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REGIONAL OFFICE FOR EUROPE

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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

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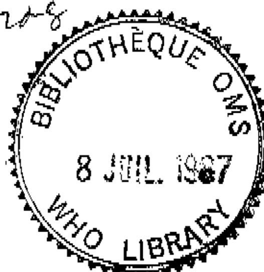

Consultation on
National HFA Policy Development

Copenhagen, 8-9 September 1986

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SCOPE AND PURPOSE

Since the adoption of the Regional HFA strategy for Europe in 1980 and the Regional Targets in 1984, a number of countries have either formulated national policies in line with HFA or are in the process of doing so. Roughly speaking, one-third of the European Member States have taken concrete steps in this direction.

It has been felt in the Regional Office for Europe of the World Health Organization (WHO) that this promising trend could be further strengthened through exchange of information regarding the formulation and implementation of HFA policies at national and sub-national levels in different settings, and by analysing the process and content of such policy-making. The Office has also been approached with requests from several countries for support in national HFA policy development.

Hence, we have now launched a project on systematic analysis and development of national HFA policies in European Member States. The purpose of this project is to facilitate and support national HFA development in Europe, to coordinate and enhance WHO efforts and expertise in this field, to exchange information and experiences in national policy formulation and implementation, and to promote systematic health policy analysis in the Region.

An in-house group for national health policy analysis and development has been established (EGPAD), which will work closely with outside experts in national and sub-national policy development and analysis.

The purpose of this meeting is therefore to:

- review the situation with regard to HFA policy development in Europe;
- exchange information with experts who have experience in national HFA development or are in the process of formulating such policy;
- discuss a draft framework document for national HFA policy development, as well as discuss future activities of the Office in this field.

There are a number of specific issues and dilemmas which ought to be openly debated in the light of experiences from different settings: How to initiate a process to develop national HFA policy? What are essential characteristics, and contents and structure of a national HFA policy? What

are the experiences in countries with regard to quantified targets in policy vs. planning documents? What is the role of regional and local initiatives in HFA policy development in different settings? What are major obstacles and difficulties (political, organizational, technical, etc.) in national HFA policy development and how can they be overcome? How can WHO support countries best? What kinds of issues does HFA raise to policy analysis and how should these be tackled?

It is expected that intensive debate and exchange of views and experience between outside experts and WHO staff would lead to concrete recommendations as to how national HFA policy development can best be facilitated.

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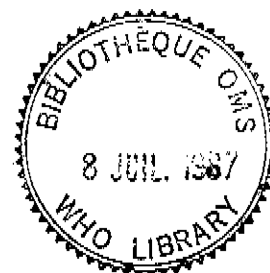
Report on Consultation for national

HFA policy development,

Copenhagen, 8-9 September 1986



Introduction

Dr J.-P. Jardel, DPM/EURO, welcomed participants to the Consultation on behalf of the RD, Dr J.E. Asvall, who was away from the Office on duty travel but who very much identified with the objectives of the meeting.

Dr Jardel drew attention to the challenges facing the Region as a whole in translating into European terms the basic objective of the HFA movement to enable all peoples to enjoy a level of health which allows them to live economically and socially productive or satisfying lives. A common European attempt to meet that challenge has been made in the Regional Strategy and in the subsequent Targets Document which together constitute a common health policy oriented to HFA. In support of this effort the role of EURO has been defined in WHO's 7th General Programme of Work as: to disseminate knowledge relevant to HFA; to promote relevant research; to act as a catalyst for HFA, and to promote international collaboration for HFA.

One clear feature of the European situation was the need to promote HFA policy development within Member States at national and sub-national levels, noting at the same time, that a number of key HFA issues, such as reducing health inequities, promoting healthier lifestyles, and environmental improvements could not be achieved by the medically-oriented health sector alone.

This entailed enhancing the policy analysis competence within EURO, to develop and promote the necessary tools and concepts, and to track and feed back to Member States the progress towards HFA being made within the Region. This task called for the pooling of experience both within the Office and among Member States. Hence the meeting was to be seen as the start of a series of consultations for that very purpose.

After this introduction, the meeting proceeded to endorse the proposals for Chairman, Dr G. Magnusson and Vice Chairman, Dr J.-P. Jardel and Rapporteur, Mr K. Barnard. Dr K. Leppo and Dr I.S. Luculescu acted as co-secretaries.

Background and Context

In light of Dr Jardel's introduction, Dr I.S. Luculescu, HPP/EURO, drew the participants' attention to a number of issues which needed to be kept in mind throughout their exchanges of views and experiences: There was an acceleration of interest in HFA in Europe and there was therefore the need to determine as a matter of some urgency:

- a clarification of the idea of "HFA policy" and how to advise Member States on its implementation; this would imply consistency in interpretation within and between categorical health programmes; it would also imply the need to know whether EURO and Member States were moving in the "right" direction;

- how is that to be done?

