



policy
coherence

Policy coherence as a driver of health equity





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ABSTRACT

Health is a human right and therefore states must ensure access to timely and affordable health care of appropriate quality, and provide for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, decent work and gender equality. This highlights the need for coherent action across different policy domains. The United Nations Sustainable Development Goals provide the framework to advance policy coherence for health equity. As policy coherence concerns different levels of governance, the mechanisms for the public health community to drive for policy coherence are both systemic and administrative. The former concerns transparency (access to health and other relevant data and capacity to use the data) and accountability (reporting to the legislature, initiatives by ministries of health and the strength of civil society). The latter mechanism includes ministerial linkages between health and others (interdepartmental committees and public engagement), public health legislation, governmental plans and targets, joint budgeting and delegated finance.

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ISBN 978 92 890 5411 9

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Edited by Alex Mathieson

Book design by Marta Pasqualato

Printed in Italy by AREAGRAFICA SNC DI TREVISAN GIANCARLO & FIGLI

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Acknowledgements

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This publication is one of the products developed under the WHO European Health Equity Status Report initiative (HESRI). The work is led by the WHO European Office for Investment for Health and Development of the WHO Regional Office for Europe based in Venice, Italy and aims to bring forward innovations in the methods, solutions and partnerships to accelerate progress for healthy prosperous lives for all in the WHO European Region. Chris Brown, Head of the WHO Venice Office, is responsible for the strategic development and coordination of the HESRI. Development of the initial framework was guided by the external Scientific Expert Advisory Group to the WHO European HESRI.

Support for this paper was provided in part by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Executive summary

Key messages

- 1. Coherence across all areas of public policy is important to realize health equity and well-being for all.** Health policies can have a greater impact and tackle unintended negative effects on health equity by other sectors if they are combined and coordinated across actors, institutions and levels of governance.
- 2. The Sustainable Development Goals (SDGs) provide a framework to strengthen policy coherence for health equity.** Policy coherence is essential to ensuring that progress achieved in one of the SDGs contributes to the achievement of other goals.
- 3. Governance mechanisms for policy coherence that account for health equity operate across a decision-making system.** Policy coherence for health equity can mean increasing transparency and participation, introducing mandatory health assessments, changing the membership of key committees to represent health-focused interests, or staffing key bureaucracies with people engaged in the topic.
- 4. Intersectoral initiatives should include equity analysis.** This is important to ensuring that no one is left behind, and interventions do not increase health inequities. The health equity in all policies (HEiAP) approach is a useful framework for bringing together the different actions concerned.

Many authoritative documents on improving health equity name policy coherence as a necessary part of policy to address health inequities.¹ While not all of them explain the logic, the reason is to be found in the failure of single policies to address intersecting inequities affecting health. Examples are not hard to imagine, or to find in the literature: active labour market policies, punitive or supportive, might not work if their target populations are mentally or physically unhealthy; and school-based policies to promote physical activity might not work if children are ill-fed or live in areas where playing outside is dangerous.

In global health, the interface between health and trade has been a particular source of problems, governance challenges and creative thinking about how to promote health in trade (2). Trade policies try to promote the equal treatment of companies and investors, while health policies attempt to address the sources of ill health and health inequities. Ensuring their coherence is a major challenge, since the logic, interests and politics of trade and health are quite different: for example, the marketing of unhealthy food and beverage products to children continues, although it is known to be a significant risk factor for childhood obesity and the development of diet-related noncommunicable diseases (3,4). How can the focus be on ensuring health equity while the world trading system broadly promotes commerce regardless of its substance or health implications?

HEiAP developed from the health in all policies (HiAP) approach. HEiAP recognizes that it is not possible to improve population health without addressing health inequities, and therefore seems to go beyond HiAP to focus policy, in a coherent manner, on the multiple mechanisms that produce or remedy health

¹ Health differences that are systematically produced by social, economic and environmental factors and are therefore preventable are considered unfair and referred to interchangeably as social inequities in health, health inequities or health inequalities. For simplicity, this paper will use the term “health inequities” (1).



inequities. It can be used prospectively, to identify policy initiatives and policy-making procedures that can reduce health inequities, or diagnostically, to identify policies that are not coherent with an approach to government that tries to reduce health inequities.

Enunciating HEiAP as a goal and working out its procedures is not the same thing as making it lasting policy. There are three major problems that advocates of reduced health inequities (or any other agenda) face in politics. The first is the *challenge of definition*, which simply means getting recognition that a problem that might widely be regarded as belonging to some other policy area is in fact a health inequities problem. Defining schools with ill-fed children, unhealthy workplaces or residences without access to green spaces as health inequity problems, rather than problems of test performance, economic competitiveness and urban amenities, is a political action that requires coalitions, evidence and persuasive narratives.

