



World Health  
Organization

REGIONAL OFFICE FOR Europe

IMPLEMENTING A HEALTH 2020 VISION:  
GOVERNANCE FOR HEALTH IN

A photograph of a busy city street with many pedestrians walking. The street is lined with buildings and shops. The text "THE 21ST CENTURY" is overlaid in large white letters.

# THE 21ST CENTURY

Making it happen





**World Health  
Organization**

REGIONAL OFFICE FOR **Europe**

# **Implementing a Health 2020 vision: governance for health in the 21st century. Making it happen**

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# Abstract

The WHO Regional Office for Europe commissioned this report to support the implementation of the Health 2020 framework. It builds on *Governance for health in the 21st century: a study conducted for the WHO Regional Office for Europe*. This report provides policy-makers with examples from around the world of how whole-of-government and whole-of-society approaches have been implemented together with a set of tools to manage the complex policy process. These policy examples have been selected with a view to the priority areas set by the Health 2020 policy framework and with the following criteria in mind: they provide useful lessons, often illustrate best practices, cover a wide variety of different contexts and countries and, as far as possible, have been implemented and, ideally, evaluated. The report aims to contribute, in particular, to the Health 2020 strategic policy objective of “improving leadership and participatory governance for health”. It is conceived as a living document that will be continually enriched with new examples and analysis.

## Keywords

DELIVERY OF HEALTH CARE - ORGANIZATION AND ADMINISTRATION  
HEALTH MANAGEMENT AND PLANNING  
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**List of abbreviations**

ANDT	alcohol, narcotics, doping and tobacco
EU	European Union
HiAP	health in all policies
NCD	noncommunicable diseases
NGO	nongovernmental organization
NHS	National Health Service [United Kingdom]
OECD	Organisation for Economic Co-operation and Development
PARTNER®	Program to Analyze, Record, and Track Networks to Enhance Relationships
SARS	severe acute respiratory syndrome
SWOT	strengths, weaknesses, opportunities, threats

## Foreword

*It is now widely recognized that diverse social and environmental determinants that lie outside of the direct control of a single ministry or government department shape population health. A new approach to integrated governance for health is therefore critical for addressing today's complex health challenges. It is important to bring together all relevant stakeholders, including various levels of government, the private sector and civil society, increasingly taking into account regional and global institutions. Health 2020, the new health policy for the WHO European Region, emphasizes this need for intersectoral collaboration and health in all policies.*

*This report, like Governance for health in the 21st century: a study conducted for the WHO Regional Office for Europe, provides valuable guidance in pursuing this agenda of good governance for health. In particular, it outlines how whole-of-government and whole-of-society approaches can achieve real health outcomes. The report reviews a range of specific policies and programmes from the European Region and elsewhere and highlights the lessons learned. Policies rarely fit perfectly in all contexts, but learning from others what works and why is vital. This is especially true for common challenges such as the noncommunicable disease epidemic and demographic shifts.*

*The WHO Regional Office for Europe will continue to collect and analyse examples of governance for health with a special focus on the new role of the health sector, political engagement and leadership for health.*

**Zsuzsanna Jakab**

WHO Regional Director for Europe



# 1.

## A changing approach to governance for health

### 1.1. The Health 2020 strategic policy framework for the WHO European Region

The challenges facing public health, and the broader world context in which we struggle, have become too numerous and too complex for a business-as-usual approach.

Dr Margaret Chan, WHO Director-General

Political leaders increasingly perceive health as being crucial to achieving growth, development, equity and stability throughout the world (Støre, 2012). Health is now understood as a product of complex and dynamic relations generated by numerous determinants at different levels of governance. Governments need to take into account the impact of social, environmental and behavioural health determinants, including economic constraints, demographic changes and unhealthy lifestyles and living conditions in many countries of the WHO European Region. A country's health system alone has neither the capacity nor adequate steering instruments to solve such multidimensional problems in a substantial and comprehensive way (Huynen et al., 2005).

The European policy framework for health and well-being, Health 2020 (WHO Regional Office for Europe, 2012a), advocates the importance of integrated policies to address the Region's priority health challenges. It emphasizes that governments can achieve real improvements in health if they work across government and society and underlines the need to improve leadership and participatory governance for health. Health 2020 supports and encourages health ministries to bring key stakeholders together in a shared effort to promote and protect health. It recognizes the contribution of such stakeholders – particularly civil society – in taking health agendas forward at Regional level. Adding value through partnerships, mutual gain or co-benefit strategies has become a common theme in governance for health.

### 1.2. Governance for health

Governance is the process through which governments and other social organizations interact, relate to citizens and take decisions in an increasingly complex and interdependent world. It differs across political systems, with many ways in which “individuals and institutions, public and private, manage their common affairs” (Commission on Global Governance, 1995).

*Governance for health in the 21st century*, a study conducted for the WHO Regional Office for Europe (Kickbusch & Gleicher, 2012), analysed recent conceptual developments in governance and their application to governance for health. It looked at trends in governance and how they have been applied to health as governments seek to improve health outcomes. The study confirmed the emerging consensus that population health can no longer be understood as an outcome produced by a single ministry, but requires a synergetic set of policies involving a wide range of actors to deal with current and emerging public health problems.

Key studies commissioned in the preparatory process for Health 2020 also underline the need to act beyond the health sector. The European review of the social determinants of health and the health divide highlights the extent to which the response to health inequalities lies outside the direct control of health ministries and requires policies based on a commitment to social values, such as equity and human rights (WHO Regional Office for Europe, 2012b). McQueen et al. (2012) provide a useful summary of mechanisms and innovative approaches already implemented by countries. Health 2020 builds on these approaches and experiences, such as health in all policies (HiAP) and intersectoral action. *Health in all policies: seizing opportunities, implementing policies* (Leppo et al., 2013), which was prepared for the 8th Global Conference on Health Promotion, draws together further evidence and lessons on the dynamics of implementing policies for health across sectors.

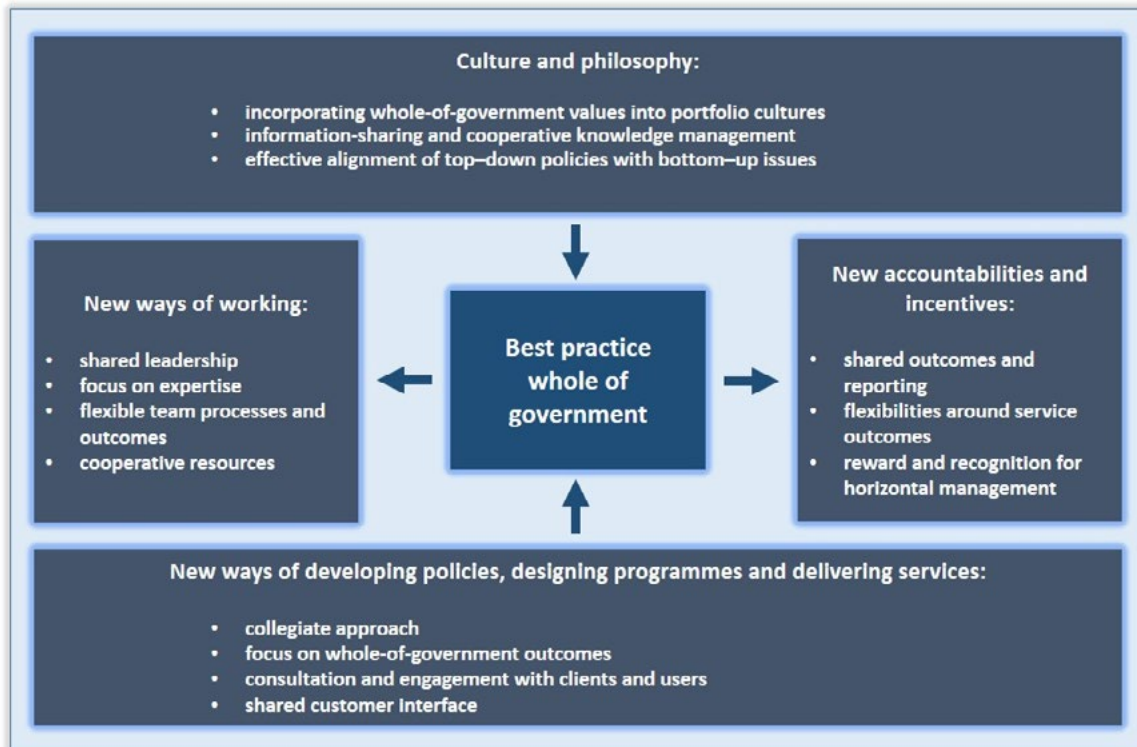
### 1.3. Focus of this report

Pressure on policy-makers to be innovative and responsive to today's quickly changing circumstances is high. Kickbusch & Gleicher (2012) concluded that major institutional adaptations are needed to cope with new and interdependent circumstances, particularly the impact of globalization and the balance of power between states and markets. Their study focused on the need to change major institutions' practices and to bring together diverse players, coalitions and networks, including community, government and business representatives: these are described as "whole-of-government" and "whole-of-society" approaches.

Anglophone countries such as Australia, Canada, New Zealand and the United Kingdom have used these terms when developing this form of governance and have implemented horizontal and/or vertical coordination activities at different levels of government. Many of the examples consequently come from such countries. Efforts are nevertheless quite diverse, and terms are used ambiguously across countries: "joined-up government" in the United Kingdom, "horizontal government" or "horizontal management" in Canada, "integrated government" in New Zealand, "networked government" in the

United States and “whole of government” in Australia and United Kingdom (Scotland) (Halligan et al., 2012). Fig. 1 summarizes approaches.

Fig. 1. Whole-of-government policy implementation



Source: Grant (2004).

The European Union (EU) adopted HiAP during the Finnish Presidency in 2006 to describe an evidence-informed strategy aimed at further integrating health aspects into European policy-making at all levels (Sihto et al., 2006). Suggestions have arisen in recent years that the EU should also consider whole-of-government and whole-of-society approaches in relation to other policy priorities, such as crime, illicit drugs and, most recently, migration:

A future [comprehensive European migration policy] is defined, above all, by an understanding that responsibility for the success of migration and integration rests across society. It demands a whole-of-government and whole-of-society approach and strong partnerships with countries of origin and transit (Åkerman Börje, 2009).

The terms “whole of government” and “whole of society” are being used in an increasing number of international and national policy documents, including Health 2020. The United Nations has called for a whole-of-

government and whole-of-society effort globally to respond to the challenge of noncommunicable diseases (NCD) and recognizes that:

... the rising prevalence, morbidity and mortality of non-communicable diseases worldwide can be largely prevented and controlled through collective and multi-sectoral action by all Member States and other relevant stakeholders at the local, national, regional and global levels (United Nations, 2012).

The 8th Global Conference on Health Promotion in June 2013 in Helsinki, Finland brought together diverse stakeholders, including Member State governments, United Nations and international organizations and civil society, to discuss insectoral public health policies. The conference's statement on HiAP declares that:

Policies in all sectors can have a profound effect on population health and health equity. In our interconnected world, health is shaped by many powerful forces, especially demographic change, rapid urbanization, climate change and globalization ... The health of the people is not only a health sector responsibility, it also embraces wider political issues such as trade and foreign policy. Tackling this requires political will to engage the whole of government in health (The 8th Global Conference on Health Promotion, 2013a).

This report, *Implementing a Health 2020 vision*, complements Kickbusch & Gleicher (2012) by providing policy-makers with examples from around the world of how whole-of-government and whole-of-society approaches have been implemented, with a set of process tools to manage the complex policy process. The policy examples have been selected to reflect the priority areas set by Health 2020 and with the following criteria in mind: they provide useful lessons, often illustrate best practice, cover a wide range of contexts and countries and, as far as possible, have been implemented and, ideally, evaluated.

The types of governance approaches proposed in Health 2020 are not yet common practice in countries, but there are indications that countries are making efforts, as shown at the WHO Conference on Governance for Health in Israel in November 2011 and the 8th Global Conference on Health Promotion in Finland in June 2013. In most cases, actions have been taken only very recently and no proper evaluation has yet been carried out, but they nevertheless indicate innovation and attempts to address the issues.

The report aims to contribute in particular to the Health 2020 strategic policy objective of “improving leadership and participatory governance for health”. It is conceived as a living document that will be continuously enriched with new examples and analysis.



# 2.

## Working together towards common goals for health

### 2.1. Considering the complexity of policy-making

The Health 2020 framework indicates that successful health policy in the 21st century largely depends on joint working towards common goals for health. Several countries have developed health goals and targets that span across government and have been developed in a broad consultative process, usually under health ministry leadership (Wismar et al., 2008). Good governance principles and defining features of modern policy-making should be reflected when health policies are being designed (Kickbusch & Gleicher, 2012), acting as criteria against which policy drafts can be analysed. Policies can then be compared and measured against these features (Table 1).

Table 1. Eight features of modern policy-making

Forward looking	Long-term view based on statistical trends and informed predictions of the probable impact of the policy
Innovative	Questioning established methods and encouraging new ideas
Informed by evidence	Using the best available evidence from a range of sources
Inclusive	Taking account of the impact of the policy on the needs of everyone directly or indirectly affected
Joined-up	Horizontal and vertical integration
Adaptive	Learning from experience of what works and what does not
Evaluative	Including systematic evaluation
Accountable	Being democratically legitimized, transparent and responsive to the demands of citizens

Source: adapted from Government of Northern Ireland (1999).

Austria's Ministry of Health has recently embarked on such a target-setting process, involving 30 key stakeholders and encouraging citizens to provide online commentary (Box 1).

**Box 1. Overarching health goals for Austria**

In May 2011 and on behalf of the Federal Health Commission, the Austrian Federal Ministry of Health launched an initiative aimed at developing comprehensive overarching health goals for the country. Organizations from different sectors across society were invited to contribute proposals on what they considered important and citizens had the opportunity to get involved via an online platform. More than 4300 responses were received.

As a result, the Federal Health Commission adopted the 10 overarching health goals for Austria in June 2012, with the government's subsequent endorsement. The goals aim to set the scope for effectively steering Austria's health system and focusing on identified priority action areas over the next 20 years. An expert committee developed concrete action plans that address the jointly established goals in late 2012.

Source: Bundesministerium für Gesundheit (Österreich) (2012).

Modern policy-making finds its expression in whole-of-government and whole-of-society approaches, bringing them together to create synergy. Processes frequently overlap: if managed well within democratic political systems, they can be mutually supportive. The interface of government and society is symptomatic of the movement of European welfare states towards being societies with much broader realms of participation and responsibilities for state and societal actors (Kaufmann, 2000).

Health policy development processes can be complex and lengthy as they involve many stakeholders, including parliamentarians from different political parties. The process of Sweden's health policy, "Health on equal terms", took nearly 10 years. Many interests and participants are involved and the environment changes throughout the process, making it difficult to provide policy-makers and change agents with definite "how-to" orientations.

All policies are influenced by context and are embedded in national, economic, political, cultural and social structures. There is great diversity in how policies are developed, adopted and implemented in different political systems – even welfare states in the Region differ significantly in how relationships between market and state and between state and civil society are managed, which "manifests itself in a different degree of trust in the state's ability to solve problems" (Kaufmann, 2000). Political science research indicates that state intervention generally has much more legitimacy in continental Europe than

in Anglo-Saxon political cultures, and more authoritarian political systems have much less acceptance of, and potential for, involving civil society.

Nevertheless, the fact that policies are dependent on, and specific to, actors, contexts, sector, site and issue (Parag, 2006) does not mean that it is impossible – based on the results of policy research during recent decades – to identify key elements that need to be taken into account when embarking on a policy process involving a wide range of actors within government or beyond. These might not be new to countries and actors with long involvement in policy processes, but can be helpful for those who are just beginning to embark on introducing and experimenting with more shared forms of governance. Some of the tools introduced, such as framing, social network analysis or the analysis of accountability relationships, can also provide experienced policy-makers with a more analytical and formalized approach.

## 2.2. Structuring the messy reality

The policy-making process is often depicted as a classic policy cycle (Fig. 2). Although policy-making “can help public servants develop and guide a policy through institutions of government” (Bridgman & Davis, 2003), policy rarely arises in such an organized manner, as anyone involved in developing it knows well. The model policy cycle can nevertheless be a useful, pragmatic and structured starting point if combined with context analysis, consideration of values and framing of issues and with analysis of networks and systems dimensions. Conducting context analysis is essential to understanding the political, economic and social underpinnings and involves scanning the entire internal and external environment. A popular method is SWOT (strengths, weaknesses, opportunities, threats) analysis, which allows an assessment of the (internal) strengths and weaknesses and the (external) opportunities and threats posed by the context.

Experience of setting health targets suggests it is critical to spend considerable time in deciding how issues are to be presented and to understand which belief systems need to be taken into account (Boxes 2 and 3). Policy processes are usually fraught with differences of ideology and opinion and require mechanisms to manage conflict and create win-win situations. Some critiques of the policy cycle model indicate that it fails to portray the essence of policy-making, which is “the struggle over ideas” (Stone, 2002). This is essential to keep in mind when considering priority-setting for the social determinants of health and issues such as equity and participation. All issues on the political agenda relate to political ideology, particularly regarding state, market, individual and family responsibility. But social issues also relate to value and belief systems beyond the political, based on culture, religion, social class or gender. Evidence alone is rarely able to overcome certain biases.

