World Health Organization

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Interim report Supporting Health 2020: governance for health in the 21st century

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."
(Margaret Chan, WHO Director-General)

This study is an interim report. It is conceived as a living document to support the implementation of the Health 2020 framework by countries at various levels of governance. It builds on *Governance for health in the 21st century: a study conducted for the WHO Regional Office for Europe* (Kickbusch & Gleicher, 2012) from 2012. It 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 process tools to manage the complex policy process as developed in the policy sciences. These have been selected with a special view to the priority areas that have since been set by the Health 2020 policy framework and with the following criteria in mind: be able to derive general knowledge, find best practice examples with model character, cover a wide variety of different contexts and countries and, as far as possible, only use policies that are implemented and ideally evaluated. The study 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.

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Keywords

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1. A changing approach to governance for health

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

Political leaders increasingly perceive health as being crucial for achieving growth, development, equity and stability throughout the world (Støre, 2012). Health is more and more 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 as well as unhealthy lifestyles and living conditions in many countries in the European Region. A country's health system alone has neither the capacity nor the adequate steering instruments to solve such multidimensional problems in a substantial and comprehensive way (Huynen et al., 2005).

The strategic policy framework Health 2020 puts integrated policy approaches to address priority health challenges in the WHO European Region in the centre of its approach. 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 (WHO Regional Office for Europe, 2012a). Health 2020 supports and encourages health ministries to bring key stakeholders together in a shared effort to promote and protect health. It also recognizes the contribution of such stakeholders – in particular civil society – in taking health agendas forward at the level of the WHO European Region. 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 refers to the processes through which governments and other social organizations interact, relate to citizens and take decisions in a more and more complex and interdependent world. This is done in many different ways in different political systems. There are 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 the field of governance and their application in relation to governance for health. It analysed the trends that have emerged in governance in general and how these trends have been applied in health as governments seek improved 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 that it requires a synergetic set of policies and involving a wide range of actors to deal with (emerging) health problems of populations.

Other 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). A recent publication by the European Observatory on Health Systems and Policies (McQueen et al., 2012) has summarized and described many mechanisms and innovative approaches already implemented by many countries. The Health 2020 policy framework further builds on approaches and experiences that have been part of public health practice in many countries, such

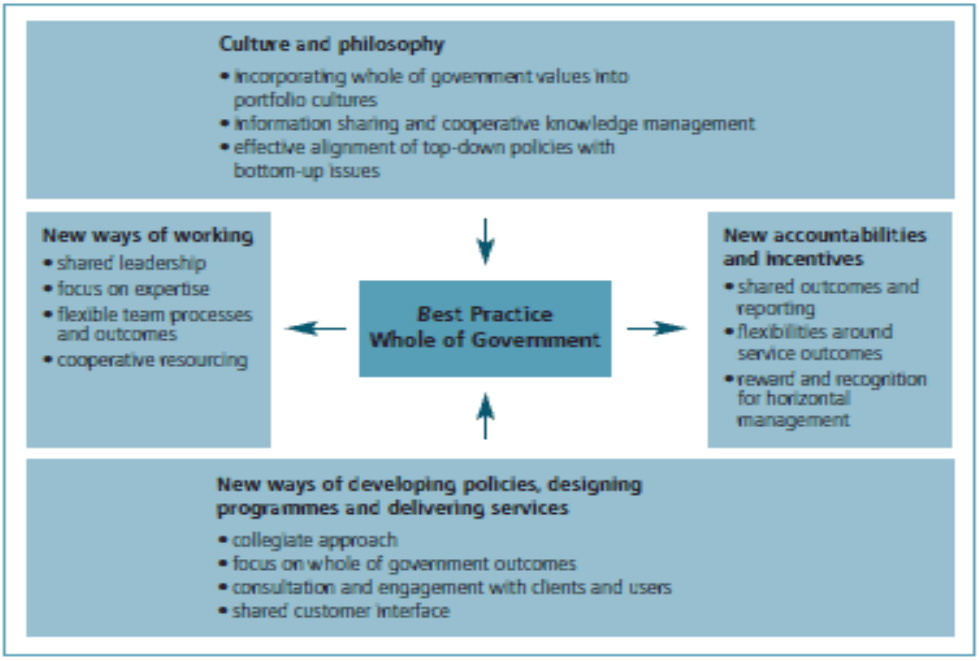
as health in all policies and intersectoral action. A wide range of studies and publications exist that provide policy-makers with examples and analysis in many public health priority areas.

1.3. Focus of this study

The pressure on policy-makers is high to be innovative and responsive to today's quickly changing circumstances. The study on governance for health in the 21st century (Kickbusch & Gleicher, 2012) concluded that major institutional adaptations are needed to cope with the new and interdependent circumstances, in particular the impact of globalization and the balance of power between the state and markets (Willke, 2007). It focused on the need to change the practices of major institutions and to bring together diverse players, coalitions and networks to include community, government and business representatives (Mikkelsen et al., 2002). Such approaches have been summarized by such terms as whole of government and whole of society.

Especially 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 governance levels. This is why many of the examples come from such countries. However, these efforts are quite diverse, and different terms are used ambiguously across countries: joined-up government in the United Kingdom, horizontal government or management in Canada, integrated government in New Zealand, networked government in the United States of America and whole-of-government in Australia (Halligan et al., 2012) and Scotland. Fig. 1 summarizes such approaches.

Fig. 1. Whole-of-government policy implementation



Source: Grant (2004).

In 2006, during the Finnish Presidency, the EU adopted health in all policies to describe an evidence-informed strategy aimed at further integrating health aspects into European policy-making at all levels (Sihto et al., 2006). In recent years, there have been suggestions 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 (Åkerman Börje, 2009): "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."

The terms whole of government and whole of society are now used in an increasing number of policy documents in the international and the national arena – including the Health 2020 framework. The most recent such policy document at the global level is the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in September 2011. It has called for a whole-of-government and a whole-of-society effort to respond to the challenge of noncommunicable diseases 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 General Assembly, 2012).

This study 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 together with a set of process tools to manage the complex policy process as developed in the policy sciences. These have been selected with a special view to the priority areas that have since been set by the Health 2020 policy framework and with the following criterion in mind: being able to derive general knowledge from illustrative examples of policies that are being implemented. The types of governance approaches proposed in Health 2020 are not yet common practice in countries. There are, however, indications that countries are making efforts, as the examples presented at the WHO Conference on Governance for Health in Israel in November 2011 showed. In most cases, the actions taken are very recent and no proper evaluation has been carried out. Nevertheless, they indicate innovation and efforts to address the issues at hand. The study 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 the ability to work together towards common goals for health. This is why several countries have developed health goals and targets that span across government and have been developed in a broad consultative process (usually) under the leadership of the health ministry (Wismar et al., 2008). When policies for health are designed, good governance principles and defining features of modern policy-making should be kept in mind. (Kickbusch & Gleicher, 2012). These should be available as criteria to all stakeholders involved in the process, and all policy drafts should be analysed as to whether these features have been maintained. Accordingly, policies can be compared and measured based on 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).

In the European Region most recently Austria's Ministry of Health has embarked on such a target-setting process, which reflects such modern policy-making 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 Austria. Several organizations from different sectors and all over society were invited to contribute proposals on what they considered important. In addition, citizens had the opportunity to get involved via an online platform. At the end, more than 4300 responses were recorded.

As a result, the Federal Health Commission adopted the 10 overarching health goals for Austria in June 2012, which have since also been adopted by the Government of Austria. The goals are supposed to set the scope for effectively steering Austria's health system and focusing on identified priority action areas within the next 20 years. Until the end of 2012, an expert committee will formulate concrete action plans that address the jointly established goals.

This and further information (in German):
https://www.gesundheit.gv.at/Portal.Node/ghp/public/content/gesundheitsfoerderung-gesundheitsziele-oesterreich.html
http://www.gesundheitsziele-oesterreich.at/information

Such modern policy-making finds its expression in both whole-of-government and whole-of-society approaches and includes the challenge of bringing them together to create synergy. Frequently, such processes overlap; they can – if managed well – be mutually supportive within democratic political systems. This interface of government and society is symptomatic for the development of European welfare states towards welfare societies with much broader realms of participation and responsibilities for both the state and societal actors (Kaufmann, 2000).

The complexity of such health policy processes can stretch over long periods of time – for example, the process of Sweden's health policy Health on Equal Terms took nearly 10 years,

especially because it involved many stakeholders, including parliamentarians from different political parties. Usually many interests and participants are involved and the environment changes throughout the process. This makes it difficult to provide policy-makers and change agents with definite "how to" orientations.

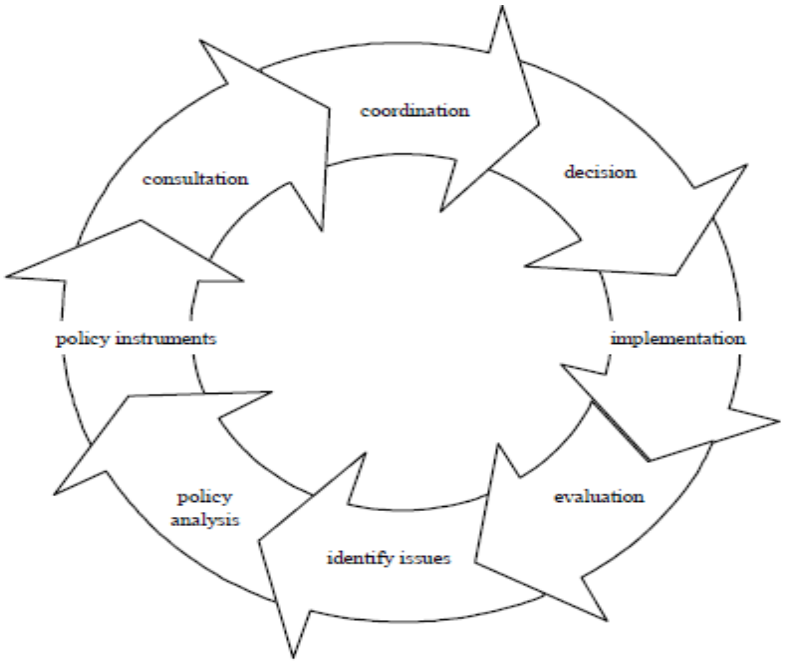
All policies are context influenced and are embedded in national, economic, political, cultural and social structures and contexts. There is great diversity in how policies are developed, adopted and implemented in different political systems – even welfare states in the European Region differ significantly in how the relationships between the market and the state and between the state and civil society are managed. Indeed, throughout the European Region, this "manifests itself in a different degree of trust in the state's ability to solve problems" (Kaufmann, 2000). For example, 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 possibility for involving civil society.

Nevertheless, the fact that policies are extremely dependent on and specific to actors, context, sector, site, and issue (Parag, 2006) does not mean that it is not possible – based on the results of policy research during recent decades – to identify certain 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. Although these might not be new to some countries and actors that have long been involved in such policy processes, they can be helpful for others that 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 to what they have been doing intuitively.

2.2. Structuring the messy reality

The process of policy-making is often described through the tool of the classic policy cycle. Although policy-making "can help public servants develop and guide a policy through institutions of government" (Bridgman & Davis, 2003), it rarely comes to fruition in such an organized manner, as anyone involved in developing policy knows well. Yet this model policy cycle (Fig. 2) can be a useful, pragmatic and structured starting-point if it is combined with context analysis, consideration of values and framing of issues as well as network analysis and systems dimensions. Conducting context analysis is essential: it will aim to cover political, economic and social context. This can be done by scanning the entire internal and external environment. A popular type of context analysis is called SWOT analysis – it allows an analysis of the (internal) strengths and weaknesses and the (external) opportunities and threats posed by the context.

Fig. 2. The policy cycle



Source: Bridgman & Davis (2003).

In particular, the many experiences with setting health targets have shown that it is critical to spend considerable time in deciding how the issues are to be presented (for example: what kind of targets?) 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 in particular to portray the essence of policy-making, which is described as "the struggle over ideas" (Stone, 2002). This is essential to keep in mind when considering setting priorities for the social determinants of health and such issues as equity and participation. All issues on the political agenda relate to political ideology – in particular regarding the responsibility of the state, the market or the individual and the family. 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.

