Perspective

TOWARDS INTERSECTORAL GOVERNANCE: LESSONS LEARNED FROM HEALTH SYSTEM GOVERNANCE

Scott L Greer,[1,2] Matthias Wismar,[2] Monika Kosinska[3]

[1] University of Michigan, Ann Arbor, United States of America
[2] European Observatory on Health Systems and Policies, Brussels, Belgium
[3] WHO Regional Office for Europe, Copenhagen, Denmark

Corresponding author: Scott L Greer (email: slgreer@umich.edu)

Keywords: DELIVERY OF HEALTH CARE, HEALTH PLANNING, POLICY

BACKGROUND

How do we design roads that are not only safe but also encourage healthy physical activity? How do we implement and oversee health interventions outside of the health sector, such as those in educational settings like nurseries, kindergartens, schools, and institutions for vocational and academic training? How do we regulate novel technologies that offer huge benefits so that the associated risks are mitigated? How do we coordinate health and social services so that both the young and old in our societies have the best support at a sensible cost? How do we build energy-efficient, quality hospitals at the minimum cost? How do we formulate budgets that promote health during economic crises?

These are pertinent public health questions that have been addressed in recent years by Health in All Policies initiatives *(1, 2)* and in intersectoral governance *(3, 4)*. They are the questions at the centre of Health 2020, the European policy for health and well-being *(5)*. Navigating competing interests, managing the diversity of stakeholders and implementing complex interventions across and between sectors are key features of the intersectoral nature of todays' policies for health.

This paper looks at some of the governance lessons available from health systems, which can be applied to intersectoral approaches across the World Health Organization (WHO) European Region *(6)*. It is easy to focus on political will, but political will alone does not make complex intersectoral decisions and implement policies. This paper addresses governments that intend to take forward intersectoral action. Its purpose is to strengthen and help them in adopting a systematic approach to implement, assess and evaluate their effectiveness and fitness for this purpose through analysis of governance.

INTERSECTORAL INTERVENTIONS FOR HEALTH

Intersectoral policy interventions have an extensive evidence base in both public health and economics *(7)*. The specific context of each intersectoral intervention will always raise complex questions that have complex answers, and which require technical expertise in diverse fields, from civil engineering to gerontology to finance. However, the answers and, more importantly, the successful implementation of each and every one of these interventions depend on their governance: on the way that decisions for health and well-being are made and implemented in society.

Evidence shows that existing governance does not always guarantee the best outcomes for the health of populations *(8)*. Some countries undergoing severe financial and economic crises introduced austerity measures that can be critiqued for their negative effects on health and health-care systems *(9–11)*.

For example, the Greek health-care system, with 2.5 million citizens, is under severe stress. One quarter of the Greek population does not have sickness fund coverage, and is dependent on time-limited vouchers in a system requiring informal payments in a country where even those with money have only intermittent access to cash *(12, 13)*. Across the WHO European Region, essential supplies and many services such as screening are no longer available for parts of the population. Access to health care has deteriorated, resulting in unmet medical needs. This is a major blow to universal health coverage in Europe *(14)*. The governance of the decisions taken regarding the financing of the health system – and, in particular, the accountability of these decisions – has played a major role in the evolution of events. Different governance at the domestic level has prevented or minimized these negative health effects of the financial crisis by changing decisions or implementing positive initiatives more successfully *(10)*. Governance can lead to less damage from austerity by improving decisions about investment, collaboration and protection, as well as sophisticated budget cuts. It can also lead to better implementation by, for example, enhancing local "ownership" of changes.

Governance for health, by implication, does not just mean a prescriptive model for operating interventions or services. Rather, it requires that governance becomes a key component of planning, implementation and evaluation of actions to better health and well-being.

Governance can often be portrayed as an abstract concept, frequently and perhaps unhelpfully linked to "good governance" and turned into a utopian wish list of desirable preconditions *(15, 16)*. It is always, however, an empirical reality. Decisions affecting health and well-being are made and implemented everywhere, in every setting and at every level of government. But it encodes preferences and power in ways that are better or worse for health and well-being.

If accountability measures are in place that encourage urban planning to prioritize moving cars quickly, rather than moving cars safely or including pedestrians and encouraging, for example, cycling, we have roads that contribute to differing outcomes in obesity, pollution and even crime. Ensuring safe and accessible bicycle lanes, green spaces, friendly street furniture and lighting requires the inclusion of health objectives in decision-making as early in the process as possible *(17)*. Once a government has mustered political will and embarked on developing an intersectoral programme for health and well-being, its success depends on governance. There is no such thing as "good governance" if we have not answered the question of "good for what?" The practical question when approaching intersectoral action in health is therefore: how can we make governance good for health and well-being?