Closely related is the *challenge of influence*, the problem of shaping agendas in other policy areas to reflect concerns about health inequities. Any other policy area, be it as close to health concerns as health-care services or as seemingly far removed as fisheries or military procurement, will have other interests, priorities and ways of working, and people in it might not want to cede ground to concerns about health inequities. Influencing them requires political support as well as institutional mechanisms.

The third is the *challenge of persistence*. Even if policies reflect health inequity concerns, there is little chance that the effects will be lasting if the policies do not outlast individual ministers or governments. The question is how to develop durable policies and make policy-making shift permanently in a way that addresses health inequities and biases future decisions towards their reduction.

The route to HEiAP and policy coherence to address health inequities is in large part determined by addressing these three concerns with what political scientists call deck-stacking, modifying procedures, laws and bureaucratic routines to ensure that policy coheres around a goal of reducing health inequities. As Cox and McCubbins (5) describe it:

Ultimately, the point of deck-stacking is not to pre-select policy, but cope with uncertainty about the most desirable policy action by making certain that the winners in the political battle over the underlying legislation will also be the winners in the process of implementing the program.

Achieving HEiAP, or at least health equity in as many policies as possible, therefore requires not just abstract good governance, but also governance that efficaciously produces coherent policy for the reduction of health inequities.

A broad literature review found that governance, as a concept, involves talk about five domains that recur in any analysis: the transparency, accountability, participation, integrity and capacity of the system (6). Policy coherence for HEiAP can be restated as: how best can the five domains of governance be structured to address the challenges of definition, influence and persistence for HEiAP? This is a practical question of how to use time in power to choose procedures, people and priorities that will entrench policies to reduce health inequities in the future.

The measurement of policy coherence for reducing health inequities – HEiAP – is therefore a challenge, since it takes legal, administrative and political expertise to tell whether a given initiative in a given context is likely to be effective. All of the challenges of defining the health inequities effects of a policy are matched by the challenges of establishing whether a given policy is effective or durable. Understanding health equity impact requires epidemiological, sociological and econometric expertise;

understanding political feasibility and durability requires administrative, legal, political and political science expertise.

Policy coherence is not in itself a value. If offered a choice between policy incoherence and a coherent policy that increases health inequities, policy incoherence would be the preferred option. The question for those who seek to reduce health inequities is how to shape governance so that it resists policies that increase inequities and promotes policies that encourage greater health equity. In other words, to promote health equity, rigorous analysis of complex policy interventions and effects must be coupled with equally rigorous analysis of policy-making, governance and politics.

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² All weblinks accessed 15 April 2019.

What is policy coherence for health equity?

Health equity is the absence of avoidable, unfair or remediable differences among groups of people. It implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this (1,2). As a strategy, policy coherence can help to tackle the inadvertent consequences that may cause and entrench health inequities by integrating the economic, environmental and social dimensions at all stages of policy-making.

Policy coherence is (3):

the systematic promotion of mutually reinforcing policies across government departments to create synergies towards achieving agreed objectives and to avoid or minimize negative spillovers in other policy areas.

Issues of policy coherence may arise between different types of public policies, different levels of government or between different stakeholders at national and international levels. It is therefore an essential component of a wider system for reducing health inequities through action on social determinants of health (4). The approach emphasizes the need to find and establish cooperation for a sufficiently long time among diverse actors on key societal issues, with objectives jointly enacted, monitored and evaluated.

Interest in policy coherence in global health stems from efforts to reconcile health objectives with trade liberalization. Research on trade partnerships since the 2000s has raised awareness about the potential for negative public health impacts of trade and investment agreements at global level. These negative impacts include inequity in access to health services, increased availability and consumption of unhealthy commodities, limits on access to medicines, reduced government regulatory flexibility and constrained policy space for health (5). Evidence of the negative impact on health rights and outcomes of policy incoherence is robust (6).

While analyses of policy coherence for health equity are scarce, the framework for analysis is readily available, as the approach is embedded in the United Nations Sustainable Development Goals (SDGs) (7). Progress on health equity cannot be achieved without addressing poverty, food security and nutrition, education, employment and environmental determinants, such as clean water and sanitation (8). The indivisibility of the SDGs is acknowledged explicitly, and Goal 10 calls for the “reduction of inequality” (9,10). An Organisation for Economic Co-operation and Development (OECD) report (8) states:

The SDGs are indivisible and integrated. This means that achieving one Goal may require action on others. For instance, poverty reduction is the objective of Goal 1 but attaining it may also require progress e.g. under Goal 9, on the economy and decent work and Goal 10 on inequalities. In other cases, mutual dependence is observed: improving education (Goal 4) will bring benefits in terms of health status (Goal 3), income and employment (Goals 1, 2, 8 and 10), and institutions (Goal 16), but improvements in these factors could also improve educational resources and outcomes.

