This process was supported and technically guided by WHO, the United Nations Children's Fund and the Food and Agriculture Organization of the United Nations through the United Nations Joint Programme on Nutrition in Albania, which was funded by the Spanish MDG Achievement Fund for Children, Nutrition and Food Security. At the invitation of the Ministry of Health and the Ministry of Agriculture, Food and Consumer Protection, after the signature of the Memorandum focal points were nominated by the five ministries to take part in an intersectoral interministerial working group to evaluate the implementation of the current plan and formulate a new Food and Nutrition Action Plan. This working group was formally established before the summer of 2011.

issues, an **interdepartmental committee** can contribute to coordination between sectors in a low-conflict situation, where coordination is an obvious need and problems and resources are already clearly identified. This reflects the recognition that the bureaucratic level is best situated to deal with coordination, including the allocation of responsibilities and ensuring processes to resolve differences and build trust to promote intersectoral working. However, in a high-conflict situation, interdepartmental committees are only likely to coordinate if there is clear political demand for resolution of an issue or if it is a part of a larger political process working on the issue. The mini case study in Chapter 5 from Finland cites a number of interdepartmental committees that function mainly as coordination mechanisms between ministries. **Mergers** encourage cooperation by realigning departmental units to work together. In this regard, reorganization becomes a mechanism for coordination, whereby the bureaucracy is put in the service of coordinating a strategy. According to

the literature reviewed in Chapter 6, this strategy does entail incurring high transition costs, and difficulties in finding a "neat" fit for all previously existing units, thus rendering coordination payoffs uncertain. However, the mini case study from Hungary in this chapter presents the creation of three umbrella ministries, which are comprised of multisectoral but interrelated administrative interests, to coordinate action such as the harmonization of policies and services and the mobilization of resources as an administrative structure to support intersectoral governance for human development, economic development and national development.

Joint budgeting has been shown to promote collaboration between departments by widening the area of interest and responsibility of stakeholders, particularly when clear institutional and legal frameworks to support partnership in budgeting activities are in place, according to the literature review in Chapter 7. Joint budgeting can contribute to collaboration by developing a common working culture between partners, particularly in the case of voluntary arrangements, as seen in the mini case studies from Sweden and Vienna in Chapter 7. Joint financial management arrangements can also help foster coordination through the development of joint services and a more integrated approach to activities. The mini case study from Sweden provides an excellent example of how joint financing supports an integrated approach to services, in particular at the local and regional levels. While not a primary outcome, **delegated financing** can also result in improved coordination given the unique position of these kinds of bodies at the interface between state, civil society and the private sector. Based on Chapter 8's review of four delegated financing bodies in the United Kingdom, Australia, Switzerland and Austria and the mini case study from Singapore, they have been shown to have the potential to serve as mediators and "bridge-builders", given their links to government and the representation of relevant stakeholders on their boards, the diversity of which can be seen in the examples in Table 8.4.

Industry engagement provides a mechanism to establish a culture of cooperation between private, public and civil society actors that can result in coordination of activities pertaining to respective interests on common issues of importance. The mechanisms provided by this structure, namely PPPs, are discussed in the synthesis of the literature review in Chapter 11 and via the example of the EU Platform on Diet, Physical Activity and Health, focusing on the intersectoral and industry interests related to the issue of obesity. These structures provide an opportunity to coordinate the commitments of industry and economic actors alongside public and intergovernmental actors, as shown by the mini case study on the EU School Fruit Scheme. They provide platforms for the coordination of regulation and shared responsibility with regard to

issues in which all actors have vested interests, such as in the mini case study on the Vision Zero road traffic policy in Sweden.

Advocacy

It is suggested that **cabinet committees** can be influential advocates, as they enable the political system at government level to engage with an issue. The capacity for cabinet committees to facilitate dialogue can raise the profile of an issue, as presented in the discussion on the impact of cabinet committees in Chapter 3. The common scenario of leadership from the prime minister's office for cabinet committees can promote access to advocate for change or increased attention to a policy area. Parliament can be an important advocate for intersectoral governance. A **parliamentary committee** can raise the profile of a cross-sectoral health issue and can endorse the importance of tackling an issue through a report from a parliamentary inquiry. The HSC inquiry in the United Kingdom shows that parliament can be an advocate for intersectoral governance and the practice of HiAP. In this way, the scrutiny process can stimulate debate and discussion, leading to the inclusion of the issue in the scope of parliamentary action, its mainstreaming across the media, and its inscription into a broader public debate and within a variety of policy networks for action, as seen in the Australian case study in Chapter 4.

An **interdepartmental unit** can also contribute to advocacy, as long as it is working on relatively non-contentious issues or has strong political support. The essential contribution of an interdepartmental unit to advocacy is the energy and momentum it can provide to the advocacy effort, as per the literature review in Chapter 5. In this regard, for issues of low salience, interdepartmental units can be very useful, as it is likely that the issue is not receiving energy from others; for situations of low conflict with highly salient issues, interdepartmental units' contributions to advocacy are likely to be very successful. In this regard, the example of the French National Public Health Committee in Chapter 5 is illustrative of the advocacy role that interdepartmental arrangements can have, in that the committee is a unique forum wherein many departments can benefit from information and be educated on the SDoH.

The reduced proximity to governmental priorities means that organizations or agencies funded by **delegated financing** can advocate for social change, as discussed in the literature and lessons from the examples in Chapter 8. Their independent status permits greater opportunity for advocacy in experimenting with innovative or controversial ideas due to their distance from political and administrative constraints. Since these groups can also engage experts, parliamentarians and the general public, they also serve as a facilitation

mechanism for feeding back experiences from practice on the ground to the political level.

Finally, engagement beyond government is a critical area of governance structures that can trigger advocacy action. According to the literature review in Chapter 9, **public engagement** can contribute to HiAP by supporting the development of public commitment to the health promotion agenda and by offering a means to empower the public to advocate for change. Public involvement can provide a mechanism for inducing change based on information to raise awareness of health implications of policies to enhance public dialogues. Methods of public engagement such as consultation and participation can contribute to advocacy by capturing a sense of the public's values, needs and preferences and actively involving them in the content of the policy-making process as a basis for public deliberation of issues as part of an advocacy process. Finally, **stakeholder engagement** through collaborative networks such as the health conferences described in Chapter 10 are in some cases linked to advocacy, since they can provide opportunities to give local health issues a voice and a platform to attract interest for political action. This chapter's mini case study from Esbjerg, Denmark, provides one such specific example with an explanation of how reaching out to stakeholders was useful for advocacy on a municipal health policy by supporting a better understanding of the need to develop an intersectoral health policy and by ensuring the future acceptance of such a policy across sectors.

Monitoring and evaluation

Joined-up government can potentially provide a structure through which strategies for monitoring cross-cutting policies can be developed and agreed upon based on indicators for evaluation. In Serbia, thirteen ministries are represented on the Council for Tobacco Control, a body established to monitor the country's action plan as part of its Framework Convention on Tobacco Control (FCTC) commitments.

Parliamentary committees of inquiry can underscore the necessity of monitoring and evaluating the government's responses and actions with regard to intersectoral governance and health issues, and in doing so stimulate support for evaluation efforts. Specifically, the HSC contributed to the call for the increased and improved use of evaluation of interventions to reduce health inequalities. Furthermore, given that parliamentary committees provide a bridge between the legislative and executive branches of government, they can also provide alternative perspectives to reconcile long-term and short-term goals and suggest evaluation as a means to improve planning. Finally, parliamentary committees can use the action of monitoring and evaluation

Joined-up government: the Tobacco Control Action Plan and the Council for Tobacco Control in Serbia

Kristina Mauer-Stender

The FCTC (WHO, 2012) was ratified by Serbia in 2006. As part of its commitments under the treaty, in 2007 Serbia adopted the Tobacco Control Strategy for the period to 2015 and the Action Plan for Tobacco Control for the period to 2011.

The implementation of the Action Plan was entrusted to the Office for Tobacco Control within the National Institute of Public Health, and the effectiveness of the implementation of the Action Plan was monitored by the Council for Tobacco Control, founded by the government of Serbia in April 2006. The Council was established as an initiative of the Ministry of Health, as a multisectoral body composed of representatives of ministries relevant for tobacco control, health professional organizations and international organizations with the status of observer (WHO, UNICEF). A large number of ministries are represented and contribute to the work of the Council: Trade and Services, Environment, Mining and Spatial Planning, Agriculture, Forestry and Water Management, Justice, Labour and Social Affairs, Culture, Internal Affairs, Education, Finance and Youth and Sport.

The example of the Council for Tobacco Control is unique in the region and its work has proved to be effective as smoking prevalence among adults is decreasing in Serbia.

as a means to increase the accountability of the executive for related actions and policies. As the mandate of an **interdepartmental unit** is to drive and lead a policy issue, they can contribute to monitoring. Monitoring is best situated as an action resulting from an interdepartmental unit's functioning, but an interdepartmental committee may also coopt the member departments' resources to support monitoring and evaluation.

Policy guidance

Parliamentary committees can help to set the agenda for government to respond to a health issue by delivering practical solutions through recommendations and policy guidance. The United Kingdom experience demonstrates that parliaments can develop scrutiny processes that facilitate their engagement in policy debates separate from the interests of government. **Interdepartmental committees and units** can also provide policy guidance, but this action is best generated by these structures when the problem is of a more technical, rather than political, nature. The mini case study in Chapter 5 from California presents an example of policy guidance through recommendations issued by the California Health in All Policy Task Force to support collaborative state government for priority policies and programmes, while promoting health and sustainability. **Public**

engagement can also lead to policy guidance, and the literature highlights that this is particularly the case with respect to what policy options are politically, socially and ethically sound. The ability for public involvement to trigger policy guidance is intimately linked to the stage of the policy cycle in which the public is engaged as well as to the dimensions of engagement such as the mechanism, level of involvement, the degree of inclusiveness and the decision-making proximity, as illustrated by the two examples from Canada and the United States in Chapter 9. **Stakeholder engagement** can contribute to policy guidance for cross-sectoral policy-making through health conferences serving as policy networks in which specific recommendations for action are proposed, as shown in Chapter 10. This chapter's mini case study from the Republic of Moldova also illustrates how stakeholder engagement, including international support, was successful in providing policy guidance for the country's Alcohol Action Plan.

Financial support

Governance mechanisms relating to financial arrangements can all contribute to financial support for HiAP. **Joint budgeting** has been shown to promote greater flexibility in the way funding is used, can increase the funds available for a single policy issue and can stimulate shared financial incentives to achieve HiAP. The case study from Vienna in Chapter 7 provides an example of how joint financing between the health and urban planning sectors provided an opportunity to create flexible structures that facilitated synergistic intersectoral partnerships to promote the health, mobility and quality of life of the aging population. The strength of **delegated financing** lies in the systematic application of the co-financing principle, which can substantially increase available funds (see Table 8.1). Delegated financing does provide an opportunity to enable intersectoral allocation of funds for programmes and projects as per the examples presented in Table 8.2. Health conferences are an example of how **stakeholder engagement** at the regional level can have a positive impact on creating financial support for prioritized health issues and the achievement of health targets. Finally, **industry engagement**, through PPPs, can provide greater financial support for projects, in addition to non-financial support, as shown in Chapter 11's mini case study on the example of the Mid-America Coalition on Health Care in the Kansas City region. Whilst the literature reviewed on PPPs generally supports the idea that these structures can help to bridge resource gaps and provide investments, the analysis of the EU Platform in Chapter 11 presents a more critical perspective of the challenges and resource implications for different kinds of actors (large private firms versus smaller NGOs) as regards the distribution of resources and capacity to contribute.

Providing a legal mandate

Joined-up government, by definition, can provide a mandate for enabling intersectoral governance. The provision of a legal mandate is one of the important outcomes in that this horizontal governance structure establishes the foundation and legitimacy for a range of practical arrangements to facilitate intersectoral governance, as shown in the mini case study from Albania presented earlier in this chapter. Additionally, the following mini case study on the Finnish Government system illustrates how ministerial linkages, through a web of mechanisms to extend policy development and implementation across the boundaries of ministries and government administrative areas, creates a legal mandate for high-level, ministerial intersectoral governance practices.

Parliamentary committees can support the establishment of a legal mandate by ensuring that policy debates are considered outside of the context of government and securing a role for parliamentary contribution to policy debates in addition to that of ministers or academic experts and elites. This can facilitate a legal mandate by ensuring cross-party ownership of an agenda, such as social justice, and can support the transition of the mandate and the agenda

Joined-up government: the Finnish Government system

Juhani Lehto

The Finnish Government, its ministries and state administration have created a web of mechanisms to extend policy development, policy preparation and policy implementation across the boundaries of the ministries or other governmental administrative sectors. The history of these mechanisms includes goals and aspirations such as improving financial control by the Ministry of Finance over other ministries, extending state security policies to ministries other than the Ministries of the Interior, Defence and Foreign Affairs, or coordinating and harmonizing the information management systems of the whole public sector. There have also historically been attempts to develop whole-of-government policies across administrative sector boundaries on issues such as the environment, EU policies, urban policy, rural policy and employment policy.

A particular Finnish pattern might be the permanent and temporary ministerial committees on issues such as foreign policy, macro-economic and financial policy and social policy, in order to allow ministerial representatives of all the parties of the multiparty governments to participate in the core political preparatory processes of the high-level government policies.

At the level of the members of the government, the ministers, the Minister of Health and her core staff for health promotion policy, the interministerial tools to enhance health promotion policies in other ministries are:

- the official decision-making sessions and (particularly) the unofficial preparatory sessions of the whole government
- the permanent ministerial committee on social policy
- the temporary ministerial working group which has been set up until the next election to guide the whole government policy programme on health promotion.

At the next level, there is the regular meeting of the permanent secretaries of state of all ministries, which deals with coordination of the preparation and implementation of government policies.

[This mini case study is the first of two parts. The second part can be found in Chapter 5: Interdepartmental committees: the Finnish Government system].

between governing parties. **Delegated financing** is often legislatively secured (see Table 8.3) and as such can facilitate statutory mandates with regard to financing and stakeholder engagement. Based on the discussion of the example of health conferences in North Rhine–Westphalia, **stakeholder engagement** requires a legal mandate for some activities to fully realize its potential for intersectoral action on health. Participating stakeholders are involved on the basis of their own legal mandates and further, the structure for engagements such as health conferences have a legal mandate in their own right. This supports the legitimacy of recommendations for public policy-making emerging from these structures, given their necessary links to existing structures of the political system.

Implementation and management

Interdepartmental committees provide a mechanism for convening departments from multiple sectors to report on and coordinate implementation. While departments and agencies implement, the interdepartmental committee serves as a place where implementation questions can be addressed with respect to a specific cross-sectoral agenda. This is seen, for example, in the mini case study in Chapter 5 from France, where the National Public Health Committee serves as a steering committee for the implementation of some national plans. The case study from Hungary in the same chapter provides an example of the Interdepartmental Public Health Committee that serves as an operational body for the implementation of intersectoral programmes. The advantage of **mergers and mega-ministries** is that they can focus bureaucracy in the service of a particular policy issue and reinforce the connections between a government strategy and how the prioritization of that strategy translates into implementation. An example of the opportunities for

implementation and management through a consolidation of services and data is developed in the mini case study in Chapter 6 on South Australia's Department of Human Services, illustrating how mega-ministries can serve as a mechanism for implementation and management. **Joint budgeting** arrangements can support implementation particularly with regard to the implementation of joint services; nevertheless, this is highly dependent upon the temporal nature of legal and financial frameworks to secure and manage the resources. Co-financing via **delegated financing** can foster ownership and sustainability, resulting in creative approaches to planning, implementation and management such as in the example from VicHealth (see Box 8.2). Further, the review of the four delegated financing bodies in Chapter 8 points to quality of the linkages between delegated financing bodies and government to support good governmental stewardship that may have a beneficial impact on implementation and management without government domination of the activities and programmes.

Conditions for effective intersectoral governance

A range of factors influence whether a governance structure is successful in facilitating intersectoral action. Some of these factors, or conditions for effectiveness, are common to a range of governance mechanisms, while others are particular for a single mechanism. These conditions for effectiveness can be divided into eight main themes: political will, partnerships and constituents' interests, leadership, the political importance of the issue, the immediacy of the problem, context for effectiveness, resources and implementation practicalities. These eight categories of factors are discussed below, with a focus on which specific governance structures are affected.

Political will

Reflecting the need for ministerial instigation or attendance, **cabinet committees** and **parliamentary committees** all inherently require political will. Without a high level of political will and engagement these governance structures cannot exist. For bureaucratic structures, such as **interdepartmental committees and units**, political will is not an essential requirement; however, the presence of political support or interest (such as the request for regular ministerial briefings) enhances their ability to remain active and relevant. In this regard, political will as a condition for effectiveness was explicitly identified and mentioned for the government, parliament and bureaucratic levels in which intersectoral governance structures operate; however, it was less prominent as a factor in the cases presented addressing the management of

funding arrangements and engagement beyond government. Nonetheless, the extent to which these broader engagements with nongovernment interests have an impact on policy developments depends on political acceptability, political attractiveness, and political will.

Partnerships and constituents' interests

Partnerships within government and outside government depend on mutual interests and personal relations, as well as on the authorizing environment. Joined-up government can be enhanced by natural or cultivated affinities with other policy fields, and familiarity with other policy fields as well as personal interests may serve as enabling factors. The quality of linkages between partners in **delegated financing** has an impact upon the stewardship of the organization: the appropriate oversight of, and engagement by, government may help to prevent fragmentation of governance. Similarly, the partners involved in **joint budgeting** all need to perceive that it is in their own best interests to be involved. Joint budgeting should take into account how the partnership arrangements cultivate trust across the various institutional cultures. Health partners must recognize the importance of non-health goals to non-health partners and develop an economic case for action.

Governance structures operating outside the government or bureaucratic levels still require the will and engagement of the various partners and stakeholders involved. Categories of governance structures that reach beyond government to involve non-state actors, such as **public, stakeholder and industry engagement**, suggest the need for the support, commitment and interest of parties represented within each respective group. It has been recognized that **industry engagement** works better when there is also community engagement and civil society participation in the PPP process. One way to secure the interest of all parties in **stakeholder engagement** is to ensure there are enough incentives for all stakeholders to want to participate, and these incentives may in part respond to correcting potential power/resource imbalances that would otherwise challenge participation. A collaborative forum should provide an exclusive venue for stakeholders to address important issues. The dimensions of **public engagement** point to issues beyond interests of participants, but include how those interests are channelled and introduced in terms of how, when and at what level the public's participation is sought and, most importantly, the degree of inclusiveness of their involvement and the proximity to decision-making. Public engagement usually engages participants on previously defined interests related to a policy question.

Thus it appears that across all levels of structures, there are important issues to consider with regard to power asymmetries. While partnership and

constituents' interests are endorsed by many of the case examples as being important conditions, all parties do not embrace partnerships equally. Many of the challenges relate to the mechanisms or arrangements for dealing with hidden agendas and potential conflicts of interest and for negotiating the basis of partnerships. A place for partnership in intersectoral governance is key, but how partners contribute to the information and resource base for decisions may be more hierarchical than horizontal.

Political importance of the specific health issues identified

The political importance of the policy issue is a key consideration in selection of governance mechanism, particularly for those mechanisms requiring political will. **Cabinet and parliamentary committees** are primarily set up in response to politically important issues, where widespread support for action is required. **Parliamentary committees** can be influential in fostering cross-party ownership of an issue like health inequalities and help maintain momentum on the issue even with a change of government. In the case of **cabinet committees**, the issue must also be difficult and require in-depth discussion, with the need for action by two or more government departments.

While **public engagement** is best facilitated by "high decision proximity", that is when public engagement is directly related to a decision on a policy question or policy change, "low decision proximity" can still be useful to initiate reflection and plant a seed in the mind of policy-makers with regard to the public's expressed needs or wants. **Public engagement** most commonly occurs early in the policy cycle, in the agenda-setting or policy formulation stage.

Immediacy of the problem

Both **joint budgeting** and **industry engagement** are good options for immediate problems. While long-term sustainability is a challenge for joint budgeting, these options are frequently employed for short-term projects. Industry linkages, however, are usually formed around a particular health issue, thus they can develop quickly. **Parliamentary committees** usually require a time-limited response from government to their findings, which suggests they provide solutions in the short-to-medium term. **Cabinet committees,** however, offer more long-term solutions across different sectors, and depending on the nature of the policy or investment decision may extend beyond the term of a government.

Leadership

Leadership may be either political or bureaucratic, and is distinguished from leadership that might be associated with the political importance of the problem mentioned above. Leadership may be vested in the roles and responsibilities for individuals and/or groups, including leading the process and resolving issues. It may also be seen through the influence exerted by individuals or teams across organizational or network settings. The establishment of **cabinet committees** requires strong leadership from the prime minister's or highest government official's office in order to provide both the structure and terms of reference as well as a supportive rationale to allow for the consideration of broad policy options of cross-departmental significance. Similarly, **mergers and mega-ministries** require good leadership and a strong minister to manage change. When the merger comes with an identifiable policy strategy supported by an identifiable leadership (body or person), it is more likely to be effective. Leadership is considered the single most important aspect for **stakeholder engagement,** in particular in order to successfully manage tensions and mediate conflicts in the network to maintain ongoing dialogue and collaboration between competing interests. Careful consideration needs to be given to possible power imbalances between stakeholders to determine who is more appropriate to lead the engagement process. Power and resource imbalances have the potential to derail stakeholder engagement. Finally, clear and managed governance structures with defined roles and responsibilities are imperative for effective **industry engagement**.

Context

The broader context in which the governance structure is being implemented is worthy of some consideration. The examples of contextual conditions raised in the case studies reflects the potential for alignment of interests. Context in this case not only refers to the political landscape, but also to the situational landscape – such as focusing events, policy images, and internal or external shocks at a point in time – that creates a window of opportunity for effecting intersectoral governance structure and action.

In the example of the Health Select Committee as **parliamentary committee**, context assisted their scrutiny process as it took place at the same time as the media picked up on several other influential reports into health inequalities, helping promote health inequalities as a mainstream political issue. The preferred political context for a substantial **merger or mega-ministry** is in the aftermath of a perceived policy failure, when coordination problems between departments are significant and more bureaucratic than political. Smaller

moves of units in and out of other policy areas or ministries are widespread, and these unremitting reorganizations are frequently disappointing in terms of their capacity to improve intersectoral coordination and policy. This contrasts with **interdepartmental committees and units** that are best suited to facilitate intersectoral governance when there is low conflict between departments and the issues are of high political importance. Questions remain as to the extent to which they are suited to address high- and low-conflict issues when they are of low political importance. In issues with high political importance and high conflict with departments, these units and committees may contribute to clarification of issues, but resolution depends on the political will.

The need to tailor **joint budgets** to different contexts and institutional arrangements reflects the fact that they are better implemented at the local level. There are few examples of joint budgets at the national level; the specific approach to joint budgeting is highly determined by the local context. Financial mechanisms such as **delegated financing** are also susceptible to economic downturns; however, creative responses in these times can mitigate possible impediments in the mobilization of funding.

The level of involvement (information, consultation or participation) and the level of inclusiveness (self-selection, random selection or purposeful selection) are important considerations for assessing **public engagement**. However, its specific effects on governance actions and outcomes are difficult to interpret. The legitimacy of the recommendations emerging from **stakeholder engagement** can be reinforced by the links to the structures of the local political system.

Resources

The idea of resources as a condition goes beyond the issue of implementation practicalities, and refers to the costs of supporting and sustaining the operations of intersectoral governance structures. Resources constitute a condition because recognizing the direct and indirect costs for supporting structures is an important commitment to be made to ensure the effectiveness of governance structures. At a minimum, the transaction cost is an unavoidable aspect to consider with regard to their feasibility and capacity to fulfill their objectives. **Mergers and mega-ministries** are associated with significant costs, and this with the caveat of uncertain payoffs. In essence, reorganization of a system is an expensive endeavour. Alternatively, **joint budgeting** may in fact be fostered by demonstrating an economic case for action, wherein ministries may be able to provide more detailed information on costs and benefits related to joint programmes for each participating sector as a justification and incentive for intersectoral governance.

Resources may be a particularly important condition, particularly for those intersectoral governance structures that seek engagement beyond government, as the cost of supporting these structures is over and above that of supporting the standard structures in government and bureaucracy that exist irrespective of their governance objectives. Furthermore, resourcing also represents an important symbolic measure of the government's intention for genuine **public, stakeholder and industry engagement**. This is implicit in the discussions in Chapters 9, 10 and 11 relating to the cost of supporting health conferences, that of organizing and supporting public engagement processes, and the disparity of costs for participating in and supporting a PPP, which are disproportionately experienced, with a much higher burden on NGOs than big business. Funding for these structures is vital for their existence and therefore in some way linked to their potential effectiveness for triggering action on HiAP.

Implementation practicalities

There is a range of practical issues to consider when implementing a governance structure. **Interdepartmental committees**, for example, need to happen in concert with other interdepartmental activities (such as copying other departments into correspondence) to reinforce the links between departments. **Interdepartmental units** need to be credible allies to at least some interests within the affected sectors. A combination of units and committees within the context of a political mechanism such as a ministerial committee should be a powerful and effective combination. **Mergers and mega-ministries** work better when the merged units are not too organizationally different and when a smaller unit is merged into a larger one, and in the process submits to the policy directions of the larger unit. Ensuring the support of an effective group of civil servants within the relevant government departments, including but not limited to an efficient **cabinet secretariat**, is critical to the optimum functioning of a standing **cabinet committee** in terms of its ability to facilitate dialogue on identified matters of cross-departmental importance.

The nature of personal interactions, without personal tensions, and the need for dedicated staff is particularly important with **interdepartmental units**. Similarly, voluntary involvement in **joint budgeting** is more likely to be sustainable as a governance structure in the long term. Additionally, measures to strengthen trust and social capital between stakeholders may be necessary to facilitate cooperation in **stakeholder engagement**. The starting point for joined-up government may affect the outcomes of intersectoral actions in terms of whether there is shared vested interest (win-win situations), neutral interest or a conflict of interests establishing the basis for horizontal policy management at government level.

Structural parameters make a difference, too. The institutional design of **stakeholder committees,** including such facets as procedural legitimacy and basic protocols, along with cyclical, iterative interaction, is considered important. Within the financial mechanisms, good accountability mechanisms, clear legal and financial frameworks, outcome indicators for joint policy goals and shared performance incentives are important for **joint budgeting**, whereas adequate funds are required for **delegated financing** to make an impact. Furthermore, structural parameters (type of sector addressed and time frame) influence investment through **delegated financing**,

Lessons

Intersectoral governance to facilitate action that supports HiAP is an evolving practice. This is evidenced by the chapters in Part II, including multiple mini case studies that provide systematic documentation of a select number of experiences in using different governance structures. Policy-makers at various levels are experimenting with a range of mechanisms within these structures to trigger or sustain intersectoral action. Less formal governance structures such as interdepartmental committees and units are increasingly being favoured, while parliamentary committees for health can look beyond the immediate interests of the health department. There is increasing interest in novel financial mechanisms for facilitating HiAP, while the involvement of external partners, such as industry, the public and other stakeholders, is becoming increasingly commonplace.

What these experiences tell us

While the current evidence does not provide decisive statements on the outcomes and actions that specific governance structures can achieve, it does offer some general lessons and principles that apply. Intersectoral governance actions rarely work in isolation; there is a need for action at multiple levels. Strong leadership (either political or bureaucratic) is required to drive HiAP, particularly within the broader policy environment, where the concept of HiAP may be unfamiliar. However, familiarity with cross-departmental and intersectoral interests in areas other than health may serve as fertile ground for nurturing an interest in HiAP. Political will is imperative in governance structures at the ministerial level, but it is also a supportive factor for governance structures at the bureaucratic and external levels too.

Further, HiAP must be appropriately framed within broader policy imperatives and include a practical action focus. The (implementation) practicalities may present facilitating factors as well as challenges, even when political will

is strong. Issues regarding the clarity of structures, terms of reference and accountability mechanisms are important to consider for ensuring a smooth operational aspect to the implementation challenges facing the day-to-day operations of governance structures. Clear roles and responsibilities can support the emergence of strong leadership within governance structures, whether governmental or departmental. The practical arrangements and leadership can also be mediated by the context in which the governance structure has been implemented. One of the most challenging aspects is that of framing the issue in terms of the immediacy of the problem for action, for it seems that the question of immediacy has implications for the appropriateness and capacity of a particular governance structure to support action in response to the problem.

Finally, from the perspective of the five levels that serve as organizing categories for the intersectoral governance structures, some observations can be made about which structures trigger which actions, based on the experiences reviewed in this publication. Evidence support appears to have the potential to be triggered relatively evenly across government and bureaucratic levels and engagement beyond government. Setting goals and targets is an action triggered by the two poles, government-level structures with some influence from engagement beyond government. Coordination appears to be the action triggered by the widest variety of structures from all levels. Advocacy actions are triggered mainly by government-level structures and engagement beyond government. Monitoring and evaluation are essentially triggered by structures at the bureaucratic level. The bureaucratic level and civil service, as well as engagement beyond government, serve as the key triggers for policy guidance. Financial support is triggered by structures managing financial arrangements and engagement beyond government. Providing a legal mandate appears to be triggered across the levels of parliament, managing funding arrangements and engagement beyond government. Providing a legal mandate, setting goals and targets, monitoring and evaluation, and evidence support are the most sparsely populated actions of the present analysis framework and may present considerable challenges for intersectoral governance structures for HiAP. Implementation and management are triggered by the bureaucratic level and structures managing financial arrangements.

Many of the structures with capacity to trigger intersectoral governance action for HiAP are found in the government, parliament and bureaucratic levels. These three levels have great potential for actions to support evidence, set targets, coordinate, advocate, monitor and evaluate and guide policy. The structures managing financial arrangements have promising potential to trigger partnerships for coordinated action, increase financial support and stimulate implementation of intersectoral programmes on HiAP with links to

managerial and oversight arrangements. The engagement beyond government remains a critical level of intersectoral governance structures with the potential to facilitate action for HiAP, but these areas have particular challenges for research and evaluation, in particular in terms of how they link to the government and bureaucratic levels in a given political and administrative context.

What are the risks and potential abuses of intersectoral governance structures?

The experiences presented and analysed in this publication underline certain considerations regarding what to avoid when considering the implementation of a governance structure. For example, it seems undesirable to rely on a single approach, or a single basis of support, for the implementation of governance structures. First, linking a structural approach with one that also relies on individual champions is recommended, as opposed to reliance on one or the other. In particular, champions and leaders are essential in government, parliamentary and bureaucratic level structures to ensure there is the commitment to use these structures as opportunities for effecting HiAP. Secondly, bipartisan support is desirable, if not ultimately necessary. Thus, ongoing reliance on the orientation of a single party (or single leader) should also be avoided where possible. The case studies highlight the necessity for bipartisan support, particularly at parliamentary level, but also with regard to other levels in government and the civil service, or funding arrangements for which bipartisan support may catalyse efforts to identify common policy issues and foster the development of a common language and understanding. Nevertheless, one must be aware of political trade-offs and the potential for overturning partisan politics that may result in the marginalization of strategies (public health ministers, for example). Bipartisan support can be useful for the continuity and institutionalization of this policy practice.

This list of factors that influence the effectiveness of using intersectoral structures may not be so different from the conditions influencing the use of governance structures in general. This suggests that the use of intersectoral governance structures for action on HiAP can potentially stray from the intended direction and if not dealt with adequately, intersectoral governance may be vulnerable to sabotage or abuse. Mini case studies on ministerial linkages that include either representation from the ministry of health or a focus on health as an issue show how valuable they are compared to ministerial linkages that exclude the health sector's voice or interests and concerns. In the context of European Union policy, the Lisbon Strategy and its successor were heavily criticized for not including health as a productive force and an aim in itself of the development of the European Union and its Member States. Chapter 5 reports on the

interdepartmental committees as one of the most common but also most derided intersectoral governance structures. In many cases these governance structures are susceptible to the suspicion that they are intentionally employed with missions they cannot achieve or with inadequate terms of reference.

The intersectoral argument can potentially be misused with regards to mega-ministries and mergers, discussed in Chapter 6, when a promise of more coherent and efficient policy-making is made yet the underlying motivation is different from that announced publically and might be more linked to coalition strategy. The stature of a minister or a coalition partner is sometimes expressed in terms of the number of units they have under their authority. Health may even be excluded from an intersectoral, horizontal arrangement in a mega-ministry if the responsible minister for health does not have a seat at the cabinet table, and instead reports to another minister. Another risk in utilizing governance structures for health is that health may lose ground or intersectoral commitment. It would be erroneous to assume that a whole-of-government approach will necessarily result in a more conducive environment for intersectoral action in which health will gain attention, support and focus in policy. In establishing a horizontal governance approach, governments might opt to choose alternative cross-cutting values or policy areas as governmental goals. For example, governments may choose order or freedom, and therefore police behaviour or deregulation would be selected, respectively, as policy aims.

Engagement beyond government as an intersectoral governance structure may mask the insufficiency of existing policy tools or may be misused when it is the only acceptable solution for reconciling diverse interests with regard to intersectoral governance action. For example, when looking at the EU example in Chapter 11, questions may be raised regarding the function and role of the state in PPPs as a broker between industry and NGO engagement, possibly due to the inability or reluctance of government to take firm measures to act on obesity prevention. A more critical approach to this kind of engagement beyond government as a governance mechanism might benefit from asking why PPPs are such politically interesting options.