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 policymaking 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)

Further information on how to consider values:
http://www.frameworksinstitute.org/assets/files/PDF/FramingPublicIssuesfinal.pdf

Box 3. Framing issues

The first stage of the policy cycle model, "identify issues", seems simple – but it does not indicate that it is absolutely central 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 continuum and the partners that come on board. Framing the obesity challenge in health terms (such as childhood obesity), in terms of equity, as ensuring health and well-being of children or as endangering future productivity can make a significant difference.

The frame question stays relevant at each step of the process: "What 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).

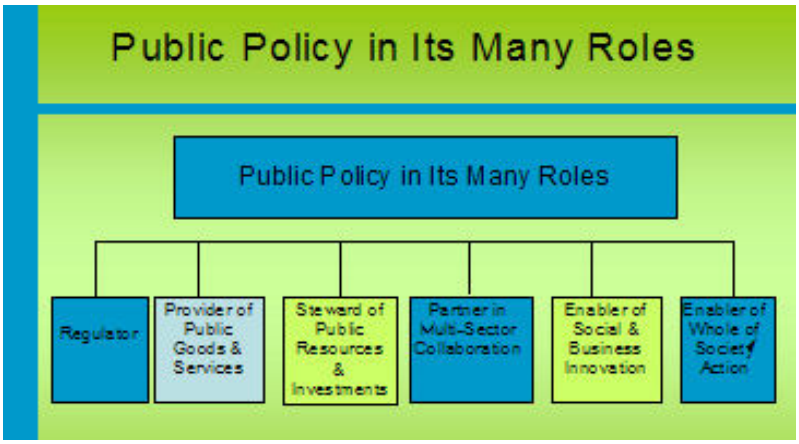
This and further information:
http://www.frameworksinstitute.org/assets/files/PDF/FramingPublicIssuesfinal.pdf

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. It is therefore essential that policy-makers 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, this means negotiating out to build coalitions with diverse actors (Fairman et al., 2012). It means understanding where partners are coming from, understanding their value systems and planning approaches and considering the potential of win-win situations. A range of formal and informal mechanisms must be considered and put in place to enable the stakeholders to find common ground and to incentivize them. In addition, "negotiating up" can imply convincing high-level decision-makers to take up the issues at stake or to take them to regional and global institutions for resolution. In the case of taking the noncommunicable disease agenda to the United Nations, all three forms of negotiation were critical.

Within a whole-of-society approach, the government (often represented by a leading agency) takes on diverse roles. It defines boundaries and rules for consumers, businesses and other stakeholders involved. In addition, the government oversees all public resources and provides the relevant public goods and services. Last but not least and increasingly important, it partners in collaborative missions with other jurisdictions, businesses and civil society organizations to increase the problem-solving efficiency and to ensure effectiveness and sustainability (Fig. 3).

Fig. 3. Public policy in its many roles



Source: Dubé et al. (2009).

Health in all policies 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 and apply at all levels of governance. Health in all policies is one approach that requires significant negotiation to make governance for health and well-being a priority for more than the health sector. Detailed analysis exists of 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 such approach to enable the 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.

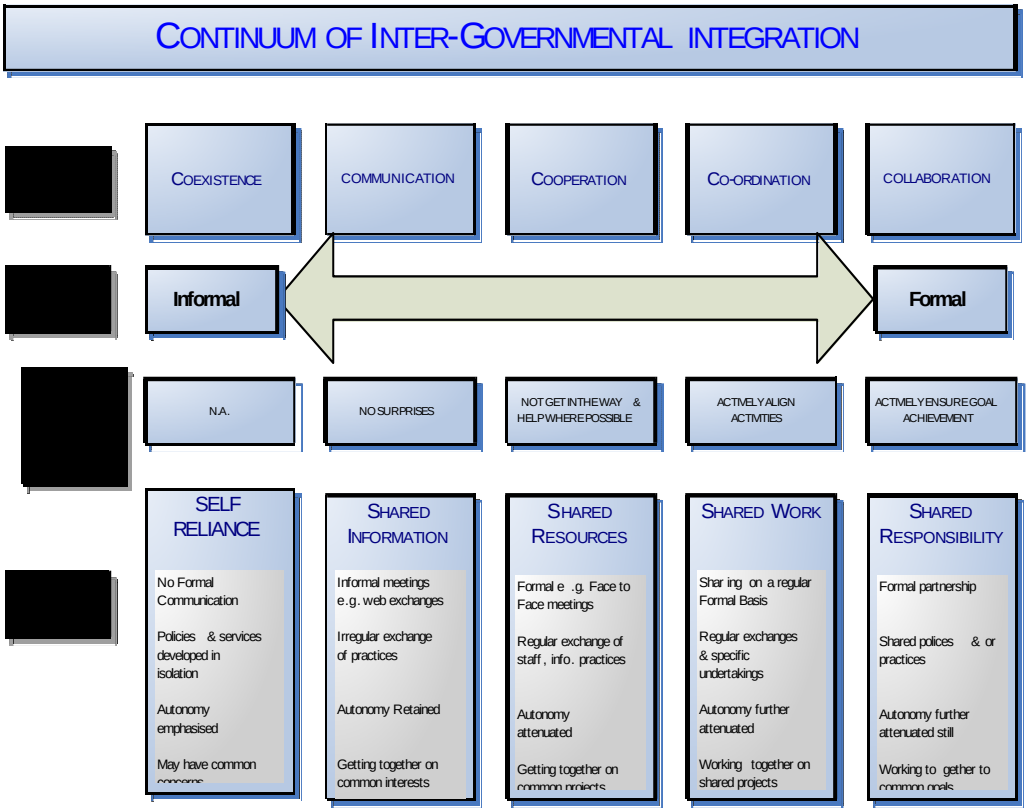
(WHO Regional Office for Europe, 2012a)

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, whole-of-government has come to mean a commitment to health at all levels of government, including the level of heads of government. One very useful model describes the continuum of intergovernmental integration in the process of policy-making. Joint working across sectors is at

the very core of whole-of-government approaches and can be quite different in depth, with different implications for accountability and relationship characteristics.

The continuum of intergovernmental integration illustrated in Fig. 4 describes the relationship between sectors ranging from coexistence to collaboration, from informal to formal. It shows where accountability relationships exist and provides a set of relationship characteristics for each of the relationships indicated. It can be used when planning the nature of a relationship – such as for getting 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".

Fig. 4. Continuum of intergovernmental integration



Source: Boston & Gill (2011).

Regardless of the institutional setting for joint working, there are always two possibilities for accountability: sole or shared. The first one should be applied whenever tasks are clearly separable and the interdependence is low. The latter, however, should always be preferred, whenever tasks are difficult to separate and the 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 – they have different levels of complexity to manage, with different implications for accountability and sharing of resources. For most problems that require joint action, shared accountability is needed and central agencies should play a key role in leadership and in establishing feasible accountability arrangements for joint working (Box 4). This is one of the most difficult issues to manage, and this document focuses more on this later.

Box 4. Policy on alcohol, narcotics, doping and tobacco in Sweden

The overall objective of Sweden's policy on alcohol, narcotics, doping and tobacco is 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 that is restrictive and based on public health.
In March 2011, the Riksdag passed a coherent strategy for alcohol, narcotics, doping and tobacco policy aimed, among other things, at facilitating central government governance of support in this area. The strategy states the goals and direction of how society's measures are to be implemented, coordinated and followed up in 2011–2015. The measures are described in the government's annual action plan for policy on alcohol, narcotics, doping and tobacco.
Apart from the overall objective, policy on alcohol, narcotics, doping and tobacco has seven long-term objectives, which can in turn be broken down into several 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 alcohol, narcotics, doping and tobacco that is restrictive and based on public health.
8.

Sweden is dependent on, and increasingly affected by, the rest of the world. It is crucial that policy issues related to alcohol, narcotics, doping and tobacco be actively pursued within the EU and internationally. Sweden is also working to ensure that the strategies and conventions that it supports or has signed up to influence national policy.
Several agencies responsible for implementing policy on alcohol, narcotics, doping and tobacco
Work to implement policy on alcohol, narcotics, doping and tobacco in Sweden is intersectoral and involves several agencies' areas of responsibility: the Swedish Consumer Agency (Konsumentverket, KO), the Swedish Prison and Probation Service (Kriminialvården), the Swedish Coast Guard (Kustbevakningen), the National Police Board (Rikspolisstyrelsen, RPS), the National Board of Health and Welfare (Socialstyrelsen), the Swedish National Institute of Public Health (Statens folkhälsoinstitut, FHI), the National Agency for Education (Skolverket), the National Board of Institutional Care (Statens institutionsstyrelse, SiS), the Swedish Transport Administration (Trafikverket), the Swedish Transport Agency (Transportstyrelsen), Swedish Customs (Tullverket), the Swedish National Board for Youth Affairs (Ungdomsstyrelsen) and the Swedish Prosecution Authority (Åklagarmyndigheten).

The ANDT Secretariat coordinates policy
The ANDT Secretariat – the Government's coordination function for alcohol, narcotics, doping and tobacco policy – is located at the Ministry of Health and Social Affairs. The Secretariat is to

strengthen the development and coordination of work within the government offices, which is to result in clearer, more coordinated and effective agency management.
The task of the Secretariat is to promote the dissemination and implementation of the coherent ANDT strategy. The ANDT Secretariat is also responsible for compiling the government's annual action plan for policy on alcohol, narcotics, doping and tobacco.

ANDT Council
The Secretariat also acts as a secretariat to the ANDT Council. The Council advises the government on alcohol, narcotics, doping and tobacco issues. The Council informs the government of research and inquiry results that are relevant for policy design in these areas. 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, Ragnwi Marcelind.

Relevant rules and documents
http://www.sweden.gov.se/sb/d/15661/a/183499

Generally, people developing the institutional design for joint working and associated shared accountability arrangements 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 of depth are needed for different problems or that the move towards a deep relationship will require a significant period of time, commitment of resources or specific windows of opportunity.
- Coordination: how many organizations and goals exist? One should not aim for more shared work than can be managed by the resources at hand.
- Complexity: to what extent are the required actions known in advance? Do all partners share the same understanding of the complexities (such as in relation to the social determinants of health)?
- Responsibility: can the performance of each actor involved be adequately specified and measured separately? This is frequently required and can present major difficulties.

Deep intergovernmental relationships, such as the integration achieved by the Swiss Health Foreign Policy (Box 5) – reflect the move from self-reliance to applying the whole spectrum of characteristics across the continuum: shared information, shared resources, shared work and shared responsibility. Initially, it was not possible to increase resources or engage in joined budgeting, but today – after a period of five years – the Swiss Health Foreign Policy actively works together for common goals, aligns activities and has joined accountability to the whole of the Government of Switzerland (the Federal Council). It makes use of both formal and informal mechanisms.

Box 5. The Swiss Health Foreign Policy

The process of globalization and the internationalization of the public health sector generate a great demand for coordination between health, foreign and development policies. To ensure Switzerland's capability to be a convincing partner with a coherent position and to represent its interests in the best way possible, the Health Foreign Policy was approved in 2012 to serve as an instrument for this coordination. On 9 March 2012, the Federal Council approved the new Swiss Health Foreign Policy, which serves as an instrument to set and execute common objectives of the federal authorities concerned with health foreign policy. It replaces the Agreement on Health Foreign Policy Objectives concluded by the Federal Office of Foreign Affairs and the Federal Office of Home Affairs in 2006, with which Switzerland had performed pioneering international work. The Swiss Health Foreign Policy was developed under the leadership of the Federal Department of Foreign Affairs and Federal Department of Home Affairs in cooperation with all other departments. In the consultation procedure, actors from outside the federal authorities (cantons, research sector, civil society, industry and health system actors) were also considered. The Swiss Health Foreign Policy is based on overarching principles and values, and it defines 20 objectives pertaining to three major areas of interest – governance, interactions with other policy areas and health issues – as well as the 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).