A vast array of factors within and outside of health affect health equity. Disadvantage and marginalization exclude certain populations in societies from enjoying good health, and for many, it is not just one area in which they face exclusion (11). For example, discrimination can be the result of an

apparently neutral policy provision, criterion or practice that disadvantages people on the grounds of racial or ethnic origin, religion or belief, disability, age or sexual orientation (12). Coordinated policy efforts are therefore needed to shift action on single risk factors to more comprehensive perspectives. Policy coherence for health equity is about planning synergistic policies (on, for instance, education, employment, fiscal policy and trade) that acknowledge intersecting inequalities (around, for example, gender, age and socioeconomic status).

How does policy coherence intersect with and drive health equity?

The Helsinki Statement on Health in All Policies (13) states that “Health inequities between and within countries are politically, socially and economically unacceptable, as well as unfair and avoidable”.

Health as a human right creates obligations for states not only to ensure access to timely, acceptable and affordable health care of appropriate quality, but also for providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, decent work and gender equity.

Equity, however, is not an automatic result of universal policies, even if they are good: the combination of policies must be coherent from a health-equity viewpoint. Consider policies that, for example, enable equal access to goods and services, such as health care, education, employment, leisure, sanitation and food. Access is related to: (i) the proximity of the goods, services and facilities to the locations in which people live and work; (ii) the ease with which services and facilities can be accessed; (iii) the availability of the goods and services; (iv) their quality; and (v) their affordability. From a health-equity viewpoint, policies and actions must be scrutinized for the inclusion of groups facing higher risks of poverty and social exclusion, such as people with disabilities, poorer households, single-parent households, migrants, ethnic minorities, older people, children and people who are chronically ill (14). This is how policy coherence as a common good can drive health equity.

Collaboration on upstream policies is needed for policy coherence to reduce health inequity. Collaboration requires an appropriate governance framework, analysis of the underlying causes of policy incoherence with negative impacts on health equity, such as the influence of commercial interests (see Box 1 for discussion of the commercial determinants of health (15–17), and facilitation of the sharing of information (18,19). The health equity in all policies (HEiAP) approach aims to prevent unintended negative consequences of policies on health equity.

Box 1. Commercial determinants of health

Commercial determinants of health (CDoH) can be defined as strategies or approaches that the private sector uses to promote products and choices, including those that are detrimental to people’s health (15). CDoH contribute directly to the growing burden of noncommunicable diseases (NCDs).

Capacity for NCD prevention and control varies greatly at national level. A WHO survey in 2015 (20) found that approximately half of the 177 participating countries reported a multisectoral policy in place to address NCDs, and a third reported having an “operational national multisectoral mechanism”. The extent to which the private sector was included in these multisectoral mechanisms was not reported, however. A minority of countries reported having policies in place to address food/beverage marketing to children or policies to limit trans-fats; no such policies were in place in low-income countries, compared to 57% in high-income countries (16).

A recent analysis revealed that the sugar industry had worked with government researchers in the United States of America to soften recommendations on reducing sugar intake to help prevent cavities. Similarly, a web of connections between the sugar industry and nutrition researchers has been under scrutiny in the United Kingdom (17).

Health is at the intersection between market forces and the state. It is therefore essential that parliamentarians are aware of the health consequences of their decisions and non-decisions, and to ensure that all democratic institutions value health. Ministers of health should aim to bring about global change by helping to create buy-in from the head of state and other ministries (15).

Health equity in policy-making: the governance challenge

The HEiAP approach aims to establish a mechanism for moving beyond the detection of health equity problems into tackling the determinants and establishing permanent links for dialogue on health in other sector policies (18,19). It draws on the principles of the health in all policies (HiAP) approach, which was founded on health-related rights and obligations and contributes to strengthening the accountability of policy-makers for health impacts at all levels of policy-making (21).

HEiAP is an intersectoral approach to national or subnational public policy development that aims to ensure health equity is given full consideration by non-health sectors. Intersectoral action means coordinating various sectors towards improving health equity; any intersectoral initiative in the HEiAP framework should include a comprehensive equity analysis to identify populations that are positively or negatively affected and the contexts under which such effects occur. This is important to ensuring that interventions do not increase population health inequities.

The key areas of HEiAP include (22):

- collaborative working and discussions on health equity at the early stages of the development of a policy or strategy;
- identification of health equity issues and impacts of policy that are supported by evidence-based practice;
- identification of policy considerations that support health equity; and
- discussions on the integration of these.

