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Time to dismiss the idea of a structural fix within government? An analysis of intersectoral action for health in Danish municipalities

DITTE H. HOLT[1], GEMMA CAREY[2] & MORTEN H. ROD[3]

[1]*National Institute of Public Health, University of Southern Denmark, Copenhagen, Denmark,* [2]*Centre for Social Impact, University of New South Wales, Sydney, Australia, and* [3]*National Research Centre for Disadvantaged Children and Young People, Metropolitan University College, Copenhagen, Denmark*

Abstract

Aims: This paper examines the role of organizational structure within government(s) in attempts to implement intersectoral action for health in Danish municipalities. We discuss the implications of structural reorganization and the governance structures that are established in order to ensure coordination and integration between policy sectors. *Methods:* The paper is based on 49 interviews with civil servants from health and non-health sectors of 10 municipalities. Based on participants' experiences, cases have been described and analyzed in an iterative process consulting the literature on Health in All Policies and joined-up government. *Results:* Continuous and frequent processes of reorganizing were widespread in the municipalities. However, they appeared to have little effect on policy change. The two most common governance structures established to transcend organizational boundaries were the central unit and the intersectoral committee. According to the experiences of participants, paradoxically both of these organizational solutions tend to reproduce the organizational problems they are intended to overcome. Even if structural reorganization may succeed in dissolving some sector boundaries, it will inevitably create new ones. *Conclusions:* **It is time to dismiss the idea that intersectoral action for health can be achieved by means of a structural fix. Rather than rearranging organizational boundaries it may be more useful to seek to manage the silos which exist in any organization, e.g. by promoting awareness of their implications for public health action and by enhancing the boundary spanning skills of public health officers.**

Keywords: *Intersectoral action for health, Health in All Policies, intersectoral governance, joined-up government, organization structure, boundary spanning, local government, municipalities*

Introduction

In public health, concerns about health inequalities and growing evidence on the social determinants of health have encouraged calls for joined-up approaches and intersectoral action for health. This necessarily entails attempts to overcome the departmental and sectoral silos of government. Most notably is the whole-of-government strategy of Health in All Policies (HiAP), which involves the introduction of governance structures and mechanisms for delivering action on the social determinants of health [1,2]. Whole-of-government strategies like HiAP are backed by recommendations from the World Health Organization [3], as their implementation is believed to be instrumental in the creation of healthier policies [4]. In other words, it has become a core element in public health to transgress the silos of different policy sectors by means of governance structures that increase intersectoral collaboration and integration of health concerns across sectors.

However, the experiences with HiAP and similar approaches appear to be mixed at best [4–7], and recent research suggests that governance structures do

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not necessarily bring about policy change. For example, in a recent commentary Breton describes how [8], despite the establishment of interministerial committees in France, no meetings had been arranged. This problem is not confined to public health and HiAP. In a recent book, Tett provides an account of the ways in which organizational silos cause problems in many areas of contemporary business and politics [9]. Tett points out that organizational silos cannot – and should not – be abolished, but it is essential to avoid overly rigid and entrenched classification systems that stand in the way of effective action. In short, silos need to be managed before they master us [9].

Though efforts have been made in various fields to break down the existence of government silos, policy actors also acknowledge that these silos exist for good reason as they enable government to break down the complexity of citizens' lives and hereby simplify the task of governing [10]. In (classic) organization and public administration research, structure is a highly-developed concept – and typically includes elements such as specialization of tasks, division of labor and designated authority relationships [11–13]. However, within the collaboration literature, structure has not attracted the same degree of interest, partly because researchers have emphasized the process of *organizing* rather than *organization* by means of formal structural arrangements [14].

The aim of this paper is to examine the role of organizational structure in attempts to implement intersectoral action for health in Danish municipalities. In particular, we look into the implications of structural reorganization as well as the governance structures that are established in order to ensure coordination and integration between policy sectors. In doing so, we argue that the current emphasis on structural solutions to enable intersectoral collaboration for health appears to be largely unsuccessful. Our analysis indicates that, rather than breaking down silos, processes of reorganization may reproduce the "siloization" of public health.

