

EUR/ICP/MPN 031  
4589v  
ORIGINAL: ENGLISH

# HEALTH STRATEGIES FOR THE FUTURE

Report on a WHO Conference

Bad Honnef, Federal Republic of Germany

1-2 September 1988

### Note

The issue of this document does not constitute formal publication. It should not be reviewed, abstracted, quoted or translated without the agreement of the World Health Organization Regional Office for Europe. Authors alone are responsible for views expressed in signed articles.

## CONTENTS

	<u>Page</u>
Background . . . . .	1
Task force for health for all management in countries with pluralist health systems . . . . .	2
Scope and purpose of the Conference . . . . .	2
Discussions . . . . .	4
Conclusions and recommendations . . . . .	5
Annex 1. Working papers . . . . .	9
Annex 2. Participants . . . . .	10



## Background

The Thirtieth World Health Assembly resolved, in May 1977, that "the main social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (resolution WHA30.43). The urgency of this goal for the European Region is underlined by two basic facts:

- despite the financial resources devoted to the health sector and the development of new drugs and medical techniques in the past 30 years, people's level of health is lower than it could be;
- despite the overall high level of development in the European Region and the scientific, economic and educational level of most countries, the challenge of inequalities in health still has to be met.

It is within this framework that the representatives of Member States of the WHO European Region, on the occasion of the thirtieth session of the Regional Committee at Fez in 1980, approved their first common health policy, the European strategy for attaining health for all.

Four years later, the European conference on planning and management for health, convened by the WHO Regional Office for Europe in collaboration with the Government of the Netherlands in The Hague, agreed that the notion of health planning and management should be enlarged to encompass the full range of forward-looking approaches to promoting health and improving the effectiveness, efficiency and quality of health systems. Member States were encouraged to select the approach that was most appropriate to them on the basis of their particular objectives and their circumstances, which

necessarily differ from country to country and change over time. They were to develop appropriate policies and managerial processes to implement the strategy for health for all, tailored to the actual situation in their own country.

## Task force for health for all management in countries with pluralist health systems

A number of Western European countries (Austria, Belgium, France, Federal Republic of Germany, Netherlands and Switzerland) recognized the similarities in their problems with respect to the development of a health for all policy, and established a task force for health for all management in countries with pluralist health systems in 1985. Other countries, operating in a comparable environment, were invited to join this group. Their terms of reference were to review the present managerial processes for health for all, to identify the approaches that are most suitable for countries with pluralist health systems, to evaluate the implementation of selected approaches and mechanisms, and to exchange experience. The task force held four discussion sessions: in Düsseldorf in January 1985), in Brussels in October 1985, in Vienna in June 1986 and in Brussels in September 1987. It also held a coordination meeting in Luxembourg in December 1987.

## Scope and purpose of the Conference

Following the recommendations of these meetings, a major conference was organized by the WHO Regional Office for Europe with the support of the Government of the Federal Republic of Germany. The Conference on Health Strategies for the Future was attended by participants from Austria, Belgium, France, Federal Republic of Germany, Israel, Luxembourg, Netherlands and

Switzerland. In countries with pluralist health systems, health policy is determined by a broad array of actors and agencies. Representatives from all these groups, who are all partners in the health field, were therefore present at the Conference, i.e. health professionals including physicians and nurses, health institutions including hospitals, sickness funds, private health insurers, consumer organizations, trade unions and different levels of government administrator. To facilitate the identification of commonalities and differences in health policies, to integrate their interrelated elements and to provide future policies with the necessary choices, the following tasks were undertaken at the Conference:

- to inform the partners in the health field in countries with pluralist systems, through their representatives at the Conference, about the health for all strategy and its adoption by many European countries;
- to review the role of these different actors in the implementation of the strategy for health for all by the year 2000;
- to analyse the present and future challenges in health care and their consequences for the health service system;
- to gain insight into the interactions of the main health agencies and analyse their possible implications for the future;
- to make recommendations about the development and implementation of national health policies and strategies for change in countries with pluralist systems.

## Discussions

Health systems are under continuous pressure for change, but experience shows that many years may elapse before the intended changes are effected. For this reason, it is important to analyse the various factors that determine health and to look ahead. This approach will help to bring about the changes in health policies necessary to improve the health of populations in modern and changing societies. A point of concern in all countries is the anticipated old age bulge at the beginning of the next century. Both the absolute and the relative increase in the number of the elderly will be substantial and the demand on resources will be tremendous.