Fig. 2. The policy cycle



Source: Bridgman & Davis (2003).

### Box 2. Considering values

The key point is that, while policy-making is a process, it is also a human endeavor and as such it is not based on objective and neutral standards. Behind every step in the policy process is a contest over equally plausible conceptions of the same abstract goal or value. Remember, those participating in policy-making are also driven by their belief systems and ideology. These values and ideologies precede and shape the decisions along every step of the policy process (FrameWorks Institute, 2002).



### **Box 3. Framing issues**

The first stage of the policy cycle model, “identify issues”, appears simple but it is critical to spend considerable time in “framing the issue”. A frame is an organizing principle – it provides, and sometimes changes, the lens through which a person or institution thinks about the issue at hand. Framing makes different interpretations and outcomes visible.

Time spent here will pay off, since it will significantly influence all further steps along the process and the partners that come on board. Framing the obesity challenge, for example, in terms of equity, ensuring the health and well-being of children and securing future economic productivity can make a significant difference. These issues are well illustrated by Branca et al. (2007).

Framing stays relevant at each step of the process. One must ask: “which frame transmits the policy with concepts that represent the values and worldviews of the public, policy-makers and other key groups that you need to persuade?” (FrameWorks Institute, 2002).



# 3.

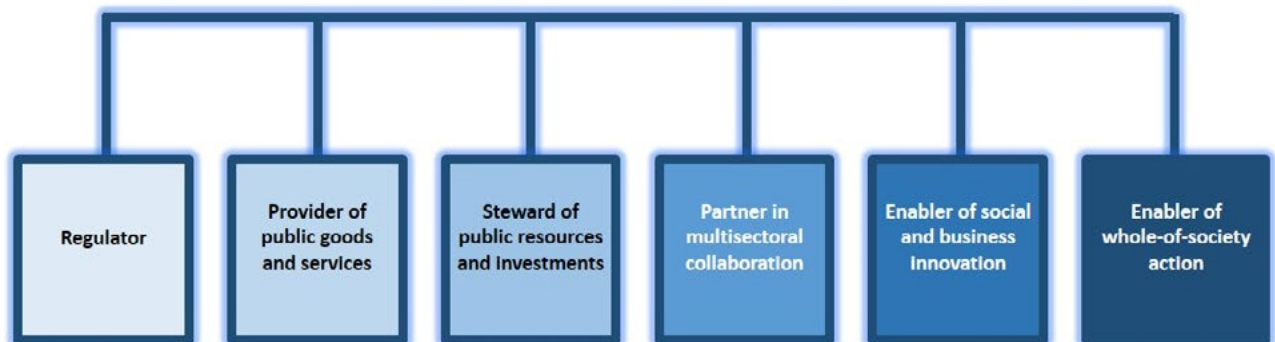
## Shared governance for health

One of the key features of whole-of-government and whole-of-society approaches is negotiation. It cannot be taken for granted that sectors and organizations will bring the same priorities, interests and attitudes to the table – indeed, it is almost certain that they will not. Policy-makers must therefore acquire the negotiating skills necessary to move the health agenda forward. For a whole-of-government approach, this means negotiating “across” to achieve national policy coherence; for a whole-of-society approach, it means negotiating “out” to build coalitions with diverse actors (Fairman et al., 2012). It also means recognizing where partners are coming from, understanding their value systems and planning approaches and looking for opportunities for win-win situations. A range of formal and informal mechanisms need to be in place to enable and incentivize stakeholders to find common ground.

“Negotiating up” can involve convincing high-level decision-makers to take up the issue nationally or escalate it to regional and global institutions for resolution. All three forms of negotiation were critical in taking the NCD agenda to the United Nations.

Government, often represented by a lead agency, takes on diverse roles within a whole-of-society approach. It defines boundaries and rules for consumers, businesses and other stakeholders, oversees public resources, provides relevant public goods and services and develops collaborative partnerships with other jurisdictions, businesses and civil society organizations to increase problem-solving efficiency and ensure effectiveness and sustainability (Fig. 3).

Fig. 3. Public policy in its many roles



Source: Dubé et al. (2009).

HiAP and other mutual-gain and co-benefit strategies for health negotiation skills – now often described as “health diplomacy” – are becoming more important for health professionals at all levels of governance. HiAP requires significant negotiation to make governance for health and well-being a priority for more than the health sector. The 8th Global Conference on Health Promotion focused on this issue (Box 4).

#### **Box 4. Helsinki statement on HiAP**

HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and equity. It improves accountability of policy-makers for health impacts at all levels of policy-making. It includes an emphasis on the consequences of public policies on health systems, determinants of health and well-being.

In order to fulfil their obligations to their people’s health and well-being, governments will need to:

- **commit to health and health equity as a political priority** by adopting the principles of HiAP and taking action on the social determinants of health;
- **ensure effective structures, processes and resources** that enable implementation of the HiAP approach across governments at all levels and between governments;
- **strengthen the capacity of ministries of health to engage other sectors of government** through leadership, partnership, advocacy and mediation to achieve improved health outcomes;
- **build institutional capacity and skills** that enable the implementation of HiAP and provide evidence on the determinants of health and inequity and on effective responses;
- **adopt transparent audit and accountability mechanisms** for health and equity impacts that build trust across government and between governments and their people;
- **establish conflict of interest measures** that include effective safeguards to protect policies from distortion by commercial and vested interests and influence; and
- **include communities, social movements and civil society** in the development, implementation and monitoring of HiAP, building health literacy in the population.

Source: The 8th Global Conference on Health Promotion (2013b).

Detailed analysis, which is touched upon below, looks at applying this to key public health issues such as reducing cardiovascular diseases (Puska & Ståhl, 2010). The health-lens analysis, as developed in South Australia, is another approach to enabling dialogue between sectors and working in both directions: how other sectors affect health and how health affects other sectors (Druet et al., 2010).

### 3.1. How to: whole-of-government approaches

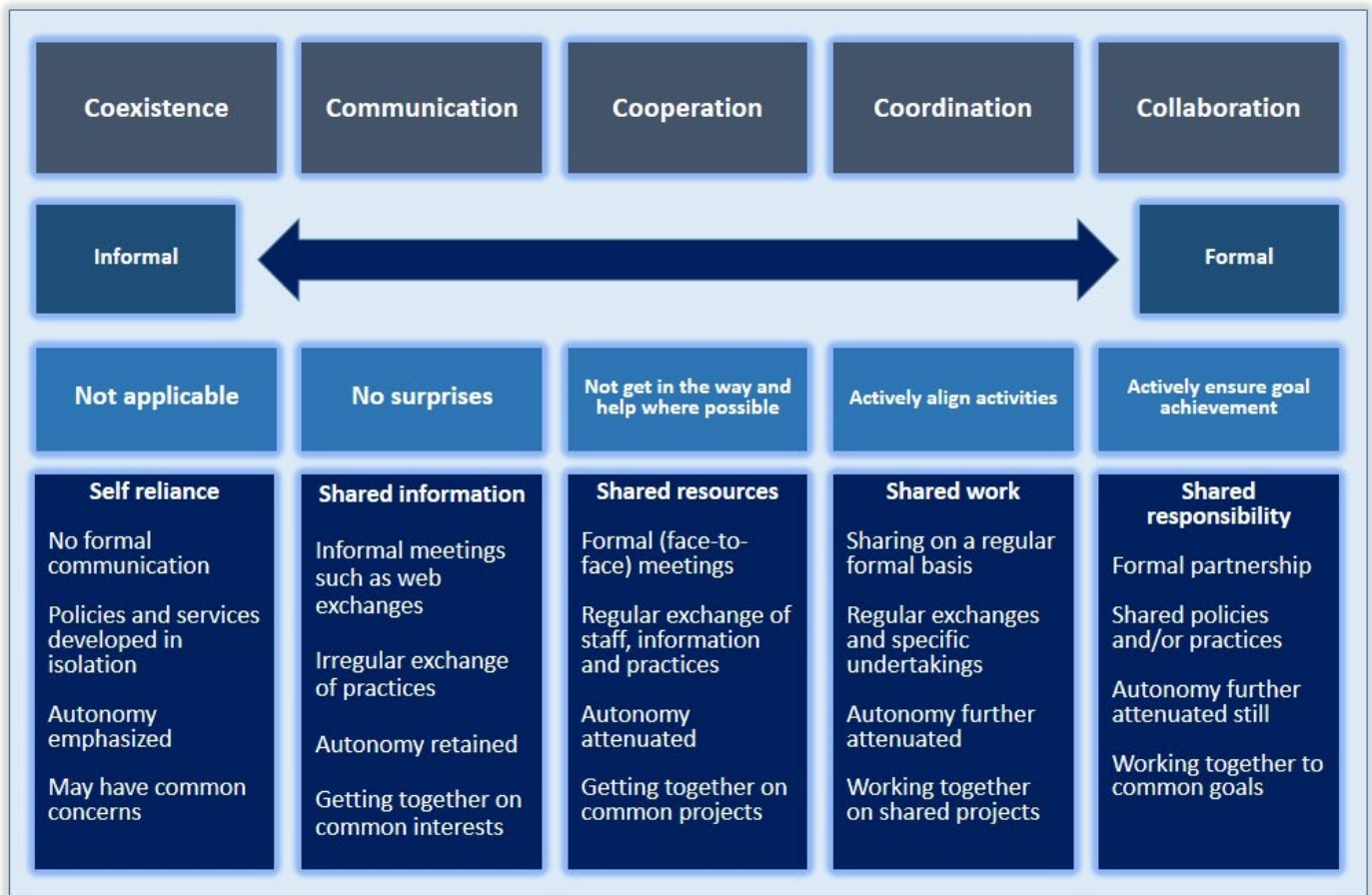
Whole-of-government activities are multilevel (from local to global) government actions, also increasingly involving groups outside government. This approach requires building trust, common ethics, a cohesive culture and new skills. It stresses the need for better coordination and integration, centred on the overall societal goals for which the government stands (WHO Regional Office for Europe, 2012a).

“Whole of government” can be understood as an umbrella term describing a group of responses to the problem of increased fragmentation of the public sector and a “wish to increase integration, coordination and capacity” (Christensen & Laegreid, 2006). In the health arena, it has come to mean a commitment to health at all levels of government, including the very top. Joint working across sectors is at the core of whole-of-government approaches and can vary in nature, with implications for accountability and relationships.

The continuum of intergovernmental integration illustrated in Fig. 4 describes the relationship between sectors, ranging from coexistence to collaboration and from informal to formal. It shows where accountability relationships exist and provides a set of characteristics for each of the relationships indicated. It can be used when planning the nature of a relationship by, for instance, achieving clarity on “how far we want to integrate” or analysing existing policies. It should be used as a tool whenever embarking on a whole-of-government approach or when looking back to analyse “what happened”.

Accountability can be either sole or shared, regardless of the institutional setting for joint working. The former should be applied whenever tasks are clearly separable and interdependence is low: the latter, however, should always be preferred when tasks are difficult to separate and interdependence is high, which is true for most health issues. Intersectoral engagement can take the form of cooperation, coordination or integration, as Fig. 4 indicates. Each has different levels of complexity to manage, with implications for accountability and resource sharing. Shared accountability is needed for most problems that require joint action and central agencies should play a key role in leadership and in establishing feasible accountability arrangements for joint working (Box 5). This is one of the most difficult issues to manage.

Fig. 4. Continuum of intergovernmental integration



Source: Boston & Gill (2011).

Generally, people developing the institutional design for joint working and shared accountability have to consider four critical issues (Boston & Gill, 2011): depth, coordination, complexity and responsibility.

- **Depth:** what is the intensity of joined working needed? It is critical to understand that different levels are necessary. Moving towards a deep relationship requires a significant commitment of time and resources and a specific window of opportunity.
- **Coordination:** how many organizations and goals are implicated? One should not aim for more shared work than can be managed.
- **Complexity:** to what extent are the required actions known in advance? Do all partners share the same understanding of the complexities (such as those related to social determinants of health)?
- **Responsibility:** can the performance of each actor be adequately specified and separately measured? This can present major difficulties.

### **Box 5. Policy on alcohol, narcotics, doping and tobacco in Sweden**

The overall objective is to secure a society free from narcotics and doping, with a reduction in medical and social harm caused by alcohol and a reduction in tobacco use. The long-term goal is to contribute to an EU and international approach to alcohol, narcotics, doping and tobacco (ANDT) that is restrictive and based on public health.

The Riksdag [Parliament] passed a coherent strategy for ANDT in March 2011 that aimed, among other things, to facilitate central government support in this area. The strategy outlines the goals and directs how measures are to be implemented, coordinated and followed up between 2011 and 2015. The measures are described in the government's annual action plan for policy on ANDT.

Apart from the overall objective, the policy has seven long-term objectives that can be broken into priority objectives for the strategy period.

1. Access to narcotics, doping substances, alcohol and tobacco must be reduced.
2. Children must be protected against the harmful effects of alcohol, narcotics, doping substances and tobacco.
3. The number of children and young people who start to use narcotics and doping substances or who have an early alcohol or tobacco debut must be progressively reduced.
4. The number of people who develop habits involving the harmful use or misuse of, or dependence on, alcohol, narcotics, doping substances or tobacco must be progressively reduced.
5. People with abuse or addiction problems must have better access to high-quality care and support.
6. The number of deaths and injuries caused by one's own or others' use of alcohol, narcotics, doping substances or tobacco must be reduced.
7. An EU and international approach to ANDT that is restrictive and based on public health is adopted.

Sweden is dependent on, and increasingly affected by, the rest of the world. It is crucial that policy issues relating to ANDT be actively pursued within the EU and internationally. Sweden is also working to ensure that the strategies and conventions it supports or has signed-up to influence national policy.

**Box 5 contd**

Work to implement policy on ANDT is intersectoral and involves several agencies' areas of responsibility: the Consumer

Agency (Konsumentverket), Prison and Probation Service (Kriminalvården), Coast Guard (Kustbevakningen), National Police Board (Rikspolisstyrelsen), National Board of Health and Welfare (Socialstyrelsen), National Institute of Public Health (Statens Folkhälsoinstitut), National Agency for Education (Skolverket), National Board of Institutional Care (Statens Institutionsstyrelse), Transport Administration (Trafikverket), Transport Agency (Transportstyrelsen), Customs (Tullverket), National Board for Youth Affairs (Ungdomsstyrelsen) and Prosecution Authority (Åklagarmyndigheten).

**ANDT secretariat**

The ANDT secretariat – the government's coordination function for ANDT policy – is located at the Ministry of Health and Social Affairs. The secretariat aims to strengthen the development and coordination of work within government to create clearer, more coordinated and effective agency management. The secretariat promotes dissemination and implementation of the ANDT strategy and is responsible for compiling the government's annual action plan for policy on ANDT.

**ANDT council**

The secretariat also supports the ANDT council, which advises the government on ANDT issues and informs it of research and inquiry results that are relevant to policy design. The council comprises a chair and 20 members, all of whom represent central government agencies, the research community or civil society, and is led by the State Secretary at the Ministry of Health and Social Affairs.

*Source: Government Offices of Sweden (2012).*

Deep intergovernmental relationships, such as those achieved within the Swiss health foreign policy (Box 6), reflect the move from self-reliance to applying the whole spectrum of characteristics across the continuum: shared information, resources, work and responsibility. The Swiss health foreign policy was initially unable to increase resources or engage in joined budgeting, but today – after a period of five years – it uses formal and informal mechanisms to actively work towards achieving common goals, aligning activities and sharing accountability across the whole of government (the Federal Council).

**Box 6. The Swiss health foreign policy**

Globalization and internationalization of the public health sector generate great demand for coordination among health, foreign and development policies. The Federal Council approved the health foreign policy in March 2012 to ensure Switzerland's capability as a convincing partner with a coherent position and to represent its interests in the best way possible.

The policy serves as an instrument to set and execute common objectives of federal authorities concerned with health foreign policy and replaces the agreement on health foreign policy objectives concluded by the federal offices of foreign affairs and home affairs in 2006, through which Switzerland had performed pioneering international work. It was developed under the leadership of these federal departments in cooperation with all others. Actors from outside the federal authorities, including cantons, research sector, civil society, industry and the health system, were also involved during the consultation phase.

The policy is based on a number of overarching principles and values. It defines 20 objectives relating to 3 main areas of interest – governance, interactions with other policy areas and health issues – and sets out measures to achieve them.

The Swiss health foreign policy enhances the country's credibility as a global actor in the health field and highlights the commitment of Swiss development cooperation to reducing poverty and promoting sustainable development. It offers Switzerland the opportunity to take part in a substantial way in international discussions on global health.

*Source:* adapted from Federal Office of Public Health (2012).