The municipal setting

Though municipalities have not received much attention in the scholarly literature on HiAP, several researchers agree that local governments are important for addressing the social determinants of health [15–17]. Municipal services are delivered where people learn, work, play, and live [18], which means municipal governments are uniquely positioned to establish healthy settings [19]. Moreover, municipal policy-makers are said to have easy access to local communities and members of differing policy sectors, and thus to impact health through intersectoral

collaboration [16,20]. Hence, municipal governments provide an important area of research. Weiss et al. find that intersectoral action at local and national levels are heavily influenced by similar factors [19]. As such, the study of municipal government may provide insights with more general relevance for efforts to introduce HiAP, not just at the local level but also at the national level.

In Denmark, the political system is decentralized compared to other countries [21,22], with 98 municipalities responsible for welfare services such as primary education, culture and leisure, social services, eldercare, employment services, and local planning. A large government reform in 2007 further strengthened the municipal government level, and the then larger municipalities were given extended public health responsibilities. As a result, general health promotion and prevention became a municipal responsibility [23]. Placing this task within the municipal jurisdiction was partly based on ideas about intersectoral action. A guide to the Danish health act states that: "prevention and health promotion are multisectoral tasks. Municipalities have good opportunities to adopt a holistic approach to the task of prevention and to think health efforts together with activities in other sectors" [24]. To comply with these expectations many Danish municipalities have established intersectoral governance structures and ensured a general mandate for health in municipal strategies and policies [25–29]. The Danish municipalities thus provide an important opportunity to study joined-up governance for health.

Method

This paper is based on data from 49 semi-structured interviews carried out during field visits in 10 Danish municipalities between June 2013 and August 2014. The initial aim of the study was to understand the tension observed between a general popularity of intersectoral policymaking for health and the great challenge posed by its implementation. In order to do this, the study was designed as a qualitative explorative study and investigated the dynamics and tensions associated with intersectoral policymaking in the context of municipal health promotion in Denmark [30].

A maximum variation strategy was applied in selecting municipalities relating to size, geographical location, socioeconomic status, and political as well as administrative organization of public health. To ensure the confidentiality of the municipalities, they have been given numbers (i.e. 1–10).

DHH carried out the 49 semi-structured interviews [31,32]. Participants were municipal civil

servants from both health and non-health sectors, mainly representing top- and midlevel bureaucracy. Interview guides were developed as a general template and then individually adapted to each interview (see the template in additional material for Holt et al. [33]). The themes included local practices of health promotion and prevention and its relation to participants' daily tasks, administrative and political organization, local policies and policymaking, and participants' experiences with intersectoral collaboration and partnerships. The interviews varied in length between ½ and 2 hours. In-depth ethnographic fieldwork was carried out in two municipalities, which serves as a backdrop for this analysis. The interviews were transcribed and thematic codes were developed through iterative readings of field notes and transcripts. Finally, cases were written up to allow for more holistic data organization where explanations derive from the analysis of the "whole" case in order to provide an understanding of the interwoven parts of the data [34]. The final analysis of the cases was conducted in an iterative "dialogue" with literature on HiAP and joined-up government, following an abductive research strategy [35]. For further details see Holt [30].

Results

To present our findings, we first outline the general argument that structural reorganization is not sufficient to enable policy change. We then analyze the implications of two common governance structures often introduced to transcend organizational boundaries: the central unit and the intersectoral committee. The final sub-section presents a case of a seemingly successful municipal organization.

