P09 / Health System Governance: in and beyond COVID19

Topic : HEALTH POLICY, COVID AND PANDEMIC ISSUE

Chair : Carmen Huckel Schneider (University of Sydney)

Second Chair : James Gillespie (University of Sydney)

Third Chair : Sara Allin (University of Toronto)

GENERAL OBJECTIVES, RESEARCH QUESTIONS AND SCIENTIFIC RELEVANCE

This aim of this panel is to explore issues of governance in health systems with respect to various dimensions and phases of the Covid-19 crisis.
The Covid-19 pandemic has put health systems under unprecedented pressure; with impacts that can be seen as a 'polycrisis' (Tooze 2001). As the pandemic intersected with economic and social crises to create multiple and compounding risks, existing strains and inequities were exacerbated and service capacities reached their limits. The success of national responses has relied on effective forms of governance (Assefa Y, et al 2022).
Governance – including the norms, structures, actors, institutions, and formal and informal relationships that shape authority and action in a system – has been at the centre of public policy analysis of the responses to the pandemic. We aim to bring together and deepen this scholarly work to analyse the policy consequences of the pandemic in three crises of governance:
1. Policy-making at the centre – including state capacities in decision making, leadership, the (mis)use of evidence, and implementation (McConnell and Stark 2021). Issues may include the legacies of neo-liberalism and 'hollowing' of state capacities or the effects of more devolved, multi-level government. (Weiss and Thurbon 2022).
We explore: To what extent have broader shifts in governance and public management manifested in responses to the Covid-19 pandemic?
2. Governance as a problem of systems integration. The crisis exposed gaps, overlaps and conflicts in health systems across multiple lines; including centralised vs local decision making; public vs private services; bio-medical vs social responses and primary vs tertiary care. Issues include how forms of governance shaped health system responses, enabling and integrating effective surveillance, testing and vaccination, public health communication and service sustainability. (Weitzberg et al (2022), Sundararaman T et al 2021).
We explore: What have been the features of (in)effective health system governance with respect to integration, coordination and equity during various phases of the Covid-19 crisis?
3. Post-pandemic policy lessons and health reform. The extent to which that pandemic, as an external shock, has acted as a catalyst for health reform beyond pre-pandemic norms is currently unfolding (Bali, He, Ramesh 2022).
We explore: In what ways has the Covid-19 pandemic catalysed reform of health systems, and in what ways have health systems been unreceptive to reform?
Assefa Y, Gilks CF, Reid S et al (2022) Analysis of the Covid-19 Pandemic: Lessons towards a more effective response to public health emergencies. Globalization and Health 18 (10).
Bali AS, He AJ, Ramesh M (2022), Health Policy and Covid-19: path dependency and trajectory', Policy and Society 41 (1) 83-95.
McConnell A and Stark A (2021), Understanding policy responses to COVID-19: the stars haven't fallen from the sky for scholars of public policy, European Journal of Public Policy, 28 (8) 1115-1130.
Sundararaman T, Muraleedharan VR, Ranjan A 2021 Pandemic Resilience and Health Systems Preparedness: Lessons from Covid-19 for the 21st century', Journal of economic and Social development 23 (Supp 2) s.290-300.
Weiss L and Thurbon E (2022) Explaining Divergent National Responses to COVID-19: An enhanced state capacity framework', New Political Economy, 27 (4).

Weitzberg et al (2022) Early Health System Responses to the Covid-19 Pandemic in Mediterranean Countries. *Health Policy* 126 (7) 722

CALL FOR PAPERS

In this panel we explore issues of governance of health systems with respect to the Covid-19 crisis.
Papers should explore issues around of the role of governance in effective and ineffective responses, as

well as health system integration, reform, sustainability, and equity. We are particularly interested papers addressing the following themes:

· The extent to which broader shifts in governance and public management manifested in responses to the Covid-19 pandemic.

· Features of (in)effective governance with respect to health system integration, coordination and sustainability during various phases of the Covid-19 crisis.

· New forms of networking and intermediation between locations of authority in health systems as well as models of governance spanning public and private, primary and tertiary, and health and social care services.

· How forms of governance responded to – or deepened – health inequity; including the interaction of economic, social as well as health interventions.

· Emerging from the crisis – the extent to which the pandemic left an imprint on health reform or reverted to pre-pandemic alignments.