What these potential misuses of intersectoral governance aim to highlight is that power relations lie at the centre of considerations of risks involved in the use of intersectoral governance structures. The underlying relationships of power to both politics and policy are pervasive and inseparable from discussions of governance. This brief set of examples is proposed to raise some of the potential for misuse of intersectoral governance structures that merit attention.

Conclusion

What we still need to know: the research and knowledge translation agenda

The paucity of evidence of the capacity for intersectoral governance as a tool for HiAP is clear, but the specific research and evaluation agenda and the methodological challenges of researching HiAP need careful consideration. Based on the cross-cutting analysis of the experiences collected in this publication, we suggest three priorities.

First, there needs to be continued tracking of experiences of these governance structures, including the impact and outcomes of governance actions. There are some difficulties inherent in doing this when there are issues of confidentiality, political sensitivity, lack of transparent negotiation and implementation processes, etc. For example, there is no written evidence to support the ability of cabinet committees to influence HiAP, due in part to the confidential nature of this structure. This can be contrasted with the relative openness of parliamentary committees, where evidence of parliamentary scrutiny efforts and their reports are on record, thus ensuring public access to information on the workings of this structure and the information collected, even if the political dynamics and dealings may not be captured. The documentation, monitoring and evaluation effort should also consider tracking and analysing experiences that use a combination of approaches and multilevel intersectoral governance structures.

It is well established that coordinated action at multiple levels to promote health is more effective than singular interventions (Richard, Gauvin & Raine, 2011; Green, Richard & Potvin, 1996; Stokols, 1992, 1996); it can be surmised that multiple governance actions may be more effective than singular actions (PHAC & WHO, 2008). Complex social systems certainly require governance arrangements that include multiple levels as well as multiple stakeholders. The analytical framework proposed for this study provides a starting point from which further research may begin. Chapter 1 outlines a number of the study's limitations, and further work on the refinement and modification to the analytical framework through documentation efforts will be necessary to further define and specify the intersectoral governance structures and actions.

Secondly, there is a need for greater understanding of the conditional effectiveness of governance structures. It is noteworthy that the discussion presented in this chapter does not necessarily broach the relationships between these conditions for each governance structure. The case studies presented in this publication reflect particular contexts and combinations of events, people, political histories and structures. To what extent these structures are replicable

is not known, but understanding the contexts within which they are effective may point to useful lessons for other countries. The contextual dimensions and conditions for intersectoral governance may also be intertwined with those for HiAP. The brief mention of the potential misuses may illuminate possible strategies for managing these risks.

Thirdly, there is a need to address the methodological challenges that arise from such a complex research and evaluation agenda. These methodological challenges require the collaboration of multidisciplinary research teams, including expertise from political science, policy science, sociology and public health, if not law, economics and psychology. Systematic documentation and exploration of intersectoral governance questions may also require interdisciplinary input with regards to methods that would most appropriately target the sources of information needed to capture relevant elements of example. Methodological development in this area would also contribute to the possibility for more meaningful comparative analyses across a variety of jurisdictions. Further, the methodological diversity called for by this research agenda would also benefit from a broader theoretical diversity. A range of theories from various disciplines could contribute to a better understanding and analysis of the phenomena at play as well as the identification of the corresponding objects of inquiry and the relevant variables relating to specific governance structures. Such research and documentation efforts might elicit the question of whether partnerships between government and academic institutions should be established for the purpose of studying intersectoral governance for health.

The research and knowledge translation agenda proposed above reflects the distinctiveness of the approach advocated, which invites a certain kind of evidence-seeking behaviour. All three of the priorities mentioned would benefit from being addressed through ongoing policy dialogues with producers and users of knowledge on intersectoral governance. This is because the approach advocated above is intimately linked with an interest in the research process itself being used to connect the evidence to its use and users. Such an agenda would be characterized by an attempt to integrate research and knowledge translation into a more interrelated endeavour, and is more akin to participatory action research. Policy dialogues would be useful venues to discuss documentation efforts, and they would be particularly helpful to stimulate conversations about the conditions for effective intersectoral governance to support HiAP. They represent a critical opportunity to convene researchers, policy- and decision-makers from government and the civil service, and other actors outside of government to exchange and share experiences. Given the dearth of evidence of the capacity for intersectoral governance as a tool for HiAP, policy dialogues would be a way to ensure that the research agenda is constantly being confronted

with the realities experienced by those in the policy process. Finally, an international dimension in these policy dialogues would be beneficial to ensure that a wide array of perspectives and policy contexts were being considered.

What are the implications for intersectoral governance structures: the future

As a concept, a policy principle and a policy practice, HiAP continues to gain momentum with the support of international documents like the Rome Declaration on HiAP in 2007 and the Adelaide Statement on HiAP in 2010. This is further evidenced by the broad range of existing policy initiatives, such as Health 2020 in Europe and the United Nations General Assembly resolution on global action on NCDs. A lack of definitive evidence has not stopped policy-makers and governments at various levels from experimenting and innovating with intersectoral governance structures as a means to support the practice of HiAP. It is our intention that the publication will on the one hand provide examples that demonstrate the potential of this framework in eliciting a discussion of the role of governance structures in the achievement and support of HiAP, and on the other initiate a debate on how the framework may be modified and adapted in order to support further research. This two-fold aim of the publication speaks to an interest of this study in supporting bridge-building between academia and policy.

This publication suggests one possible analytical framework to support the organization of documentation of these experiences and a research agenda. Based on the framework, this volume proposes a select number of examples of how intersectoral governance structures are being experimented with in some countries to incorporate a focus on intersectoral action on health. While they are not necessarily representative of the full spectrum of the policy practice defined and described herein, they illuminate some of the ways in which structures are being used in countries and regions to respond to particular challenges being faced in their attempts to operationalize some of the policy initiatives mentioned in Chapter 1. It is our view that policy initiatives calling for HiAP would benefit from the availability of systematic documentation of the intersectoral governance experiences to support dialogue across ministries and sectors who are contemplating how they might feasibly begin to address HiAP or improve their current implementation of this policy practice.

This publication aims to provide a resource for reflection by policy-makers, ministers, advisers and administrative staff as an entry point to a variety of examples. The examples are mere snapshots of this policy practice in action. As suggested earlier in this chapter, there are a number of conditional factors that were identified across the examples. Given these conditions that influence

the effectiveness of governance, the following set of questions can help policy-makers identify key factors for consideration that might highlight under what circumstances one structure might be used over another. Starting with an understanding of what the desired outcomes and actions are and which level of governance structure is being explored, questions to guide the process inquiry in an exploratory phase may include:

- What is the general political context for policy change? What has previously been tried? What other external factors are at play (i.e., growing public interest, landmark report released, policy disaster/event)?
- Who is driving the desire for HiAP?
- Is there political will? Or, who else is "on board"?
- Is there strong leadership? By whom?
- Which stakeholders are engaged?
- What are the resourcing requirements? How much money, if any, is there to contribute?
- What is the time frame? Is this a long-term solution, or a one-off?
- Is the timing appropriate – for the political climate, phase of the political cycle and constituency interest?

The challenge for the future development and critical analysis of this practice is to document the experience, assess the evidence, and compare the effectiveness of different governance structures in producing action on social determinants of health, and ultimately on improving population health outcomes. We urge the initiation of a sustained policy dialogue within and between countries that can support discussion and exchange on the accumulation of evidence over time and highlight the implications for the modification of this policy practice. It is our wish that ongoing policy innovations in HiAP be supported by research, and that policy networks interested in HiAP should play a key role in the dissemination of research. The future challenge is to link research and this policy practice in a way that provides an ongoing dialogue between theoretical and empirical perspectives on governance for HiAP. It is our desire that the overall objective of this publication be fulfilled by demonstrating how governance structures are currently being experimented with and how the analyses of these experiences with the use of this framework can promote a more structured approach by policy-makers seeking various mechanisms and methods to address HiAP through governance.

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Part II
Analysing Intersectoral Governance for HiAP

Chapter 3

Cabinet committees and cabinet secretariats

Owen Metcalfe and Teresa Lavin

Introduction

This chapter aims to add to the understanding of cabinet committees and cabinet secretariats as structures to support a whole-of-government approach, particularly focusing where possible on those committees and secretariats that endeavour to progress a HiAP agenda.

It provides information on the rationale for establishment of cabinet committees and cabinet secretariats as well as their functions, terms of reference and membership. It examines examples of cabinet committees and cabinet secretariats in Ireland, Scotland, Wales, New Zealand and Australia, identifies potential impacts and explores the advantages and disadvantages associated with these structures.

Cabinet committees

A cabinet committee is a group made up of cabinet ministers,[1] formed to enable fuller discussion than may be possible in the cabinet on a particular issue or general area of importance to government. It comprises cabinet ministers, junior ministers or civil servants, who advise the cabinet and prime minister on certain matters. Some committees are standing committees which have a broad remit; others are ad hoc committees which are established to deal with specific matters. Ad hoc committees are rarer now than throughout most of the

1 In Scotland, Japan and the United States of America, the title of cabinet secretary may be used as an alternative term for a cabinet minister.

20th century. Many matters are now expected to be resolved bilaterally between departments or through more informal discussion rather than requiring the formation of a committee.

Rationale for establishment/function

The primary function of cabinet committees is to allow for engagement by ministers with important policy issues of cross-departmental significance. While cabinet remains the ultimate decision-making body, cabinet committees exist to allow ministers to consider broad policy options and their development in a more reflective and deliberative way when dealing with issues in major cross-cutting areas. Cabinet committees also provide a mechanism for ministers to work with outside interests as appropriate. Unlike cabinet, officials may be invited to attend a meeting to assist ministers if the committee wishes.

Structure, terms of reference and membership

Most cabinet committees are standing committees of cabinet and meet regularly. Cabinet may also establish ad hoc cabinet committees to undertake particular tasks or to consider proposals on a specific issue which require cross-departmental cooperation.

The initiative for setting up a cabinet committee usually comes from the prime minister's office. The structure, terms of reference, chair and membership of each cabinet committee are decided by the prime minister, in consultation with the leader of the coalition partner, if there is one.

Cabinet committees have a membership comprising two or more members of government. In general, cabinet committees are chaired by the prime minister, with a minister who has lead functional responsibility being designated as convenor, to deal with day-to-day issues relating to the activities of the committee.

The (re)establishment by the government of a cabinet committee should be recorded, formally or informally. Cabinet committees other than ad hoc committees should set out a work programme for the year ahead which sets out explicit priorities and targets for benchmarking the achievement of key objectives in the government programme or other frame of reference. They should provide a progress report to government at least once a year unless other reporting arrangements have been specified. A final report to government should be produced on conclusion of their remit and the committee then stands dissolved.

Committees must refer substantive issues to government for approval except where a committee has been expressly mandated to take a decision. Government memoranda which deal with substantive issues that come within the remit of a cabinet committee should, where time permits, be considered by that committee in advance of being brought to government.

Discussions at cabinet committee meetings are bound by cabinet confidentiality. A notable exception to this is found in Wales, where cabinet committee meeting minutes, papers and agendas are routinely published on the government web site unless there are overriding reasons not to do so.

Cabinet secretariats

The cabinet secretariat works on behalf of all ministers and all directorates in the government to coordinate and facilitate collective decision-making. The cabinet secretariat's role includes:

- providing advice on the handling of issues and on the preparation and circulation of papers for consideration by cabinet secretaries in cabinet and to cabinet secretaries and other ministers in other fora;
- collating and distributing the papers for cabinet meetings, briefing the first minister for cabinet, as required, recording cabinet conclusions and following up decisions;
- working with directorates and ministers to help schedule business for cabinet through regular dialogue and forward-look exercises;
- servicing cabinet subcommittees, working in close consultation with colleagues in relevant policy directorates; and
- issuing cabinet correspondence and providing coordinated advice for the first minister on any issue being handled in that way.

The role of the cabinet secretariat is to ensure that proper collective consideration of policy takes place when it is needed before policy decisions are taken and to ensure that the business of government is taken forward in a timely and efficient way. The cabinet secretariat prepares the agenda of committee meetings, with the agreement of the chairperson and the deputy chairperson; it also provides them with advice and support in their functions as chairperson and deputy chairperson; and it issues the minutes of the committees, in addition to providing wider support as set out in this guidance. The cabinet secretariat is located in the cabinet office and reports to the prime minister, deputy prime minister and ministers who chair cabinet committees.

Other relevant structures: senior officials groups

Senior officials groups (SOGs) exist to support the working of cabinet committees and other interdepartmental structures. They comprise senior civil servants who meet and prepare items ahead of ministerial meetings. Issues are discussed and potential solutions negotiated by senior officials to enable ministers to move more quickly through difficult or complex items. In Ireland, a number of senior officials groups have been set up to mirror cabinet committees, including on European affairs, social inclusion, health and climate change, and energy security. In addition, SOGs may produce their own reports.

Examples of cabinet committees

Government structures in the United Kingdom, Ireland, New Zealand and the devolved administration of Wales were examined to establish the types of cabinet committees in place and the extent to which they dealt with health. The level of health representation was determined either by the name of the committee or by whether or not its membership included the health minister (Table 3.1).

Table 3.1 *Level of health representation in selected cabinet committees*

Name of cabinet committee	Country	Cabinet committee with mandate for health across sectors	Cabinet committee with mandate for health	Other cabinet committees	
				Membership includes health minister	Membership excludes health minister
Public Health	United Kingdom	√			
Health	Ireland		√		
Social Justice	United Kingdom				√
Social Inclusion, Children and Integration	Ireland			√	
Social Policy	New Zealand			√ (Chair)	
Children and Young People	Wales			√	
Economic Renewal	Ireland			√	
Economic Renewal	Wales			√	
Economic Growth and Infrastructure	New Zealand				√
Economic Affairs	United Kingdom				√

Table 3.1 *(contd)*

Home Affairs	United Kingdom	√	
Domestic Policy	New Zealand	√	
Climate Change and Energy Security	Ireland	√	
Sustainable Futures	Wales		√
European Affairs	Ireland	√	
European Affairs	United Kingdom		√
Transforming Public Services	Ireland	√	
Strategic Directions for Local Government	Ireland		√

In Ireland, for example, the Cabinet Committee on Health comprises the Prime Minister, Deputy Prime Minister, Minister for Finance, Minister for Health & Children and Minister of State for Children & Youth Affairs. The Committee's purpose is to oversee implementation of the Health Service Reform Programme and to drive improvements in selected priority service delivery areas. It met on eight occasions in 2009.

In South Australia, the newly established Executive Committee of Cabinet has been used to drive a HiAP approach, as described in the case study.

The South Australian experience: ExComm and Health in All Policies

Carmel Williams

The Government of South Australia established the Executive Committee of Cabinet, or ExComm as it is referred to across government, to drive the implementation of South Australia's Strategic Plan (SASP). SASP outlines a long-term vision for the whole of South Australia, by committing the government to achieving 98 high-level targets across six interrelated objectives covering the economy, environment, communities, well-being, education and innovation. It has provided a starting point for the government to adopt an integrated approach to joined-up policy development. ExComm, led by the Premier of South Australia with members including a small number of senior government ministers but not the Minister for Health, monitors the performance of departmental chief executives who are responsible for progressing sets of individual SASP targets.

The targets themselves are ambitious, in that they address complex policy issues that frequently cross sectoral boundaries. While ExComm and the government have an expectation that departments will think beyond their own concerns or portfolio areas,

there has been limited investment in the development of joined-up policy-making processes.

At the same time, the health system has been struggling with escalating health care costs, the growing burden of an ageing population and increasing incidence of chronic disease. This was coupled with a growing evidence base that stated the best opportunities or factors to change these dynamics lay outside the health sector's direct influence. These factors, the social determinants of health, provide the social, economic and environmental levers to influence population health outcomes. In this context, Professor Ilona Kickbusch proposed that South Australia adopt a HiAP approach and that the approach be applied to targets contained within SASP.

The unique advantage of this proposal was the significant and strategic importance of SASP to all government agencies. All government agencies are required to achieve targets relating to their portfolio areas and departmental chief executives are responsible to the Premier of the State for achieving the targets, which is monitored through a subgroup of ExComm, the Chief Executive's Group. HiAP provides the opportunity to explore some of the interconnections between the SASP targets and to identify joint areas of work to achieve a win-win solution; that is, to work to achieve the target as well as to improve the health of the population.

HiAP has also provided a mechanism for agencies to jointly reflect on a particular policy and work in a collaborative and deliberative way to determine issues and take timely and proper policy decisions. Government departments have been very receptive to South Australia's HiAP process and responses from ExComm and, in particular, its subgroup, the Chief Executive's Group, have been very positive.

Through the backing of ExComm, SASP provided a mandate for the health sector to engage in collaborative policy-making on issues that would normally be beyond its ability to directly influence, such as migration, digital technology, water security, children's literacy and drivers licensing. As a result of the HiAP approach, the health sector has slowly and tentatively begun to shape the economic, social and environmental conditions that create health, by working collaboratively on the policies of other sectors.

The impact and effectiveness of cabinet committees

Due to confidentiality issues, no written information could be found on the impact and effectiveness of cabinet committees. However, anecdotal evidence suggests that the following issues are important.

- Leadership from the prime minister's office is important to give the committee sufficient status and secure engagement from all the relevant ministers.

- The issue requires political engagement: for example, a cabinet committee on health enabled the political system to engage with the establishment of a new service delivery mechanism for health.
- The issue requires difficult political decisions to be made. Issues which require in-depth discussion to progress or resolve are particularly suited to the cabinet committee mechanism as there is more opportunity here for detailed discussion as well as access to advice from outside agencies.
- The issue requires action by two or more government departments to progress or resolve.
- The political importance of the issue under discussion is important (it is hard to get engagement if the issue is not seen as being politically important):
  - general climate: e.g., economic recession;
  - political agenda: e.g., climate change of particular interest to Green Party (as well as being an issue of global importance).
- The immediacy of the problem is important – for example, the cabinet committee on economic renewal does not have an explicit focus on health promotion; however, it is assumed that job creation and economic stability will be beneficial to health.
- The work of cabinet committees is supported by the SOG. The SOG comprises senior civil servants from relevant government departments who meet on a more frequent basis than the cabinet committee to prepare papers and items for discussion. Effective working of the SOG, including cooperation between senior officials across departments, is essential to the smooth operation of cabinet committees.

A range of indicators have been agreed against which to test each structure. Based again largely on anecdotal evidence, cabinet committees have been found to be effective in the following dimensions:

Conclusions and lessons learned

This chapter has presented an overview of how cabinet committees and cabinet secretariats work to support a whole-of-government approach. It provided examples of committees in a number of countries, particularly highlighting those that may endeavour to progress a HiAP agenda. Examining the impact and effectiveness of these structures proved difficult due to the confidential nature of issues under discussion. A number of measures were taken in an attempt to overcome this barrier, including meetings with identified personnel, examination of publicly accessible minutes of cabinet committee meetings in

Table 3.2 *Indicators and dimensions of effectiveness for cabinet committees*

Indicator	Dimension of effectiveness
Evidence support	No evidence found
Setting goals and targets	Allowed for identification of priorities
	Considered an essential part of any cabinet committee, without which meetings become purposeless
Coordination	Better cross-sectoral working regarding planning
	Better coordination across "social" departments such as health, education. Best work done on "real cross-departmental problems that needed to be cracked", such as homelessness or disability
	Better cooperation across departments on an issue of high political importance
Advocacy	Enabled the political system to engage with the establishment of a new service delivery mechanism for health
Monitoring and evaluation	No evidence found
Policy guidance	No evidence found
Financial support	No evidence found
Providing legal mandate	No evidence found
Implementation and management	No evidence found

Wales and exploration of other structures such as SOGs which support cabinet committees but whose work is not subject to the same level of confidentiality protection.

Anecdotal evidence suggests that the strength of cabinet committees and their supporting structures such as SOGs lies in their ability to facilitate dialogue and reach agreement on matters of cross-departmental importance. It may be the case that governments which utilize other mechanisms for interdepartmental or whole-of-government working may not rely so much on cabinet committees to facilitate dialogue and discussion.

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2 The online factsheet has since been updated and the original is available on request from the Department of Health in Dublin.

Chapter 4

The role of parliaments: the case of a parliamentary scrutiny

Ray Earwicker

Introduction

This chapter explores the contribution of parliaments to an intersectoral governance framework that promotes HiAP, drawing on the system of parliamentary scrutiny in England, using as a case study the House of Commons Health (Select) Committee (HSC) inquiry into health inequalities (2009), with reference to the experience of Australia and Estonia. It identifies some general and practical lessons from this process.

Intersectoral governance is most usually seen as the realm of government ministers, policy-makers and other stakeholders, including regional and local government, and other agencies, including the voluntary and private sectors. Parliaments also have a role to play through agenda setting, promoting a cross-government approach and wider political ownership, and providing practical suggestions that can improve the quality of policy-making and the focus on implementation and action.

This paper will show how the process of parliamentary scrutiny works in England through the HSC inquiry. It will look at the impact on cross-government action and the structural arrangements that underpin such action. It will also consider the links between this inquiry and the wider health inequalities perspective provided by the review undertaken by Sir Michael Marmot (Marmot, 2010).

The HSC inquiry shows that parliament can be an important advocate for intersectoral governance for a HiAP approach, and how a clear assessment of policy development and action can inform better governance. The HSC

endorsed the importance of the health inequalities issue and, through a clear, critical and constructive report (House of Commons, 2009), confirmed the validity of the overall approach. It raised the profile of health inequalities and helped extend all-party ownership of the health inequalities issue.

A framework for scrutiny

The role of parliament

Democratic government comprises two elements – the executive (ministers), which formulates policy, and the legislature (parliament), which translates policy proposals into law.[1] Parliament's role can be constrained when a government has a clear mandate for action and a large majority that can reduce the effectiveness of the parliamentary voice. The scrutiny process can help parliament reassert its influence.

In the United Kingdom parliament, scrutiny is bi-partisan, evidence-based, rational and aimed at improvement and the avoidance of error (Sear et al., 2002). Each department of state is "shadowed" by an all-party select committee – for the Department of Health (DH), this "shadow" is the HSC. The select committees are formal parliamentary institutions that can influence and shape future policy-making through reports and recommendations.

The select committee

The HSC's remit is to examine the expenditure, administration and policy of the DH and its associated public bodies in England[2] (House of Commons, 2002), as DH powers relate only to England. The departmental select committees have a minimum of 11 members who usually sit for the full term of a parliament – broadly representing the party strength in the House.[3] They decide on a line of inquiry and gather written and oral evidence, including from expert witnesses. There are usually several inquiries a year. All evidence is published and an inquiry report requires an official response and is followed by a parliamentary debate to which the relevant government minister responds.[4]

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1 The United Kingdom Parliament has two chambers – the House of Commons (policy-making/finance) and the House of Lords (revising). Both houses seek to hold governments to account, e.g. through parliamentary questions from individual members of parliament (MPs) or peers (members of the House of Lords) to a government minister, in either written or oral form

2 The committee's standing orders provides it with powers to appoint subcommittees and publish their reports, send for any persons, papers or records and appoint specialist advisers.

3 HSC members as at 15 March 2009 were: Rt Hon Kevin Barron MP (chairman) (Labour (L)), Charlotte Atkins MP (L), Peter Bone MP (Conservative (C)), Jim Dowd MP (L), Sandra Gidley MP (Liberal Democrat), Stephen Hesford MP (L), Dr Doug Naysmith MP (L), Mr Lee Scott MP (C), Dr Howard Stoate MP (L), Robert Syms MP (C), Dr Richard Taylor (Independent).

4 A small number of select committees work across departmental boundaries, such as the public accounts committee (PAC). The PAC scrutinizes public spending and is supported by the National Audit Office (NAO) to explore value for money and cost–effectiveness. In July 2010, the NAO published a cost–effectiveness study of the health inequalities life expectancy target (National Audit Office, 2010).

Box 4.1 *Parliamentary committees of inquiry*

- Provide independent scrutiny that matters and is transparent – speaking for the whole of parliament, it calls ministers to account
- Deliver an open challenge to the evidence base and methodology used in government programmes – using expert and other witnesses
- Determine how to proceed in the light of their inquiries – including making cross-cutting connections across government
- Require a time-limited government response to their findings
- Undertake and encourage follow-up – keeping the issue warm through parliamentary debate and other action
- Promote a revised approach to government policy, such as improved monitoring and evaluation and better policy guidance

A developing process

Although parliamentary procedures and processes are well established in the United Kingdom, the provisions for effective scrutiny of the executive are much more recent. Select committees in their current form were established in 1979. Committees had existed prior to this but changes – and the introduction of departmental scrutiny – followed after it was acknowledged that "the balance between the executive and Parliament was now weighted in favour of the Government to a degree which arouses widespread anxiety and is inimical to the proper working of parliamentary democracy" (Sear et al., 2002).

Not every country follows the same route. The federal government model, as in Australia, ensures that individual states have their own separate rules and processes for parliamentary scrutiny. New and emerging democracies, such as Estonia, are still shaping the role of parliament and the scrutiny function is undeveloped. Even in the United Kingdom, there have been several efforts to strengthen further the power of the select committees by widening their role, providing greater resources, and electing committee chairs by the whole House of Commons to prevent government interference (these elections happened for the first time only in June 2010).

Applying the scrutiny process

The HSC's inquiry into health inequalities (2007–2009) shows how this process can enable parliament to play a part in tackling health inequalities and promoting a HiAP approach.

Tackling health inequalities in England

Tackling health inequalities has been a policy priority area in England since 1997. The issue now has bi-partisan support since its status as a priority was reaffirmed by the new coalition government in May 2010. The coalition emphasized the importance of fairness and social justice (HM Government, 2010a).

The Acheson inquiry on health inequalities identified a growing health gap and provided a scientific basis for action in this area (Acheson, 1998). The first-ever national health inequalities target, on infant mortality and life expectancy, was adopted in 2001. It was supported by a national strategy that provided a basis for intersectoral collaboration for tackling health inequalities and encouraged a HiAP approach across 12 government departments (Department of Health, 2003).

Performance against the target and the wider determinants of health were monitored annually through a series of status reports and other updates (Department of Health, 2005) and health inequalities became a "top six" priority for the National Health Service (NHS). Although health outcomes for the population as a whole improved, the health gap continued to widen.

The development of health inequalities as a policy priority and its rising public profile engaged the attention of the HSC at the end of 2007. The committee's view was that that the target was unlikely to be met and, as HSC chair Kevin Barron said, "on that basis, we launched the inquiry" (Hansard, 2009).

The HSC inquiry into health inequalities – a case study

The HSC announced its inquiry into health inequalities in October 2007 and formally invited written evidence. It was concerned that the health gap was continuing to widen and was not proving amenable to action by current policies.

The link between action and its impact was complicated by time lags in the data. This uncertainty was reflected in the 2007 status report published on the first day of the oral evidence hearing (Department of Health, 2008a). It was clear, however, that effective action required a balance between the wider determinants of health, like housing, child poverty and education, and health service and lifestyle factors.

Written evidence

The inquiry invited views on the:

- extent to which the NHS can contribute to reducing health inequalities

- distribution and quality of general practitioner (GP) services
- effectiveness of public health services
- effectiveness of specific interventions
- success of the NHS in coordinating its activities
- effectiveness of the Department of Health
- whether the government is likely to meet its health inequalities targets.

One hundred and fifty-four pieces of written evidence were submitted during the inquiry – ranging from pharmaceutical and food manufacturers to the medical Royal Colleges, academic experts and the DH. Individual responses tended to focus on the areas the witnesses knew best (House of Commons, 2008).

Table 4.1 *Extracts from written evidence to the committee*

"Given the cross-cutting nature of health inequalities and the cross-cutting role that football can play in tackling these, a health minister should be identified who can act as an ambassador for football and wider sport" (Football Foundation, p.165)
"individuals [should be encouraged] to switch from 'less healthy' to 'more healthy' foods within popular staple categories at the centre of dietary advice intended to counter growing obesity" (McCain Foods (GB) Ltd, p.24)
"We suggest…a need for a strategic approach involving collaboration [between] government departments in developing joint programmes to fill gaps in the evidence base about multisectoral action to deal with public health problems" (National Institute for Health and Clinical Excellence (NICE), p.116)

The DH evidence to the inquiry (House of Commons, 2008) said that reducing health inequalities:

> requires a balanced approach of a broad front between the role of the NHS on prevention and treatment of disease, and local government working in particular on the wider social determinants of health.

It also emphasized that:

- There is scope to improve GP and primary care services; action to narrow health inequalities is in hand.
- Public health is most effective when action for health improvement is matched by action to tackle health inequalities.
- Specific programmes raise the health inequalities profile, promote innovative work and act as a catalyst for further local action.

- The systems, processes and tools are in place to allow effective action.
- Effective partnerships [to deliver the target] have been in place since 2002.
- The target is challenging; some progress has been made but it will be difficult to meet all of the target.

Oral evidence

The Committee proceeded to clarify the issues raised in the written evidence and by other material by taking a number of expert or interested witness statement or oral evidence in 11 sessions over 18 months, starting on 13 March 2008. The witnesses were drawn from a wide range of interests, including scientific and other experts, interested parties, officials and ministers.

Table 4.2 *Some of the organizations and witnesses for oral examination*

Thursday 13 March 2008 – senior officials, Department of Health
Thursday 27 March 2008 – Professor Sir Michael Marmot (University College, London and chairman of [WHO] CSDH); Professor Richard Wilkinson (University of Nottingham)
Thursday 5 June 2008 – British Medical Association, Age Concern, Men's Health Forum
Wednesday 5 November 2008 – Jamie Oliver (chef and broadcaster)
Thursday 6 November 2008 – officials from HM Revenue and Customs, United Kingdom Border Agency, and from NHS London Healthy Urban Development Unit
Thursday 13 November 2008 – Baroness Morgan of Dreflin, Parliamentary Under-Secretary (minister), Department for Children, Schools and Families
Wednesday 19 November 2008 – Rt Hon Alan Johnson MP, Secretary of State for Health

The committee also undertook a series of visits, to Glasgow, the Netherlands and Norway, during the course of the inquiry and was supported by special advisers.

The committee report

The report was published on 15 March 2009 and it found that the causes of health inequalities were complex. These causes included lifestyle factors as well as the wider SDoH, but access to health care seemed to play a less significant role (House of Commons, 2009).

The widespread praise and support for the government's efforts in tackling health inequalities nationally and internationally had to be set against the continued scarcity of good evidence and lack of proper evaluation of current policy that had handicapped the design and introduction of new policies. While the report suggested that this weakness could be addressed by simple changes to policy design, it noted that the Marmot Review offered an ideal opportunity for the

government to show its commitment to rigorous methods for introducing and evaluating new initiatives.

The report identified a series of key challenges, including the need:

- to design and evaluate policy effectively (para. 75);
- to explore the distribution of NHS resources (para. 105) and the cost–effectiveness (para. 200) and distribution (para. 219) of NHS services;
- to recognize the wider aspects of health inequalities over and above socioeconomic disadvantage (para. 160);
- to focus on delivery, especially in disadvantaged areas (para. 138);
- to develop local leadership in the NHS to support the agenda (para. 218);
- to strengthen the contribution of hospital (secondary) care (para. 245);
- to build effective cross-government working (para. 268).

It also called for the government to reiterate its commitment to health inequalities by reaffirming the target for the next 10 years (para. 159).

The need for effective coordinated action across government through a HiAP approach featured strongly in the report. Many of the direct causes of health inequalities lay outside health and health policy and it said that the DH had "a valuable role to play in providing leadership across all sectors and government departments to promote joined-up working to tackle health inequalities" (para. 379). This finding on leadership was mirrored in the Marmot Review[5] and reflected in the government's public health white paper, *Healthy lives, healthy people* (HM Government, 2010c).

The government response

The government's response was published on 18 May 2009 (HM Government, 2009).

It said that the government had used the experience of the last 10 years to shape its approach to addressing health inequalities. From the first, it saw that this would not be easy, recognizing that the causes were deep and ingrained and often socially determined. The government had:

- emphasized – and renewed – its determination to reduce inequalities in health and matched this determination with a comprehensive range of actions across government departments, and at regional and local level;

5 "Cross-cutting leadership on health inequalities should be vested at Cabinet level, with the Secretary of State having lead responsibility, working with other ministers across government, to deliver this cross-departmental agenda" (Marmot, 2010, p152).

- learned from the evidence – a decade ago there was little evidence about what to do and action was random and ineffective; and
- focused on the national target to identify priorities for action, understand what works, and develop evidence-based resources for local use.

The inquiry's recommendation on debate on evidence and evaluation was challenging. The government's response noted Derek Wanless's[6] conclusion in his review on the future health of the whole population, that "the need for action is too pressing for the lack of a comprehensive evidence base to be used as an excuse for inertia" (Wanless, 2004). A recent academic paper has suggested that the position has changed and that there is enough knowledge to take action on social inequalities in health. However, in an explicit reference to the HSC report, the paper recognized the general view that everyone "like us, wants a stronger evidence base to inform action" (Marmot, Allen & Goldblatt, 2010).

The results of the scrutiny process

Agenda setting

The HSC report had helped set the agenda, notably through its recognition of the high importance of action on health inequalities, the value of a cross-government approach, the use of a target as a catalyst for action and the underlying need for a scientific and evaluative approach.

The Australian example (see case study below) shows that scrutiny in a different, federal system comes up with the same messages about the potential role of parliament as an agenda setter for cross-government action in improving health outcomes and tackling health inequalities.

The scope for parliamentary committee action varies across countries. While not all have the systematic departmental oversight of the United Kingdom system, most have other routes that enable parliament to explore HiAP issues. In Estonia, the parliament (or Riigikogu) has the power to establish select committees around legal issues and international agreements, and to establish study committees **to analyse problems of considerable importance** by inviting expert evidence and advice and publishing a report on its activities (Estonian Parliament, 2003).