The failure of continuous reorganization

Across the 10 municipalities, the interviews gave accounts of continuous reorganizations in the attempt to find a structural fit for the public health tasks introduced with the 2007 reform. For instance, between 2007 and 2015 municipality 3 first organized public health in an intersectoral unit made up of culture, communication, integration, and public health teams. The intention was to combine portfolios that cut across the municipality. By referring directly to the Chief Executive, the administrative head of the municipal government, the new structure was aimed at (1) avoiding sectoral bias and (2) ensuring a powerful mandate. As the public health manager described it:

> "it was really exciting on paper because it was some interesting areas to combine."

Nonetheless, their work lacked consistency as there was no coordinating body to ensure coherence. The public health manager described how the unit kept changing its focus following the political winds and current focus of the Chief Executive and thus was unable to push for a public health agenda to be integrated across government. Consequently, they moved the public health team to a Strategy and Analysis unit for a brief period, before they decided to establish a public health office in the line-department Health and Care. The new public health office should provide a few public health services such as smoking cessation and patient education besides pursuing the strategic aim of integrating health into non-health services. To compensate for moving the public health team to a line-department (that is, a department that delivers services rather than a "central" agency or part of government concerned with strategic planning), the municipality introduced an intersectoral committee consisting of top- and mid-level managers to ensure coordination and shared decision-making. They further introduced three intersectoral working groups to support the committee in developing new policies and strategies and ensure their implementation. The new public health office functioned for little more than two years before the functions were divided into two separate sections; one decentral service delivery section offering health promotion services, and a small public health team at the City Hall with seven to nine public health professionals with the mission to work "strategically" to integrate health concerns across policies and ensure the intersectoral implementation of their health policy. After little more than one year, the whole municipality reorganized and the strategic public health team was again divided: a small group of staff was left in the strategic public health office still placed in the Health and Care line-department, some were placed in other line-departments to ensure integration of a health perspective with the so-called "core services" of non-health sectors, while two members of staff were once again placed in the central Strategy and Analysis unit. The intersectoral committee too was reorganized as it had failed to provide the shared decision-making intended. The public health manager explained that, while the different ways to organize public health held different advantages and disadvantages, they had not managed to solve the overall problem of establishing more widespread and profound intersectoral commitment and decision-making for health.

Other municipalities had similar stories. For example, in municipality 4 the public health team had been in a more or less constant reorganization for more than two years at the time of the interviews. This involved a merger from being a separate

line-department, to becoming integrated with the bigger department of Social Services, to being separated out again as a distinct unit, to then becoming integrated with the central unit Center for Policy and Staff. At the time of writing (fall 2017), the public health team was once again organized in a line-department together with other health services. The public health officers voiced the conflict they experienced between getting lost (disappearing) in the bigger service areas when merged, and struggling to establish relevant relations and partnerships when organized separately. They also pointed to a dilemma of combining the different requirements posed by their intention to work strategically with their service delivery tasks and local partnerships.

While the stories of restructuring were numerous in our empirical material, they were not accompanied by numerous stories regarding changes in policy – generally, the aim of integrating health across sectors remained the guiding principle – and the resulting benefits of restructuring appeared limited. In a neo-institutional perspective, the reorganizations may thus be interpreted as a recurring ritual to compensate for structural disadvantages and limitations by introducing new structures [36,37]. As phrased in an interview with a municipal mid-level manager:

> It is difficult to find out how to handle it [public health], so it's hard to find a good way to organize it. (Mid-level manager from public health unit, municipality 4)

In line with this quote, O'Flynn and colleagues have argued that while structural reorganization may dissolve some boundaries [38,39], it will inevitably create new ones. This is because no tasks in government are completely separate; they each naturally contain parts of the other. Both our research and the broader literature on restructuring indicates that while the benefits of restructuring in terms of improving inter-sectoral collaboration are limited, restructuring is resource demanding and inevitably breaks established relationships, which need to be reconfigured and rebuild. As phrased by Bardach [13]: "if there is one proposition on which consensus among students of public administration is firm and widespread, it is that reorganization normally produces little of value at a very high cost in time, energy, and personal anxiety." Moreover, these stories of ongoing restructuring without corresponding changes in policy indicate that the basic understandings of public health policies and interventions remained silo-fixed. That is, the public health objectives remained the same and to a large extent reproduced a classic public health agenda. In other words, reorganizing was used in an attempt to promote the aims of public health, but did not have substantial implications for the ways in which public health was practiced. Below we illustrate this further by showing how common governance structures tended to reproduce the problems they were intended to solve. In order to further understand the implications of restructuring for joined-up governance, we analyze the two most common examples of governance structures introduced in the municipalities: the central unit and the inter-sectoral committee.

