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WORKING FOR HEALTH FOR ALL

HEALTH POLICY PLANNING AND MANAGEMENT IN EUROPE: AN EVOLUTION

by

Keith Barnard
Nordic School of Public Health
Gothenburg, Sweden

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EUR/HFA targets 33, 34

TARGET 33

Policies for health for all

Before 1990, all Member States should ensure that their health policies and strategies are in line with health for all principles and that their legislation and regulations make their implementation effective in all sectors of society.

TARGET 34

Management of planning and resource allocation

Before 1990, Member States should have managerial processes for health development geared to the attainment of health for all, actively involving communities and all sectors relevant to health and, accordingly, ensuring preferential allocation of resources to health development priorities.

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1. Summary

This paper offers a reasoned synthesis of EURO's technical cooperation with Member States and the European experience of policy, planning and management in support of HFA. It records the progress to date, identifies the major characteristics and significant influences in Europe and clarifies the particular challenges faced in implementing HFA. It explains in some detail the evolution of the approach to policy, planning and management taken in Europe and reviews recent and current activities to sustain the momentum.

1.1 Introduction

WHO, by one means or another, e.g. Programme System Analysis (PSA), Country Health Programming (CHP), and currently Managerial Process for National Health Development (MPNHD), has been promoting managerial processes for the health sector and health development for many years, and over the past decade explicitly in support of Health for All. The work of the Regional Office and the programmes of the European Region have been quite consciously shaped by these purposes. And at this midpoint between the HFA Resolution and the year 2000, it is possible to assess progress and the tasks yet to be done, including a frank appraisal of the problems to be overcome.

A fully considered assessment of progress in the Region would take cognizance of the particular constraints and obstacles experienced in the different political, organizational and other circumstances of countries, the status of their health infrastructure development including modes of intersectoral collaboration and community participation, and their achievements in HFA policy development and implementation. To the extent it is possible that is the intention underpinning this paper. It summarizes a general impression, drawing on informed opinion and reviewing Regional Office activity, and provides a reasoned synthesis of European experience.

2. Health for all in Europe: the achievement

Since managerial processes and associated activities related to policy making and implementation are enabling measures and not ultimately to be seen as achievements in their own right, it is as well to stress at the outset the very significant success in HFA terms which has been gained in Europe over the past decade.

Based on reasonable assumptions reflecting what is known about actions being taken within countries, by the autumn of 1988, over one third of all Member States have formulated a national HFA policy; a further one-fourth have policies in process of development some of which are expected to be finalized before the end of the year. In another subset comprising most of the remaining Member States there are either significant HFA policy initiatives being taken at subnational level or there are specific agencies or geographical localities taking part in EURO inter-country projects (Countrywide Integrated Noncommunicable Diseases Intervention Programme (CINDI) and Healthy Cities) specifically designed to promote the HFA strategy and its implementation (see attached Fig 1).

The analysis of problems of constraints and obstacles which has a prominent place in this paper, needs to be seen in this light. The achievement clearly outweighs any setbacks. The achievement also prompts enquiry into what more needs to be done, what is possible, and what further progress might be made. But given many apparent adverse conditions, including

the frequent absence of strong early proponents for change towards HFA, it is in fact pertinent to point up the positive indications. These suggest that there is indeed a real HFA momentum within the Region evidenced by the range of activities directly related to or supportive of HFA. Accordingly a second dominant theme in this paper, as will be seen, is to chart the historical evolution of the steps taken over almost two decades to create the momentum, and what the Regional Office with Member States is doing to sustain that momentum.

3. The European context for health for all

3.1 Relative advantage

In making an attempt to set the study of progress and needs in Europe in the global context, recognition must be given to the specificities of the Region which mark it out clearly from many other areas of the world. Conventionally these are principally seen in terms of the relative advantage enjoyed by European populations.

- Life expectancy is high with low maternal, infant and child mortality rates.

- The economies are developed and the prerequisites for health where these can be met by national or subnational action are generally satisfied.

- Medical care provision either funded by taxation or health insurance is virtually universal.

- Medical care is well resourced in terms of financial allocation, manpower and facilities.

- Health services are complemented by various other forms of social welfare to provide necessary support to those in difficulty through disability, old age, unemployment, etc.

- Public health combined with other technical services are functioning at a level to provide an adequate standard of environmental control.

- Well established mass media (TV, radio, press, etc.) combined with (near)universal literacy ensure that there is rapid dissemination of information relating to health and disease giving the potential for community involvement in health, politically, through voluntary organizations, and in responsible self care.

- The administrative and professional infrastructures to support public policy formulation and implementation and the organization and management of various health and health related services are in place and functioning at a level generally acceptable to the public.

3.2 Problems arising

Against such positive factors, certain other observations need to be made.

- The epidemiological and demographic trend is towards more social and economic dependency in the population with more people surviving to late old age, giving rise to major financial and human resource consequences

for their care, both professionally and within families (e.g. the role of women as carers).

- Many of the prevailing health problems are not amenable to simple and low cost solutions, and given the long lead times for many noncommunicable diseases to become clinically manifested, it is now increasingly realized that disease prevention and health promotion programmes are additional to treatment and rehabilitation, not cheaper alternatives.

- Many countries are going through phases of major economic and political transition with important social consequences which may be manifested in persisting health inequities (as between various population groups) and in demands on the health services.

- There is often a misalignment of health problems (whether analysed demographically, geographically or epidemiologically) and the actual allocation of resources (finance, manpower, facilities), accompanied by a sustained growth in technology where innovations may not be adequately assessed and the rate of substitution of proven improved technology for obsolescent is often notably slow. Nor is the drive for new technology always matched by a concern with quality of care and consumer satisfaction and any emphasis on quality focusses on the process (assessed against professional consensus norms) rather than health outcomes.