### 3.2. How to: whole-of-society approaches

A whole-of-society approach goes beyond institutions: it influences and mobilizes local and global culture and media, rural and urban communities and all relevant policy sectors, such as the education system, the transport sector, the environment and even urban design, as demonstrated in the case of obesity and the global food system. ... Whole-of-society approaches are a form of collaborative governance that can complement public policy. They emphasize coordination through normative values and trust-building among a variety of actors. ... By engaging the private sector, civil society, communities and individuals, the whole-of-society approach can strengthen the resilience of communities to withstand threats to their health, security and well-being (WHO Regional Office for Europe, 2012a).



Whole-of-society approaches involve the private sector and civil society as well as political decision-makers. They include new forms of communication and collaboration in complex, networked settings and highlight the role of the mass media and social movements. Each party must invest resources and competence within a common strategy. A whole-of-society approach can strengthen communities' resilience to withstand threats to their health, security and well-being by engaging the private sector, civil society, communities and individuals (Box 7) (Kickbusch & Gleicher, 2012).

**Box 7. A whole-of-society approach: the “Decade of Roma Inclusion 2005–2015”**

The “Decade of Roma Inclusion 2005–2015” is an international initiative that brings together governments, intergovernmental and nongovernmental organizations (NGOs) as well as Romani civil society to accelerate progress toward improving the welfare of Roma and to review such progress in a transparent and quantifiable way. It focuses on the priority areas of education, employment, health and housing and commits governments to consider other core issues of poverty, discrimination and gender mainstreaming.

Twelve countries are taking part: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Hungary, Montenegro, Romania, Serbia, Slovakia, Spain and the former Yugoslav Republic of Macedonia. All have significant Roma minorities who are relatively disadvantaged economically and socially. Slovenia and the United States have observer status.

Each country has developed a national action plan that specifies goals and indicators in the priority areas. International partner organizations include The World Bank, Open Society Foundations, United Nations Development Programme, Council of Europe, Council of Europe Development Bank, Contact Point for Roma and Sinti Issues, Office for Democratic Institutions and Human Rights, the Organization for Security and Co-operation in Europe, the European Roma Information Office, European Roma and Traveller Forum, European Roma Rights Centre, United Nations Human Settlements Programme, United Nations High Commissioner for Refugees and United Nations Children’s Fund. WHO became a partner in 2011.

Participating governments must reallocate resources to achieve results, aligning their plans with funding instruments of multinational, international and bilateral donors.

Source: Decade of Roma Inclusion Secretariat Foundation (2012).

Managing conflicts of interest, which can be viewed broadly as any professional, financial or other interest that could impair an individual or organization from carrying out his, her or its duties, is important in whole-of-society approaches. It is imperative to establish transparent procedures for declaring and resolving these: failure to do so can risk eroding the legitimacy, integrity, trust and credibility of government agencies leading the negotiations and can seriously threaten the health outcomes the approach pursues.

Generally, a whole-of-society approach may or may not start with a whole-of-government approach. Government is often the leader or broker, but a strong NGO or an alliance of organizations, such as the NCD Alliance or civil society coalitions fighting for tobacco control or access to HIV medicines, can also lead.

The “how-to” process for a whole-of-society approach to addressing health issues includes the following steps (Dubé et al., 2009).

**1. Identify several initial domains for action as lever points for change.**

This may include enhancing production-chain traceability, increasing supply and demand of fruit and vegetables, improving nutrient and caloric characteristics of industrially processed food, supporting healthy consumer choices by providing nutrition and health information and introducing mandatory and non-mandatory policy tools for advertising, especially towards children.<sup>1</sup> Tools to help with identifying such levers for change are available : an example is described in Box 8.

At the same time, it is critical to be prepared for unexpected opportunities that may bring a policy agenda to fruition. In many cases, an issue that has long been recognized and analysed and for which policy proposals exist suddenly becomes feasible because of changes in the political environment, often precipitated by crisis situations: the severe acute respiratory syndrome (SARS) outbreak, for example, enabled the adoption of the revised International Health Regulations in 2005. This is referred to in the political science literature as “a window of opportunity” (Kingdon, 1984). It is particularly important for civil society actors to recognize such windows and make full use of them (Box 9).

**2. Assemble around each lever point a strategic network of key stakeholders from government, the business sector and civil society.**

This is critical for whole-of-government and whole-of-society approaches, as it can help gauge the extent to which state and non-state actors’ networks

<sup>1</sup> The spectrum of concrete policy tools and instruments for tackling nutrition-related NCD is presented in more detail in section 6.2.

**Box 8. Tactical mapping**

Tactical mapping, a tool developed for civil society organizations, is “a method of visualizing the relationships and institutions that surround, receive benefit from, and sustain human-rights abuses” (Johnson & Pearson, 2009). It can also be used for a range of issues on which not-for-profit organizations work.

The emphasis is on relationships between people and institutions rather than on concepts or causes. According to Johnson & Pearson (2009):

Illustrating these relationships thus creates a picture that represents a social space. When this diagram is sketched out, it becomes possible for actors to select appropriate targets for intervention and to map actors’ possible tactics to influence issues of concern. Thus, the map generates a process flow to plan and monitor how a tactic might function and which relationships it should influence to effectively intervene. Because multiple groups can use the diagram to map their respective targets and interventions, the tactical map becomes a coordinating tool that creates a more comprehensive strategy than is possible when groups act independently.

**Box 9. Windows of opportunity**

Kingdon (1984) first proposed that three streams of processes occur simultaneously and independently:

- recognition and defining problems
- creating policy proposals
- shifting politics.

According to Guthrie et al. (2005):

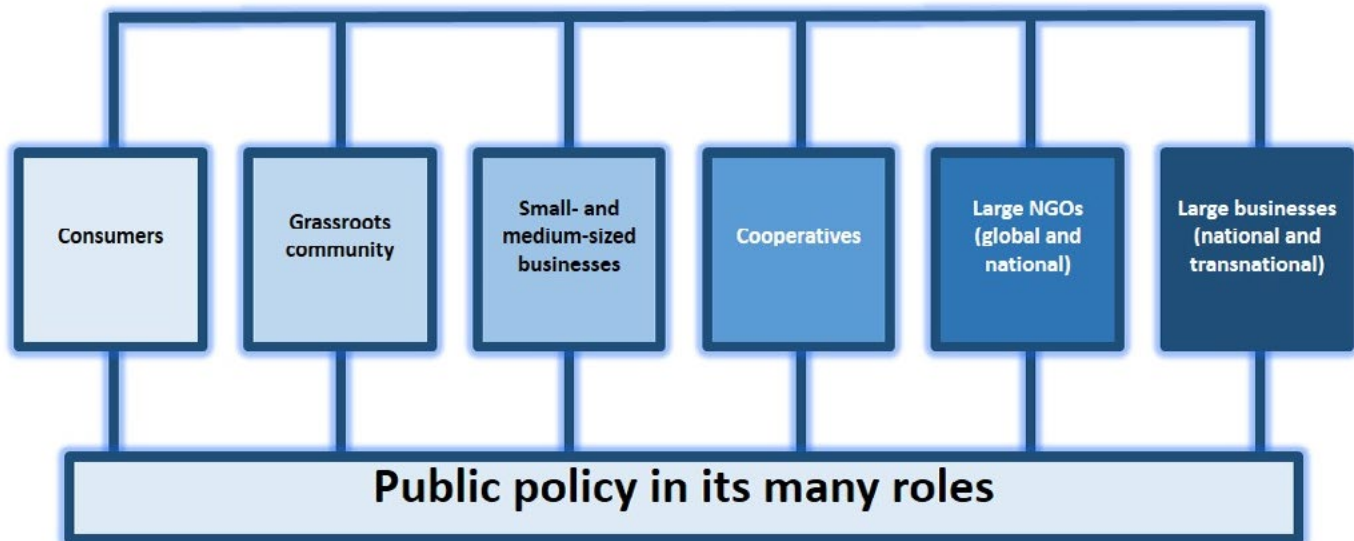
It is when these three streams come together, in what is termed a “policy window”, that policy change happens. These separate streams of problems, policies and politics each have lives of their own. ... But there comes a time when the three streams are joined. A pressing problem demands attention, for instance, and a policy proposal is coupled to the problem as its solution. Or an event in the political stream, such as a change of administration, calls for different directions. At that point, proposals that fit with that political event, such as initiatives that fit with a new administration’s philosophy, come to the fore and are coupled with the ripe political climate. Similarly, problems that fit are highlighted, and others are neglected.

The policy process is therefore at core an irrational and nonlinear process in which advocates must move quickly when a policy window opens; this lack of linearity is an unsettling feature of democratic societies for many people.

shape policies and are defined by their contexts and characteristics. All involved organizations must be willing to invest time, expertise, core competencies and financial resources to achieve the goal set by respective networks (Fig. 5).

Several tools can enable a network analysis to efficiently bring key stakeholders together. The Program to Analyze, Record, and Track Networks to Enhance Relationships (PARTNER®) tool (Box 10), for example, helps to answer questions such as: “do gaps, vulnerabilities and inefficiencies exist among the partnership?” and “which models or frameworks for collaboration work best?”

*Fig. 5. Consumers and stakeholders involved in developing and implementing policy for the whole of society*



Source: Dubé et al. (2009).

Performing a network analysis makes it possible to check systematically:

- which sort of activities and expertise are required at each stage of the policy process;
- which state and non-state actors ought to participate in different policy stages, how they affect not only the policy, but also each other (by, for example, forming alliances) and how they influence different stages of the process; and
- how each stage’s outcomes affect other stages and actors concerned (Parag, 2006).

Innovative and inclusive business models can be used in this context to trigger change on the ground, such as:

**Box 10. PARTNER®: a social network analysis tool**

The Robert Wood Johnson Foundation has designed a tool to measure and monitor collaboration among people and organizations. It can be used to demonstrate how members are connected, how resources are leveraged and exchanged, levels of trust and linking of outcomes to the collaboration process. The tool includes an online survey for collecting data and an analysis programme for evaluation. It enables demonstration of how collaborative activity has changed over time and progress in community members' and organizations' participation for stakeholders, partners, evaluators and funders.

Source: PARTNER® Tool (2009).

- bottom-up collective actions in communities;
- social businesses that replace the principle of maximizing business or profit by the principle of maximizing social benefits; and
- for-profit ventures that create social as well as business value by promoting health in various strategic business functions (Box 11).

The commonly used term “social business” was first defined by Nobel Peace Prize laureate Muhammad Yunus as “a non-loss, non-dividend company designed to provide a product and/or service with a specific social, ethical or environmental goal”. A prominent example is Grameen Danone Foods Ltd. (Grameen Creative Lab, 2013), which produces a yoghurt enriched with crucial nutrients at an affordable price for the poor, but also ensures benefits along the whole value chain.

### **3. Bring together all the networks created according to the lever points within a whole-of-society compact that is supported by a platform to share information and research and build capacity.**

A whole-of-society approach is needed to, for instance, tackle the social and environmental determinants causing obesity. Such an approach has been advocated by WHO:

Bringing about changes in dietary habits and patterns of physical activity will require the combined efforts of many stakeholders, public and private, over several decades. A combination of sound and effective actions is needed at global, regional, national and local levels, with close monitoring and evaluation of their impact (WHO, 2004).

An example at regional level is the European platform for action on diet, physical activity and health (European Commission, 2005), described later in the report.

**Box 11. Corporate social responsibility**

Whole-of-society compacts include the principles of corporate social responsibility and what has been termed “inclusive capitalism”. Changing patterns of consumer awareness and consumption have caused many companies to begin to see corporate social responsibility as a strategic investment (Fortunato, 2011). Corporate social responsibility initiatives have become a core part of business activities in the food sector, a development described as being of “considerable promise in improving the conduct of agri-food firms in the direction of accepting accountability for the impacts of decisions and activities over which they have control” (Hartmann, 2011).

Corporate social responsibility alone, however, is not enough. When market failures and negative externalities arise, private companies often face a trade-off between private profits and social welfare. Companies may choose to satisfy private shareholders’ interests instead of investing in the public good. In such a case, a government may opt to provide incentives to change company behaviour.

Experience shows that self-regulation is rarely sufficient to achieve health goals for the public interest: regulation is required. To be effective and legitimized, regulation must be transparent, accountable, proportionate, consistent and targeted (Karnani, 2011). Proportionality is highly challenging in public health as it is value based and focused on perceptions of public health ethics; it has consequently become the subject of highly ideological debates. The response to the obesity epidemic shows this clearly, with the present battle over regulating the size of sugary soft drinks in New York City a model example (Moskin, 2012).



# 4.

## Health 2020 priority area one: investing in health through a life-course approach and empowering people

Supporting good health throughout the life-course leads to increasing healthy life expectancy and a longevity dividend, both of which can yield important economic, societal and individual benefits. The demographic transformation underway in many countries requires an effective life-course strategy that gives priority to new approaches to promoting health and preventing disease. ... Healthy children learn better, healthy adults are more productive and healthy older people can continue to contribute actively to society (WHO Regional Office for Europe, 2012a).

Social policies for children in the early years and older people can be related to different types of welfare state regimes. In Europe, Esping-Andersen's (2006) categorization of liberal (such as the United Kingdom), conservative (Germany) and social democratic (Sweden) welfare states can be applied to describe differences in size and scope of national policies.

Social expenditure alone cannot completely capture these differences. It is also crucial to take into account the terms and conditions on which resources and opportunities are based. Esping-Andersen defines the size and scope of a welfare state by the social rights granted and the active role of the state in ordering social relations: "The welfare state is not just a mechanism that intervenes in, and possibly corrects, the structure of inequality; it is, in its own right, a system of stratification" (Esping-Andersen, 2006).

In this context, the Nordic welfare state model has, over many decades, tried to take into account every citizen's right to good health, well-being and education and address social determinants of health and health inequalities. Social policy in general, and early childhood development and policies for older populations in particular, can be viewed as outcomes of a country's overall welfare performance, labour-market opportunities and family characteristics (Petrogiannis & Dragonas, unpublished data, 2013). Also highly relevant are reproductive health and maternal health policies, which have been instrumental from a social viewpoint to achieving higher levels of equality for women in education and labour-market participation, supported by flexible working arrangements and welfare support for parents.

This is also illustrated in relation to policies for older populations. The Organisation for Economic Co-operation and Development (OECD) has identified a range of policy interventions in different sectors that can contribute to good health, well-being and active ageing (OECD, 2009a). They include traditional policy responses, such as labour policies, but also innovative solutions in the care sector supported by new technologies.

In health, the OECD highlighted the life-course approach, which includes an increased focus on disease prevention and the promotion of healthy lifestyles at all stages of life to keep people active and to prevent or mitigate chronic disease. Focus was placed on keeping people independent and out of institutional care.

The OECD overview emphasized that policies related to flexible work, gradual retirement and decent housing can significantly affect health and well-being. Within the framework of the Europe 2020 initiative, the European Commission (2011) has introduced the concept of European innovation partnerships, the first of which will be on active and healthy ageing.

## 4.1. How to: a whole-of-government approach to early years

### 4.1.1. The issue

Available evidence suggests that events and experiences in the first months and years of a person's life can set a basis for lifelong well-being or future physical and mental health challenges (Jenkins, 2005). The Commission on Social Determinants of Health pointed out that investing in early years provides one of the greatest potential methods of reducing health inequities (WHO, 2011). In this context, the European review of social determinants of health and the health divide (WHO Regional Office for Europe, 2012b) has emphasized that, in the past, non-integrated services had difficulty in effectively responding to the complex needs of families with young children.

### 4.1.2. Solutions and approaches

Many countries have developed policy frameworks and innovative approaches for early years that involve different levels and sectors of government and reach out to other parts of society. Sweden, for example, has successfully united many different forces and actors in efforts to create good living conditions for all citizens. The public sector is highly decentralized and adaptive to local needs. People at local authority level decide about service provision. Twenty regions are each governed by a political assembly that ensures everyone can access good and equal health care. Preschool children in child health care centres (similar centres exist in other Nordic countries, Croatia, the Netherlands and Slovenia) are offered free health check-ups that involve vaccination and education for parents, while 2000 district nurses make free home visits and run parents' workshops. The overall aim is to promote children's health and well-being, support parents and prevent any physical or mental illnesses (Samuelsson et al. unpublished data, 2013).

South Australia has developed more than 20 "one-stop shops" with integrated children's centres for early childhood development for 0–8-year-olds. The



centres provide “care and education from birth through the early years of school, parent/carer information and education, parenting networks, and links to health services including immunisation, health checks and advice and therapy services” (Press et al., 2010).

The United Kingdom has 3600 “Sure start” children’s centres that were initially designed to focus on vulnerable families and communities and develop sensitive interventions to tackle health inequalities at an early stage of life. Funding comes mainly from central government and is weighted depending on poverty levels in local areas (Eisenstadt & Melhuish, unpublished data, 2013). Services that target preschool children have been integrated across government agencies, with policies on early education and care being successfully brought together. “Sure start” centres “provide family support, interventions to improve parenting and the home learning environment, advice on employment and benefits, health advice, and social facilities” where parents can meet within an informal child-friendly setting (Eisenstadt & Melhuish, unpublished data, 2013).