· Comparative analysis, including at regional level and the sources and effectiveness of different approaches to crisis governance

We invite empirical, normative, theoretical, as well policy-in-practice papers that address how governance has shaped responses to the pandemic.

We welcome papers from disciplines that include (but are not limited to) health policy, public policy, administration and management, political science, political economy and comparative public policy.

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Session 1Global and comparative national responses

Tuesday, June 27th 13:30 to 15:30 (KHE321A)

Discussants

James Gillespie (University of Sydney)

Still in the Shadow of the Developmental State: Achievements and Limitations of South Korea's Response Strategy to COVID-19

Ungki Jung (Seoul National University College of Medicine)

SangJune Kim (London School of Economics and Political Science, University of London)

It is a puzzle that the *Korean style in COVID-19 management* has received contrasting assessments: Some saw its successful response derived from a kind of "authoritarian residue" (Kundnani 2020) that fellow nations in East Asia (such as Japan and Taiwan) share, while others highlighted its strong democracy which enabled mature citizens to coordinate with each other. Taking a critical look at these two perspectives, this paper instead presents an institutionalist framework that underlines the role of the *multifaceted legacy* of the developmental state (DS) in responding to the pandemic.

On the one hand, the industrial policy dimension of the DS legacy, the government's strategic link to biotechnology firms, was conducive to the manufacturing and procurement of test kits and PPEs, thereby helping minimize positive cases and deaths. Yet it was paired with the social policy dimension of the legacy: The developmental state has only played a minimal role in fostering the health care system, which led to underinvestment in both public health and health care in the public sector. As a consequence, understaffed community health centers and a tiny number of public hospitals were forced to take care of most COVID patients, which resulted in severe exploitation of their health workforce.

On the other, even compared to other OECD countries, a relatively high level of public acceptance of the NPIs (such as physical distancing or masking) remained over the course of the pandemic in South Korea. At the same time, however, confirmed patients often found themselves socially shunned and even blamed for contracting the coronavirus. It should be also noted that huge economic damage due to the pandemic fell almost exclusively on a certain group of the population, i.e., the self-employed and small business owners. We argue that this paradox—i.e., a combination of people's remarkable compliance with public health measures, and their indifference to those (physically and financially) inflicted by the pandemic – is attributable to the weak social security net or "small welfare state" (Yang 2017), another social policy dimension of the DS legacy. People felt not protected against physical and social risks, thereby being incentivized to think that they have to secure their safety and well-being by themselves. Given this, the high degree of adherence to NPIs would not be explained by their obedience or acquiescence to the strong authority, but by their "personal responsibility crusade" (Hacker 2006) against the coronavirus.

The alternative approach we present in this paper helps one have a much more *nuanced* understanding of both achievements and limitations of South Korea's pandemic response.

(Virtual) Stability and Change in International and Global Health Governance: Looking Backward from Covid-19

Jeremy Shiffman (Johns Hopkins University)

The world's ineffective response to the Covid-19 pandemic has sparked expressions of alarm concerning

the state of global health governance, and claims that the crisis represents a transformative moment for global health. In this paper, we take the pandemic as a point of reference for a historical analysis of international and global health governance, drawing on more than 40 analyses of health governance to understand the nature of the global health order across time. The historical review indicates that far from representing an aberration or transformative moment, the pandemic reveals continuity in the nature of the global health order and exposes the global health governance system's fundamental aims. These aims have been the protection of the security, commercial and population health interests of industrialized states—both established (e.g., United States) and newly so (e.g., China)—tempered by the pursuit of cosmopolitan norms on improving population health on a global basis and securing the right to health for all.

We draw on an organizing framework for a volume of which this article will be a part—encompassing the dimensions of order and level—to conduct the historical analysis. For the purposes of this article, we understand the dimension of order to pertain to stability and change in the aims of the governance system. This dimension encompasses three states: stasis, adaptation, and transformation. We consider the dimension of level in terms of a field of action, one in which actors deploy various forms of capital to pursue position and objectives (i.e., a Bourdieusian understanding of the concept of field). The framework identifies three levels: micro, meso and macro. We take micro to pertain to an individual actor, meso to relationships among these actors, and macro to principles and forces that structure these relationships.