Intersectoral actions and integrated governance are required to achieve policy coherence for health equity. This refers not only to coherence of policies across sectors within a government, but also between different levels of governance: global, supranational, national and subnational. These different layers add to the complexity of policy coherence processes (Ben Barr, Senior Clinical Lecturer, University of Liverpool, United Kingdom, unpublished data, 2017).

For example, unhealthy diets and overnutrition are responsible for the overwhelming majority of NCDs and ill health in Europe (23–25). A range of NCDs has been found to follow a social pattern in which lower socioeconomic status predicts a higher risk of disease (26). To tackle the NCD epidemic, policy coherence is crucial; trade policy that actively encourages the unfettered production, trade and consumption of foods high in fats and sugars, to the detriment of fruit and vegetable production, is contradictory to health policy (27). Health equity must therefore gain a stronger presence within the matrix of policies in which strong commercial determinants influence consumer and health behaviour, falsely individualizing responsibility and choice through driving the global consumer society and the political economy of globalization (15). Table 1 presents policy coherence intersections with health equity at different governance levels.

Governance for policy coherence is specific to each country and context, in which competences and responsibilities differ. There is vast diversity in decision-making processes in the WHO European Region, and the 27 Member States of the EU have an additional level of governance complexity due to the EU's supranational structures (Ben Barr, Senior Clinical Lecturer, University of Liverpool, United Kingdom, unpublished data, 2017). Simultaneously, the aim of the Policy Coherence for Sustainable Development Partnership (PCSD) is to “strengthen the capacity of governments to design, implement and monitor coherent and integrated policies for sustainable development” (38). Specifically, the PCSD

brings together governments, international organizations, civil society, think tanks, the private sector and other stakeholders from all regions of the world that are committed to working to enhance policy coherence for sustainable development (SDG target 17.14) as a key means of SDG implementation (39).

Table 1. Matrix: policy coherence for health equity and well-being

Governance	Approaches to policy coherence	Topics of concern/ locales	Policy coherence and health equity intersections
Global and supranational	SDGs; OECD PCSD; ^{ab} European Union (EU) policy coherence for development	Global trade; medicines, vaccines; commercial determinants (such as tobacco, unhealthy consumables); food security; development policies; health workforce brain drain; health security; climate change; peace and security; corruption	SDGs: ^c 1. poverty; 2. zero hunger; 3. health; 4. quality education; 5. gender equality; 6. clean water and sanitation; 9. infrastructures, industrialization, innovation; 10. reduced inequalities; 14. oceans; 17. partnerships for the goals EU: ^d Common Agricultural Policy, Common Fisheries Policy, environmental agreements, trade agreements, security
National	OECD PCSD monitor 2017; social determinants of health monitoring; ^e HEiAP; ^f ISA ^g	Policy interactions and their implication on the well-being “here and now”, “elsewhere” and “later” (OECD); social determinants of health (such as health equity through intersectoral action); intersectoral governance; ^h universal health coverage	Alcohol and drugs policy; agriculture; corruption; education; employment; environmental policies; health; migration; road safety; social protection; working conditions
Subnational	HEiAP; ISA	Local governments promoting health; ⁱ Regions for Health Network; Healthy Cities; South-eastern Europe Health Network	Civic engagement; community capabilities; criminal justice services; healthy living; ^j healthy urban environments; public infrastructure, such as transport, health and care facilities, housing; social coherence; urban planning

- a PCSD = Policy Coherence for Sustainable Development Partnership (28).
- b PCSD outputs include *Better policies for sustainable development 2016: a new framework for policy coherence* (8); *Policy coherence for sustainable development 2017: eradicating poverty and promoting prosperity* (29); and *Policy coherence for sustainable development 2018: towards sustainable and resilient societies* (30).
- c Global Burden of Disease Study 2015. SDG Collaborators (31).
- d European Commission (32).
- e WHO (33).
- f Bauman et al. (34).
- g ISA = Intersectoral Action for Health.
- h McQueen et al. (35).
- i Rantala et al. (36).
- j De Leeuw et al. (37).

Health equity is an essential component of sustainable development, but getting it on the wider policy agenda continues to prove challenging. Ways to enhance policy coherence for equitable public health outcomes are explored in the following sections.

What can public health actors do to promote policy coherence for health equity?

Policy coherence by its nature requires action from policy actors within and outside the field of public health. Actions by the public health community forms the focus of this section.

Challenges

Three broad challenges to understanding the role of public health actors in health equity stand out: definition, influence and permanence. These challenges arise because the public health field is a large topic of interest attached to a relatively small bureaucracy that often lacks political support or influence.

