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CONSULTATION OF COUNTRIES WITH NATIONAL
HEALTH FOR ALL POLICY DOCUMENTS

Report on a WHO Meeting

Sofia
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Note

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Introduction

Seventeen of the 32 Member States in the European Region either have or are preparing a national health for all (HFA) policy document, while a further six have found it more appropriate to develop comprehensive HFA policies at subnational level. Representatives of these Member States attended the Consultation of Countries with National Health for All Policy Documents, organized jointly by the Government of Bulgaria and the WHO Regional Office for Europe in Sofia from 12 to 13 December 1989. A number of temporary advisers and observers from the Bulgarian health services also attended. The participants were invited specifically because of their "hands-on" experience in preparing HFA policy documents.

The Consultation was held to enable Member States to exchange experiences on the development of national HFA policies, and to facilitate discussion on:

- the manner in which HFA is put on to the policy agenda;
- the processes and methodologies used to formulate policies, and the facilitating factors and obstacles which countries encounter;
- the process and methods used in selecting national targets;
- the problems and conflicts associated with implementing and monitoring HFA policies.

Each participant was asked beforehand to complete a checklist designed to elicit details of the process of HFA policy development in each country. Prior to the meeting, a detailed analysis of the replies was provided to the participants as background for the discussion.

All discussions were held in plenary session as the overall purpose was to encourage a frank exchange of experiences. There were no presentations of formal papers, the discussions being organized around the main issues arising from the checklists.

Background

The context for the Consultation was set by an opening review of the current HFA situation in the Region. Participants were reminded that HFA is an adaptive tool which is long-term in outlook, addresses equity issues, gives priority to health promotion and disease prevention, identifies areas for intersectoral action, promotes community participation and involvement, and fosters international cooperation. It is a common policy for Europe, the first to be agreed upon by all Member States and accepted by politicians across the full ideological spectrum.

The development of a HFA policy requires time, patience and perseverance. In this respect the experience of those who have already produced a national policy is crucial, both to an understanding of the process and as guidance and advice for those Member States which have yet to initiate the process at national and/or subnational level.

With regard to the policy-making process, some of the questions the participants were asked to reflect on were: what was the political climate when their HFA policy was initiated? Was it necessary to draft or enact major health laws? Was the development of a policy the continuation of an existing trend or a completely new departure?

What advice could they give to newcomers to the process? What were the important factors to build on or

take advantage of? In what manner could WHO be used to accelerate the process? How could WHO best facilitate and support the formulation of a national HFA policy?

The 38 regional targets were designed as a reference point for Member States when formulating their own HFA policies. Therefore one aim of the Consultation was to consider the relevancy of the targets as a framework for formulating country policies at national and subnational levels.

The participants were asked to comment on: their own experience with the targets, more specifically whether they had covered all 38; the process and criteria used (if any) to prioritize targets; whether they were following the same procedure when revising their policies; how far their targets had been quantified and why; whether it was appropriate to set certain targets at different levels (national/subnational); and if so, whether that would imply different structures.

Synopsis of replies

The purpose of the checklist was to obtain information about the HFA policy-making process in those countries which had produced a national policy document. The replies can be summarized as follows.

Three main factors, it appeared, were instrumental in stimulating the development of a national HFA policy: economic pressures, rising public concern and promotion of the HFA concept by WHO, which played a central role. Generally speaking the initiative came from the ministry of health. The policy was formulated either by a small group of senior officials or by a broader, multidisciplinary working party.

Participation in the policy-formulation process and in dissemination of the document varied widely, but in most cases both formal and informal mechanisms were used, such as established bodies or organizations, conferences or colloquia, media involvement and key opinion-formers. In a number of countries, however, participation had been limited largely to experts.

Some of the benefits of a national policy document were said to be the support and commitment of ministers of health, other government agencies and public health professionals; the possibility of shifting greater resources to primary health care; and the opportunity to generate a number of research projects. However, a "down" side was also identified. Some of the more important problems were a lack of understanding of the HFA concept, resistance to HFA by the medical profession, and intersectoral conflicts, especially over resources.

What emerged very clearly was the strong commitment in the countries concerned to HFA principles. As part of this, respondents emphasized the need to continually review their HFA policies, and to generate greater and sustained support for them at subnational level.

Discussion

The analysis of the checklist replies highlighted a number of important issues, which were discussed as follows.

Building on the past and taking advantage of the policy environment

The participants were first asked to reflect briefly on two questions: to what extent is there continuity between the development of health policy before and after HFA, and what is meant by "taking advantage of" the policy environment?