We find that the history of international and global health governance includes many instances of meso-level adaptation, when new actors such as the World Bank and the Bill and Melinda Gates Foundation entered the field and modified to a degree the system's aims. However, there have been only two moments of macro-level transformation: inflection points initiating fundamental change in the system's aims. The first of these two occurred in the mid-1830s, when states first established an international health governance system, with the aim of safeguarding European commercial and security interests against threats posed by diseases originating in Asia. The second occurred immediately following World War Two, when states made the first serious effort to promote health and well-being on a global basis, establishing the World Health Organization (WHO) as the centerpiece of this mission. Since World War Two, initiatives animated by norms pertaining to global solidarity have gradually chipped away at the governance system founded on the interests of industrialized states but have never managed to displace these interests. The result is the present order, revealed by the world's response to Covid-19, driven by tensions between industrialized state interests and cosmopolitan norms, with the former rather than the latter dominant.

Expert Knowledge for Global Pandemic Policy: A Chorus of Evidence or a Clutter of Global Commissions?

Diane Stone (European University Institute)

Anneke Schmider

'Global Commissions of Inquiry' have usually been associated with the multilateral initiatives of governments and international organizations (eg., the Brundtland Commission). This century, another variety of 'global commission' have emerged – those that are created, funded and staffed as private 'eminent-persons' panels or as public-private 'hybrid' initiatives. Global Commissions are also a key aspect of the COVID-19 international policy landscape. Headed by eminent academics or (semi-)retired senior states-people, this paper argues that these Commissions are engines for new ideas and policy knowledge feeding into transnational governance.

However, the 'clutter' of Commissions and their recommendations raise concerns: a clouding of the global focus, bureaucratic fragmentation, waning attention spans of politicians and publics, and the prospect of wasted resources on duplicative exercises. Despite their number, there are additional concerns that on the one hand, they do not present sufficiently viable policy options, and on the other, that they lack or have insufficient authority and legitimacy in global health governance.

There are many questions about the current and future purpose, function and impact of Global Commissions. For example: In the international context, what does 'independent' mean? Do these Commission shift paradigms, or simply maintain them? What is their real impact on global policy, international organizations and state actors? Do they create and corral new knowledge (evidence for policy) or are they 'evidence ratifiers'? With so many Commissions 'commissioned' during the pandemic, are they concerted and coordinated, or do they have discordant effects?

This paper focuses on Global Commissions which emerged during the COVID-19 pandemic and their influence on global actors and policies. They include, inter alia, Reform for Resilience, The Lancet Covid Commission and the Global Commission for Post Pandemic Policy. The paper examines the authority under

which these private and hybrid commissions were constructed, their leadership and backing, how they acquire legitimacy (or not), and their influence (to date) not only on state and international actors and actions, but also on globalising health policy. We develop a typology :

1. 'Official' Global Commissions are convened and, therefore, legitimated by International Organizations and may be considered government-supported. Examples include the IPPPR and Monti Commissions.
2. Epistemic Commissions can be characterized as gathering the 'current state of knowledge' across challenging global policy topics with the aim to translate this information into contemporary global policy knowledge. These are scholarly-style commissions, such as Lancet Commissions.
3. Thinktank-style Global Commissions emerge with a structure that includes political representatives, civil society and the private sector and use think-tank style processes. These commissions may raise consciousness within specific communities such as business sector, but operationalization of policy options will be dependent on government and international organization recognition. The Resilience Commission and the Commission for Universal Health are examples.

'Legitimacy' is crucial to the current and long-term relevance of Commissions. As we argue, this entails on the one hand ensuring and preserving their 'independence' (with an appreciation of the different meanings attached to this concept) and on the other hand, carefully constructing epistemic credibility through rigorous and sound methods and procedures of investigation.

An international review of primary care governance reforms: new models and approaches for health systems after Covid-19

Stefanie Tan (University of Toronto)