From this it followed that the particular objectives for this Consultation were:

- to take stock of HFA developments in Member States;
- to identify tools of analysis for charting direction and progress;
- to determine more precisely the issues in HFA policy development requiring more examination and discussion, e.g.:

  What are the necessary steps to initiate the HFA process, building support, handling opposition and working with both short and longterm considerations;

  The place of quantified targets, i.e. what dimensions should be covered; What is appropriate for the Region as a whole; what makes sense to Member States?;

  What is the nature of the policy analysis competence which is necessary, i.e. to find out what is happening within Member States, (such as the economic environment and its consequences for HFA) so that EURO advice to Member States can be framed and timed most appropriately.

Dr K. Leppo, STC/HPP, then drew attention to the background paper offering an overview of national HFA developments. Approximately one-half of the Regions' Member States had announced a start. The information available was necessarily partial; the sources were the official responses of Member States to WHO. One particular problem was the lack of knowledge of the content of policies where this was not available in one or other of the EURO official languages. There were risks in making an interpretation based on what was available and in relying solely on written documentation. Nevertheless, it was hoped to develop and improve the progress monitoring process and to undertake regular updates. It was also possible to make some comments based on what was available. The overall situation was encouraging and the momentum had certainly increased after the Targets Document. The responses from Member States revealed a variety of approaches and variations in content, some comprehensive and others selective (e.g. confined to restructuring the health services). This posed certain questions for EURO:

- how can EURO best continue to promote the comprehensive approach with a health orientation?;

- should EURO continue to emphasise the value of specific quantified targets to Member States; or encourage the adoption of enabling policy measures and instruments?

Dr K. Leppo commented that the work already done as cited in his paper was to be the prelude to future work involving more in-depth analyses of the process and content of health and HFA policies and their implementation. This called for the sharing of knowledge and experience of what was useful for Member States.

In the plenary discussion which followed, a number of points emerged:

- the value of the Targets Document as a focus for HFA debate and a stimulus to action was endorsed. There would however be a danger if it appeared that a too systematic and uniform approach was being attempted: a tolerance of variety between Member States was vital;

- if "policy" was taken to imply legislation and other forms of central action, that might be seen as contradicting the HFA philosophy of mobilising popular support through a broad-based debate and other means. But in some situations, central action may be essential to ensure some movement forward; in other circumstances, central action was not forthcoming and pressure from below was essential to change this. In some pluralist states, it was not always clear where the "centre" with policy responsibility was, or what policy action it could take;

- in some situations, there was the possibility that reported activity did not necessarily represent any meaningful policy implementation or reflect any actual progress towards HFA. Reporting systems which demanded tight

categories which Member States were expected to adhere to would be no more than bureaucratic formalism. Existing reporting systems in use within Member States and by EURO may not be able to answer crucial questions relevant to HFA development; nor would Ministries of Health always be in a position to have access to the full range of information on action at the sub-national levels;

- it was noted by some that in general HFA appeared easier to implement in the Northern parts of the Region than in the Southern; and alternatively in the smaller than the larger countries; it was thought to be partly a matter of political culture and partly a matter of administrative systems. There was a need for greater understanding of such phenomena if EURO approaches to Member States were to be helpful and sensitive to their situations.

- there was a pressing need to clarify terms, as the term "policy" itself was not a unitary concept. HFA policy needed elaborating - was it the same or different from activity "target by target" at the various levels. How was "equity" operationalised or manifested in specific programmes and activities.

National HFA policy development

Two presentations were made, one offering a framework for addressing the opportunities and problems in health policy development, stressing particularly its inter-sectoral dimension; and the other representing a reflection and interpretation of the national experience in Sweden.

Mr K. Barnard opened by highlighting that the policy development process was the interplay between politicians and civil servant administrators and other technical-professional personnel. Typically, civil servants comment on the lack of interest politicians show in general strategy, and their preference for concentrating on specific questions. The two groups find common ground when the resource projections are stable enough for detailed development of specific proposals within a strategic framework. For their part, the politicians stress their awareness of human needs and wants and the pressure which they have to put on administrators and technicians to focus on practical programmes of action.

He then went on to cite a number of related problems which had been identified, notably sectoral isolationism or resentment at the inter-sectoral action implicit in policy development; the lack of power and status of some Ministries of Health and the problem, at least so far, of health development being too limited a concept to command sustained political and governmental attention. There may be as well an indifference in political decision makers towards scientific knowledge as the basis for making "better" decisions; they may prefer other rationales. Against that backgound he elaborated a series of propositions for inter-sectoral HFA policy formulation. They were put forward in the form of an ideal type, although they were ultimately derived from an analysis of direct experiences. As such, they were a framework for the discussion of practical feasible strategies rather than as a blueprint to be endorsed:

1. The requirements of an effective approach to the political management of health policy would include;

- a multi-level, inter-sectoral process with agencies designated as responsible for securing initiation and implementation;

- sustained political commitment, including action when and where required;

- improved, targetted information dissemination on health, health problems, and risk assessment; and on possible counter measures to problems and risks with an assessment of likely impact.