Not surprisingly, the ensuing discussion was very wide-ranging. For many countries, the move to a national HFA policy had been a radical departure in policy-making terms. This in itself tended to create the problems of learning-by-doing. On the other hand, the matter of policy continuity struck a common chord at the meeting. A number of policy trends in harmony with HFA principles were already visible or emerging when the country HFA policies were formulated.

Critical factors in the policy environment were mentioned, including apparent mismatches between the priorities of the general public, politicians and political parties, and health-sector professionals. A second factor was the issue of credibility relating to the difference between the long-term goals of HFA and the short-term demands placed on the health sector. A third area of concern was the relationship between national and subnational levels, and there was a call for a research programme to explore this complex field. The final issue was the balance between care and curative services, one view being that currently the emphasis is too much on cure and not enough on care, particularly for disabled people and those with chronic illnesses.

Participation was identified as a crucial concern, and although it is discussed in greater detail below it is worth noting here that participants were uncertain as to who might feasibly be involved.

The vexed matter of the relationship between theory and practice, or the link between policy formulation and implementation, was raised by many participants. Since HFA policy was sometimes seen as being almost too radical, many of the more powerful groups in the health sector were opposed to it. This opposition meant that in some cases HFA policies produced little change, as short-term crises continued to dominate.

A final concern mentioned was fluctuation in the environment in which policy-making took place. Factors affecting this environment were identified as an aging society, changes in social mobility, increasing public expectations, political upheaval, economic constraints and technological developments. The policy environment of the 1990s is expected to be quite different from that of the early 1980s.

Comprehensiveness/selectivity/prioritization

With reference to use of the 38 regional targets, it was stressed that a national HFA policy must refer to the broad scope of the targets and not only to parts of them. On the other hand, in the short term it might be difficult to deal with all the targets at once. To avoid the danger of discrediting the whole policy, therefore, it was suggested that it should set the long-term policy directions and, under this umbrella, countries should focus on those targets which reflected local priorities and circumstances.

The question of the political level at which priorities should be set was a matter of some debate. It was agreed that certain priorities and targets could be more appropriately set nationally and others subnationally. What was most important was to disseminate information on the various countries' experience in modifying the regional targets to local needs.

Information background and methodologies

As a prelude to discussion on this important subject, the participants were reminded that both quantitative and qualitative data are important in the

formulation of health policies and programmes. Therefore, what were the main gaps in existing information, and specifically were equity issues adequately reflected? What consideration was given to data required for monitoring? What changes might be necessary in the future? And to what extent did the health sector provide relevant information to other sectors?

Most participants stated that their national data base was good, but that it was underutilized for generating health care information and there was a need for an improved information system. This was a situation they were seeking to rectify.

It was acknowledged that data related to equity issues were missing from health information systems and that this matter required urgent attention. It was recognized also that there was merit in linking the data system of the health sector with that of other related sectors.

The use made of health data and the information derived from it was regarded as an important matter. It was accepted that more attention must be paid to the presentation and dissemination of such information. The providers and users of information must learn to understand each other's needs and concerns better.

WHO was seen as having an important role to play in giving Member States assistance and guidance on the adoption and development of indicators, especially those relating to the quality of care and behaviour or lifestyles. It could also give publicity to examples of successful case studies from various countries.

Achieving wider participation

As before, this discussion was preceded by questions, such as: does the existing planning process facilitate participation? How soon in the process can wide participation begin? How successful are efforts to generate participation? And finally, with hindsight, what changes should be made?

All were agreed that participation in policy development was essential, but they differed on how it should be accomplished. The different opinions reflected a number of concerns: the trade-off between wider participation and speed of policy-making; the dilemma between "top-down" and "bottom-up" policy-making; the type of political system; who should be involved; and when participation should take place. Behind this debate lay anxieties about the different aspects, definitions and mechanisms of participation. For example, participation is a value-laden process and the important thing is whose values dominate. Moreover, participation can take different forms depending on the particular stage in the policy-making process; and the form of participation is governed by the political, moral, and/or technical factors encountered at each stage.

The prevalent feeling was that the HFA policy-making process can only start with a relatively small group, which may or may not be confined to the ministry of health. Once a first draft was prepared, every attempt should be made to generate extensive discussion, not only to ensure contributions but also to encourage acceptance and commitment for the implementation stage. The issue of how to facilitate participation in problem-definition remained unresolved.

The general feeling was that although some serious attempts had been made to achieve wider participation, on

the whole this is still a weak area where considerable improvement is needed.