This and further information:
http://www.bag.admin.ch/themen/internationales/13102/index.html?lang=en

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 refers to an approach with the aim of extending the whole-of-government approach by additional emphasis on involving the private sector and civil society as well as political decision-makers such as parliamentarians. It implies new forms of communication and

collaboration in complex, networked settings and highlights the role of the mass media and social movements. Each party must invest resources and competence into a common strategy, and 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 (Box 6) (Kickbusch & Gleicher, 2012). Generally, a whole-of-society approach may or may not start with a whole-of-government approach – often (see above) it includes the role of the government as a leader or a broker. This can also be led by a strong nongovernmental organization or an alliance of organizations – such as the NCD Alliance or the civil society coalition to fight for the WHO Framework Convention on Tobacco Control or for access to HIV medicines.

Box 6. 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 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. The Decade focuses on the priority areas of education, employment, health and housing and commits governments to take into account the other core issues of poverty, discrimination and gender mainstreaming.

Twelve countries are taking part in the decade: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Hungary, Montenegro, Romania, Serbia, Slovakia, Spain and the former Yugoslav Republic of Macedonia. All these countries have significant Roma minorities, and the Roma minority has been rather disadvantaged, both economically and socially. Slovenia and the United States of America have observer status.

Each of the countries has developed a national Decade action plan that specifies the goals and indicators in the priority areas. The international partner organizations of the Decade include the World Bank, the Open Society Foundations, the United Nations Development Programme, the Council of Europe, Council of Europe Development Bank, the Contact Point for Roma and Sinti Issues of the Office for Democratic Institutions and Human Rights of the Organization for Security and Cooperation in Europe, the European Roma Information Office, the European Roma and Traveller Forum, the European Roma Rights Centre, UN-HABITAT, the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Children's Fund (UNICEF). In 2011, WHO also became a partner in the Decade. The Decade of Roma Inclusion is not another new institution, bureaucracy or fund. Participating governments must reallocate resources to achieve results, also aligning their plans with funding instruments of multinational, international and bilateral donors.

http://www.romadecade.org/about

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

1. Identify several initial domains for action as lever points for change. These may include enhancing the production chain traceability, increasing the supply and demand of fruit and vegetables, improving the 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 related to advertising (towards children).1 Tools to help with identifying such levers for change are available (Box 7).

Box 7. Tactical Mapping

Tactical mapping is a tool developed for civil society organizations. It is "a method of visualizing the relationships and institutions that surround, receive benefit from, and sustain human-rights abuses" (Johnson & Pearson, 2009) – but 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), "Diagramming 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."

This and further information:
http://www.newtactics.org/sites/newtactics.org/files/Tactical%20Map%20NPQ%20article.pdf

At the same time, it is critical to be prepared for unexpected opportunities to 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 this is a crisis: for example, the severe acute respiratory syndrome (SARS) outbreak enabled the revised International Health Regulations in 2005 to be adopted. In the political science literature, this is referred to as a window of opportunity – a concept developed by Kingdon (1984). It is particularly important for civil society actors to recognize such windows and make full use of them (Box 8).

Box 8. Windows of opportunity
Kingdon (1984) first proposed that there are three streams of processes occurring simultaneously and independently (Guthrie et al., 2005):

- recognition and defining problems;
- creating policy proposals; and
- 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. The 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.

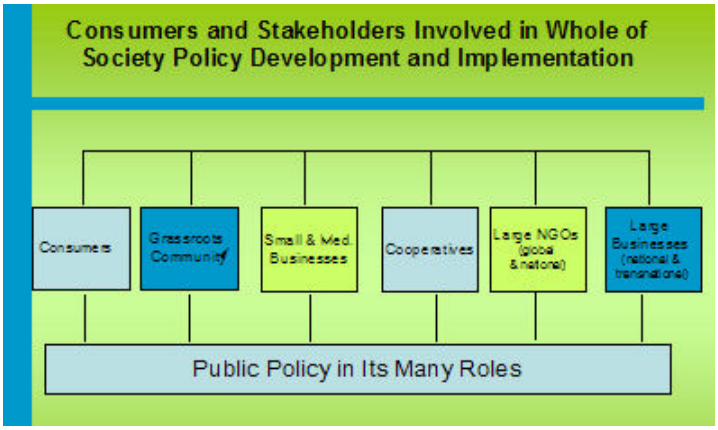
[1] The whole spectrum of concrete policy tools and instruments available when tackling nutrition-related noncommunicable diseases is presented in more detail in section 6.2.

Thus, the policy process is at its core an irrational and nonlinear process, where advocates' work is often building their own capacity to move quickly when a policy window opens. For many people, this lack of linearity is an unsettling feature of democratic societies.

This and further information:
http://www.calendow.org/uploadedFiles/Publications/Evaluation/challenge_assessing_policy_advocacy.pdf

2. Assemble around each lever point a strategic network of key stakeholders from the government, business sector and civil society. This is critical for whole-of-government and whole-of-society approaches, since it can help gauge the extent to which networks of state and non-state actors shape policies and how these networks are defined by their contexts and their network characteristics. All assembled organizations must be willing to invest time, expertise, core competencies and financial resources to achieve the goal set by this respective network (Fig. 5).

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



Source: Dubé et al. (2009).

Several tools exist to conduct a network analysis that then helps to efficiently bringing key stakeholders together (Box 9). The tool helps answer questions such as: "Do gaps, vulnerabilities, and inefficiencies exist among partnerships?" or "What models or frameworks for collaboration work best?"

Box 9. 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 and the levels of trust and to link outcomes to the process of collaboration. The tool includes an online survey that you can administer to collect data and an analysis program that analyses these data. By using the tool, you will be able to demonstrate to stakeholders, partners, evaluators and funders how your collaborative activity has changed over time and progress made in regard to how community members and organizations participate.
This and further information:
http://www.partnertool.net

Once the network analysis is completed, it is 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 and how they affect not only the policy but relate to each other (for example, by forming alliances) and influence different stages of the process; and how each stage's outcomes affect other stages and the actors concerned (Parag, 2006).

In this context, innovative and inclusive business models could be used to trigger change on the ground: 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 10). Social business, as the term is commonly used, was first defined by Nobel Peace Prize laureate Muhammad Yunus as "a non-loss, non-dividend company designed to providing a product and/or service with a specific social, ethical or environmental goal". A prominent example is Grameen Danone Foods, which produces a yoghurt enriched with crucial nutrients at an affordable price for the poorest – but also ensures benefits along the whole value chain (http://www.grameencreativelab.com/live-examples/grameen-danone-foods-ltd.html).

Box 10. Corporate social responsibility

Whole-of-society compacts include the principles of corporate social responsibility and what has been termed inclusive capitalism. Due to changing patterns of consumer awareness and consumption, many companies begin to see corporate social responsibility as a strategic investment (Fortunato, 2011). In the food sector, corporate social responsibility initiatives have become a core part of business activities, and this development has been described as a "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 rather choose to satisfy private shareholders' interests instead of investing in the public good. In such a case, a government can attempt to provide incentives to change company behaviour. Experience shows that self-regulation is rarely sufficient to achieve health goals that are within the public interest. Regulation is required. To be effective and legitimized, regulation must be transparent, accountable, proportionate, consistent, and targeted (Karnani, 2011).[2] In public health, the issue of proportionality is highly challenging because it is value based and focused around perceptions of public health ethics and has become the subject of highly ideologized debates. The response to the obesity epidemic shows this clearly – the present battle over regulating the size of sugary soft drinks in New York City is a model example (Moskin, 2012).

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. For example, a whole-of-society approach is needed for obesogenic environments in which governments are regulators, catalysts or partners within a broad collaborative framework of all

[2] For further information on regulative measures, please see section 7.1 on various policy tools.

relevant actors. Such an approach is consistent with the WHO Global Strategy on Diet, Physical Activity and Health (WHO, 2004): "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". One such combined effort at the regional level is the EU Platform for Action on Diet, Physical Activity and Health (2005) described later in this study.

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 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 towards the early years as well as ageing can be related to different types of welfare state regimes. In relation to Europe, Esping-Andersen's (2006) categorization of liberal (such as the United Kingdom), conservative (such as Germany) and social democratic (such as Sweden) welfare states can be applied to describe differences in size and scope of national policies. Social expenditure alone, however, cannot grasp these differences. Rather, it is 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 respective welfare state by the social rights granted and the active role of state in the ordering of 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 the right of every citizen to good health, well-being and education and thus address the social determinants of health and the levels of health inequalities. Based on this, social policy in general and early childhood development and ageing policies in particular are an outcome of a country's overall welfare performance, labour-market opportunities and family characteristics (Petrogiannis & Dragonas, forthcoming). Also highly relevant are reproductive health and maternal health policies that have been instrumental from a social viewpoint on achieving higher levels of equality for women in education and labour market participation, supported by flexible working arrangements and welfare support from mothers and fathers.

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

focus is put on keeping people independent and out of institutional care. The review highlights 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 (2010) 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 the early years

The issue

Based on the evidence available, events and experiences in the first months and years of a person's life can set a basis for lifelong well-being or may be the reason for future physical and mental health challenges (Jenkins, 2005). Moreover, as the Commission on Social Determinants of Health pointed out, 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 made clear that, in the past, non-integrated services had difficulty in effectively responding to the complex needs of today's families with young children.

Solutions and approaches

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

In a similar approach, South Australia has developed more than 20 one-stop shop integrated children's centres for early childhood development and parenting for children from zero to eight years of age. 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. The funding of these centres comes mainly from central government and is weighted depending on the poverty levels in local areas (Eisenstadt & Melhuish, forthcoming). Services that target preschool children have been integrated across government agencies, and policies on early education and care have been 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, forthcoming).

Shared governance

By recognizing the inseparability of the education and care of young children, various sectors and professions are closely working 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 also strongly emphasized involving local parents in designing and delivering programmes to ensure that local needs and circumstances are sufficiently taken into account. As a result, an evaluation conducted in 2011 reveals high satisfaction among parents and successes in fighting social exclusion as well as the intergenerational transmission of poverty (National Evaluation of Sure Start (NESS) Team Institute for the Study of Children, Families and Social Issues, 2011).

Fig. 6 provides a helpful model – irrespective of government systems – for how one can move from coexistence to integration in relation to supporting early child development, acknowledging that partnerships need time to develop, integrating service delivery is progressively developed 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) under section 3.1 can also be applied to a community environment in which early years' services are integrated.

Fig. 6. Integration stages

Program 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 same governing body & some common members on school governing body. Representatives influence direction, services to be delivered in the Children's Centre and decisions about service delivery in their own agency.	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 DECS governing bodies to these groups.
Health elements Families & Communities elements Other organisations' elements	Separate governing bodies for each program	Representation on Enabling Group	Representatives influence direction and 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. Represented on child care/ preschool/ school governing body
Service planning & 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/ school governing body
Policies and practices	Separate policies Informal individual partnerships	Share policies Service Agreements, protocols and MOUs 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 groups. Parent Advisory Group represented on child care/ preschool/ school governing body and Partnership Group/ Regional Advisory and Planning Group.

Challenges

At the national level, negotiating the differing interests of departments has been a barrier to success and continues to be challenging. Similar challenges that arose in both the United Kingdom and South Australia when launching the initiatives in the communities were the "varying cultural norms, value systems, and approaches to practice based on different professional training" (Press et al., 2010). In addition and more practically, increased workload, inequitable working conditions, insufficient funding and a lack of leadership at the macro level have been reported (Press et al., 2010). In the United Kingdom, a failure has been identified to correctly anticipate the complexities of setting up a local programme and provide the adequate skill mix and levels needed to run the programme (National Evaluation of Sure Start (NESS) Team Institute for the Study of Children, Families and Social Issues, 2011). Fully benefiting from a life-cycle approach requires accumulating health benefits over different and salient life cycles. This is something that is not yet common practice: what usually happens is that there are services for infants, fewer and unsystematic for adolescents etc., all rather unsystematic. This lack of strategic vision and poor governance allows inequities to persist and grow.

Lessons learned

- Political will (as well as time and money) is needed to invest in evaluation and to design and implement evidence-informed policies (National Evaluation of Sure Start (NESS) 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 child services. Moreover, what seems to be working well at the local level is a dynamic and adaptive process that constantly enhances the working together of multidisciplinary teams with the aim of significantly improving service delivery. Especially at the beginning, strong leadership at different levels can be 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 will be appropriate in every community. Clear functions and roles as well as a commitment to promoting a common ethos and culture with shared values and responsibilities may help to overcome shortcomings.
- Within the process of increased integration the joint development of innovative assessment tools for long-term systematic evaluation should be promoted; learning from experience is considered to be crucial.