- There is a persisting anxiety in the developed countries about environmental problems (such as those associated with the industrial, energy and defence sectors) and their health consequences.

- The concept of health as well being, particularly in its social, psychological and spiritual dimensions is a potent issue particularly in urban areas, as reflected (e.g.) in the disturbing trend in suicides especially among the young and in various forms of violent and self-destructive behaviour, and in various manifestations of family stress.

- The growth in interest and consumption of various forms of alternative medicine and health promoting/sustaining regimes and of self care, while having its positive and desirable side may also be a reflection of a reaction by some sections of the population against professional providers and a consequence of exaggerated expectations about the services being unfulfilled.

3.3 Political context

It will also be readily observed that within Europe the whole spectrum of politico-economic systems can be found from unitary centrally planned economies, through mixed economy-welfare states of the social democratic tradition, to federalist-pluralist market economy countries. All countries had well established medical care systems when the HFA movement was launched which became key influences on how that movement could develop. But the scope and pattern of the health sector and the planning and management mechanisms, necessarily reflect where a country fits on that ideological spectrum, and also (given that all societies are dynamic) the direction in which it is moving along that spectrum. It is not possible for WHO to advocate a particular mode of health development (e.g. through decentralization or intersectoral action) without taking cognizance of the wider political culture

and developments in Member States. Any health sector innovation is dependant on the wider political-administrative system.

It is also therefore noteworthy that in a number of countries in different parts of the Region there has been an intense debate, often of an ideological character, about the future fundamental character of the society and economy. These debates can have profound implications for health sector policy, e.g. how much public intervention, how much is health a personal behavioural and economic responsibility, how far should health and particularly medical care be treated as within the ambit of the market for consumer goods and services.

3.4 EURO's role in the Region

All these phenomena summarized above are major influences on the way WHO can and does function in Europe. Apart from countries in certain specific situations (now only Turkey) there are no WHO representatives as function in other Regions. Nor would it be appropriate or cost effective even if the budget allowed. In Europe WHO can operate most effectively under the guidance of the Regional Committee, working through and with many partners within countries - national health administrations, local governments and other health authorities, associations of providers and consumers and other pressure groups, etc. By harnessing expertise of different kinds at different levels in all countries, and seeking to build coalitions of support for HFA at all political, professional and community levels through its activities, both at regional and inter-country levels, and increasingly in bilateral dialogue with particular countries, EURO is discharging the two functions it is uniquely placed to fulfil - that of advocate and clearing house for all intelligence on health development.

4. Health for all progress - the challenges

4.1 Established systems: the consequences

While every country in pursuing HFA goals is constrained by the evolution of its political and other systems, there are recurring challenges and difficulties which can be observed.

Perhaps the most crucial characteristic of European countries is that the health service structures are so strongly institutionalized and in some cases very complex, with a number of different systems providing services to various segments of the population, especially curative care. The thrust for Health for All/Primary Health Care confronts entrenched medical care establishments and also perhaps consumer groups with strongly vested rights and/or purchasing power. Social equity claims on behalf of underserved populations, as well as resource claims to improve disease prevention and health promotion for the entire population, may constitute challenges to the status quo and if so, are highly political. The strength of advocacy observed whether between or within countries, varies from nominal to intense on such HFA issues as coverage and accessibility, protective, preventive, and promotive measures, intersectoral cooperation for health and social development, and community participation.

Where HFA policies have been enunciated, the next step of obtaining resources to implement the policies, likely involves intense competition with those parts of the established structures which are not instinctively sympathetic, and therefore not readily adjusted to HFA objectives. Even within lead agencies, usually ministries of health, resistance or at least

inertia can sometimes be expected in matters of reforming existing programmes, promoting the integration of services, or increasing community participation and intersectoral action. Since health is not too often a major Ministerial portfolio, there is a risk (sometimes observed as fact) that government health departments are not under pressure from the political level to treat health policy development as a departmental priority (as opposed to efforts to contain the political damage of immediate problems).

So although the systems are well established, they are by no means all readily adaptable to and for HFA. Indeed many public health agencies may be the "poor relations" in complex health sectors, subordinated in some way to social insurance or other agencies that supply medical care. By contrast in other countries public health agencies have extensive responsibilities for hospital services, and thus staff oriented toward and budgets dominated by curative care. Community services have often had weaker systems of staffing, support service, and less certain financial provision.

Thus the issues may be summarized as follows:

- the inertia of existing health and other sectoral bureaucracies;
- political and managerial resistance to changes perceived as changing the status quo and making additional claims on resources;
- non-governmental institutions (in pluralist systems) providing curative care, although receiving public subsidies, are powerful and many dominate resource competition;
- physicians (especially hospital based specialists) as leaders are strongly institutionalized, which tends to foster inertia and disinterest in management framed in wider terms.

4.2 Constraints and obstacles

It would be possible to cluster countries according to progress made in policy, planning and in infrastructure developments in relation to HFA strategies. A broad distinction would be made between countries where there are as yet no policies or only embryonic policies, and those which have in some degree developed policies and are facing the challenges in making progress as planned.

The following themes give an indication of the range of issues which, from observation, warrant political attention within countries:

- lack of a national social policy framework to which HFA can be related;
- lack of political concern about national health development;
- segmented political and administrative structures;
- over-centralized processes of decision-making and management;
- absence of effective mechanisms for intersectoral social development planning and management;
- determining appropriate roles for both market mechanisms and self regulation of the health sector, and collective (public) action.

It is clear that for countries in the Region experiencing those kinds of problems which inhibit the development of policies or the requisite changes in the infrastructure, constraint analysis as a step towards creating better possibilities for policy and strategy formulation must now be the main challenge.