The national/subnational relationship

The responses to the checklist indicated that the relationship between the national and subnational levels was particularly important for the outcome of the HFA policy-making process. Participants were asked to consider what is best done centrally and what locally, what happens to the equity issues when policy-making is decentralized, and what issues or areas WHO can assist with.

This issue sparked considerable discussion, including on the possible impact of the huge political changes sweeping through Europe. It was clear that the importance of the national/subnational question is also affected by the type of administrative structure a country has.

The importance of better information for decision-making at local level was also stressed. Although decentralization does not necessarily create inequities, this was felt to be a real danger needing careful monitoring and possibly calling for specific counterbalancing action from the central level. It was felt that WHO should play a leading role in facilitating an exchange of experience on recent trends, particularly as they affect equity.

Achieving intersectoral action

The cooperation and involvement of sectors other than health is imperative for the successful outcome of HFA policy. It was felt, however, that the meaning of intersectoral action may not always be understood, and

that there was some uncertainty concerning the level at which it should take place. Even though in some countries national-level mechanisms for intersectoral action existed, it was acknowledged that they should really extend down to local level. WHO could help Member States develop intersectoral procedures by circulating information on good examples of cooperation and action. It should also encourage Member States to give greater priority to intersectoral action in their plans for health.

Participants described the procedures developed in their countries for intersectoral cooperation. Among these were three interesting examples, one using a matrix approach, one a multisectoral advisory body and one scenarios.

Other key points made during the discussion were that proper resources should be allocated for intersectoral activities; that it is better to focus on a few major issues rather than try to do too much at once; that one should be prepared to negotiate; and that one should respond to and utilize public pressure for change, to make the cooperative process easier.

Providing for implementation

The success of any policy consists in the extent to which it is endorsed and made operational by those responsible for implementing it. Participants were asked to reflect on their approach to policy implementation, as regards the stage at which responsibilities for action were assigned, whether these responsibilities were backed up by the necessary resources, and at what point problems, if any, of implementation emerged.

As was to be expected, experience varied. The 38 targets were seen as a useful tool for policy implementation. It was acknowledged that in many cases it was easier to identify target thresholds than to create and sustain a climate for change. Nonetheless it was recognized that a number of initiatives could assist policy implementation, such as regularly producing and feeding back information on progress; relating resources to policy targets; assigning responsibility for reaching targets to specific groups or individuals; offering incentives for achievement of targets; being prepared to modify or amend the policy or parts of it if the evidence suggested that the aims were unattainable; and securing appropriate and adequate resources.

The medical profession was thought to be one of the major obstacles in the path of HFA policy implementation, possibly due to its concerns about loss of income, status, prestige and employment and its lack of understanding of HFA. It was suggested that a way of overcoming this resistance might be, through WHO, to enlist the aid of the European Medical Association, in order to investigate ways in which medical educational objectives and curricula could be made to better reflect HFA concepts and principles.

Perhaps the most important factor identified by participants for keeping HFA policies to the fore was the need to sustain the political commitment to it.

Monitoring progress

Although monitoring is an integral part of the policy-making process, it is often not apparent that it is taking place. With this in mind, the participants were asked to consider what was being monitored (political or managerial processes, outcomes), who was

doing the monitoring, and how. It was suggested that both process and outcome should be monitored and that it was perhaps too soon to measure outcomes in terms of health status.

One of the countries with long experience is Finland. In its case, monitoring has been done by a small steering group, although no additional resources were allocated for this purpose, the group relying on existing procedures and resources. One innovative development was that the Finnish HFA policy was reviewed by an external group of international experts and WHO officials.

The experience of other countries also suggested that although the monitoring process was considered valuable and worthwhile, many improvements could be made. It was felt that the indicators used were perhaps too much concerned with mortality, and that it would be helpful if more attention were given to socioeconomic conditions and morbidity. Many of those present believed that it was important to develop indicators to measure healthy lifestyles, and functional capacity or disability. It was hoped that WHO might take the lead on this.

With regard to specific indicators, participants thought it would be useful if methods of collecting data for indicators could be standardized in some way. One suggestion was to use standardized questions in routine surveys such as population censuses, household budget surveys, and so on.

Next time round

In the final session, the participants were asked what, with hindsight, they would have done differently.

The majority would not radically have altered the procedure used to develop their national HFA policy. There were aspects of it, however, that they felt could be improved. They would have laid greater emphasis on equity issues; recognized and done something about the care of the aging and the chronically sick; broadened the policy-making process to reach outside the ministry of health, and - allied to the last point - ensured greater participation, especially of those concerned at local level.