2. The range of possible types of action to be proposed as policy should be identified and assessed for appropriateness to any given situation (e.g. legislation, regulation, financial, education and research) together the agency(ies) which would be responsible, whether solely or in cooperation with others.

3. The conditions likely to be necessary to be satisfied for effective policy development would include:

- strong evidence available of the size of the problem and the need for action which would be affordable and broadly acceptable;

- the action is seen to require inter-sectoral action at ministerial managerial and operational levels;

- the priorities, programmes, resource allocations and operating methods of the sectors involved can be reconciled or harmonised;

- no policy proposal should be perceived as a "zero sum game" by any of the interests involved;

- the number of policy initiatives being developed in detail at any one time should be limited to increase their impact;

- there should be a high probability of early visible and positive results, so that a success can be demonstrated publicly and politically.

4. The options open in attempting HFA policy formulation in descending order of preference would be:

- to identify mutual benefit to other sectors in cooperation over health policy development;

- to identify a range of possible "exchange of favours" in inducing other sectors to cooperate;

- to argue to other sectors that there is an overriding national/public interest to be served in adopting health criteria in their policy formation;

- to defer attempts to engage with other sectors until in a stronger political position and in all circumstances to avoid any posture that would appear as health "imperialism" or attempts to "colonise" other sectors.

5. Given the above analysis, the planner attempting HFA policy development should ask of the political decision maker(s) he is serving, 4 basic questions:

1. What can be controlled?
2. What can be changed?
3. What can be influenced and how?
4. What can be negotiated over (or build up credit for use later)?

Mr G. Dahlgren opened by clarifying that his perspective was at the national level and within the health sector, although his recent extensive involvement in the 1986 WHA Technical Discussions had given him a vivid experience of how other sectors and Ministries viewed health issues when these were made the focus of inter-sectoral action. He also observed that it was a universal task to translate HFA ideology into real implementation and he would interpret Swedish experience of health policy development in that light, identifying a number of areas which he felt warranted comment.

He saw health policy development as a basic tool for creating the framework which would interest politicians. It needed a range of complementary tools for action, e.g. legal, finance, research and training. But political realities came first as in shaping legislation in which specifics were often avoided. There was, however, an interesting paradox that such legislation can be interpreted and applied in practice to provide a radical driving force.

He then went on to review the Swedish experience with Health Targets. The first steps were taken some 10 years ago. Their significance became clearer with hindsight, as they represented a new health planning involving the institutions and power structure of the health sector. Subsequently stimulated by the HFA resolution, a government report was published on health problems. It offered a new perspective using morbidity and mortality indicators and pointing out that if the indicators were changed, the relative importance of different health problems changed too. The report also served to focus on "perceived health" as being as important as professionally defined need. Information was also presented concerning major health hazards and on the socio-economic and occupational distribution of disease (interestingly, information not previously known to the influential professional groups of health care providers). This was all presented as empirical evidence without any explicit policy content, yet it showed the potential of information to create a policy debate and it had the advantage that the presentation was not perceived as threatening by any interest group. Even so, at that stage, there was little reaction ouside the expert health sector audience i.e. in the general public, except for interest in the health implications of unemployment.

Next, Mr G. Dahlgren commented on some of the Disease Reduction Programmes which had been initiated. In the field of accidents, there had been some successful local programmes with really active commmunity participation, such as to reduce home accidents of the elderly. Evaluation of such programmes provided the basis for a national programme. With regard to cardio-vascular disease, a national initiative had been taken involving the presentation of what could be done, the driving force being found in those at local and other levels, willing to use the material. In the case of Mental Health, the motivation for action had resulted from international cooperation. When the government acts as host to an international conference, there is need to have positive activity and results to report.

Drawing lessons from these and other such experiences, Mr G. Dahlgren suggested that in some circumstances, proposals for disease reduction programmes can be used to secure binding political decisions, although politicians will not allow themselves to be exposed if they have any sense that the administrators cannot be precise on the ministerial action required. A second reservation was that disease programmes do not lend themselves to easy inter-sectoral dialogue: it is much more satisfactory to couch inter-sectoral policy proposals in terms of risk factors and the means to reduce them. A final comment on disease programmes is that the process of policy development and implementation for existing problems can always be thrown by new overriding political and public concern, most recently the preoccupation with AIDS.