#### 4.1.3. Shared governance

By recognizing the inseparability of education and care for young children, sectors and professions are working closely together for “the best possible learning, health and wellbeing outcomes in a universal setting with targeted responses for families who may require additional support” (Government of South Australia, 2012). The United Kingdom has strongly emphasized the importance of involving parents in designing and delivering programmes to ensure local needs and circumstances are sufficiently taken into account. An evaluation in 2011 revealed high satisfaction among parents and successes in fighting social exclusion and intergenerational transmission of poverty (National Evaluation of Sure Start Team Institute for the Study of Children, Families and Social Issues, 2011).

Table 2 provides a helpful model for moving from coexistence to integration in relation to supporting early child development. It acknowledges that partnerships need time to develop, integrating service delivery advances progressively and the process towards full integration has several stages. In this context, the possible relationships – ranging from coexistence to collaboration – introduced by the continuum of intergovernmental integration (Fig. 4, section 3.1) can also be applied to a community environment in which early years services are integrated.

#### 4.1.4. Challenges

Differing interests of departments at national level have been a barrier to success and continue to challenge. Early childhood initiatives in the United Kingdom and South Australia have encountered similar initial challenges,

Table 2. Integration stages

Programme elements	Coexistence	Coordination	Collaboration	Integration
Education and child care	Separate governing bodies for child care, preschool and school	Some common members of each governing body Representation on enabling group	Child care and preschool have some governing body and some common members on school governing body	Child care and preschool have same governing body and are formally linked with school governing body Representatives lead the establishment of partnership group and/or regional advisory group and link decisions made in their governing bodies to these groups
Health elements Families' and communities' elements Other organizations' elements	Separate governing bodies for each programme	Representation on enabling group	Representatives influence direction, services to be delivered in the children's centre and decisions about service delivery in their own agency	Representatives lead the establishment of partnership group and/or regional advisory group and link decisions made in their own agency governing bodies to these groups
Service planning and monitoring	Links between local services based on informal relationships and past practice	Enabling group supports planning phase of the children's centre Services provide each other with copies of strategic plans	Enabling group influences direction and services to be delivered within the children's centre	Partnership group and/or regional advisory group is underpinned by a statement of purpose and is responsible for developing and providing an annual outcomes achievement report  Partnership group and/or regional advisory group represented on child care/preschool governing body

Table 2 contd

Programme elements	Coexistence	Coordination	Collaboration	Integration
Policies and practices	Separate policies Informal individual partnerships	Share policies Service agreements, protocols and memoranda of understanding clarify service pathways and arrangements between service providers	Statement of purpose outlines guiding principles, commitment and vision of all who work in the children's centre Shared policies, resource and operational agreements are developed as required	Integrated policies for all involved in a children's centre support integrated practices and seamless services
Parental and community participation	Each local service maintains separate mechanisms for engaging parents and the community in decision-making	Sharing of information from parents and community groups associated with each agency	Processes developed that engage families and community members in the children's centre	Parent advisory group is established Comprehensive processes across the children's centre engage all families in the community, including priority population group

Source: adapted from Government of South Australia (2012).

including “varying cultural norms, value systems, and approaches to practice based on different professional training” (Press et al., 2010). Increased workload, inequitable working conditions, insufficient funding and a lack of macro-level leadership have been reported (Press et al., 2010). It has been difficult at times in the United Kingdom to anticipate the complexities of setting up a local programme and provide the adequate skill mix and levels necessary to run it (National Evaluation of Sure Start Team Institute for the Study of Children, Families and Social Issues, 2011). Fully benefiting from a life-course approach requires that health benefits be accumulated over an extended period. This is not yet common practice: there are usually services for infants but fewer and less-systematic services available for adolescents and young adults. Lack of strategic vision and poor governance allows inequities to persist and grow.

### 4.1.5. Lessons learned

- Political will, time and money are required to properly design, implement and evaluate evidence-informed policies (National Evaluation of Sure Start Team Institute for the Study of Children, Families and Social Issues, 2011).
- The collaboration of ministries such as those responsible for finance, health, education and employment has been crucial in setting up integrated early years services. A dynamic and adaptive process that constantly enhances multidisciplinary team-working with the aim of significantly improving service delivery seems to be effective at local level. Strong leadership at different levels, especially at the beginning, is necessary to develop high levels of collaboration and teamwork (Press et al., 2010).
- There is no one-size-fits-all approach and no single model of integrated service delivery that will be appropriate in every community. Clear functions and roles and a commitment to promoting a common ethos and culture with shared values and responsibilities may help to overcome shortcomings.
- The joint development of innovative assessment tools for long-term systematic evaluation should be promoted within the process of increased integration; learning from experience is crucial.

## 4.2. How to: a whole-of-society approach to an ageing population

### 4.2.1. The issue

The population of Europe is ageing. The EU designated 2012 as the “European year of active ageing and solidarity between generations” with the aim of raising awareness and helping local and national policy-makers, social partners and civil society understand the magnitude of the demographic challenge. The European Commission published a white paper on how the EU and Member States can tackle the major challenges confronting pension systems. It puts forward a range of initiatives to help create the right conditions so that more people can continue working. Other initiatives aim to help people save more and ensure those who move to another country can keep their pension rights (European Commission, 2012a).

### 4.2.2. Solutions and approaches

Whole-of-government and whole-of-society approaches to healthy and active ageing aim to enable older people to remain employed and financially

independent. Goals include ageing-in-place barrier-free environments and easy access to public transport. Health care systems will increasingly take into account the special needs of older citizens and provide services accordingly. As in early child development, countries require service providers to work together to increase the number of one-stop shops in which older people can find all necessary services in one place.

These approaches are particularly critical at local level. WHO (2007) sees active ageing in supportive and enabling cities as “one of the most effective approaches to maintaining quality of life and prosperity in an increasingly older and more urban world” (Box 12). WHO asked older people in 33 cities in all WHO regions to describe the advantages and barriers they experience in 8 aspects of city living to enable understanding of the characteristics of an age-friendly city: the results led to the development of a set of age-friendly city checklists (WHO, 2007).

#### **Box 12. Finland’s active ageing initiative**

Finland embarked on an intersectoral action programme in summer 2012 focusing on ageing sustainably. The lead will lie with the Minister of Social Affairs and Health:

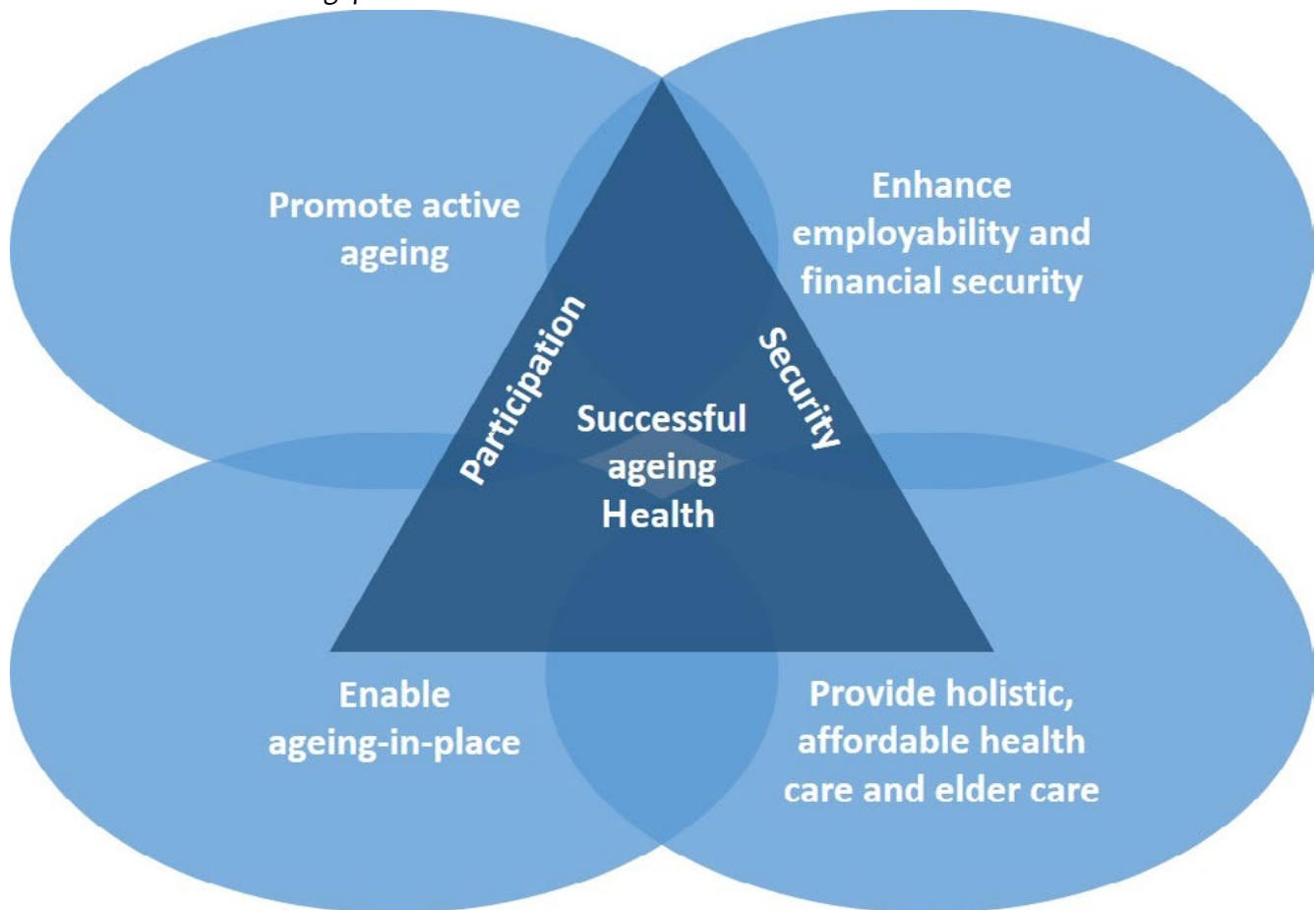
The action programme should address e.g. attitudes, accessible environment, housing, movement and traffic, social protection, combining work and retirement, inclusion, services, preventive action, forms of support for family members, support for nongovernmental organizations, skills and knowledge, training, and financing (Government of Finland, 2012).

A high-level working group was asked in September 2012 to draw up a concrete and innovative action programme to build an age-friendly Finland. Active ageing has been one of the main themes in the cross-sectoral Finnish Government employment programme since 2006. This approach has been highly recommended to other countries.

### 4.2.3. Shared governance

Some high-income countries are seeking integrated approaches. Singapore, for example, has set up a high-level ministerial committee on ageing, which is the current interdepartmental committee on ageing issues. It has adopted a life-course perspective and established a framework with four key strategies aimed at increasing participation, health and security of older people (Fig. 6). The key pillars illustrated in Fig. 6 can also be applied to other population groups, such as adolescents, children and working-age people.

Fig. 6. Key pillars and strategic thrusts of the ministerial committee on ageing, Singapore



Source: Ministry of Community Development, Youth and Sports (2007).

#### 4.2.4. Challenges

Financial security must remain a priority, and inclusiveness largely depends on the affordability and responsiveness of active-ageing opportunities. Community participation should be promoted and social space created to provide incentives for intergenerational activities.



# 5.

## Health 2020 priority area two: tackling the European Region's major health challenges – noncommunicable and communicable diseases

### 5.1. NCD

A combination of approaches is required to successfully address the high burden of noncommunicable diseases in the Region. Health 2020 supports the implementation of integrated whole-of-government and whole-of-society approaches that have been agreed in other regional and global strategies, since it is increasingly recognized that action to influence individual behaviour has limited impact (WHO Regional Office for Europe, 2012a).

#### 5.1.1. How to: governing NCD through whole-of-society approaches

The WHO Framework Convention for Tobacco Control emphasizes the importance of political will and intersectoral collaboration, particularly given conflicts with the tobacco industry and other societal actors (such as owners of restaurants and bars). This was illustrated recently by the plain-packaging for tobacco products initiative by the Government of Australia, which has now been upheld by the highest Australian court – with significant international implications (BBC, 2012a). Even where legislative frameworks are in place, special interests continually challenge them: a strong organizational mechanism for health is necessary to overcome other agendas and enable civil society voices to be heard.

##### 5.1.1.1. The issue

The United Nations General Assembly held a high-level meeting on the prevention and control of NCD in September 2011 and adopted a political declaration. It was only the second time in history, after HIV/AIDS in 2001, that the General Assembly had addressed a health issue on a global scale. The declaration argued that a whole-of-society effort was needed to reduce risk factors for NCD and called upon the United Nations Secretary-General to present “options for strengthening and facilitating multi-sectoral action for the prevention and control of non-communicable diseases through effective partnership” by the end of 2012 (United Nations, 2011).

##### 5.1.1.2. Solutions and approaches

Several collaboration efforts at regional and national levels are underway in the Region. Their successes and challenges could provide valuable insights into constructing a global NCD platform led by the European Commission. The EU platform for action on diet, physical activity and health was founded in 2005 with the overall aim of containing or reversing the trend of increasing

overweight and obesity rates among Member States. The platform operates under the leadership of the European Commission, whose role is to guide a cooperative and action-oriented approach. These issues, and the development of the platforms, are discussed at length by Branca et al. (2007).

### 5.1.1.3. Shared governance

The platform is an innovative multistakeholder forum in which representatives from the business sector and civil society come together “to share knowledge and ideas, and discuss their concrete efforts towards healthy nutrition, physical activity and the fight against obesity” (European Commission, 2010). Actors such as the food industry and consumer-protection NGOs often have antagonistic views: by bringing them together, the platform aims to enhance dialogue. It has 33 members from 9 sectors (Table 3), but members are European-level umbrella organizations: 73 member organizations fall under one umbrella group for the food and drink sector alone.

Table 3. Members of the EU platform for action on diet, physical activity and health by sector

Sector	For-profit members	Not-for-profit members	Total
Advertising	3	0	3
Agriculture	2	0	2
Broadcasting	1	0	1
Consumer groups	0	2	2
Food and drink	1	0	1
Health	0	9	9
Research	0	3	3
Retail and catering	6	0	6
Sports and fitness	2	4	6
<b>Total</b>	<b>15</b>	<b>18</b>	<b>33</b>

Source: European Commission (2010).

What makes the platform unique is that it seeks to generate concrete actions in the following overlapping fields (EU Platform on Diet, Physical Activity and Health, 2010):

- marketing and advertising: proposing and/or implementing limits or codes of practice, often focusing on curbing advertising of high-fat, sugary or salty foods (especially to children);
- reformulation: altering the nutritional composition of food products, usually to modify levels of fat, sugar and salt;
- labelling: modifying food product labels;
- lifestyles: educating certain populations about healthy diets and physical activity to change behaviour; and



- others: the remaining commitments include promoting research into obesity prevention and management and monitoring, training and policy work.

Members have made 292 commitments so far, with more than half focused on lifestyles. Many, however, were not new actions, but scaled-up or reframed activities (European Commission, 2010).

A monitoring system aiming to evaluate each commitment in terms of its alignment with the platform's aims, the resources attached, its objectives and ultimate outcome (European Commission, 2010) is in place.

#### **5.1.1.4. Challenges**

It is too early to assess the health effects of the platform's commitments, but some major problems and challenges have been identified. Although the monitoring system has required members to be accountable for their actions, it is not succeeding in effectively determining how the commitments are reducing obesity. The system in place has shown only "limited capacity to enhance members' trust in the commitments of others" (European Commission, 2010). Members should therefore be encouraged to provide clear targets and baseline data and, where possible, set outcome evaluation measures for each target. Evaluations must also identify best practice examples that can serve as guidance for future commitments (European Commission, 2010).

Mutual understanding among sectors has increased, but initiatives that involve members from different sectors are lacking, mostly because of an obvious clash of interests between the for-profit and not-for-profit organizations on concrete vision, goals and priorities. A European Commission survey found that while 70% of industry respondents had a positive opinion of the platform's rather general objectives, 80% of civil society members argued in favour of a renewed mandate (European Commission, 2010).

#### **5.1.1.5. Lessons learned**

To "maintain the buy-in of the not-for-profit sector", it was recommended that the European Commission define a new mandate, taking into account what has been achieved so far, setting priorities for future work and establishing operational objectives for joint working. It will be crucial to balance and take into account the interest and needs of both sides. In particular, stronger commitments from the business sector should be rewarded through better and more transparent communication of activities (European Commission, 2010).