The central unit

Central units are generally created in order to ensure coordination and reorient existing agencies and departments around a shared intersectoral priority. They consist of a group of civil servants and are deployed specifically to pursue a particular policy agenda. In contrast to agencies and line-departments, the central unit is generally not responsible for delivering any services [40]. Policy teams or specialized groups are sometimes moved into central units in the belief that bringing groups to "the center" can strengthen their coordination and oversight role and imbue them with institutional power to enforce action amongst other departments [41]. However, in our study of Danish municipalities we find a number of challenges that restrict the ability of public health teams placed in central units to integrate health across local government policies and services. This is consistent with the broader literature on central committees [41].

In our material, several municipalities had attempted to organize public health as part of a central unit in order to make health a stronger priority across government departments and to ensure integration of health concerns into non-health policies and services where appropriate. In Municipality 3, interview participants described how the public health team had been placed in Strategy and Analysis: a central unit that served the line-departments, in order to integrate public health as a central aim in municipal policies and strategies.

> Then we were part of the Strategy and Analysis unit for a brief period, but it did not work well either because the Strategy and Analysis unit does not deal with subject specific issues, they will not be subject specific. They aspire to be consultants who jump from department to department while the subject specific should come from the line-departments. But we [public health] say, we may be skilled facilitators, we must be skilled analysts, but we must also provide expertise about the particular policy content from a public health perspective […] we know about evidence in the subject area. (Manager of public health team, municipality 3)

The quote describes a tension between two different objectives: facilitating processes on behalf of line-departments, which is the central mission of the central unit; and introducing evidence and promoting public health outcomes, which is the mission of the public health team. Being organizationally placed in the central unit (that facilitated policy development across the municipality) meant that the public health team was unable to advocate for the integration of health concerns, because pursuing their own mission conflicted with the overall facilitating role of the central unit. This constituted a dilemma between promoting their health objectives and serving the needs of other departments. Consequently, the public health team did not experience increased institutional power or legitimacy by being placed in the central unit and was soon reorganized again, as it had not brought about the desired integration of health concerns in policymaking.

In municipality 4, the public health team had been placed in the central unit, Center for Policy and Staff, which focused on overall municipal development at a strategic level. Moving the public health team to the central unit was understood as a way to make public health more prominent and visible among line-departments across the municipal organization, thus providing the uptake and integration of health concerns in non-health policies and strategies.

> The politicians felt that their goal had been achieved because health would now be integrated everywhere. (Public health professional, municipality 4)

However, the public health team struggled with adapting to their new role and felt stifled:

> We are madly frustrated because we've been in this nothingness for two years now. (Public health professional, municipality 4)

> We have been placed in this Center for Policy and Staff where we are not very visible. We are supposed to work across the organization and that's what we are waiting for. (Public health professional, municipality 4)

Hence, placing public health in the central unit, in order to increase the internal visibility of health concerns across the municipal organization, ultimately resulted in decreasing the public health team's ability to engage in local collaboration. The objective of facilitating policy development and internal strategies – rather than service delivery – in Center for Policy and Staff was experienced as distant and somewhat irrelevant to the public health team's focus on health promotion activities:

> It's not working […] it is better to place the team in the department where we have most of our collaboration and partnerships. It does not make sense to be in a unit where the discussions are foreign. (Mid-level manager, public health team, municipality 4)