Turning to policy monitoring and evaluation, he said he did not expect national quantified targets to be developed, but WHO targets had been found useful as an influence on ministerial thinking. He attached particular importance to the procedure which had been adopted of regular three-yearly reports to parliament on the health of the population, especially disadvantaged groups. Such reports would form the basis of a parliamentary discussion in a form which would be widely understood.

He then discussed equity and how it was being handled as a policy issue. In Sweden, equity had been accepted across a broad (though not the total) political spectrum as a key policy objective. There were two principal observations to be made on this.

First, health sector statistics do not record social or socio-economic class. There was a need to link health with the statistics of other sectors to undertake the analysis of disease distribution. This could possibly become a political problem at some time, but so far there had been no political opposition expressed. Secondly, there is no explicit strategy to reduce inequity. It is the case that existing legislation can be made use of for this purpose. There is also debate as to whether good general social welfare policies will of themselves reduce inequities, and also whether the potential to reduce inequities is dependent on high economic growth (some developing countries' experience suggests that it is not). The future debate may be influenced by an inclination of the labour unions to shift their focus of

interest from occupational health to a more broad-based interest in equity as it impacts on their members. A Research Policy bill to be presented to Parliament by the Minister of Education will have research on equity and determinants of health as a component, e.g. living conditions and communicable diseases, living conditions and life styles and non-communicable diseases. At the same time he welcomed the WHO focus on health indicators especially for the disadvantaged. He proposed that some such health indicators could be used as social development indicators, analogous to economic development indicators. The stress on equity in the European HFA strategy implied that EURO should increase its efforts to build contacts with parliamentarians as a key group in sustaining the Strategy.

Finally, Mr G. Dahlgren commented on some constraints as he saw them. There is a limit to the number of inter-sectoral issues/targets which can be introduced at any one time. There is a need to have realistic expectations, to be clear as to what action is being called for, and to be politically sensitive over the timing of moves (premature action will probably end as being counterproductive). There is also the need to reduce ambitions as to how much can be done at the highest political level: there is the risk of creating formal government machinery which in the event will not work because it will be difficult to sustain interest. It would be more pragmatic to act flexibly with subject matter groups geared to specific topics. At the national level, the weakness of the health sector in inter-sectoral action has become apparant: there is a lack of pressure from either professionals or politicians which could be exploited by the health sector. This contrasts

with the local level where community pressure outside the health sector can be very effective (as in accident prevention campaigns). There is very positive evidence of public interest in health issues. A possible strategy would be to find ways of strengthening Parliament's role in the policy development process: it is welfare-oriented and naturally inter-sectoral. This suggests a role for WHO in identifying and influencing key individuals; in facilitating dialogue between parliamentarians of the Member States; and in promoting pilot studies: concrete accounts of "how it worked" would appeal to parliamentarians.

In the general discussion which followed the presentations, a number of points were made:

- the vocabulary used in WHO documents implies homogenity: this may be acceptable within some Member States and rejected in others;

- health policy development and health policy analysis efforts must start from a recognition of what is common to Member States. Common ground is likely to be found in equity problems and in the weakness of the health sector and Ministries: politicians have to be persuaded that responsibility for health goes beyond the health sector itself;

- WHO should maximise its contacts outside the health sector, recognising the importance to the health sector in some countries in its dealings with other sectors to have the extra backing of external pressure which WHO involvement would bring;

- HFA policies should be clarified as social policies which go beyond medical care provisions, but this also implies the need to understand the power dynamics of other sectors before any negotiation is attempted. This also raises a more elusive question as to what are the circumstances under which a Minister of Health would be prompted to take inter-sectoral initiatives in health/HFA policy formation?;

- there is a paradox in that, in many countries, evidence of keen interest among the general public in health is not matched by any political awareness or interest in health policy issues. An understanding of this phenomenon could be the starting point for finding ways to improve health policy development;

- there are signs that the HFA vocabulary is being used less prescriptively than previously; perhaps this trend should be taken further. It was notable that Sweden had made use of WHO concepts and documentation, but its actions had not been determined by them. This reinforced the view that HFA is useful when harnessed to a Member State's own health policy process.

Health policy development at the sub-national and local levels

Two contrasting presentations were made; one on the action being taken at the district level to apply HFA thinking and objectives to the presenting problems; and the other perceptions of the issues as seen at the intermediate governmental level in a country with pluralistic traditions.

Dr June Crown, as a District Medical Officer in the UNK NHS, has a technical planning and managerial role, influencing the organization and provision of services and advising the local governing body, the District Health Authority (DHA) on policy issues. Dr June Crown identified her District, Bloomsbury, in the centre of London, with its diversity of socio-economic conditions, from affluence to severe deprivation. In health services terms, there was a concentration of medical school teaching hospitals in the District, but in financial terms the District was projected to have its budget cut annually until the year 1993 as part of a national resource reallocation policy. This was expected to lead to cuts in staffing and to the closure of some health institutions. The NHS was the largest single employer in the locality.