#### **5.1.1.6. Other examples**

The EU platform inspired the creation of several similar national initiatives in the EU, such as:

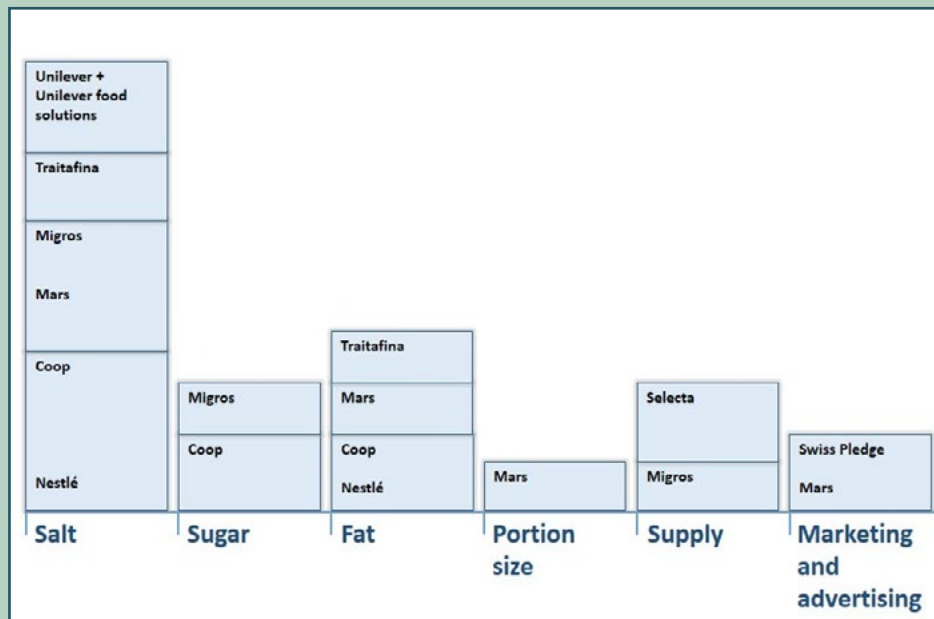
- Germany – Plattform Ernährung und Bewegung [platform on diet and exercise];
- Hungary – Hungarian diet, physical activity and health platform;
- Italy – piattaforma nazionale su alimentazione, attività fisica e tabacismo [national platform on diet, physical activity and tobacco];
- Netherlands – Rotterdam covenant on nutrition and physical activity;
- Poland – Polska rada ds. diety, aktywności fizycznej i zdrowi [Polish council on diet, physical activity and health]; and
- Portugal – plataforma contra obesidade [platform against obesity].

It has nevertheless had limited impact on them (European Commission, 2010). Permanent institutional links should therefore be established, with the platform’s work being made more visible to EU citizens at national and local levels. The EU platform can positively influence the work of its national counterparts (Box 13).

**Box 13. Action Santé**

Action Santé (2012) is a networking platform in Switzerland through which private organizations make voluntary commitments. The mass media is used to make the population aware of the companies’ efforts in, for example, reducing salt, saturated fat and sugar within their products, which acts as an incentive to the companies’ participation. Fig. 7 shows companies involved so far.

*Fig. 7. Companies involved in Action Santé*



Source: Federal Office of Public Health (2013).

Examples of other policy interventions in nutrition, including pricing policies for healthy eating, marketing of food to children and strategies for salt reduction, were informally presented during the “Europe day” at the 8th Global Conference on Health Promotion.

The platform approach has been used in some countries to develop a national policy. In United Kingdom (Scotland), for example, the “Food and drink leadership forum” has been successful in bringing together more than 400 organizations from public and business sectors and civil society “including food outlets, retailers, NHS [National Health Service], Scotland Food and Drink, enterprise agencies, local authorities and communities” (Scottish Government, 2009). As a consequence and within an interest-balancing process, the platform has provided the foundations for Scotland’s first national food and drink policy, which addresses quality, health and well-being as well as environmental sustainability and recognizes the need for access and affordability (Scottish Government, 2009).

A collaborative governance approach was used in South Australia to develop the “Eat well, be active” strategy for 2011–2016, which aims to change behaviour and support people to lead healthier lives (Government of South Australia, 2010, 2011). It is one of the most comprehensive of such strategies, with five key action areas identified (similar to the steps described under section 2.3 around lever points for change). A strategic network of key stakeholders has been assembled around each lever point and complementary actions (built on existing good-practice programmes) have been enacted to increase the proportion of people who eat a healthy diet, undertake regular physical activity and maintain a healthy weight (Government of South Australia, 2011). A HiAP strategy will be applied and effective communication developed to reach the public and all relevant stakeholders, who will meet annually to share information and support. The government will provide leadership, incentivizing changes in organizational, individual and household behaviour through further policies, legislation and taxation. Constant monitoring and evaluation aims to ensure the best mix of actions is achieved: effectiveness and efficiency need to be taken into account, with initiatives being based on the latest research results and evidence from similar approaches in other countries (Government of South Australia, 2011).

## 5.2. Communicable diseases

As already described, whole-of-government approaches are joint working arrangements across the public sector via horizontal and vertical links. As is the case with NCD, this may not be sufficient when dealing with many communicable diseases. New actors in global health have evolved, claiming a place in decision-making on health issues and changing governance mechanisms (Low-Beer, 2012). This is reflected institutionally through the

constituency approach applied by organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. In this approach, “government” is at the centre, surrounded by:

- the private sector
- bilaterals
- multilaterals
- people affected by health issues
- civil society
- private foundations (Low-Beer, 2012).

In practice, the boundaries of whole-of-government and whole-of-society approaches are often fluid. Many whole-of-government approaches use whole-of-society elements, such as citizen and community involvement, to achieve better outcomes. The term “whole of government” is used interchangeably with “whole-of-society” in the context of pandemic preparedness (Towards a Safer World, 2011). This report, however, builds on the definition above which, because of the involvement of a wide range of (non-public) actors, describes whole-of-society approaches as a collaborative governance effort that goes beyond institutions. A whole-of-society approach aims to influence culture, media, communities and all relevant policy areas.

Shared creation of societal and economic value must be the goal, and the HIV epidemic has clearly shown that this requires a response throughout society, particularly where societal norms need to be addressed to resolve health issues. Shared governance is necessary and has been successfully applied for other communicable diseases, as the experience of the GAVI Alliance has shown. The GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria are using comprehensive constituency governance approaches within their strategies.

### 5.2.1. How to: a whole-of-society approach to respond to HIV

#### 5.2.1.1. The issue

The *Global strategy framework on HIV/AIDS*, published in June 2001, called on “all sectors of society to show leadership in galvanizing the response to HIV/AIDS – among towns and villages, young people and those not so young, companies and community organizations, countries and continents” (UNAIDS, 2001). Experience highlights the importance of multilevel governance to coordinate formal and informal multistakeholder responses from national to community levels (Low-Beer & Sempala, 2010). The emergence of new global health actors has resulted in parallel structures in recipient countries increasing transaction costs over the last two decades, often leading to a “governance and coordination gap” (Low-Beer, 2012). The “partnership period” of the 2000s (Low-Beer, 2012) has changed the balance of power at global, regional and national levels.

### 5.2.1.2. Shared governance

Innovative health partnerships are increasingly combining major health constituencies to improve population health. As the constituency model of governance indicates (see above), national programmes need to build on different sources of authority and community responses as “the basic unit of governance” (Low-Beer & Sempala, 2010). Effectively including a wide range of actors and interests to change behaviour and norms among individuals and social networks is the crucial challenge in tackling HIV. Partnerships must bring together actors in new ways through, for example, board structures, country coordination and innovative implementation arrangements involving partners from different constituencies (Low-Beer, 2012). In this context, the five principles from the 2005 Paris Declaration on Aid Effectiveness (OECD, 2009b), a key strategic document for improving the quality of aid and its impact on development – ownership, alignment, harmonization, managing for results and mutual accountability – should be applied whenever donors work with national and local partners to achieve common goals (Low-Beer, 2012). These are clearly the same basic principles as are laid out in many whole-of-government and whole-of-society approaches.

Within the Region, the Global Fund to Fight AIDS, Tuberculosis and Malaria has established country coordinating mechanisms – “country-level public private partnerships central to the Global Fund’s commitment to local ownership and participatory decision-making” (Abovskaya, 2007) – in Bulgaria, Romania and Tajikistan. These develop and submit grant proposals to the Global Fund based on priority needs at national level and, after approval, oversee progress during implementation, evaluate policies, hold recipients accountable, identify potential bottlenecks and design new policies if necessary. They involve representatives from the public and private sectors, including governments, multilateral or bilateral agencies, NGOs, academic institutions, private businesses and people living with illness (Global Fund to Fight AIDS, Tuberculosis and Malaria, 2011).

The country coordinating mechanism in Romania was established in 2002. Prior to this, the national commission for the surveillance, control and prevention of HIV cases had prepared a grant application and, in doing so, invited several NGOs to submit project proposals. These were later included in the country coordinating mechanism, which comprised 43 members by the end of 2005 (Abovskaya, 2007). Initiating fruitful strategic discussions was almost impossible within such a large forum, so an executive committee with members from each constituency was established with a mandate to pass bylaws to define and decrease membership. Other bylaws have subsequently been adopted in response to changing circumstances, making the country coordinating mechanism a “self-governing learning body” (Abovskaya, 2007) that continues to develop necessary instruments. It comprised 30 elected

member organizations in 2007, including government ministries, NGOs, academic institutions, international development organizations and partners (the Joint United Nations Programme on HIV/AIDS, WHO and the United States Agency for International Development), pharmaceutical companies and organizations representing people living with HIV (Abovskaya, 2007).

Sectors represented in the country coordinating mechanism in Romania were:

- NGOs (41%)
- government (37%)
- development partners (13%)
- people living with AIDS (3%)
- academic sector (3%)
- pharmaceutical industry (3%) (Abovskaya, 2007).

The Ministry of Health and Family was nominated as the first principal grant recipient, with NGOs that had participated in the grant application process the initial subrecipients (other NGOs could also apply after clear requirements had been established). The technical assistance project of the United States Agency for International Development assisted principal and subrecipients in developing more collaborative ways of working and transparent monitoring and evaluation mechanisms for shared accountability (Abovskaya, 2007). The international development partners successfully mediated conflicts between the government and NGOs, improved communication and helped to institutionalize the country coordinating mechanism and current procedures, including the selection of subrecipients. As a result, all members seemed to accept the country coordinating mechanism as an innovative and effective means to achieve consensus and joined decision-making (Abovskaya, 2007).

It should be noted, however, that the substantial money spent by the Global Fund to Fight AIDS, Tuberculosis and Malaria provides a strong incentive for countries to accept country coordinating mechanisms within their context. This kind of incentive is often lacking in other areas in which similar cooperation is necessary. Equal participation rights nevertheless significantly strengthened NGOs in Romania, a country in which civil society organizations had previously played a minor role. By bringing a diverse range of stakeholders together, the country coordinating mechanism effectively applies the idea of “lesson sharing”: the government has a leading role, but the approach acknowledges that it cannot solve the challenge of HIV alone.

### **5.2.1.3. Challenges**

Policies and processes were not well established at the beginning of the process in Romania, with no clear rules on how to deal with specific problems. Overarching principles were in place, however, making it possible to address problems after the adaptation period.

Country coordinating mechanism members elected a new principal grant recipient in 2006: as a consequence, the government felt itself “overruled”, arguing that the NGO Romanian Angel Appeal had “won” because of a biased majority of NGOs and international development partners within the country coordinating mechanism (Abovskaya, 2007). More efforts are needed to build trust and common values so that it becomes clear that all members have a common goal that can only be fulfilled through working together.

Last, proper coordination and monitoring between the country coordinating mechanism and the principal recipient must always be secured (Abovskaya, 2007).



# 6.

## Health 2020 priority area three: strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response

### 6.1. Strengthening people-centred health systems

Changing demography and disease patterns mean that countries are having to reorient their health care systems by focusing on preventive measures, integrating service delivery, supporting self-care and coproduction and relocating care as close to home as is safe and cost-effective to do so (WHO Regional Office for Europe, 2012a).

#### 6.1.1. How to: governing through citizen engagement

People now have access to a much wider range of choices and lifestyle options than was the case in previous decades. Expectations on how governments should interact with the public have changed, with examples from throughout the Region of people wanting to be involved in different stages of the policy cycle at local, subnational and national levels. In this context, “citizens value the right to have an informed say in the decisions that affect their lives” (Sheedy, 2008). Discussions about introducing methods of direct democracy in several European countries are gaining momentum, with the ongoing debate on the democratic legitimacy of the EU reflecting some of these developments. Several recent regional and national policies, such as the European Citizens Initiative, emphasize the “sharing of power, information, and a mutual respect between government and citizens” (Sheedy, 2008).

Governments are recognizing the need for more direct participation to tackle today’s societal problems (Kickbusch & Gleicher (2012) describe a range of examples). Experiments are under way in the area of service provision, giving users more choice by offering a greater variety of services and making them more accessible and giving citizens a say about how services are provided by, for instance, conducting surveys. New communication channels such as social media tools or smart phones facilitate the introduction of these “choice and voice” mechanisms, which can significantly enhance the responsiveness and accountability of government services (Public Administration Select Committee, 2005).

Citizen engagement in relation to health means offering opportunities that allow the public to hold health structures to account and empowering people to care better for themselves (Kickbusch & Gleicher, 2012). Health can



only be promoted and disease can only be prevented with citizens' active participation: the health sector must therefore engage with individuals in their roles as patients, consumers and citizens (Kickbusch & Gleicher, 2012) and keep equity considerations highly prominent.

Engagement is about people being involved in their own health care and treatment and in planning, implementing and evaluating health policies and services (Health Consumers Queensland, 2012). Coproduction is a central feature of welfare societies; governments must promote the establishment of community-based organizations that encourage coproduction, which is defined by Giddens (2003) as a “central component of the ensuring state and ... a process of collaboration between the state and the citizen in the production of socially desirable outcomes”. It could be argued, for example, that parents who prevent their children from eating junk food not only care for their children's health, but also coproduce better outcomes for the community (Alford, 2009).

#### **6.1.1.1. Policies that empower people: the Social Support Act in the Netherlands**

The Netherlands Social Support Act entered into law in January 2007. It transfers the focus of providing support and care from national- to local-level government (Schoonheim, 2009). According to the act, local authorities must be responsive to the needs of the people and empower citizens with disabilities and impairments “to run a household, move within and around their home, take local journeys and meet other people” (De Klerk et al., 2010).

The act supports a demand-led approach. Local authorities have established inclusive Social Support Act boards designed to represent the interests of people with physical disabilities and older people. The boards seek to include people with disabilities and decide which services to provide (De Klerk et al., 2010). The act also encourages informal caregiving: money is available to provide personal budgets to allow disabled people to purchase the care they see as fitting best to their needs. This means that disabled people can hire the people they wish, including family members (Schoonheim, 2009).

Horizontal (and not vertical) accountability between local authorities and citizens in the community is given priority, with evaluations of clients' satisfaction conducted after fixed time periods. The latest, carried out by the Netherlands Institute for Social Research, states that 28 of every 1000 inhabitants use the services under the Social Support Act and that major shifts in the number or type of services provided have occurred (De Klerk et al., 2010). Expenditure on household help provided via the personal budget system has increased considerably, although some recipients have complained about the complex application procedure (Schoonheim, 2009).

Many local authorities are using their newly gained freedom to establish adaptive integrated policies involving other policy domains. Generally, it has been shown that residents living in municipalities in which local authorities focus more on the proposed demand-led approach have higher social and life skills, but it will be important to ensure that the interests of other target groups, such as people with learning disabilities or chronic mental disorders, are not overlooked and that these groups are represented on Social Support Act boards.

#### **6.1.1.2. Empowering patients: the “Expert patients programme” in the United Kingdom**

Sharing of information and decision-making can result in better health outcomes for people with chronic diseases, because these patients are often experts in their own condition. In the context of health care delivery, coproduction aims to individualize treatment solutions and support patient self-management (Realpe & Wallace, 2010). Fig. 8 illustrates the resulting coproductive partnership between service users and providers.

The United Kingdom has acknowledged that the rising number of patients with chronic diseases should not be mere recipients of care. By ensuring that knowledge is developed to a point where patients are empowered to take responsibility for managing their disease, the “Expert patients programme” gives people living with long-term health conditions greater control of their lives (Department of Health, 2001). The programme is based on the assumption that patients and professionals have their own valuable area of knowledge and expertise and should therefore work together to optimize treatment. Free six-week courses aimed at helping people who are living with a long-term health condition to manage their condition better on a daily basis and educate them on how to make better use of their health care visits are at the programme’s core (Holmes, 2011).