Definition

The amorphous nature of public health actors and the context-dependency of any public health actor or initiative means definition is often a challenge. The extent of variation in public health is considerable and poorly mapped. Variance is found on almost any axis, including priorities, structures, staffing, legislation, scientific capacity, surveillance techniques and capacity, the organization of responses, connection to health-care systems and position in government. International calls to various forms of best practice, such as the extension of the model of public health institutes, generally have limited effects on legislators and budgets. Variation means that no strong assumptions can be made about the organization, capacity, priorities, staffing or institutional location of public health actors in any given system.

Influence

This is exacerbated by the well-established fact that many of the causes of health and ill health in general, and especially health inequities, lie outside the formal purview of health care and public health bureaucracies. Income inequities impair the health and well-being of disadvantaged people and may even diminish the health and happiness of everyone in the society: equity turns out to be a benefit across the entire society (40). Racial inequities produce stress in the discriminated groups that undermine their health.

Health care and public health can affect these big issues: health services, depending on their financing and methods of allocation, can have a major redistributive and egalitarian effect (41). Public health effects are generally indirect: for example, lead reduction and abatement will disproportionately benefit poorer communities because they are likelier to live in houses with unremediated lead paint and near busy old streets where automotive exhausts introduced lead into the soil. Reducing their exposure to lead, particularly that of their children, reduces the odds of their educational failure or criminal activity, which naturally increases earnings and wealth. The cost of removing lead from a building or the soil is very high for any single landlord or person, but the benefits for society of happier, healthier individuals could be dramatic. This indirect effect of public health policies partly explains why they are hard to promote. Nonetheless, the big effects on health equity are through overall fiscal policy and government policies that shape the entire economy (see: Kentikelenis et al. (42) on structural adjustment; Boushey et al. (43) on distributional effects of fiscal policy; Greer (44) on how the politics of industrial relations and workplace regulation affect health; and Stuckler & Basu (45) for an account focused on public health and austerity in Europe.

These decisions are not the responsibility of health ministries. At best, they are in the hands of the entire government (although this may not be the case in, for example, Eurozone Member States or any country with an independent central bank) and are subject to multiple and powerful political and commercial forces. Public health expertise is not widely perceived to extend to broad fiscal policy (46), though it is an area in which recurrent evidence-based analyses of the fiscal policy impact on health might be relevant. Given that health scholars and policy-makers are often perceived as interlopers in areas such as fiscal policy, it is likely that they will face challenges making health-based arguments for broad changes to the economy.

Permanence

This challenge is about the difficulty of sustaining policy coherence of any kind, including policy coherence for health equity. Governments will often commit in good faith to coherent policies, but over time, ministers, challenges and governments change. Methods of promoting policy coherence that depend on direct expressions of political will, such as direct oversight by the prime minister or a plan agreed across government, will therefore often cease to work relatively quickly.

Leaders who want policy coherence to be sustainable will need to look to two mechanisms beyond political will: bureaucracy, and empowering allies. Entrenching policy coherence for health equity in the bureaucracy can lead to a variety of policies (the HEiAP approach), including mandatory health assessment, changing the membership of key committees to represent health-focused interests, or staffing key bureaucracies with people engaged in the topic.

Empowering allies means anticipating when a given politician or government is no longer in power and ensuring that allies in civil society will be able to monitor and push for health equity (47). This means not only strengthening allies through, for example, support for civil society organizations, but also ensuring that government can be affected by outsiders through judicial review of decisions, transparency about decisions and performance data, and participatory opportunities for affected interests. These policies, well known to politicians, make it easier to sustain policies after the initial enthusiasm has gone away, and make it harder for opponents to root them out.

Overcoming the challenges: building HEiAP into governance

The following list presents concrete actions that policy-makers can take. Part I of the list touches on big systemic points, while Part II focuses more on administrative issues. Each point is listed and described, and the description is followed by concrete action points.

The question in each case is how to modify governance to favour health equity – in other words to design or redesign governance for HEiAP. If it appears like a list of actions about public administration, that is because often it is; the goal is to design HEiAP into public administration.

Context means that very specific recommendations are hard to make. The aim is to inform a rigorous analysis of the actual health, political and governance context and suggest actions, rather than prescribe courses of action to be followed.

Part I. Systemic mechanisms

A. Transparency

This refers to the ability to inform the public and any other actors not only of upcoming decisions, but also how and on which grounds these decisions are going to be made (48). The importance of transparency lies in its ability to identify misrepresentation and advance understanding of institutions. Data and decisions should be made available, particularly to health services and health experts, so they have the opportunity to challenge them if necessary and also be able to provide the public with simplified explanations.