This created a complication for promoting HFA as the basis for local health policy development, as it was in danger of being perceived as a diversion from or cover for, the consequences of financial restraint. This exacerbated problems of lack of understanding of HFA vocabulary, of lack of information and of coordination within and between agencies.

Nevertheless, it had been possible to promote HFA at the local level with considerable impact. It was presented as a vehicle for communicating a genuine community health view as opposed to medical services. While the emphasis on health promotion, disease prevention and primary care in the Regional Strategy was seen to be consistent with existing DHA policies and priorities, HFA was presented as a catalyst for increased collaboration

between the health services and other agencies - housing, social services, various voluntary organizations, community groups, the media, and the general public. Such collaboration also implies joint information efforts - on the population and their needs, on present policies and provision of services and their effects - for planning and monitoring purposes. HFA is seen to provide a disciplined way of coordinating and integrating objectives, targets, and resources in a common framework which makes sense to politicians, professionals and public. Social issues such as unemployment and housing and specific health policies, e.g. prevention are all put in context. It is also possible to show what can be done with little or no extra expenditure if there is good coordination and people are motivated.

The approach adopted has three aspects:

1. analytical: applying HFA to the district identifies the courses of action required, who are the interested parties to be involved, and what consequences follow (e.g. training needs);

2. strategic: seeking political commitments, network building, encouraging the grass roots;

3. operational: action on specific issues/targets with proper preparation and consultation and building in agreed monitoring and evaluation procedures.

This approach has involved a series of specific interrelated steps, the most significant of which have been:

- to adapt the Regional targets to the local situation;

- to secure a public commitment by the DHA;

- health promotion has been built into the development plans for all service provided by the DHA;

- a requirement to present an annual report publicly on the health of the district's population;

- the focus of interest is the general population, patients receiving treatment, and the staff;

- the Mayor of the London Borough of Camden (a corresponding local government authority providing various services complementary to the health service) has identified herself with the HFA movement and asked her authority's various departments to identify what their contributions could be;

- the initial focus has been on easy issues to build up confidence.

The role of DHA as an organization has several aspects:

(a) to highlight those concerns of interest to the local population and to analyse the local circumstances;

(b) to spread the enthusiasm to other NHS districts, other agencies, other levels of government, etc.;

(c) to put pressure on others, where possible, to adopt HFA;

(d) to educate colleagues (especially medical staff) in HFA and to introduce HFA concepts in training programmes especially at the undergraduate/learner levels;

(e) to use opportunities of collaborative health services research with clinicians to enhance the credibility of HFA thinking;

(f) to use all small successes to demonstrate the HFA links and make clear its relevance;

(g) to disseminate results of activities in order to share succeses and failures with others.

Notwithstanding the progress made, some problems can be readily identified. These relate to, first, the need to maintain enthusiasm, such that the local commitment is sound enough to withstand changes in personnel who have been key HFA advocates. Secondly, there is a need for academic help

in finding means of measuring progress at the local level with a small and mobile population, and of handling the intrinsic time-span problems in tracking action to outcome. Thirdly, there are resource problems: the lack of resources may focus attention on priority selection and innovation, which are positive. But more negatively, there is the frustration of seeing some larger but worthwhile projects stopped for the same reason.

Mr Affeld identified himself as addressing the issues from the länder level in the DEU, having previously had experience at the federal level within the Chancellor's office and at the Ministries of Health and of Labour. He stressed that in federal states with pluralist traditions, such as DEU, there were constitutional and legal factors which highlighted the importance of the sub-national/federal levels in health policy development and, specifically, consideration of HFA. Further, the pluralist health insurance system, with the various autonomous, self-governing agencies in the health sector, tended to identify priorities not in health terms, but in managerial and resource terms - cost containment, co-payment, etc.

At the national federal level of the health sector, it is possible to conceive a framework for health policy, but not to specify or take concrete actions. At the intermediate länder level, there are both responsibilities for health policy and some possibilities for action, but the local level has political and bureaucratic independence and no meaningful discussion of HFA could take place without active local participation. It should also be noted that non-governmental organizations, such as professional associations, are as

powerful as the levels of government to stimulate - or frustrate - HFA development, and as a general rule, the higher the level of government, the less the possibilities to act. As an instance, disease and risk reduction have never been discussed as health policy issues even at the länder level. The information which would be relevant for health policy development is not collected for federal or länder use; whether such information is collected at all depends on the interest of the local Public Health Officer. In all the circumstances, it is not surprising that there is an inclination of both the federal and the länder levels to delegate responsibility for problem solving.