Country health sectors are being implicitly encouraged to identify crucial factors as the first step in constraint analysis; followed by a classification into those factors which reflect obstacles which can be changed in the short-term, those whose change will require a medium term strategy, and those constraints which currently must be treated as "givens" and for which a long-term strategy must be followed. The understanding gained can be used as a base for planning what can best be done, and when.

4.3 Central tasks

In countries where policy instruments, plans and programmes expressing HFA strategies have been drawn up, the central task is to take the actions required to achieve and sustain HFA objectives, whether these are in:

- ensuring that health sector activity can and does contribute to broader goals of social policy as well as improved health status of individuals; compatibility of different health related activities - including those of other sectors - at each political/administrative level, the linkage of the several levels of policy management and operations so that they are mutually supportive;

- developing, implementing and systematically reviewing objectives and where necessary quality standards for all health related activities and resources (human and physical), making these known to those whom they are to guide; using the insights of operational level staffs, consumers, community groups, etc. to help assure practicality and efficiency;

- ensuring, at each and every level, that workers know clearly what work and behaviour is expected of them, what they can expect of others, and where they fit into the total system of health and health related services, etc.;

- designing and installing information systems to support clinical work and other direct services, evaluation and planning, and management of operations;

- monitoring and evaluating throughout the health and health related systems, so as to keep the work "on track" and to detect quickly, needs for adjustment and adaptation.

4.4 Problems encountered

It should be noted that in practice much of the interest in Member States in such issues is selective, related to their current efforts to rationalize health services systems and structures. But their immediate objective is not necessarily to link rationalisation with aligning the systems to health policy development. Rather it is to find incentives, pressures and a variety of devices to move managers and providers closer to the most efficient use of resources (i.e. to reduce unit costs of existing and projected activities). This follows from the awareness of a resource crisis (financial and human) in the health services which is felt in many if indeed not most countries in the

Region. This selective interest also reflects another observed phenomenon that when general systemic inadequacies are in some degree perceived (whether or not they are adequately analyses and understood), national and health leaders tend to pick specific "entry-points" to solve the problems. One aspect of system management - training, information support, closer supervision, organizational restructuring, efficiency programmes, market mechanisms - comes to be the "theory in good currency" and espoused as the key. Remedial efforts are then centred on that aspect.

Such a "panacea" response has not infrequently been observed in the health sectors of some European countries. The seemingly often uncritical European interest in the U.S. innovation of Diagnostic Related Groups (DRGs) would be a recent manifestation of this phenomenon. This comes as a result of seeing hospital cost containment as the "real" issue and cost identification as the "key", without regard for the particular circumstances which prompted US government interest and the subsequent behaviour in response by the hospitals generating the need for yet another approach.

Empirically speaking this seems natural or instinctive decision making behaviour in complex circumstances. It is more difficult to take a comprehensive view of the problem (i.e. put it in context) or undertake a broad analysis to prepare for an integrated attack on the systemic shortcomings. One perennial danger is the felt need to made a visible and preferably dramatic gesture.

The more encouraging impression emerging in Europe is that such narrow thinking may not be so prevalent now as sometimes in the past. It becomes a function of the Regional Office to reinforce this trend by advocating a comprehensive approach, not so much to find "perfect" (and hence unattainable) answers but to avoid "tunnel vision" or using isolated projects as the path to broad appropriate solutions. This is a crucial point for EURO to keep visible because success in the "what" of policy - progress in the achievement of HFA - is dependant on what is done by and within countries, i.e. the "how" of action on their policies and objectives.

The lessons which the European Regional Office has drawn from its cumulative experience in working with and serving Member States, as will be developed later, are that the recognizable common ground of the Member States of the Region can only be on the "what" of policy and that its implementation, the "how" of action, depends in considerable part on their individual activity at national and subnational levels. The sustained focus on policies has been achieved through the Regional HFA Strategy, Targets and Indicators which constitute the basic content of a common health policy for Europe; and implementation is being supported through various Office-wide initiatives and cooperation with promising projects initiated or mounted elsewhere. A full account of that cumulative experience, the insights gained and the present objectives and actions of EURO now follows.

5. Health policy, planning and management in Europe: an evolution

5.1 Health planning in Europe - the origins

The early 70s in the European Region saw the emergence of "planning" as a philosophy and an administrative approach in many countries' health sectors. It had a number of roots, principally: the various developments in public administration and private sector corporate planning which had evolved primarily in the US during the 1960s; the acceleration of new hospital

building programmes and their service development implications; and a new interest in rational decision-making and management and hence in the experience of the socialist countries in rational planning systems. The new European health sector agenda was reflected in the 1974 European National Health Planning Conference (Bucharest) and the earlier Stockholm (1972) and other preparatory meetings.

5.2 1970s experiences in planning

The Bucharest Conference was held in the belief that countries could learn from each other and that this would promote health planning as a means towards the more efficient use of resources in the improvement of health services generally. Already at that time there was concern to promote participation of the general public and also of health service personnel who, it was felt, might be resistant to any apparent attempts to curtail traditional professional freedoms. The 1970s agenda also already identified as key issues information systems and evaluation, quantitative techniques (Planning, Programming and Budgetting Systems (PPBS), Operational Research, etc), linkages between finance, manpower and other resources, and activities, and policy formulation and decision-making processes including relationships between key actors, and the need for related research and training. Finally, it was perceived that health planning could benefit the general socioeconomic development of countries. It is clear from the report of the Bucharest conference that EURO was envisaged as having a substantial supportive and facilitating role and a responsibility for generally stimulating the development of health planning.