6 Derek Wanless, a former chief executive of NatWest bank, was asked by government to look at the long-term affordability of the NHS. His report *Securing our future health: taking a long-term view* (2002) was followed by a second report in 2004 on the future health of the whole population.

An Australian Auditor-General's Report on Promoting Better Health Through Healthy Eating and Physical Activity

Vivian Lin

In Australia, the Auditor-General reports to parliament on the performance of government departments and other public sector bodies.

In 2007, the Victorian Auditor-General tabled a report to the Victorian Parliament on whether the government's investment in health promotion had encouraged people to adopt healthier eating habits, to eat more regularly and to achieve healthy weight levels. It asked, was enough being done?

Because of a wide range of factors which contribute to ill health, and the diverse actors and actions required to improve health, the audit took a whole-of-government approach. The audit also sampled seven local government areas and communities, including Aboriginal community organizations.

The report found that while the growing importance of obesity had been recognized and some positive steps had been undertaken, a stronger whole-of-government approach was needed together with better evidence, data, monitoring and evaluation processes.

The scrutiny process through the Auditor-General had placed the issue firmly in the parliamentary ambit, ensuring that parliament helped set the forward agenda and was part of the wider public debate and follow-up action.

Source: Victorian Auditor-General's Office, 2007

A window of opportunity?

The appointment in November 2008 of the independent Marmot Review on health inequalities gave new impetus to the debate and offered a window of opportunity to embed health inequalities in the wider policy agenda.

The HSC report was published between *Closing the gap in a generation*, the report of the WHO CSDH (2008), and the publication of the Marmot Review report, *Fair society, healthy lives* (2010). *The spirit level* was published in the same month as the HSC report and it explained that more equal societies almost always do better than less equal societies (Wilkinson & Pickett, 2009).

Not surprisingly, the HSC report was not as influential as these publications, but it did show that parliament could contribute to the wider health inequalities agenda with real and practical suggestions through the scrutiny process.

A combination of local and other national parliamentary activity – including through the emerging child poverty and equality bills that became law in March

2010 – reinforced attention on issues of health inequalities, disadvantage and poverty.

Interest in the committee's work – and its ability to contribute to this wider agenda – was perhaps reflected best in the decision of the BBC to devote virtually the whole of its half-hour lunchtime news programme to health inequalities to coincide with the opening of the inquiry's oral evidence sessions on 13 March 2008.

The parliamentary debate

The systematic debating of select committee reports in the House of Commons has increased their influence and their ability to help set the wider agenda by engaging government directly and requiring the responsible minister to respond to their findings.

The inquiry debate on 12 November 2009 provided an opportunity for committee members and other MPs to challenge the minister about the government's approach to tackling health inequalities and set out common ground. From the outset, the difficulty and complexity of the challenge was recognized. Kevin Barron (Labour), the committee chair, said "I hope the report has done what was intended – to find that there is no silver bullet on health inequalities. It is not there: we would have done something about it years ago if it had been" (Hansard, 2009).

Equally, although the lack of evidence and poor evaluation made it "nearly impossible to know what to do", and although the target was "probably the toughest target in the world", the HSC concluded that the target was "a useful catalyst to improvement and we recommend that the commitment be reiterated for the next 10 years".

The role of the social determinants – and a HiAP approach – was a prominent aspect of the debate, given that the "lack of access to good health services did not appear to be a major cause of health inequalities", a broader approach was needed. This meant greater focus on local programmes and local action, such as Sure Start children's centres.[7] Peter Bone (Conservative) said that these programmes needed to "get to the hard-to-reach cases…it is working well, but it is not getting to the very difficult and hard-to-reach cases…it is the silent voices that [we must reach]".

Howard Stoate (Labour) raised the question of the physical environment of local neighbourhoods. It was said that while "Unquestionably, people's housing conditions have improved…the condition of their neighbourhoods leaves a lot

7 Sure Start children's centres are a national cross-government programme led by the education department for children 0–4 years and their families for securing better readiness for school and improving health, initially in disadvantaged areas but subsequently rolled out on a universal basis.

to be desired and has not improved to the same extent. [Equally, there was a need to look to schemes that help] cut crime and improve access to jobs, education and health services".

The cross-party consensus on seeking improvements and avoiding error was emphasized by Mike Penning (Conservative), who said that the "contributions we have heard today have been eminently sensible. They show the House really cares about the issue. It is not party political."

Gillian Merron (Labour), the public health minister, replied to the debate. Echoing earlier comments about a constructive approach across the parties, she welcomed the committee's "constructive criticism about how we might better improve".

She emphasized the complexity of health inequalities and the need for a HiAP approach across government: "People who experience material disadvantage, poor housing, lower education attainment, insecure employment or homelessness are most likely to suffer from poor health and an early death compared with the rest of the population."

For the future, she noted that the Marmot review "will set us on a firmer footing for the development of a national cross-government health inequalities strategy" (Hansard, 2009).

After the debate

The attention and welcome given to the publication of the Marmot Review in February 2010 reflected how far the health inequalities debate had come over the last 10 years. It was now a mainstream political issue. It commanded coverage and discussion across the media and in policy fora. All political parties were engaged in the debate. It was also increasingly recognized as part of the way that business was done in the NHS and other public services – including through the planning, delivery and performance processes. It also fostered better governance and the promotion of a HiAP approach.

The scrutiny exercise provided by the HSC health inequalities report had contributed to this wider debate that informed the development of the Marmot Review. It had also directly contributed to its thinking on several key points, including the use of evaluation.

> "The Health Select Committee has identified the need for interventions on health inequalities to be more adequately evaluated…[and it has identified] a number of basic steps that can be taken to ensure novel interventions are implemented in a way that significantly reduce the challenges involved in evaluating social interventions." (Marmot, 2010)

The review also shared the report's concern about the scale and timing of policies, the need to reconcile long-term goals with short-term gains and the need to pay greater attention to the planning process as a way of integrating action on the SDoH, including planning, transport, housing, environmental and health systems.

The key test came with the change of government in May 2010, when a new coalition government of Conservatives and Liberal-Democrats was established. It succeeded the New Labour administration that had been in office since May 1997. The previous administration had established health inequalities as a plank in its social justice agenda, appointed the Acheson inquiry and set the health inequalities target and national strategy. The HSC report provided at least a partial verdict on the way this system had worked in practice and offered practical suggestions to strengthen it.

The new government set out its commitment to fairness and social justice at the outset by proposing an outcomes-based approach in place of the system of national targets and placing greater emphasis on local and community action. Health inequalities have continued to inform policy development and service delivery, including through a proposed new health inequalities duty on the NHS (HM Government, 2010b).

The 2010 election also meant new chairs and members for the select committees. The new HSC chair is Stephen Dorrell (Conservative), a former Secretary of State for Health. The practical suggestions from the 2009 health inequalities report remain relevant. For example, it called on early years' interventions to remain "focused on those children living in the most deprived circumstances" (House of Commons, 2009). This recommendation become embodied in the policy of the new government by "refocusing Sure Start Children's Centres for those who need them most" (HM Government, 2010c), with these centres providing health and educational support for 0–4 year olds and their families.

Conclusion

This study has shown the impact of the parliamentary scrutiny process on raising the key issues around the health inequalities agenda and claiming a voice for parliament in the wider debate. Its practical suggestions and recommendations are part of a wider discussion about what happens next in promoting effective governance in HiAP to tackle health inequalities and to reduce the health gap.

It has also shown how the all-party HSC encouraged a more consensual bi-partisan approach between the parties by drawing on the evidence and the data, helped win wider support for an approach recognizing the wider causes of

health inequalities and the scope for action across a range of policies needed to address them. It reflected an all-party approach to improvement.

The HSC report was published at a timely moment as part of a wider social justice debate in 2009/2010 seeking to address issues of inequalities, disadvantage and poverty, such as the children's health strategy – including the development of Sure Start children's centres – and the child poverty and equality bills.

The report's findings remain relevant in the context of the coalition government's explicit commitment to fairness and social justice, mirrored in the establishment of new social justice and public health cabinet committees. The Marmot Review has also carried these issues forward in staking out the ground for a broader approach post-2010 and the review provides the basis for the work of the new University College London Institute of Health Equity led by Sir Michael Marmot and partly funded by the DH. The conclusions of the 2009 HSC report will help inform this forward look.

Health inequalities have remained a political priority through a change of government in May 2010. This is shown by the coalition government's adoption of the Marmot Review in the public health white paper (HM Government, 2010c) and the decision to create a new duty on the Secretary of State and the NHS to have regard to the need to reduce health inequalities in their decisions – from 1 April 2013 (Department of Health, 2012). Cross-party ownership of the social justice agenda evident in the transition between governing parties in May 2010 is a relatively new phenomenon. Previous transitions have been sharper, as in 1979 – with adverse consequences for health inequalities. The Black report, commissioned by the Labour Government in 1977, reported to a Conservative Government in 1980. Its findings ignored, it was not until 1997, with another change of government, that a further inquiry was set up to explore the root causes of ill health by addressing "the link between health and wealth" (Hansard, 1997). In the meantime, the health gap had widened between the 1970s and the 1990s (Acheson, 1998).

There are clear signs that, since 1979, departmental select committees have strengthened the ability of parliament to scrutinize and hold the executive accountable and the executive's sense of being accountable. This greater effectiveness shows through in the conclusions of the HSC and subsequent PAC inquiries. These inquiries raised the profile of health inequalities as an issue for the whole of government by concentrating minds through the scrutiny process. It has also given parliament a voice in a debate conducted hitherto mainly through ministers and academics.

More generally, the parliamentary scrutiny process shows how parliaments can engage in policy debates, separate from the interests of government. This is

a developing agenda, as shown by the different experiences in Australia and Estonia – and by the adoption of a scrutiny process in English local government.

The all-party process enhances the potential influence of any findings and can challenge the government's approach, ultimately making it more effective in narrowing the health gap as well as promoting a more consensual approach across party boundaries to issues like health inequalities.

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Chapter 5

Interdepartmental units and committees

Scott Greer

Introduction

Both interdepartmental committees and interdepartmental units are intersectoral governance structures that try to reorient existing government ministries around a shared, intersectoral priority. They work at the bureaucratic level without disruptive organizations; between them, they have many benefits and uses, but the demerit that they need political support to do their work best, and as bureaucratic structures they generally cannot generate such political support on their own.

Both of these mechanisms are fundamentally bureaucratic. They operate within the bureaucracy, their fundamental justification is that they can move the bureaucracy to engage in a particular intersectoral priority, and their vigour depends on their ability to persuade other bureaucrats to engage with them (which is much more likely if they have strong political backing).

It is important to note that committees, in particular, do not capture all of the bureaucratic interdepartmental coordination within government. They focus it, but are probably a minority of coordination. Focus on them should not exclude the yet more humdrum techniques such as copying documents to contact persons in other departments. Nor should it suggest that the only interdepartmental units and committees of interest are the ones that are led by health specialists. Service on committees and units led by other departments, and participation in their consultation mechanism, is ubiquitous and a vital technique for intersectoral governance

Interdepartmental committees

Interdepartmental commitees are committees made up of representatives from the civil service (or possibly political appointee) level of departments. They might shadow a ministerial committee, or be serviced by an interdepartmental unit. For a discussion of ministerial, or political-level, commitees, see Chapter 3.

Interdepartmental committees appear throughout the history of modern public health – as with a 1904 Interdepartmental Committee on Physical Deterioration in the United Kingdom and the United States Interdepartmental Committee on Nutrition for National Defense. The former's recommendations, made in the aftermath of problems recruiting healthy troops for the Boer War, contributed to the nascent campaign for child nutrition and school meals in the United Kingdom and around the world (Soloway, 1995). The latter was prompted by American concerns that the troops and populations of its Cold War allies (especially the Republic of Korea and Taiwan, China) were malnourished, and caused the United States to invest more in studying population nourishment and explaining the role of vitamins at home and abroad (Hegsted, 2005). In both cases, the committees channelled departmental and external resources to produce important data and recommendations, though in both cases it was worries about healthy military recruits that lay behind their formation and prominence.

Today, there are many examples of interdepartmental committees, many of them scarcely visible to outside observers. The two case studies below provide examples. The French Public Health National Committee is the steering committee for broad intersectoral health plans, allying (and educating) multiple important ministries.

Developing a cross-government approach to health at administrative level

Nicolas Prisse

A Public Health National Committee (the Comité national de santé publique – CNSP) was created by the Public Health Act in 2004. It is supposed to function as a cross-government group to improve coordination and information among the main ministries whose policies may have a health impact, especially in the fields of prevention and health security.

The following institutions are members of the CNSP: ministries in charge of health, social affairs, education, universities, security, defence, justice, economics, agriculture and environment; and also the national health insurance service. The Directeur Général

de la Santé, representing the Minister of Health, leads this committee. As with the Ministry of Health, the other ministries are not represented at the political level, but by civil servants.

The committee stands every three months. It can be organized, if needed, in subgroups.

The CNSP has also been chosen to play the role of a steering committee for the implementation of some national health plans, when they have a large field of application depending on many administrations.

Since 2004, the CNSP has certainly improved coordination between ministries about health topics. It has also been a place of education for these institutions to consider the social determinants of health.

However, it also has to improve its capacity to generate common decisions, especially during the phase of elaboration of public policies.

Source: Government of France

The Slovak traffic safety committee has a narrower remit and more detailed tools, and has contributed to a dramatic decrease in road fatalities.

Traffic safety committee of the Government of Slovakia

Gabriel Gulis

The Government of Slovakia established a permanent intersectoral committee on road traffic safety ("the committee") by governmental decree in December 2004. The government has delegated the task of running the committee to the Ministry of Transport, Post and Telecommunications of Slovakia, where a special unit has been established to provide coordination, administrative and content-related support to the committee.

Members of the committee are the Ministries of Internal Affairs, Finance, Defence, Justice, Education and Science, Environment, Health and Construction and Regional Development. The aim of the committee is to improve road traffic safety in Slovakia and decrease the number of road traffic accidents, casualties and fatalities by serving as an advisory committee for the government.

The unit responsible for the committee is accountable to the Ministry of Transport, Post and Telecommunications and the committee is accountable to the Government of Slovakia. Activities conducted by the committee include evidence gathering and evaluation, goal and target setting, advocacy, health education, monitoring and evaluation of trends and leadership on the theme. To fulfill all these tasks the unit at the Ministry of Transport, Post and Telecommunications has a crucial role. The impact

of the work is assessed on the basis of national statistics on road traffic accident incidence, number of fatalities, and economic losses related mostly to direct costs of destroyed property.

The work of the committee is acknowledged as the most important contribution to the dramatic decrease in road traffic accidents and fatalities related to road traffic accidents observed in Slovakia during 2008 and 2009. Data on this decrease, as well as other references, are available from the web site of the committee (http://www.becep.sk) (at present in Slovak language only).

Source: Case study prepared by Gabriel Gulis, SDU Esbjerg, Denmark in 2010 based on communication with Milos Dunajsky, the BECEP Unit of the Ministry of Transport, Post and Telecommunications, Slovakia.

In addition, the United Kingdom is particularly rich in examples, in large part because its Cabinet Office put special effort into researching, creating, evaluating and publishing on the topic under Tony Blair, though other countries with the Whitehall form of government[1] tried hard to formulate and evaluate models of intersectoral governance (Sabel, 2001). One kind of structure found in almost every EU Member State is that responsible for EU policy coordination. There is enormous variation in their role and effectiveness, but they are often the most effective coordinating committees in many Member States (the need to formulate a coherent position for EU discussions is an imperative often lacking in domestic politics). Such committees are generally supervised by a central ministry (often the prime minister) and are charged with identifying, stating and resolving interdepartmental disputes (Greer, 2010).

The virtue of interdepartmental committees is that of any functional committee: representatives of the different relative units use them as a forum for problem solving. Committees lower the costs of a decision by maximizing the relevant information at the table, and lower the costs of implementation by involving the affected interests (departments) in the decision. Affected groups can know, in principle, that a committee decision could have come after their concerns were aired and debated. Regular committee meeting schedules can also be a stimulus to action; they allow participants to review new information, actions and progress. A report – such as the United States and United Kingdom reports – can have all the impact of any major, well-researched report.

The weakness is that the committee will fall prey to any of the perils of committees that have been discussed in millions of jokes, cartoons and satires from every culture that has known bureaucracy. These risks fall into a number of simple categories. One is depleted energy: it ceases to meet, high-ranking people

1 The Whitehall model refers to countries with a nonpartisan, generalist civil service, typically modelled on that of the United Kingdom and co-existing with a "Westminster" style of government in which the government is from within a Parliament elected by single-member constituencies. See Greer and Jarman (2010).

send low-ranking deputies, its mission is forgotten. A second is irrelevance: the departments might send representatives, but do not actually feel committed to the agenda or its implementation. A third is sabotage: departments use it solely as a way to spy on people who might ask them to do things they dislike.

The Interdepartmental Public Health Committee assisting the implementation of the National Public Health Programme in Hungary

Roza Adany

Compared to the average of the 27 Member States of the EU, the relative risk of premature mortality for the Hungarian population is double for males and 1.7 times higher for females, which reflects not only a serious public health problem for the country but may also weaken the sustainable development and international competitiveness of the Hungarian economy due to loss of human resources.

The government recognized the ultimate need to improve the health of the population, and also that it requires long-term, concerted action at intersectoral level. In 2001, a public health programme – "For a Healthy Nation" – was developed, accepted by government (1066/2001 Gov. Decree) and launched. An Intersectoral Public Health Committee (IPHC), with representation from all ministries, was also established. Among the actions of the Programme, mammography screening was started in the country. Although there was a governmental change in 2002, the Public Health Programme was continued as the National Programme for the Decade of Health (46/2003 Parliamentary decree).

A Programme Bureau was created to coordinate the operational tasks, under the leadership of the Secretary of State, Zsuzsanna Jakab. The role of the IPHC was reinforced and it became a real operational body, which decided on the steps to be taken and budget allocation. Intersectoral programmes were launched in which different ministries worked together on planning and implementing programmes. The period 2002–2006 was the most successful phase of the Public Health Programme, with the introduction of the public health regulations of the EU, continuation of the organized breast screening programme, start of a cervical screening programme, elaboration of an AIDS Strategy and of the National Food Safety Programme, and launch of the settlement, workplace and school health promotion programmes.

Source: Hungarian Ministry of Health

Interdepartmental units

Interdepartmental units are groups of civil servants, detailed and organized specifically to pursue a particular policy issue or agenda. They are typically delegates of somebody: a ministerial committee, an interdepartmental committee, or a central government minister. They differ from agencies in

that they are not responsible for delivering any services; they are creatures of the need to coordinate policy rather than autonomously deliver a service as agencies are generally created to do (Talbot, 2004). Otherwise, the language is often locally distinctive, with substantially similar groups called "units", "offices" or something else in different places and times. Their small size, civil service composition, and coordinating or priority-setting functions rather than their names distinguish them.

The virtue of interdepartmental units, above all else, is that they have staff. Intersectoral governance work can be even more time- and energy-consuming than ordinary bureaucratic work. All too often, governments' activity is hard to redirect because it is set by the rhythms of established bureaucracies and the frenzies of daily politics. Daily politics makes it hard for ministers to focus on redirecting the bureaucracies, and a result the bureaucratic machines grind on in their paths.

A unit is a partial solution because it can continue to carry out the political mission of intersectoral governance when the politicians have been called away to other tasks. As a delegate, it can continue to work on a priority regardless of the time commitments of its political sponsors. All it requires to maintain political salience is a credible commitment by those sponsors that they will back it up if it is challenged.

The weakness of an interdepartmental unit, of course, is that nobody listens. It is common to hear of units that are sidelined as too intellectual, or too impractical, or too distant from the core preoccupations of the bureaucracy. There are three broad kinds of responses. One is that the political will does ultimately matter. Any unit has a chance of being effective if it is known that it "belongs" to a senior minister who will engage to defend it if called. The second is that personnel matters. Units' individual circumstances will vary, but a mixture of energy and dedication with more senior officials can work, as can the presence of outsiders (insofar as new thinking is required). The key requirement is that the unit be staffed to combine technical competence, energy and a sense of the bureaucratic and political issues. The third is in strategy. One pitfall, for example, is that the unit sets itself up as a kind of in-house critic – which is likely to both alienate its targets and reduce its value to its supporters. Another is that it develops proposals that look impractical. The strategic solution will vary, but a key requirement is that it make itself a credible ally for at least some interests within the affected sectors. This means both bureaucratic "good manners" and genuine efforts to help departments solve problems. Intelligence and a confrontational approach alone tend to end badly; departments and their ministers repel unhelpful criticism (House of Lords Select Committee on the Constitution, 2010).

Intersectoral committee at state level: California's Health in All Policies Task Force

Linda Rudolph, Aimee Sisson and Julia Caplan

Recognizing the impact that non-health policies have on health, as well as the complex relationship between sustainability and health, the State of California created a Health in All Policies Task Force in 2010. The Task Force uses health as a linking factor to bring people together from across State government sectors to address issues of equity and environmental and economic sustainability. The Task Force's approach to Health in All Policies focuses on co-benefits and win-win strategies. Created by executive order of the Governor and placed under the auspices of the State's Strategic Growth Council (SGC), the Task Force was charged with identifying "priority programs, policies, and strategies to improve the health of Californians while advancing the SGC's goals of improving air and water quality, protecting natural resources and agricultural lands, increasing the availability of affordable housing, improving infrastructure systems, promoting public health, planning sustainable communities, and meeting the State's climate change goals."

California's Health in All Policies Task Force represents the first formal use of HiAP by a United States state governmental panel. Over an eight-month period, representatives from 19 California executive branch entities came together in individual and group Task Force meetings, held public input workshops and received written comments from a diverse array of stakeholders. These state leaders developed a broad-ranging set of recommendations geared toward improving the efficiency, cost–effectiveness, and collaborative nature of state government, while promoting health and sustainability.

The Task Force's recommendations address two strategic directions:

1. building healthy and safe communities with opportunities for active transportation; safe, healthy, affordable housing; places to be active, including parks, green space, and healthy tree canopy; the ability to be active without fear of violence or crime; and access to healthy, affordable foods;
2. finding opportunities to apply a health lens during public policy and programme development.

The recommendations range from one-time actions by a single agency to ongoing opportunities for all agencies to consider health when making decisions. Many of the recommendations can be implemented through administrative action, while others will require legislation. Examples of recommendations include removing barriers to institutional acquisition of locally grown produce, adding a health lens to transportation and city planning guidance documents, and assessing tools that might be used to project long-term costs and benefits of proposed legislation.

Source: The Strategic Growth Council

Such units often attract scholars, consultants and policy entrepreneurs – small groups of people on a mission are interesting. The most attention has recently gone to units in the United Kingdom such as the Prime Ministers' Delivery Unit (Barber, 2007) and the Performance and Innovation Unit (Performance and Innovation Unit, 2000) or older such units (Klein and Plowden, 2005).[2] United Kingdom experiments have included a unit to deal with "rough sleepers" (the homeless living on the streets, who often have very complex problems) that focused on joining up relevant aspects of local government, housing, social work and health services (Page, 2005) as well as drug harm reduction.

Interdepartmental committees: the Finnish Government system

Juhani Lehto

At the level of leading and middle-level civil servants of different ministries, the web of permanent and temporary committees, working groups and cooperation projects between the ministries is quite large. According to the official government register on such bodies, the government has, every year between 2008 and 2011, set up about 75–120 such bodies that include the representatives of both the Ministry of Social Affairs and Health (MSAH) and representatives of at least some other ministries. These include:

- the Permanent Interministerial Committee on Public Health, coordinated by the MSAH, with the primary task of enhancing the implementation of the government's comprehensive health promotion programme Health 2015;
- other permanent interministerial committees coordinated by the MSAH, with tasks related to some aspects of health promotion policies, such as committees on occupational health, on rehabilitation, on gender equality and on welfare and health of children and adolescents;
- other permanent interministerial committees coordinated by other ministries with tasks related to some aspects of health promotion policies, such as committees on the EU structural funds and on work, entrepreneurship and working life (coordinated by the Ministry of Industry and Employment), on the information society in everyday life (Ministry of Communication and Traffic), and on physical exercise (Ministry of Education and Culture);
- a great number of interministerial working groups with broad and significant tasks (also from the perspective of health promotion), such as the Working Group on Comprehensive Reform of Social Security and the Working Group on the Reform of Local Government and Public Services; and

2 The Central Policy Review Staff's job was to develop independent thinking outside the departments, at the service of the Prime Minister; it did not necessarily have good relations with departments. The Performance and Innovation Unit was a small group whose job it was to identify ways in which government could organize itself to deliver better; while it was in constant danger of giving offence, it seems to have handled the challenge well and published influential reports. The Prime Minister's Delivery Unit, one of several overlapping units, was in charge of monitoring delivery on key goals as disparate as shorter elective surgery waiting times and introduction of new rolling stock for railways.

- an even greater number of interministerial working groups with more restricted tasks (but still significant from the perspective of health promotion), such as working groups on reducing homelessness, on employment and integration of immigrants, on reducing poverty and exclusion, on improving the conditions for economic growth, on the care of the elderly and on the financing of local authorities.

In addition to the official and registered interministerial committees, working groups and projects, there are unregistered ad hoc working groups, information networks, reporting responsibilities and many other collaboration and coordination mechanisms, between the ministries. A large part of the working time of key civil servants is used in the meetings, preparation and secretary functions of the committees, working groups, projects and ad hoc cooperation.

From the perspective of the Minister of Health and her core staff for health promotion policy, the issue might not be whether there are administrative tools to enhance intersectoral health promotion. Rather, the issue is: how to use the existing mechanisms to attain an optimal result.

Problems they can solve

If the solution is an interdepartmental committee (with all relevant groups around the table with an agenda) or a unit (which can apply energy to a specific agenda), what would the problem be? There are a variety of relevant tasks. The key problem is to work out what kinds of tasks would be done by a unit or committee in any given circumstance.

Relevant circumstances

Intersectoral governance – coordination in general – is rarely just a bureaucratic problem, and bureaucratic reforms fix some problems of governance better than others. It is often a political problem: the government does not agree within itself.

We can see this by thinking through four quite common situations.

1. Two ministries refuse to agree because their ministers refuse to agree. A common example of such conflict is between health ministries and finance ministries with regard to tobacco control. Another is between programmes for vulnerable populations such as illegal immigrants or drug users, and programmes for law enforcement. In this case the problem is political; we cannot really blame administrative procedures if the health minister is in conflict with the finance or interior minister.

2. Two ministries refuse to agree about some minor problem and nobody more important cares enough to fix the problem. For example, there are often disputes about the role and cost of school or prison health care: who should pay for it (the education, prison or health ministry), and how much of it should there be?
3. Two ministries have not formulated any particular disagreements but need to iron out details and do not necessarily get around to fixing it. For example, it would often be helpful for home visitors to the elderly to carry out multiple tasks – health visiting, checking smoke detectors and advising on tax problems. On the practical level, such integration is often hard. Likewise, measures to protect the vulnerable in heat-waves (e.g., paying to keep libraries open late) involve an impressive amount of bureaucratic coordination that might not happen.
4. Two ministries basically agree that they need to cooperate because it is an important government agenda, they do not disagree much, and senior ministers want cooperation. This was, for example, the case with the English task force on rough sleepers.

These are all common enough in the life of any government, but they are different problems and need different solutions. Bureaucratic reorganization is not going to resolve a battle between two powerful ministers (situation 1).

Page (2005) presents this framework for understanding intersectoral governance problems that captures the different types of coordination problems. A high-conflict situation is one in which there is little or no basic agreement. Political importance is the extent to which it matters to the government, and especially senior politicians within the government. Table 5.1 presents the four situations listed above in the grid, along with the potential role of interdepartmental units and committees.

Table 5.1 *Conflict, salience, and coordination challenges*

	High political importance	**Low political importance**
High conflict	Situation 1. Interdepartmental committees and units might clarify issues, but resolution depends on political will.	Situation 2. An interdepartmental committee or unit with strong political support could impose a solution. Risk of departmental sabotage.
Low conflict	Situation 4. Optimal for interdepartmental committees and units – strong political backing and few political conflicts.	Situation 3. Interdepartmental committees and units very useful – committees can clarify problems and solutions, while units can add missing energy to search issue.

Source: Page, 2005.

The situations are friendly to units and committees in rough numerical order. In general, the worst situation for a unit or committee is situation 1, when they are as likely to be damaged in conflict between top politicians as to be effective in mediating conflicts between people who operate on a higher political level. This is the basic structural situation for some famously abolished units such as the United States Office of Technology Assessment, the New Zealand Public Health Commission, and the United Kingdom's Central Policy Review Staff. The New Zealand Public Health Commission is the emblematic case of such a problem: it was created in 1992 as a well-resourced, high-profile public health agency with the ability to start debates, and it offended so many high-level politicians and affected interests that it was quickly abolished in 1995 (Barnett & Malcolm, 1996). Situation 4 is the best for units and committees – they can bring their respective advantages to bear on an intersectoral governance task that the government supports and that does not involve too much interdepartmental conflict.

Intersectoral action and interdepartmental committees: the Decade for Action for Road Safety 2011–2020

Dinesh Sethi

The United Nations General Assembly resolution (A/Res/64/255) on "Improving global road safety" was tabled by the Ministry of Interior of the Russian Federation and called for, inter alia, a Decade of Action for Road Safety (2011–2020). This resolution, as well as a World Health Assembly resolution (WHA57.10) on "Road safety and health", called for intersectoral collaboration and for WHO to coordinate international action to reduce death and disability from the leading cause of death in young people aged 10–29 years. In response, 37 countries from the European Region have held launches for the Decade of Action since its instigation on 11 May 2011. These launches have been linked to national action plans for road safety for the Decade. In some countries, involvement by the prime minister or president at these launches gave intersectoral action a high priority (e.g., Cyprus, Slovenia and the United Kingdom). In other countries, health ministers or top officials from health ministries led the debate to implement road safety programmes requiring intersectoral action (Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Croatia, Hungary, Italy, Lithuania, Portugal, Serbia, Spain and Uzbekistan). The United Nations resolution, the global Plan of Action and the launch of the Decade has empowered health ministries to take a leading role in road safety. This area of increased intersectoral working has been assisted by international policy urging a coordinated response. The long-term effectiveness of this in terms of health outcomes will be evaluated. For example, in Slovenia an interdepartmental committee has been set up with defined budget and clear actions in order to ensure achievement of targets in road safety of a halving of road traffic mortality by 2020 and is being closely monitored.

Sources: United Nations, 2010; WHO, 2004

Governance outcomes

We can, then, use this map of situations to consider which of this book's governance actions a unit or committee could carry out. There are many possibilities.

- *Evidence*. An interdepartmental committee is a forum for aggregating information; this could include information from around government but it might be inefficient. A unit is more commonly found in this role, with tasks ranging from collecting existing information to commissioning or performing research, engaging in public debates or simply informing ministers. In their different ways, this was the job of the Central Policy Review Staff in the United Kingdom and the New Zealand Public Health Commission. In principle, evidence is a function that a unit or committee could fulfill in any of the four situations, though higher conflict makes information harder to gather and creates more of a risk that evidence will be ignored or incur retribution.
- *Coordination*. Coordination, an administrative "Holy Grail", means the processes necessary to promote intersectoral working. This includes allocating responsibilities and making sure bureaucracies are carrying out their appropriate tasks. It can also, above all, resolve differences and even build trust. It is best done by the experts in bureaucracy – ideally, the bureaucrats themselves. They know the problems and resources, and their cooperation is obviously needed. A committee is therefore the logical choice and it can carry the task out in low-conflict situations. An interdepartmental committee is only likely to coordinate in high-conflict situations, for example if there is a very clear political demand to resolve the issue or if it is backing a ministerial committee or other political process that can resolve the issue.
- *Advocacy*. The virtue of a unit is that it can add energy. Advocacy requires energy. A unit should be well suited to such advocacy, so long as it is either working on relatively noncontentious issues, or has strong political support (or both). A unit in a high-conflict, politically salient situation probably needs the backing of the most senior politicians to survive, let alone win. A unit in low-salience situations can be particularly useful because nobody else puts in energy. A unit in a high-salience, low-conflict situation is likely to be spectacularly successful, for obvious reasons.
- *Monitoring*. Monitoring is best done by a unit, though a high-functioning committee could in theory coopt the member departments' resources. The Prime Minister's Delivery Unit was a success in this regard. This is because monitoring requires energy and engenders conflict. It is more likely to work in low-conflict situations, but can work in high-conflict ones.

- *Guidance development*. Done by a committee, it can reduce conflict, but (in a catch-22 situation typical of government) that is more likely if there is not much conflict. Done by a unit, it can reduce transaction costs in formulation, but requires diplomacy and political support to be implemented. Again, this means that it works best in situations 3 and 4, where the problem is technical, not political.
- *Implementation and management*. Departments and agencies implement, not units. Other activities (monitoring and evidence) might feed in, but a committee is where departments and agencies can report on and coordinate implementation. It puts the key actors around the table with an agenda and, ideally, a powerful chairperson.

Neither interdepartmental units nor committees are likely to resolve high-conflict issues of high political importance (situation 1). Both are likely to succeed at most tasks in situation 4. The real questions come down to the extent to which they are suited to act in situations 2 and 3.