In contrast, at the local level, action must be taken, since responsibility cannot be further delegated. It is, then, at the local level that pressure can be generated and maintained. Furthermore, HFA issues, if not the vocabulary, are closer to the inclination of the local health officers. There are those of them who are frustrated at handling only short-term, single-issue items, as well as having a sense of isolation. This suggests, as a potentially favourable starting point, engaging the interest of the younger health officers in HFA.

There are other tactical reasons for concentrating on the local level. There is the intrinsic importance attached to community participation, but also the potential of HFA can be exploited as an input to serious health policy discussions which harness a variety of experiences and conflicting opinions. If the fundamental issue is to create a positive climate for HFA this is much more likely to produce the desired outcome than one single national document which might influence little or nothing. Indeed having enemies articulating their opposition is better than no response at all if an issue is to be kept alive.

At the present time, North Rhine-Westphalia ready to support a länder-wide health policy discussion. But this will depend on active partisans being ready at local level with experiences to report. The possibilities look quite positive and a snowball effect may well result. In federal pluralist states, it is necessary to distinguish between government statements about policy and the realities at other levels of government which may or may not be consistent that formal statement. Even so the formal national statement of policy can be used to good effect if it is reflected at federal and länder levels with backing and the stimulus of financial support to the local level.

HFA policy analysis in the European Region

Two complementary presentations were made, one raising conceptual and general issues and the other offering observations on and proposals for the European Region.

Dr Altenstetter offered a working definition of policy as a commitment to purposeful action which results in decisions on programmes and specific projects with their component activities. Policy analysis in this context is a tool for preparing policy proposals to improve on the past and/or present situation; it is an activity of providing a response which can be presented as optimal for a given set of circumstances. Policy analysis is concerned with all the key variables and influences in a situation, economic, political, technical, organizational, etc. It is both scientific and pragmatic: it must be rigourous in its examination of factors, but its identification of feasible options must take into account the political and organizational factors. It will, for instance, take into account the differences between actors in values and perceptions and how these filter the understanding of problems.

Policy analysis, in its best developed form, is inter-disciplinary, i.e. the insights, concepts, frameworks of different contributory disciplines are integrated in one approach to a problem. This distinguishes it from multi-disciplinary work whereby different disciplines say economics, sociology, political science, proceed to examine the same problem in parallel. While such work can still be valuable it does not offer the same potential for insight as the inter-disciplinary or "meta disciplinary" (where all the disciplines are totally subsumed in one framework of thinking). With hindsight, it can be seen that over recent decades, health and social problems have been successively "medicalized", "economized" and "managerialized". In each mode, they have been subjected to the filter of <u>one</u> discipline, but the weakness of this is that the separate disciplines do not understand each

others' ways of thinking, so there are real problems in the exchange of knowledge and understanding. Policy analysis seeks to correct this by creating a synthesis of insights drawing on disciplinary frameworks and analyses where these are useful, and taking into equal account the full context in which a problem arises. This is to ensure that recommendations in terms of objectives, strategies, etc. have been subjected to the "reality" test of fitting the circumstances. In summary, policy analysis is concerned with problem identification and consequences; the selection of relevant interventions with the expected benefits; and the criteria for assessing alternatives.

This concept of policy analysis highlights a number of problems in policy-making, as practiced currently.

In terms of the Regional Strategy Targets, those with a strong public policy content are unlikely to be attacked by a policy analysis approach. It was more likely that the policies would be developed within some Member States as reflections of the preferences of the decision-makers, without the benefit of any relevant research or, at best, through the application of the partial insights yielded by disciplinary-based research. There would be few instances where the process was based on the integrated approach of policy analysis. One important reason for this was the absence of policy analysts, as such, in Ministries; and the nature of the "on the job" training which typically civil servants received, and which did not expose them to the policy analysis mode of working. There was, in fact, little policy analysis training available

anywhere; even potential centres such as Schools of Public Health and University Departments of Social Studies, preferred to pursue traditional academic disciplinary research. Consequently, there was a very urgent need for "crash training" in policy analysis for those already involved in policy work and to build up educational and other resources to ensure a supply of people with good policy analysis training in the future.

Dr Sokolowska, in her presentation, drew a distinction between a monitoring role for EURO , tracking HFA progress in Member States and a policy analysis role of seeking to understand the dynamics of progress in terms of policy development. This latter role was essential if WHO was to maintain its catalyst/facilitator role and offer sound advice and support to Member States. This policy analysis role is a research activity, incorporating operational research, health services research, policy research, action research, and other comparable activities. It provides the basis for purposeful change and the plan for change. It covers both process and substantive HFA content from problem identification to implementation and evaluation of the chosen action. It is the link betwen theory, which is concerned with finding explanation, and application, which is proposed change rooted in the understanding offered by theory.