It can be noted that the Bucharest agenda was being fashioned against a background of certain specific WHO initiatives. The first notable WHO model for planning in the 1960s, "Health planning - problems of concept and methods" in cooperation with the Pan American Bureau Scientific Publication No 111, Washington 1965 (PAHO/CENDES), a very detailed approach to problem identification, activities and resources, had been succeeded in the early 1970s by Project Systems Analysis (PSA), which was however generically the same approach. It was tested in various countries, in Europe in the United Kingdom (Scotland) where it was hypothetically applied to a child health programme. PSA undoubtedly aroused the interest and enthusiasm of those immediately involved and in Scotland, at least initially, had support at the most senior level of the national health administration. It was, however, not applied operationally. In retrospect it is clear that the PSA approach provided a very necessary pointer to the importance of rigorous analysis and of coherence in programme development. Whether fairly or not, it was seen as too technocratic, underplaying the importance of political, social and other human factors, and by focusing on detail failed both to present the sense of a wider vision and to face up to the limitations of imperfect and incomplete data.

A second WHO initiative of the time was the preparation of qualitative country case studies in planning practices and objectives, reflecting the variety of political, economic and organizational contexts to be found in the Region, published in 1980 as "The planning of health services, studies in eight European countries". The anthology is probably most significant for its explicit treatment of the variety of approaches which would inevitably develop out of the different contexts observed in the Region. It argued that if the various developments could be understood in their contexts, then it would be possible for others to learn from them.

5.3 Country Health Programming (CHP) in Europe - planning in transition

Globally PSA was succeeded in 1973 by Country Health Programming (CHP) as the WHO "model". It was reported at the end of the decade that some 40 countries had made some use of it. There was less take-up in Europe than elsewhere but, as stated at the 1979 Vienna workshop on CHP, many of its principles were being actively if selectively practised. Poland and Yugoslavia were cited as applying CHP and also Algeria, then in the European Region, where a large exercise in problem identification was carried out with EURO assistance. Two other major exercises were launched, one in Spain and one in Portugal in areas with a population of 1.2 and 0.5 million respectively. As with the earlier PSA exercise in Scotland, the CHP exercises generated enthusiasm and lessons for future planning activities, yet ultimately remained separate developments not shaping the main stream of planning in these countries.

But much more significant was that by the end of the 70s it was possible to place planning in the setting of a coherent health policy which it must serve - the HFA Resolution and the Alma Ata Declaration. This, together with a recognition of the limitations of earlier approaches meant that CHP had to be presented as serving a larger purpose than technocratic rigor and logic. Macro political organizational and cultural factors were given a much more explicit recognition and CHP was offered as a framework for ensuring that policy making and planning were in every sense appropriate to the circumstances, working with and encouraging adaptations to existing structural features in pursuing health and, after 1977, HFA objectives.

The main thrust of the Vienna workshop was to acknowledge the positive potential of CHP in Europe and to suggest the need for some region specific adaptations to the global model and for guidance to make it more immediately and visibly relevant to people involved in policy and planning within countries. A subsequent analysis of the relevance of CHP to Europe went so far as to imply the need for different guidance for different clusters of countries (centrally planned, market-pluralistic, those with emergent national health services, etc.), and also to provide different packages of guidance for the education/information of politicians, technical planners, professional providers. It was not however feasible to act along these lines.

5.4 Managerial Process for National Health Development (MPNHD) - a stimulus to planning in support of HFA

So by the end of that stage (ca. 1980), it could be fairly said that the general approach to planning was evolving into a more realistic and sensitive mode with an emphasis on key issues. Much of this had been anticipated in the Bucharest agenda so a sense of evolution in thinking, both within Member States and EURO, was apparent. CHP was then absorbed into (rather than replaced by) MPNHD which, maintaining the same underlying rational approach, offered a comprehensive framework for understanding and pursuing the HFA goal.

It was in this context that first CHP and then MPNHD were consciously used by the Regional Office to accelerate HFA awareness in health sector planning and management in Member States. A major series of MPNHD workshops was initiated and ran for several years at Collaborating Centres in the United Kingdom (Leeds/Edinburgh), USSR (CIAMS) and Federal Republic of Germany (Dusseldorf/Munich/Kiel). These workshops were attended by senior personnel with policy, planning and management responsibilities from many Member States. One important consequence was the series of opportunities so created

to test the ideas against the first hand experience of people in positions of responsibility who between them covered the whole span of European systems. A most important feature of these workshops was that they were designed to bring together nationals and WHO staff members (at both service director and unit/programme manager levels). They, therefore, very effectively served to enhance mutual understanding. Nationals became more sensitive and sympathetic to WHO initiatives. WHO staff members received a frank insight into country realities. The workshops also served to enhance EUROs internal cohesion as staff were encouraged to analyse and develop their programmes using MPNHD concepts.

In advocating MPNHD (Fig 2) in Europe as a basis both for examining country problems and needs, and for developing the necessary responses, a clear distinction has been made between commending it as an approach to the issues in national health development, and the alternative (and likely counterproductive) use of specific elements of MPNHD and associated instruments, to provide direct criteria or a checklist for assessing national progress.

It must be said that promoting MPNHD in Europe has presented some particular challenges. Despite the substantial efforts made to generate a MPNHD momentum, there was the underlying difficulty that few key actors in Member States saw its intra-national marketability as the specific basis for national health development. Thus a position typically taken was: is MPNHD guiding us in the direction we are already following - if so there is no call for change; if not, are the changes required worth the costs incurred and effort required and are they feasible in terms of our wider constitutional framework or political and bureaucratic cultures. To make this point is not to suggest that the impact of MPNHD advocacy was inherently negative, but that it would have been unrealistic to expect visible, explicitly related results in many countries, and particularly in say those pluralist countries where the policy making and implementing frameworks did not appear readily to lend themselves to a straightforward application.