Further information:
http://www.direct.gov.uk/en/Parents/Preschooldevelopmentandlearning/NurseriesPlaygroupsReceptionClasses/DG_173054
http://www.childrenscentres.sa.gov.au/pages/CC/

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

The issue

Europe is ageing. In response, the European Union has designated 2012 the European Year of Active Ageing and Solidarity between Generations with the aim of raising awareness and making local and national policy-makers, social partners and civil society fully aware of the magnitude of the demographic challenge and act throughout governments and throughout society with regard to active ageing, pensions, restructuring and employment. For example, in 2012, the European Commission (2012) has published a white paper on adequate, safe and sustainable pensions that looks at how the EU and the Member States can work to tackle the major challenges that confront pension systems. It puts forward a range of initiatives to help create the right conditions so that those who are able to can continue working – leading to a better balance between time in work and time in retirement; to ensure people who move to another country can keep their pension rights; to help people save more; and to ensure that pension promises are kept and people get what they expect in retirement (European Commission, 2012).

Solutions and approaches

Whole-of-government and whole-of-society approaches to healthy and active ageing aim at enabling older people to remain employed and financially independent. Goals include: ageing-in-place barrier-free environments and easy access to a public transport system. Further, the health care system 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 where older people can find all the needed services at one place.

These approaches are particularly critical at the local level, and 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 11). For the purpose of understanding the characteristics of an age-friendly city, WHO (2007) has asked older people in 33 cities in all WHO regions to describe the advantages and barriers they experience in eight areas of city living. The results led to the development of a set of age-friendly city checklists (WHO, 2007).

Shared governance

Box 11. Finland's Active Ageing Initiative

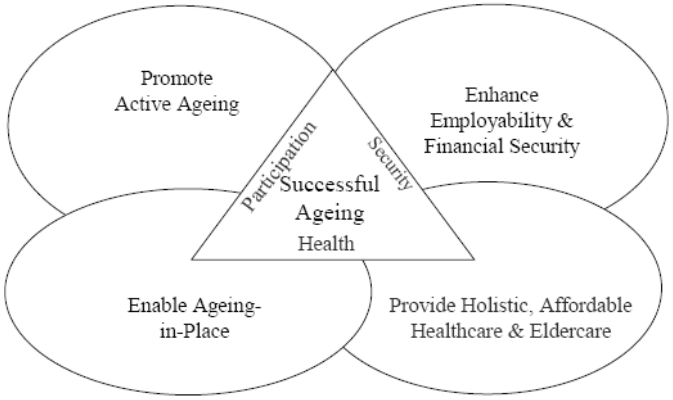
In summer 2012, Finland embarked on an intersectoral action programme that will be focused on ageing sustainably. The lead lies with the Minister of Social Affairs and Health (Government of Finland, 2012): "The action programme should address e.g. attitudes, accessible environment, housing, movement 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."

In September, a high-level working group will be asked to draw up a concrete and innovative action programme to build an age-friendly Finland. Already in 2006 Active Ageing was one of the main themes in the cross-sectional Employment Programme of the Finnish Government – an approach that was highly recommended to other countries.

This and further information:
http://government.fi/ajankohtaista/tiedotteet/tiedote/en.jsp?oid=362931

Integrated approaches are being sought in other high-income countries. For example, Singapore 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 aiming at increasing the participation, health and security of older people (Fig. 7). The key pillars illustrated in Fig. 7 can be applied to other population groups such as adolescents, children and working-age people.

Fig. 7. Key pillars and strategic thrusts of the Ministerial Committee on Ageing in Singapore



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

Challenges

Financial security must remain a priority, and inclusiveness largely depends on how affordable the respective services (such as active ageing opportunities) are. Community participation should be promoted and social spaces created that also provide incentives for intergenerational activities.

Further information:
http://www.bca.gov.sg/BarrierFree/others/AccessibilityCode2007.pdf
http://www.hdb.gov.sg/fi10/fi10328p.nsf/w/UpgradeWhatsLUP?OpenDocument
http://www.edb.gov.sg/edb/sg/en_uk/index/industry_sectors/healthcare/health___wellness.html

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

5.1. Noncommunicable diseases

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.

(World Health Organization 2012a)

5.1.1. How to: governing noncommunicable diseases through whole-of-society approaches

The WHO Framework Convention for Tobacco Control has very well shown the importance of political will and intersectoral collaboration, particularly given the conflicts with the tobacco industry and with other actors in society such as owners of restaurants and bars. This was again experienced recently with the plain-packaging initiative by the Government of Australia, which has now been upheld by the highest Australian court – with significant international implications (BBC, 2012a). This indicates that, even where legislative frameworks are in place, they are continually challenged by special interests and require a strong organizational mechanism for health to be able to beat other agendas and civil society voices to be heard.

The issue

The United Nations General Assembly held a High Level Meeting on the Prevention and Control of Noncommunicable Diseases in September 2011 and adopted a Political Declaration. It was only the second time in history that the General Assembly addressed a health issue on a global scale (after HIV/AIDS in 2001). The Declaration argues that a whole-of-society effort to reduce risk factors for noncommunicable diseases is needed and calls 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).

Solutions and approaches

However, in the European Region there are several collaboration efforts on the regional and national level and their successes and challenges could provide valuable information for constructing a global noncommunicable disease platform with the leadership of the European Commission. The EU Platform for Action on Diet, Physical Activity and Health (2005) was founded in 2005, and the overall aim is to contain or reverse the trend of increasing overweight and obesity rates in the EU. The Platform operates under the leadership of the European Commission, whose role is to guide a cooperative and action-oriented approach.

Shared governance

The Platform is an innovative multistakeholder forum in which members 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). The Platform brings together actors with often antagonistic views such as the food industry and consumer protection nongovernmental organizations and, by doing so, aims at enhancing dialogue between them. In total, the Platform has 33 members from 9 sectors. To keep a manageable size, Platform members are European-level umbrella organizations. For example, 73 member organizations fall under one umbrella group for the food and drink sector (Fig. 8).

Table 2. 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 & Drink	1	0	1
Health	0	9	9
Research	0	3	3
Retail & catering	6	0	6
Sports & Fitness	2	4	6
Total	**15**	**18**	**33**

Source: European Commission (2010).

What makes the Platform special 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 for advertising, often focused on curbing the advertising of high-fat, sugary or salty foods (especially towards 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 including promoting research into obesity prevention and management as well as commitments focusing on monitoring, training and policy work.

So far, members have made a total of 292 commitments (action plans that explain what will be achieved and by what means), more than half of them focused on lifestyles. Many of these commitments, however, were not new actions, but scaled-up or reframed activities (European Commission, 2010).

A monitoring system is in place that is supposed 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).

Challenges

It is too early to assess the health effects of the Platform's commitments. However, some major problems and challenges have been identified. Although the monitoring system has forced members to be accountable for their actions, it is not succeeding in effectively determining how the commitments are reducing obesity. Further, 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. In addition, evaluations must

identify best practice examples that can serve as guidance for future commitments (European Commission, 2010).

Moreover, although mutual understanding has increased between sectors, there is a lack of initiatives that involve members from different sectors. This is mostly the result of an obvious clash in interests between the for-profit and not-for-profit organizations regarding a more concrete vision, goals and priorities. In a survey conducted by the European Commission, 70% of industry respondents had a positive opinion of the Platform's rather general objectives, whereas 80% of the civil society members argued in favour of a renewed mandate (European Commission, 2010).

Lessons learned

As a result and in order "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. In this context, it will be crucial to balance and take into account the interest and needs of both sides, and stronger commitments by the business sector should be rewarded through better and more transparent communication of these activities (European Commission, 2010).

Other examples

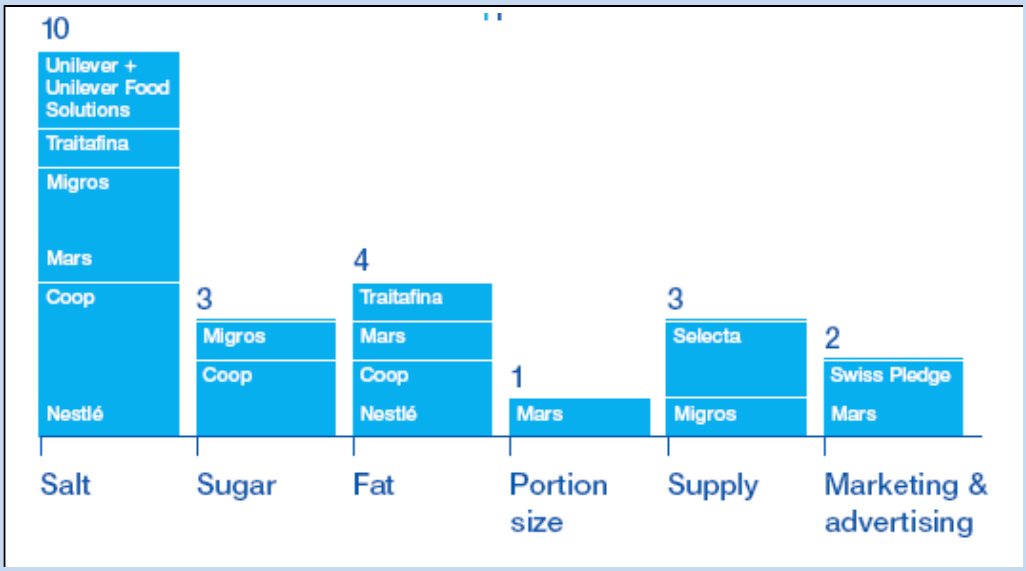
The EU platform inspired the creation of several national platforms in the EU and beyond but has had limited impact on these platforms (European Commission, 2010). Consequently, permanent institutional links should be established, and the work of the platform should be made more visible to EU citizens at the national and local level. The EU Platform might positively influence the work of its national counterparts (Box 12):

- Germany – Plattform Ernährung und Bewegung
- Hungary – Hungarian Diet, Physical Activity and Health Platform
- Italy – Piattaforma nazionale su alimentazione, attività fisica e tabacismo
- Netherlands – Rotterdam Covenant on Nutrition and Physical Activity
- Poland – Polska Rada ds. Diety, Aktywności Fizycznej I Zdrowi
- Portugal – Plataforma contra obesidade.

Box 12. Action Santé

In Switzerland, Action Santé (2011) is a networking platform through which private organizations make voluntary commitments. As an incentive, mass media are used to make the population aware of the companies' efforts in, for example, reducing salt, saturated fat and sugar within their products. The following companies are involved so far (Fig. 8).

Fig. 8. Companies involved in Action Santé



This and further information:
http://www.bag.admin.ch/themen/ernaehrung_bewegung/05245/index.html?lang=de

In some countries, the platform approach was used to develop a national policy. For example, in Scotland, the Food and Drink Leadership Forum has been successful in bringing together more than 400 organizations from the public and business sector as well as civil society "including food outlets, retailers, NHS, Scotland Food and Drink, Enterprise Agencies, local authorities and communities" (Scottish Government, 2009). As a consequence and within an interest-balancing process, the platform provided the foundations for Scotland's first National Food and Drink Policy, which addresses quality, health and well-being, as well as environmental sustainability, while recognizing the need for access and affordability (Scottish Government, 2009).