Conclusion: evidence, coordination, advocacy, monitoring, guidance, implementation, management

The appeal of these two governance structures is that they work within the bureaucracy, do not require the significant costs of reorganization, can work with departments over time, and can apply sustained pressure. They both work in multiple situations, but as bureaucratic devices are less useful in resolving political conflict. Indeed, a unit or committee that engages in a high-salience political conflict might end up abolished.

There are two summary lessons. First, political support is helpful for them to work best. Even if it is just a repeated signal from senior politicians – a request for regular briefings, mentions in speeches, and so on – it keeps units from isolation and committees from being comatose. Second, a combination is a good idea – a unit to provide energy, a committee to resolve technical issues, and political leadership such as a ministerial committee to channel and contain political disputes. If a unit, committee and some political mechanism are assembled, the combination should be powerful and effective.

Committees are among the most derided of human institutions, it seems, and small units of energetic people on a mission can be annoying. Yet, this analysis argues, governments use them so often for a simple reason. Many of the problems of intersectoral governance, and many of the solutions, lie within government. Interdepartmental committees and units go straight there.

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Chapter 6

Mergers and mega-ministries

Scott Greer

Introduction: uniting functions as a way to affect policy[1]

Ministerial reorganization is not, on the face of it, a rewarding activity for any reason. It is costly; it is invisible to voters; its benefits are not always obvious; and it does not have to happen much to create cynicism. Observers in different political systems routinely use departmental reorganization as a sign that a government is running out of political power or energy (in some countries, big cabinet reshuffles have gone down in folk history as the moment that a dying government's desperation became obvious).

It is, however, easily one of the most popular ways to create intersectoral governance of any kind and a constant topic of conversation among political elites, even in systems where it is rare. It is a derivative of cabinet politics, an indicator and base of the power of different politicians and parties. It is fun in the abstract, letting the mind play across the affinities between two organizationally disconnected policy fields. It is also an obvious solution to a coordination problem: if two units won't work together, then put them in one ministry, with top civil servants and a minister to make them behave.

This chapter reviews the reasons for reorganization, the common effects, and the expectations we should have for it as an intersectoral governance structure. It draws on the small literature about ministries, ministerial reorganization and health ministries (Rose, 1987; Pollitt, 1984; Briatte, 2010; Ettelt et al., 2010; Greer, 2010; Jarman & Greer, 2010; Mätzke, 2010).

1 I would like to thank Edward Page, the editors and the workshop participants for their comments.

Kinds of reorganization

Reorganization can take two forms. One is the "mega-ministry" approach, in which a government combines the large classic functions of government (such as health, transport, labour, social security, education, interior) to create very large and powerful ministries with very large and powerful ministers (e.g. health and social affairs, environment and health). There are not many cases of this in the world. Not only does the size and complexity of big ministries create an administrative problem, but also the creation of such a powerful new minister can upset internal government relations. In the EU, we have a case of this kind of big reorganization: the creation of DG Sanco itself as a large merger that was designed to put a special focus on public health, including by detaching food (and now drug) safety from industry-dominated DGs and putting them in a DG dedicated to health (Grant, 2012).

The other is the simple reorganization, in which a basically stable health portfolio gains or loses some units, as when Spain added first research and then social policy to its central health ministry, or when Scotland and France added sports to the health portfolio. The idea is to take some function – usually a small one – and incorporate it into the strategic direction of another department. Sports, for example, could be seen as the work of a number of different departments (or not the business of government at all), but putting a small sports unit in a large health ministry increases the chances that sports policy will be directed towards improving population health rather than promoting professional football.

Creation of mega-ministries in Hungary: opportunities for intersectoral governance?

Roza Adany

After the latest parliamentary elections in Hungary, new acts (XLII and XLIII/2010) on the governmental structure were enacted and introduced by May 2010. Instead of the 12 ministries of the previous government, eight ministries were created "to make the governmental work more effective". In addition to the traditional ones (the Ministry of Foreign Affairs, the Ministry of Defence, the Ministry of Internal Affairs, the Ministry of Rural Development, the Ministry of Public Administration and Home Affairs), three new ministries were created (the Ministry of National Resources, the Ministry of National Economic Development and the Ministry of National Development), which are special umbrella ministries representing multisectoral but strongly interrelated administration.

The secretariats of the Ministry of National Resources are that of health, education, welfare, culture and sports. Although there are some sceptical voices saying that such a mammoth ministry cannot run smoothly and work effectively, the dominant opinion is

that the legal framework and the administrative structure enable intersectoral governance at least in the field of human development. There is a general belief that if the Ministry can harmonize health, educational, cultural and social policies, to offer appropriate services (among them health and public health services) and to mobilize relevant resources, it can amplify the beneficial effects of actions targeting human resource development and can provide HiAP guidance at governmental level. Intense, continuous collaboration with other ministries and governmental offices is a prerequisite to its success. The questions still open will be answered by future actions.

Source: Hungarian Official Gazette, 25 May 2010

End-points: what ministerial reorganizations achieve

Reorganization is a quintessentially process-based approach. The end-point is a government that is better at mobilizing its internal resources for intersectoral governance (for health). There are four mechanisms in reorganization that can produce this objective.

Changing coordination through hierarchy

The best underlying theory is that if two units now coexist in a single ministry they can be given a mission and ordered to cooperate. Putting the youth portfolio in the health ministry means that the health minister, and health department officials, give orders to the youth unit and can thereby oblige it to contribute to the health agenda. This works almost by definition, but can incur a cost in anything from sheer administrative hassle to sabotage by offended officials. It works best if there is a clear strategy, rather than a general sense of an affinity – if there is a desire to incorporate sports into an anti-obesity strategy, rather than a simple sense that sports "fit" with health as against culture, education or something else, for example. If there is a strategy, then the hierarchy can focus on its implementation. If not, then what exactly is the coordinating we are easing with the reorganization?

Changing priorities within the department

A closely related reason to reorganize is that it will change the priorities of a government ministry. For example, the United Kingdom Ministry of Agriculture, Fisheries and Food (MAFF) was abolished after it presided over a series of public and animal health disasters, including the vCJD ("mad cow") and foot and mouth disease responses. The government deliberately merged it with environment into a Department for Environment, Food and Rural Affairs (DEFRA). Even down to the name, this was an effort to turn a traditional, low-

quality, producer-oriented agriculture ministry into a ministry responsible for sustainable agriculture and good-quality food. The addition of the environment ministry allowed ministers to promote environment ministry officials over MAFF officials, which maximized the chances of the new priorities taking root in a department that had previously just been the farmers' friend.[2]

Changing visibility within the department and government

The case for reorganization to change visibility is very similar to the case for reorganization to change priorities. Creating a cabinet minister or a ministry for a function is a way to signal that the government takes an issue seriously. Looking at ministries across Europe, it suggests that governments are concerned about families, community cohesion and immigration. If we start to see the creation of new public health ministries, that will be an indicator of high-level political interest, regardless of the effectiveness of such ministries.

Changing hierarchy within government

Another reason to change the shape of departments is to change their ability to affect the rest of government. The previous end-points have been internal – better coordination within the areas reorganized. However, making a different department also changes the status of the minister and officials. In general, ministers are more powerful if their ministries command legal authority, money, visibility and resources such as expert staff (Greer, 2010). Creating a bigger department usually means creating a more powerful ministerial post; alternatively, it is possible if not probable that folding a minor unit such as health promotion into a more powerful ministry will increase its status and power within government.

The legacy of a mega-ministry: the South Australian Department of Human Services

David Filby

In October 1997, the South Australian government reformed public administration by creating 10 mega-departments, including the Department of Human Services (DHS), in order to create a streamlined and coordinated public service to provide better services and more efficient and effective government.

The DHS was responsible for health and hospital services, public housing, disability services, ageing, and family and community services, reporting to a single minister. Internal opposition to this consolidation included concerns from non-health services

2 The relative failure to reorient other European agriculture ministries at the same time makes an interesting contrast.

that they would be swamped by the ever-increasing demands for health services, and from health services worried that their growth funding would be transferred to other services. Part of the external opposition arose from the sheer size of the DHS, both as a single public sector entity and as the user of the largest proportion (40%) of the state budget.

As a mega-ministry, the DHS had some success in developing policy, planning and service delivery around a broader picture of individual and community needs rather than specific episodes of care. The focus was on delivering a seamless service, concentrating on those with multiple and complex needs, on common clients of multiple services and partnerships with the non-government services. The exchange of client data between human services became possible, "clients in common" were identified to allow targeting of services, and there was some consolidation of community service providers. Matters in dispute could be decided by a single chief executive and minister.

With a change of government in 2002 the DHS reported to two ministers – Health and Social Justice and Housing. As a result there were tensions on priorities and budgets. In 2004 the government created two departments – Health and Families, and Communities – in part to allow a dedicated focus on health reform (arising from the Generational Health Review) and on child protection.

The ongoing legacy of the DHS can be seen in better partnerships between health and other agencies, a more consolidated response across all human services agencies to the health and well-being target with SASP (http://saplan.org.au), and the current cross-government focus within the HiAP.

Less desirable effects

The mechanisms above are all, essentially, ways to a desirable end. None of them is totally reliable. Unfortunately, the literature suggests that two other effects are much more reliable. They are transition costs, which should be a major part of any government's decisions about this topic, and the fact that neatness will still be difficult to achieve.

Transition costs

Needless to say, any reorganization incurs costs: from obvious ones such as new letterheads to less obvious ones such as changed career ladders for civil servants and turbulent office politics as newly merged staff try to preserve or gain positions. Estimating the obvious costs of departmental reorganization is extremely difficult, but the numbers are large; one systematic United Kingdom study found that a single new department cost an additional £15million in its

first year as a result of the reorganization (White & Dunleavy, 2010). Such a study, obviously, cannot measure the costs of distracted officials, office politics or general confusion – which probably are large. In general, it seems that a reorganized organization will operate below its previous level for three years after its reorganization; any efficiency gains come more than three years after the changes (Fulop et al., 2005).

Organization theory, then, would confirm what many people in government might say: reorganizations waste much time and energy. These costs are perhaps the most reliable consequences of reorganization.

Neatness

Finally, one simple fact of government can never be forgotten: reorganization is not abolition. At the end of the process, every unit and function must be housed somewhere in government. Traditionally, interior ministries had this warehousing function, but as they become more focused on internal state policing we have seen vagabond units spread out across governments. We can read the whole 21st century history of the Spanish central health ministry in this light – a ministry that did not have much to do was hitched first to consumers, then to research and then to social policy, making the best of the necessary process of housing homeless functions somewhere reasonable. An out-of-place unit can absorb more ministerial time and energy than is reasonable, or can receive less than it really deserves. In some political cultures, it might turn into a standing invitation to more reorganization.

What kinds of problems might reorganizations solve?

Bureaucratic coordination is not always the problem in intersectoral governance. We can think of coordination problems in terms of a four-cell diagram. On one axis is the extent of the conflict: how reconcilable are the two positions? On the other axis is the political importance of the conflict, which may be gauged by the status of the politicians involved or the amount of attention it receives in elite political conversation.

In other words, a ministerial reorganization might fix low-conflict situations, regardless of political importance, but is probably too costly. It might work in situations of low political importance and high conflict by changing the priorities of the newly united units. It might work for the same reason in situations of high conflict and high political importance, but the costs of the reorganization might be particularly large.

Table 6.1 *Political conflict and coordination problems*

	High political importance	Low political importance
High conflict	The hardest problem for intersectoral governance. Reorganization might change the parameters of conflict in a way that makes it easier to resolve, but could increase political conflict and cost.	In principle, this requires some sort of hierarchical decision. Forcing the antagonists into one common ministry might make it easier to note and resolve their conflict.
Low conflict	The second easiest kind of problem to solve. Almost any sort of intersectoral governance arrangement could, potentially, fix it.	The easiest kind of problem to solve, requiring only a hierarchical decision. Fundamentally bureaucratic problem; forcing antagonists into one common ministry might make it easier to note and resolve their divergence.

Conclusion

Reorganization is a governance structure with guaranteed significant costs and uncertain payoffs. Systems where it is easy generally would benefit from doing it as little as possible and systems where it is hard should not want it to be much easier.

Null hypothesis: little or no payoff relative to costs

The null hypothesis, the starting expectation, is that reorganizations create transition and organization costs without delivering anything commensurate in terms of changed policy. The larger the scale of the reorganization, the less likely it is that the benefits will ever come close to the costs. Furthermore, benefits of departmental changes tend to come years after the costs. For most governments, the reorganization's benefits in terms of intersectoral governance will come far too late.

Scope conditions: when it might work well

When might ministerial reorganizations work well? The four-cell table above and the political science literature suggest that there are conditions under which reorganizations can work better.

- The most successful big mergers happened in the aftermath of a policy disaster, specifically the vCJD ("mad cow") scandal. That produced both the United Kingdom's new DEFRA (which is an improvement over MAFF) and DG Sanco (an improvement over the previous performance by the Agriculture DG). In such situations, bureaucratic and political advocates of intersectoral governance have an advantage.

- When coordination problems are significant. If they are sporadic, then a mechanism for priority-setting or informal coordination is probably less costly.
- When coordination problems are bureaucratic. If they are political, then reorganizations are a rather inefficient way to overcome divisions within government (of course, if a reorganization is an indicator that one side won, then the reorganization cements the victory, as in the creation of DG Sanco and DEFRA in the United Kingdom).
- When mergers are likely to last, so officials adapt to the incentive structures and guidance of their new department. If governments routinely reshuffle and change borders, then officials' incentive is to focus on avoiding actual change.
- When the merger comes with an identifiable policy strategy that involves joint working. If the merger is based on a general sense of affinity without a strategy, bureaucratic obstacles could easily keep the general affinity from translating into any particular policy change.
- When the minister in the new department is strong within the government and can manage both integration and policy issues. If the minister is weak or distracted, or lacks a strong team, then the new department might have trouble managing itself, and the component units might not change.
- When the merged units were not too organizationally different (in recruitment, pay, career structure, interest group affiliations, bureaucratic corps, party politics, etc.). If merging one unit into a new department damages the careers of its officials, the result could be turbulence and resentment instead of intersectoral governance.
- When one smaller unit is merged into a bigger department with the explicit intent to make it adopt the bigger department's priorities, as with the routine insertion of sports or youth units into health ministries. The bigger department can hierarchically impose its objectives, and the smaller unit is unlikely to be able to resist. Of course, if the bigger department has no particular objectives for the new addition, then the mere fact of hierarchical authority over it does not contribute much.

There are quite a few conditions because there are a good number of cases of qualified success. However, for reorganization to be successful – as organization, let alone intersectoral governance – it probably needs as many of them as possible.

Coordination, implementation, and management

This chapter has not been positive about the potential of reorganizations for most purposes. The costs are guaranteed and the benefits probabilistic. Reorganization is unlikely to produce intersectoral governance of any description if it puts together a set of loosely connected units on the assumption that a minister can find an affinity between them.

When it works, it is likely to work per the scope conditions in the previous section. The more of them hold, the more promising a strategy it might be.

What, then, can it achieve? It is dependent on bureaucracy and hierarchy and operates within government. Its attractiveness is that it can mobilize hierarchical power in the service of a strategy (such as intersectoral governance for health) – directly, by putting units under orders to participate, and indirectly, by connecting the strategy to a powerful minister and showing the priority that the government attaches to the issue.

These point to reorganization as a mechanism, above all, for coordination, implementation and management. There is no guarantee that a reorganization will formulate a strategy, let alone involve new partners. If anything, organizations distracted by changes might be less likely to develop new ideas or relationships. But it can put bureaucracy in the service of a strategy: by putting hierarchical authority in the service of coordination, and by focusing a government ministry on implementation.

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Chapter 7

Joint budgeting: can it facilitate intersectoral action?

David McDaid

Good horizontal relationships between health and other sectors are critical to the implementation of actions for better HiAP. This is by no means a new idea; the importance of intersectoral actions and sharing responsibility for health has long been recognized by those working in the area of health promotion (WHO, 1986). Nonetheless, it is an issue that all too often is either neglected or has been challenging to implement, with a focus therefore on actions that take place within different departmental fiefdoms and budgetary silos.

Health promotion is unlikely to feature prominently as a key goal for most government departments and non-health sector budget holders. Education budget holders, for instance, are more likely to be concerned how their funds might affect average examination grade scores on national tests or the level of truancy in schools, while labour ministries will focus on improving the rate of employment. That is not to say that health concerns are completely off the radar: for instance, the importance of road safety and concerns about the health impacts of car pollution in the transport sector (Stead, 2008). Nonetheless, the predominance of vertical policy structures and funding silos means that, unchallenged, many health concerns that potentially could be addressed through actions outside the health care system remain of low concern to these policy-makers (Timpka, Nordqvist & Lindqvist, 2009). Opportunities to realize substantial health, non-health and economic benefits may thus be missed (Audit Commission, 2007).

Previous chapters have looked at a number of different mechanisms that may help overcome barriers to intersectoral action, including arrangements for political accountability, organizational structure, governance, professional cultures and intersectoral communication. This chapter looks at the potential

for integrating streams of funding across sectors to help facilitate health in all policies. Chapter 8 looks at another important but different approach linked to funding, that is, to delegate funds from health and/or other budgets to semi-autonomous statutory bodies that have a focus on promoting HiAP.

Funding as a catalyst for action

Why look at funding arrangements? The mechanisms by which services are funded can act as a catalyst or barrier to action. The long-term nature of many health promotion and public health initiatives, requiring actions and funding across different sectors, has long been vulnerable to resource constraints and uncertainties. Multiple short-term funding streams, often with tight restrictions on how funding can be used and subject to different financial incentives and cost containment concerns, can act as major impediments to efficient use of resources for HiAP. At both national and local government level, separate funding streams inevitably are more likely to mean that policies may concentrate on achieving internal departmental goals and policy targets rather than broader cross-sectoral aims.

Take, for instance, action to improve the health and well-being of children at school, one of the few places where public health interventions can easily reach most children. There is a growing evidence base supporting the effectiveness of intervention in the first few years of school to prevent and/or tackle bullying and conduct problems. These interventions have the potential not only for better health, but also to generate economic gains to the economy, arising not only from a reduction in the use of specialist health care services, but also reductions in the need for specialist social and foster care services and contacts with the juvenile criminal justice system (Kilian et al., 2010; McDaid & Park, 2011). However, the education sector may be reluctant to invest its limited resources in school-based mental health promotion programmes rather than on core education-related activities. This reluctance may be even more pronounced in times of constrained economic circumstances, when all public services are under heightened pressure to demonstrate their efficiency and added value.

Changing funding arrangements could help overcome some of these narrow sector-specific interests. Cross-sectoral collaboration could be fostered through establishing one single budget for the provision of school-based health promotion. Creating a dedicated budget for a non-health sector health-promoting activity, bringing together resources from the health sector and beyond, provides health policy-makers with a direct means of influencing policy in other sectors. For instance, the approach might be used to ensure adequate funding and priority is given to road safety measures by ministries of transport, or to address health concerns in new urban housing developments.

It has also been argued that joint funding across sectors could help eliminate unnecessary gaps and duplications in services (Audit Commission, 2008; Advisory Group on the Review of the Centre, 2001; Audit Commission & Healthcare Commission, 2007). Flexibility and innovation may also be encouraged through more flexible funding that can allow actions across sectors. Pooling funds may help reduce administration and transaction costs, generating economies of scale through pooling of staff, resources and purchasing power, while facilitating more rapid decision-making (Weatherly, Mason & Goddard, 2010).

How have these arguments been borne out in reality? What lessons can be learnt from the experience to date and what are the implications for the use of joint budgets more broadly in the areas of health promotion and disease prevention? These are questions that this chapter seeks to address. It firstly looks at the different types of joint budgeting arrangements, institutional frameworks and governance structures that may be used, reviews what is known about their effectiveness and highlights some examples where they have been used in practice. It ends by looking at additional factors that need to be considered when implementing joint budgeting arrangements in different contexts and settings.

Joint budgeting: a variety of approaches

The term "joint budgeting" can itself cover a number of quite different mechanisms (Box 7.1), involving two or more government departments and/or tiers of government, in order to help achieve one or more shared goals. They can range from fully integrated budgets for the provision of a service or policy objective to loose agreements between sectors to align resources for common goals, while maintaining separate accountability for use of funds. Another limited approach might be to have jointly funded posts to help coordinate intersectoral policies.

Agreements on joint budgeting can be mandatory or voluntary in nature and operate at a national, regional and/or local level. They may be accompanied by legislation and regulatory instruments. There may be very detailed agreements between sectors on how budgeting mechanisms will work. These could, for example, include identification of any host partner, clarity on functions, agreed aims and outcomes and the levels of contributions, 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.

Box 7.1 *Different approaches to joint budgeting*

Budget alignment: Budgets may be aligned rather than actually joined together. For instance, a health commissioner can manage both a health budget and a separate local authority budget to meet an agreed set of aims.

Dedicated joint funds: Departments may contribute a set level of resources to a single joint fund to be spent on agreed projects or delivery of specific services. This may often be a time-limited activity. There is usually some flexibility in how funds within the budget can be spent. A variant of this in the United Kingdom is the Individual Budget, which pools funds from several sectors but leaves it to the discretion of service users as to how funds should be spent.

Joint-post funding: There may be an agreement to jointly fund a post where an individual is responsible for services and/or attaining objectives relevant to both departments. Theoretically this can help ensure cooperation and avoid duplication of effort.

Fully integrated budgets: Budgets across sectors might become fully integrated, with resources and the workforce fully coming together. One partner typically acts as the "host" to undertake the other's functions and to manage all staff. To date this has largely been restricted to partnerships between health and social care organizations, or for the provision of services for people with mental health needs.

Policy-orientated funding: Central or local government may set objectives that cut across ministerial and budget boundaries and the budget system. Money may be allocated to specific policy areas, rather than to specific departments, as has been seen in Sweden and England.

The temporal nature of joint budgeting arrangements also varies – they can be time-limited, short-term initiatives, particularly when receiving grant funding from central government, or envisaged as a longer-term, more permanent organizational change. In most cases decisions on how joint budgets will be spent will be taken by policy-makers and/or service managers, but recently initiatives which are intended to empower users of services by giving them a pooled budget have also begun to develop, as with the Individual Budgets scheme in England (Moran et al., 2011).

Experience in joint budgeting

The problems of fragmented, inflexible, funding structures and poor collaboration across sectors in respect of the management of chronic health problems and

disabilities, as well as the challenge of sustaining initiatives in the area of health promotion and public health, have been one spur to the development of joint budgeting initiatives in high-income countries. Joint budgets have also been seen as a route to efficiency savings and also give more choice to service users in those models where they are given direct control of budgets.

Examples of joint budgeting and discussion in policy documents in the health sphere can be identified in a number of countries, including Australia, Canada, England, Italy, the Netherlands and Sweden (McDaid et al., 2007). A feature of many of these initiatives is that they focus on easily identifiable population groups that have a clear need not only for health care services, but also support from services such as social care, education, housing and employment. Continuity of care and support for these population groups requires a coordinated approach across sectors and schemes. Initiatives have often been set up with the explicit aim of overcoming the fragmentation in funding and service provision that has hindered the development of seamless care pathways.

The four parts that make up the United Kingdom, as well as Sweden, have been particularly prominent in the joint funding of services and programmes to support older people who may be frail, as well as those who have physical disabilities or chronic health problems, including mental health needs (Weatherly, Mason & Goddard, 2010). Pooled budgets have also been used to help develop joint approaches to rehabilitation and return to work for individuals with chronic health problems, as in the case of those with musculoskeletal health problems in Sweden, where the health, social insurance and social work sectors have worked together to address this issue (Hultberg, Lonnroth & Allebeck, 2007). In England, Scotland and Wales, road safety initiatives have also brought together partners from the health, transport, child and safety sectors (Audit Commission, 2007).

In England, the 1999 and 2006 NHS Acts also set out a number of different statutory arrangements for the joint financing of health and social care services by the NHS and local authorities. In this case, joint financing initiatives could also be accompanied by legislation allowing the delegation of functions between partners, theoretically making joint working arrangements easier to achieve. Limits remained on what could be delegated, with responsibility and accountability for some issues staying with the appropriate department. Legislation also allowed for the control of pooled budgets from different sectors (excluding the NHS) directly by social care service users as part of the Individual Budgets programme (Moran et al., 2011). However, despite much discussion and policy documentation on collaboration and joint funding, uptake of these mechanisms remains very modest: by 2008 they accounted for just 3.4% of total health and social care expenditure in England (Audit Commission, 2009).

In the Netherlands, joint budgets have been used for research and policy activities in connection with the national action programme on environment and health, funded by the ministries of environment and health (Stead, 2008). In New Zealand, there has been a drive to encourage more partnership arrangements, with funding arrangements being one way of achieving this (Advisory Group on the Review of the Centre, 2001). Legislation in response to recommendations from a major report on the workings of the public sector now allows 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 (Public Health Advisory Committee, 2004). For instance, the Healthy Eating, Healthy Action (HEHA) 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 nongovernmental organizations, the fitness and food industry and Sport and Recreation New Zealand. The aim was to promote improved nutrition, physical activity and a healthy weight for all New Zealanders (Ministry of Health, 2008).

Are joint budgeting arrangements effective?

The evidence on the effectiveness of joint budgeting arrangements is limited and rather equivocal, as illustrated in one review of experience from England and Sweden (Hultberg et al., 2005). In part, this is because much evaluation to date has focused on process measures, such as the level of agreement and cooperation, rather than on final outcomes (Norman & Axelsson, 2007). However, there can be significant complexities and administrative difficulties in their implementation (Public Health Advisory Committee, 2006; Audit Commission, 2009).

Joint budgets can help overcome narrow sectoral interests by widening the area of responsibility and interest of stakeholders and promoting flexible funding, but there is as yet no strong evidence that they have made a difference to final outcomes and little is known about their cost–effectiveness compared to previous arrangements (Audit Commission, 2009). Exceptions can be noted, though, as with some experiences in transport safety in the United Kingdom, where the impact of jointly funded actions on casualty rates can be identified as a key indicator of success (Department for Transport, 2009). Another example is that of the town of Swindon in England, where £28 million in health and social care funds were pooled for children's services, at a set-up cost of £10 000. Involving three separate agreements and phasing in integration, moving first from aligned to pooled budgets, there were improvements both in rates of

obesity and youth employment or training participation rates in the year after the scheme was launched (Willis, 2011).

In Sweden, cross-sectoral initiatives have been the subject of much evaluation. The SOCSAM scheme allowed social insurance and social services to voluntarily move up to 5% of their budgets, along with a matched contribution from health services, to a pooled budget to jointly manage rehabilitation services to help individuals on long-term sick leave return to employment (see case study for more details). It was evaluated in eight localities and compared with experience elsewhere in the country where schemes were not introduced. Along with funding, joint financial management arrangements were set up, helping to foster the development of joint services and a more holistic approach to activities. The evaluation found that interdisciplinary collaboration between health and social care professionals improved compared to control areas (Hultberg, Lonnroth & Allebeck, 2003). This Swedish experience also suggests joint funding arrangements and collaboration at local or regional level, where institutional structures are closer to stakeholders and have a better understanding of local problems, can be effective. Following evaluation, a new FINSAM scheme to support cooperation across these sectors was rolled out on a voluntary basis nationwide (Stahl et al., 2010).

Coordinated budgeting in Sweden: collaboration in vocational rehabilitation across sectors and levels of society

Runo Axelsson

Since the early 1990s, there have been extensive experiments in Sweden with intersectoral collaboration in the field of vocational rehabilitation. As in many other countries, the responsibility for rehabilitation is divided between welfare institutions belonging to different sectors and levels of society. Between 1993 and 1997 there was an experiment where resources for rehabilitation were transferred from the national social insurance system to the health care system in five localities, with the aim of reducing the costs of sickness benefits. Between 1994 and 2002 the experiment was extended in eight municipalities to include social services and the national employment service.

In this experiment, there was financial coordination between the different institutions involved and intersectoral collaboration in cross-boundary groups or teams. Both of these experiments were evaluated and initial positive results led to the 2003 Act on Financial Coordination of Rehabilitation Measures. Although not binding, this legislation made it possible for institutions in the rehabilitation field – the national employment service, the national social insurance administration, the regional health services and municipal social services – to form local associations for financial coordination.

This collaboration across levels of society was possible since the national agencies and the regional health services are also represented at the local (municipal) level. Local associations are formed voluntarily by the institutions themselves and financed by their own resources, which are pooled into a joint budget and allocated for different rehabilitation services or programmes.

Models of intersectoral collaboration developed in these associations include case management or working with multidisciplinary teams. The rehabilitation activities of the local associations have been evaluated regularly and positive developments are spread throughout the country. Intersectoral collaboration has grown from the bottom up and as at 2011 there were more than 80 local associations for vocational rehabilitation in the country. Although it is difficult to evaluate their overall impact, the growth of these associations is an indicator of their efficiency and usefulness. Experience suggests that intersectoral collaboration may be more effective at local or regional level, where it is closer to problems and the individuals concerned, than at national level.

Joint budgets are unlikely to be sufficient on their own to promote intersectoral activity, although they have in some circumstances improved understanding across sectors and promoted flexibility in how funds are used. In England and Sweden, joint budgeting has been associated with the development of more of a whole-systems culture approach, ending the cross-sectoral "blame game", generally contributing to more flexibility in how resources are actually used, particularly for complex care packages (Hultberg et al., 2005). Different funding stream leads collaborating on Individual Budgets in England have also improved their relationships with other funding stream leads, as well as their knowledge of colleagues from different sectors and of the different aims, objectives and procedures in those sectors (Moran et al., 2011). In England, partnerships with integrated budgets between health and local authorities for the provision of services for children have been perceived by participating stakeholders as ultimately helping to promote efficiency and improve care pathways for children in need (Lorgelly et al., 2009). One challenge, however, is the long-term sustainability of partnerships arising from joint budgets; where time-limited grants from central government were included in the budget, partners have had to make up the shortfall in the budget after the end of grant funding if work is to be continued.

Joint funding arrangements can be poorly understood and be the subject of complex legislation (Audit Commission, 2008, 2009). The rules governing joint budgeting can be very different in different sectors and/or in respect of specific target groups. For example, evaluation of the Individual Budgets initiative found that the legislative framework established at national level

created restrictions on who was eligible for support, as well as on individual and organizational accountability, meaning that there was little flexibility on how resources pooled together from different sources could be used at local level (Moran et al., 2011).

Similarly, in England, while legislation in the 2004 Children's Act allowed joint objectives to be agreed between local authorities and health care commissioners in respect of children's services, allowing parties to contribute towards the costs of meeting these objectives through whichever partner was providing the service, it did not enable the delegation of functions or allow partners to deliver services not identified as their responsibility (Lorgelly et al., 2009). There may be other complex legal barriers to partnership and pooling of budgets: in Germany, for example, the Federal Constitutional Court ruled as unconstitutional an already implemented programme, Hartz IV, which had merged social assistance and unemployment programmes (Bundesverfassungsgericht, 2009).

Factors to aid in the implementation and success of joint budgeting

A number of factors that can aid in the implementation of joint budgets have been identified (Box 7.2). It is clear that the process must begin by carefully defining health and other policy issues that may benefit from joint budgeting, considering what actors and stakeholders need to be involved and understanding their priorities and goals.

Box 7.2 *Factors that can aid in implementation of joint budgets*

- Identify rationale, potential health and non-health benefits and added value to sectors of pooling resources.
- Establish clear outcomes to be achieved.
- Speak the languages of all sectors, not just that of the health sector.
- Determine how current funding and legislative frameworks are operating across sectors.
- Move towards flexibility in legislative and regulatory frameworks governing joint budgeting.
- Engage in sustained efforts to build cross-sectoral trust, and training in common skills and competences.
- Consider use of performance-related incentives.
- Identify economic costs and benefits of joint budgets.
- Consider using financial instruments to ensure where budgets are aligned rather than shared so that all sectors can benefit equally from any efficiency gains made.

Partners need to perceive any pooling of resources and structures as being in their own interests, adding value to what they can achieve in isolation. Health stakeholders also need to be able to converse in the language of potential partner sectors; too often stakeholders from the health sector do not look at the consequences of health promotion for their partners. As Stead (2008) notes in respect of partnerships between transport, the environment and health, "there is the impression that [the health sector] is not so very interested in transport or environmental matters and more concerned with medical infrastructure (hospitals), equipment or consumables (medicines)". Similarly, in the case of initiatives to promote return to work by those with chronic health conditions in Sweden, a lack of willingness of the Employment Service to contribute to joint budgets did hinder effective implementation of the scheme (Stahl et al., 2010).

In both of these cases, stakeholder willingness to participate could have been enhanced by highlighting non-health benefits – for example, a reduction in delays due to accidents as a result of safer roads, or a reduction in the need to pay disability benefits to individuals who can return to employment. In the case of the education sector, this may mean highlighting any positive impacts that investing in better emotional health and well-being at school can have on classroom disruption, teacher sickness leave and pupil educational performance.

Encouraging participation in joint budgeting may also be fostered by demonstrating the short-, mid- and long-term economic case for action. This analysis can take into account any administration and other costs incurred as part of the joint budgeting process. For example, in the case of new road safety partnership schemes in the United Kingdom, overall a favourable rate of return on investment of around 190% was anticipated (Department for Transport, 2009). The business case can also be strengthened by looking at cost offsets for different sectors, such as reduced costs to the health care system if road casualties decrease. The economic impacts on the environment of the promotion of cycling and walking have also been considered (Kahlmeier et al., 2011).

At national and local levels, therefore, finance ministries and departments have an important role to play in quantifying and disseminating information on the costs and benefits of better intersectoral working (Audit Commission, 2007). Tight economic conditions can be a barrier to investment by different stakeholders in joint budgets (Lorgelly et al., 2009). Where budgets are aligned rather than joined, compensatory financial mechanisms might therefore potentially be used to distribute any cost offsets that are realized between different budget holders so that all sectors benefit from any overall reduction in costs (McDaid, Drummond & Suhrcke, 2008).