No less important, it could never have been the sole message reaching the political systems or health sectors. Public policy making and management methods have a substantial history in the European Member States. There is an extensive and expanding professional and academic literature in the main languages of the Region. Governments and subnational authorities can draw on the skills and expertise of universities, research institutes and other bodies such as management consulting firms when addressing their policy and organizational problems, as well as harnessing the in-house talents of ministries and other agencies. In doing so they will be given the models, underlying theories and vocabularies which these consultants and advisers have developed or already found useful in other work.

The foregoing is intended to stress the reality that the influence of MPNHD in shaping a developed country's health policy and health system would most often be partial and even obscured by other influences. There is, however, nothing in this to suggest that MPNHD has been unhelpful or irrelevant or that its conception has not been a necessary element in WHO's own HFA leadership role.

5.5 Managerial Process for National Health Development (MPNHD) as a model for Europe

Beyond its endorsement by the World Health Assembly as a means to develop HFA policies and strategies, the model's inherent strengths were widely recognized. Its basic concepts are those of a traditional model of rational management with its logical sequential method to determine needs and responses. Thus, it could enjoy universal recognition among planning practitioners, policy analysts and their associates in all sectors, and provide a framework for a systematic intersectoral process of health development.

In this sense it indeed has been proven as an effective framework, no less in Europe than elsewhere, for discussing how problems revealed by situation analysis can be responded to by appropriate policies translated into strategies, programmes and activities. This is irrespective of the nature of the political system and its health sub-system to which the particular discussion might relate. It has also been found superior as a starting point to other more "realistic" policy making models such as "incrementalism" or "mixed scanning" (which are most easily understood in terms of their departure from the "rational comprehensive" tradition to which MPNHD belongs) or even economic analysis *per se* which could contribute significantly when prudently applied to problem definition and appraisal of policy options, but not so much to the working out of the chosen response in implementation.

Such has been the assessment coming out of numerous inter-country workshops over the past decade and also from bilateral contact with key figures in Member States. It confirms both the strengths and the limitations of the model. The planning process is conceptually easy to follow, in that each of its main steps is based on a more general preceding step (policy is deduced from the health and social situation; broad programming is based on the formulated policy, etc.). However, it is not simplistically linear because it is also characterized by feedback loops - so that decisions made in the earlier steps can and may have to be revised in the basis of information developed in later steps.

Some European health planning experience suggests that there may be legitimate questions about how complex organizations or multi-agency systems can actually operationalize a reiterative approach of this kind, even if its logic and intrinsic value as a mode of thought are unquestioned and can be applied by the individual manager in certain situations. But there is a gap between country realities and the theoretical promise of the model revealed in the European experience. The model gives considerably greater emphasis to the national planning functions of management which (except in those countries where the role of the national/federal level is either constitutionally or in practice constrained) are well established if imperfect, than to the guidance and control of operations which are now issues of some major importance in many countries.

In practice, from the perspective of HFA development, this has been compensated in this Region by the broad range of initiatives within countries at the local level, many of a health systems or action research character, which implicitly or explicitly take the district concept or some equivalent as the frame of reference or initial assumption for action.

5.6 Planning in the 1980s

The 1984 European Conference on Planning and Management for Health (The Hague) provided a major opportunity to take stock. This meeting confirmed the new agenda.

- The need to address clearly and consistently the place of a variety of approaches for different political and organizational systems, distinguishing the underlying value of planning as a discipline in policy and decision making from the particular specifics of certain techniques, procedures, organizational and other arrangements.

- The need for a special effort to tackle the challenges of broad based involvement in planning both through community participation and intersectoral collaboration. In particular to be able to identify and understand resistance to planning proposals whether intellectual, political, economic or psychological and to respond accordingly
- the imperative of facing up to the consequences of finite resources (economic stringency) and to ensure that planning whatever form it might take, was realistic.

- The need for sustaining efforts in training for policy, planning and management, and for research and development in all the main areas of concern which had emerged: planning contexts; health situation assessments; information and evaluation; retraining and reorientation of health workers; policy, planning, management and diplomatic skills for key personnel.

In retrospect it can be seen that while in a number of respects the agenda created by the 70s focus on "planning" remained stable and consistent, certain important new insights emerged by the time of the Hague conference.

It was now borne out by experience that the actual approach to planning within a country had necessarily to be tuned to its socioeconomic and administrative environment. The fundamental concept of planning as the conscious attempt to influence the future (or in Sir John Brotherston's terms at Bucharest "planning as the means to make the future better than the present") remained valid. But that did not imply that there was only one planning method or one political and administrative mechanism. Once the implications of pluralism in political, cultural and organizational systems are fully grasped, it follows that there is a need (recognized at the Hague Conference) to encourage a variety of secondary concepts and multiple methods of pursuing the purpose of planning.

Among the concepts secondary to the basic concept of planning are those of "desired outcome", "alternative futures", "consensus building", "negotiated strategies" and "flexibility in implementation". In terms of methods, as alternatives to "command" or centrally directed planning, there is a range of approaches evolving which might be labelled "inter-active" or "bargaining" involving negotiated mutual adjustments between partners in the process.

In a number of cases (Netherlands, Finland and others) the scenarios approach has been found useful: by identifying a variety of possible future states and tracing the consequences and implications of present trends and likely development, making certain explicitly stated assumptions, it becomes possible to initiate a dialogue with a variety of partners whose involvement and support would be crucial to any decisions and implementation.

The "soft" approaches do not require any less rigour in analysis and formulation of options than more formal planning methods and are much more politically and culturally acceptable in countries without either tradition or political structures to facilitate formal comprehensive planning. Moreover, the general experience now suggests that irrespective of the degree of formal structures and the existence of lines of command, the complexity and scope of the policy field enshrined in HFA is such that interactive and cooperative approaches creating a shared agenda are almost always preferable if successful implementation of policy is to be made possible. And given the essential intersectoral character of HFA objectives, in all countries whatever the degree of formal structure in the health sector as such, achieving horizontal intersectoral coordination and intra sectoral vertical integration of different political, administrative and technical levels, is the main challenge. The greater the number of autonomous bodies (either constitutionally or in practice) with different accountabilities, the more critical this task becomes.

