INSTITUTIONALISING INTER-SECTORAL ACTION: A TIME FOR LEAPING AND POLE-VAULTING

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Abstract: Too often there are insufficient incentives or governance arrangements in place to facilitate intersectoral working and funding. Yet many cost-effective strategies to tackle the risk factors for NCDs are at least partly delivered beyond the jurisdiction of the health sector. This article looks at ways to kickstart intersectoral working and leapfrog, or perhaps even pole vault, over some of the barriers that have limited its use. Financial and governance mechanisms are available to help harness support and stimulate actions in other governmental departments, and indeed more widely within society, to attain the goals of both lower levels and better management of NCDs.

Keywords: Intersectoral Action, Funding, Prevention, Early Intervention, NCDs

It is vital that health systems devote greater levels of attention to noncommunicable diseases (NCDs), the most important public health problem in the European Region. This is not as straightforward as it sounds. There are many practical and institutional barriers to system change. To make substantive progress requires smarter thinking about the way that resources are allocated to health promotion, disease prevention, treatment and recovery in order to counter the challenge of NCDs. This article will argue that this smart thinking needs to go beyond the jurisdiction of health care services. There is a pivotal role to be played by health care systems in harnessing both support and stimulating actions in other governmental departments, and indeed more widely within society, to attain the goals of both lower levels and better management of NCDs.

Why is this the case? Well many of the most effective and cost-effective strategies to tackle some of the risk factors for NCDs and promote positive social determinants of health are at least partly delivered in other sectors. Take for instance the health benefits of active commuting. Urban planners will not usually work in health care systems. Yet they can play an important role in increasing sustainable physical activity by ensuring that new towns and other developments are pedestrian and cyclist-friendly in order to encourage more active commuting to work or school. Such active commuting is associated with reduced body mass index (BMI) and fat levels that in turn can reduce the risks of many chronic disease including obesity, diabetes and cardiovascular disease. In the same fashion, tackling harmful alcohol consumption will be more effective when it involves enforcement of drink-driving.
legislation, business and local government restrictions on retail access, advertising authorities monitoring of alcohol advertising and schools delivering health literacy and public health messages to young people. 

Yet despite the evidence on the benefits of early intervention and preventive actions, investment within health care systems remains stubbornly low. One study (solely of OECD countries in the Region) suggested that the highest level of expenditure on prevention was to be found in the United Kingdom at 5.2% of current health expenditure, with only Finland and Italy also spending at least 4% per annum on prevention. Moreover, this analysis also indicated that between 2009/10 and 2012/13, on average, spending fell in real terms and still in 2014/15 was only growing at around 2% per annum in the OECD, a rate that is much lower than before the onset of the global economic crisis.

These low levels of investment not only reflect major pressures on health system budgets but inevitable short term perspectives; one challenge is that investing in measures to tackle NCDs may take time to have an impact. Any reduction in avoidable use of health care services in some cases will be more likely to benefit budget holders and policymakers many years in the future rather than in the current financial year. This is why it is important to also work with budget holders in other sectors to encourage investment in actions against the risk factors for NCDs that will contribute to additional long (and in some cases short) term benefits to health systems. For example, working with a range of sectors to reduce the levels of harmful drinking, will in addition to generating further additional long term health benefits, also have immediate benefits in terms of a reduced risk of violence and accidental injuries that need to be dealt with by the health system.

Calls for better intersectoral working arrangements are not new, but finding examples of successful partnership working remain the exception rather than the rule. For instance, one consultation in 2013 found that only 3 of 25 EU countries reported fully developed approaches to generate funds from different sectors for intersectoral interventions to promote gender equity and health. Too often there are insufficient incentives or governance arrangements in place to facilitate intersectoral working and funding. This article therefore looks at ways to kickstart intersectoral working and leapfrog, or perhaps even pole vault, over some of the barriers and cul-de-sacs that have limited its use. In particular, it looks at how good intersectoral governance arrangements with clear mandates potentially could rapidly facilitate greater levels of funding for this goal.

Leaping forward

Momentum towards the financing of intersectoral actions to tackle NCDs is growing; a review of actions in 2016 was able to point to some experience within and beyond the European region. These actions change governance arrangements in different ways, making it easier for health and other sectors to share resources and funding; importantly there can also then be joint accountability for the achievement of specific health related goals.

One way to leapfrog or even pole-vault over hurdles to intersectoral activity is to provide funding streams from health (or indeed other sectors) on a project by project basis where funding is contractually conditional on having an intersectoral partnership between health and one or more other sectors. These funds might be managed at a national or local level by health budget holders or by local governments. Social insurance funds potentially may also set aside some funds for these types of activities. The process for allocating funding may be prescriptive, i.e. stipulating that funding is linked to use of a specific cross-sectoral programme to address an issue, or it may allow for innovation in the way in which a priority issue is addressed.