In South Australia, a collaborative governance approach was used to develop the Eat Well Be Active Strategy 2011–2016, which aims at changing behaviour and supporting people to lead healthier lives (Government of South Australia, 2011). It is one of the most comprehensive such strategies. Similar to the steps described under section 2.3, lever points for change – five key action areas – have been identified. Subsequently, a strategic network of key stakeholders has been assembled around each lever point. Finally, complementary actions that build on existing good-practice programmes and implement new policies were and will be undertaken 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 health in all policies strategy will be applied and effective communication means developed to reach the public and all relevant

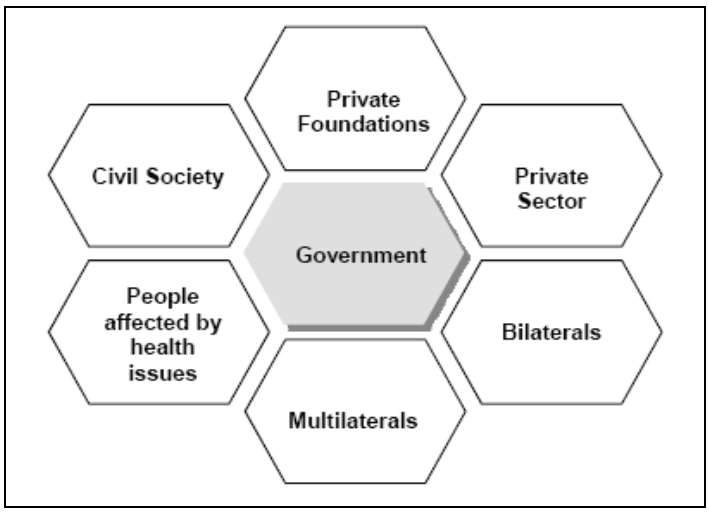
stakeholders, which will meet annually to share information and assist each other's efforts. The government will provide leadership, incentivizing changes in organizational, individual and household behaviour through (further) policies, legislation and taxation (as has been the case in tackling other public health problems such as smoking).

Constant monitoring and evaluation aims at ensuring that the best mix of actions (policies, programmes and infrastructure deployment) is achieved. Effectiveness and efficiency need to be taken into account, and initiatives are supposed to be based on the latest research results as well as on results of 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. Similar to noncommunicable diseases, this may also not be enough when dealing with many communicable diseases. In global health, new actors have evolved, claiming a space in decision-making on health issues and thereby changing governance mechanisms (Low-Beer, 2012). This has also received its institutional form through the constituency approach applied by organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Fig. 9).

Fig. 9. Constituency model of governance



Source: Daniel Low-Beer, personal communication, 2012.

In practice, the boundaries of whole-of-government and whole-of-society approaches are often fluid. For example, as has been shown, many whole-of-government approaches use whole-of-society elements to achieve better outcomes (such as citizen and community involvement). In the context of pandemic preparedness, the term whole of government is even used as an equivalent for whole of society and vice versa (Towards a Safer World, 2011). This study, 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 and influences 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 needed and already successful applied for other communicable diseases, as the experience of the GAVI Alliance has shown – a public-private partnership focused on saving children's lives and protecting people's health by increasing access to immunization in low-income countries. 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

The issue

Already in June 2001, the Global Strategy Framework on HIV/AIDS 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 that coordinates formal and informal multistakeholder responses from the national to community levels (Low-Beer & Sempala, 2010). New actors on the global health scene have evolved during the last two decades, and resulting parallel structures in recipient countries have increased transaction costs and often led to a "governance and coordination gap" (Low-Beer, 2012). Although the new "partnership period" of the 2000s (Low-Beer, 2012) has changed the balance of power – at the global, regional and national levels – the arising global partnerships were relatively ineffective in relation to the money spent, and partnerships on the global level could often not be adequately transferred to the respective national context.

Shared governance

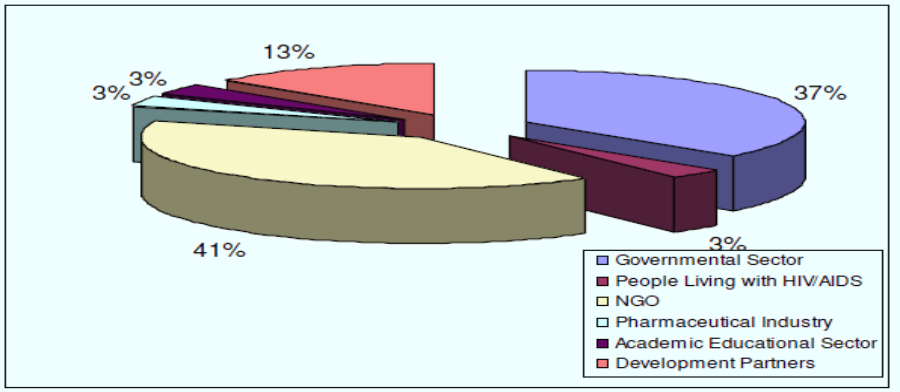
Increasingly and more recently, however, innovative health partnerships combine major health constituencies to improve population health. As the constituency model of governance (see above) indicates, national programmes need to build on different sources of authority and community responses as "the 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: for example, through board structures, country coordination and innovative implementation arrangements that involve partners from different constituencies (Low-Beer, 2012). In this context, the five principles from the 2005 Paris Declaration on Aid Effectiveness, a key strategic document to improve 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 laid out in many whole-of-government and whole-of-society approaches.

Within the WHO European Region, the Global Fund to Fight AIDS, Tuberculosis and Malaria has established country coordinating mechanisms in Bulgaria, Romania and Tajikistan. Country coordinating mechanisms are "country-level public private partnerships central to the Global Fund's commitment to local ownership and participatory decision-making" (Abovskaya, 2007). Country coordinating mechanisms develop and submit grant proposals to the Global Fund based on priority needs at the national level. After grant approval, they oversee progress during implementation, evaluate policies, hold recipients accountable, identify potential bottlenecks and design new policies if necessary. Country coordinating mechanisms involve representatives from both the public and private sectors, including governments, multilateral or bilateral agencies,

nongovernmental organizations, academic institutions, private businesses and people living with the diseases (Global Fund to Fight AIDS, Tuberculosis and Malaria, 2011).

In Romania, the country coordinating mechanism was established in 2002. Before this, the national commission for the surveillance, control and prevention of HIV cases had prepared a grant application and, by doing so, invited several nongovernmental organizations to submit their project proposals. These were later included in the country coordinating mechanism, which comprised 43 members at the end of 2005 (Abovskaya, 2007). Since initiating fruitful strategic discussions was almost impossible within such a large forum, an executive committee (working group) was established with members of all constituencies and the mandate to pass by-laws that would define and decrease membership. The by-laws were adapted in an inclusive and transparent manner, and the established procedures for the operation of the country coordinating mechanism included the duties and responsibilities of its members (Abovskaya, 2007). Since then, in response to changing circumstances, other by-laws have been adopted making the country coordinating mechanism a "self-governing learning body" (Abovskaya, 2007) that continues to develop necessary instruments during its meetings. In 2007, the country coordinating mechanism comprised 30 elected member organizations: government ministries, nongovernmental organizations, academic institutions, international development organizations/partners (UNAIDS, WHO and the United States Agency for International Development), pharmaceutical companies and organizations representing people living with HIV (Abovskaya, 2007) (Fig. 10).

Fig. 10. Sectors represented in the country coordinating mechanism in Romania



Source: Abovskaya (2007).

The Ministry of Health and Family was nominated as the first principal grant recipient. Initial subrecipients were the nongovernmental organizations that already had participated in the grant application. Later, when clear requirements were set up, other nongovernmental organizations and stakeholders could apply as well. The technical assistance project of the United States Agency for International Development assisted both principal recipients and subrecipients in developing more collaborative ways of working as well as transparent monitoring and evaluation mechanisms for (shared) accountability (Abovskaya, 2007). Moreover, the international development partners successfully mediated conflicts between the government and nongovernmental organizations, improved communication and helped to institutionalize the

country coordinating mechanism and its current procedures (such as selecting subrecipients). As a result, all members seemed to accept the country coordinating mechanism as an innovative and effective mechanism to reach consensus and joined decision-making (Abovskaya, 2007). Here, however, one should take into account that the substantial money spent by the Global Fund to Fight AIDS, Tuberculosis and Malaria is a strong incentive to accept country coordinating mechanisms within any given country and context. This is often lacking in other areas in which such cooperation would also be very necessary. In Romania, nevertheless, equal participation rights significantly strengthened nongovernmental organizations in a country where civil society organizations had long played a minor role. Therefore, by bringing a diverse range of stakeholders together, the country coordinating mechanism effectively applies the idea of lessons sharing. Although the government has a leading role, the approach acknowledges that it cannot solve the wicked problem of HIV alone.

Challenges

At the beginning, policies and processes were not well established, and it has been criticized that no clear rules were provided how to deal with certain problems. However, overarching principles were in place and made it possible to adapt and solve problems after a certain adaptation period. Moreover, in 2006, country coordinating mechanism members elected a new principal grant recipient. As a consequence, the government felt itself overruled and argued that the nongovernmental organization Romanian Angel Appeal had won because of a biased majority of nongovernmental organizations 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 together. Last but not least, proper coordination and monitoring between the country coordinating mechanism and the principal recipient must always be secured (Abovskaya, 2007).

Further information:
http://www.theglobalfund.org/en/ccm/documents/reports/
http://www.theglobalfund.org/en/ccm/guidelines/

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

Due to changing demography and disease pattern, countries are required to reorient their health care systems by focusing on preventive measures, integrating service delivery, supporting self-care and co-production by patients and relocating care as close to home as is safe and cost-effective (WHO Regional Office for Europe, 2012a).

6.1.1. How to: governing through citizen engagement

The number of available choices in consumption and personal life has increased significantly. At the same time, expectations on how governments should interact with the public have changed. Throughout the European Region, there are examples of how people want to be involved in the different stages of the policy cycle at the local, subnational and national levels. In this context, "citizen engagement values the right of citizens to have an informed say in the decisions that affect their lives" (Sheedy, 2008). There are increased discussions about introducing methods of direct democracy in several European countries. Also, the ongoing debate on the democratic

legitimacy of the EU reflects 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 wicked societal problems. Kickbusch & Gleicher (2012) describe a range of examples. In the area of service provision, experiments are under way with giving service users more choice by offering a greater variety of services and making them more accessible. In addition, they give citizens a say about how services are provided, such as by 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).

In relation to health, citizen engagement, however, not only means offering opportunities that allow the public to hold health structures to account but also to empower people to care better for themselves (Kickbusch & Gleicher, 2012). Health can only be promoted and disease can only be prevented with the active participation of citizens. Hence, the health sector must 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 as well as in planning, implementing and evaluating health policies and services (Health Consumers Queensland, 2012). Co-production is a central feature of welfare societies, and governments must promote the establishment of community-based organizations that encourage co-production – 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" (Dunston et al., 2009). For example, it could be argued that parents who prevent their children from eating junk food care for their children and co-produce better outcomes for the community (Alford, 2009).

Policies that empower people: the Social Support Act in the Netherlands
In the Netherlands, the Social Support Act entered into force in January 2007. It transfers the focus of providing support and care from the national level to the local government level (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, and take local journeys and meet other people" (De Klerk et al., 2010).

The act supports a demand-led approach, and local authorities have established inclusive Social Support Act boards that are supposed to represent the interests of people with physical disabilities as well as older people. The boards seek to include people with disabilities and decide which services to provide (De Klerk et al., 2010). Moreover, the Act encourages informal caregiving, and a certain amount of money can be spent on informal caregivers. A personal budget that allows disabled people to purchase the care they see fits best. This means that disabled people can hire the people they choose – including family members (Schoonheim, 2009).