5.7 Health for all in Europe - through policy

It is this very variety of contexts which inhibits EURO from formulating and commending to countries explicit and concrete specific guidance on programme development and implementation. Even at the highest level of generalization in categorizing member states, one is left with a dichotomy between those where the conditions for effective formal planning mechanisms exist and those where such mechanisms would not be appropriate or acceptable. It must be left to member states to determine within the setting of their commitment to HFA, how they wish to act on that commitment, choosing whatever mechanisms they believe will work for them. Again in terms of the broad dichotomy, it means EURO can reasonably expect some countries to adapt HFA to their planning structures and vice versa and to produce planning documents as the basis for implementation of objectives. In other countries there will be an incremental approach, building up awareness and fashioning to the extent possible, an HFA consensus through consultation and negotiation and, ultimately, leaving it to autonomous partners to take action.

While steps can be taken by EURO to promote country action on HFA implementation, the difficulties inherent in specifying "how" means that the primary focus must be on "what", i.e. a focus on national health policy, and then to monitor and reflect back to countries what happens by way of their action on policies. This is in fact the path which has been taken in Europe.

The first and most crucial step was the formulation and endorsement by Member States at the 1980 Regional Committee for Europe (Fez) of the Regional HFA Strategy. The Strategy document was crucial in two respects: first, by its analysis of the existing situation and trends in Europe, it demonstrated the relevance of HFA to the circumstances of the Member States; and secondly, it provided the essential elements of a common health policy for the countries of the Region - health promotion and disease prevention, environmental health improvements and, more appropriate patterns of care. Creating a health agenda for the Region in this way, it became a natural development to articulate these components as general objectives into more specific objectives or "Targets" which would provide indications of desired action.

Creating a health policy agenda was in fact an important watershed. Analysis of trends in the Region confirmed what was increasingly intuitively felt, that the expansion of the health services infrastructure of personnel and facilities, had been accompanied by a growing mismatch between health

sector resources and the prevailing health problems of populations. The agenda offered by the Regional HFA Strategy meant that decisions on health service development could in future be put into a comprehensive policy framework. By its emphasis on health promotion, disease prevention and environmental improvements, whether by legislative, fiscal, educational, administrative or other measures and services, the strategy also convincingly changed the terms of debate on health services from expansion to appropriate care. This meant the most appropriate organization and configuration of services to meet the predominant health needs of local populations. This, in turn, carried implications of harnessing appropriate technology, suitable training programmes for present and future cadres of health workers, and budget and manpower allocations (however made) which can sustain the pattern of appropriate care.

5.8 Regional strategy - the significance of targets

In terms of maintaining the momentum starting with the strategy, the support of Member States in developing its main thrusts into more specific objectives or "Targets" was vital. Otherwise the strategy could easily have been lost, overtaken by later events. The development of the Targets, agreed to by the Regional Committee in 1984, ensured that the Strategy now had its own dynamism: Member States accepted both the Targets as a relevant stimulus to action by and within countries and the corollary of periodic progress reporting by Member States to the Regional Committee according to agreed indicators which reflected the substance of the various Targets.

The specification of more concretely defined objectives as HFA Targets and the identification of relevant indicators were the result of a careful preparation steered by the Regional Committee. The inhouse resources of all EURO units were complemented by a very extensive network of external experts (both enthusiasts and sceptics to ensure not only ideas but also a searching critique) producing provisional proposals which were synthesized, reviewed and further revised in light of contacts with Member States, this iterative process culminating in their acceptance at the Regional Committee. In the process a potentially much larger range of Targets was distilled down to the approved 38. These can be seen as subdividing into various clusters around the main thrusts of the strategy and each cluster (lifestyles, environment, etc) has a lead policy target which offers a framework for Member States to work with, followed by a "subset" of the most pertinent substantive topics within that cluster (e.g. the target of establishing environmental policies is followed by targets focusing on pollution, hazardous wastes, urban settlements, etc.).

5.9 A European agenda - and the response

It was in this way that a common health policy/HFA agenda was constructed for the European Region. The initiative was with countries as to what action to take. EURO had interpreted its remit as a facilitating role. The mechanism of indicators and periodic reporting ensured that it would be in continuing dialogue with Member States over this agenda and its responsibility to respond to requests from them for information, technical assistance, etc. was self evident. But the Targets as a checklist of health policy issues was for countries to adapt to their particular circumstances as was repeatedly made clear in the relevant documentation. As expected, the responses from and within countries has been varied.

In some cases a national policy document has been produced which will provide a national point of reference for future WHO/country contact. As anticipated earlier, in other countries it would be inappropriate to expect such a document, and other evidence of action needs to be tracked. In some cases action has been initiated at the national level which has been mirrored subsequently at the subnational/local levels reflecting an emerging consensus and growing HFA awareness. In other cases there has been a number of initiatives taken at the "lower" levels independent of any move by the central administration: provincial or local government bodies have sought to fashion their health or social development policies within a HFA framework. In yet other cases an initiative has been taken by particular interest groups (e.g. community medicine in the United Kingdom, nurses in Denmark). In all cases the result has been to add to the momentum to get health issues understood, debated, and acted on in HFA terms.

6. Health for all: building and maintaining momentum in Europe

6.1 Stimulating interest and action

In the meantime EURO continued to discharge its facilitating role not least by initiating or responding to international, national and local movements which reflect HFA values, and when so requested EURO provides direct support to Member States in HFA policy formulation (e.g. Malta, Israel, Spain).