Project overview
National experiences with the COVID-19 pandemic demonstrate that primary care systems require reforms to improve integration with the wider health system and to ensure sustainability and resilience to shocks. There are varied approaches to reforming primary care systems aimed at improving access and experiences of care to strengthen the linkages between primary care and the wider health system. In this study, we compare and characterize primary care reforms, with a focus on health systems reforms that emerged during and since the COVID-19 pandemic to address issues related to systems integration. We examine international comparators and Canadian provinces to identify promising policy options for overcoming institutional barriers to reform primary care. This study is guided by the research question, how do primary care governance reforms contribute to greater integration after COVID-19?
Methods
We conducted a rapid jurisdictional review (Fall 2022) across five Canadian provinces (British Columbia, Alberta, Manitoba, Ontario, and Nova Scotia) and six international comparators (Australia, Netherlands, New Zealand, United Kingdom (England and Scotland), and the United States). We drew from academic and grey literature about primary care delivery models, financing, governance, recent system reforms impacting primary care (e.g., integrated systems), and evaluations. Case reports were created for each province/country and validated by local experts. We mapped our results along the various dimensions and later phases of the COVID-19 pandemic (2022 onward) against a conceptual framework built upon the sub-functions of primary care governance and financing to draw out similarities, differences, innovative and/or promising reforms.
Results
In all jurisdictions, policymakers have responded to the COVID-19 pandemic through the continuation or introduction of primary care reforms that aim to strengthen governance and accountability in their respective health systems. These reforms include adapting the role of virtual care in primary care provision, payment reform, and pursuing integrated care reforms by refining team-based interprofessional care to improve pathways between physician practices and other providers/community clinics. There is widespread support for more collaborative approaches to primary care reform that emphasise physician buy-in and voluntary participation in new contractual models rather than a 'command and control' model. Formal and informal studies of these reforms underscore the challenge in maintaining strong relationships between governments (payers) and primary care providers to achieve health system objectives. Reforms to primary care financing tend to involve a shift away from fee-for-service payment models toward alternative payment plans that promote greater stewardship and accountability. These novel funding programs include capitation, blended models (capitation with targeted incentives, a variant of pay for performance targeted at physician practice), or additional funds to support the development of inter-professional teams. Our results are a starting point for further research on how ongoing primary care reforms may address ongoing challenges brought by the COVID-19 pandemic and to pursue more integrated, sustainable and resilient health systems.

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Session 2COVID19 and health system reform

Tuesday, June 27th 15:50 to 17:50 (KHE321A)

Discussants

Sara Allin (University of Toronto)

Public perceptions on digital contact tracing during COVID-19: A sentiment analysis using social media data in Singapore

Shaleen Khanal (The University of Nottingham Ningbo China)

Lin Zhu (National University of Singapore)

Governments around the world have used various digital contact tracing tools to manage and contain the spread of COVID-19 virus. However, the use of such digital tools often involves collecting, storing, and analyzing citizen data, including their identifies, close contacts, and locations. Therefore, use of such tools has often led to polarizing and volatile emotions and consequently have met with varying degree of success amongst the public. This paper aims to understand the factors that shape the evolution of public sentiments towards digital contact tracing tools. We select the case of Singapore's DCT devices—TraceTogether (TT) and SafeEntry(SE) apps, and analyze individual perceptions of the devices based on data collected from social media. Particualrly, we collect comment data from the online discussion website Reddit and focus on its Singapore section (i.e., r/singapore), ranging from March 2020 when DCT was developed in Singapore to April 2022 when DCT was announced stop of using. Using both topic modelling and sentiment analysis, we find that the polarity of the Reddit comments on contract tracing started out positive and started to decline from specific quarters where unpopular revelations related to TT emerged. Similarly, analysis of emotions showed that "Trust" was the most important emotion associated with TT followed by "Fear" and "Anticipation". Although temporal analysis showed nosignificant changes in trends of the emotions, results showed that emotions of trust and fear were often negatively correlated. We also generated hypotheses to explain the possible factors that lead to major changes to public emotions overtime.

Enrolling users to monitor compliance in long-term care

Poland Lai (School of Administrative Studies, York University)

Regulation and governance scholars have, for some time now, challenged the notion of regulation as simply a government function (for example, see Grabosky 1995). In the age of governance, regulation, monitoring, and enforcement can have many different sources and that there is no longer one centralized actor responsible for overseeing and coordinating the entire process (van Wingerde and Bisschop 2022). The influence and pressure from various "third parties", neither official regulatory agencies nor businesses themselves, might be harnessed or "enrolled" to drive business compliance with the law (Nielsen and Parker, 2008). This paper is intended to extend the debate about enrolment of third parties in regulatory processes by investigating the willingness and capabilities of third parties to influence the behaviours of regulated entities and activities of the regulator. This paper will focus on a subset of third parties in the long-term care (LTC) sector (residents and their families and friends) in Ontario. This paper draws on the results from an on-line, anonymous survey (English and French) conducted in March 2023. The survey will be based on convenience sampling. The survey will ask respondents questions about: 1) their prior experience and knowledge of the regulatory processes in LTC (e.g. compliant procedures); 2) their willingness and capabilities to participate in the regulatory processes; and 3) likelihood of exercising vigilance over the actions of the regulator (Ministry) and the homes. The survey results will be used to

hypothesize pre-conditions necessary for third parties to be enrolled to promote compliance in LTC.