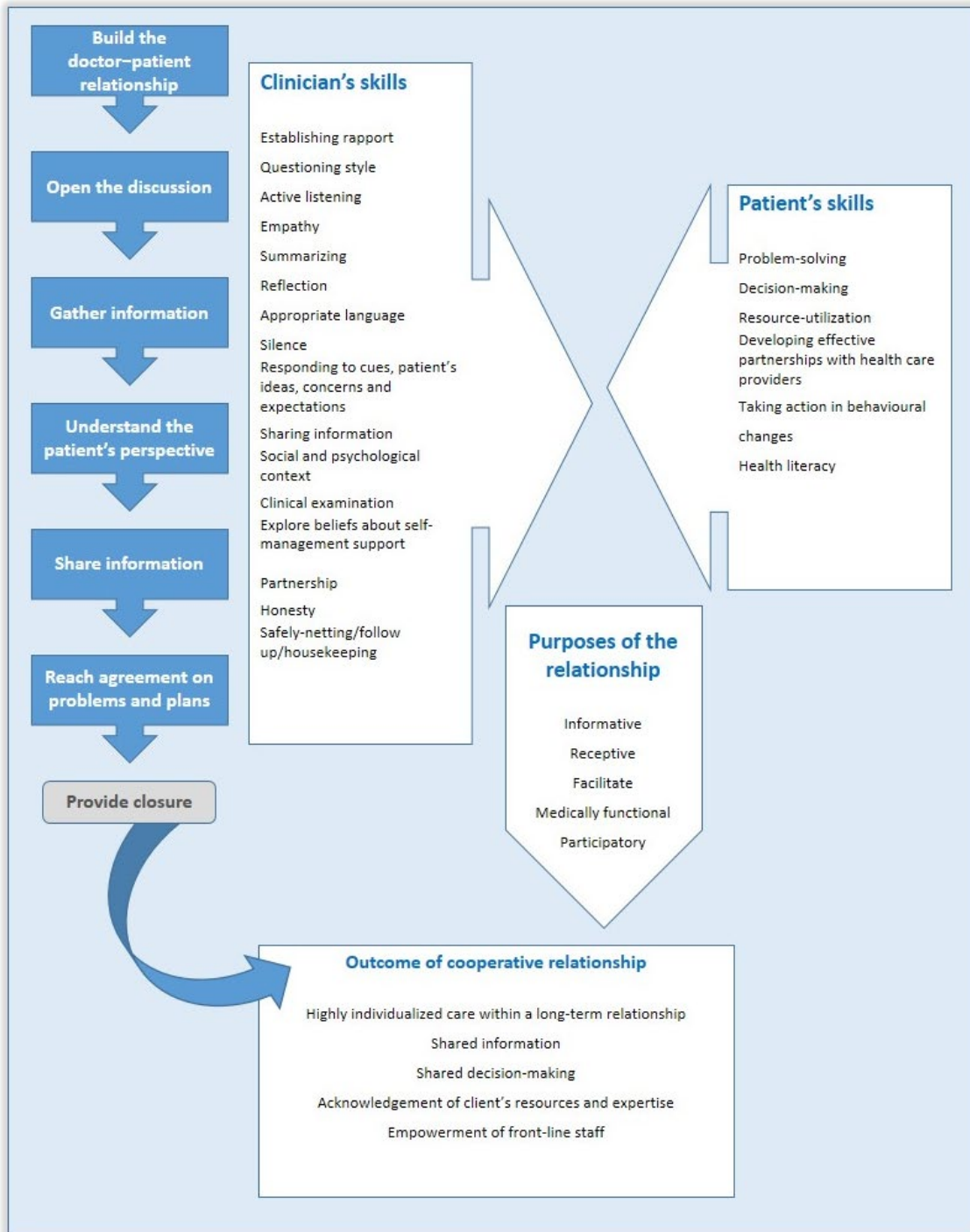
The aim is to give people the confidence to take more responsibility to self-manage their health while encouraging them to work collaboratively with health and social care professionals. Evaluations have shown a “significant improvement in satisfaction with quality of life” (Holmes, 2011) for those who participate. One important reason is that the programme successfully builds social networks, which have a significant positive effect on people’s health and well-being (Box 14). Last, but not least, although the programme is free, the analysis found it was cost-effective compared with treatment as usual (Holmes, 2011).

### **6.1.2. How to: local democratic legitimacy in health**

#### **6.1.2.1. Health and well-being boards in the United Kingdom**

Government services in many countries are delivered through different departments, each with its own programmes and delivery channels (Coe,

Fig. 8. Coproduction of health in consultations for people with long-term health conditions



Source: Realpe & Wallace (2010).

**Box 14. PatientsLikeMe® – sharing health data for better health outcomes**

PatientsLikeMe® (2005–2013) is a social networking format through which patients can share their data online. This is especially useful for patients with chronic diseases because they can share their experiences worldwide and obtain information on new therapies and medication. Patients with rare diseases are often able to find other patients like them matched by demographic and clinical characteristics (Wicks et al., 2010). The personal research platform not only empowers patients to make better-informed treatment decisions, but also gives them the opportunity to access support from others.

Research indicates that a substantial proportion of members experience benefits from participating in the community (Wicks et al., 2010). Some groups that have come together on PatientsLikeMe® provide combined collections of data that are large enough for clinical research: pharmaceutical companies have conducted clinical trials based on information from the web site (Kickbusch & Gleicher, 2012).

The “openness” philosophy provides a value system based on transparency, which allows the creation of mutually beneficial initiatives. However, as one incident of private information being unknowingly disclosed illustrated, transparency is highly important: patients must always be informed about what happens with their data and to whom and for what purpose it might be given away. Knowledge coproduction between society and science can lead to win–win situations only if trust is ensured (Kickbusch & Gleicher, 2012).

2008). Countries are aiming to address this, a recent example being the introduction of health and well-being boards in United Kingdom (England).

The Health and Social Care Act 2012, adopted in March 2012, is one of the greatest restructuring reforms in the history of the NHS. Although the act has created controversy, the setting up of health and well-being boards (Department of Health, 2012) has been almost universally welcomed. The vision is to create joined-up, well-coordinated and jointly planned services. Health and well-being boards are the only component of the reformed NHS that “would bring together different organizations and interests to promote local collaboration and integration” (Humphries et al., 2012).

They aim to improve accountability and democratic legitimacy by enhancing local authorities’ role in the planning and oversight of local health services by:

- assessing the needs of the local population through a joint strategic needs assessment process;
- producing a local health and well-being strategy based on the data collected;
- using this overarching framework to develop health services, social care, public health and other services that the board agrees are relevant; and
- promoting greater integration and partnership, including joint commissioning, integrated provision and pooled budgets where appropriate (Humphries et al., 2012).

The aim is to engage with a wide range of stakeholders, local people and communities to better involve general practitioners in strategic planning and to focus increasingly on preventive measures. One starting point will be to effectively integrate health and social care and other local services, such as leisure or housing, that directly or indirectly affect the health and well-being of local communities (Humphries et al., 2012).

It has been argued that a board membership of 8–12 people is most effective, although the majority of boards have more than this. According to a survey undertaken by Humphries et al. (2012), the boards are expected to represent the following stakeholder groups: public and patient involvement groups, hospital trusts and secondary providers, public health, voluntary or third-sector groups, councillors, social care, clinical commissioning groups and district councils.

Strong working relationships, commitment to integration, agreement on priorities, trust and commitment of primary care and evaluations and joint strategic needs assessments are needed (Humphries et al., 2012). These arrangements are in their infancy, and it is too early to draw any conclusions.

## 6.2. Strengthening public health capacity

Achieving better health outcomes requires substantial strengthening of public health capacity (WHO Regional Office for Europe, 2012a). Capacity in this context must be understood as the ability of a system to solve new problems and respond to unfamiliar situations. Policy interventions that promote health and prevent disease are a means of reducing costs and building capacity within the health system and society as a whole (Van den Broucke, 2009).

### 6.2.1. How to: governing through a mix of regulation and persuasion

Governing is becoming more fluid, multilevel, multistakeholder and adaptive. Hierarchical means of governance are increasingly complemented by other mechanisms such as “soft power” and “soft law”. Successfully responding to modern health problems such as NCD requires an effective mix of policy instruments. Traditional policy approaches – legislation,

sanctions, regulations, subsidies or taxes – may not be sufficient and must be augmented by additional tools underpinned by an understanding of how to engage citizens in behavioural change. Banning junk food advertisements for children, for example, may be relatively ineffective without the proactive use of mass-media campaigns to educate people (especially parents) and promote healthy eating.

Originating from behavioural economics, “nudge policies” aim to make healthy decisions an easier choice. A nudge is “any aspect of the choice architecture that alters people’s behaviour in a predictable way without forbidding any options or significantly changing their economic incentives” (Thaler & Sunstein, 2008). School cafeterias offer a prominent example in this context. Changing how offered food is arranged can significantly influence children’s food choices in the direction of healthier eating (Thaler & Sunstein, 2008). This shows that small details can significantly affect people’s behaviour.

The assumption behind nudges is that traditional economic views of a rational Homo economicus fall short. This is especially true for dieting or risk-related behaviour such as smoking or drinking (Thaler & Sunstein, 2008). People have “a strong tendency to go along with the status quo or default option” (Thaler & Sunstein, 2008). Interestingly, inertia can be used effectively: making a decision often involves effort and may be stressful, whereas accepting a preset default is effortless (Johnson & Goldstein, 2003). The premise is that “changes in the choice architecture can make people’s lives better” (Thaler & Sunstein, 2008). By setting the rules or choosing the defaults, governments affect health choices and outcomes. They are choice architects.

The following examples are drawn from different countries and backgrounds and reflect persuasive and regulative measures.

#### **6.2.1.1. Persuasion through nudge policies: organ donation and the Austrian default option**

The power of nudge policies becomes obvious in the context of defaults and organ donations. It appears that certain default rules can solve the supply problem by increasing available organs and consequently saving lives (Thaler & Sunstein, 2008). In Germany, for example, as in many countries, an explicit consent rule (opting in) was used for many years, meaning that people had to take concrete steps to demonstrate that they wanted to be donors. Although most people would have agreed to donate organs, they often failed to take the necessary steps. The rate of potential organ donation was therefore low (12%). In contrast, Austria uses a default rule of presumed consent that preserves freedom of choice, but it is different from the explicit consent rule because it shifts the default rule. Under this policy, all citizens are

presumed to be consenting donors but have the opportunity to register their unwillingness to donate (opting out). Almost all citizens (99%) are therefore potential donors (Thaler & Sunstein, 2008): the “presumed consent” system (opting out) produces an effective rate of organ donation of 99.98% in Austria, while in Denmark, which employs the “explicit consent” (opting in) option, the respective rate is only 4.25% (Johnson & Goldstein, 2003).

There are many other examples of how nudge policies can influence people’s behaviour in eating healthier and taking part in more physical activity, including the arrangement of fruit and vegetables in supermarkets, more attractive stairs in public buildings and making cycling easier and more visible in cities by introducing bicycle-lending schemes (Kickbusch & Gleicher, 2012). Cost-free and easily accessible outdoor gyms have become popular in the United Kingdom (BBC, 2012b). Nudge policies alone, however, are clearly not sufficient to solve today’s societal problems.

#### **6.2.1.2. Salt-reduction strategies: approaches to shared governance**

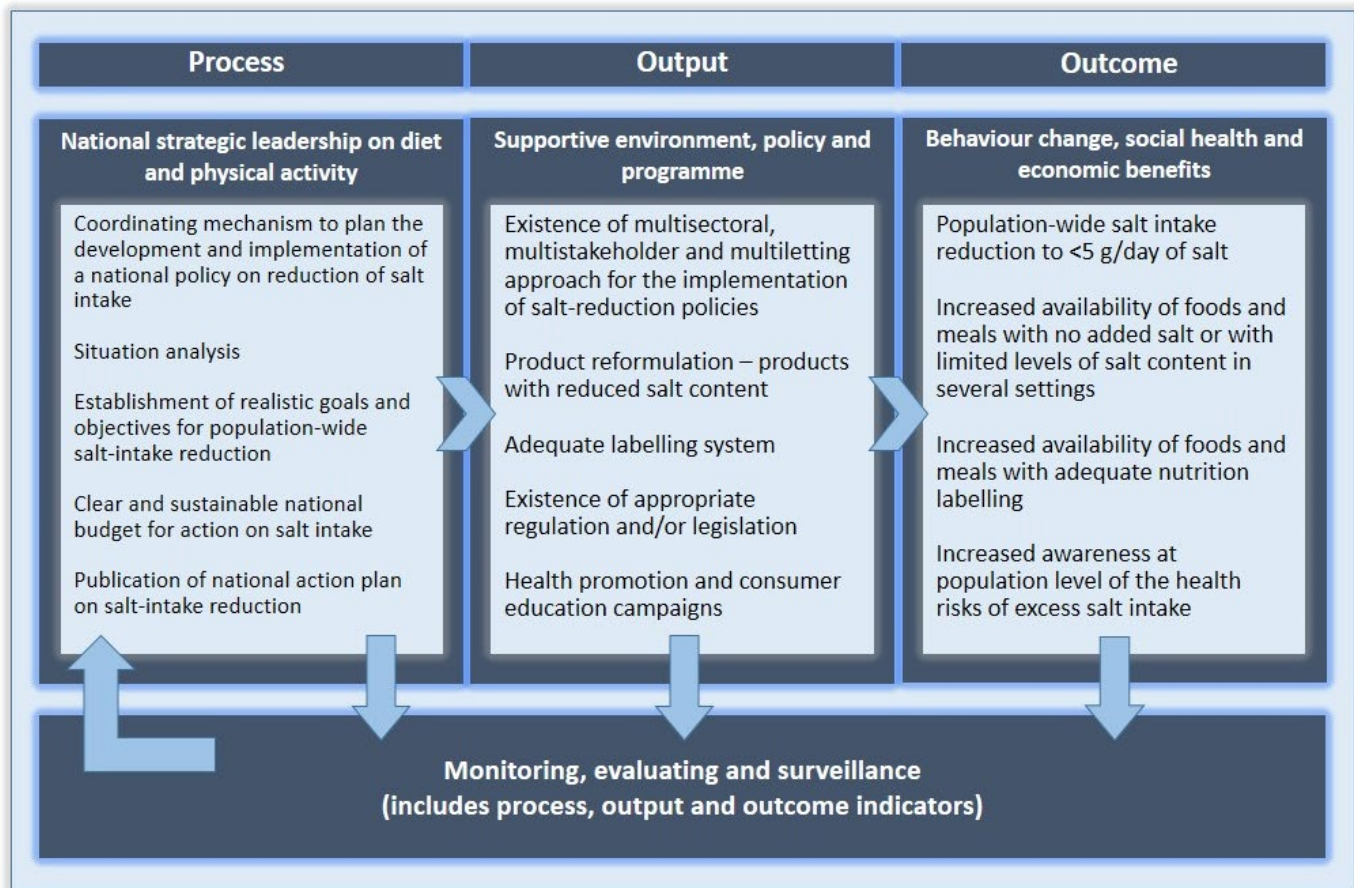
Epidemiological studies have demonstrated that a high salt intake significantly contributes to an increased risk of high blood pressure and cardiovascular diseases (WHO, 2007). Research indicates that strategies to reduce population levels of salt intake are very effective in terms of health impact and costs (Millett et al., 2012).

The following steps in planning and implementing national salt-reduction strategies were identified at the 2006 WHO forum and technical meeting in Paris (Penney, 2009; WHO, 2010) (Fig. 9).

- **Leadership:** strong political leadership by national health ministries, adequate resources and a clear mandate are crucial for the success of population-wide salt-reduction strategies. A coordinating group needs to be formed at an early stage.
- **Data collection and measurement:** evidence-informed policy-making is only possible if sufficient scientifically recognized data are available and the population’s salt intake and eating patterns and the salt content of manufactured food are well known.
- **National target-setting:** WHO recommends a salt intake per person of less than 5 grams per day. Based on collected data, countries may, however, choose a higher target to begin.
- **Stakeholder identification and engagement:** the coordinating group must identify all relevant stakeholders (such as the food industry, NGOs, mass media, academia and government departments) with whom it needs to collaborate and the methods to achieve this.
- **Consumer awareness campaign and food labelling:** a media campaign on the negative effects of high salt consumption and clear and easy-to-understand food labels are necessary to inform consumers.

- **Product reformulation and regulation:** agreements with the food industry need to be negotiated. Regulation for the reduction of salt in foods should be introduced gradually.
- **Monitoring and evaluation:** a national surveillance system should measure all efforts and include a review of resources needed to maintain a sustainable and effective strategy.

Fig. 9. Developing and implementing a policy for salt reduction



Source: WHO (2007).

The EU adopted a salt-reduction framework in 2008 to meet the WHO recommendations (European Commission, 2012b). The framework supports national plans through initiatives such as involving EU-level stakeholders and promoting best practice. The number of country initiatives has increased as a result: today, 29 European countries – all those in the EU, Norway and Switzerland – have adopted salt-reduction strategies, although to varying scale and scope.



Finland has the most comprehensive strategy, adopted in 1982. It has succeeded in reducing the average salt consumption from 14 grams per person per day to less than 10 over the past 20 years, using a rather regulatory approach with an efficient mix of legislation, consumer education, dietary recommendations and new product development (WHO, 2010) (Box 15). Compulsory food labelling and food-industry cooperation have been key elements of the strategy's success and the broad approach to raising public awareness by, for example, improving information through the education system has significantly contributed to enhancing health consciousness towards salt within the population (European Commission, 2012b).

#### **Box 15. A long-term strategy in Finland**

Finland's National Nutrition Council recommended taking action on salt intake in 1978. The 24-hour urine test method was undertaken within a population sample, complemented with dietary surveys. These measures continue on a regular basis. The target was set at 5 grams of salt per day. Although the strategy started in one region, it was quickly expanded to national level and engaged national and local health authorities, schools and NGOs, the last of which (rather than the government) conducted broad-based consumer education projects and mass-media campaigns to raise public awareness by, for example, improving information through the education system.

Compulsory food labelling introduced high-salt warning labels on all foods that exceeded the limits for salt content in categories such as bread, meat and fish products, butter, soups and ready-made meals. Many products disappeared from the marketplace as a result, with new lower-salt alternatives appearing. A new mineral salt product to replace sodium (PANSALT®) was developed and is now widely recognized in the country.