The "Debate on Health for All", held in Leeds, UK in March 1986 was a national gathering with WHO and international participation, where the potential for HFA implementation at local level was explored. It was the consensus of that meeting that the European HFA Targets document was indeed a stimulus for action at all levels and that the health sector must now reach out to other sectors and address them on their terms. Actions at the national and local levels were both necessary and complementary, including the establishment of the requisite political and administrative machinery for consultation and collaboration. There was a continuing need to build up awareness and to find the most effective means of gaining the politicians attention.

The Consultation held at EURO in September 1986, saw the development of national and local HFA policies discussed. Discussion there focussed on the need for better policy analysis within Member States in support of HFA. It was noted that it was problematic to attempt to impose specific objectives on the political machinery. A judgement would always be needed as to whether in a given situation a planner should propose to political decision makers quantified targets or more generally expressed policy measures. Whatever the judgement, awareness building is always essential and it is generally effective to work with existing structures, thus acting in a rather pragmatic fashion to do that which works through that which is available.

A number of meetings (e.g. Manchester, Gothenburg) have focussed on intersectoral action, designed to improve both the policy analysis and implementation phases by focussing on concrete issues and examples (Working Group on Intersectoral Action: practical argumentation and mechanisms, Netherlands, December 1988, focused on tobacco and accidents).

Considerable efforts have been made to establish contact with potential new partners particularly those who for one reason or another might not be considered instinctively enthusiastic for HFA, e.g. initiating a regular series of meetings with national medical associations; discussions with

universities on reorienting medical school curricula to HFA; in pluralist countries contacts with health insurance interests to open the possibilities of adjusting their orientation from specifically medical care to HFA.

At the same time close working relations continue to be enjoyed with established partners and their representative bodies, (health administrators, Schools of Public Health).

6.2 The place of major initiatives

A major component of the strategy to maintain momentum involves a selected number of major Office initiatives.

One of the most prominent of these is the Anti-Smoking Campaign which has received explicit endorsement by the Regional Committee and which by a battery of concurrent intersectoral measures in a sustained campaign will seek through advocacy, education and other means, to enable people to review their smoking behaviour and to promote social and physical environments which will encourage healthy (i.e. no smoking) choices.

Another initiative is the Countrywide Integrated Noncommunicable Diseases Intervention Programme (CINDI). CINDI is based on long term (to the year 2000) cooperation agreements between WHO and various Member States. The basic working assumption based on current epidemiological clinical and other knowledge is that the principal non communicable diseases have associated risk factors in common. Moves of whatever kind made in a sustained systematic way to reduce the incidence of these risk factors should eventually be reflected in a reduction in the diseases themselves. Although itself an action project it should be seen as running in parallel with relevant epidemiological, clinical and sociological research the results of which can influence the subsequent direction of the CINDI project. CINDI is seen as having considerable potential to engage the interest and the commitment of both professional health workers and research scientists to the HFA movement.

In contrast the "Healthy Cities Project" is another European movement which for the most part (but by no means entirely) makes its appeal outside the formal health sector. The project strategy is different in a number of respects from CINDI. A number of cities - the political jurisdictions of urban settlements of different sizes (currently within the population range of 50 thousand to 3 million) - have formally declared their commitment to implement the HFA strategy at local level with a strong emphasis on intersectoral collaboration and forms of community involvement and focussing especially on the health promotion and environmental targets. So far some 25 cities have been designated WHO HCP cities. The total is expected to rise to approximately 30 and will reflect all geographical sub-regions, and the range of socio-political systems adopted by different Member States. Project cities have committed themselves to reporting their experience and to share the lessons learned with EURO, with other project cities, and with other cities etc. within their countries. While by no means excluding health workers, the natural target partners in the Health Cities Project are local political leaders, professionals outside the health sector, community groups and various social movements.

6.3 Education and research for health for all

Complementary to these initiatives have been the development and endorsement by the Regional Committee of the HFA Research Strategy (RHFA) and

the study underway on manpower for HFA to be presented to Regional Committee in 1989 which should result in an analogous HFA education strategy. RHFA is notable in that it seeks to make a direct appeal to the academic research community and identifies a range of research areas where knowledge needs to be developed and applied to strengthen HFA strategies, whether these relate to the nature of health problems, policy analysis or organizational behaviour, etc.

The Education and Manpower Study starts from a frank appraisal of present shortcomings, questioning whether health workers are adequately equipped to meet the challenge of fulfilling HFA. Three target groups are identified - physicians, nurses, and public health managers. The training needs of the last named group have been given special attention as they are the officials (of whatever prior technical-professional background) responsible for the formulation and implementation of HFA policies and strategies at all levels, and for whom the development of leadership qualities and skills is vital if they are to be credible advocates for HFA both within the health sector and outside. EURO is actively engaged with Schools of Public Health and other post graduate institutions in developing training strategies and materials designed to orient personnel towards HFA. A consultation on Masters level training in Health Promotion was held (Gothenburg, November 1987) and a joint Task Force with ASPHER is at present developing HFA learning materials and proposals for a model of a Masters level course for public health managers.

All of this builds on earlier valuable experience gained, e.g. MPNHD workshops (supra), developments in health economics training especially for non-economists and stressing inter alia, resource allocation and management to ensure "value for money", initiated by the Health Economics unit; and a pilot series of seminars for leading public health administrators (Antalya, 1982; Oslo, 1983; Corfu, 1985; New Market/on/Fergus, 1986), bringing together key figures from different national systems to join together with independent experts and WHO staff to explore the key issues in health development.

In parallel with global efforts to strengthen district health systems, a start has been made to further clarify the concept of primary health care in the context of European health systems and the role of the district.