This may be a competitive process where organisations from two or more sectors have to develop a proposal setting out how funds will be used to address a NCD concern. Examples include schemes in Finland and Denmark where different tiers of local government apply for funding for intersectoral health promotion programmes. While in many ways relatively simple to design, these schemes tend to be time limited and often small in scale. This may mean that partnership sustainability beyond the terms of the contract may be difficult to achieve. But this barrier is surmountable. One approach used in the Public Health Agency of Canada’s Innovation Strategy may provide a useful way of getting round this issue.

To encourage appropriate sustainability, funding is provided in three phases for intersectoral projects. Potentially they can receive funding for up to eight years to scale up those projects shown in the first and second phases to be successfully implemented and evaluated.

A more radical way of changing governance arrangements would be for health (or other sector) budget holders to set aside an agreed level of funding with the explicit intention to facilitate many different intersectoral activities to address NCDs and their determinants. Such funding schemes would not be time limited; governments would commit to having such funds in place for the very long term – ideally this would be done with cross-party consensus, so that schemes would be more likely to survive a change in government. In a sense this would mean the creation of a ‘Health for Wealth’ fund, operating for the common good in the same way that some Wealth funds, e.g. in Norway, are used. This would mean that even if specific intersectoral projects came to a natural end, or were shown to be ineffective, funding would be available to encourage new innovative ways of working together.
One challenge with a ‘Health for Wealth’ fund may be that it remains under the control of one ministry, e.g. health. This might mean that funds are at risk of being diverted to a different purpose than intended, for instance to plug shortfalls and urgent demands in other areas of the health care system. In countries with well-established governance and regulatory mechanisms, such as the UK, funds that in theory have been earmarked for a particular purpose, such as for public health or mental health, have quietly been used at local level for other purposes when budgets are tight. So to pole-vault over this potential obstacle one option would be to create new institutional structures, such as an independent agency, so that the way that dedicated funds for intersectoral activities were used could be independent of but still accountable to one or more government departments.

One example of this is the Health Promotion Switzerland agency. This agency receives funding from an annual surcharge on health insurance premiums; it then co-finances (via a competitive process) intersectoral projects that are aligned with its strategic goals, particularly in the areas of diet, physical activity and risks to mental health. Other examples include the Healthy Austria Fund and the recently established Lithuanian State Public Health Promotion Fund.

Leveraging resources from many sectors

Intersectoral action is not facilitated simply by allocating dedicated funds (often from the health sector alone) to specific projects and activities. It will also be helped if it is easier to leverage resources and funds from sectors other than health. Different sectors will also have different priorities and organisational and regulatory structures. They may not be persuaded that improving health outcomes is of sufficient importance, even if financially compensated for taking action. Health systems need to become more savvy in the way that they work with other sectors. They will need to identify and highlight benefits, including economic returns, of interest to these sectors from addressing risk factors for, or better managing, NCDs.

For example, measures to improve health literacy and mental health promotion initiatives in schools have been associated with education sector specific benefits, including reduced teacher stress and absenteeism, better classroom atmosphere and better educational attainment and reduced need to attend expensive special educational needs classes or schools.

In the same way if the police and transport sectors collaborate with health to reduce the risks of harmful drinking, as well as having direct health benefits, this will positively impact on the costs of dealing with road related accidents and congestion, as well as levels of anti-social behaviour and inter-personal violence. If sectors other than health become more aware of the benefits of addressing risks of NCDs, then the likelihood of potential buy-in improves.

If buy-in is achieved, then one practical way to leverage funding from multiple sectors is to adopt a joint budgeting approach. This might involve some form of budget alignment to address a specific issue, with mutually determined targets and outcomes, or there may be a formal legal process to establish a pooled budget, often time limited, to be spent on agreed projects or delivery of specific services.

Leapfrogging cannot happen in isolation

As the saying goes, Rome was not built in a day. Even if the importance of intersectoral activities is recognised and financial incentives are provided, the extent to which implementation will be effective will in part be dependent on many other factors including the time needed to build trust and mutual respect between organisations in different sectors. This is a topic in itself for another article, but practical measures that can help include the co-location of staff from different organisations in order to help build up relationships and strengthen trust, as well as the early involvement of all sectors in any planning and priority setting process. Contractual arrangements can also provide safeguards in partnership working. Finally, the whole process of intersectoral working can also be made even more effective if Ministries of Finance can be engaged and potentially take a lead in reforming governance and regulatory frameworks to further create the conditions to share resources and funding across intersectoral boundaries.

References