The food industry was engaged from an early stage, but change appears to have been driven more by legislation (especially labelling regulations) and mass-media attention than by voluntary agreements.

*Source: Penney (2009).*

Strategies adopted by, for instance, the United Kingdom and Switzerland focus more on collaboration with the food industry. Negotiations and voluntary food labelling have been relatively successful in the United Kingdom, where 40% of processed foods in the marketplace use traffic-light labels (Penney, 2009). The system was developed with extensive consumer

testing and shows at a glance whether a food is high, medium or low in salt, sugar, fat and saturated fat.

Experience shows that salt-reduction strategies must be based on evidence, be forward-looking and be monitored constantly to ensure they can adapt to changing circumstances. Finland's approach has been cost-effective and successful in reducing the population's salt intake partly because of its regulative aspect. Other countries are seeking appropriate measures to effectively reduce their population's salt intake: barriers include lack of capacity to carry out necessary research and monitoring, insufficient resources for mass-media campaigns, resistance by the food industry, food imports from other countries and media campaigns' lack of relevance for some cultures within a country. WHO and other regional networks can, however, provide assistance and resources for research and the development of a national surveillance system. NGOs and consumer groups can use the media to name and praise, or alternatively "name and shame", to motivate the food industry. Media campaigns should use different types of media to engage as many people as possible (WHO, 2010).

It must be noted, however, that salt reduction is only one aspect of broader efforts on reformulation designed to improve the nutritional quality of foods.

#### **6.2.1.3. Taxing unhealthy food to improve health: Denmark's fat tax**

Research and food-demand models suggest that (at least hypothetically) taxes have considerable potential to influence food choices, change diets and improve health (McColl, 2009). It is assumed that a fat tax could potentially fulfil two goals: decrease the consumption of unhealthy food and increase revenue aimed at supporting programmes to improve diets and prevent obesity (Allais et al., 2010).

It is argued that Pigovian taxes (taxes applied to a market activity that generates negative externalities) on tobacco and alcohol have been successful in the past and that those who live unhealthily should pay more to internalize negative externalities and cover social costs (such as treatment within a public health care system). Taxing tobacco to control smoking is, however, easier than taxing (saturated) fat to control obesity. Smoking directly causes several diseases, while fat, which can be found in most food products, does not necessarily and directly lead to illness. Targeting fat-containing foods and reducing their consumption to achieve better health outcomes are therefore difficult.

Generally, governments have two options for taxing fat: they can tax certain food groups, such as junk food, or tax all products that have a fat content over a predetermined threshold (Box 16) (Clark & Dittrich, 2010).

**Box 16. Denmark's fat tax**

Denmark introduced a fat tax in 2011 to respond to the fact that 80% of adults and children had intakes of saturated fat that exceeded dietary recommendations (Smed, 2012). Acknowledging that obesity is not simply the result of fat intake, the fat tax was part of a larger tax system reform that reduced income taxes and increased or established “sin” taxes on tobacco, alcohol, sweets, soft drinks and saturated fat.

The fat tax was paid on the weight of saturated fat in meat, dairy products, oils and other fats if the content of saturated fat exceeded 2.3%. All kinds of drinking milk were exempt (Smed, 2012). Companies that commercially produced these foods or imported them for consumption within Denmark had to pay the tax; it was not imposed on food that was exported (Smed, 2012).

Despite evidence that the tax was having some effect on the consumption of saturated fat, it was abolished in January 2013. The main reason was concern about cross-border trade and competitiveness.

Denmark's taxation approach has triggered debates in many European countries such as Finland, Romania and the United Kingdom. Taxes on unhealthy food are presently being considered in Hungary (tax on foods with high sugar, salt and fat content) and France (tax on soft drinks) (Villanueva, 2011).

Denmark's attempt at taxing products over a defined threshold of saturated fat, instead of taxing certain food groups, had two perceived advantages: consumers could not easily look for substitutes, and a subjective or even stigmatizing selection of certain products for tax was avoided.

Many consumers circumvented the tax by shopping in neighbouring countries. One study found that 48% of Danes were doing some of their shopping over the border in Sweden or Germany, and a report by the tax ministry put the value of these trips in 2012 at DKr 10.5 billion, which was a 10% increase on the previous year (The Economist, 2012).

It was anticipated at the outset that this method of taxation would carry a high administrative cost and be expensive to monitor, as foods would need to be regularly tested for their fat content. Another predicted issue was the inelastic demand for food. This is potentially good for a government in that it receives consistently high tax revenue, but it has been shown that a tax must be as high as 20% on top of the original price to significantly change consumers' demand (Hawkes & Mytton, 2012). Another general problem of saturated fat taxes is that they are regressive, meaning that low-income

households spend a higher proportion of their income on the tax than higher-income households (McColl, 2009).

Taxes alone are therefore not sufficient and should only be used in combination with tax cuts or subsidies on, for example, fruit and vegetables to reduce the price of healthier foods (McColl, 2009). Ultimately, the opposition of small-scale food producers and sellers to the tax's impact on their competitiveness proved significant in Denmark's case (The Economist, 2012). This example highlights some of the political and technical challenges of such interventions. More research on how to design a subsidy or taxation scheme most efficiently and effectively is probably needed.

As Fig. 10 illustrates, governments can choose from a great variety of instruments to achieve policy objectives such as healthy eating and a sustainable food system.

Fig. 10. Policy tool options



Source: Dubé et al. (2009).

Concepts of persuasion and voluntary self-regulation may have their limits in relation to NCD and the food industry. An approach originally termed “smart regulation” can become necessary when cases of conflicts of interest with the food industry arise. Under this model, an enforcement pyramid is used, with persuasive measures on the bottom and more regulative ones at the top. Policy-makers following this logic apply persuasion and voluntary commitments as long as they work and respond with carefully targeted and progressively coercive strategies whenever it becomes necessary (Gunningham, 2010). A “minimal sufficiency” principle can often be applied as long as potential larger “sticks” are kept in the background (Ayres & Braithwaite, 1992). Past experience has shown that the mere threat of regulation may often be sufficient to change companies’ behaviour.

### 6.3. Strengthening emergency preparedness, surveillance and response

Developing adaptive policies, resilient structures and foresight to effectively anticipate and deal with public health emergencies is crucial. It is important for policies to reflect the complexities of causal pathways and respond quickly and innovatively to unpredictable events, such as communicable disease outbreaks (WHO Regional Office for Europe, 2012a).

#### 6.3.1. How to: a whole-of-society approach towards disaster preparedness

##### 6.3.1.1. The issue

Global biological disasters such as SARS, bovine spongiform encephalopathy and the avian influenza H5N1 have occurred several times over the last two decades. The latest major influenza outbreak was in 2009, when WHO declared the new strain of swine-origin H1N1 to be pandemic. Lessons learned from outbreaks offer opportunities to develop more effective regional and national disaster preparedness. Instead of focusing on specific outbreaks, pandemics must be included in an all-hazards approach to disasters that effectively increases resilience at individual and community levels.

##### 6.3.1.2. Shared governance

Acknowledging that the risk of future severe pandemics remains, the United Nations adopted a whole-of-society approach to disaster preparedness, emphasizing the role of government, business and civil society. Preparedness requires integrated planning and “the management of complex relationships across different sectors and between international, national and local actors” (Towards a Safer World, 2011). Inadequate and uncoordinated preparedness and action among stakeholders such as governments, private companies, the mass media, NGOs and the military directly affect the health sector’s ability to effectively respond during a pandemic. Stakeholders therefore need to be identified and brought together to communicate and agree on their roles.

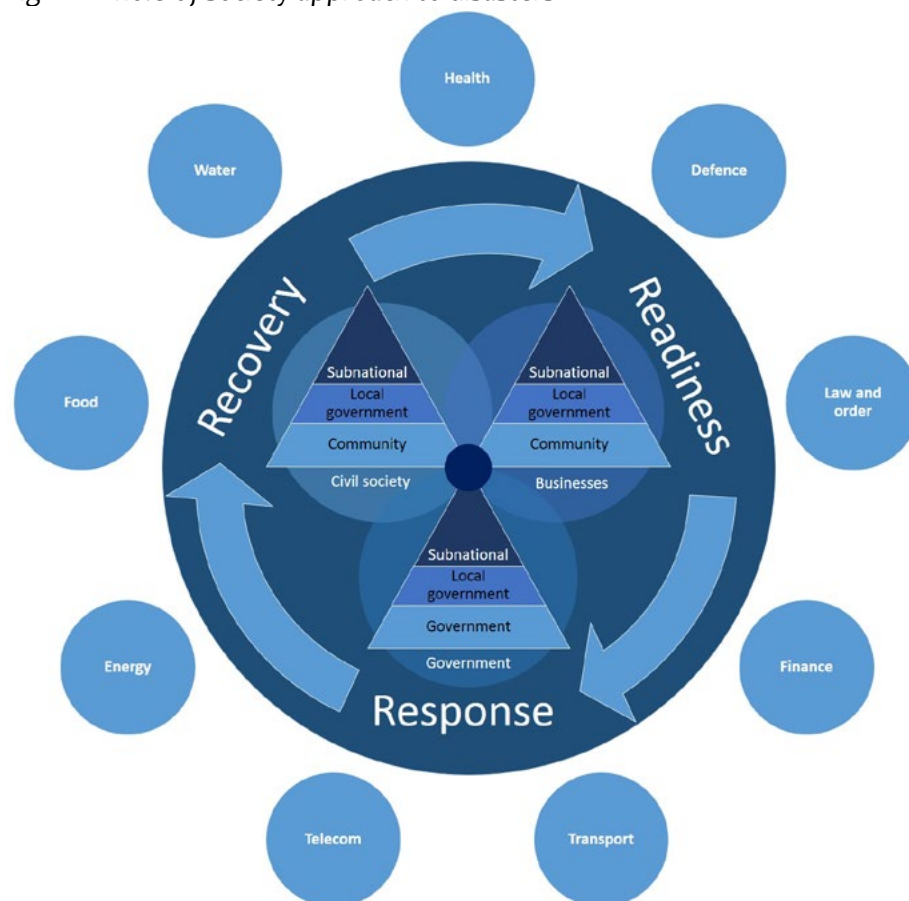
A starting point for a whole-of-society approach may be interdepartmental collaboration among all relevant ministries by, for instance, establishing a joint task force that can then serve as a platform for engaging a wider range of societal actors. A lead agency must be identified at all government levels to command, coordinate and communicate with other actors and the public. This agency would be responsible for ensuring that the private sector, NGOs and other relevant community entities were engaged in preparedness planning (Towards a Safer World, 2011).

Fig. 11 illustrates the whole-of-society approach to disasters in which:

- all levels of government are prepared
- attention is paid to critical interdependence
- a scenario-based response is undertaken
- ethical norms are respected (Kickbusch & Gleicher, 2012).

The nine circles represent key essential services needed in a disaster situation: health, defence, law and order, finance, transport, telecommunication, energy, food and water.

Fig. 11. Whole-of-society approach to disasters



Source: Towards a Safer World (2011).

The Association of Southeast Asian Nations has embarked on a whole-of-society approach and has significantly increased the degree of pandemic planning and response of its Member States. As a result, each of the association's countries has acknowledged the value of a holistic multisectoral approach and created two-tier structures in which the national disaster management agency functions under the auspices of one of the involved ministries (Towards a Safer World, 2011). Simulation was crucial in the process of building common understanding and determining the roles of government, the business sector and civil society in providing essential services. Each country has now developed a national pandemic preparedness plan that includes business continuity strategies (Towards a Safer World, 2011).

### 6.3.1.3. Challenges and lessons learned

The quality of Singapore's national pandemic preparedness plan could be tested in 2009, when the H1N1 pandemic hit the country. Key lessons from the pandemic were the following (Tay et al., 2010).

**Be prepared but be flexible.** The relatively aggressive H5N1 influenza was expected to hit the country, and preparation was made for high morbidity and mortality within a time frame of about six weeks. Instead, H1N1 emerged with high transmissibility rates over a longer time horizon with low morbidity and mortality and consequently made different demands on health services. Joined-up preparedness plans should be easily adaptable to changing circumstances: reality may differ significantly from the original planning scenario.

**Surveillance and access to information for evidence-informed decision-making.** Early detection of infectious disease outbreaks and the best available epidemiological data for evidence-informed risk management are essential at global and local levels.

**An inclusive whole-of-society response.** Singapore's pandemic planning was primarily based on the health sector and public institutions, but the newly established coordinated and collaborative efforts of government agencies, the health care system, businesses and members of the public were crucial in ensuring that the measures to control spread of H1N1 were implemented efficiently and effectively to minimize morbidity and mortality and the disease's impact on society and the economy.

**Health workforce supply.** Demand for health care services rises quickly during a pandemic, so creative human resource strategies must be established beforehand. A good and forward-looking understanding of crisis scenarios and the skill sets and workforce required is necessary for surge-capacity planning.

**Communication with the public.** A whole-of-society approach to disaster preparedness can only be successful if communication is a central part of collaborative efforts. Stakeholders must be accountable to the public and transparent risk communication can engage citizens successfully in measures to curb the spread of the disease and explain burdensome policies. Working closely together with the mass media is essential. Although new social media tools were used, the traditional communication channels remained most effective in disseminating pandemic information.

Unfortunately, the prevention of complex infectious diseases is still poor in many countries and must be enhanced. Suggestions for joint working always include addressing issues of professional territories and culture through strategies such as joint workforce development and training and joint accountability mechanisms (Battams, 2008). Cross-border professional collaboration is crucial for successful whole-of-society approaches to disaster preparedness in particular and health in general. In this context, “one health” has been described as a new paradigm that recognizes the interrelatedness of human, animal and ecosystem factors for the emergence of disease vectors. According to Butler-Jones (2012), “Looking at human disease without including the context in which human illness occurs will not inform our decision-making ability.”





# 7.

## Health 2020 priority area four: creating resilient communities and supportive environments

Building resilience is a key factor in protecting and promoting health and well-being at both the individual and community levels. ... Resilient communities respond proactively to new or adverse situations, prepare for economic, social and environmental change and deal better with crisis and hardship (WHO Regional Office for Europe, 2012a).

### **7.1. How to: involving local people in building supportive environments and reducing health inequities**

#### 7.1.1. The issue

The notion that chronic diseases are the result of individual choices to adopt unhealthy lifestyles is common. This view ignores, however, the social dimensions of health-related risks that shape patterns of morbidity and mortality in all populations. As the Regional Office has noted: “People’s health chances are closely linked to the conditions in which they are born, grow, work and age” (WHO Regional Office for Europe, 2012b). Individual responsibility can have its full effect only when individuals have equitable access to a healthy life and are supported in making healthier choices. Examples of integrated action to address health inequities are presented in more detail in the complementary European study of social determinants of health and the health divide (WHO Regional Office for Europe, 2012b).

#### 7.1.2. Solutions and approaches

Governments have a crucial role to play in improving the health and well-being of populations and in providing special protection for vulnerable groups (WHO, 2005). Creating supportive environments and empowering disadvantaged individuals and communities is increasingly seen as being integral to public health as a means of tackling the underlying social determinants of health and increasing the ability of disadvantaged people to take better care of their own health (Box 17). The assumption is that the more community members are empowered by being involved in the design, development and implementation of activities, the more likely it is that their health will improve (Attree et al., 2011). Local ownership of health issues not only improves the health of individuals, but also increases the resilience of the whole community (Box 17).

**Box 17. Building supportive environments – WHO Healthy Cities**

The WHO Healthy Cities project (WHO Regional Office for Europe, 2013) is a global movement that engages local governments in health development through a process of political commitment, institutional change, capacity-building, partnership-based planning and innovative projects. About 90 cities are members of the WHO European Healthy Cities Network and 30 national healthy cities networks across the WHO European Region have more than 1400 cities and towns as members.

The primary goal of the WHO European Healthy Cities Network is to put health high on the social, economic and political agenda of city governments. Health is the business of all sectors and local governments are in a unique leadership position, with power to protect and promote their citizens' health and well-being. The Healthy Cities movement promotes comprehensive and systematic policy and planning for health and emphasizes: the need to address inequality in health and urban poverty; the needs of vulnerable groups; participatory governance; healthy urban planning and design; and the social, economic and environmental determinants of health. This is not about the health sector alone: it also includes health considerations in economic, regeneration and urban development efforts.

The approach to governance consists of the following action elements: strong leadership and support from city mayors; cross-party support in city councils; partnership agreements with statutory and non-statutory sectors; a range of structures and processes to support intersectoral cooperation and citizen engagement; joined-up strategic planning and target-setting; and formal and informal networking. The model has been tested in a wide range of political, social and organizational contexts across the European Region.

### 7.1.3. Shared governance

The difference in life expectancy between those living in the most- and least-deprived neighbourhoods of London is 7.2 years for males and 4.6 for females (Hine-Hughes, 2011a). “Food deserts” exist in some streets in which only fast or junk food is available, contributing to unhealthy diets.