It was clear that Member States needed HFA research plans in support of their national policies and strategies, but had little tradition of the inter-disciplinary research required for policy analysis. A more modest step forward was the trend towards multidisciplinary groups working together on a social issue, using a common format and developing a consistent common language.

One pressing research challenge posed by the HFA strategy was that of equity. The problem of inequities in health faced many countries, but it was difficult in practice to discuss whether it was inequities within the health sector or inequities in other sectors having consequences for health. This raised questions of what kind of policy analysis could be applied, including the choice of indicators. One approach would be to reanalyse and interpret existing offical statistics and other public knowledge within a new framework. Whatever the approach, the focus on equity could meet opposition and defensive behaviour if the analysis revealed obvious gaps between the observed situation and the assumptions behind current policy. Alternatively, the research results could be appropriated by one interested party or other and used to pursue sectional interests, taking subsequent policy in quite the wrong direction.

It was therefore necessary that research related to policy analysis should be located in an institution of the highest possible status, and also independent of the health sector, if it is to have the attention of the policy makers. An Academy of Sciences or an analogous body would be appropriate: it would be more likely to foster the integration of disciplines, and would have the necessary status to enable a shift from basic to applied research to be stressed.

In the general discussion following the presentations, a number of points were made:

- Policy analysis needed to demonstrate that the quality of HFA policy development would be better through its application. The risk was that it would be seen as yet another academic pursuit. The Regional experience of such policy analysis as had been found useful should be used to substantiate the claims being made for its superiority over traditional academic disciplinary research in tackling "real world" problems.

- There was a need to clarify whether policy analysis for HFA was to be carried out as independent academic research, or as policy analysis in and for the health sector, or as a specific act of inter-sectoral collaboration.

- It would, in any event, be inappropriate to promote policy analysis purely as a highly sophisticated activity: in some Member States it would be a case of making intelligent and imaginative use of whatever was available as evidence.

- Researchers would need to be fully aware of the political sensitivity of some policy analyses and the importance of timing and presentation: when would a politician be ready to be advised that a policy "isn't working"? Likewise, under what circumstances would a Minister show positive interest in evaluation and policy analysis?

- EURO's role in policy analysis must hinge on: what does EURO need to know to serve Member States; and how can it be presented in ways which would have the most appeal to Member States.

Issues in the development of a national HFA policy

At certain points in the Consultation, participants divided into working groups to develop ideas on issues which had been identified within EURO as critical. The following summarizes the points which emerged from these groups:

How to initiate a process to develop a national HFA policy

(1) There is no one method. An "entry point" must be tailored to the circumstances of each Member State. The political administrative and cultural framework would be a determining factor.

(2) It is critical to ease the access to HFA philosophy and objectives for a much wider audience than those presently involved, e.g. international relations divisions of Ministries, some professional bodies, academics. This means more than the translation of documents beyond the official WHO languages: it demands clear presentation of the central messages and a better use of the media.

(3) Improved dissemination should facilitate broad awareness building: this implies approaching groups beyond those who are likely to be sympathetic.

HFA must be demonstrated as being relevant to national policy concerns. The argument can be geared to interest group reasoning, but without being so far adapted that it induces contradictions between statements to different groups. It means there is a need to identify evidence from all relevant fields to strengthen the empirical support for the core issues - equity, priority setting, the need for a long-term perspective. The role of WHO Collaborating Centres and other academic institutions should be considered in this context.

(4) Once there is widespread awareness, it is possible to initiate a national HFA policy discussion. It is a matter of judgement whether this is better carried-out with key leadership and opinion-forming groups within the health and other sectors, or as a formal open public debate. In any event, there needs to be a conscious effort made to engage the critical attention of politicians, professionals, especially physicians, as well as the general public. It is important that any latent conflicts are brought out into the open, so that the debate can also focus on their resolution as the first step towards strategy formulation. As in awareness building, different approaches may be effective with different groups. Some politicians may become more interested if the emphasis is on cross-national comparisons, particularly if these are given prominence by the mass media; others may be persuaded by the "bandwagon" effect. Some interest groups may be persuaded by information about how clearly their counterparts are involved in other Member States. Often, a clear exposition of the available information on the major health issues in a Member State will, of itself, begin to shape the tasks and identify the responsible agencies. Lastly, the same kinds of approaches will be required to sustain the momentum for HFA once it has been established.