Even when agreement in principle has been reached between partners that some form of joint budgeting is worth pursuing, it is important to determine how current patterns of funding operate in different sectors and clarify what institutional and legal structures are in place, in order to consider what joint budgeting arrangements may work best. Establishing clear outcomes on what should be achieved is a prerequisite to looking at issues around budget and risk sharing. Legal and regulatory frameworks ideally should have sufficient flexibility to allow maximum discretion in how pooled funds are used. Ideally, they should allow funds to be used for any reasonable purpose rather than being earmarked; a single accountability structure looking at actions of the joint planning team as a whole rather than separate accountability structures for each sector can also help promote transparency and flexibility in how funds are used.

For new arrangements which are not specified in legislation and where there may not be much history of shared working and trust, formal or informal agreements on how joint funding will operate are needed. These, for instance, could look at who should contribute what, the type of resources to be combined, how much, for how long, and with what management and accountability arrangements. In seeking to get joint budgeting up and running it may be easier initially to begin by pooling any externally acquired funds, such as one-time central government grants, before integrating existing sector-specific resources.

Once mechanisms are in place, sustained efforts will probably be needed to develop good cross-cultural working relationships to help realize potential benefits that may come from the elimination of duplication of effort and reorganization of working practices (Ovretveit, Hansson & Brommels, 2010). The reality is that it can take time to build up trust between partners with very different languages and perspectives, even when all partners are financially contributing to the budget. Involving team members from all sectors in determining the culture and values operating within an integrated team has been considered important in establishing clear identity and purpose in successful initiatives (Willis, 2011). There may also be a need for training in common skills and competences for all individuals, in addition to preserving their key skills and expertise. In both England and Sweden, training and team bonding exercises have been used to help with changes in roles within multidisciplinary teams.

Physically co-locating staff from different sectors in the same office so that they can start to build up face-to-face working relationships and start thinking of themselves as part of a common team can also help. Other mechanisms to build up communications and trust include regular networking between different stakeholders and the establishment of intersectoral committees to oversee implementation of a programme, as in the case of an initiative to improve the quality of life of older people in Vienna.

Joint financing in Vienna: sALTo – improving the quality of life of older people

Sabine Haas and Elisabeth Teuschl

The pilot project sALTo, which ran from November 2006 to May 2008, was initiated by the Vienna City Department for Urban Planning to improve and sustain the quality of life, mobility and health of older people in two areas of the city. A budget of €260 000 was jointly financed by the local authority and health sectors. Project planning and implementation was undertaken by an intersectoral committee involving different city administrative departments, the Viennese health promotion agency, two external contractors, local policy-makers, nongovernmental organizations and residents. It focused not only on urban, health and social service planning but also integration, diversity and housing.

Coordination was the responsibility of intersectoral teams and contractors. At district level, local residents, politicians and institutions interested in the project were consulted regarding measures to be implemented. Tools for communication and advocacy were used to ensure sustainability. Networking at district level between urban planning, health and social services was initiated to promote data exchange.

Measures for specific target groups focused on empowerment to support active ageing, for example through better public spaces (pavements, green areas, meeting points), intergenerational cooperation and the more active involvement of old people in the planning of their environment. The partnership between the health and urban planning sectors managed to achieve a high level of synergy. The opportunity to interact at different levels on the built environment and health promotion, often through "softer" tools, turned out to be a "win-win" situation. The common language and understanding established in the pilot project would benefit further opportunities for collaboration and the structures implemented continue to be used in a modified form.

Sources: Doringer et al., 2009. See also the web site: https://www.wien.gv.at/ stadtentwicklung/grundlagen/ stadtforschung/sozialraum/salto.html.

Employing facilitators at the start of a partnership can help in fostering trust and dealing with disagreements (Norman & Axelsson, 2007). Transparency and access to information from different financial systems is also important. Employing a dedicated individual, funded through the joint budget, to help coordinate efforts across sectors can also be important for those forms of joint budget that stop short of the full integration of funding and services.

Finally, and regardless of model of joint budgeting used, potentially there may be a place for performance-related financial and non-financial rewards linked to achievement of joint policy goals. The establishment of a common set of performance and outcome indicators that include success in establishing

joint budgeting initiatives or in the proportion of budgets that are pooled for health-related actions would be a prerequisite to this (Schwedler, 2008; Audit Commission, 2009).

Conclusions

Different forms of joint budgeting can be used to help promote opportunities for intersectoral work for HiAP. Examples of intersectoral work with some form of shared or aligned budgets can now be seen in several high-income countries. All of these efforts indicate that when it comes to joint budgeting arrangements, no one approach is ideal in all circumstances.

While the legal frameworks under which joint budgeting operates may be established at national level, schemes appear to be more likely to be successfully implemented at a very local level, such as at city or town level. This in part may be a reflection of institutional structures in countries such as Sweden and England, where many decisions are taken at a local level, but the need to tailor joint budgeting arrangements to meet different contexts and institutional arrangements may mean that above a certain geographical or budgetary size, schemes become difficult to manage. At national level, despite attempts to encourage collaboration across government departments, research work in England suggests that civil servants may find it difficult to look beyond their departmental silos (Moran et al., 2011).

Careful consideration, therefore, needs to be given to the design of any joint budgeting initiative, taking account of context and resources. There appears to be an important distinction to be made between those schemes that may be mandatory and imposed, usually by central government, and those schemes that are voluntary in nature and require buy-in from different stakeholders.

Both approaches have strengths and weaknesses. In the short term, the mandatory pooling of budgets and de facto requirement that different sectors collaborate may help facilitate HiAP and will provide opportunities for mutual learning across sectors. However, the imposition of these schemes from above may mean that there is resistance to collaboration from different sectors, which may not augur well for their long-term sustainability. 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 (Glendinning, 2003). If mutual learning or trust does not develop between sectors, mandatory partnerships may be difficult to sustain in the long term if any mandatory joint funding or central government grant funding dries up.

Approaches whereby different sectors come together voluntarily to pool funds will take more time to establish. They rely more heavily on securing the buy-in of different stakeholders by demonstrating the potential added value of collaboration, both in terms of health and objectives of importance to other sectors. This voluntary approach to sharing funds necessarily relies more heavily on trust and open discussion; in turn, mutual learning and innovation is enhanced by the development of trusting relationships. Voluntary pooling of resources may thus be more sustainable in the long term as long as all partners have a sense of ownership over collaboration, making them more willing to continue to make a contribution towards the pooled budget (Armistead & Pettigrew, 2008).

Where well implemented, measures to bring budgets together can help embed health impacts in all policies. In the longer term, if such initiatives and partnerships are sustained, then a common working culture can be established, reducing potential distrust and misunderstandings between partners. It should, though, be stressed that joint budgeting arrangements are more likely to be successful when complemented by other actions to facilitate intersectoral actions and improved partnership working. These can include additional ways of enhancing dialogue across sectors, such as co-location, equal sharing of financial rewards of collaboration and the use of performance-related incentives. It is also important that the lessons and outcomes of different successful and unsuccessful approaches to pooling resources be disseminated widely and the evidence base on the extent to which different budgeting mechanisms have been associated with improved health and other outcomes, as well as cost efficiencies, be strengthened.

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Chapter 8
Delegated financing

Laura Schang and Vivian Lin

Introduction

Provision of funding across sectoral lines tends to be one of the main challenges for governments to enable and sustain preventive action on the SDoH (PHAC, 2007). Addressing this challenge, some governments have developed intersectoral funding arrangements placed either within government, such as joint budgets (see Chapter 7), or beyond government. Delegated financing is an example of the latter. Delegation does not necessarily entail intersectorality. However, country experiences suggest that delegated financing offers, based on a transfer of authority and dedicated resources from government to semi-autonomous statutory bodies, various opportunities for intersectoral governance. Therefore, this chapter offers an insight into the contribution of delegated financing to facilitating intersectorality for HiAP.

The chapter draws on four cases from Europe and Australia. While these delegated financing bodies evolved in different country contexts and not necessarily to enhance intersectorality (Box 8.1), they illustrate how delegated financing gives rise to various potentials, and constraints, as an intersectoral governance structure for HiAP. The chapter first reviews the intersectoral actions that delegated financing bodies may trigger, before going on to discuss key structural parameters of delegated financing underlying these intersectoral actions. Seven lessons learned are included, regarding the extent to which delegated financing may (and may not) contribute to HiAP.

Intersectoral actions: what delegated financing can achieve

Delegated financing can enhance intersectoral action for HiAP by stimulating shared financial commitment for health, and providing funds for intersectoral programmes and projects.

Box 8.1 *Why delegation?*

In the Australian State of Victoria, delegation of health promotion financing to a statutory body resulted from political prudence. Delegation was supposed to counter concerns that government might try to control community groups through its funding decisions. The creation of a relatively independent body to administer the funds – VicHealth – thus symbolized governmental commitment to investing in health promotion, but as a function to be realized independently from party politics.

In Austria and Switzerland, in turn, delegation seemed more related to the effective use and upgrading of existing structures. In both countries, small information and coordination platforms had been evolving and building health promotion expertise during the 1980s. When in the 1990s parliaments decided to earmark financial resources for health promotion, the existing organizations – today known as the Austrian Health Promotion Foundation and Health Promotion Switzerland – were mandated to channel these funds through their infrastructure.

The establishment of Big Lottery Fund and its predecessor organizations as delegated bodies conformed to a long administrative tradition in the United Kingdom. Delegation of authority and resources to nondepartmental independent bodies has been increasingly pursued since the 1970s, in various policy fields and by both Conservative and Labour governments, to render the delivery of public services more efficient.

Sources: Borland, Winstanley & Reading, 2009; EDI, 2008; www.fgoe.org; Flinders, 2004.

Stimulating shared financial commitment

Some delegated financing bodies use co-financing as an instrument to achieve shared financial commitment for health. In 2008, for instance, the Austrian Health Promotion Foundation co-financed total project costs of €20.16 million with €4.24 million (21% on average). The remainder was invested by local and state governments and project partners such as companies, insurers or other external funders (FGŐ, 2009a). Evidence suggests that the Foundation's high-quality criteria mobilize and encourage other funders to contribute as well, meaning that a grant issued by the Foundation functions as "door-opener" to other grants (Christ & Plunger, 2009). Therefore, while the volume of statutory revenue provided by government can vary remarkably between delegated bodies, systematic application of the co-financing principle can double or even triple available funds for health promotion (Table 8.1).

However, the effectiveness of co-financing as an instrument to achieve intersectoral collaboration will most likely depend on the type of sector involved. Big Lottery Fund, for instance, perceives full funding as an instrument to engage sectors for health. The Fund explicitly recognizes that its grant receivers

Table 8.1 *Impact of co-financing on available funds for health promotion*

	Big Lottery Fund	VicHealth	Health Promotion Switzerland	Austrian Health Promotion Foundation
Statutory revenue in 2008[a]	€751 million[b]	€21.3 million[c]	€12.3 million[d]	€7.25 million
Budget per permanent resident in 2008[e]	€12.2	€3.9	€1.6	€0.9
Estimated impact of co-financing on available funds for health promotion[f]	(projects receive full funding)	(projects receive full funding)	€24.94 million Total project costs: €19.6 million (including €7.56 million contributed by the organization) Remaining funds of the organization: €5.34 million[g]	€23.41 million Total project costs: €20.16 million (including €4.24 million contributed by the organization) Remaining funds of the organization: €3.25 million[h]
Budget per permanent resident in 2008 including the impact of co-financing	(see above)	(see above)	€3.2	€2.8

[a] Based on VicHealth, 2009b; GFCH, 2009; BIG, 2009a. All exchange rates as at 31/07/2010.
[b] Based on £625 million from Lottery income, financial year 2008/2009, used for all funding areas under the general description of "health, education, environment and charitable purposes" (BIG, 2009a). Many programmes are responsive to the needs of grant receivers, meaning that the level of spending on health varies from year to year and can be considerably lower. The Fund does not split out the amount spent on health annually, as funding programmes run over several years (Gerald Oppenheim, Director of Policy and Partnerships, Big Lottery Fund, personal communication, 2010).
[c] Based on $A 30.8 million appropriated by government; total income including investment was $A 32.7 million (€22.7 million) (VicHealth, 2009b).
[d] Based on CHF 16.73 million from insuree surcharges; total income including interest/investment and not exhausted project grants was CHF 17.39 million (€12.8 million) (GFCH, 2009).
[e] Own calculations based on: 5.43 million permanent residents in Victoria (www.census.abs.gov), 7.7 million in Switzerland (www.bfs.admin.ch), 8.3 million in Austria (www.statistik.at), 61.4 million in United Kingdom (www.statistics.gov.uk).
[f] Own estimations based on GFCH, 2009, FGÖ, 2009.
[g] These are allocated to research, conferences, services, campaigns, administrative expenditure.
[h] Sixteen lottery funders in total deliver the funds raised through the National Lottery for "good causes" such as arts, charities, voluntary groups, heritage, health, education, environment and sports (28 pence of every pound spent on a Lottery Ticket). Big Lottery Fund is responsible for allocating 46% of these funds (about 13 pence of every pound spent on a Lottery Ticket). See also http://www.lotteryfunding.org.uk/ uk/lottery-funders-listing.htm and http://www.biglotteryfund.org.uk/index/about-uk/about_blf.htm (accessed 31 July 2010).

– voluntary and community organizations – require ongoing funding, but have scarce access to other income sources (BIG, 2009a).

Providing funds for intersectoral programmes and projects

Enabling delivery of intersectoral programmes and projects is a main allocation strategy across all organizations studied. Delegated financing bodies can address a range of health issues and sectors, which differ between organizations and partly also over time. VicHealth, for instance, was initially created to fund tobacco sponsorship replacement in the sports and arts sectors. When, in

the mid 1990s, health promotion was recognized as hardly reaching socially disadvantaged groups, VicHealth's funding focus shifted towards developing sports and arts organizations as settings that promulgate change in the social and physical environment. Nowadays, VicHealth collaborates with many sectors on various health issues beyond tobacco control. Health Promotion Switzerland, in contrast, has focused on two priorities – healthy body weight for children and adolescents and workplace health promotion – to fill the gaps in the Swiss health promotion landscape. Cantonal governments and the private sector are major partners. Big Lottery Fund, in turn, allocates most of its grants through voluntary and community sectors, given their closeness to deprived populations. Funding is targeted at communities in need within and beyond the United Kingdom. The Austrian Health Promotion Foundation has concentrated on setting-based projects in workplaces, schools and municipalities targeted at employees, children and vulnerable groups, respectively.

To varying degrees, these organizations have linked programme and project funding to investment in broader knowledge- and capacity-building. Examples include funding for research, evaluation and workforce development, as well as networking and/or advocacy (Table 8.2, Box 8.2).

Table 8.2 *Intersectoral funding activities of delegated financing bodies*

VicHealth	Funding projects, research and development activities with strategic focus on tobacco control, healthy eating, physical activity, social and economic inclusion, freedom from discrimination and violence, prevention of alcohol misuse and UV protection
	Collaboration with sports and arts sectors, health, planning, transport, local government, education, community organizations
	Networking/developing strategic alliances with national and global public health organizations to strengthen health promotion action and advocacy
	Promoting workforce development through seminars and training courses with university partners
Big Lottery Fund	Funding projects that improve health, education and the environment: under the strategic themes of supporting community learning and creating opportunity, promoting community safety and cohesion and promoting well-being – mainly through voluntary and community sectors
	Programmes for England, Scotland, Wales, Northern Ireland
	UK-wide programmes: commissioning of research and evaluation; collaborations with the media, such as with a TV broadcaster on public voting and decision-making on grant allocation ("The People's Millions"); and on inspiring communities to create and care for local green spaces for wildlife and people ("Breathing Places")
	International programmes to tackle the causes of poverty and deprivation overseas

Table 8.2 *(contd)*

Austrian Health Promotion Foundation	Development and awarding of projects regarding cardiovascular health, and in municipality, kindergarten/school and workplace settings
	Commissioning of research for further development of health promotion and prevention and epidemiology, evaluation and quality assurance
	Continuing education of health promotion and prevention professionals and (inter)national networking through conferences, training courses and cooperation with international umbrella organizations
	Support of the self-help community through continuing education and publications
Health Promotion Switzerland	Negotiation of Cantonal Intervention Programmes on healthy body weight for children and adolescents with cantonal governments; coordination and impact management of the programmes
	Planning, implementation and evaluation of workplace health promotion measures with health insurers, the Swiss Insurance Association and workplaces of all sizes and sectors; other workplace health promotion cooperations with private and public sector partners
	Networking at national and international level to strengthen health promotion and prevention

Sources: www.vichealth.vic.gov.au; www.gesundheitsfoerderung.ch; www.fgoe.org; www.biglotteryfund.org.uk (accessed 31 July 2010).

Box 8.2 *How funding can trigger intersectoral action – an example from VicHealth*

VicHealth supports integrated planning within local governments as an approach to linking discrete municipal plans (on housing, youth, care of elderly people, public health, corporate policy, etc.) to increase cross-government synergies and, ultimately, improve community well-being. For instance, the MetroACTIVE programme aimed to build local government capacity for integrated planning to foster physical activity. VicHealth provided grants (ranging between $A 72 000 and $A 140 000) to six metropolitan councils to conduct two-year projects for integrated planning on physical activity. During the project phase, VicHealth organized cluster meetings for participating councils to share experiences and develop steps for improving practice. Moreover, VicHealth funded short courses in integrated planning to enhance knowledge and awareness of council staff on the linkages between health, social, environmental and economic factors, and identify options for integrating policy across council divisions. To promote integrated planning more widely, VicHealth created a Local Government Physical Activity Network for all Victorian councils. City councils used the funding to set up cross-council steering committees and to collaborate with external partners such as neigbourhood and community health centres in the implementation of community physical activity initiatives. VicHealth funding enabled the participating councils to develop their current capacities; while some had experience in cross-council collaboration, others established new planning processes and structures. Corresponding to diverse local needs, the outcomes of integrated planning differed between city councils and included, for instance, the creation of a sustainable transport planning group or the adoption of urban design principles to facilitate walking.

Sources: VicHealth, 2002; Thomas, Hodge & Smith, 2009.

Explaining intersectoral actions: structural parameters of delegated financing

This section aims to disentangle key structural parameters of delegated financing that may explain how linking governance action to governance structure might occur, and to what extent the proposed end-points of effective delegated financing – providing funds for intersectoral action and engaging various sectors for health – can be reached. Relevant structural parameters are legislatively secured resources, engagement in governance, and government linkages.

Legislatively secured resources

The delegated financing bodies under study were endowed with dedicated public resources by parliament in the late 1980s and 1990s. Their legislative revenue sources originate from within the health system or from outside the health system (Table 8.3), but the feasibility of a source may depend on the context. For instance, following a court case brought by the tobacco industry, the Australian High Court declared VicHealth's funding model through tobacco fees levied by the Victorian state government as unconstitutional, as only the Federal Government may levy excise duties (Borland, Winstanley & Reading, 2009). Eventually, the Victorian Health Ministry assumed funding for VicHealth (VicHealth, 2005).

Table 8.3 *Statutory basis and revenue sources of delegated financing bodies*

	VicHealth	Big Lottery Fund	Health Promotion Switzerland	Austrian Health Promotion Foundation
Statutory basis	Tobacco Act (1987)	National Lottery Act (1993, 1998, 2006)	Sickness Insurance Act (1996)	Health Promotion Act (1998), Federal Law on Healthy Austria GmbH (2006)
Revenue sources	*1987–1997*: dedicated levy of 5% on top of existing Victorian state tobacco fees *since 1997*: appropriation of Victoria's annual health budget	Appropriation of 14% of National Lottery ticket sales income[8]	Levy of CHF 2.4 (€1.6) on top of compulsory health insurance premiums	Dedicated sum of €7.25 million from sales tax revenue

Sources: VicHealth, 2006; GFCH, 2009; Nationalrat, 1998, 2006; www.biglotteryfund.org.uk.

The structural design of their legislatively secured revenue sources enables delegated financing bodies to provide sustainable funding, but potential volatilities in revenue and funding continuity require consideration.

Relatively high statutory revenue, as appropriated to VicHealth and Big Lottery Fund, certainly expands their scope of action, including potentially on the SDoH.[1] However, both organizations are, at the same time, subject to potential annual fluctuations in their statutory income, because the state retains relatively high control over their annual appropriations. VicHealth's budget, for instance, was cut twice by government in the context of a fiscal crisis (VicHealth, 2006). Similarly, the United Kingdom Parliament decided to transfer £638 (€766.7) million of the Fund's income between 2009 and 2012 to another fund preparing the Olympic games. The unpredictability of future lottery ticket sales, the Fund's revenue source, also complicates long-term planning and, eventually, the scope of action (BIG, 2009a).

Health Promotion Switzerland and the Austrian Health Promotion Foundation, in contrast, face low or no annual fluctuations in their income. Their statutory revenue is a legislatively fixed appropriation per health insuree (every legally established resident) or a lump sum, respectively. This "legislative shell" ring-fences funds for health promotion and facilitates long-term planning for the organizations. However, revenue sources of both Health Promotion Switzerland and the Austrian Health Promotion Foundation have not been inflation-adjusted since their establishment in 1996 and 1998, respectively, meaning that total disposable income suffered a real loss of 12% and 20% over the past decade.[2] In this respect, the state can also shape the scope of action through political inaction (Hill, 2009).

Except for VicHealth in some cases, the organizations under study provide seed-funding. From the perspective of sustainability, this seems to create a paradox of long-term and (relatively) secured organizational budgets, but short-term funding. Seed-funding may stimulate change, but also sow scepticism among grant-holders rather than support sustainability (Higgins, Naylor & Day, 2008). In some cases, achieving lasting changes in the policies of other sectors may require financial commitment over decades. VicHealth's ongoing funding since 1988 for the UV protection programme "SunSmart", for instance, has been identified as a decisive factor in adopting and modifying sun protection policies of local governments, schools and leisure organizations, influencing weather forecasting and shaping the regulatory framework for solaria, the fashion and sunscreen production industry (Montague, Borland & Sinclar, 2001).

1 In terms of number of funded projects, for instance, the Austrian Health Promotion Foundation funded 82 projects in 2008, while VicHealth awarded 946 grants (FGÖ, 2009a; VicHealth, 2009a).

2 Own calculations based on Austrian Chamber of Economy, http://www.wko.at/statistik/prognose/inflation.pdf, and on http://www.indexmundi.com/switzerland/inflation_rate_(consumer_prices).html. (accessed 1 March 2010).

Engagement in governance

Who decides on the allocation of funds is another parameter of delegated financing as an intersectoral governance structure, because intersectorality can be achieved through an intersectoral governing board involving experts from different sectors, parliament, different ministries and levels of government and/or stakeholder organizations, or through mechanisms for external public and stakeholder engagement. As regards HiAP, the approach to intersectorality may influence *which* policies are addressed.

The Austrian Health Promotion Foundation and VicHealth exemplify structural arrangements that may not only contribute to intersectorality, but also to endurance of the structure itself. The Austrian Health Promotion Foundation's board members are delegated from all three levels of government (federal, state, municipal). The Health Minister presides over the board, ensuring high-level commitment. Moreover, the Ministries of Education and Finance – which administers the annual appropriation to the Fund – are represented with one seat each (FGÖ, 2009).[3] For VicHealth, parliamentary engagement manifested as a key parameter. The Victorian Parliament appoints three deputies – one from each party – to VicHealth's board. This arrangement was designed to build, and apparently succeeded in building, cross-party commitment to VicHealth even after changes in government (VicHealth, 2005).

VicHealth's other board members are (similar to Big Lottery Fund) appointed by government based on personal professional expertise. VicHealth's statutory basis stipulates quotas for experts in health, sports, arts, business and marketing. To fulfil these quotas, two major stakeholders in Victoria – the Cancer Council and the Sports Federation – have each been empowered to propose a panel of candidates from which the Health Minister has to choose one candidate. This was seen as crucial to ensure VicHealth's credibility with the public and to counter criticism that government might try to dominate community groups (Borland, Winstanley & Reading, 2009). Emphasis on intersectorality and professional expertise is also a common response to policy complexity (Elgie, 2006) and may, thus, enable the pooling of sector-unique expertise for HiAP.

In both Austria and Switzerland, stakeholder affiliation constitutes the main board membership criterion. The statutory basis of the organizations enables various stakeholders, mainly from the health sector, to represent their interests in the governing boards. Some groups have more seats than others: as Health Promotion Switzerland is legislatively under their responsibility, cantons and insurers delegate four and six representatives, respectively, to the 17-member

3 To achieve terminological coherence, the term "governing board" is used for all foundations. Literally, the boards translate as Foundation Council (Health Promotion Switzerland) or Board of Trustees (Austrian Health Promotion Foundation).

board (GFCH, 2009), which certainly influences the funding focus on cantonal programmes and workplace health promotion with insurers.

By definition, stakeholders may function as legitimate partners in governance. In 2006, Austrian senior citizen associations convinced the Federal government of their importance in view of the ageing society, and now also delegate two representatives. However, stakeholder governance also raises the problem of "entryism": if organized groups joined to represent the concerns of specific groups, while other interests were systematically excluded, this could weaken the legitimacy of delegated bodies (Wilmot, 2004). While a flexible approach to governance seems desirable in a changing environment, hard-to-hear groups risk being neglected in the selection of stakeholders for governance (Stone, 2002).

Illustrating an approach to tackle this challenge, Big Lottery Fund has systematically integrated public engagement mechanisms into the governance structure. For instance, the development of the long-term strategy involved extensive public consultation through a national survey on future funding priorities, eliciting over 3400 responses and engaging more than 3000 people through nationwide events, and a further 8000 through web forums, online videos and social networking sites (BIG, 2009b). Citizen engagement in actual decision-making on allocation of funds takes place, for instance, through cooperation with a TV broadcaster where TV viewers can (since 2005) vote on the allocation of funds to project applicants ("People's Millions"). These public engagement mechanisms are considered a success, as they reinforce and reflect ownership of public money.[4]

Advisory structures supporting the governing boards reflect another approach to enhance intersectorality and interest-balanced allocation of funds. The Austrian Health Promotion Foundation and Health Promotion Switzerland, for instance, rely on one permanent advisory committee for strategic planning, whose membership is drawn from academia. In contrast, VicHealth's board convenes advisory panels according to need, and draws members partly from VicHealth staff and partly from external stakeholders such as academics, practitioners, local governments, the National Heart Foundation or the Cancer Council. In 2008, three panels supported the executive in quality, knowledge and performance questions, eight topic-specific panels with 10–20 members reviewed project applications to handle the high number of applications for over 900 funded projects (FGÖ, 2009; GFCH, 2009; VicHealth, 2009a,c).

4 Gerald Oppenheim, Director of Policy and Partnership, Big Lottery Fund, personal communication, 2010.

Table 8.4 *Interest representation in the governing boards*

VicHealth	Health Promotion Switzerland	Austrian Health Promotion Foundation	Big Lottery Fund
President: elected by the board	**President:** elected by the board	**President:** Health Minister	**Governance board of 12** appointed based on personal professional expertise through open recruitment, including:
Members: *3 members elected by parliament* based on their experience in health, sport, arts, research, communication	**Representatives:** 5 for health insurer associations	**Representatives:** 2 further representatives from the Ministry of Health	a Board Chairperson
11 ministerial appointments:	1 for accident insurers	1 for the Ministry of Finance	the Chairpersons of the 4 committees in England, Scotland, Wales and Northern Ireland
3 with expertise in health and illness prevention, one of whom chosen by the Minister from a panel of three names submitted by the Cancer Council	4 for the cantons	1 for the Ministry of Education	7 general members including a Vice Chairperson appointed by the Board from its general members
4 with expertise in sport/ sports administration, one of whom is chosen by the Minister from a panel of three names submitted by Victoria´s Sports Federation	1 for the Federal government,	2 for the insurers	
2 with expertise in business, management, communications or law	1 for the physicians association	2 for the Seniors' Council	
1 with expertise in the arts/arts administration	1 academic representative	1 for the Austrian Cities Association	
1 with expertise in advertising	1 for the health leagues	1 for the Austrian Municipalities Association	
	1 for the association of health professionals	1 for the Conference of Health Referees	
	1 for consumers	1 for the Chamber of Pharmacists	
	1 for the pharmacists	1 for the Chamber of Physicians	
		1 for the Regional Chiefs Conference	

Sources: Parliament of Victoria, 1987; GFCH, 2002; FGÖ, 2009; www.biglotteryfund.org.uk.

Government linkages

Operating at arm's length from government, delegated bodies experience the tension inherent in the combination of political accountability yet independence from political interference (Birrell, 2008). In practice, the nature of government linkages, such as board appointments, statutory directions and organizational linkages, influence the balance between accountability to, independence from, and coordination with government.

Governance through independent boards enables delegated financing bodies to fund and work across sectoral boundaries and to advocate for social change, as they are able to trial innovative ideas beyond political constraints of governments

Delegated financing and public/private partnership in Singapore: the case of the Health Promotion Board

Ling Chew

The Health Promotion Board (HPB) in Singapore was formed on 1 April 2001 to drive the national health promotion and disease prevention agenda. Its goals are to increase the quality and years of healthy life for the population and prevent illness, disability and premature death. HPB's annual operating budget amounted to about SGD 164 million (€105.7 million) in 2011. The funding is from the Singapore Ministry of Health through general taxation. In spearheading the health promotion agenda, HPB aligns its responsibilities and annual workplans with national health care priorities. While HPB is accountable to the Ministry of Health through a set of negotiated performance measures, it has the autonomy to maximize its efficiency and effectiveness in its operations. HPB, currently 860 strong, is led by a Chief Executive Officer and has an 11-member Board of Directors, drawn from various industry sectors to ensure good corporate governance and provide guidance in the strategic direction of the agency. To achieve its vision and mission, HPB forms sustainable partnerships with the public and private sectors as well as civic organizations to build capacity and capability in health promotion. The majority of such partnerships are based on mutually agreed goals and may include co-financing initiatives. Multipronged strategies, based on WHO's Ottawa Charter, drive the structured engagement of the stakeholders and partners to develop initiatives which facilitate the practice of healthy behaviours in the different segments of the population in various settings. Increasingly, HPB has drawn upon Singapore's whole-of-government approach to include a health agenda in public policies and private markets: for example, the provision of infrastructure to promote physical activity in urban planning and influencing eating establishments, industry and retailers to create demand for and supply of healthier food options. The health status of the nation is monitored regularly though national surveys.

Source: HPB, 2009, 2011

(Mouy & Barr, 2006). For example, VicHealth has been pioneering policies on mental health promotion that go beyond early intervention towards social participation, community well-being and prevention of gender violence (VicHealth, 2009a; Moodie & Jenkins, 2005). Experience suggests that, based on such cross-cutting approaches, delegated financing bodies have contributed to shifting public attitudes and developing local settings.[5]

While independent governance creates opportunities for cross-cutting and creative approaches, some involvement (without dominance) of government in governing boards may be beneficial: it can create structural linkages to

5 Professor Horst Noack; Professor Vivian Lin, School of Public Health, La Trobe University, Australia; personal communications, 2010.

the political level and thereby facilitate bottom-up feedback from practice to policy. It may also prevent duplication of efforts if more than one agency is involved in health promotion (Carol, 2004). Majority and voting distributions in the governing boards are likely to influence the potential tension between coordination with government and freedom from political interference.

Besides representation of government, two further structural parameters can limit the independence of a governing board: first, the board members of all organizations under study are appointed (yet not always *selected*, as previously described) by government; second, the boards are accountable to government in their annual operations.

Accountability arrangements can be traced to statutory directions that specify funding areas and/or target sectors. For instance, the Austrian Health Promotion Foundation's mandate lays down priority groups and funding approaches (Nationalrat, 1998, Art.2). VicHealth is, among others, legislatively required to allocate at least 30% of its budget through sporting bodies (Parliament of Victoria, 1987, Art.33).[6] Big Lottery Fund even receives policy and financial directions on grant receivers, funding themes and conditions, and financial management and control. These directions also stipulate public engagement in governance (DCMS, 2006, Art.3D). Relatively open statutory directions, in contrast, might complicate accountability arrangements. Health Promotion Switzerland's mandate, for instance, merely requires the organization to "initate, coordinate and evaluate measures for health promotion and disease prevention" (BSE, 1994, translation of Art. 19(2)).

The structural risk for an organization that operates at arm's length from government is its relationship with the ministry of health, from the viewpoint of authority, coordination and accountability. The existence of a delegated financing body can lead to perceptions of a parallel public health world.[7] In Switzerland, perceived fragmentation of health promotion financing due to 26 cantonal policies in general and Health Promotion Switzerland in particular has caused dissatisfaction. To increase stewardship capacities at Federal level, the Confederaton proposed in 2009 to redirect the funds from Health Promotion Switzerland to a new Prevention Institute steered by the Federal government (SBR, 2009).[8]

6 This legal quota related to political efforts to reduce the dependence of sporting bodies on tobacco sponsorship during the creation of VicHealth in 1987. As the Liberal Party opposed a tobacco sponsorship ban, VicHealth was mandated to fund tobacco sponsorship replacement and thereby leave free choice to sporting bodies to promote either health or tobacco (VicHealth, 2005).

7 Dr Salome von Greyerz, Head of Section Innovative Projects, Swiss Federal Department of the Interior/ Ministry of Health; Professor Vivian Lin, School of Public Health, La Trobe University, Australia; personal communications, 2010.