According to Greer et al. (48), strategies to increase transparency include:

- reporting requirements through mandatory information-sharing for private and public entities (publishing annual reports for the public or reporting to the legislature, for example);
- performance-based measurements that regularly assess policy and programme results for effectiveness and efficiency (by putting strategies and statistics online, for instance);
- inspectorates;
- watchdog committees; and
- clear and useful public information through, for example, having open meetings and presenting information in a clear and usable format.

B. Accountability

This refers to the relationship between an actor (an agency) and a forum (government) in which it is the actor's responsibility to inform others (such as the public and colleagues) of decisions for which they can be sanctioned (48). This is a process by which the state ultimately is accountable to the rights-holders. Accountability can most easily be promoted and upheld using clear mandates and reporting. A policy has a higher chance of being effective when responsibility is delegated to an entity that can be held accountable for its success or failure.

Strategies to increase accountability include:

- a free, unbiased and popular scientific press (journals and medical articles that are easily accessible to the public, for instance);
- consumer protection from medical malpractice (through, for instance, patient advocacy services);
- standards and codes of conduct to define acceptable behaviour (such as rules on publishing information about the health sector); and
- means of addressing conflicts of interest to ensure decision-makers are not motivated by private interest (through functioning watchdog organizations, for example).

Part II. Administrative mechanisms (participation, integrity and capacity)

A. Ministerial linkages and the public health minister

Ministerial linkages can be understood as coordinated governmental approaches, or working together at cabinet level. It can also be referred to as joined-up government, a whole-of-government approach

and horizontal management (35). Linkages can vary in form, duration and intensity, sometimes involving all the ministers of a cabinet and other times encompassing narrow activities or policies.

Strategies to increase the capacity and integrity of ministerial linkages include:

- integrating the health ministry with relevant interdepartmental committees to increase health exposure in other ministries; and
- increasing communication between ministries.

B. Interdepartmental committees

These committees generally operate at bureaucratic level, where the main goal is to reorient ministries around a shared priority. Their roles depend almost exclusively on context and are focused on problem-solving, generating evidence, coordination, advocacy, monitoring or implementation around a given policy or issue. Ideally, each government structure would have a specific interdepartmental committee focused on health. The problem is that most governments have an enormous amount of coordinating committees; some committees have been around for 50 years or more, but is the health ministry part of them?

Instead of reinventing the wheel and creating yet another interdepartmental committee to support health, it would be more efficient and effective to integrate members of the health department into committees that already exist in the outlined areas. For example, if there is a committee on benefits that involves the social security minister, finance minister and minister of economics, but not the health minister, then an opportunity is being missed.

Strategies to increase the health ministry's involvement in interdepartmental committees include:

- looking beyond the realm of health to factors that influence health, such as education, income, nutrition and living conditions; and
- inviting health ministry members to sit on other relevant committees.

C. Public engagement

Stakeholder and public engagement is about a continuous process of involvement rather than single consulting events. The benefits include having an informed citizenry and increasing public trust, and promoting the generation of new ideas.

Stakeholder engagement involves collective decision-making for health usually through a combination of public agencies, institutions and non-state actors. Public engagement can be regarded as an expression of the public's needs, values and preferences in their own voices, ideally resulting in successful health promotion charters or other intersectoral governance initiatives.

Strategies to increase public engagement include:

- client surveys, the main goal of which is to obtain feedback from those affected by governmental decisions;
- forums that provide feedback for those directly affected or involved in decision-making, such as interactive engagement platforms; and
- advisory committees that provide the opportunity for consistent and regular interaction between an organization and the people it serves.

D. Joint budgeting and delegated financing

Joint budgeting promotes collaboration between two or more government departments to achieve a shared goal. Its main strengths include expanding the area of interest and responsibility of stakeholders and promoting greater flexibility in the way funds might be used.

Delegated financing, on the other hand, does not necessarily mean intersectorality, but it offers opportunities for intersectoral governance. The concept finds its strength in the systematic application of the co-financing principle, allowing for an increase in available funds. It can also enhance intersectoral action for HEiAP through the promotion of a collaborative commitment to health.

The main difference between the two is that delegated financing needs adequate funds to make an impact, while joint budgeting can work well when an organization/institution has good financial and accountability mechanisms, clear legal and financial frameworks and shared policy goals.

Strategies to increase joint budgeting and delegated financing, as described in McQueen et al. (35), include:

- identifying the rationale, potential health and non-health benefits, and added value to sectors of pooling resources;
- establishing clear, achievable outcomes;
- determining how current funding and legislative frameworks are operating across sectors;
- moving towards flexibility in legislative and regulatory frameworks governing joint budgeting;
- engaging in sustained efforts to build cross-sectoral trust, and training in common skills and competences;
- considering performance-related incentives;
- identifying the economic costs and benefits of joint budgets;
- securing resources through legislation;
- engaging in governance; and
- promoting government linkages.