THE TAPIC FRAMEWORK FOR INTERSECTORAL HEALTH GOVERNANCE

A recent study addressed this question *(8)*. It combined a review of the existing literature on health governance with a set of commissioned case studies of complex health governance problems as diverse as communicable disease control, primary care reform, hospital governance, technology assessment and private insurance markets. It started with the premise that governance matters because it can determine the success or failure of policies, every bit as much as financial means, political support, or the quality of the policy as an evidence-informed intervention. This means that a diagnostic approach to policy, focusing on actual or potential failures, is suitable. If an evidence-informed policy with sufficient political resources and political backing is in danger, it might be due to governance problems as diverse as corruption, lack of local ownership, or weak technical implementation.

The study then reviewed a range of academic research and international organizations' publications to identify five components of governance that can affect the success or failure of policies. This "TAPIC" framework was named for its components: **T**ransparency, **A**ccountability, **P**articipation, **I**ntegrity and policy **C**apacity.

The first component is *transparency*: policies are better when the decisions and their grounds are made clear. This does not mean that every stage of policy-making should be made public, a demand that most often empowers well-resourced interest groups that can engage in multiple and complex fora and back up their preferences with research, litigation and intensive

lobbying *(18)*. What it does mean is that any interested citizen can know what policymakers have done and why. In this respect, transparency flows into the second component of governance, which is *accountability*. Accountability is by definition explanation and sanction *(19)*: those entrusted with power should explain their actions and be held responsible if their actions are inappropriate. Accountability can exist without transparency. Two organizations can have an accountability relationship without explaining it to the broader public. Likewise, transparency can exist without accountability. It is possible to make decisions clear without being accountable for them.

It is possible to focus on accountability at the expense of everything else, as indeed principal–agent models invite us to do. But practice shows that the next component, *participation,* meaning engagement of affected interests in decision-making, is also crucial. Participation is conducive not only to ownership and political viability, but also to the information necessary to improve health. Without participation in decision-making, noncompliance and sabotage are always risks, as long experience of conditional lending by international financial institutions shows *(11)*. Participation does not mean that everybody constantly influences the direction of travel, or is happy with outcomes.

In fact, we do need better rules of participation as, for example, in the Framework Convention on Tobacco Control, which clarifies that tobacco producers shall not participate and governments need to empower those who are otherwise unheard.

Transparency, accountability and participation all lessen the chances of corruption, unresponsiveness or incompetence among policy-makers, but good health policy also requires competence among institutions and individuals, including responsiveness to evidence and objectives. This leads to the last two aspects of the TAPIC framework: *integrity* and *capacity*. Integrity refers to good public management such as meritocratic hiring, clear performance standards and clear organizational missions. Capacity, in the context of the TAPIC framework, refers to the specific capacity for policy. That means a mixture of technical skills and networks, both networks across government and among experts and civil society. It also means the ability to formulate evidence-based and politically sensible recommendations for health.

Transparency, accountability, participation, integrity and capacity exist in every political system. They are merely descriptive categories. As we work for health across multiple sectors, the framework identifies ways in which governance is working or can work for health.

CONCLUSION

The way decisions are made and implemented is crucial to the success of policies for health and to achieving the desired health outcomes in any system *(20)*. Policies with a strong evidence base and financial resources can fail in implementation because of governance, while governance can shape the likelihood that good policies are adopted. In response to the complexity of today's public health priorities, the solutions themselves have become increasingly complex, involving multiple and new partners and drawing on diverse interventions, models and approaches. Within this context, the need to pay attention to components of systemic and intersectoral governance is becoming increasingly clear. The contribution of governance to the success of health policies can be found in transparency, accountability, participation, integrity and capacity.

As interest in intersectoral action to address health and well-being continues to translate into new models and approaches, there is a clear need to further develop new tools and methods to support policy-makers in navigating these new dynamics and relationships. The TAPIC framework, which is built on the lessons learned from within health systems, provides a simple framework for analysis to address the key governance questions of intersectoral interventions. It can contribute to the evidence base for successful intersectoral approaches and governance for health and well-being.

Successful intersectoral approaches are challenging and resource intensive. It is essential that policy-makers are supported in taking this forward and utilizing the political window of opportunity offered by Health 2020 and current discussions on furthering its implementation through strengthening intersectoral governance in the European Region. Therefore, this is an exciting moment to bring research and practice together, using the naturally occurring policy innovations and experiments in every kind of jurisdiction to test frameworks such as TAPIC, and

identify transferable lessons for others from within the health governance research arena.