8 This institute would shift the power balance towards the Confederation, which would assume five of nine seats in the governing board, alongside three cantonal representatives and one insurers' representative. The proposal was supported by the majority of cantons and adopted by the Federal government, but not yet discussed by the legislator. See also Swiss Health Ministry, http://www.bag.admin.ch/themen/gesundheits politik/07492/ index.html?lang=de (German language, accessed 3 May 2010).

For similar reasons, the Austrian Health Promotion Foundation was in 2006 integrated into a government-owned company in the remit of the Health Ministry. However, the Foundation remains governed by an independent board with the same (relatively strong, but not majority) representation of Federal government as before. Experience suggests that this tentative recentralization facilitates collaboration with other operational divisions.[9] This includes planned cooperation for developing health targets, and identifying partners for promoting HiAP (FGÖ, 2008). Moreover, the organizational linkages have facilitated an agreement with the federal institute in charge of health reporting to expand the indicators on SDoH.[10]

Lessons learned

The aim of this chapter is to give an overview of delegated financing as an alternative governance structure to finance health promotion. Delegated financing has potentials and constraints. Against this background, seven lessons learnt can be identified regarding the degree to which delegated financing may contribute to HiAP.

Lesson 1: delegated financing can facilitate intersectoral action

Although delegation does not necessarily lead to intersectorality, and intersectorality can be achieved without delegation, the country experiences presented in this chapter suggest that delegated financing does provide an opportunity to promote intersectoral action. This may include systematic co-financing that effects joint budgets, statutory mandates enabling intersectoral allocation of funds, and engagement of stakeholders, experts, parliament and/or the public in governance.

Lesson 2: structural parameters make a difference

Structural parameters will influence the extent to which delegated financing bodies will be able to perform their primary governance action – the provision of sustainable funding for health promotion. If the volume of statutory revenue is rather symbolic and static, for instance due to lack of inflation adjustment, delegated financing may merely "window-dress" the problem of securing sustainable funding. While systematic co-financing can multiply funding for health promotion, the type of sector addressed and the funding timeframe also require consideration. Thus, effective use of structural parameters will be essential to coordinate investment in health promotion.

9 The government-owned company also comprises the Austrian Federal Institute for the Health System and the Federal Institute for Quality in the Health System. See http://www.goeg.at/en/About-Us.html (accessed 3 May 2010).

10 Mag. Christoph Hörhan, Chief Executive Officer, Austrian Health Promotion Foundation (at the time of study), personal communication, 2010.

Lesson 3: co-financing can foster ownership and sustainability

Co-financing can propagate sustainable change in policies across sectors by building shared financial responsibility and ownership. Arguably, economic downturns may impede the mobilization of funding. However, creative responses to the economic crisis may include media outreach reinforcing the linkages between health and wealth, such as increased workforce productivity and educational attainment as returns on investment in HiAP, and more effective use of synergies and existing structures.

Lesson 4: delegated financing can enable social change

Delegated financing bodies can function as advocates of social change. Their independent governance enables the trialling of innovative, cross-cutting and controversial ideas where government units might be politically or administratively constrained. Involvement of government in governing boards creates opportunities to feed back practical experiences from funded projects to the political level and thereby support social change from the bottom up.

Lesson 5: quality of linkages affects stewardship

The quality of linkages influences the degree to which delegated financing serves as a governance tool for *governments*. Structural linkages with government should not result in conformity with the political agenda or prevent delegated financing bodies acting as advocates of social change. Nonetheless, delegation requires appropriate oversight of government to prevent fragmentation of governance. Presidency of the health minister in the governing board illustrates a possible approach to high-level governmental stewardship without domination.

Lesson 6: coordination could be a secondary governance action

Their position between the state, civil society and the private sector creates high – possibly unused – potential for delegated financing bodies as platforms for coordination. Board membership of relevant stakeholders and effective linkages to government may enable delegated financing bodies to function as mediators and bridge-builders. This will be relevant especially in highly complex policy environments with various actors.

Lesson 7: delegated financing is not a magic bullet

While there are many good reasons for delegation, such as policy complexity, state tradition or increased legitimacy through an independent body (Elgie, 2006), similar arguments are often raised against (Flinders, 2004). In this respect, delegated financing is not a magic bullet for every context.

Delegated financing bodies that are embedded in a comprehensive health promotion infrastructure can help to stimulate intersectoral action in various ways, but are unlikely to change overall economic and social policies without such embeddedness. Nevertheless, the lessons learnt regarding delegated financing may inspire country-specific searches for models of financing health promotion.

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Chapter 9

Involving the public to facilitate or trigger governance actions contributing to HiAP

François-Pierre Gauvin

Introduction

Involving the public in decisions affecting their lives is a fundamental value entrenched in health promotion charters (Ritsatakis & Järvisalo, 2006; Scutchfield, Hall & Ireson, 2006), and it is increasingly perceived as an ingredient of success in intersectoral initiatives for improving the health of communities (Ministry of Health, 2005), as well as an effective strategy to facilitate or trigger governance actions contributing to Health in All Policies (HiAP) (Koivusalo, 2006).

For example, the Bangkok Charter stipulates that the "active participation of civil society is crucial" to place health at the centre of development (WHO, 2005). In addition, the Adelaide Statement on HiAP indicates that citizen involvement mechanisms have proved to be useful in assisting policy-makers to integrate considerations of health, well-being and equity in public policies (WHO, 2010).

These calls for greater public involvement are also made against a backdrop of dissatisfaction towards standard policy-making mechanisms, which appear inadequate to address the "wicked problems" we are facing today, such as health inequities, obesity, HIV/AIDS and climate change (Evoy, McDonald & Frankish, 2008; OECD, 2009). As suggested by Kreuter et al. (2004), policy-makers, public health professionals and other stakeholders who are grappling with such problems cannot expect to resolve them effectively by relying

exclusively on experts. "Wicked problems" need to be discussed and articulated by all relevant stakeholders, including the public, to fully understand their complexity and achieve agreement on acceptable solutions (Australian Public Service Commission, 2007).

In addition, governments cannot effectively tackle such severe problems if they rely exclusively on a "command and control" strategy. As Salamon (2002) pointed out, the new governance necessitates "cooperative actions orchestrated through complex networks" of stakeholders. To achieve such cooperative actions, public administrators must develop new skills and strategies: convening, conflict assessment, negotiation, active listening and reframing, facilitation, and consensus building (Blomgren Bingham, Nabatchi & O'Leary, 2005).

Although there are growing calls for public involvement to facilitate or trigger governance actions, the concept remains poorly articulated and several terms are often used interchangeably and inconsistently (e.g., public consultation, public participation, public engagement) (Rowe & Frewer, 2004). Therefore, there is little practical guidance for public administrators: "How and when does a public manager attempt to engage the public and how broadly? Which forms of citizen or stakeholder engagement are most effective?" (Blomgren Bingham, Nabatchi & O'Leary, 2005).

The purpose of this chapter is to explore how public involvement can facilitate or trigger governance actions contributing to HiAP. To do so, two contrasting cases will be presented: (1) one that was initiated by a nongovernmental organization – the Strategic Meeting on Health (Quebec, Canada); and (2) one that was initiated by a government – Healthy People 2020 (United States). Analysing and comparing these two information-rich cases will serve to reveal five key dimensions of public involvement in the context of HiAP. The chapter will conclude with a brief discussion of the factors that may influence the effectiveness of public involvement strategies.

Two contrasting cases

The Strategic Meeting on Health (Canada)

The Strategic Meeting on Health was initiated in 2005 by the Institut du Nouveau Monde, a nongovernmental organization based in Montreal. The Strategic Meeting on Health was a series of eight public dialogues held across Quebec, which culminated in a national public dialogue in Montreal. Overall, 175 citizens and 20 experts gathered in the regional and national dialogues. Although the dialogues were organized by a NGO, they spurred interest among civil society actors and public agencies, many deciding to collaborate on the

initiative, either by providing financial sponsorship or expertise to inform participants.

The overarching objective of the Strategic Meeting on Health was to construct a vision of the Quebec that citizens aspired to inhabit in 20 years from now. In order to achieve this vision, members of the public were informed about five dilemmas affecting the health of the population and the sustainability of the health care system: Is health an individual or a collective responsibility? Is the role of the State to prevent or cure? What should be the public and private sector roles in health care? Should we pay more or should we reduce the Medicare basket? Who should decide: bureaucrats, physicians, politicians or citizens? Participants were invited to exchange and debate with experts before proposing recommendations to tackle these five dilemmas. At the end of the national dialogue, citizens formulated 100 ideas for a healthier Quebec (Saint-Pierre, Venne & Villeneuve, 2005).

Among these ideas, citizens suggested that Quebec's National Assembly should appoint a commissioner with the mandate to appraise the impacts of governmental policies on the health of the population and its determinants, in order to minimize potential negative impacts and maximize positive impacts. In the same vein, participants proposed the creation of the Office for Public Audiences on Health, a neutral and independent organization responsible for conducting health impact assessments of any major projects that may be implemented in the province, but also to allow citizens to express their views on these projects (Venne & Famhy, 2005).

Healthy People 2020 (United States)

The second case is the public consultation organized during the preparation of Healthy People 2020 by the Office of Disease Prevention and Health Promotion (ODPHP) of the United States Department of Health and Human Services. Healthy People 2020 is a comprehensive set of health promotion and disease prevention objectives with targets for the United States to achieve by the year 2020. These objectives are informed by a nationwide public consultation and stakeholder dialogues to ensure that Healthy People 2020 is relevant to the health needs of the population (ODPHP, 2009).

Three public involvement mechanisms were used to inform the first phase of work of the Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Starting in the spring of 2008, members of the public were invited to comment on the vision and mission statements, overarching goals and focus of Healthy People 2020 via a public comment web site (http://www.healthypeople.gov/hp2020). Comments submitted to

the web site were periodically analysed and submitted to Advisory Committee members. Next, the ODPHP organized six regional meetings across the United States in the spring of 2008 to discuss the development of the framework for Healthy People 2020. The regional meetings were open to members of the public, as well as representatives of state and local health departments, universities, professional associations, public and private health organizations, and other civil society actors. A representative of the Advisory Committee was also present at each regional meeting. Finally, the public was also invited during that period to present oral comments to the full Advisory Committee at one of its face-to-face meetings in Washington, DC. The overarching goal was to incorporate public input into the recommendations formulated by the Advisory Committee.

In 2009, following the release of the Healthy People 2020 framework, another round of public consultation was organized. Members of the public were invited to submit comments on the draft set of proposed objectives and topic areas. Comments could be submitted by email, via the public comment web site, or during three public meetings held during the autumn of 2009. This public input informed the final set of objectives of Healthy People 2020, released in 2010 along with guidance for achieving the new 10-year targets (ODPHP 2010). Early reports indicate that the public involvement strategy generated 8000 public comments via the web site and public meetings (Blakey et al., 2010).

Five dimensions of public involvement

Public involvement scholars and practitioners have tried over the years to identify some key dimensions to distinguish different types of public involvement, which has led to the development of various conceptual frameworks. These have ranged from simple one-dimensional frameworks which describe the degree of influence (or power) that the public yields in a decision-making process (Arnstein, 1969; IAP2, 2010), to multidimensional frameworks which reflect that different "publics" can play different roles at different moments in the policy-making process (Fung, 2006; Tritter & McCallum, 2006; Wilcox, 1994).

Drawing from that body of knowledge, a conceptual framework is proposed below that identifies five key dimensions in which public involvement can vary: (1) the paths of influence; (2) when the public is involved in the policy-making process; (3) the level of involvement; (4) the degree of inclusiveness; and (5) the decision-making proximity.

The paths of influence

The first dimension relates to paths of influence. In other words, public involvement can facilitate or trigger governance actions contributing to HiAP in at least four ways.

(i) *Advocacy*. Public involvement can help to build public commitment to the health promotion agenda and empower the public to advocate for HiAP (Evoy, McDonald & Frankish, 2008; Koivusalo, 2006). Such public advocacy can help to induce legal changes as well as promote a cultural shift within governments and other relevant stakeholders contributing to HiAP.

(ii) *Evidence support*. The public's experiential knowledge constitutes valid and legitimate evidence that can help to find innovative and local solutions to collective problems (Elliott & Williams, 2004; Evoy, McDonald & Frankish, 2008; Fischer, 2000).

(iii) *Setting goals and targets*. Public deliberations can help to build momentum and reach agreement between citizens, experts, policy-makers and other stakeholders on a set of goals and targets (Ellen & Shamian, 2011).

(iv) *Policy guidance*. Involving the public can offer policy guidance on how to move forward, or what policy options are socially, politically and ethically sound. This is why the public can be seen as "value consultants" offering guidance on complex issues (Beierle, 1999).

The overarching objectives of the Strategic Meeting on Health were to trigger government actions through the four strategies, but with a specific focus on advocacy. The idea was to nurture public commitment for HiAP, with the intention of triggering a cultural shift within the provincial government. In contrast, the overarching objectives of the public consultation for Healthy People 2020 were to facilitate government actions through the four strategies, but with a specific focus on setting goals and targets. The idea here was to move from policy prescription to concrete policy goals and targets.

When to involve

The second dimension highlights when the public is involved in the policy-making process. Policy-making can be conceptualized as a cycle with five stages[1] (Howlett & Ramesh, 2003), each offering different opportunities for

1 The policy cycle is a simplification of a complex and, sometimes, chaotic process. It should not suggest that policy-makers go about solving complex problems in a systematic and linear fashion. For example, the policy formulation stage may sometimes precede the agenda-setting stage as policy-makers try to find a problem that could be linked (or attached) to a policy option that has already been formulated (Howlett & Ramesh, 2003). Nonetheless, the policy cycle can facilitate understanding of the different stages when the public can be involved, but also help to understand the intended goals of public involvement.

public involvement (Moro, 2005).

(i) The *agenda-setting* stage refers to the process by which problems come to the attention of governments. At that stage, the public can help to identify and define problems, and influence the governmental agenda.

(ii) The *policy formulation* stage refers to how policy-makers formulate different options to address a problem. At that stage, the public can set governmental objectives, identify policy options to solve a problem, and identify the implications of these options (e.g., in terms of effectiveness, equity, feasibility, as well as social and political acceptability).

(iii) The *decision-making* stage refers to the process by which governments adopt a particular course of action (or non-action) to address a problem. At that stage, the public can help to build consensus that will inform the government's decision.

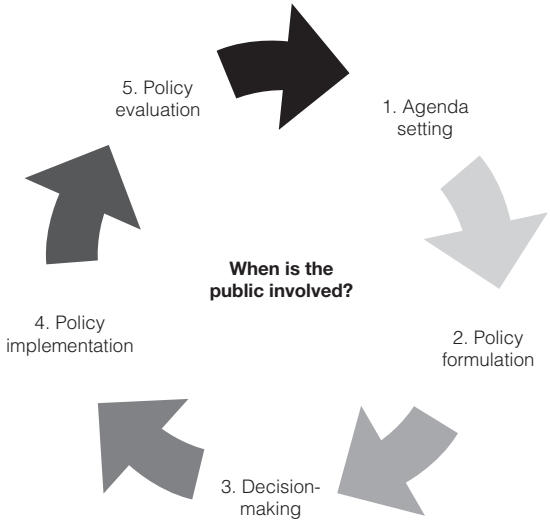
(iv) The *policy implementation* stage relates to how governments put policies into effect. At that stage, the public can help to achieve effective policy implementation by mobilizing the enthusiasm and knowledge of those who will be affected by the policy.

(v) Finally, the *policy evaluation* stage refers to the process by which the results of policies are monitored by both state and other stakeholders, including the public. Given the outcomes of the policy evaluation, a feedback loop may reconceptualize a problem and the solutions to address it.

The two contrasting cases presented above took place at different stages in the policy cycle (Fig. 9.1). In the case of the Strategic Meeting on Health, the public dialogues were organized during the agenda-setting stage. In 2004 the provincial government launched a committee to offer recommendations on a highly politically sensitive issue: the sustainability of the universal health care system in Quebec. The Institut du Nouveau Monde wanted to take advantage of this window of opportunity by creating citizens dialogue that could influence the committee and, ultimately, the governmental agenda. As regards Healthy People 2020, the public consultation was held at the policy formulation stage. Since 1979, there has been a regular 10-year cycle of public consultations in order to set national health goals and targets that will guide policy decisions.

These two cases illustrate a tendency to involve the public early in the policy cycle. Yet we often neglect to involve the public meaningfully in later stages: to make policy decisions, to implement policies and/or evaluate policies. Thus, policy-makers who wish to build on public involvement as part of a wider strategy for HiAP should reflect on the opportunities and benefits to engage the public in the full policy cycle.

Fig. 9.1 *Five stages of the policy cycle*



Level of involvement

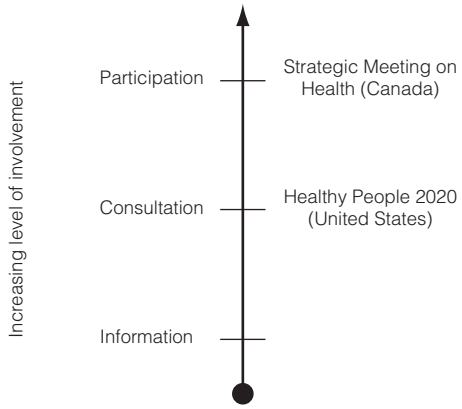
The third dimension refers to the level of involvement, or the degree of influence that the public will have in the policy-making process. This dimension was first highlighted by Arnstein (1969) in her seminal article about the "ladder of citizen participation". This ladder depicts eight rungs, ranging from non-participation and tokenism to citizen power. It illustrates gradations of participation depending on the degree of power redistribution among decision-makers and the public.

Arnstein's work inspired the development of various frameworks commonly used today to illustrate different levels of public involvement (Health Canada, 2000; IAP2, 2010). Yet, most recent efforts tend to synthesize these ladders or continuums in three main levels: information, consultation and participation (Fig. 9.2) (OECD, 2001; Rowe & Frewer, 2005).

Information

Information refers to a one-way relationship in which the government (or the sponsor of the public involvement initiative) produces and delivers information for use by the public. It covers both "passive" measures (e.g., access to information upon demand by the public and web site) and "active" measures to disseminate information (e.g., advertising and social marketing campaigns, information kits, media events, expert testimonies, press releases, telephone information lines) (OECD, 2001).

Fig. 9.2 *Levels of public involvement*



This constitutes the lowest level of public involvement. Nonetheless, as stated by Creighton (2005), "inside every public participation program is a good information program". Therefore, the public needs clear, complete and unbiased information in order to contribute meaningfully to the policy-making process. Public information appears particularly relevant in the context of HiAP. According to Ollila et al. (2006), it is important to inform the public and raise awareness about the health implications of policies in order to enhance public dialogues and open decision-making.

Both the Strategic Meeting on Health and Healthy People 2020 relied on information mechanisms, either through expert witnesses presenting information to the public, the development of workbooks, or the launch of web sites with information about the issues at stake.

Consultation

Consultation refers to a relationship in which the public provides feedback to government (or the sponsor of the public involvement initiative) (OECD, 2001). As Rowe and Frewer (2005) point out, there is no formal dialogue between individual members of the public, as well as between members of the public and the sponsor of the initiative. Although consultation mechanisms offer limited public influence (Gregory, Hartz-Karp & Watson, 2008), they can be useful to gain a better understanding of the public's "raw opinions".

Public consultation methods cover both and scientific methods of data collection (e.g., surveys, questionnaires, focus groups and interviews) and more open and democratic methods (e.g., public comment web site, public hearings, town hall meetings) to collect the public's views (Health Canada, 2000; IAP2, 2010). As seen above, the public involvement strategy for Healthy People 2020 relied mostly on open and democratic consultative mechanisms, such as large public meetings and the use of a public comment web site (Fig. 9.2).

Participation

Participation refers to a relationship based on partnership with government (or the sponsor of the public involvement initiative), in which the public is actively engaged in defining the process and content of policy-making (OECD, 2001). According to Rowe and Frewer (2005), "there is some degree of dialogue in the process that takes place". It covers both participatory methods (e.g., involving members of the public in advisory committees) and more deliberative methods (e.g., deliberative polls, consensus conferences, citizens juries, scenario workshops, citizens assemblies) (Abelson, 2001).

The Strategic Meeting on Health is a case of participation which relied on dialogue and deliberation (Fig. 9.2). Citizens were invited to receive information about five dilemmas, they discussed with other citizens and experts on these dilemmas, and they deliberated in order to reach agreement on a series of recommendations for a healthier Quebec.

This case illustrates the growing interest in recent years in deliberative mechanisms (Gregory, Hartz-Karp & Watson, 2008; Scutchfield, Hall & Ireson, 2006). There is indeed a desire to engage the public actively in policy-making as problem solvers, rather than simple political commentators or spectators (Abelson, 2010). It is assumed that deliberation will help to transform the public's "raw opinions" into more thoughtful and considered public judgments (Rowe & Frewer, 2005; Yankelovich, 1991).

Degree of inclusiveness

The fourth dimension specifies the degree of inclusiveness of the public involvement process. Both the Strategic Meeting on Health and Healthy People 2020 were open to all who wished to be involved (Fig. 9.3), which is the case in the vast majority of public involvement mechanisms (Fung, 2006). Although such high degree of inclusiveness may be appealing, participants remain self-selected and may be quite unrepresentative of those who will be affected by a given issue.

Other public involvement processes (e.g., deliberative polls, citizens juries and citizens assemblies) use strategies to randomly recruit members of the public based on a set of predetermined criteria, an approach that may best guarantee representativeness (Fung, 2006). For example, civic lotteries can be used to randomly select citizens for public service in order to create panels that roughly match the demographic profile of the wider population (Dowlen, 2008).

A less inclusive approach would be to purposefully recruit participants. For example, the sponsor of a public involvement initiative may be interested

Fig. 9.3 *Degree of inclusiveness*

in recruiting participants from subgroups of the general population that are seen as less likely to engage. The sponsor may also be interested in recruiting participants who have very different opinions regarding the issue at stake, or the sponsor may wish to recruit politically important public representatives.

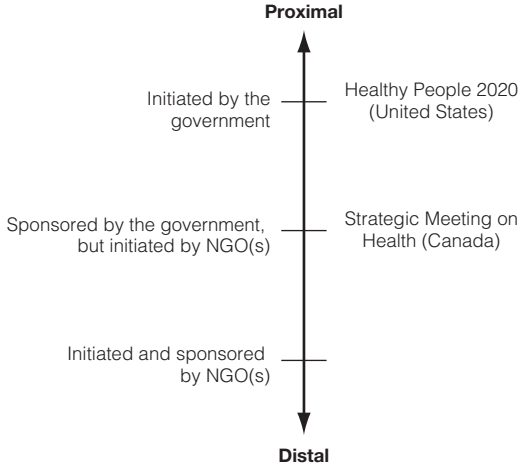
Decision proximity

The fifth dimension refers to the decision proximity (Dobrow, 2010). It describes the strength of the link between the public involvement process and the policy-makers (Fung, 2006). In many cases, a public involvement initiative will be organized by the government, like Healthy People 2020. In such cases, the public involvement initiative is linked to a specific decision outcome and it is embedded within the policy-making process (Fig. 9.4).

However, public involvement processes can also be initiated by nongovernmental organizations (NGOs). Indeed, governance is not the turf of policy-makers and bureaucrats alone. Civil society organizations can play a crucial role by promoting public debates and dialogues that can influence governance actions.

Thus, a public involvement process can be initiated by a NGO, with or without sponsorship from the government. This was the case with the Strategic Meeting on Health, which was initiated by the Institut du Nouveau Monde (Fig. 9.4). The initiative was not directly linked to a specific decision outcome and it was not embedded within the policy-making process. However, it generated enough interest from government officials who were willing to commit resources to support the initiative.

Fig. 9.4 *Decision proximity*



The effectiveness of public involvement

Despite the demonstrated commitment to public involvement in public health, there is still a lack of good quality research evidence about which public involvement strategies are the most effective. Yet, there has been some consensus in recent years over principles or criteria necessary for a public involvement exercise to the considered effective or successful (Abelson & Gauvin, 2006; OECD, 2005). For example, Frewer and Rowe (2005) identified nine criteria that should be satisfied for a public participation exercise to be considered successful (Table 9.1). In light of these nine criteria, the two cases presented above reveal how too much independence may impede influence over policy-making, and how public involvement processes that are too inclusive sometimes raise questions about their representativeness.

Although the Strategic Meeting on Health could score highly in terms of independence since it was initiated by a NGO, the low decision proximity certainly hindered the capacity of the public to have a genuine impact on governance actions contributing to HiAP. Yet one could argue that the public dialogues had a symbolic influence by raising the awareness of the public and provincial policy-makers. Indeed, this event opened the doors of many public organizations to the Institut du Nouveau Monde, which was able to promote the recommendations formulated by the citizens. As evidence, the dialogues were referenced by the provincial committee in its final report about the sustainability of the health care system (Ménard, 2005). The executive director of this Montreal-based NGO was also invited to present the initiative at various international forums, including a forum organized by WHO Regional Office for Europe (Venne, 2007). Thus, this initiative was able to plant a seed in the

Table 9.1 *Nine criteria for effective public participation*

Representativeness	The public involved in the exercise should comprise a broadly representative sample of the population affected by the policy decision
Independence	The participation exercise should be conducted in an independent (unbiased) way.
Early involvement	The participants in the exercise should be involved as early as possible in the process, as soon as societal values become important to the development of policy.
Influence	The outcome of the procedure should have a genuine impact on policy.
Transparency	The process should be transparent so that the relevant/affected population can see what is going on and how decisions are made.
Resource accessibility	Participants should have access to the appropriate resources to enable them to fulfil their brief.
Task definition	The nature and scope of the participation exercise should be clearly defined.
Structured decision-making	The participation exercise should use appropriate mechanisms for structuring/displaying the decision-making process.
Cost-effectiveness	The process should be cost-effective from the point of view of the sponsors.

Source: Frewer & Rowe, 2005

mind of policy-makers, which illustrates that civil society organizations may play a role, albeit limited, in triggering governance actions.

In the case of Healthy People 2020, it could be expected that the public consultation would score highly in terms of influence, since it was embedded in the policy-making process. However, early reports suggest that two dimensions of the public involvement strategy have generated some challenges: the use of loosely structured public consultation methods (public comment web site and public meetings) and the high degree of inclusiveness of the initiative (Blakey et al., 2010). Not only did the sheer breadth of public input present a challenge (more than 8000 public comments), but the public input varied significantly "from well-supported, actionable recommendations to anecdotes and personal preferences" (Blakey et al., 2010). Thus, these two dimensions challenged the sponsor of the consultation as regards how to manage and integrate the public input into the Healthy People 2020 framework.

In terms of representativeness, the Strategic Meeting on Health and Healthy People 2020 were both open to every citizen willing and able to participate. However, participants remained self-selected and it could be wondered whether or not these exercises comprised a broadly representative sample of

the population. This issue illustrates how important it is for governments (or the sponsors of a public involvement initiative) to provide the resources and incentives necessary to support those who are "willing but unable" to participate, as well as those who are "able but unwilling" (OECD, 2009). If not, the selection of participants is likely to be influenced by inequitable public involvement structures and processes.

Conclusion

Although it remains difficult to determine what public involvement mechanisms can be most effective or successful (Abelson & Gauvin, 2006; Rowe & Frewer, 2004), we can identify three key lessons for policy-makers who wish to build on public involvement as part of a wider strategy for HiAP.

Form should follow function …

The public involvement literature increasingly recognizes that form should follow function; that is, the choice of a public involvement strategy should be primarily based upon the underlying goal (Bishop & Davis, 2002). Thus, it is recommended that sponsors of a public involvement process clarify their underlying goal early on. Launching a public involvement process with undefined or ambiguous goals can result in conflicting assumptions and expectations among the public and other stakeholders (Rowe & Frewer, 2004).

Context matters …

Nonetheless, it is important to acknowledge that choosing a public involvement strategy is not a simple exercise of matching well-defined goals to well-defined methods. Other contextual factors can also influence such decision: type of issue, institutional arrangements, resources, community characteristics, ideologies, interests and politics (Abelson et al., 2007). Thus, an element of discretion remains for designing public involvement strategies to fit specific contexts. In the same vein, we should not expect to put any public involvement mechanism into any particular context and expect that it will function in the same way as it has functioned elsewhere.

… and principles, too!

There is growing consensus over a set of principles for effective public involvement (IAP2, 2011; Rowe & Frewer, 2004). The emergence of such ethics of public involvement is generated in large part by theoretical developments in the field, as well as discussion and debates among practitioners, and innovative research–practice partnerships. Policy-makers who wish to involve the public as

part of their HiAP strategy should hold themselves accountable to such guiding principles to enhance the effectiveness and integrity of the public involvement process.

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Chapter 10

Collaborative governance: the example of health conferences

Helmut Brand and Kai Michelsen

Introduction

The WHO Ottawa Charter states: "The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned […]." While the Ottawa Charter focuses on health promotion, coordinated action is also of relevance for the development of health services and prevention, and for the development and implementation of health policies. The coordination might be established in the form of collaborative governance: a "type of governance on which public and private actors work collectively in distinct ways, using particular processes, to establish laws and rules for the provision of public goods" (Ansell & Gash, 2010). The term refers to a "governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus-oriented, and deliberative and that aims to make or implement public policy or manage public programs or assets" (Ansell & Gash, 2010). In line with this definition, collaborative governance is characterized by six criteria.

1. Collaborative governance is initiated by public agencies or institutions.
2. Participants include non-state actors.
3. Participants are not only consultants but engage directly in decision-making (two-way communication).

4. The forum is formally organized and meets collectively.
5. The forum aims to make decisions by consensus.
6. Focus is on public policy and public management.

There are various forms of collaborative governance that can fall under this definition. For example, corporatism is a specific kind of collaborative governance. But collaborative governance is broader because stakeholders do not automatically need to hold monopolies of interest representation. At the same time, not all kinds of (horizontal) networks can be seen as examples of collaborative governance because they are not always initiated by public agencies or institutions or formally organized.

Collaborative governance is seen as an opportunity to react on turbulences faced by policy-makers and managers (Gray, 1989, cit. in Ansell & Gash, 2010). Networks of stakeholders and consensus-oriented styles of coordination and cooperation are expected to overcome failures in downstream implementation and high costs of a politicization of regulation. They seem to be alternatives to the antagonism of interest-group pluralism as well as the accountability failures of managerialism. Further, it has been mentioned that the consequences of functional differentiation – the distribution of knowledge and institutional capacity to different institutions, increasing complexity and interdependency – demand intra- and intersectoral collaboration (Ansell & Gash, 2010).

This chapter presents some general experiences and recommendations for collaborative governance. We have chosen to focus on the "innovative health policy intervention" (Knesebeck et al., 2002) of local and regional health conferences in North Rhine–Westphalia (Germany). Thanks to its elaborated and sophisticated structures, but also to the subsequent evaluation, this case offers key insights into and experiences with this type of governance. It can serve as an example for similar approaches which can be found in other regions and countries. Starting at state level (Länder) and in some local communities in the late 1980s, followed by a project phase (1994–1998) and backed up by law since 1997, the health conferences have developed over 20 years and are now established in all 54 local communities (cities and districts) of North Rhine–Westphalia. The experiences with health conferences have been documented by a couple of evaluations, giving insights into the opportunities and challenges of health conferences. They relate well to the international debate about collaborative governance.

The concept of health conferences in North Rhine–Westphalia (Germany)

The meaning of "conference" (from the Latin word "confero": to bring together, to compare) is to screen, analyse and interpret compiled materials.[1] Meanwhile, a lot of different kinds of "health conferences" (also called "round tables") are being organized. The term is used for single events or continuous activities. The events addressed are based on different philosophies, ideas, concepts, aims and objectives: they have, for example, been organized to involve major stakeholders or to include the general public, to inform decision-makers or to make decisions by themselves. They have different structures, are placed at different levels of policy-making (e.g. local, regional, national) as well as in different health systems and political environments. They vary in the availability of resources and the ways they are regulated.

Within Germany, the state of North Rhine–Westphalia was a forerunner in implementing health conferences at the local level as well as at the level of the federal state. This attracted interest because a federal state with 18 million inhabitants had implemented health conferences in all 54 local entities (municipalities and districts), based on a law regarding public health services.

At the level of North Rhine–Westphalia, a health conference was established in 1991. Moderated by the Ministry for Health, the stakeholders[2] defined common topics and objectives and developed recommendations for coordinated action. Activities were based on voluntary commitment (Werse, 2010).

At the local level, the development was part of broader reflections on the future of local policies and public health services (Müller et al., 1988; MAGS, 1992a, 1992b; Canaris, 1992; Brandenburg & von Ferber, 1992; Brandenburg, von Ferber & Nowak, 1994; Brandenburg & Winkler, 1996; Brandenburg, von Ferber & Renner, 1998; Renner et al., 1998). Decentralization should strengthen local policy-making. Instruments for local health policy-making, planning, steering and management should be developed further. The services of public health agencies should be better integrated with other social and health services. They should become more oriented to the needs of citizens. More should be done for underprivileged population groups. The orientation towards prevention and health promotion should be strengthened (Murza, Werse & Brand, 2005).