Measuring policy coherence

Policy coherence, as discussed above, is the so-called holy grail of public administration, but is one of the most difficult concepts to measure within and across fields.

Indicators: structure, process and outcome

The necessary condition for coherent policies on health equity is stable political institutions and governance. Political institutions hold much of the responsibility for creating an environment that allows for an unequal distribution of health and health care. This can be lessened through the creation of binding legal documents that prevent inequitable welfare state policies, labour markets and systems of health-care provision (49).

Annex 1 presents examples of policy coherence measurements. As explained by McQueen et al. (35), governance is a relatively old concept which ultimately proclaims that state action matters. It has been defined simply as a way of managing the course of events within a complex social system (50). Some of the key features of governance, as defined by Stoker (51), can be viewed as:

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

Annex 2 focuses on assessing policy coherence with a self-assessment questionnaire.

Indicators and self-assessment

Governance is a process rather than a structure or an outcome, one that ideally includes three criteria: information, intelligence and influence. Information tells us what is going on, intelligence is the ability to adapt what is going on for one's own benefit, and influence is having the power to support the process and see it through.

Because governance is seen as a process, process indicators can be used to survey administrations. These indicators have a sensitivity to differing institutional and political contexts and are suited to gauging the extent to which coherence is possible. They also serve as complements to general governance indicators (such as Quality of Governance and Varieties of Democracy) already in existence.

Based on the six established systemic and administrative mechanisms, a list of relevant indicators can be determined. Beginning with the systemic mechanisms, *transparency* can be made up of three indicators described by Greer & Lillvis (52). The first is expanding access to health data, which can include various other indicators that disclose territorial-, class- or ethnicity-related health inequities, but more importantly, allow increased international comparison. The second is expansion of the range and capacity of people involved in using health data; this would imply a need to get finance and social welfare committees involved in the health sphere. The final indicator points to access expansion to ordinary citizens, allowing citizens to take on a more active role in assessing health policies and regulations.

In the realm of *accountability*, the most traceable indicator is the sending of regular reports to the legislature. Party manifestos and government documents, such as relevant public health initiatives issued by the ministry of health, can also be examined. Other indicators include the strength of civil society and legislative actors' resources.

In relation to administrative mechanisms, many indicators overlap. Beginning with *ministerial linkages* and the *public health minister*, the most important indicator is public health legislation, followed by manifestos and legislative documents relating to each ministry. Other indicators may include government plans and targets, regular reports to the legislature, and expanding access to data and implementation using health equity impact assessments.

Many of the previously mentioned indicators, including government plans and targets, regular reports to the legislature, expanding access to data and implementation, can also be used in *interdepartmental committees*. Key indicators for *public engagement* include stakeholder access to knowledge and engagement, and discussion of the issue through social media. Indicators surrounding *joint budgeting* and *delegated finance* could contain revenue and debt measures, and budgeting behaviours.

The governance domains of integrity and capacity matter. Integrity means organizational coherence, coherent missions and lack of corruption. Corruption almost always exacerbates health inequities by effectively privatizing public goods such as justice or public health protection. Policy coherence is often easier when the organizations that are to be made coherent with each other are coherent and functional in themselves. Capacity is important in analysing the impacts of health inequities, detailing policy problems that could undermine coherence, and understanding the political implications. For example, passing tobacco-control legislation without creating opportunities for challenge by the tobacco industry requires skilled project management within government that can anticipate and prevent procedural challenges under a variety of treaties, EU legislation and constitutions (53). Understanding how to manage such prospective threats is a specific skill, and an example of the crucial contribution of policy capacity.

Annex 3 provides examples of policy coherence contributing to health equity.

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Annex 1. Policy coherence measurements

Examples of policy coherence measurements are set out in Table A1.1.

Table A1.1. Examples of policy coherence measurements

Institution	Framework	What is measured
United Nations Statistical Commission	SDG 17.14, enhance policy coherence for sustainable development	Number of countries with mechanisms in place to enhance policy coherence for sustainable development (SDG 17.14.1)
United Nations High-level Political Forum on Sustainable Development ^a	National reviews of policy coherence	Country and context dependent
Organisation for Economic Co-operation and Development (OECD)	<i>Policy coherence for sustainable development 2017: eradicating poverty and promoting prosperity</i> ^b	Monitoring institutional mechanisms; policy interactions; policy effects on other countries and future generations
OECD	Development cooperation peer reviews ^c	<i>Measuring distance to the SDG targets:</i> ^d assessing the performance of a country on how its commitment to the 2030 Agenda translates into action

a High-Level Political Forum on Sustainable Development. In: United Nations [website]. New York (NY): United Nations; 2018 (<https://sustainabledevelopment.un.org/hlpf>).