Horizontal accountability (and not vertical accountability) between the local authorities and the citizens in the community is given priority, and evaluations on clients' satisfaction are conducted after fixed time periods. The latest evaluation carried out by the Netherlands Institute for Social Research states that 28 of every 1000 inhabitants use the services under the Social Support Act

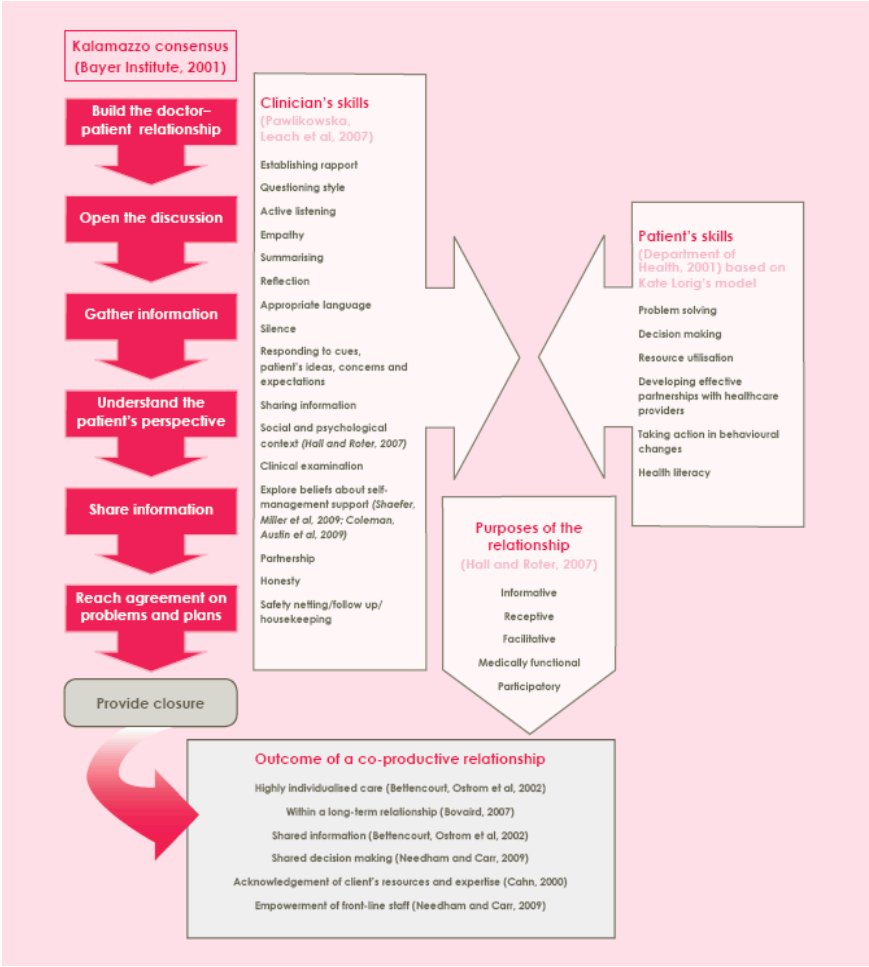
and that major shifts in the number or type of services provided have occurred (De Klerk et al., 2010). The expenditure on household help provided via the personal budget system has increased considerably, although some recipients have complained about the application procedure and too much paperwork (Schoonheim, 2009). Moreover, many local authorities use their newly gained freedom to establish adaptive integrated policies that also involve other policy domains. In general, 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 on average. However, it will be important to ensure that the interests of other target groups such as people with learning disorders or chronic mental disorders are not overheard and are represented in the Social Support Act boards as well.

Further information:
http://www.scp.nl/english/Publications/Summaries_by_year/Summaries_2010/The_Social_Support_Act_the_story_so_far

Empowering patients: the Expert Patients Programme in the United Kingdom

For people with chronic diseases, the sharing of information and decision-making can result in better health outcomes because often the patients are experts in their own disease. Therefore and in the context of health care delivery, co-production aims at individualizing treatment solutions and supporting the self-management of patients (Realpe & Wallace, 2010). Fig. 11 illustrates the resulting co-productive partnership between the service users and providers.

Fig. 11. Co-production of health in consultations for people with long-term health conditions



Source: Realpe & Wallace (2010).

In the United Kingdom, it has been acknowledged that the rising number of patients with chronic diseases should not only 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). Further, the programme is based on the assumption that both patients and professionals have their own valuable area of knowledge and expertise and hence should work together to optimize the treatment. On the core of the programme are free six-week courses aimed at helping people who are living with a long-term health condition to manage this condition better on a daily basis and educate patients how to make better use of their health care visits (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 that "a significant improvement in satisfaction with quality of life" (Holmes, 2011) for those who participated in the programme. 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 13). Last but not least, although the programme is free, the analysis found that the courses are cost-effective compared with treatment as usual (Holmes, 2011).

Box 13. Patientslikeme.com – sharing health data for better health outcomes

PatientsLikeMe is a social networking format, where 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. Especially patients with rare diseases are often able to find other patients like them matched on demographic and clinical characteristics (Wicks et al., 2010). As a result, they are able to make better-informed treatment decisions and gain social support from others. Moreover, the personal research platform not only empowers patients to make more informed treatment decisions but also gives them the opportunity to gain support from others. Research indicates that a substantial proportion of members experience benefits from participating in the community (Wicks et al., 2010). Further, some of the community groups that have come together on PatientsLikeMe represent combined collections of data that are large enough for clinical research. For example, some pharmaceutical companies 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 data scraping showed, transparency is most important, and patients must always be informed about what happens with their data and to whom and for what purpose it might be given away. Only if trust is ensured can knowledge co-production between society and science lead to win-win situations (Kickbusch & Gleicher, 2012).

Further information:

http://www.nhs.uk/conditions/Expert-patients-programme-/Pages/Introduction.aspx

http://www.patientslikeme.com/

6.1.2. How to: local democratic legitimacy in health

Health and well-being boards in the United Kingdom

In many countries, government services have been delivered through many different departments, each with its own programmes and delivery channels (Coe, 2008). Countries are aiming to address this – a recent example being the introduction of health and well-being boards in England.

The Health and Social Care Act 2012 adopted in March 2012 is one of the greatest restructuring reforms in the history of the National Health Service (NHS). Although the act has been discussed very controversially, the setting up of health and well-being boards 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). The aim is to improve accountability and democratic legitimacy by enhancing the role of local authorities in the planning and oversight of local health services.

For this purpose, health and well-being boards will fulfil the following functions (Humphries et al., 2012):

- assess the needs of the local population through a joint strategic needs assessment process;
- produce a local health and well-being strategy based on the data collected;
- use this overarching framework to develop health services, social care, public health and other services the board agrees are relevant; and
- promote greater integration and partnership, including joint commissioning, integrated provision and pooled budgets where appropriate.

The aim is to engage with a wide range of stakeholders, local people and communities (such as by using social media); 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 as well as 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 most boards have more members than this). According to a survey undertaken by Humphries et al. (2012), these people 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.

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

Further information:
http://healthandcare.dh.gov.uk/health-and-wellbeing-boards-one-year-to-go

6.2. Strengthening public health capacity

Achieving better health outcomes requires substantially strengthening public health capacity (WHO Regional Office for Europe, 2012a). In this context, capacity 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 as well as society as a whole to better cope with and change broader conditions influencing health (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 noncommunicable diseases requires establishing an effective mix of policy instruments. Traditional policy approaches such as legislation, sanctions, regulations, subsidies or taxes may not be enough and must be accompanied by additional tools and an understanding of how to engage citizens in behavioural change. For example, advertisement bans on junk food for children may be relatively ineffective without proactively using mass-media campaigns to educate people (especially parents) and promote healthy eating at the same time. Originating from behavioural economics, the idea of nudge policies that aim at making the healthier choice the easier choice has gained ground recently. The following examples are drawn from different countries and backgrounds and reflect both persuasive as well as regulative measures.

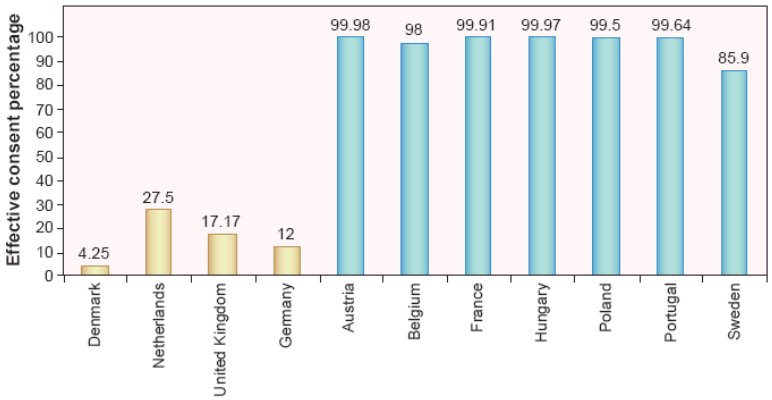
Persuasion through nudge policies: organ donation and the Austrian default option

According to Thaler & Sunstein (2008) and based on the concept of libertarian paternalism, 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". In this context, a prominent example is school cafeterias. Only changing how the food offered is arranged can significantly influence children's food choices in terms of healthier eating (Thaler & Sunstein, 2008). This example 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). Further, 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 could make their lives go better" (Thaler & Sunstein, 2008). By setting the rules or choosing the defaults, governments affect health choices and outcomes. They are choice architects.

The power of nudge policies becomes obvious in the context of defaults and organ donations. It turns out that certain default rules can solve the supply problem by increasing available organs and thus save lives (Thaler & Sunstein, 2008). For example, in Germany as in many other 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. Very often, although most people would have agreed to donate organs, they 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 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). Here, almost all citizens (99%) are donors (Thaler & Sunstein, 2008). However, politically easier to promote and agreed on in Germany in May 2012 is a mandated choice in which people are asked by, for example, their insurance whether they want to be donors or not. Such a procedure is also

expected to yield higher donation rates than the explicit consent rule. Fig. 12 illustrates the impact of the choice of the default option in various countries.

Fig. 12. Effective rates of consent to organ donation by country: explicit consent (opting in, gold) and presumed consent (opting out, blue)



Source: Johnson & Goldstein (2003).

There are many other examples of how nudge polices can influence people's behaviour in eating healthier and moving more: the arrangement of fruit and vegetables in supermarkets, more attractive stairs in public buildings or making cycling easier and more visible in cities, such as by introducing city bicycle-lending schemes (Kickbusch & Gleicher, 2012). In the UnitedKingdom, cost-free and easily accessible outdoor gyms have become popular (BBC, 2012b). Nevertheless, nudge policies alone are clearly not sufficient to solve today's wicked societal problems.

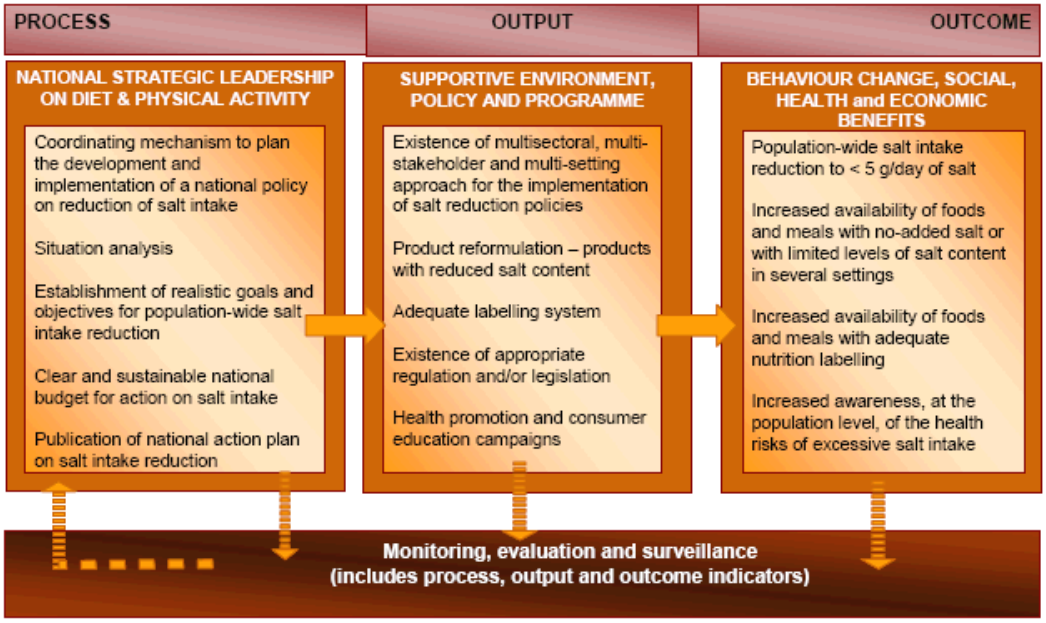
Salt reduction strategies: approaches to shared governance

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 further indicates that strategies to reduce population levels of salt intake are very effective in terms of both the impact on health as well as costs (Millett et al., 2012). At the 2006 WHO Forum and Technical Meeting in Paris, the following steps in planning and implementing national salt reduction strategies were identified (Penney, 2009; WHO, 2010) (Fig. 13).

- 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 this 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 the collected data, countries may, however, choose a higher target to begin with.
- Stakeholder identification and engagement: the coordinating group must identify all relevant stakeholders (food industry, nongovernmental organizations, mass media, academe, government departments etc.) 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 as well as clear and easy to understand food labels must 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. 13. Developing and implementing a policy for salt reduction



Source: WHO (2007).