Conceptually the district is more easily understood in the health services systems which in previous WHO documents have been referred to as highly or moderately structured than those which are "modestly" organized (i.e. pluralist rather than unitary). For this reason special efforts are needed and being made to see how the concept of the "district" may be usefully interpreted in a variety of European health systems (just as they are needed to show how the notion of national health policy can be adapted where for constitutional or other reasons it cannot be applied in a conventional or literal sense).

6.4 Programme-specific initiatives

In addition to these general initiatives to support and sustain the HFA strategy more subject specific steps have also been taken. Two examples may be quoted: First the EURO nutrition programme which, while cited in the text of the Target 16 on health behaviour, by embracing food policies, education in nutrition programmes for specified population groups (elderly, children) etc. provides a stimulus to lateral cooperation and coordination with various other activities. Secondly, the model protocol for Cancer prevention and Control programming, starting from a disease reduction orientation, both spans the

spectrum of the overall strategy (prevention, lifestyle, environment, appropriate care) and offers a rigourous framework for developing a cancer strategy which can be adapted to a variety of organizational contexts.

Other smaller scale initiatives also fit into the general pattern: for instance "Tipping the Balance of PHC" is a cooperative venture with EURO support between a number of Schools of Public Health (Nordic, Portuguese, Andalusian etc.) and some 15 local health administrations located in different countries focussing on action research on identified operational problems, e.g. in planning and budgeting, coordination, decentralization, PHC workers' skills, community participation.

6.5 Related in-house EURO activities

Administratively, EURO has taken a number of enabling steps to ensure that the Office can discharge the requisite facilitating role.

- An in-house steering mechanism is now in place - Advisory Group on Policy Analysis and Development (AGPAD) an inter-service group (comprising Directors and programme managers) which in its membership covers the whole spectrum of HFA strategies. AGPAD is in a position to review and synthesize all intelligence coming into EURO from countries on HFA related developments and relate it to WHO policies and developments.

- For purposes of policy analysis, countries have been grouped according to their principal social, political, and health sector characteristics and studies of health policy trends in these groups are envisaged (a series of working papers leading to a Study of Health Policy trends in Southern Europe, has been prepared).

- Policy documents from countries when these become available in one or other of the EURO official working languages (either a complete text or a full summary) can be analysed using the Regional Strategy and Targets as a reference point.

- Country profiles are being established to bring together all information relating to health policy as it becomes known and available.

- Medium-term programmes (MTPs) as frameworks of cooperation between EURO and individual member states are being reshaped to reflect the HFA targets and to identify relevant priorities, and should provide the basis for a more purposeful and penetrating discussion with Ministers or their representatives on country intentions in policy and strategy.

- All the foregoing steps are now supported by an HFA data base capturing country data as it becomes available and classified according to Targets and their indicators. Information systems/data bases are also in existence or being developed for particular programme areas (e.g. health manpower, health legislation, quality assurance and technology assessment).

- Formal HFA monitoring is built into the HFA strategy whereby member states have committed themselves to periodic reporting according to the Target indicators. Reports are synthesized and submitted to the Regional Committee. The stage is being reached whereby trends can now be assessed as to whether the Region as a whole is on course to achieve the various

targets by the years stipulated. Such a trend analysis will be used to update the Targets and Indicators, probably in 1992;

6.6 Ensuring coherence - health policy development

The overall coherence of all these initiatives, developments etc., whether in countries or in EURO, is ensured by the high profile given to Health Policy Development stimulating and encouraging policy and related activity at national and subnational levels according to country circumstances. As a consequence the general political climate in the Region for HFA is positive generating a measured optimism for the decade up to the year 2000. Problems remain and these are recognized, most recently at the WHO meeting on national HFA policy formulation and implementation, held in Haikko, Finland, last February 1988 which identified a number of constraining factors - political, operational, cultural, and organizational - which were discerned in various member countries, also a number of technical issues in the field of policy analysis and development requiring further work. Nevertheless it emerged that the prospects for progress were good provided that within countries the requisite intersectoral coalitions of support for HFA policies could be built and sustained including improved advocacy for health policies and more competent insightful political behaviour in the health sector particular in dealings with other sectors.

7. Health for all in Europe at the midpoint - a balance sheet

The successes and the strengths of the approach adopted by the Regional Committee and the Regional office in the 1980s are now clear:

- a limited technocratic understanding of planning has evolved into a politically, socially and economically sensitive concept of health policy development which can be adapted by all Member States

- the sense of vision, the adherence to the central UN ethic of social justice (equity), the long term perspective, and the comprehensive character of health policy have been retained through the adoption of the HFA Strategy and Targets. This is particularly emphasized by the stress on outcomes, pursued through an interlocking set of focussed substrategies (disease prevention and control, promotion, environment, appropriate care, supportive measures), countering short term effects whether related to political or economic instability or to a dominant preoccupation whether social (AIDS) or economic (health services cost containment).

Now in the late 80s many of the long standing planning issues remain as the European agenda, but with growing experience of working within the framework of HFA in a number of countries, it is possible to identify the overarching issues which will constitute the ongoing agenda for WHO/EURO technical cooperation with Member States:

- getting the right balance between political, technical, cultural and economic factors in health policy making;

- maintaining momentum in the HFA movement, creating opportunities to share the message and the values with all health-related sectors and the whole population; reaching out to a wide spectrum of potential partners;

- a new emphasis on implementation: ensuring that policies are transformed into action by focusing on the subnational/local levels through various mechanisms (subnational health policy mechanisms, district health systems, devolution and delegation of powers, local action strategies in health promotion, disease prevention and environmental improvement, etc.);

- keeping the new focus on health, preventing a return to the traditional but narrow and exclusive focus on "health services".

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