The Well London project was a four-year programme that targeted 20 of the most-deprived communities in London (Wall et al., 2009). The project promoted healthy physical activity, healthy eating and mental health and well-being by delivering a complex set of integrated interventions in partnership with different NHS bodies (especially local primary care trusts), the University of East London and other organizations and NGOs. It gained

many plaudits, including this from Professor Sir Michael Marmot, Director of the Institute of Health Equity at University College London:

If we are to reduce health inequities, it is essential to take action on the social determinants of health – the causes of the causes of ill health. That means working in partnership at local level to improve the social conditions in which we are born, live, grow, work and age. The Well London alliance partnership does just that. Empowering individuals and communities and giving people a voice is integral to addressing health inequalities.

The projects are listed in Box 18.

#### **Box 18. Well London projects**

**Healthy spaces:** improves the quality and security of public space and encourages physical activity.

**Active living:** provides residents with maps informing them of local resources for making healthy choices (such as farmers' markets).

**Be creative, be well:** supports cultural activities to foster social networks.

**Buywell:** various interventions that improve access to healthy food choices in local shops.

**Changing minds:** local people with experience of mental ill health are recruited to raise awareness of mental health issues and promote understanding of its impact.

**DIY happiness:** activities try to reduce stress and increase psychological resources to cope with difficult situations.

**Eatwell:** improves diet and nutrition by raising awareness and making healthy eating easier and more attractive

Source: Wall et al. (2009).

The mix of projects built up in each community was decided through “priorities identified by residents and complementary to the facilities and services already provided” (Wall et al., 2009). Priorities were identified through inclusive health needs assessments, considered a key element of Well London. Multistakeholder workshops were arranged with local organizations and community cafés established. In such an informal environment, people could voice their needs within a structured conversation. Information collected through street interviews and community mappings revealed existing successful initiatives on which to build and avoided the risk of duplication of effort (Institute for Health and Human Development, 2012a).

## 7.1.4. Challenges

Evaluations indicate that the multimethod approach to data collection and involving local communities in the intervention delivery process was

important in identifying barriers and facilitators that determined the success or failure of the projects (Wall et al., 2009). Healthy eating and physical activity have increased and mental health and well-being has been enhanced (Wall et al., 2009), but Well London has also shown that managing expectations of what is actually possible right from the beginning is important and that advertisements must make the projects visible to people. Maybe most importantly for community projects is accountability, in the sense of sustainability and long-term views: Well London had a time window of four years, but this was not enough to really make a difference, and those engaged “did not want to see lots of little projects coming and then disappearing after three years” (Boxes 19 and 20) (Institute for Health and Human Development, 2012b).

#### **Box 19. Time banks – building social networks and enhancing health**

Time banks, or time dollars, are elements of social infrastructure that can keep people healthy, speed up recovery, save money within the health system and help to fight health inequalities (New Economics Foundation, 2002). They engage citizens to take care of themselves and can be a valuable asset in creating supportive environments. The currency of exchange is time, which ensures that people who are not an active part of the economy because of unemployment, chronic diseases or disabilities are still able to participate. Participants who provide practical help and support to other time bank members deposit this time in a “bank”. They can then withdraw their time credits to use skills and support offered by other participants. No pricing system exists in a time bank, meaning that everybody’s skills are valued equally (one hour means one credit) (Hine-Hughes, 2011b).

Many time banks, such as the “time2trade” project in Birmingham, use databases: whenever a member needs a certain service, the appropriate person with the particular capacity can be found. Time2trade has partnered other local initiatives and organizations, making it an “innovative co-production initiative which helps public service providers to get in touch with so-called ‘hard-to-reach’ groups” (Hine-Hughes, 2011b). Members can use their time credits to, for example, purchase healthy food, go to the gym, study or use other services they may need.

Since the time bank was founded, 34 100 hours have been traded (Hine-Hughes, 2011b). Findings show that this bank in particular, and

**Box 19 contd**

community-driven time banks in general, are able to actively engage vulnerable groups and produce positive effects on “physical and emotional health and well-being, self-confidence, self-esteem, social relationships and individual empowerment” (Attree et al., 2011).

Here again, managing expectations is crucial. Whenever imbalances of services arise, a time bank should try to “buy in” services or link with other social organizations. The larger a time bank becomes, the more investment in paid staff will be required: this money, however, seems to be reasonably well spent.

**Box 20. Whole-of-government approach to crime prevention: the German Forum for Crime Prevention**

The German Forum for Crime Prevention seeks to establish best practice recommendations for early crime prevention and to create synergy effects across sectors. The coordination platform aims to incentivize networking, cooperation, pooling, knowledge transfer and improved public work by comprehensively including “all relevant societal forces” (Seitz, 2010).

Crime, similar to health, is a problem that requires collaboration among many societal stakeholders. This has not only been acknowledged in Germany but also in Australia and the United Kingdom, where whole-of-government approaches to preventing crime based on the assumption that preventive responses will be more effective if the efforts of all relevant government agencies as well as community and business groups are combined within a single coordinated strategy have been established (Hemel, 2004).

Significant management and coordination effort is needed to achieve effective whole-of-government work (Hemel, 2004). Investment in time and resources is necessary if the potential gains of whole-of-government approaches are to be released.



# 8.

## Joint or shared accountability

### 8.1. Agreeing on accountability relationships

Accountability is listed as one of the eight features of modern policy-making. Successful governance for health requires systematic evaluation, review and a continual dialogue about the wishes and needs of the population and all actors involved. Institutional arrangements that provide citizens with the opportunity to hold political decision-makers and other actors accountable for their actions are essential elements of the policy-making process.

Traditionally, the most dominant public accountability relations have been vertical in nature, but this top-down chain of principal-agent relations of “unequals” is slowly “giving way to a more diversified and pluralistic set of accountability relationships” (Bovens, 2005) in which participants are jointly accountable for a certain outcome or activity. Cross-organizational accountability networks, such as the concept of whole-of-government accounts, have become more and more important.

Public accountability as an institutional arrangement means democratic control. It enhances public sector transparency and responsiveness, with the resulting legitimacy helping to bridge the gap between government and people. Accountability functions as a safeguard against corruption and other abuses of power (Bovens, 2005) and increasingly applies to private actors and businesses, as has been seen in the recent economic crisis.

There are different kinds of accountability: legal (the rule of law), political (responsiveness), professional (expertise), managerial (effectiveness) and financial (probity). It is important to consider which form of accountability is operative in any given context and to what extent it is effective and sufficient (Boston & Gill, 2011). Recent initiatives worldwide seek to enhance public accountability by introducing joint or shared accountability. For whole-of-government and whole-of-society approaches, it is critical to see accountability as part of the process of engagement as well as a pathway to better performance (Box 21).

Defining accountability in the context of partnerships nevertheless remains difficult. In particular, it is sometimes hard to ascertain the relative contribution of different actors to a given outcome.

**Box 21. Accountability in relation to shared governance**

First and foremost, accountability is about engaging with, and being responsive to, stakeholders. It means taking into consideration their needs and views in decision-making and providing an explanation of why they were or were not taken on board. In this way, accountability is less a mechanism of control and more a process for learning. Being accountable is about being open with stakeholders, engaging with them in an ongoing dialogue and learning from the interaction. Accountability can generate ownership of decisions and projects and enhance the sustainability of activities. Ultimately it provides a pathway to better performance.

Source: Blagescu et al. (2005).

**8.2. Accountability challenges**

Transparency and accountability are key factors of governance. Many complex problems require whole-of-government and whole-of-society approaches. Increased interdependence among actors has created the need for joint or shared accountability – an approach that is difficult and challenging in many ways.

Establishing joint accountability arrangements can be difficult even if only two actors from different sectors are working together, as there is often a lack of clarity on responsibilities. “Passing the buck” or shifting the blame may contribute to the risk that “shared accountability becomes, in practice, joined irresponsibility, where no one is accountable” (Boston & Gill, 2011). Rewarding good performance and applying sanctions for poor performance are also difficult and may further contribute to the fact that many managers are reluctant to participate in joint working arrangements.

Accountability largely depends on good measurement. New forms of accountability require new forms of measures, standards and rules. A measurement framework that links input (resources, capacity, processes, interventions and policies) with output (short- and long-term health outcomes) holds every actor with a stake in health accountable for his or her actions (Committee on Public Health Strategies to Improve Health, 2011). Such a system would lead to robust performance information, which in turn leads to better performance and, consequently, better health within the population (Boston & Gill, 2011).

Countless factors, however, contribute to the health of a population. Policies across many sectors affect health, and no single organization or entity can be charged with improving only one specific health outcome for which it then can be held accountable. Clear lines from input to output are not identifiable and knowledge about effective interventions is lacking.

### 8.3. Measuring impact

The question of government performance is at the centre of a whole-of-government approach. In this case, this relates to the commitment of the whole of government to improve health.

Experience from various countries shows that the effectiveness of shared accountability largely depends on a country's history of active reform and political will. Cross-sector collaborative efforts are constrained by "path dependence", which is the tendency to continue with an established practice even if better alternatives are available. Health 2020 implementation is built on government learning and the exchange of experience between countries in the Region and beyond. Generally, there is agreement that it is insufficient to measure the health system's efficiency and effectiveness without taking into account the impact of social, environmental and behavioural determinants of health (Committee on Public Health Strategies to Improve Health, 2011). Measuring the effects of various approaches to governance can become an important part of making governance and sharing experience (Pollitt, 2010). Evaluation of policies nevertheless has to contend with several factors.

- **Policies for health designed to work within a certain range of conditions are often confronted with challenges outside their range of influence.** The reliable evaluation of the impact of such policies and of public sector reforms is a challenge because of the many factors and influences (Weibel et al., 2009). It is especially difficult for public service institutions that have to deliver a complex product such as "good health" within short time frames (Pollitt & Dan, 2011). In addition, policy evaluation does not typically represent the perspectives of stakeholders.
- **Policies always have unintended consequences: if they are negative, they may hamper previously envisioned goals.** They can also be positive, however. An evaluation of the effectiveness of health interventions (Jepson et al., 2010) draws attention to the fact that most research does not take a multifaceted approach and neglects to consider how specific policies or interventions in areas such as alcohol use or smoking could be enhanced if their interrelationship was taken into account and complementary action developed. It is important to bear in mind that policies, similar to the circumstances they are supposed to govern, may change during implementation.
- **Taking no action also has consequences.**



A model of accountability that works for areas with already established best practices, such as tobacco control, and for areas with a less-developed evidence base, such as policies to tackle the problem of obesity, is therefore needed (Committee on Public Health Strategies to Improve Health, 2011). A measurement system for accountability among government and private-sector organizations could be based on agreements, contracts and transparent social media tools for communicating with the public on the progress of joint efforts (Committee on Public Health Strategies to Improve Health, 2011). An effective approach to health requires all sectors to be accountable for the health effects of their policies.

## 8.4. Whole-of-government accounting

The objectives of whole-of-government accounts are “to enable Parliament and the public to understand and scrutinise how taxpayers’ money is spent” (HM Treasury, 2011). It is assumed that the information gained will result in better decision-making at all levels of government and help to address issues of intergenerational fairness and fiscal sustainability (Chow et al., 2007). One approach is to produce comprehensive financial reports that treat the public sector as a single entity by eliminating all significant transactions between public-sector entities (HM Treasury, 2011).

The boundaries of what actually constitutes the public sector are not, however, well defined (Chow et al., 2007). Resulting disagreements and turf wars complicate the task of establishing well-functioning whole-of-government accounts. Once these challenges are overcome, the problem that “a consolidated account is only ever as good as the underlying accounts on which it is based” (Chow et al., 2007) remains. More experiences that provide comparable evidence are needed to really identify the effectiveness of such an innovative approach.

## 8.5. NGOs as necessary watchdogs

NGOs have long been perceived as whistleblowers and watchdogs, there to ensure that government fulfils commitments. Public accountability remains important, but companies are now also increasingly facing NGO campaigns over a broad range of issues such as the environment, human rights, consumer protection and health. According to Yaziji (2008), a watchdog campaign has the goal of pressurizing targeted companies to comply with dominant institutional standards, which may or may not be formalized by regulation. In the health arena, this can include an agreement such as the International Code of Marketing of Breast-Milk Substitutes. By using mass and social media channels, NGOs often use a “blame-and-shame strategy” and appeal to a wide audience including not only the public, but also judicial, legislative and regulatory bodies to establish new norms or to punish a company for not complying with already existing norms.

This may be important in the context of health, especially if products are either life-saving or life-threatening, such as pharmaceuticals, health care or tobacco (Yaziji, 2008). Increasingly, however, civil society organizations also hold the food industry accountable for its production chain, processing methods and the health effects of ingredients. A good example is the German NGO Food Watch, which was founded in 2002 to strengthen and protect consumers. It lobbies particularly for mandatory traffic-light labelling and climate-neutral food and against genetic engineering and financial speculation that drive food prices up.



# 9.

## Whole-of-government and whole-of-society approaches: assessment and key lessons

The study *Governance for health in the 21st century* (Kickbusch & Gleicher, 2012) forwarded a strong recommendation for strengthening policy sciences for health and measuring the impact of the political determinants of health. Examples of such research in the field of welfare and poverty studies indicate that the variation in poverty among high-income countries relates to social policy commitments and different welfare state regimes (Brady, 2009). Studies of the equity gap and social determinants of health provide a similar indication. They can help identify and analyse different levels and types of capacity for health governance among the 53 countries in the Region. Each country can improve, and there are opportunities for European cooperation and sharing of experiences based on reliable policy analysis, in the spirit of Health 2020.

There is no one-size-fits-all approach. Whole-of-government and whole-of-society approaches must be adapted to each country's unique circumstances and background. Certain constitutional and cultural traits are necessary to overcome these constraints, or at least mitigate their impact. Implementing whole-of-government approaches may be impossible or ineffective without a common ethos and strong unified sense of values that help to build trust across sectors (Christensen & Laegreid, 2006). A risk-averse bureaucratic culture that overemphasizes the minimization of errors can inhibit horizontal experiments right from the beginning (Halligan et al., 2012). A culture that is supportive of thinking and acting across agency borders can be attained through incentives and rewards that encourage organizational flexibility, adaptability and people's openness to creative and innovative policy-making (Halligan et al., 2012).

Many existing whole-of-government and whole-of-society approaches focus on communication, cooperation and coordination. The final step in whole-of-government approaches, collaboration or even integration, in which risks, responsibilities and rewards for a common goal are shared, seems to be less common and the most difficult to achieve (Halligan et al., 2012). It may also be true that whole-of-government approaches are easier to implement in countries or cities where the number of staff and size of the budget are relatively small and informal negotiations are easier to pursue (Moss, 2010). This is reflected in existing examples.

While many whole-of-government applications have led to a strengthening of central coordination bodies, such as the departments of premier and

cabinet in Australian states, it may be that the cooperation required in whole-of-government approaches works best at lower levels of governance, such as local authorities. This is very important, since several countries, including Norway and United Kingdom (England), have reformed their public health laws and are giving increasing responsibility to local authorities to implement public health priorities. Whole-of-government approaches at this level can significantly enhance transparency, accessibility and responsiveness, as long as institutional arrangements are adaptive to change and create accountability to the citizens they serve. At local level, however, the move from a whole-of-government to a whole-of-society approach through the involvement of many local stakeholders has become a strong feature of “smart governance”. Any approach should consider the whole diversity of human motives blocking and facilitating a move toward healthy lifestyles. For any joint efforts to promote health, the concept of HiAP remains crucial to understanding how other sectors affect health and how health affects other sectors (Dubé et al., 2012).

Whole-of-society approaches may have different starting-points at community level, but they can build on whole-of-government approaches. New challenges arise by incorporating actors from the business sector and civil society: one might be more acceptable than the other, depending on political systems and outlooks. As has been mentioned previously, companies may be reluctant to invest in a public good. Conflicts must nevertheless be addressed and ways must be found to engage the business sector for the purpose of creating common societal value. Local communities are frequently the anchor for many innovative governance approaches.

Once policies are designed and approved, implementation begins. Unfortunately, it is common to observe a gap between what was planned and what actually occurred as a result of a policy (Steinbach, 2009). Policy implementation is complicated, as a whole-of-society approach requires top-down approaches, bottom-up approaches and horizontal governance. Evaluation and accountability measures can be challenging to introduce because the influence of different actors and levels on policy outcomes is difficult to separate and therefore hard to measure. The following attributes are needed to render the interactive process within whole-of-society approaches in relation to health successful (Steinbach, 2009):

- **strong and sustained commitment of all actors at all levels**
- **good communication, adequate time and resources**
- **shared and innovative accountability arrangements**
- **clarity regarding different responsibilities and tasks**
- **a common understanding of the objectives**
- **a valid theory of cause and effect and of managing change.**

More research on, and comparison of, governance for health across countries is clearly needed to create reliable evaluation measures and indicators for best policy practice. This need is echoed in the literature. A key recommendation by leading researchers in the field underlines that “to advance health policy analysis, researchers will need to use existing frameworks and theories of the public policy process more extensively” (Walt et al., 2008). Such policy research can also be part of “a more circular process that includes organisational learning, accountability, trust and partnership development” (Rencoret et al., 2010), as the study on governance for health in the 21st century (Kickbusch & Gleicher, 2012) and this report have outlined.



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The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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