To meet the WHO recommendations on salt intake, the EU adopted a Salt Reduction Framework in 2008 (European Commission, 2012). The framework supports national plans by such initiatives as involving stakeholders at the EU level and promoting best practice. As a result, the number of country initiatives has increased. Today, 29 European countries – all EU countries and Norway and Switzerland – have adopted salt reduction strategies, although varying in scale and scope. Worldwide, many countries are experimenting with different approaches, and Table 3 briefly summarizes the experiences of Finland, the United States, the United Kingdom, Canada, and France.

Finland has the most comprehensive strategy, which had already been adopted in 1982. During a period of 20 years, Finland's strategy has succeeded in reducing the average salt consumption from 14 grams per person per day to less than 10 grams (Federal Office of Public Health, 2009). By doing so, Finland used a rather regulatory approach with an efficient mix of legislation, consumer education, dietary recommendations and new product development (WHO, 2010) (Box 14). Compulsory food labelling and the cooperation of the food industry have been key elements of the strategy's success. Moreover, the broad approach to rising public awareness by, for example, improving information via the educational system has significantly contributed to

enhancing health consciousness towards salt within the population (European Commission, 2012) (Table 3).

Table 3. Comparison of salt reduction strategies in selected countries

Country	Regulation of food industry	Food labelling	Collaboration with food industry	Voluntary action by food industry	Product reformulation	Public education	Comments on strategies and changes in population sodium intake
Finland	Yes	Yes	Yes	Yes	Yes	Yes	• Government regulation and implementation of food labeling with high sodium content warning • Replacement of usual salt with potassium-enriched Pansalt • Strong media campaigns to increase public awareness • Sodium intake decreased from 5600 mg in 1972 to 3200 mg in 2002
United States	No	Yes	No	Yes	No	Yes	• Consistent advice from all health care bodies since the 1980s and call for sodium reduction by the American Medical Association in 2007 • No reduction has taken place • Sodium intake increased from 3329 mg in 2001/02 to 3436 mg in 2005/06
United Kingdom	No	Yes	Yes	Yes	Yes	Yes	• Collaborative effort with food industry for targeted sodium reduction in specific groups of foods under the oversight of the Food Standards Agency • Ongoing monitoring and evaluation of population intake • Public campaigns to increase public awareness and simple consumer-friendly labelling strategy • Sodium intake decreased from 3800 mg in 2004 to 3440 mg in 2008
Canada	No	Yes	Yes	Yes	Yes	Yes	• Early voluntary reductions by food industry combined with public education and labelling had no impact on sodium intake from processed foods • Too early to access the more recent collaborative effort
France	No	Optional	Yes	Yes	Yes	Yes	• Efforts initiated since 2004 • Optional sodium labelling being developed • Limited public education in which sodium reduction is the main message is done through the National Nutrition and Health Program • Not much change to date except in the bakery sector where 33% of bakers claim to have reduced sodium

Source: Mohan (2009).

Box 14. A long-term strategy in Finland

Following the six steps above, in 1978, Finland's National Nutrition Council recommended taking action on salt intake. As a consequence, the 24-hour urine test method was undertaken within a population sample and complemented with dietary surveys. These measures continue on a regular basis. The target was set to be 5 grams per day. Although the strategy started in one region, it was quickly expanded to the national level and engaged national and local health authorities, schools and nongovernmental organizations. The latter rather than the government conducted broad-based consumer education projects and mass-media campaigns to raise public awareness, for example, by improving information via the educational system. Further, compulsory food labelling introduced high-salt warning labels on all foods that exceed the limits for salt content in categories such as bread, meat and fish products, butter, soups and ready-made meals. As a result, many products disappeared from the marketplace, and new lower-salt alternatives have appeared. Moreover, a new mineral salt product was developed that can replace sodium (PANSALT®) and that is now widely recognized in Finland. Last but not least, the food industry was engaged from an early stage. However, the change appears more to be driven by legislation (especially labelling regulations) and mass-media attention than by voluntary agreements (Penney, 2009).

Source: Penney (2009).

In contrast, other strategies such as those in the United Kingdom and Switzerland have undertaken more collaborative efforts 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.

The experiences show that salt reduction strategies must be based on evidence, forward-looking and be monitored constantly to adapt to changing circumstances. Finland's approach has been cost-effective and successful in reducing the population's salt intake in part because of a rather regulative approach. Other countries are still seeking appropriate measures to effectively reduce the population's salt intake. In this context, barriers that have been identified are a 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 different cultures within a country so that media campaigns do not adequately cover all groups. WHO and other regional networks can, however, provide assistance and resources for research and the development of a national surveillance system. Moreover, nongovernmental organizations and consumer groups can use the media to name and praise or alternatively name and shame to motivate the food industry. Last but not least, media campaigns should use different types of media to cover as many people as possible (WHO, 2010). However, salt reduction is only one aspect of the broader efforts on reformulation designed to improve the nutritional quality of foods.

Further information:
http://www.food.gov.uk/multimedia/pdfs/saltreductioninitiatives.pdf
http://www.bag.admin.ch/themen/ernaehrung_bewegung/05207/05216/index.html

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 foods 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 unhealthy should also pay more to internalize negative externalities and cover social costs (such as treatment within a public paid health care system). However, taxing tobacco to control smoking is easier than taxing (saturated) fat to control obesity. Smoking directly causes several diseases, whereas fat can be found in most food products and does not necessarily and directly lead to illness. Targeting fat-containing foods and reducing their consumption to achieve better health outcomes are therefore difficult. In general, governments have two options for taxing fat: they can tax certain food groups such as junk food or soft drinks or tax all products that have a fat content that lies over a pre-determined threshold (Box 15) (Clark & Dittrich, 20109).

Box 15. Denmark's fat tax

In 2011, Denmark introduced a fat tax to respond to the fact that 80% of both adults and children have intakes of saturated fat that exceed dietary recommendations (Smed, 2012). Acknowledging that obesity is not simply the result of fat intake, the fat tax is 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 is a tax paid on the weight of saturated fat in meat, dairy products, oils and other fats if the content of saturated fat exceeds 2.3%. All kinds of drinking milk are exempt from taxation (Smed, 2012). Companies that commercially produce these foods or import them for consumption within Denmark have to pay the tax. The fat tax is not imposed on food that is exported (Smed, 2012). Denmark's taxation approach has triggered debates in many European countries such as Finland, Romania and the United Kingdom. Moreover, taxes on unhealthy food have also been established in Hungary (tax on foods with high sugar, salt and fat content) as well as France (tax on soft drinks) (Villanueva, 2011).

Denmark's method of taxing products over a certain threshold of saturated fat instead of taxing certain food groups has two advantages: consumers cannot easily look for substitutes and a subjective or even stigmatizing selection of certain products for taxing does not take place. However, this method bears high administrative costs and is also more expensive to monitor since foods need to be regularly tested on their fat content. Further, the demand for food is rather inelastic. This may be good for the government, which receives consistently high tax revenue. Nevertheless, 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 major problem of saturated fat taxes is the fact 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 enough 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). Last but not least, more research on how to design a subsidy or taxation scheme most efficiently and effectively is needed. It must also be taken into account that many types of taxes that can lead to health improvements are not introduced for health reasons but to generate revenue (Box 16).

Box 16. Policy tool options

Fig. 14. Policy tool options

Source: Dubé et al. (2009).

As Fig. 14 illustrates, governments can choose from a great variety of instruments to achieve their policy objectives such as healthy eating and a sustainable food system. However, in relation to noncommunicable diseases and the food industry, concepts of persuasion and voluntary self-regulation may have their limits (in this context, see section 2.3 on corporate social responsibility). In the case of conflicts of interest with the food industry (such as salt reduction) and to implement legislation, an approach originally termed smart regulation can become necessary. Under this model, an enforcement pyramid is used, with persuasive measures on the bottom and more regulative ones at the top. Following this logic, policy-makers would apply persuasion and voluntary commitments as long as they work and respond with carefully targeted and progressively coercive strategies whenever this becomes necessary (Gunningham, 2010). In this context, 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 in communicable disease outbreaks.

(WHO Regional Office for Europe, 2012a)

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

The issue

Global biological disasters such as severe acute respiratory syndrome (SARS), bovine spongiform encephalopathy (BSE) or the avian influenza H5N1 have occurred several times during the last two decades. In 2009, WHO declared the new strain of swine-origin H1N1 to be a

pandemic. This has been the latest major influenza outbreak. Lessons learned from these former 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 both the individual and the community level.

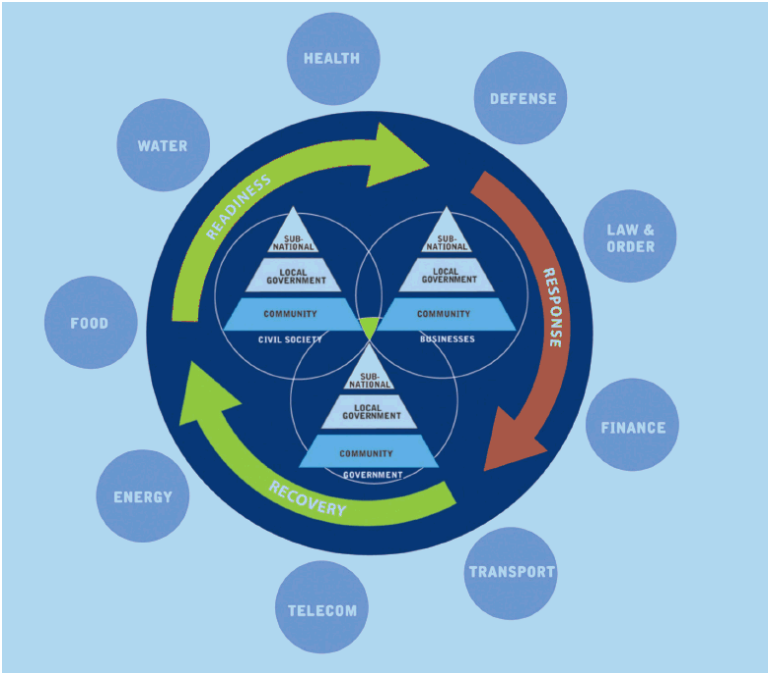
Shared governance

As a consequence and acknowledging that the risk for future severe pandemics remains, the United Nations adopted a whole-of-society approach towards disaster preparedness that emphasizes 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 the different stakeholders such as governments, private companies, the mass media, nongovernmental organizations and the military directly affect the ability of the health sector to effectively respond during a pandemic. Stakeholders therefore need to be identified and brought together to communicate and agree on their roles.

One starting point of a whole-of-society approach may be interdepartmental collaboration of all relevant ministries (such as by establishing a joint task force), which then can serve as a platform for engaging a wider range of other societal actors. In this context, a leading agency must be identified at all government levels that commands, coordinates and communicates with other actors and the public. This agency would be responsible for ensuring that the private sector, nongovernmental organizations and other relevant community entities are engaged in preparedness planning (Towards a Safer World, 2011).

Fig. 15 illustrates the whole-of-society approach to disasters, in which all levels of government must be prepared, attention must be paid to critical interdependence, a scenario-based response must be undertaken and ethical norms must be respected (Kickbusch & Gleicher, 2012). In addition, the nine circles represent the key essential services needed in a disaster situation: health, defence, law and order, finance, transport, telecommunication, energy, food and water (Fig. 15).

Fig. 15. WHO's whole-of-society approach



Source: Towards a Safer World (2011).

The Association of Southeast Asian Nations (ASEAN) has embarked on a whole-of-society approach and thereby significantly increased the degree of pandemic planning and response of its Member States. As a result, each of the region'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 the government, the business sector and civil society in providing essential services. As a result, each country has developed a national pandemic preparedness plan that also includes business continuity strategies (Towards a Safer World, 2011). The quality of, for example, Singapore's national pandemic preparedness plan could be tested in 2009, when the H1N1 pandemic hit the country.

Challenges and lessons learned

Key lessons from the pandemic were the following (Tay et al., 2010).

Be prepared, but 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, a longer time horizon, low morbidity and mortality and, hence, a different demand on health services than originally expected. This shows that joined-up preparedness plans should be easily adaptable to changing circumstances because reality may differ significantly from the original planning model (scenario).

Surveillance and access to information for evidence-informed decision-making

Early signals, detecting infectious disease outbreaks and using the best available epidemiological data for evidence-informed risk management are essential – both at the global and local levels.