Concepts for local health conferences were developed in the mid 1980s (Schräder et al., 1986), while the first pioneers were collecting pragmatic

1 Taken from http://de.wikipedia.org/wiki/Konferenz_.

2 Social insurance providers, associations of physicians, dentists and pharmacists, the hospital association, employers and trades unions, charitable associations, associations of local and regional communities (kommunale Spitzenverbände, Landschaftsverbände), organizations for prevention and health protection, as well as self-help groups.

experience, e.g. in Herne, where the first health conference took place in 1989. From 1995 to 1998 the federal state of North Rhine–Westphalia organized the project Ortsnahe Koordinierung, in which 28 out of the 54 local entities in North Rhine–Westphalia participated. By implementing health conferences as the organizational tool in conjunction with public health reporting as the information tool, missing services should be identified and implemented, double structures and superficial services should be abolished, and the services should be organized and offered close to the citizens and their needs.

Even before the project was finished, the state government adopted a new public health law at the end of 1997 (Gesetz über den öffentlichen Gesundheitsdienst (ÖGDG) vom 25 November 1997), followed by an additional, more detailed regulation (Ausführungsverordnung zum Gesetz über den öffentlichen Gesundheitsdienst (AV-ÖGDG) vom 20 August 1999, abolished in 2006). The regulations stated that health conferences should establish cooperative structures and networks, create transparency, offer the opportunity for local discussions of health problems as well as the development of common solutions and recommendations (Lafontaine & Stollmann, 1998; Werse, 2010).

Today, health conferences take place once or twice a year in all 54 local entities, with 29 participants on average.[3] The composition of participants varies, but mainly consists of representatives of the relevant actors for the locally provided health-related services. They are formally announced by the local government (see Box 10.1).

The health conferences are accompanied by regular meetings of working groups. Rules of procedure are in place, oriented towards a consensus between the stakeholders affected by the respective topic. The conferences are often moderated by the head of the local public health department, which also runs a secretariat for the managerial issues of the health conference and working groups. The public health department also supports the health conferences with public health reporting activities. Links with local government, especially the committee for health and social affairs, might be more or less established. The Institute for Public Health in North Rhine–Westphalia supported the local activities by organizing educational events, exchange of information, materials and the implementation of an information infrastructure. The Akademie für das öffentliche Gesundheitswesen in Düsseldorf was involved in qualification measures.

The implementation of health conferences has to be seen in the light of characteristics of health policies and the health system in Germany (Knesebeck et al., 2002). The system is placed between a national health system and a

3 A constructive athmosphere and active participation were negatively associated with the size of the health conference. A maximum of 30 participants seems to be the upper limit (Knesebeck et al., 2002).

Box 10.1 *Examples of topics discussed at health conferences*

Topics discussed by the federal state health conference (examples)

The activities of the federal health conference were linked with specific health targets of North Rhine–Westphalia. They have addressed national health targets (diabetes, breast cancer, tobacco consumption, healthy growing-up, patient self-determination, depressive disorders, healthy ageing). Cross-cutting issues are orientation towards citizens and patients, equity, evidence base, gender mainstreaming, health of children and adolescents, citizens with disabilities, prevention, quality assurance and management, cross-sector cooperation and integration (mainly within health services), and support for self-help activities.

The resolutions of the North Rhine–Westphalia health conference give further information about priorities over the past 20 years (www.mgepa.nrw.de/gesundheit/landesgesundheitskonferenz/beschluesse_der_lgk/index.php#top).

Topics discussed by local health conferences (examples)

Local health conferences have focused on certain population groups (e.g., newborns and mothers, children, elderly people, female or male population, migrants, socially deprived), diseases (psychiatric diseases like dementia, addictions linked with tobacco, alcohol and illegal drugs, communicable diseases like HIV/AIDS, noncommunicable diseases like cardiovascular diseases, dental health), different kinds of interventions (health care services, prevention, health promotion), the coordination of services and information about health and health services, in different combinations.

market system. Health insurance is mandatory for most of the population. Markets are politically regulated, with neo-corporatist structures and a system of self-regulation in decision-making. Further characteristics are (or have been) deep institutional divisions (e.g., between in- and outpatient care), lack of uniformity in public health service organization across the federal states and a relatively weak interest in public health services.

While health policies were strongly influenced by cost containment, health conferences were expected to offer opportunities to develop more effective health services by collaboration and coordination in the fields of health and social care, prevention and health promotion. Activities at the local level promised to develop services close to those who needed them (Werse, 2010). While health policy-making at the national level and at the level of the federal states follows sectoral divisions, intersectoral cooperation in the organization and provision of services at the local level was seen as necessary and possible to achieve. Health conferences were also seen as an opportunity to revitalize public health services and to motivate for action in the fields of prevention and health promotion.

Despite being based on public health law, differences exist between local health conferences in North Rhine–Westphalia. At a general level, it can be said that health conferences are different from scientific conferences. They are oriented towards action, objectives and results. Decisions and activities are based on a consensual approach and commitments. Health conferences have been described as an intermediary cooperation structure, characterized by voluntary participation of representatives of the state, the health system (including self-help groups), economy, labour market and citizens, with an orientation towards target groups, areas or problems which is based upon cross-organizational and cross-sectoral common-interest representation and directed to common recommendations, planning and implementation (Trojan & Legewie, 2001). They are seen as an opportunity for participation, to engage civil society and to support communication, coordination and cooperation, based on the development of common understanding and a qualified information base for decision-making (Brandenburg et al., 1999). They are expected to cover the whole public health policy cycle (Nowak & von Ferber, 2000). An ideal process starts with the selection of one or more topics for the health conference. A decision on the topic is followed by an assessment of the current situation. Based on this assessment, recommendations are developed by working groups and discussed with stakeholders. Invitations for the health conference are sent out. At the health conference, recommendations are decided. Following the recommendations and based on commitments, projects are developed and implemented. Workshops are organized to monitor and evaluate the outcome of projects and the realization of recommendations. The local government is informed by reports.

Reaching out to stakeholders and civil society: municipal health policy development process in Esbjerg, Denmark

Gabriel Gulis

Esbjerg is the fifth largest city in Denmark and after development and presentation of a new health profile in 2010 the municipality launched a process leading to acceptance of a new municipal health policy.

The new Esbjerg health policy development process was a genuinely intersectoral process with the objective of setting up an intersectoral health policy. A health policy development steering group was set up within the municipality, involving representatives of all sectors. Following a series of targeted health conferences, round-table discussions were launched. Academia, industry representatives, the education sector, the environment sector and civil society representatives were invited to join the process via participation in an opening round-table meeting in spring 2010. In addition, the health department launched a series of health profile explanatory meetings with

other departments of the municipal administration to increase understanding of the need to develop an intersectoral health policy and ensure future acceptance of the new health policy across sectors. The process included activities on evidence support (and identification, mostly by academic members of the round table), setting goals and identification of target population, advocacy (industrial societies for individual industry entities, schools for pupils, NGOs for citizens, etc.), monitoring and evaluation and identification of implementation tools.

The end-points in this case were predefined by the municipal health profile as an increase in life expectancy, increased level of citizen involvement, decrease in inequalities among different subpopulations of the municipality (immigrant vs. Danish origin, for example), and improved collaboration between different sectors within the municipality.

Case study prepared based on own participation in the health policy development team and by reference to Aarestrup, Due & Kamper-Jørgensen (2007).

Positive experiences and challenges

Early experiences with health conferences are documented by an evaluation of activities in Herne (Kreuger, 1996; Renner, 1997). Further evaluations accompanied the period of the model project and the first five years after the new public health law was adopted (1998–2002) (Badura et al., 2000; Knesebeck et al., 2001, 2002; Brand, 2004; MGSFF, 2003).

The findings were overwhelmingly positive (Murza, Werse & Brand, 2005; Werse, 2010). Health conferences were established in line with the conceptual thinking. They were linked with more transparency and the development of instruments for monitoring and information. Recommendations for actions and programmes have been developed (even if some of them were modest and others more far reaching), often based on local public health reports. Health targets have become prominent at the federal level as well as in some local entities.

The working climate has been assessed as positive. The majority of local health conference participants experienced health conferences as a useful tool to improve the coordination of local activities. Mistrust and hidden competition seemed to be reduced. Conflicts have been reported, but seemed not to challenge the project as such (Knesebeck et al., 2002).

Health conferences offer the opportunity to bring decision-makers, practitioners, providers, financing institutions, consumers and others together. They can be organized so that participants meet as representatives of organizations (and de facto it is often stressed that they should have the authority for decision-making) or that particular interests of organizations are balanced with the perspectives

which the participants have as citizens and consumers of local health services (e.g., health professionals as patients, etc.). The second option might be helpful to overcome stereotypes (Knesebeck et al., 2002).

While the evaluations have brought to light the positive effect of health conferences in North Rhine–Westphalia, a number of criticisms have been raised that need further clarification and reform.

1. Sometimes participants were not satisfied with the engagement of other participants (Nowak & von Ferber, 2000).
2. While decision-makers expect to be able to measure the outcome, practitioners are interested in the formulation of targets and orientation for their practice (Nowak & von Ferber, 2000).
3. Who should set up a health conference? Staff from public administration might have specific perspectives, might be linked with specific networks and have specific viewpoints. Can they motivate and integrate all relevant and interested stakeholders and perspectives?
4. How should a topic be chosen? What recommendations should be given? It is recommended that decisions be based on pragmatism (chance of success for local activities, concreteness) and a strategic orientation (common efforts, activating civil society, transparency, need for cooperation) (Brandenburg et al., 1999; Nowak & von Ferber, 2000). It should be taken into account if topics are of common interest, if there is a need for better coordination and transparency and if the stakeholders are able to intervene. The experiences with health conferences in North Rhine–Westphalia have shown there was a high probability of programme implementation if the programmes were in line with the scope of local authorities, if health care providers accepted the responsibility for working groups and if high-quality data were available. The probability was low when regional or federal responsibilities were affected. Problems in communication between local actors and policy-makers at federal state level were reported (Knesebeck et al., 2002). But while a pragmatic approach increases the probability that recommendations can be developed and implemented successfully, there is the risk that relevant but more challenging topics are not addressed[4] and intersectoral collaboration stays limited.
5. Who should be invited? It is important to mobilize the available local knowledge, to reach local decision-makers and to bring in self-help groups, prevention and health promotion. Some of the health conferences

4 The chosen topics vary between the local entities. The majority of recommendations and health reports address the health of children and adolescents, elderly people, sometimes also women and migrants. Immunization, drugs/addiction, HIV/AIDS, psychiatry, chronic diseases, dental health, prevention, promotion, environmental health are more or less prominent issues. Capacities, the cooperation between organizations and the integration of services are sometimes addressed. The aims of activities vary between delivering pure information and concrete planning ambitions (MGSFF, 2003; Murza, Werse & Brand, 2005).

in North Rhine–Westphalia focus on representatives of key stakeholders with authority to decide, and continuity of participants is seen as an advantage to establishing cooperation. Others invite members of a core group, additional participants who have been identified as stakeholders for a specific topic, and the interested general public. While it can be assumed that a broad professional base goes hand in hand with a better acceptance of recommendations, a maximum of about 30 participants seems to mark the upper limit for a constructive and engaged collaboration.[5] Nevertheless, it might be difficult to identify all relevant stakeholders.

6. Difficulties have been reported (Knesebeck et al., 2002; Murza, Werse & Brand, 2005) in integrating self-help groups, representatives of organizations for health promotion and protection, private health insurers and social insurers, as well as health insurers and care organizations. In addition to limitations on capacity and resources, interest and motivation matter, as well as organizational structures: organizations and associations are not always organized in line with the political system. Many actors have no direct link to local or regional entities. They do not see themselves as local actors. The number of social health insurers is shrinking while the remaining ones become more centralized. Also, it has become more difficult to persuade representatives with the power to make decisions to take part in local health conferences (Werse, 2010).

7. How should the conference be organized? It is a challenge to balance information and knowledge and to bring in the perspectives of different experts. Should there be presentations and expert panels? Are other forms more appropriate?

8. How should horizontal collaboration with other networks (e.g., care conferences) and the institutions of the local political system be organized?

9. How should vertical collaboration be organized? The implementation of local health conferences was supported by the federal state with financial resources (in the first three years), technical infrastructure (computers and internet), education and planning (e.g., organized by the Public Health Institute of North Rhine–Westphalia and the Akademie für das öffentliche Gesundheitswesen). While the adoption of the Gesetz über den öffentlichen Gesundheitsdienst für Nordrhein-Westfalen is in general seen as important for the establishment of health conferences, there was also a critical discussion about the advantages and disadvantages of a more or less detailed regulation of local activities at the level of the federal state (definition of participants, procedures, topics, etc. (Nowak & von Ferber, 2000)). So, on the one hand,

5 At least in principle it is possible to organize health conferences with many participants while organizing the work in somewhat smaller networks.

the vertical interaction is not strong. The consequences of the abolishment of the regulations accompanying the law are not clear yet (fewer regulations or fewer responsibilities?). On the other hand, the health conference of the federal state sees their local counterparts are very important to implement their own recommendations and realize their health targets.

A further challenge is political engagement and leadership. The engagement of the Ministry or the local government has proven to be important to convince and motivate the actors to participate in the health conferences and to realize their voluntary commitments. In addition to lacking support from the centre of political power, limited financial resources and a stronger orientation towards competition are counterproductive for cooperation. Finally, it has not always been easy or even possible to prove that the collaborative action has had positive effects – with negative consequences for the motivation of the actors.

While the evaluations are positive, including the need for further clarification and developments, differences in the use of health conferences between local entities have to be mentioned, For many local communities health conferences have become the centre of activities. Others have adopted at least a very active approach to health conferences. However, there are also some local entities where engagement is low. Here, health conferences are organized because they have to be organized, and in some cases they are not conferences at all (Werse, 2010).

Stakeholder involvement in Denmark: negotiations across levels

Gabriel Gulis

In January 2007, responsibility for public health and health promotion were moved to local level in Denmark. This introduced the process of health negotiations. The municipalities have to agree with the region on division of tasks and the State formally approves their agreement. After approval, the health negotiation document is binding for both region and municipality. The health negotiation documents are periodically evaluated (planned in four-year phases) and updated. Health promotion is one of the main areas tackled by health negotiations, divided into patient-oriented and citizen-oriented health promotion. Within citizen-oriented health promotion, the national guidelines recommend setting up intersectoral meetings involving all relevant sectors of the municipality and the regions to achieve consensus upon necessary division of work and funding across levels and sectors. Such a unit should aim towards an intersectoral approach to municipal provision of health promotion and disease prevention work and also include elements of the health care system, such as general practitioners and hospitals (especially in patient-oriented health promotion). This structure has the potential to coordinate intersectoral working and HiAP, not only at a particular administrative level but also across such levels. The structure could initiate evaluation

of regional development plans, link municipal development plans to regional, identify which sectoral responsibility is local and which is regional, and bring relevant actors of different sectors to one table. As the process is very new, launched in 2007 (with the first signed health negotiation documents on board mid-2007), there is no experience with effectiveness as yet.

The international debate about collaborative governance

The positive and critical experiences with health conferences in North Rhine–Westphalia relate well to the international debate about collaborative governance. For example, to be motivated to collaborate, organizations and/or people must see a reason or benefit. It is important that they can answer the question why it is useful or even necessary to work together – as well for the realization of their own goals as for the realization of collaborative goals.

Stakeholder engagement and intergovernmental working group: an Alcohol Action Plan for the Republic of Moldova

Lars Møller

In the *European status report on alcohol and health 2010* (WHO Regional Office for Europe, 2010), published in early 2011, and the *Global status report on alcohol and health 2011* (WHO, 2011), published in February 2011, it was shown that the Republic of Moldova has the highest adult per capita alcohol consumption in the world.

This information gave rise to debate in the Republic of Moldova but also many questioned the calculation done by WHO: Dr Andrei Usatîi, Minister of Health, took the data very seriously and consulted the WHO Regional Office for Europe for advice.

In April 2011 a WHO delegation visited a number of governmental organizations, including the Ministry of Health, National Centre of Public Health, Republican Dispensary of Narcology, Department of Prison Facilities, Ministry of Justice, Ministry of Agriculture and Food Industry and the Ministry of Economy. The aim was to create support for an intergovernmental working group on reducing the harmful use of alcohol.

The Minister of Health invited all stakeholders for a meeting at the end of the WHO mission and established a working group to draft a national alcohol strategy. The Deputy Minister of Health was asked to chair the working group. The working group received the draft European action plan to reduce the harmful use of alcohol 2012–2020, covering 10 action areas, and for these areas a number of policy responses were listed as options for action.

It is expected that the government, and later parliament, will adopt the plan with the aim of reducing both alcohol consumption and the harm done by alcohol.

Based on studies of experiences with different forms of collaborative governance, Ansell & Gash (2010) have developed a "contingency theory" and a "general model of collaborative governance". They address a couple of further negative aspects and recommend measures to overcome the challenges.

Firstly, power/resource imbalances (e.g., own resources to engage in time-consuming processes, infrastructure for sustainable representation of interests, skills and interest in discussing technical details, informal access to high-rank officials) challenge participation and need to be encountered by a "commitment to a positive strategy of empowerment and representation of weaker or disadvantaged stakeholders".

Secondly, there must be enough incentives to participate. The collaborative forum should be an exclusive venue to realize important outcomes with the cooperation of independent actors. Incentives to participate can also be linked with the defence of autonomy (collaborative government can take place in the shadow of the state, framed by implicit or explicit expectations of government). If available and promising enough, actors will prefer uni- or bilateral ways to pursue their goals.

A history of antagonism and distrust is a barrier for collaborative governance. The acknowledgement of interdependences and measures to strengthen trust and social capital might be needed.[6] Intermediate outcomes and small wins are important to motivate stakeholders to continue the cooperation, making the development of trust possible.

Additionally, leadership is needed, for example for agenda setting, motivating, mediating, developing and monitoring ground rules, facilitating dialogue and collaboration between different interests, mediating in conflicts, and so on. If power is more or less equally distributed and the stakeholders are interested in participating, this can be realized by an honest broker. If this is not the case, leadership by an "organic leader", "who commands the respect and trust of the various stakeholders at the outset of the process", is more promising.

Beside leadership, the institutional design is important for successful cooperative governance. Procedural legitimacy and basic protocols for collaboration are needed. Rules for the access and the participation of all relevant stakeholders have to be set. As mentioned before, the exclusiveness of the venue has to be addressed.

Consensus rules are a critical issue. They should not prevent the open discussion of conflicts. As Davies (2008) has mentioned in the case for joined-up governance, "[t]rust between partners … may matter little if built on conflict

6 On the other hand, a history of strong interdependence and trust might be counterproductive for a broader collaborating network.

avoidance". A partnership ethos seems to encourage shallow consensus and the avoidance of value conflicts. Moreover, the failure to confront political conflict might explain why networks tend to operate primarily in silos and not cross-sectorally.

Finally, collaboration should be organized as a cyclical, iterative interaction. It should be accepted as being non-linear and part of a learning process, promoting shared understanding. Face-to-face communication is supportive for the development of trust and mutual respect. The process must be clear, fair and transparent. Collaborative governance is based on the assumption that a shift of ownership towards the stakeholders has positive effects on motivation. It is critical that the stakeholders accept the shared responsibility (Ansell & Gash, 2010).

Leadership is perhaps the most important single aspect. Tensions between neutrality and persuasion, as well as the needs, opportunities and challenges of managing a political network, have to be taken into account. Management of a political network is the process by which consensus regarding goals, implementation and collaboration, information processing, knowledge management and governance is organized (Rethemeyer & Hatmaker, 2007). The activities can target "games" (actions of the network) and the network itself (see Table 10.1).

It has to be taken into account that networks are often managed by cooperating as well as competing multiple network managers. To enhance the chances of successful management, the network managers should have access to further networks, especially the fiscal network, allocating resources within the respective policy field, and the social service network system. Activities directed towards "games" and the network itself (activation/deactivation, mobilizing, synthesizing) occur across multiple networks. Therefore, network managers

Table 10.1 *Political network management*

	Activation/ de-activation (participation)	**Synthesizing (relations)**	**Framing (cognitions, beliefs)**	**Mobilizing (engagement, commitment)**
Games	Directing attention of network participants to/ away from game	Conflict resolution, "fixing", using existing network structures	Framing issue using existing "constructions" of dependence	Motivating active/enhanced participation in games, especially through mass mobilization
Networks	Directing attention of participants/ nonparticipants of network	Norm building, altering existing network structures	Creating/updating "constructions" of dependence	Integrating existing participants/ socializing new participants

Source: Rethemeyer & Hatmaker, 2007

have to take the environment of their own network and broader perspectives than their own network into account.

The requirements for leadership in a collaborative governance setting are challenged by a couple of barriers for horizontal governance (Termeer, 2009).

- Networks develop around content, and content is important for the interest to participate in networks. It is possible that the members of a network only confirm their own perspectives.
- Public managers vary in their support for new modes of governance. The rules and values needed for new forms of governance might clash with rules and values of more established institutions. Stereotyping advantages of new modes of governance might provoke defensive reactions.
- If some of the stakeholders feel pressure to act (crisis, deadlines), they are less open for experiment. The orientation towards a successful realization of government targets and existing policies might limit the motivation of public officials/agencies.
- If some groups see themselves as the "real experts", they will have no interest in collaborating.
- If a group is afraid their own positions will be undermined, there might be a taboo on communicating.
- If competences are asymmetric, there might be a dynamic that all stakeholders share the impression that the experts should or must do the job – with the consequence that the asymmetry of competences will not be reduced and may be even further widened.
- Cover-up strategies (e.g., not showing doubts, hiding internal struggle, not being willing to face disappointments) are counterproductive for reflection and learning.

The health conferences in North Rhine–Westphalia can be analysed as a network, but the situation is more complex. Health conferences sometimes try to establish different networks around specific topics of interest. Sometimes networks existed before a health conference was established. It was not always easy to integrate them into the health conference. Often health conferences and care conferences worked in parallel (Murza, Werse & Brand, 2005). Health conferences have sometimes to cooperate with other networks. Maybe it is better to see health conferences as a framework or institution for networking and not as a network on its own (Trojan & Legewie, 2001, cit. Wilhelmi, 2006). At the same time it is important to think about the structure of the networks of networks, to use synergies and prevent double structures.

The health conferences in North Rhine–Westphalia can be seen as a formalized network or a formalized framework for networks. They can be studied from different research perspectives as policy, service delivery and implementation, as well as governing networks (Klijn, 2008), even if the conceptual ideas are linked with governing as well as service delivery and implementation networks, in which public agencies take the leading role in the management of collaborative stakeholder engagement.

Table 10.2 *Different kinds of networks*

	Policy networks	Service delivery and implementation	Governing networks
Main origin	Political science	Organizational science/ interorganizational theory	Public administration
Focus	Decision-making and effects, closure and power, relations on issues and agenda setting	Interorganizational coordination, effective policy/service delivery, integrated policy/ services	Solving societal problems, managing horizontal governance relations, connecting governance networks to traditional institutions, deliberation processes
Main research questions	Which actors are involved in decision-making? What are the effects on decision-making?	How can complex integrated services be coordinated? What mechanisms are effective and efficient (contracting, partnerships, etc.)?	How can governance networks be managed? How should governance networks be organized and connected to traditional institutions? How can the variety of content be improved? How can various value judgements be combined?
History	Starts with the pluralist political science research of the 1960s and continues to research on subsystems, policy communities and policy networks	Starts with the first interorganizational theorists that focus on interorganizational coordination and continues to research on service delivery, contracting and implementation	Starts in the mid 1970s with work on intergovernmental relations (Hanf & Scharpf, 1978) and continues with analysis of new governance forms, including their effects and management requirements

Source: Klijn, 2008

In a similar way, Rethemeyer and Hatmaker (2007) make a distinction between policy networks and collaborating networks. Policy networks are seen as "net of public agencies, legislative offices, and private sector organizations (including interest groups, corporations, non-profit, etc.) that have an interest in public decisions within a particular area of policy […] because they are interdependent and thus have a shared "fate" […]". They "encompass parties that have an

interest in how that good or service is provided". In contrast, collaborative networks "work together to provide the goods and services at all or in desired quantities".

Also with regard to this distinction, it has to be mentioned that health conferences can direct their activities in both directions. Most conferences develop recommendations for action and handle implementation issues.

Potentials for cross-sector activities

The local health conferences in North Rhine–Westphalia – by taking the differences between them into account – meet the six criteria for collaborative governance listed in the introduction to this chapter: they are initiated by the public sector, include non-state actors and decision-makers, are organized formally, based on consensus and focused on public policy and management. They have been established to give support to a couple of different kinds of governance actions. They are linked with public health reporting activities and aim to exploit expert knowledge for supporting informed policy-making. They coordinate activities in the fields of priority setting, the development of recommendations and the setting of goals and targets (policy guidance) in addition to in the field of implementation and management. The relevance of monitoring and evaluation has been stressed. Health conferences are also seen as an opportunity to give local health issues a voice and to attract interest. Therefore, they are in principle also linked with advocacy.

Health conferences can also have positive effects on creating financial support for prioritized health issues. Finally, they have a legal mandate of their own and the stakeholders participate on the basis of their legal mandates, while the legitimacy of recommendations and activities as far as public policy-making is concerned is given by the links with the structures of the local political system.

However, they are not an instrument for encompassing planning or resource allocation. Compared with the overall expenditures and activities of the participating actors, the reallocation of resources based on collaboration might be limited. There have been examples of voluntary commitment based on plans for activities which had already been decided upon before and outside of the collaborative structure. Nevertheless, positive effects have also been reported, and realistic expectations are needed to assess and evaluate the effects of the health conferences.

Health conferences offer the opportunity for cross-sectoral policy-making, and to a certain degree sectors are crossed (e.g., social care, programmes for elderly people, education/schools). However, the activities are far removed from a realization of HiAP. While the Department for Public Health and

sometimes also other departments from public administration are represented in the health conferences, most departments do not participate. Further, the majority of topics chosen are close to the responsibilities of the local public health departments – and not focused on HiAP. The North Rhine–Westphalia type of health conference has not been designed as a tool for HiAP. However, it offers valuable opportunities for intersectoral cooperation (while exploiting the potential is an ongoing challenge for managing health conferences).

To establish and develop the potential of health conferences takes time and resources (finances, technical infrastructure, personnel, qualification/education). To a certain degree it takes political, juridical and material support from higher levels. Yet it would be wrong to underestimate the relevance of small steps towards intersectoral cooperation – in the North Rhine–Westphalian case within and at least to a certain degree transcending the health system.

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Chapter 11

Industry engagement

Monika Kosińska and Leonardo Palumbo

Introduction

This chapter is about the public sector reaching out to industry to establish and achieve common orientation and action on important public health issues. It focuses on the so-called private-public partnership and in particular on aspects related to the governance of this intersectoral structure. The particular example on which the chapter is based is the EU Platform for Action on Diet, Physical Activity and Nutrition and the attempts to integrate health in those policies.

The operating framework for public health has been changing over the last two decades in many ways: new challenges, redistribution of power and resources, external environmental and demographic pressures, as well as changes in social and behavioural norms. Studies on global trends show the private sector is one of the major driving forces behind global environmental, economic and social changes, at the same time as increasing its venture into traditional health promotion. This creates a power environment where the actors driving unforeseen global consequences or disturbing "side effects" of consumer culture – such as the mass production of commercial products, increasing time pressures, economic crisis, climate change, poverty and growing social inequality, as well as rising life expectancy and health life years – are seen as partners to meet these challenges.

Together with the changing context, public health as a discipline and sector has also changed, and is continuing to change, with governments and the public sector actors looking for innovative ways to face modern challenges. The role of industry through the development of PPPs, and their impact on our understanding and framing of traditional and new public health questions, has become increasingly common. However, the relatively recent venture of public and private sectors in health means that their impact, relationships and governance questions are still new and to some extent uncertain. PPPs in

health have been received with controversy and high expectations, as well as scepticism.

In what follows we will try to shed light on this venture by means of a case study. The chapter therefore starts with a brief description of the aims, composition and functioning of the EU Platform for Action on Diet, Physical Activity and Health. This is followed by briefly reviewing the changing context that facilitated emergence of PPPs and a definition of PPPs. The changing strategy towards PPPs introduced by the United Nations and other international and supranational organizations will be revisited. This is followed by reviewing key themes of PPPs, such as bridging the resource gap, leverage for health change in intersectoral governance actions, governance principles and risk management and conflict of interest. The chapter will end with concluding comments.

EU Platform for Action on Diet, Physical Activity and Health

The authors have used their practical experience of one high-profile PPP to discuss some of the main issues surrounding the rise in the use of PPPs identified by the current literature. The EU Platform for Action on Diet, Physical Activity and Health was established in 2005 and gathers food and health stakeholders from across Europe. As Hawkes (2008a) notes, the Platform is not a traditional PPP because there is involvement from nongovernmental organizations (NGOs), no direct partnership with the food industry and it is a forum to discuss practices and commitments to activities on healthy nutrition, physical activity and the fight against obesity. The Platform grew out of the growing recognition that "obesity is a multi-causal condition which requires a comprehensive preventive approach" (Council of the EU, 2005, p.29) and "action by different parts of society to deal with the many aspects of the problem".[1] The Platform became a tool of the implementation of the 2007 Strategy for Europe on Nutrition, Overweight and Obesity-related Health Issues. There is no leadership or management mechanism, and the initiatives are set by the public sector. These efforts are being duplicated at the national level and similar platforms are now present in Austria, Germany, Hungary, Ireland, Italy, the Netherlands, Poland, Portugal and Spain. The five fields for action identified so far by the Platform members are: consumer information, including labelling; education, including lifestyle modification; physical activity promotion; marketing and advertising; composition of foods (reformulation), availability of healthy food options, portion sizes; and advocacy, information exchange. Some of the commitments in the EU Platform database are themselves PPPs, such as EPODE (Ensemble,

1 http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/platform/platform_en.htm.

Prévenons l'Obésité Des Enfants), Food Dudes, Media Smart, Health4Schools, and Fit am Ball – Der Schul-Cup von funny-frisch.

Engaging private sector and civil society: Vision Zero road traffic policy in Sweden

Dinesh Sethi

The Road Traffic Safety Bill was passed by a large majority in the Riksdag, Swedish parliament, in October 1997. The basis of the bill is Vision Zero: that no one will be killed or seriously injured within the road transport system (Ministry of Transport and Communications, 1997). The bill highlighted a systems approach to preventing serious road crashes which involves the transport, justice, environment, health and education sectors, including partnership by the private sector and civil society. It called for a partnership between the designers, road users, employers and police to achieve Vision Zero whereby designers should design roads, vehicles and safety equipment to ensure that serious crashes and injuries do not occur and road users should follow rules to ensure safety for themselves and other road users. The police have an obligation to enforce the rules, such as speed limits, drink driving, seat belt use and following the highway code. Organizations (both private and public) are required to demonstrate corporate responsibility by ensuring safe driver behaviour. Fuel consumption is being considered as a performance indicator for transport operations. Environmental concerns are also addressed as less aggressive driving leads to reduced fuel consumption and emission of gases. The role of the emergency services and health sector is to ensure efficient transportation and quality emergency trauma care to minimize fatality and long-term disability. The bill has been considered a huge success and since its introduction there has been a threefold reduction the number of road traffic injury fatalities and Sweden's roads are considered amongst the safest in the world.

The EU Platform for Action on Diet, Physical Activity and Health was an initiative of the public sector in response to one of the biggest modern public health challenges – the obesity boom. It was part of a larger movement of the European Commission to ensure better and more simplified regulation and was therefore welcomed with caution by public health NGOs at its inception, as there was a fear amongst civil society that this would be used as a justification for regulatory inaction on one of the complex policy challenges facing the public health community. It was a unique concept at the point of its creation and brought industry and NGOs face-to-face, to bring to the public debate issues which up until this point had not been part of a structured public discourse. The theory behind the creation of the Platform was that it allows for action to be taken by the private sector faster than through legislation, and if the results are

not satisfactory there is still the alternative of regulation. In practice, there was little or no political will in 2005 to use regulation to change industry behaviour as part of tackling obesity and the Platform encouraged a public debate on the responsibility of the food industry for the rise in obesity, including marketing, formulation of unhealthy products and misleading labelling. The Platform has four objectives: a global objective to contain or reverse the EU trend towards overweight and obesity; and three specific objectives to provide a common forum for exchange amongst the stakeholders, generate specific actions in key areas and produce evidence.

Participation in the Platform is entirely voluntary; NGOs and the economic operators are required to submit commitments to the European Commission and must maintain an "active" commitment at all times in order to continue membership of the Platform. Examples of commitments include McDonald's providing nutritional information on packaging throughout Europe and the Union of European Soft Drinks Associations' (UNESDA) pledge not to market directly to children under 12 across the EU. The participants must submit monitoring reports annually on the commitments, and they regularly form part of the discussions during the Platform itself. A parallel high-level group involving Member States is organized as part of the same process, and WHO sits as an observer. As member of the Platform, the European Public Health Alliance's (EPHA) primary objective is to bring constructive criticism, defend a public health approach during the debates and draw to the attention of the European Commission when public health interests are not being prioritized. As part of its role, it facilitates coordination meetings with other nongovernmental actors participating in the process, in order to review the authenticity of the material presented by the participating economic actors, share experiences and knowledge and ensure a coordinated and strong civil society voice in the debate. This chapter will explore the functioning of the Platform in relation to issues raised by the literature on PPPs, as well as in relation to the challenges and achievements to date.

Reaching out to the building and construction sector: WHO–CIB collaboration on healthy buildings

Matthias Braubach

CIB is the International Council for Research and Innovation in Building and Construction established in 1953 to facilitate international cooperation and information exchange between governmental research institutes in the building and construction sector. In 2009, a Task Group was established with the title TG77 – Health and the Built Environment. Its objective is the increased consideration of health aspects in research

on building and construction, both in relation to residential buildings and health care facilities. TG77 started with the support of members from several national building institutes and academic research entities, and liaison to WHO activities is ensured by a WHO representative being a member of the TG77 steering group.