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d Measuring distance to the SDG targets: an assessment of where OECD countries stand. Paris: Organisation for Economic Co-operation and Development; 2017 (<https://www.oecd.org/std/measuring-distance-to-the-sdgs-targets.htm>).¹

¹ All weblinks accessed 15 April 2019.

Annex 2. Assessing policy coherence

A focus on structures and process is suggested as the means for exploring intersections of health equity and policy coherence concretely for countries in the WHO European Region. A self-assessment questionnaire (Table A2.1) enables countries to reflect on where and how they are performing in terms of the mechanisms that drive policy coherence for greater health equity.

Table A2.1. Self-assessment questionnaire on policy coherence

Part I. Systemic mechanisms	
A. Transparency	<p>Are health data regularly collected and published?</p> <p>Are health strategies and monitoring data available to the public (online)?</p> <p>Does the ministry of health host public meetings?</p> <p>When the health minister makes a major decision, how is it communicated?</p>
B. Accountability	<p>Is it mandatory for both public and private entities to publish annual reports for the public, or report to the legislature?</p> <p>Are watchdog organizations sufficiently funded and well-functioning in the country?</p>
Part II. Participation – administrative mechanisms	
A. Ministerial linkages	<p>What types of governmental decision-making is the health ministry involved in?</p> <p>Is the health ministry a member of all relevant interdepartmental committees (such as those on education, income, nutrition, and living and labour market conditions)?</p> <p>Are there established communication channels between health and other ministries?</p> <p>Is health equity impact assessment or health impact assessment mandatory in preparation of policies?</p>
B. Interdepartmental committees	<p>What are the key decision-making bodies within the government?</p> <p>Is the health department a member of these bodies? If so, in what capacity?</p> <p>How often does the ministry of health attend meetings/committees hosted by other ministries?</p> <p>When the government makes a major decision, to what extent is the health ministry involved?</p>
C. Public engagement	<p>To what extent is public feedback considered in the decisions made by the health ministry?</p> <p>Is feedback regularly obtained from population groups that are affected by governmental decisions (through, for instance, interaction with advisory committees or service-user surveys)?</p>
D. Joint budgeting and delegated financing	<p>What are the top three forums for deciding policy on fiscal and budgetary legislation? Explain the health ministry's participation in these.</p>

Annex 3. Examples of policy coherence contributing to health equity

The French national multiannual roadmap tackling poverty and social exclusion

The roadmap responds to the increase in poverty and social exclusion among groups in vulnerable situations, especially children, young people and single parents. An assessment was organized to identify and tackle the causes of poverty, the result of which was the roadmap's adoption in 2013 by an interministerial committee.

The plan includes a new approach to poverty, including greater coherence between different public policies at national and subnational levels. The approach is applied to six public policy areas: access to social rights and minimum benefits; jobs, work and vocational training; families and children; housing and shelter; health and access to health care; and access to banking services and the fight against overindebtedness.

The General Inspectorate of Social Affairs is responsible for implementing and revising the plan, with support from the prime minister. The tools used for implementation at national level include regular interministerial meetings organized by the Directorate-General of Social Cohesion and multistakeholder discussions. Similar meetings are organized at subnational level by government services. Reports on regional developments are requested at national level on a regular basis (1).

The French example demonstrates how policy coherence for reducing health inequities can be implemented through action on social determinants of health (2). The initiative:

- employs a formal framework for stakeholders involved in actions for improving equity in health
- is linked to ministerial portfolios nationally and locally
- promotes institutionalization of collaboration across different sectors and levels of government.

Promoting sustainable employment through active labour market policies in North Macedonia

Labour market outcomes in North Macedonia have been improving and the unemployment rate has been declining, but still remained high at 26.1% at the end of 2015. At the same time, the employment rate increased by 6.9% from 2007. Despite these favourable developments related to the employment and unemployment rates, the activity rate continued to be the main challenge, as it improved only moderately from 55.7% to 57%.

The government introduced active labour market policies in 2017 to tackle the high unemployment and inactivity. The key objectives were to: increase social inclusion of vulnerable groups on the labour market; reduce unemployment; increase employability of long-term unemployed people; and foster competitiveness of the economy (3).

This promotion of sustainable employment supports:

- poverty reduction, with consequent benefits to health
- employment that provides fair conditions and healthy working conditions
- tackling the negative impact of long-term unemployment on mental health (4).

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² All weblinks accessed 15 April 2019.



The WHO Regional Office for Europe

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

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Original: English



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