An inclusive whole-of-society response

Singapore's pandemic planning had been primarily based on the health sector and public institutions. However, the newly established coordinated and collaborative efforts of government agencies (education, border control, trade and industry and foreign affairs), the health care system, businesses and members of the public were crucial in ensuring that the measures to control the spread of H1N1 were implemented efficiently and effectively to minimize morbidity and mortality from the disease and its impact on the society and the economy.

Health workforce supply

Since demand for health care services rises quickly during a pandemic, creative human resource strategies must be established in peacetime. A good and forward-looking understanding of the crisis scenarios and the actual 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 any 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 (such as personal hygiene or social responsibility) and explain burdensome policies. Working closely together with the mass media is essential. However, although new (social) media tools were used, the traditional communication channels (newspapers, television and radio) 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 as well as joint accountability mechanisms (Battams, 2008). The collaboration of professions across borders is crucial for successful whole-of-society approaches towards 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. Priority area four: creating resilient communities and supportive environments

Building resilience is a key factor in protecting and promoting health at both the individual and community levels.

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

The issue

The notion that chronic diseases are the result of individual choices to adopt unhealthy lifestyles is common. This, however, ignores the social dimensions of health-related risks that shape patterns of morbidity and mortality in all populations: "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. The examples for integrated action to address health inequities have been dealt with in more detail in the complementary European study of social determinants of health and the health divide (WHO Regional Office for Europe, 2012b).

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 integral to public health as a means of tackling the underlying social determinants of health and to increase the ability of disadvantaged people to better take care of their own health (Box 17). The assumption is that, the more community members are supported to take control by being involved in the design, development and implementation of activities, the more likely their health will improve (Attree et al., 2011). In this context, local ownership of health issues not only improves the health of individuals but also the resilient capacity of the whole community.

Box 17. Building supportive environments – WHO Healthy Cities

The WHO Healthy Cities project 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 only. It includes health considerations in economic, regeneration and urban development efforts.

The healthy cities approach to governance consists of following action elements: strong leadership and support by 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 (city health development plans) 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.

Source: This and more information:
http://www.euro.who.int/en/what-we-do/health-topics/environment-and-health/urban-health/activities/healthy-cities

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.

Michael Marmot, Director, Institute of Health Equity, University College London, United Kingdom

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 years for females (Hine-Hughes, 2011a). In addition, 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). By including different NHS bodies (especially local primary care trusts), the University of East London and other organizations and nongovernmental organizations, the project promoted healthy physical activity, healthy eating as well as mental health and well-being by delivering a complex set of integrated interventions. Box 18 shows the projects.

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 the 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 exact mix of projects built up in each community has been decided on "through priorities identified by residents and complementary to the facilities and services already provided" (Wall et al., 2009). Priorities were developed through inclusive health needs assessments, which can be seen as a key element of Well London. Together with local organizations, multistakeholder workshops were organized and community cafés established. In such an informal environment, people could voice their needs within a structured conversation. Moreover, information collected through street interviews and community mappings showed which initiatives were already available to build on existing successful structures and avoid duplication (Institute for Health and Human Development, 2012a).

Challenges

Evaluations indicate that the multi-method approach to data collection and involving local communities in the intervention delivery process was important to identify barriers and facilitators that determined the success or failure of the projects (Wall et al., 2009). Moreover, the projects have increased healthy eating and healthy physical activity and enhanced mental health and well-being (Wall et al., 2009). However, the case of Well London has also shown that managing expectations of what is actually possible right from the beginning is important. Further, advertisement must make the projects visible for the people. Maybe most important 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 is not enough to really make a difference, and those engaged "do not want to see lots of little projects coming in 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 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 makes sure that people who are not an active part of the economy – such as because of unemployment, chronic diseases or disabilities – are able to participate. The idea is simple: 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 being valued equally (1 hour means 1 credit) (Hine-Hughes, 2011b).

Many time banks like the time2trade project in Birmingham use databases: whenever a member needs a certain service, the appropriate person with this particular capacity can be found. Moreover, time2trade has partnered with 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). For example, members can use their time credits to purchase healthy food, go to the gym, study or use other services they may need (Hine-Hughes, 2011). Since the time bank was founded, 34 100 hours have been traded (Hine-Hughes, 2011b), and findings show that this bank in particular and community-driven time banks in general are able to actively engage vulnerable groups and produce positive effects "in terms of 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. Further, whenever imbalances of services arise, a time bank should try to buy in services or link with other social organizations. Last but not least, the larger a time bank becomes, the more investment in paid stuff will be needed. 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 prevention and to create synergy effects across sectors. Moreover, the coordination platform aims at incentivizing networking, cooperation, pooling, knowledge transfer and improved public work by comprehensively including "all relevant societal forces" (Seitz, 2010). Similar to health, crime is a problem that requires involving many societal stakeholders. This has not only been acknowledged in Germany but also in Australia and the United Kingdom (Crime Reduction Programme), where whole-of-government approaches to preventing crime have been established 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 (Homel, 2004). However, again, it has been shown that a significant management and coordination effort is needed to achieve effective whole-of-government working (Homel, 2004). Investment in time and resources is needed if the potential gains of whole-of-government approaches are to be released.

Further information:
http://www.welllondon.org.uk/7/case-studies.html
http://www.govint.org/good-practice/case-studies/time-2-trade-for-the-time-rich-and-cash-poor/
http://www.kriminalpraevention.de/

8. Joint or shared accountability

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 as well as other actors accountable for their actions are essential elements of a policy-making process. Traditionally, the most dominant (public) accountability relations have been vertical in nature. This top-down chain of principal–agent relations of unequals, however, 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. Further, it enhances transparency and responsiveness of the public sector, and the resulting legitimacy helps in bridging the gap between the government and the people. Finally, accountability functions as a safeguard against corruption and other abuses of power (Bovens, 2005). Increasingly such accountability also applies to private actors and businesses – as indicated 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). When they function responsibly, the mass media play an important role in ensuring accountability to the general public. As a consequence and in any given context, it is important to consider which form of accountability is operative 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).

Box 21. Accountability in relation to shared governance – One World Trust

First and foremost, accountability is about engaging with, and being responsive to, stakeholders; taking into consideration their needs and views in decision-making and providing an explanation as to 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).
This and further information:
http://www.oneworldtrust.org

But the problems that emerge in trying to define accountability in the context of partnerships remain a key difficulty – we still grapple with how to ascertain the relative contribution of different actors to a given outcome.

Accountability challenges

Transparency and accountability are key factors of governance. Wicked problems require whole-of-government and whole-of-society approaches, and 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 may already be difficult if only two actors from different sectors are supposed to work together because there is often a lack of clarity regarding different responsibilities. Especially if things do not happen in the way that was planned (as it most often does), 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 public managers are reluctant to participate in joint working arrangements.

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

Countless factors, however, contribute to the health of a population. In addition, 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. Hence, clear lines from input to output are not identifiable, and for many health challenges knowledge about effective interventions is lacking.

Measuring impact

At the centre of a whole-of-government approach is the question about government performance – in this case the commitment of the whole of government to improve health. In a new and challenging policy environment, new structural and instrumental features as well as organizational forms are sought to do better – and they are linked to the realization that these must be accompanied by different frames of mind. The experience of various countries shows that the effectiveness largely depends on a country's history of active reform and political will. Cross-sector collaborative efforts are constrained by path dependence (the tendency to continue with an established practice even if better alternatives are available), imbalances of power, turf wars as well as different systems of values and beliefs. The Health 2020 implementation is built on government learning and the exchange of experience between countries in the European Region and beyond. On the whole, there is agreement that it is not sufficient to measure the health system's efficiency and effectiveness without taking into account the impact of social, environmental and behavioural determinants on health – the causes of the causes (Committee on Public Health Strategies to Improve Health, 2011). Measuring the impact of various approaches to governance can become an important part of making governance and sharing experience (Pollitt, 2010). Nevertheless, the evaluation of policies 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). further, policy evaluation does not typically represent the perspectives of stakeholders.

- Policies always have unintended consequences: if they are negative they might hamper the previously envisioned goals. They can also be positive. A recent review of reviews on 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 that specific policies or interventions such as on alcohol use or smoking could well be enhanced if one considered their interrelationship and developed complementary supportive action. 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 is therefore needed that works for both: areas with already established best practices (such as tobacco control) as well as areas with a less-developed evidence base (such as policies that tackle the problem of obesity) (Committee on Public Health Strategies to Improve Health, 2011). Such a measurement system for accountability among government and private-sector organizations could be based on agreements and contracts as well as transparent (social media) tools for communicating with the public on the progress of the 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.

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 one single entity by eliminating all significant transactions between public-sector entities (HM Treasury, 2011).

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

Nongovernmental organizations as necessary watchdogs

In the context of accountability, nongovernmental organizations have long been perceived as whistleblowers and watchdogs to ensure that government fulfils commitments. Public accountability remains important, but today companies as well are increasingly facing campaigns by nongovernmental organizations 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 to pressure 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, nongovernmental organizations often use a blame-and-shame strategy and appeal to a wide audience including the public as well as judicial, legislative and regulatory

bodies to establish new norms or to punish a company for not complying with already existing norms.

In the context of health, this may be important, 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, the food-processing methods and the health effects of certain ingredients. A good example is the German nongovernmental organization Food Watch, which was founded in 2002 to strengthen and protect consumers. It especially lobbies for mandatory traffic light labelling, 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 on governance for health in the 21st century (Kickbusch & Gleicher, 2012) put forward a strong recommendation for strengthening policy sciences for health and measuring the impact of the political determinants of health. Examples of such research exist in the field of welfare and poverty studies, which indicate that the variation in poverty among high-income countries relate to social policy commitments and different welfare state regimes (Brady, 2009). Studies in the equity gap and social determinants of health provide a similar indication. Such studies can help identify and analyse the different levels and types of capacity for health governance among the 53 countries in the European Region – for the benefit of all. Every country can improve and, in the spirit of Health 2020, opportunities for good and intensified European cooperation to share experiences based on reliable policy analysis should be created.

There is no one-size-fits-all approach, and 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 needed to overcome these constraints or at least mitigate their impact. Without a common ethos and a strong unified sense of values that helps to build up trust across sectors, the implementation of whole-of-government approaches may be impossible or ineffective (Christensen & Laegreid, 2006). Moreover, a risk-adverse bureaucratic culture that overemphasizes the minimization of errors can inhibit any horizontal experiments right from the beginning (Halligan et al., 2012). A supportive culture for thinking and acting across agency borders could be attained through incentives and rewards that encourage organizational flexibility, adaptability as well as the staff'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 of whole-of-government approaches, collaboration or even integration, in which risks, responsibilities and rewards for a common goal are shared, seems to be less frequent and, hence, the most difficult to achieve (Halligan et al., 2012). In this context, it may also be true that whole-of-government approaches are easier to implement in countries or cities, where the number of staff as well as the size of the budget is relatively small and informal negotiations easier to pursue (Moss, 2010). This is also reflected in the examples that are available.

Although many applications of whole-of-government have led to a strengthening of central coordination bodies – such as departments of premier and cabinet in the Australian states – it

could well 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 – such as Norway and England – have reformed their public health laws and are giving increasing responsibility to local authorities to implement public health priorities. At this level, whole-of-government approaches can significantly enhance transparency, accessibility and responsiveness as long as the institutional arrangements are adaptive to change and accountable to the citizens they serve. At the 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 health in all policies remains crucial to understand 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 the community level, but they may as well build on whole-of-government approaches. New challenges arise by incorporating actors from the business sector and civil society. Depending on political systems and outlooks, one might well be more acceptable than the other. As has been mentioned before, companies may be reluctant to invest in a public good. Such conflicts, however, must be addressed and ways must be found to engage the business sector for the purpose of creating common societal value. Frequently, local communities are 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). Since a whole-of-society approach requires both top-down approaches, bottom-up approaches and horizontal governance, policy implementation becomes complicated. Evaluation and accountability measures may be difficult to introduce because the influence of different actors and levels on policy outcomes is difficult to separate and, hence, hard to measure. What are needed to render the interactive process within whole-of-society approaches in relation to health successful are the following attributes (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; and
- 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 study have outlined.

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