There was general agreement that health for all is, indeed, relevant to countries with pluralist health systems. Most participants emphasized, however, that every country has to establish its own policy, priorities and targets, given due consideration to the particular circumstances in which people live and taking into account the characteristics of each national health system. General approaches to achieve consensus on policies, priorities or targets do not exist, and country-specific processes of consultation and negotiation have to be adopted. All the relevant parties should be involved in these processes and be well informed. This includes the actors and agencies who are working at the local level. Innovators will have important roles to play, in particular in initiating changes. The effectiveness of the health for all policy may depend to a large extent on the general public's understanding of the broad concept of health and on their willingness to share responsibility for their own health. Some participants therefore emphasized the necessity of informing the public and recommended close collaboration with the mass media. Health promotion and disease prevention are key elements in a health policy,

but the execution of such a policy should not remain the responsibility of governments alone. Sickness funds, in cooperation with other partners in the health field, should give greater consideration to health promotion and disease prevention. A point of general concern was the need to set priorities for research into the most cost-effective means of disease prevention and health promotion. In particular, the concept of healthy lifestyles needs further analysis, particularly of empirical data and testing, so that the most beneficial areas of action can be identified.

## Conclusions and recommendations

1. There is a need to set priorities, to define outcome-oriented targets and to formulate long-term strategies for health policies, taking into account the particular values of the pluralist system. This has to start with an analysis of the relationship and interdependence between lifestyles, biological factors, the physical environment, social and economic conditions, and the activities of the health care system.
2. Health for all offers a suitable framework for analysis and policy development. It focuses on health, shows interdependences within the health sector and between it and other sectors, and offers a long-term perspective. It provides a simple and flexible approach, which can be adapted to different requirements and settings.
3. Health for all is of major relevance to countries with pluralist systems, including those with federal and decentralized administrations, since it can be applied at all levels and by a multitude of potential partners in the health field. It does not imply any encroachment by public authorities on the freedom of action of health professionals and institutions. Moreover, it should help to encourage individuals or partner groups in the private sector to collaborate in achieving health targets.

4. Health for all is recognized as a set of strategies for solving common problems:
- it addresses equity issues;
  - it emphasizes health promotion and disease prevention;
  - it highlights the importance of an appropriate system for health care delivery; and
  - it helps to improve returns from health expenditure.
5. Every country should establish its own priorities, targets and strategies, taking into account the particular circumstances of its population and its own health system. A specific means of debate, consultation and negotiation should be established to achieve the necessary level of consensus. Besides governments, all health professionals including physicians and nurses, all health institutions including hospitals, sickness funds, private health insurers, consumer organizations, employers and trade unions should be involved. In principle, no partner can be left out and due attention must be paid to the local level.
6. All the partners in the health field are urged to take initiatives, individually or jointly, and to initiate action for health development where and when needed.
7. Innovators will have an important role to play in initiating the required changes. Appropriate mechanisms and processes, including economic arguments, should be developed to facilitate this.
8. A public health attitude needs to be fostered among health professionals, health insurance agencies, and politicians and government officials at all levels.

9. Sickness funds and health insurance agencies, in cooperation with other partners in the health field, should give greater consideration to health promotion and disease prevention, since they have positive effects on equity, quality of life, effectiveness and efficiency.

10. Health promotion and disease prevention programmes should be carried out on the basis of reasonable scientific evidence of their efficacy and their broad acceptance by the public. Monitoring and evaluation of such programmes are essential. All the partners in the health field should collaborate with the mass media and encourage them to transmit regularly well prepared messages about health promotion and disease prevention addressed to the entire population.

11. The increased demand for complex care caused by the absolute and relative growth in the number of old and very old people will require particular attention. Specific targets and policies should be developed in this respect.

12. National information systems based on health outcomes and international exchange of information are of vital importance and should be improved. Emphasis should be given to applied epidemiological research.

13. Health policy analysis and health system research should be extended and the relevant research capacities strengthened. Emphasis should be given to studies that show up the returns from implementing the health for all policy, e.g. the effects of health promotion and disease prevention in economic terms.