TG77 is committed to contribute construction-related expertise to the WHO work on the health aspects of buildings and indoor environments. Specifically, TG77 will coordinate – reaching out to and benefiting from the expertise of all members and task groups of CIB – the production of manuals and technical recommendations providing guidance on how to implement and realize WHO recommendations in the building construction and engineering sector. The outcomes of the TG77 work will be reported to the CIB secretariat.

TG77 and the WHO–CIB collaboration is new and while both actors are not yet in a position to evaluate the experience, both sides agree that there is a range of mutual benefits. Following years will show to what extent the approaches, paradigms and working processes within the two sectors can be merged and to what extent WHO publications can be translated into clear technical advice documents on construction of more healthy buildings.

Source: CIB, 2009, 2010

A changing political context

How did we get here? It is beyond the scope of this chapter to explore the changing political and historical context leading to the current trend in increasing PPPs. However, the substantial shift in geopolitics marked the beginning of the trend towards greater industry involvement in health promotion and is therefore noteworthy in creating the context and means for new models and relationships in health. Traditional models of diplomacy, policy and politics – and in particular the power and responsibilities of the state – were challenged and revised following the geopolitical changes of the late 1980s and early 1990s (Reinicke & Witte, 1999), and the last two decades have seen a transfer of resources to private enterprise as well as a spirit of great collaboration between state and non-state actors in the field of international relations, particularly in the context of the United Nations (Walt & Buse, 2006). The emergence of non-state actors in the geopolitical arena, the drivers and influences of these actors on health and social outcomes, together with a shift in global governance, are fundamental to understanding the recent increase in PPPs in health, as well as understanding the need to move beyond traditional centralized or devolved governmental models in tackling health challenges.

The World Health Assembly in 1993 reflected these shifts and changes, concluding that WHO should involve all actors in health promotion, including

nongovernmental organizations, the private sector and governments, when implementing national strategies for health for all. Indeed, WHO interaction with NGOs and the private sector has seen an increase since these conclusions (Buse & Waxman, 2001). This is fundamental to the discussions in this chapter – PPPs are in existence and on the increase despite the concerns of conflict of interest, ownership of public health as a "public good" or indeed doubts as to the interests of economic actors in their desire to become involved in PPPs. What is a PPP, how should they be defined and devised, governed and held accountable are important questions in this changing reality within public health governance. Unsurprisingly, PPPs meet the strongest resistance amongst those who believe that the responsibility and duty for the delivery of public goods remains with the state. However, as this chapter attempts to show, PPPs are themselves a manifestation of the shift in power and resources towards the private sector, and indeed at times an attempt at public health governance in areas where traditional government cannot instigate change for political or financial reasons.

A public-private partnership across levels of governance: the EU School Fruit Scheme

João Breda and Caroline Bollars

In November 2008, the Directorate General for Agriculture and Rural Development of the European Commission (DGAGRI) adopted a proposal for a European Union-wide scheme to provide fruit and vegetables to school children. The scheme provides funds to build the market for sustainable fruit and vegetable supplies for schools, as well as added incentive for schools and local authorities to get involved in promoting horticulture and healthy eating.

European funds worth €90 million pay for the purchase and distribution of fresh fruit and vegetables to schools. This money is matched by national and private funds in those Member States that choose to make use of the School Fruit Scheme, which is now implemented in 24 Member States of the European Union. Known as The School Fruit Scheme (though also including vegetables), the scheme provides fruit and vegetables to schoolchildren, but also requires participating Member States to set up strategies including educational and awareness-raising initiatives and sharing good practice. The scheme started in 2009.

The structure not only asks for participation and commitment from the health sector but it requires commitment from the agriculture and education sector.

The EU School Fruit Scheme is based on co-financing at 50%, and 75% for convergence regions. To reinforce healthier eating habits, in addition to the provision of fruit and vegetables accompanying measures are implemented, such as education, parental involvement and farm visits.

The implementation of the School Fruit Scheme is integrated both as a central and local government policy and school food policy.

A recent evaluation of the European Court of Auditors produced in 2011 a special report on the effectiveness of the Milk and Fruit School Schemes. The School Milk Scheme introduced a flat rate for milk and milk products in schools, regardless of fat content. The School Milk Scheme has been rated very negatively and still has very limited impact according to the European Court of Auditors' report. In September 2007, the Council adopted a package of measures that introduced a flat-rate subsidy for the European School Milk Scheme, allowing skimmed milk distribution to have the same support as full fat milk. It was hoped that this would contribute towards reducing childhood obesity by enabling schools to provide healthier milk options. On the other hand, according to the Auditors' report, while it is still too early to come to any definitive conclusions about the School Fruit Scheme's ultimate effectiveness, it does appear considerably more likely to achieve its short- and long-term objectives.

Source: European Court of Auditors, 2011

Definition of "public-private partnership"

Although there is extensive literature on PPPs, there is little agreement on the definition, therefore for the purpose of this text the authors have taken Reich's (2002) definition, who outlines the following three points that can also be found in most of the literature reviewed.

1. The collaborations should involve at least one public organization and one private profit-making organization. The public organization could include national government bodies and international agencies such as WHO, the World Bank or a United Nations agency. The "private sector" normally would extend to any type of profit-making corporation.[2]
2. The partners will have certain common goals for a particular health problem.
3. The different partners will divide the workload and mutually receive benefits.[3]

This broad definition covers several different types of partnerships: from small one-off collaborations with a single economic actor to large entities that involve intergovernmental agencies, non-profit-making organizations and the private sector. In reality, defining PPPs is more complex than simple descriptive terms – particularly within the public health field, where public health values are an important consideration in the use and function of PPPs. Public health can be

2 There is general agreement in the literature that partnerships with nongovernmental organizations do not constitute a "private" partnership. Although partnerships can include non-profit-making organizations, these are normally grouped with the public sector or used to balance commercial interests.

3 Most authors distinguish between PPPs and privatization. This discussion falls outside the scope of this paper, and thus will not be addressed.

considered a public good, in which case PPPs could be considered unpalatable or indeed inappropriate. A tobacco company's involvement in the development of smoking awareness literature, or involvement of pharmaceutical companies in actions for affordable medicines whilst the same companies are lobbying government against generics, are two extreme but not unheard of examples. The Platform can arguably be seen as meeting conditions 1 and 2 from the above definition.

Condition 3 (dividing the workload and mutually receiving benefits) requires a closer look and analysis. The Platform has been criticized as a forum where both NGOs and economic actors are obliged to provide commitments on action to tackle obesity, despite the significant difference in resources between the civil society actors and the associations of economic actors. The Platform could, however, be considered successful in terms of its engagement of economic actors, both in terms of attribution of responsibility as contributors to the obesity crisis, as well as driving responsibility and action in tackling obesity. This is an innovative success when compared to the more traditional model of public sector attempts to mitigate the health outcomes of obesity. For economic actors, their participation in what is in effect a self-regulatory process provides two "wins": firstly in the continued absence of direct regulation in this area, and secondly as their actions can be used to promote their image via public relations activities or branded as examples of corporate social responsibility. The benefit for the European Commission can also be seen as twofold: achieving action (arguably quicker than through direct regulation) in an area with little political will, as well as enabling a setting where the issues and arguments can be debated directly between economic actors and public health NGOs, whereas previously this had taken place bilaterally between stakeholders and the Commission, with antagonistic behaviour between the two sets of stakeholders. The benefit for the participating NGOs is less immediately obvious, as the process is time-consuming, resource-intensive and some have argued distracting from other political discussions on the issue – such as the intensive lobbying of the European Parliament on the food labelling Regulation,[4] where economic operators were claiming a strong commitment to public health outcomes in the Platform setting while aggressively lobbying the European Parliament against a coherent nutrient profiling mechanism, evidence-based traffic light schemes, etc. Some have remarked, however, that it does benefit their work by maintaining political attention on the issue of obesity.

4 Regulation (EU) No 1169/2011 of the European Parliament and of the Council of 25 October 2011 on the provision of food information to consumers, (amending Regulations (EC) No 1924/2006 and (EC) No 1925/2006 of the European Parliament and of the Council, and repealing Commission Directive 87/250/EEC, Council Directive 90/496/EEC, Commission Directive 1999/10/EC, Directive 2000/13/EC of the European Parliament and of the Council, Commission Directives 2002/67/EC and 2008/5/EC and Commission Regulation (EC) No 608/2004 (text with EEA relevance).

A changing strategy

The year 1997 saw two developments which enabled the growth of engaging industry for health promotion. The first of these was a turning point in the relationships between the United Nations and economic actors: in July of that year, the new Secretary-General of the United Nations, Kofi Annan, "unveiled a long-awaited [UN] reform proposal that stated openly that the relationship of the UN system with the business community was of 'particular importance'" (Tesner & Kell, 2000). According to Richter (2004), this development enabled the active promotion of agency-business partnerships, subsequently normalizing and creating a culture of cooperation between the business community and intergovernmental agencies such as WHO and UNICEF. The Platform can be seen as a successful example of this reform, where the public, private and civil sectors entered into a structured dialogue with a common aim of reducing obesity.

The second critical development was the Jakarta Declaration from the 4th International Conference on Health Promotion – New Players for a New Era: Leading Health Promotion into the 21st Century. Given the lack of an international legal framework governing the use and scope of PPPs, this Declaration acts as a useful starting point for the analysis of the framework in which PPPs operate. The starting premise of the Declaration is "[t]o address emerging threats to health, new forms of action are needed. The challenge for the coming years will be to unlock the potential for health promotion inherent in many sectors of society, among local communities" (WHO, 2012). It states that traditional boundaries between government sectors, governmental and NGOs, and the public and private sectors need to be broken, and calls for the creation of new partnerships for health between the different sectors at all levels of governance in societies, on the basis that they be on equal footing. This was the first time a governmental declaration addressed the responsibility of the private sector and its impact on health. The Platform is fully in line with the Declaration, having as its starting point the role of the food and associated industries in the societal challenges faced by the rise in obesity, and the definition and engagement of concrete commitments to take action on the issues.

The Platform quickly assumed a prominent role for the European Commission in its action on tackling obesity, amid a growing governmental dialogue on the role of PPPs in obesity actions. At the WHO European Ministerial Conference on Counteracting Obesity (Istanbul, Turkey, 15–17 November 2006), former Commissioner Marcos Kyprianou used the Platform as an example of partnership with stakeholders to counteract obesity, and it was presented and discussed during at least one workshop during the Conference. Member States endorsed the European Charter on Counteracting Obesity that established

guidelines and a framework for future intersectoral action on obesity which included that the private sector should also have responsibility in building a healthier environment. The framework maintains that economic operators from the entire food chain should be included and action should be focused on manufacturing, marketing and product information, and consumer education with guidance from public health authorities. Recommendations for policy tools include PPPs, policy reformation, regulatory action, fiscal and public investment policies, health impact assessments, awareness campaigns, research, capacity building and monitoring.

Public-private partnerships in health care: advancing health promotion in Kansas, United States

Sara Poage and Wendy Heaps

The Mid-America Coalition on Health Care (MACHC), a non-profit employer membership organization in the Kansas City region, works with key employers and health care delivery stakeholders (e.g., physicians, health plans, hospitals, public health, and government) to improve population health. MACHC helps employers adapt public health tools for workplace health and provides feedback to public health agencies on how these tools can be used with employers and stakeholders. The following two examples illustrate what the MACHC has done.

In the first example, MACHC, the Kansas Department of Health and Environment and Kansas City, Missouri, Health Department worked with Hallmark Cards to implement the Centers for Disease Control and Prevention (CDC)-funded Chronic Disease Self-Management Program (CDSMP). Prior to this project, the CDSMP was used for health promotion in community settings exclusively. In order to translate this program to the workplace, the public health agencies helped Hallmark implement organizational policies to encourage employee participation in the CDSMP, including offering flexible work schedules and paying employees for their time to attend chronic disease management peer support groups. The program has now become a permanent feature of Hallmark's workplace health activities.

The second example involved nine small businesses employing 18 000 workers in the bi-state Kansas City region (Missouri and Kansas). Initially, all nine of these employers felt they were unable to implement robust prevention and wellness programs because they had limited capacity and expertise. MACHC collaborated with this group and used a CDC worksite health scorecard to identify the gaps in their workplace policies and ways in which public health experts could assist employers to reduce chronic disease. This assessment led to the employers' addressing prehypertension and hypertension by increasing promotion of tobacco cessation services and availability of blood pressure monitoring devices in the workplace, and offering healthier food options in the cafeteria.

Sources: DeNavas-Walt, Proctor & Smith, 2008; McGinnis, Williams-Russo & Knickman, 2002.

Bridging the resources gap

Generally, most of the available literature supports the conclusion that PPPs with good governance structures can be effective to reduce costs, provide investments and provide improvements to service provision. Some argue that they improve efficiency due to reduced management, increased expertise, new investments in infrastructure and potential to improve technology (Goel, Galhotra & Swami, 2007). The partnership allows actors to tackle the broader determinants of health and promote health-conducive behaviour (Gillies, 1998). Some argue that PPPs "enable different people and organizations to support each other by leveraging, combining and capitalizing on their complementary strengths and capabilities" (Lasker, Weiss & Miller, 2001). It is generally recognized that when governed effectively, they are able to share risks, pool public and private resources, and maximize the skills of the respective sectors to improve the delivery of services in innovative ways, and it is clear that with tightening public sector purses, this is a compelling argument for their increased use.

The distribution of resources within the work of the Platform has been a topic of debate amongst participants and highlights the different resources and abilities of actors. Participation in the Platform is voluntary, and therefore has proven a higher resource burden for the NGOs and other non-profit-making organizations to be involved. Not only does the economic actors' participation outnumber and outscale the participations from civil society, some civil society participants note that to contribute fully to the Platform they have had to reduce their normal activities of monitoring, dissemination of information and performing a watchdog role for public health in food policy discussions.[5] Many also feel that the industry is better able to commission expertise in legal, academic, scientific and other fields, whereas non-profit-making organizations depend mainly on the goodwill and volunteering of experts. This can be seen where economic actors have been represented by professional public affairs firms, government relations specialists and lawyers, whereas civil society is represented by senior staff members or volunteer academics. The platform has also been criticized because several commitments and actions of the industry tend to favour investing in research on the causes of obesity rather than making healthier food choices available or regulating advertising, labels or health claims. There is no "quality" monitoring of commitments, on either their appropriateness or effectiveness according to public health evidence.

The imbalance of resources also affects the internal discussions of the platform. Despite the fact that of the members, fifteen are profit-making and eighteen are non-profit-making, the platform is not entirely balanced in its participation

5 This is also partly due to the core work of the non-profit-making organizations being linked to advocacy and lobbying.

and representation. This is due to the fact that some members represent large companies and others represent smaller organizations. An economic operator made the following remark: "the space given to larger companies is bigger compared to small producer associations because of the lobbying power of larger companies" (The Evaluation Partnership, 2010). The evaluation of the Platform noted that "the for-profit sector generally has more resources to send more representatives to the Platform meetings than the not-for-profit sector, which might struggle to send a representative at all" and "members of the private sector had "6 to 10 people" attending" (The Evaluation Partnership, 2010). This undoubtedly could affect the debate if not managed carefully, as well as the issues discussed at the meetings. It is this tendency towards a dominant over-representation of economic operators that drove EPHA to organize coordination meetings prior to the Platform. A well-organized and -prepared pre-meeting has caused the process to be more time- and resource-consuming for the organizer and the participants at the meeting, but does arguably improve the contributions of the non-profit-making sector during the meetings through empowering the NGOs, sharing knowledge and information.

PPPs as a lever for health change and intersectoral action

In the second model of PPPs, the public sector seeks partnerships with the private sector to use the industry lever to incite behavioural change (Gillies 1998). The traditional model of public sector responsibility for the health and well-being of its population could be considered to have led to a fragmented approach to tackling health issues – health-sector-led and in isolation from other sectors and organizations. The increased engagement of the private sector in health promotion can be seen as an extension of the realization of HiAP, in using the drivers and resources outside the health sector. It could also be thought of as risk-sharing, where the industry actors involved are themselves the producers of products leading to poor health outcomes. However, this presumes a willingness of industry to take responsibility for the outcomes of the consumption of its products, something which the tobacco industry has consistently demonstrated is not easily achieved despite evidence, public opinion and political pressure. It also maintains a level of optimism in the desire to achieve good public health outcomes. One of the criticisms of this model of PPPs is that politically, economic actors are able to demonstrate they are committed to tackling public health problems while in reality using the PPP as a delaying tactic – the criticism levelled towards the self-regulation of advertising is an example. At least, any involvement in health promotion of those industries contributing to ill health is particularly sensitive and in need of robust governance structures, if desirable at all.

About 300 commitments have been submitted under the Platform since 2005, with 56% in traditional "health promotion", tackling lifestyle and education (The Evaluation Partnership, 2010). NGOs have been particularly concerned about the large number of health promotion actions that are put forward by the economic operators, for three main reasons: firstly, many of the commitments target the employees of the economic operators themselves, and therefore should not be considered sufficiently in the spirit of the objectives of the Platform; secondly, any health promotion activity should be governed by an evidence-based public health framework in order to ensure good public health outcomes and it is not certain that economic operators are competent to do this; and finally, there is a conflict of interest for economic actors who are the producers/manufacturers or retailers of products high in fat, salt or sugar (HFSS) to be providing educational campaigns on healthy eating.

The remainder of the commitments focus on marketing/advertising, reformulation and labelling – what NGOs would consider the "real" action to tackle obesity. Given that this is the core business of many of the economic operators, it presents a demonstration of genuine commitment to tackle the issue in the areas where they are able to have the greatest impact. There is little evidence to suggest that these commitments came about as a direct result of the Platform, rather than happening to a greater or lesser degree regardless (The Evaluation Partnership, 2010). However, it can be argued that the case studies on marketing to children and food/drink reformulation can be considered as having had a real, if limited, impact.

Regarding marketing and advertising to children, there is a regulatory framework with the EU Audiovisual Media Services Directive (AVMSD) which provides guidance on the protection of minors. However, the economic actors largely attribute the Platform in their adoption of commitments for self-regulatory approaches towards marketing and advertising aimed at children. There is no evidence to support or disprove this claim, given that at least some of the EU Member States have a self-regulatory approach such as a voluntary code which could also act as an incentive to action here. The evaluation found that in the context of these commitments, the exposure of children to marketing of HFSS foods has decreased. However, this was over-reported by the economic actors and the impact on exposure in a broader context was much lower (owing to the limited number of products chosen for the commitment, the definition and threshold of the target audience, etc.).

Reformulation, on the other hand, does not have an overarching, "hard" EU regulatory framework, although there is a "soft" mechanism via the high-level group. Reformulation makes up a quarter of all the Platform commitments and this can be concluded as being effective, as the commitments were undertaken

by multinationals on a wider range of products, or a significant market share of HFSS products, affecting both existing and new products, and affecting a significant number of products in general, with 25–50% (but up to 80%) reduction in fat, salt or sugar (The Evaluation Partnership, 2010). Reformulation has, however, spilt over into the political sphere with the approval process of health claims. Some have suggested that there was considerable pressure on the European Commission to approve a certain health claim as a "reward" for having reformulated certain HFSS products, despite NGO concerns that the claims were misleading and potentially harmful, although the European Parliament ultimately rejected the claim in question.[6]

The multistakeholder model has also been exported to national levels. In Germany, its national platform is part of the national action plan for fighting obesity and collaborates with the Ministry of Health, and in Poland the Programme POL-HEALTH consulted members of the Polish Platform on Diet, Physical Activity and Health before final approval by the Minister of Health. In Portugal, the discussions held during its national Platform affected regulations on salt and on the "Fruit at School" programme. In Hungary, the national Platform has been seen to influence its institutional priorities. For example, the Platform offered to develop an educational programme on salt, which was accepted by the Ministry of Health and has been used as an example where the financing of such an educational programme has shifted from the public to the private sector (The Evaluation Partnership, 2010). In the Netherlands, the ministries for education and health have left many of the regulatory functions to the national platforms as well. One of the main differences, however, between the national and EU platforms is the focus on "actions" rather than dialogue, with the Netherlands being seen as an exception to this.

Governing public-private partnerships

Hawkes (2008a) identifies five core areas of governance in the public health field: legitimacy; representation and participation; accountability; transparency; and effectiveness. Further, Hawkes (2008a) states that a "well-governed PPP should be legitimate, representative and participatory, accountable, transparent and effective." In the analysis undertaken by the Dutch National Institute for Public Health and the Environment (Rijksinstituut voor Volksgezondheid en Milieu – RIVM) prior to the high-level group, problems in PPPs for health have been identified as: failure to clearly specify partners' roles and responsibilities; inadequate performance monitoring; insufficient oversight of corporate partner

6 European Parliament resolution of 2 February 2012 on the draft Commission regulation amending Regulation (EC) No 1924/2006 with regard to the list of nutrition claims. Available at: http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P7-TA-2012-0022+0+DOC+XML+V0//EN.

selection and management of conflict of interest; and a lack of transparency in decision-making (Hawkes, 2008a). The Platform experience can be seen as a contradiction to these concerns, where the transparency surrounding the discourse (and at times antagonism) between the economic and civil stakeholders has increased since the Platform was created. However, the conditions on roles and responsibilities, legitimacy, representative and participatory actions have largely been met.

Questions and fears also arise that partnering with commercial actors undermines the values of the public sector and may change its mission and priorities. PPPs also have the potential to change the focus of, and put certain health issues on, the agenda and overshadow others. Reich (2002) argues that this was the case for several partnerships focusing on malaria, on vaccinations and on antiretroviral drugs for HIV/AIDS. When this occurs, it undermines the role of the public sector in creating a public health agenda and transfers responsibility from the public sector to PPPs. This transfer also blurs the role of the normative function of the public sector and gives a greater voice to the partnership, which may then be able to access government discussions (Reich, 2002). Buse and Waxman (2001) also highlight that critics have argued that involvement in a PPP allows the public sector to abdicate their responsibilities for the promotion and protection of their citizens' health. These concerns are all valid within the context of the Platform; however, the presence of civil society has kept a critical voice in the proceedings where the economic actors would have perhaps preferred to shift the discourse towards the individual's responsibility in lifestyle choices, rather than an obesogenic or public health approach. The question of whether responsibility has been transferred from the public sector to the Platform is complex, with a vibrant and active political debate on many of the issues – such as reformulation, labelling and more recently fiscal measures addressing HFSS foods – also addressed in Platform meetings. However, what can be seen from discussions is a push from the economic operators and to a certain extent from the European Commission to give greater visibility to the Platform itself. This is largely opposed by the NGO participants, who view the Platform as a strategy tool and not an objective in itself, where some NGOs who are present because they feel it necessary to act as a watchdog in the setting are uncomfortable with being portrayed as willing and committed to the process itself.

The WHO European Action Plan for Food and Nutrition Policy 2007–2012 outlines the role for government: "The primary obligation of governments is to provide leadership and to formulate, monitor and evaluate a comprehensive food and nutrition policy. Public health policy-makers have a responsibility to act as advocates and to demonstrate stewardship and leadership for health

across different government departments and with the public and private sectors." At the EU level, the Platform, which has become the backbone of the implementation of the EU's Strategy on Nutrition, Overweight and Obesity-related Health Issues, may have resulted in the absence of further legislative action, although some still argue that there is little political will for more concrete measures. Action to tackle obesity across various policy areas at different levels is arguably still not visible enough, nor has the European Commission taken further action in stimulating a cross-cutting policy development approach. Self-regulation and partnerships with the private sector are one of several tools used to counteract obesity. However, the European Commission has rarely used its powers to initiate legislative proceedings in the action areas of the Platform. In terms of the role performed by the Commission, it is mostly neutral and comprises moderating the meetings, putting together the agenda, and communicating the activities of the Platform to the high-level group. The appropriateness of the neutrality of the European Commission in this setting has been questioned by some, who see the role of the public sector as guardian of the public interest and of the public good. Maintaining a broker position could be seen as not fulfilling its obligations in this function, where the confrontational role is passed onto the NGOs in the room.

Governance principles and risk management

The nature of PPPs raises three governance issues, since many PPPs are formed to face challenges and thus evolve quickly, and strategic decisions need to be made without the ability to fully assess their consequences. The parameters of the field of action may change, for example moving beyond the original remit, and the result may require more resources and time commitment than originally agreed. Participation in a PPP comes with no guarantee of success for the project and thus a reputational risk is involved for all partners (Hawkes, 2008a). The United Nations Economic Commission for Europe has developed a *Guidebook on promoting good governance in public-private partnerships* that identifies seven principles. These principles address the majority of concerns that are raised when collaborating with the private sector and have implications for the health sector. To try to relieve the concerns of stakeholders, WHO developed safeguards for working in global PPPs. An internal Committee on Private Sector Collaboration was established in 1999 to review the sustainability and compatibility of proposals for partnership with organizational policies and guidelines and in 2000 WHO developed a declaration of interests form, which asked experts to disclose information on financial and other interests with commercial entities (Buse & Waxman, 2001). A briefing paper on conflict of interest was also commissioned. These efforts are being duplicated elsewhere

to minimize these risks and many public organizations are also developing selection criteria.

When governance processes are comprehensive, clear and transparent it greatly reduces the level of risk (Mannar, 2003). However, unfortunately this is not done widely enough in PPPs for health (Hawkes, 2008b) and many causes for concern remain. Certainly, participation in the Platform for some of the civil society stakeholders has raised questions about reputational risk. There is a soft push from the European Commission for commitments from the partners that bridge both the economic and nongovernmental stakeholders – in effect, PPPs in themselves. However, this does not account for the reputational issues that the NGOs in the room need to manage very carefully. For many NGOs, including the employing organization of these authors, there are strict guidelines on the nature of partnerships that can be undertaken with economic operators. When operating in a highly political and visible environment, questions are raised as to who is paying for the "voice" and the legitimacy and representation of the supposedly non-profit-making organization. Issues which are often complex and multifaceted in an implementation environment become stratified and politicized in the political context. Therefore, reduction to a "simple" message – such as no economic actors involved – is seen as preferable to being considered at risk of concerns about legitimacy. This tension towards economic actors is particularly prevalent amongst NGOs working on population health rather than patient issues. Simply participating in a process that could be construed as delaying action on obesity, acting as a distraction from regulatory approaches or "approving" commitments that are marketing exercises masked as corporate action to tackle obesity, can be damaging to an NGO in other contexts.

Conflict of interest

Richter (2004) argues that the push for partnerships with economic operators has not taken into account issues such as conflict of interest. Two areas of concern are the role of the private sector in steering or management of a partnership, and funding. She criticizes the emphasis on "win-win" situations and argues it is more appropriate to ask "Who wins what?" and "Who loses what?" Furthermore, there is a need to assess if the gains from PPPs result in losses from a public interest perspective. At times, commercial actors use the interaction to gain political and market intelligence information in an attempt to gain political influence or a competitive edge over companies who are not seen as government partners (Richter, 2004). As PPPs are relatively new, there is little known transparency in how they operate and what they achieve (Goel, Galhotra & Swami, 2007). This conflict of interest is raised frequently during

the Platform, particularly in discussions on the role of economic operators in providing promotional or educational campaigns on healthy living. The balance between corporate support for public health messages and the need for robust, evidence-based public health promotion strategies is a fine one, and not always easy to navigate in practice.

In addition to this, the high-level political endorsement of the Platform has at times been problematic for stakeholders, whether economic or civil society. The Platform started out in effect as an informal experiment and within four years had developed into an official stakeholder group endorsed by the College of Commissioners, the European Parliament and the Council of Ministers of the EU Member States. Robert Madelin, Director-General of DG Sanco at the time of the Platform's creation, attributes the wide membership as part of its success and stated, "when something fails at European level, it is because there were too few allies in the beginning. The Platform builds a big alliance to solve real problems" (EUFIC, no date).[7] Some of the stakeholders, on both sides, certainly became part of the process because politically they could not afford not to. This is part of the innovative nature of the Platform; as already mentioned, many civil society representatives felt that by participating in the process they were legitimizing partnerships with industry organizations and being held open to questions about their independence. Some of the economic operators as well as the NGOs were reluctant participants, as they were concerned this would become a "talking shop" or a public affairs exercise. On the other hand, if the organizations had not participated, they would not be able to express their views, nor their concerns. It is part of the success of the Platform that these concerns are no longer often heard.

Concluding comments

Given the complexity of the political context and regulatory framework, as well as the multiplicity of policy challenges raised by the prevalence of obesity in Europe, it is hard to draw a simple conclusion on the Platform success overall. It has certainly acted as an innovative process to bring together actors with very different interests, who are often antagonistic towards each other in policy settings. Dialogue within the Platform has become more constructive and less confrontational over the years, although still retains a clear divide between the economic and non-economic participants. The Platform brought to the forefront of the public discourse the nature of the "culture clash" between the economic operators and the public health NGOs. There is certainly a greater understanding between the two sides since the inception of the Platform, but

7 The full interview with former DG Sanco Director General Robert Madelin can be accessed at http://www.eufic.org/page/es/page/ MEDIACENTRE/podid/European-Commission-seeks-action-in-response-to-their-Nutrition-White-Paper/.

without greater trust (with some exceptions). Joint actions between the two sets of actors are rare and the Platform raises some key questions about the role of NGOs and the public sector in creating a regulatory and policy environment that facilitates better health. The conclusions of the evaluation of the Platform calls on the NGOs to be less "watchdogs" and more "guide dogs", but it could be argued that this is not a realistic expectation or demand on these political or advocacy NGOs, whose mandate is limited to acting as a counterweight for economic interests in policy-making. This also raises the question as to the role of the public sector – whether the state should sit as a neutral actor in an environment with a polarized corporate interest versus public interest debate. The question of whether this should be seen as a pragmatic, market-based political model, or a political push to prioritize and pander to economic arguments, remains open.

The onset of and increase in formal relationships between industry and the public sector in health promotion clearly raises challenges for health governance. From the evidence available, largely from partnerships formed around specific products or pharmaceutical initiatives, it is clear that PPPs require clear and managed governance structures, with defined roles and responsibilities as well as expectations, something that is largely successfully achieved in the context of the Platform.

A number of health governance questions remain, dominated by the changing role of the state and the impact on health outcomes. How should the responsibility for health be shared between those who hold the drivers of health determinants and those who regulate them? The use of PPPS to increase the accountability of industry for poor health outcomes, and in particular given the changes in international governance, is in need of greater research. The impact of the transfer of legislative power from state to international actors – for example, the World Trade Organization globally, and the European Union regionally – has reduced the ability of national governments to introduce regulatory measures to protect public health, seen in recent policy discussions ranging from chlorine-washed chickens, to trans-fats, to advertising and marketing. To what extent are PPPs a mechanism to bridge this regulatory gap, and is this the most effective method of improving health? What are the health governance impacts of international regulatory frameworks for industry and economic activities?

Trust, personal relationships and changing expectations of different actors is also not covered by the literature, all very important in the example of the Platform. In addition, the last two decades have seen changes in the nature of employment. Traditional models of individual careers in public, private or academic sectors are becoming less common – how does this affect health

governance in terms of mobility of personnel, development of human capital and changing expectations from the different actors?

The literature does not reflect on whether PPPs are more or less effective in different industries – pharmaceuticals over food, for example – nor on how the political importance or the potential for public controversy surrounding a topic can affect the drive for and implementation of a PPP on the issue (such as a PPP to provide sexual and reproductive health services). Finally, as regards the governance impact of PPPs and increase in health inequalities, there is scope to examine further the relationship between shifting power and responsibility and the impact on health outcomes, particularly on growing global health inequalities.

Despite the questions that remain and the clear need for greater research on the issue, it is important not to lose sight that often PPPs, such as the Platform, are put forward where regulation (the traditional tool of government) is not achievable for political or financial reasons. Public health, throughout its existence as a discipline, has trod the line of trade-off and working across sectors and groups. PPPs are a modern reality and are not likely to disappear: how can the public health sector ensure they are efficient, appropriate and not distorting or damaging? Given that the private sector works best where markets exist, and works least well when individuals are poor or economies of scale do not exist, the tensions between the short-term goals for a private actor and the long-term sustainability needs of a community become a very pertinent question in the debate. The question that remains is: what becomes of the role of the state?

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Many of the policies and programmes that affect health originate outside the health sector. Governments need, therefore, to address population health using a strategy or policy principle that fosters intersectoral action.

Health in All Policies (HiAP) does just that, encouraging intersectoral approaches to management, coordination and action. This volume captures the research on how intersectoral governance structures operate to help deliver HiAP. It offers a framework for assessing:

- how governments and ministries can initiate action, and
- how intersectoral governance structures can be successfully established, used and sustained.

This volume is intended to provide accessible and relevant examples that can inform policy-makers of the governance tools and instruments available and equip them for intersectoral action.

The European Observatory on Health Systems and Policies and the International Union for Health Promotion and Education have worked with more than 40 contributors to explore the rationale, theory and evidence for intersectoral governance. This volume contains over 20 mini case studies from Europe, the Americas, Asia and Australia on how countries currently use intersectoral governance for HiAP in their different contexts. It also highlights nine key intersectoral structures and sets out how they facilitate intersectoral action. They include:

- cabinet committees and secretariats
- parliamentary committees
- interdepartmental committees and units
- mega-ministries and mergers
- joint budgeting
- delegated financing
- public engagement
- stakeholder engagement
- industry engagement.

It is hoped that in addition to being policy relevant this study will also contribute to reducing the current knowledge gap in this field.

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