The quote gives voice to a tension, which we found across the 10 municipalities, between the public health team's service delivery tasks, where they mostly collaborate with frontline staff, and the strategic ambition of integrating health concerns into non-health policies and strategies. At least two challenges seem to be at stake here. (1) The public health team's competences and previous experiences were focused at service delivery while the relocation to the Center for Policy and Staff changed their role and function thus expecting them to operate at the strategic level of the organization. This was done without attention to the composition of competences and skills of employees in the public health team. In addition, (2) the example highlights a more general dilemma regarding how to organize intersectoral action for health, which involve collaboration both at strategic, tactical, and operational levels [42]. Politicians and high-level management in municipality 4 emphasized how placing the public health team in the central unit was a means to increase visibility and ensure integration of health concerns across the municipality, but this constituted increased visibility *centrally* in the municipal organization. Meanwhile the public health professionals wanted to engage more closely with Children and Youth Services and Social and Health Services among others, in order to provide health promotion programs to the public. Their experience of meaningful intersectoralism was an experience of local service delivery collaboration and thus visibility *decentrally* among their partners. Consequently, and contrary to the expectations of top-management and politicians, the public health team did not experience increased institutional power when placed in the central unit. Their experience was that they lost the close relations to their daily partners and were subsumed by other agendas.

The intersectoral committee

The second example of governance structures introduced to ensure coordination and help integrate health concerns across sectors is the intersectoral committee. Intersectoral committees are a common organizational response to deal with the challenge of coordination across government, be it local, national or federal [43,44], as well as one of the preferred governance structures recommended in the HiAP

literature [1,2,40]. They can take numerous forms, both as political committees, like parliamentary or interministerial committees, as well as administrative coordination groups and interdepartmental committees. Their mandate is to work across government to improve knowledge sharing and information flows, as well as to introduce shared decision-making, thereby promoting holistic thinking and innovative solutions to wicked policy problems [41]. In our study, intersectoral committees were the preferred way of engaging non-health policy sectors in intersectoral collaboration for health, and were established, at least in part, in all 10 municipalities. Members of the intersectoral committees varied, but would often consist of either top- or mid-level bureaucracy.

In line with findings reported elsewhere [41,45], the success of the intersectoral committees were mixed. Across the 10 municipalities, interviews often portrayed how the intersectoral committees were ill functioning and lacked the necessary energy to ensure significant policy change. They were often referred to as running "ad hoc," "lukewarm," or in need of being "revitalized." Several accounts reported how intersectoral committees, often equipped with the mandate to ensure the implementation of an intersectoral health policy, had turned into a forum for sharing information:

> We have formed an intersectoral committee, we have it, but it must simply be revitalized. It needs to be relaunched in a way [...] it has become a bit fossilized [dead/unproductive, ed.]. You are sitting there and discussing, or not discussing. You are sitting there and presenting the work we do and what we've done in the past three-five months... and it's bloody irritating for people to participate (Managing Director, municipality 2)

The risk of intersectoral committees losing energy and commitment has also been reported elsewhere [41,45], and the consequences are often that the committee ceases to meet or that high-ranking members either send lower-ranking deputies or simply abandon their commitment whereby the committee's mission is forgotten [40]. This also constituted a main challenge in the municipalities:

> No, I don't think there is a strong management focus [...] obviously, everyone wants to, but we also need to acknowledge that in reality we have limited resources [...] and probably you always have three or four other projects [commitments ed.] with higher priority than this. They [management] want it, but they always have something that is more important. (Policy Officer, Health and Social Services, municipality 1)

The quote illustrates that health is not a key priority of non-health sectors. While not surprising, this often conflicted with the public health strategies aiming to introduce health as an overarching aim. Greer and Maresso have argued that in situations of low political importance of an issue – here integrating health concerns across sectors – interdepartmental committees could impose a solution and be very useful [40]. Our study contradicts this to some extent; we found a lack of commitment and priority across bureaucratic levels created mixed success of governance structures like the intersectoral committee. Most of our accounts show intersectoral committees being low priority and constituting a "mutual orientation club." Importantly, however, the public health teams rarely managed to translate their public health aims into relevant boundary issues (i.e. policy issues that sit across portfolios and given priority) that would encourage stronger commitment from non-health sectors. The strategy of introducing health as an overarching aim and priority of other policy sectors was generally not accompanied with new understandings that reached beyond the "silo of public health" itself. Instead, the public health teams remained dedicated to their public health agenda, primarily focusing on the risk factors and lifestyle issues: diet, smoking, alcohol, and lack of exercise [6].