Commissioning in Covid and Beyond: How have experiences of commissioning services during the Covid pandemic shifted healthcare policy?

Carmen Huckel Schneider (University of Sydney)

James Gillespie (University of Sydney)

There has been a trend towards commissioning, or strategic purchasing, of services, both front line and support, in many health systems. This can be seen as a continuation and evolution of new public management and new public governance.

With the onset of the Covid-19 pandemic, many health systems had to pivot functions and close gaps, leading to the commissioning of new services within tight timeframes, under unusual circumstances and for a wider range of new services including data management, logistics, delivery of mass services (testing, vaccination delivery), quarantine, and maintenance of core services.

This paper takes a comparative case study approach to address the questions: Under what conditions, and for what purposes, were new services commissioning during Covid? What were the successes and challenges of these experiences? To what extent were these experiences reflective of broader public policy trends? And what have been the lasting effects?

We compare experiences in four countries: Australia, Canada, Germany, and England. We outline specific instances of commissioning new services in four areas, 1) data systems; 2) testing and vaccination services, 3) shifting non-covid front-line services to new providers, and 4) outreach to vulnerable communities.

We observed several key challenges. First, existing relationships were key to rapid commissioning, however these were often absent when it came to specific, highly technical services, or across health and social care lines. Second, with additional available funds, often to an unprecedented level, concerns of quality control, rorting and favouritism were a point of contention across systems. Third, the capacity and utility of roles and responsibilities in existing health system structures was often exposed and questioned; including relationships between public, not-for-profit and private sectors. This occurred on many levels, including the expertise of decision makers and administrators, right through to the locations and providers of primary care.

Experiences of commissioning services to address the Covid-19 pandemic can be seen as reflective of the capacity of public services following shifts towards new public management and governance. These models depend on long-term complex processes where a market of suppliers and/or interdependencies between agents develop and stabilise. This presented several key challenges in the unique environment of the Covid-19 pandemic.

(Virtual) Success and failure in establishing national physician registries: a comparison between Canada and Israel in the aftermath of the COVID-19 pandemic

Baruch Levi (University of Toronto)

Background and Objectives: Physician registries generally contain updated demographic and occupational data on practicing physicians and therefore constitute an essential component of healthcare workforce planning. However, while some countries have successfully established functioning national physician registries, others have failed to do so. The lack of comprehensive up-to-date data on medical workforce in real time was felt even more acutely during the COVID-19 pandemic. We compared two healthcare systems of technologically and economically developed countries, Canada and Israel, which represent cases of success and failure in establishing physician registries respectively. Lessons learned by both systems in regard to medical workforce planning in the aftermath of the pandemic will also be examined.

Approach: A comparative analysis was conducted through the lens of a historical-institutionalist approach to examine contemporary occurrences such as health policy success and failure as an outcome of historical processes and institutional arrangements. These include governance traditions, organizational structures, and stakeholder interrelationships between pivotal players such as the state, the medical profession, and the business sector. White papers and studies on healthcare human resources, reports of professional committees, Auditor General reviews, and press releases were examined to explore the aims, interests, positions, and actions of stakeholders regarding the establishment of a national physician registry.

Results: In Canada, Scott’s Medical Database (SMDB) is the main source of information on the supply, distribution and migration of physicians across the country and run by a private company. Data is collected,

among the rest, from physician colleges. This form of data governance expresses an Anglo-Saxon bureaucratic tradition of Public-Private Partnership and also reflects the colleges' longstanding regulatory role. Furthermore, SMDB could be seen as a solution to challenges presented by Canada's federated structure. However, the pandemic has exposed significant gaps in knowledge about the health workforce due to the fragmented nature of the Canadian healthcare system.

In Israel, a periodically updated physician registry does not exist. The Ministry of Health have long desired its formation but failed to do so in the face of strong opposition by the Israeli Medical Association, which historically controls the medical colleges and tends to function as an outsider interest group. However, it seems that the pandemic spurred the Israeli Ministry of Health to enhance its planning capacities by establishing a comprehensive administrative database of medical residents and setting quotas for medical residency positions in hospitals.