14. Countries should collaborate within the health for all framework. This collaboration should not remain confined to governments, but individual partner groups should also work directly with their colleagues in other countries. In these joint ventures, they should

concentrate on the most urgent subjects and areas such as priority-setting and target-setting, health indicators, health promotion and disease prevention, environmental hygiene, the development of health scenarios and technology assessment.

15. The task force for health for all management in countries with pluralist health systems should continue to act as a clearing-house to review the present processes for health for all, to identify the approaches that are best suited to the countries concerned, to evaluate the implementation of selected approaches and mechanisms, and to exchange experience. WHO should therefore provide the task force with more visibility and actual support. The task force is expected to assist both WHO and the countries in developing and implementing health policies.

## Annex 1

### WORKING PAPERS

- ICP/MPN 031/5 Health strategies for the future - what can be done in countries with pluralist systems?, by Dr H. Locher & Professor A. van der Werff (task force paper)
- ICP/MPN 031/6 Anticipating the future, by Dr E. Dekker
- ICP/MPN 031/7 Zum Stand der Entwicklung von Gesundheitszielen in der Bundesrepublik Deutschland, by Dr I. Weber
- ICP/MPN 031/8 Evaluation of a population based primary prevention programme, by Dr G. Domenighetti
- ICP/MPN 031/9 Collaboration between national and local government with respect to health planning, by Y. Talhouarn
- ICP/MPN 031/10 Action in health promotion in pluralistic systems, by Dr Ingrid Erlacher
- ICP/MPN 031/11 From curative to preventive medicine - the role and means of the sickness funds, by Dr R. van den Heuvel
- ICP/MPN 031/12 How to promote health efforts with respect to the care of the elderly, by Ms Josée Thill
- ICP/MPN 031/13 Health promotion and disease prevention within Kupat Holim, by Dr Aviva Ron

## Annex 2

### PARTICIPANTS

#### Temporary Advisers

Dr J.-P. Berger

Chef du service de médecine interne, Hôpital du Samaritain, Vevey, Switzerland

Dr T.H.G. van Berkestijn

Deputy Secretary, Royal Dutch Medical Association, Utrecht, Netherlands

Mr R. Bervini

Conseiller d'Etat, Directeur du Département des affaires sociales, Bellinzona, Switzerland

Professor F. Beske

Direktor des Instituts für Gesundheits-System-Forschung, Kiel, Federal Republic of Germany

Dr Boehme

Bremen, Federal Republic of Germany

Professor H. Bourmer

Vorsitzender, Harmannbund, Verband der Ärzte Deutschlands, Bonn, Federal Republic of Germany

Mrs Monique Butlen

Chef du bureau de la santé des enfants, des adolescents et des jeunes, Direction générale de la santé, Paris, France

Mr A. Coulomb

Directeur général de la Caisse primaire  
d'assurance-maladie du Val d'Oise, Cergy Pontoise,  
France

Mr D. van Daele

Secrétaire général, Ministère de la santé publique  
et de la famille, Brussels, Belgium

Mr Decoster

Attaché, Cabinet du ministre des affaires sociales  
et des réformes institutionnelles, Brussels, Belgium

Dr E. Dekker

Coordinator Health Policy Development, Ministry of  
Welfare, Health and Cultural Affairs, Rijswijk,  
Netherlands

Mr J.-F. Domenighetti

Chef du service de la santé publique, Canton du  
Tessin, Bellinzona, Switzerland

Dr Ingrid Erlacher

Oberrat, Referatsleiter, Bundeskanzleramt, Sektion  
Volksundheit, Vienna, Austria

Mr R. Fonteneau

Directeur-adjoint, chargé de l'hospitalisation et de  
l'action sanitaire et sociale, Caisse nationale  
d'assurance-maladie des travailleurs salariés,  
Paris, France

Dr Marie-Thérèse Fritz

Médecin chef du service départemental de protection  
maternelle et infantile, Direction de l'action  
sanitaire et sociale, Hôtel du département, Dijon,  
France

Dr Fuchs

Ministerialdirigent, Ministerium für Umwelt und  
Gesundheit, Mainz, Federal Republic of Germany

Dr J. Gelbenegger

Leiter der Abteilung für Sanitärrecht und  
Krankenanstaltenwesen im Amt der NO Landesregierung,  
Vienna, Austria