The overall tendency across the 10 municipalities was that the intersectoral committees sometimes functioned rather well short-term with a fixed task, e.g. developing a shared strategy. As a long-term governance structure, most of them failed in terms of providing intersectoral decision-making and implementation. Rarely did the intersectoral committees initiate productive collaboration resulting in new innovations and solutions, as was often hoped when bringing together knowledge, competences and decision-mandates from different policy sectors.

A structure that works?

While stories of multiple reorganizations and lack of success associated with the coordinative governance structures were common in our material, one municipality stood out by reporting on a somewhat well-functioning intersectoral governance structure. Municipality 5 used what they referred to as a matrix organization to integrate health concerns across the traditional siloed line-departments. This matrix consisted of an intersectoral committee, referred to as the strategic management group, which was mandated to make decisions regarding the municipality's intersectoral health policy. A small public health unit

served the intersectoral committee. In each line-department small "health groups," funded partly by the public health unit, were established to translate and implement the decisions of the intersectoral committee into sectoral policies and programs. The relative success was attributed to strong political commitment and substantial management support as well as long-term dedication to the intersectoral agenda, which had allowed them to adjust their governance structures in an iterative process and establish strong intersectoral relationships over a period of more than 10 years.

Despite their overall positive evaluation of the established governance structure, the municipal participants still described low priority of health in their accounts of intersectoral collaboration:

> A challenge is the dual management where a manager in the strategic health group also has other core functions. Balls are probably dropped on the floor [expression: to juggle many balls] […] many balls are being dropped. (Coordinator, Children and Youth Services, municipality 5)

The interviews described how planned meetings were being compromised with some being cancelled altogether:

> … it is vulnerable to have another core task while also having a commitment to health […] when there is time pressure […] you have to make priorities. And then it's the secondary [i.e. health] you neglect. It's completely natural. (Coordinator, Children and Youth Services, municipality 5)

Making health a shared priority was a challenge voiced by participants across all 10 municipalities. In the material, we have multiple accounts of public health acknowledged as being important but low priority compared to core operations of non-health services. However, what seemed to be accommodating in municipality 5 in terms of translating their intersectoral ambitions into local practice was their implementation structure, their strong management focus, and the long-term commitment to the intersectoral agenda allowing for intersectoral relationships to develop.

Particularly, strong leadership at all levels, not solely political commitment, appeared vital to their ability to translate high-level decisions into local programs and practice.

> It cannot be controlled centrally. It depends on whether it is possible to convey to all the local managers who are out there and who lead the front staff, that when they build competences and capacity they need to include the health perspective. […] It is a communicative task

and a massive management task because if we don't have a management saying WE WANT THIS then it will not happen. (Head of Social Services and member of strategic management group, municipality 5)

The quote voices how strong leadership at all levels was experienced as being key to successful joining-up. This finding is reflected elsewhere, where studies have highlighted the need for leadership support and commitment to cross boundaries both at strategic, managerial and local levels [41,42,46]. As Carey and Crammond phrase it: "Without champions at each level, joined-up ethos tends to 'wash out' and fail to take hold;" thus decisions or interventions at top-levels of governments fail to be implemented [41].