Acknowledgements: None.
Sources of funding: None declared.
Conflicts of interest: None declared.
Disclaimer: The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions or policies of the World Health Organization.

REFERENCES

1. Stahl T, Wismar M, Ollila E, Lahtinen E, Leppo K, editors. Health in all policies: prospects and potentials. Finland: Ministry of Social Affairs and Health; 2006 (http://ec.europa.eu/health/ph_information/documents/health_in_all_policies.pdf, accessed 28 July 2015).
2. Leppo K, Ollila E, Pena S, Wismar M, Cook S, editors. Health in all policies – seizing opportunities, implementing policies. Finland: Ministry of Social Affairs and Health; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf?ua=1, accessed 28 July 2015).
3. McQueen D, Wismar M, Lin V, Jones C, St-Pierre L, Davies M, editors. Inter-sectoral governance for health in all policies: structures, actions and experiences. Copenhagen: WHO Regional Office for Europe/ European Observatory on Health Systems and Policies; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0005/171707/Intersectoral-governance-for-health-in-all-policies.pdf, accessed 28 July 2015).
4. Kickbusch I, Gleicher D. Governance for health in the 21st century. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/__data/assets/pdf_file/0019/171334/RC62BD01-Governance-for-Health-Web.pdf, accessed 28 July 2015).
5. Health 2020: the European policy for health and well-being [web page]. Copenhagen: WHO Regional Office for Europe; 2015 (http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being, accessed 28 July 2015).
6. WHO Regional Committee for Europe. Health 2020: a European policy framework supporting actions across government and society for health and well-being. Copenhagen: WHO Regional Office for Europe; 2012 (http://www.euro.who.int/en/publications/abstracts/health-2020-a-european-policy-framework-supporting-action-across-government-and-society-for-health-and-well-being, accessed 28 July 2015).
7. McDaid D, Sassi F, Merkur S. Promoting health, preventing disease: the economic case. McGraw-Hill Education; 2015.
8. Greer SL, Wismar M, Figueras J, editors. Strengthening health system governance: better policies, stronger performance. Brussels/Philadelphia: European Observatory on Health Systems and Policies/Open University Press; 2015.
9. Greer SL. The three faces of European Union health policy: policy, markets and austerity. Policy and Society. 2014;33(1):13–24.
10. Repullo Labrador JM. Austerity: reforming systems under financial pressure. In: Greer SL, Wismar M, Figueras J, editors. Strengthening health system governance: better policies, stronger performance. Brussels/Maidenhead: European Observatory on Health Systems and Policies/Open University Press; 2015.
11. Greer SL. Structural adjustment comes to Europe: lessons for the Eurozone from the conditionality debates. Global Social Policy. 2014;14 (1):51–71.
12. Chrisafis A. Greek debt crisis: 'Of all the damage, healthcare has been hit the worst'. The Guardian, 9 July 2015 (http://www.theguardian.com/world/2015/jul/09/greek-debt-crisis-damage-healthcare-hospital-austerity, accessed 28 July 2015).
13. Economou C, Kaitelidou D, Kentikelenis A, Maresso A, Sissouras A. The impact of the crisis on the health system and health in Greece. In: Maresso A, Mladovsky P, Thomson S, Sagan A, Karanikolos M, Richardson E, et al., editors. Economic crisis, health systems and health in Europe: country experiences. Copenhagen: WHO Regional Office for Europe/European Health Observatory on Health Systems and Policies; 2015: 103 (http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/economic-crisis,-health-systems-and-health-in-europe-country-experiences, accessed 28 July 2015).
14. Reeves A, McKee M, Stuckler D. The attack on universal health coverage in Europe: recession, austerity and unmet needs. Eur J Public Health. 2015;25(3):364–5.
15. Barbazza E, Tello JE. A review of health governance: definitions, dimensions and tools to govern. Health Policy. 2014;116(1):1–11.
16. Grindle MS. Good enough governance: poverty reduction and reform in developing countries. Governance. 2004;17(4):525–48.
17. Wernham A, Teutsch SM. Health in all policies for big cities. J Public Health Manag Pract. 2015;21(Suppl 1):S56–S65.
18. Ehrlich SD. Access points: an institutional theory of policy bias and policy complexity. New York: Oxford University Press; 2011.

19. Weale A. New modes of governance, political accountability and public reason. Government and Opposition. 2011;46(1):58–80.

20. Greer SL, Méndez CA. Universal health coverage: a political struggle and governance challenge. Am J Public Health. 2015 Jul 16:e1-e3. [Epub ahead of print]