They agreed that a similar but larger meeting involving all the Member States of the European Region would be most desirable, in order to exchange the experiences of all the countries concerned.

Recommendations

The first group of recommendations from the Consultation is intended for the Regional Office.

1. The Office should concentrate further efforts on promoting HFA concepts (especially the idea of its short-term benefits for health professionals) and on developing HFA leadership. For the latter purpose, the role of nongovernmental organizations such as the European Medical Association, and of UNESCO should not be overlooked.
2. When revising HFA targets, the Regional Office should give greater attention to quality of care and to mental health.
3. It should make a greater effort to design a data base of standardized information collected from all countries, with particular reference to lifestyle issues.

4. It should further support the development of computer software systems for monitoring different kinds of health care, and for monitoring equity, health status, quality of life and quality of care.

5. It should simplify the language it uses - even the 38 targets are not easy for some people to understand.

6. It should make further efforts to publicize and stimulate the adoption of HFA policy.

7. The Regional Office should help Member States by facilitating an exchange of information on the relationship between national and subnational levels, including an investigation of those issues best dealt with at one level or the other.

8. It should disseminate examples of good practice in achieving wider participation.

9. It should examine recent changes in the health sector, especially decentralization and the use of incentives in health services, and evaluate their effect on health care and equity.

10. It should clarify the concept and principles of equity.

11. The Office should give high priority to intersectoral action, and collect and disseminate information on successful experiences for use as training material.

12. It should continue to support changes in the training of health professionals necessary for HFA development.

13. It should reduce the number of indicators for monitoring HFA, and consider defining a small set of essential indicators.

14. It should develop HFA indicators which are less concerned with mortality and more with quality of life and quality of care.
15. It should facilitate an exchange of experience on the use of various matrices for policy-formulation purposes.
16. It should carry out or support a study or survey to find out to what extent HFA is known about and understood by the population and the medical profession in Member States.
17. It should publish a short report on this Consultation and its recommendations.
18. It should organize a further meeting of a similar type to address the following issues: equity; monitoring and evaluation, including of the state and stage of implementation; quality of care indicators; and a comparison between countries, especially those with minimum government involvement and those with strong government involvement whether at central or local level.

The second group of recommendations is intended for the attention of Member States.

1. Member States should try to balance short-term expectations and action against long-term HFA goals, bearing in mind the different perceptions of politicians, the public and health experts.
2. They should encourage greater involvement in policy formulation, implementation and evaluation at subnational level.
3. When formulating national HFA policies, Member States should try to achieve a better balance between prevention and promotion, curative services and community-based care.

4. They should refer to all 38 targets as a checklist and framework for developing overall policy guidelines, and then focus on specific targets according to national circumstances.
5. They should examine to what extent past policies can be used as a foundation on which to build a HFA policy.
6. When formulating the policy they should consider adapting national targets to subnational conditions.
7. They should not only collect but publish, or otherwise make widely available, their information on HFA policy development.
8. Member States should make greater efforts to collect and utilize information on equity.
9. They should ensure wide participation, involving groups and sectors of society as appropriate in the development of HFA policies.
10. They should try to provide more information on the outcome of primary health care.
11. Member States should distinguish between information which serves to mobilize people and resources for HFA policy purposes, and that necessary for technical purposes, and in each case they should pay more attention to the way in which information is presented and the level at which it is directed.
12. They should consider the production of health reports on a regular basis as an effective means of mobilizing people and obtaining their informed participation.
13. They should secure local-level information both for policy formulation and for monitoring and evaluating progress.

14. Member States should consider organizing consensus conferences which bring together various interest groups, including epidemiologists and policy-makers, as a particularly effective way of formulating policy.

15. They should consider using simulation models for planning and management purposes.

16. They should exchange their experiences of developing HFA policies.

17. They should develop mechanisms for formulating, implementing and evaluating intersectoral action, either through an overall multisectoral body or on an issue-specific basis.

18. Member States should encourage intersectoral action at both national and subnational levels.

19. They should ensure that the health sector understands the power structure, relationships and objectives in other sectors.

20. They should consider using parliamentarians, ex-politicians and key leaders to promote HFA and foster intersectoral cooperation.

21. They should try to anticipate problems with implementation at the policy formulation stage, and establish procedures for dealing with them, including the assignation of responsibility for specific tasks.

22. Member States should assess the progress of policy implementation critically and revise the policy accordingly.

23. They should consider possible changes in the policy environment and try to use HFA as a consensus area by involving all political parties.

24. They should monitor their HFA policies in terms of both processes and outcomes.

25. They should adapt the training of health professionals to the requirements of HFA.

Annex 1

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