Moreover, what appears particularly important to the success of municipality 5, in addition to strong leadership, is the long-term commitment which had maintained the intersectoral agenda a key priority for a decade. This contrasted the "change fatigue" often voiced by participants:

> First, they must do this, then that, and then you must do it in another way. (Head of section, Children and Youth Services, municipality 3)

The long-term commitment had allowed for close, networked relationships across line-departments to develop, which several participants emphasized. In other municipalities, continuous restructuring, though motivated by the need to find the right fit for public health, seemed to be counter-productive in terms of ensuring the strong working relationships required to effectively manage boundary-relations:

> The challenge with reorganization is always to find new relationships. It takes a very long time. You lose knowledge and you lose relationships which need to be rebuilt. It's as if you're pulling wires apart and need to rewire, and it is often forgotten that you have to find new pathways and understand your new context. How am I now connected to everything else? (Mid-level manager, public health team, municipality 4)

This is supported by Williams [47], who found that building effective, sustainable relationships is a necessary part of intersectoral working. Similarly, O'Flynn et al. found that long-term professional relationships were important to the ongoing commitment to joined-up agendas [38], and further that the development of rich, networked relationships constitutes a significant leadership quality. The formation of such rich, intersectoral relationships takes time and thus requires ongoing priority

of the intersectoral agenda, not continuous structural reorganization.

Discussion

Our analysis indicates that structural (re-)organization alone is not enough to bring about collaboration and integration and, ultimately, policy change and action. Even if attempts are made to facilitate action and coordination across organizational silos it seems that, in many cases, public health remains in an entrenched and narrow silo of its own. In other words, the basic agenda of public health remains the same across different governance structures and processes of reorganization.

Placing policy teams within central units is based on the belief that this imbues said groups with authority to change policy and practices across the diverse portfolios of government departments. However, we found that the public health teams placed within central units did not experience increased institutional power. This is consistent with broader literature, outside of public health [41]. In our research, we found that these groups were unable to push for changes in other departments as the public health objectives, belonging to their own, separate sectoral agenda, conflicted with the facilitative role of central units. The focus on specific public health issues – coupled with a lack of training and skills in how to navigate the strategic level of government – left the public health teams in the central units marginalized and their problems in gaining traction across sectoral boundaries were mostly reproduced.

Forming intersectoral committees is based on the assumption that bringing sectors together, with the mandate to implement policy across government sectors, will improve knowledge sharing and information flows as well as ensuring innovative solutions and joined-up commitment. However, as our analysis illustrates, bringing policy sectors together does not necessarily entail that they are able to provide shared decision-making, nor that they feel committed to pursue health as a shared objective. This finding is consistent with the literature on joined-up government which shows that intersectoral units and committees often lack the accountability mechanisms to "get things done" in terms of changing policy and practice in other departments [4,43]: line-departments continue to carry the burden of accountability and implementation, while intersectoral committees without formal authority in other departments may generate ideas, but lack the capacity to ensure implementation. In their review of empirical research on joined-up government, Carey and Crammond thus find that interdepartmental committees have been found to limit [41], rather than facilitate, collaboration and will generally generate limited change at best.

Our analysis further substantiates this claim, as it shows how intersectoral committees do not easily translate as an implementation structure. Instead, they often turn into forums for sharing information. The matrix structure in Municipality 5 provides the best example of an implementation structure with the small health groups in each line-department dedicated to translating and implementing decisions concerning health into sectoral policies and practices. According to the findings by Carey and Crammond [41], intersectoral committees need to be supported by strong structural links (e.g. shared outcome targets) to the departments they are working with in order to function. However, even in municipality 5, prioritizing health concerns was voiced as a main challenge that needed to be addressed by measures other than structure alone.