Dr R. Grupp

Ministerialrat, Bundesministerium für Arbeit und  
Sozialordnung, Bonn, Federal Republic of Germany

Dr R. Hess

Hauptgeschäftsführer der kassenärztlichen  
Bundesvereinigung, Cologne, Federal Republic of  
Germany

Dr R. van den Heuvel

Président, Alliance nationale des mutualités  
chrétiennes, Brussels, Belgium

Mr N. de Jong

Secretary General, Netherlands Union of Sickness  
Funds, Zeist, Netherlands

Mr C. Kleiber

Chef du service de la santé publique et de la  
planification sanitaire, Lausanne, Switzerland

Dr H. Locher

1. Sekretär der Gesundheitsdirektion des Kantons  
Bern, Berne, Switzerland

Dr D. van der Meer

Director, Netherlands Hospital Institute, Utrecht,  
Netherlands

Dr Therese Neuer-Miebach<sup>a</sup>

Bundesvereinigung Lebenshilfe für geistig  
Behinderte, Marburg, Federal Republic of Germany

Dr Oldiges

Hauptgeschäftsführer, Bundesverband der  
Ortskrankenkassen, Bonn, Federal Republic of Germany

Dr F. Paccaud

Institut universitaire de médecine sociale et  
préventive du canton de Vaud, Lausanne, Switzerland

Professor A.V. Prims

Faculté de médecine, Université catholique de  
Leuven, Belgium

Dr H. Rengelink

Director, Municipal Health Service, Amsterdam,  
Netherlands

Dr Aviva Ron

Director, Planning and Information Division, Kupat  
Holim Health Insurance Institution, Tel Aviv, Israel

Mr R.F. Schreuder

Staff Bureau for Policy Development, Ministry of  
Welfare, Health and Cultural Affairs, Rijswijk,  
Netherlands

Mr G. Spaninger

Leiter der ökonomische Abteilung der Sektion  
Volksgesundheit, Vienna, Austria

Dr H. Stein

Ministerialrat, Bundesministerium für Jugend,  
Familie, Frauen und Gesundheit, Bonn, Federal  
Republic of Germany

---

<sup>a</sup> Participation expenses not paid by WHO.

Dr M. Steinbach

Leiter der Abteilung Gesundheitswesen,  
Bundesministerium für Jugend, Familie, Frauen und  
Gesundheit, Bonn, Federal Republic of Germany

Mr Y. Talhouarn

Bureau Planification - Etude - Recherche -  
Innovation technologique (PERI), Direction générale  
de la santé, Paris, France

Mrs Josée Thill

Infirmière hospitalière graduée, Directrice adjointe  
de l'école des infirmières, Clinique Sacré-Coeur,  
Luxembourg

Mrs Lise Thirry

Chargé de mission, Secrétariat Etat santé publique,  
Brussels, Belgium

Mr J. Vattier

Vice-Président de la Fédération nationale de la  
mutualité française, Mutuelle générale des PTT,  
Paris, France

Mr H. Voigtländer

Ministerialrat, Leiter des Referates Internationale  
Beziehungen, Bundesministerium für Jugend, Familie,  
Frauen und Gesundheit, Bonn, Federal Republic of  
Germany

Dr I. Weber

Projektleiter, Zentralinstitut für die  
kassenärztliche Versorgung, Cologne, Federal  
Republic of Germany

Mr W. Weiss

Coordinateur scientifique de l'école internationale  
sur les indicateurs de santé, Institut de la  
médecine sociale et préventive de l'Université de  
Berne, Switzerland

- Mr D. Wenty  
Osterreichische Arbeiterkammertag, Vienna, Austria
- Professor A. van der Werff  
Vrouwgeestweg 20, Woubrugge, Netherlands
- Mr J. van der Wilk  
Director, National Patients and Consumers Platform,  
Utrecht, Netherlands
- Dr S. Zobrist  
Wissenschaftliche Adjunktin des Bundesamtes für  
Gesundheitswesen, Berne, Switzerland

### Observer

- Mr B. von Alvensleben  
Permanent Representative of the Federal Republic of  
Germany with the International Organizations in  
Geneva, Switzerland

### WHO Regional Office for Europe

- Dr J.E. Asvall  
Regional Director
- Dr I.S. Luculescu  
Director, Health Policy
- Dr R. Bengoa  
Acting Regional Officer for Health Policies and  
Planning