Conclusion: Healthcare systems are shaped by particular circumstances that forge stakeholders' dynamics and interactions. Therefore, policy outcomes such as success or failure in establishing physician registries, as the comparison between the Canadian and Israeli cases demonstrates, may be explained against the backdrop of broader political, governance and organizational contexts. Both cases also illustrate how a shocking event such as a global pandemic may cause healthcare systems to implement long-awaited data governance reforms.

(Virtual) The Reform of the Primary Healthcare in a Context of Weak Institutionalisation

Nicola Giannelli (University of Urbino Carlo Bo)

According to a set of post-pandemic measures, the European Union has allocated a fund of 220 billion (Next Generation EU) in favour of Italy for a large infrastructure investments plan and for revamping its welfare system. The national instrument adopted by the government, the National Recovery and Resilience Plan (NRPP), has a focus on the healthcare system. Deliberated in March 2021, the NRPP states that the pandemic has clearly highlighted the need for strengthening the capacity of the national health system to provide adequate supply of services on the national territory. The primary healthcare is considered the main strategic target. The measure aims at strengthening the intermediate care through the activation of the so-called Community Hospital, i.e. a healthcare unit envisaging 'short hospitalisation' and intended for patients who require medium/low clinical intensity healthcare interventions for short hospital stays.

The pandemic emergency has shed light on the historical deficiency of primary healthcare, which is grafted onto an ageing demographic process that, in the absence of intervention, will inevitably lead to a progressive worsening of the conditions of care. Therefore, through Decree No. 77 of 23 May 2022, the Draghi government has undertaken the reform of the territorial assistance through the strengthening of its infrastructures. The reform aims at bridging the gap between the hospitals and the network of services on the territory. In particular, the policy is aimed at overcoming: (i) the significant disparities in the provision of services in terms of prevention and care on the national territory that now discloses strong differences between northern and southern regions; (ii) the inadequate integration between hospital services, territorial services and social services; (iii) the long waiting times for the provision of health services on the territory; (iv) the poor response and integration capacity between environmental, climatic and health risks. The reform has a technocratic approach.

In the fragmented health care governance, some Italian regions had already tried to fill the void of primary care with new institutions called Health Houses lacking a national model. The new national decree tries to overcome this gap with a clear policy design. The capability to implement it in the regions (which in Italy are delegated to manage health services) is jeopardised by many risk factors.

Our paper aims at analysing the implementation of the reform through the identification of the weakness factors e the resistance of the actors that have slowed down the process and the innovations at all levels. The paper is a first step for a preliminary assessment of the reform's potential in order to set up a field-research through regional case studies. After a reconstruction of the goals and a longitudinal analysis of the weak institutionalisation of primary care in Italy, the paper focuses on the stakeholders, the strategies and the resources put in place to achieve the objective of realising community hospitals. This description will be carried out at national level with some focus on pilot regional cases.

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Session 3Sub-national responses to COVID19 and beyond

Wednesday, June 28th 08:00 to 10:00 (KHE321A)

Discussants

Carmen Huckel Schneider (University of Sydney)

(Virtual) Collaborative governance to the test of the Covid-19 pandemic

Vanessa Turri (Università degli Studi di Milano-Bicocca)

In this paper, we explore the issue of the preparedness of public local health governance for an uncertain crisis like the Covid-19 pandemic. Our insights originated from broad research about the health services of three Italian regions characterized by different governance models: Lombardy, Emilia Romagna, and Friuli Venezia-Giulia. Our analytical framework rotates around the distinction between transformative and conservative preparedness. Where conservative preparedness aims to restore the pre-crisis status quo, transformative preparedness entails a transformation of society in the direction of greater social-ecological solidarity and a change in the logic guiding the organization of the response to vital needs. Transformative preparedness copes with uncertainty by enhancing heterogeneity, interdependence and systemic data interpretation. Frameworks. Its tools are social inclusion and knowledge sharing (Bifulco et al., 2022).

The governance of health crises is generally based on the technologization of information gathering and processing, the verticalization of the chain of command and the top-down implementation of security and disciplinary strategies for emergency management (Lakoff, 2017).

The One Health Approach, in contrast, promotes an integrated approach to health crises since it assumes that human health, animal health, and the ecosystem's health are inextricably linked (Mackenzie & Jeggo, 2019). However, the Covid-19 pandemic has made the limited implementation of this approach more evident.

In essence, what does an integrated approach to governance of the health crises involve?

How does the integrated approach materialize in the governance of local health services during an unexpected health crisis?