The multiple stories of continuous reorganization, together with the constraints and tensions associated with the most commonly introduced governance structures to improve coordination and intersectoral decision-making, illustrate that there is no perfect governance structure to ensure the integration of health concerns across sectors. Though structural reorganization, when done right, may help to ensure a supportive architecture needed for successful intersectoral collaboration, O'Flynn has argued that reorganizing inevitably creates new boundaries [39], not only structurally but also symbolically and culturally: "Decades of practical experimentation with public administration reform shows us that restructuring does not remove boundaries; it simply reconfigures them" [39]. This further entails that joined-up governance is not a panacea avoid of the limitations of siloed government. Hence, instead of pursuing a structural fix, we propose that more attention must be paid to the creation of intelligent compensations for the disadvantages necessarily following any organization structure [48]. Thus, boundary spanning is required to compensate for structural limitations regardless of organizational structure chosen by governments.

Boundary spanning is the art of collaborative working across departmental and sectoral boundaries. The concept highlights the abilities to manage inter-organizational and multi-sectoral collaborative relations in networked forms of governance [46]. Carey and Crammond have found that the skills required for successful joined-up working are "problem-solving skills, coordination skills (getting people to the table), brokering skills (seeing what needs to happen), flexibility, deep knowledge of the system, and, for front line workers, knowledge of both how to work with their

community and how to obtain information about their community (demographics, needs, and so on), a willingness to undertake emotional labor associated with relational working" [41]. Williams furthermore points to the role of the boundary spanner as an interpreter and communicator [47]. This involves the ability to translate public health aims into relevant boundary issues, as well as an appreciation of otherness; i.e. valuing different cultures, motivations, gazes and practices of a wide range of professionals, organizations, and sectors. Others have referred to this function as "cultural brokers" who "make a real effort to empathize with, and respect another's values and perspectives" [47]. This appreciation of otherness somewhat contrasts the common approach of public health seeking to integrate health as an overarching aim across government without profoundly engaging with non-health sector perspectives.

Building on insights from Williams, O'Flynn et al. argue that joining up requires a supportive architecture that not only includes organizational structure [38], but reshapes incentives and behaviors, and in the longer-term, cultures and norms. As Tett points out [9], the ways organizations are divided into specific departments, or silos, reflect particular ways of categorizing the world. Such categories are culturally defined and historically contingent. The examples in this paper show how public health officers become frustrated, because various organizational solutions do not enable the intersectoral action for health they envisaged. But what if intersectoral action for health depends not simply on structural reorganization, but also on "mental reorganization" concerning the very category of public health[9]? For example, one way of mental reorganization would be for the health sector to increasingly support non-health sectors in meeting their own aims for equity and quality services (thus following the collaboration strategy as set out by Ollila [49]).

In terms of moving the intersectoral agenda forward, it is important to begin to delineate different types of cross-boundary work and entities and the training that individuals engaged in these need. As Keast has argued [50], there are a range of terms used to describe efforts to "join-up" or integrate different policy areas. These are often used interchangeably but actually connote different practices. Keast has identified cooperation, coordination, collaboration, and consolidation as four terms regularly deployed to create integration which all have, in practice, quite distinct implications. For example, cooperation requires the establishment of informal and voluntary relationships [51]. Coordination implies a need to align or "orchestrate" people, tasks, and activities in order to achieve shared goals. Consolidation describes the bringing together, or merging, of two entities into a whole [50]. Our data shows that consolidation is often sort out as the "fix" for silos (i.e. restructuring), however greater emphasis needs to be placed on coordination in order to achieve the goals associated with intersectoral and interdepartmental action for health (i.e. integration between policy areas). As Williams and others have argued, this requires both the right supportive architecture as well as specific training. In particular, an appreciation of "otherness" is required in order to translate the public health aims into relevant boundary issues and reach beyond the narrow silo of public health itself. Without this, efforts to joined-up responses to health may in fact dissolve into more entrenched silos which focus on lifestyle issues rather than the social determinants of health [6].

Conclusion

In conclusion, we suggest that it is time to dismiss the idea that intersectoral action for health can be achieved by means of a structural fix within government. Rather than spending time and resources rearranging organizational boundaries it may be more useful to seek to manage the boundaries and structural silos which exist in any organization, e.g. by promoting awareness of their implications for public health action and by enhancing the boundary spanning skills of public health officers.

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