We propose the concept of “collaborative governance” as a driver for reorganizing public action (Bifulco, 2017; Voets et al., 2021) to stimulate the transformative preparedness of health services for unexpected crises. In general, collaborative governance involves non-state stakeholders in a formal consensus-oriented and deliberative decision-making process to make or implement public policy or manage public programs or assets (Ansell & Gash, 2008).

In particular, we present the case of the "Habitat Microaree" program of Trieste as an experimentation of health collaborative governance during the Covid-19 emergency. Such a program was launched in 2005 by the local health authority to assist the socially and healthy fragile population of some areas using an approach to health based on: 1) the constant presence of social and health workers in the neighbourhoods; 2) vertical integration between local institutions and horizontal integration between citizens and social, educational and health services; 3) citizen participation in the management of public spaces and services.

Between 2019 and 2022, the operators of the Habitat Microaree program applied the same approach as in the past to the Covid-19 pandemic, shedding light on the positive results that collaborative governance can produce during an unexpected crisis: the ability to trace infections, early identification of contagion outbreaks, improvement of institutional communication towards citizens, facilitating access to the vaccine, containing the psychological effects of social isolation. Collaborative governance is, therefore, a salient ingredient of transformative preparedness. Moreover, the experience of Trieste shows that collaborative

governance cannot be improvised but must be implemented in the medium-long term through training, organization and daily practice interventions in the area.

Capacity and Crisis: Examining the State-Level Policy Response to COVID-19 in Tamil Nadu, India

Veena Sriram (University of British Columbia)

Girija Vaidyanathan (Indian Institute of Technology, Madras)

In India, COVID-19 resulted in a complex set of public policy challenges. The southern state of Tamil Nadu (population: 76 million) is considered a 'high capacity' state with a longstanding history of prioritizing public health. Analyzing the response of Tamil Nadu provides critical insights for how states navigated governance challenges during a nationwide emergency between national, state and local level, and diverse state-level constituencies. Tamil Nadu experienced early and sustained levels of COVID-19 transmission, with myriad factors influencing the response including an upcoming statewide election and loosely-defined roles of the central and state governments in pandemic preparedness. In this paper, we focus on the experience of Tamil Nadu during the first two waves (2020 – 2021) and combine a framework on institutions, politics, organizations and governance (Berman et al, 2023), with governance capacity theory (Lodge et al 2014). We conducted an extensive document review and media analysis, and ten interviews with high-ranking government officials, civil society representatives and media personnel.

We found that the **institutional framework** for Tamil Nadu, through a strong bureaucratic cadre, a public health cadre and the Tamil Nadu Public Health Act, laid the groundwork for an effective statewide response. Bureaucrats also gained experience in managing health emergencies (i.e., chikungunya, dengue, H1N1 and cyclones). Despite this, state policymakers were slow to heeding the warning of public health officials. Moreover, gaps in the national institutional framework meant that certain aspects – such as treatment protocols and oxygen – required 'firefighting' measures by the state. **Coordination capacity**, most effectively took place during the first wave through the Chief Secretary, the highest-ranking bureaucrat, mobilizing effective bureaucrats across the state. However, this coordination capacity gave way to complacency as the pandemic progressed. From an organizations standpoint, **analytical capacity** appeared diffused across state and national units, with respondents highlighting the need for empowerment of public health officials and the need for a more robust alert and response system that can be activated at all times, including during periods of political transition. The alignment of politicians and bureaucrats, particularly during the nationwide lockdown in the first wave, meant that **regulatory capacity** at the central and state level were extremely high, particularly due to the invocation of the Disaster Management Act; however, some concerns were raised about a lack of civil society engagement in decision-making, as well as coercive measures to enforce compliance. **Delivery capacity** was seen as strong, but districts with high performing bureaucrats likely fared better. Two factors strongly influenced these aspects of capacity – the dominant role taken by the **central government** during the first wave (and its shifting of responsibility during the second wave) and the fact that bureaucrats' attention was diverted during **state elections** that preceded the second wave.

Overall, our findings suggest that high performing individual bureaucrats, prior experiences with crises and state-level institutional powers enabled a strong response in Tamil Nadu. Yet, several gaps also emerged in the institutional and organizational framework nationally and in the state that must be addressed to avoid adverse impacts of crises such as COVID-19.

Governing Australian primary care: COVID-19 and beyond

James Gillespie (University of Sydney)

Carmen Huckel Schneider (University of Sydney)

The onset of the COVID-19 pandemic unleashed crises in most primary care systems. In Australia, weak business models built on fee-for-service, poor integration of care and constrained government funding left primary care in a particularly vulnerable position. This paper uses a case study of Australian primary care to unpack the impact of the pandemic. It explores shifts in public and private governance of primary care in response to the Covid-19 pandemic.

We start by identifying longer term problems of primary care which have undermined Australian general practice's pivotal place in the health system as the point of entry and gatekeeper for specialist services. Most general practice services are provided on a private, fee-for-service basis. However, most fees are paid from the federal government's Medicare national health insurance scheme. This public payment of private practice has been the fault line shaping most primary care policy. The paper applies Moran's (1999) concept

of ‘embeddedness’, the interfusion of private providers and government in the ‘health care state’, to Australian health care politics.

The paper focuses on interventions in governance by federal governments that aimed to resolve problems of primary care. A succession of intermediary organizations – funded by government but with substantial autonomy – General Practice Networks, Medicare Locals and Primary Health Networks - have operated in this space. Each has had a complex set of relationships with central government and private sector providers.

Tuohy’s (2018) approach to policy cycling, and the scale and scope of health reform are used to assess the policy priorities of pre-pandemic intermediation, its organizational forms, policy aims, successes and failures. Primary care went into crisis with the onset of COVID-19. Its fee-for-service model was incapable of quick adaptation to the new demands. We look at how existing forms of governance responded and assess innovations from government and service providers. Each phase is assessed according to how tensions between central policy and the business models of primary care played out, strategies for improving care integration and developing more sustainable business models in general practice.

The COVID-19 crisis accelerated policy change. As primary care markets temporarily collapsed, government s made new demands on producers and experimented with new forms of service delivery – especially the use of e-health. Many of the Primary Health Networks led in innovation with respiratory clinics, vaccination and testing centres, encouraging innovation.

At the same time, primary care continued to suffer from business models locked into fee-for-service, creating system rigidities that encouraged new forms of entrepreneurial competition especially in e-health. Governments moved to weaken general practice’s gatekeeper role by devolving more tasks, including diagnosis and prescription, to community pharmacy.

(Virtual) Public Health Systems in Canada’s Provinces: What, Where, Who?

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Canada devolves almost all the discretion about how and where to organize systems and services for public and population health to its provinces. This study compares the organization of key public health functions across four provinces in Canada, e.g., in the level of centralized authority for decision making and in the presence and role of an arm’s length public health agency. Areas of difference are identified and their causes and implications discussed. Areas of uncertainty or lack of clarity are also identified and their implications discussed. Using document review and key informant interviews, we explore whether and how these organizational differences, helped to explain different approaches to health systems governance during the pandemic, with a focus on regulating public spaces. Changes in organization implemented in response to the COVID-19 crisis are reviewed along with observations on their influence on response results.[Note: this study involves multiple authors beyond those noted above).

Transformation of governance in health systems after Covid-19. Comparative analysis of three areas of governance, Toronto, Chicago and Mexico City

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The crisis generated by the COVID-19 pandemic has significantly changed the governance of health systems around the world. Most of the countries adopted the policies recommended by international organizations and others complemented them with their own policies. As a result, the crisis has been shown to be a critical juncture (Twigg, 2020) that has modified health systems at all levels, especially at the local one, which are the levels that have the closest contact and affect most directly. the health of the population. Thus, the purpose of the article is to carry out a comparative analysis of the way in which the governance of health systems has been transformed in three cities, Toronto in Canada, Chicago in the United States and Mexico City in Mexico, as a result of the management of crises in those countries. Among other reasons, these countries have been chosen for their similarities in terms of their administrative political context, all three have federal systems; as well as the importance of these cities and their relationship with the levels of government, which allows a better observation of the transformations in the governance of health systems. Organizational / institutional approaches will be used, (Bailey and Breslin, 2021) as well as the literature on

crisis management (Boin et al 2018) and the comparative approach of public policies. The text is part of a broader project on crisis management and governance (Culebro et al 2021, 2019), and is based on the idea of ??the growing interest in studying the learning processes produced by the covid-19 pandemic from comparative analysis, such as a means to produce reforms that affect the governance of health systems. We hope to find important similarities and differences that allow us to explain the transformations in the governance of health systems from the local level, but with an impact on the national health systems of these three countries and their interactions with the political-administrative context.

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