2. Essential elements of a national health policy

The Regional Strategy and Targets Document together offer a conceptual framework which Member States can apply: this framework can be used as a stimulus and guide in problem identification and situation analysis, posing concrete questions, i.e. "Where are we?" and "Where do we want to get?". Member States differ in the degree to which they have explicit answers to such questions. They vary in the extent to which, by practice and tradition, they are geared to making health policy statements, which are further developed through formal planning documents; the extent to which they have political structures which facilitate a health policy development process. Change may occur as a result of planned action, but this may not have emerged from an explicit policy development process. The essence of a HFA policy must therefore be expressed in terms of underlying criteria being statisfied:

- is the observed policy, however manifested, in keeping with HFA philosophy and principles and specifically the Targets?; if the policy is not explicit, is it identifiable?;

- is it health oriented (going beyond medical services)?;

- is primary care the focal point of a system of comprehensive services?;

- does the policy have a long term/strategic perspective?;

- does it address the relevant equity issues in the country?;
- does it identify where inter-sectoral action is required?;
- does it acknowledge the need for and promote community participation and decentralisation to the lowest appropriate political and administrative level powers of decision-making, management, etc.?;
- is there an acceptable balance struck between criteria which may, in some cases, be in conflict (e.g. equity and decentralization)?;
- are the tools for policy implementation in place - e.g. legal, organisational, financial, political and other influence networks?;
- is there a built-in monitoring and evaluation process (to compare the baseline situation with progress towards HFA objectives)?

3. Key issues for policy analysis in HFA development

(1) To clarify and maintain the distinction between policy (the content of a desired and intended action or set of actions) and politics (the process of debate and negotiation by which decisions on proposed actions are reached and implemented).

(2) To clarify the focus of interest for which a policy is to be prepared, e.g. a total population or a subset of it, health promotion, or disease risk reduction, etc. and to develop a framework for HFA policy constraint and feasibility analysis, such as an issues matrix, e.g.

HFA policy components \ situational factors	prevailing values and beliefs	economic circumstances	available appropriate technology	existing organization structures	etc.
Equity					
Disease reduction					
Health Promotion					
Environmental Improvement					
Etc.					

(3) To identify the most useful approaches to priority determination which, in fact, is the link between general HFA policy and subsequent programming (the selection of specific strategies for policy implementation). These approaches would be based on different sets of criteria or on mixes of sets:

- health criteria - mortality, morbidity and disability reduction using the most effective available technology;

- resource criteria - cost, manpower implications;

- political criteria - pressure on decision makers to act;

- social criteria - dominance of the issue in a community (e.g. elderly, substance abuse).

The selection of a preferred approach would then generate as a prelude to strategy selection, "what/how" questions: what action is to be taken by whom, where and for what purpose.

(4) HFA policy analysis would need to be sensitive to wider trends and values and concerns being generated both outside and within the health sector. These emergent issues encompassed, e.g.:

- privatisation; de-regulation;

- decentralisation - structural devolution of power in pluralist or federal structures; administrative delegation in unitary structures;

- equity - life/health chances;

- access to medical care; i.e. geographical, financial, cultural barriers;

- information - information systems to support policy-making and management, health indicators and resource indicators;

- resource control - manpower utilisation, drug-prescribing;

- the infinity of need/demand - minimum acceptable, public provision of services, an acceptable level of environmental controls.

4. Potential sources of opposition to HFA

Opposition may reflect:

(1) concrete-vested interests (e.g. according to circumstances, tobacco-related industries, equipment manufacturers, the hospital suffering a budget cut, etc.);

(2) reservations about new "-isms" - HFA as "health-ism"; health for all is propogated as "health above all else";

(3) reluctance to encourage or participate in controversy and change - existing smooth-running organisations prefer to carry on as they are.

Opposition may be expressed through arguments formulated on various bases. Objectives to HFA might maintain for example that:

- the status quo is an acceptable state of affairs, e.g. opinion poll surveys show that people are generally satisfied;

- there is no room for the introduction of policy-making and planning; the future is best left to the dynamics of the relationships between interests, or to the market;

- HFA objectives are based on assumptions which have no scientific validity; it is all unrealistic and unfeasible;

- HFA is a veiled form of "victim blaming"; by emphasising the individual's responsibility for life style and hence health state, the individual is made the focal point for change.

If the opposition is not a reflection of a perceived threat to concrete interest, it may be possible to engage in debate with the objectors and to argue that their rejection of HFA is based on a misconception or that their view is incompatible with the evidence. In all events, the probability of opposition emphasises the need to have in place a variety of tools for change involving both public and private initiatives.

5. WHO's support role in national HFA policy

EURO should concentrate its resources and efforts in the following areas:

- stimulating key individuals in Member States (potential influence builders, opinion formers, decision makers, etc.);

- feeding back the intelligence gathered to Member States in forms which make sense to them and stimulate action;

- encouraging national evaluations before and after HFA policy formulation and implementation;

- sponsoring action programmes such as the development of health impact analyses which may explore cause-effect linkages;

- problem-centred case studies (developed with appropriate individuals in Member States) which analyse widely-experienced problems and demonstrate possible ways forward;

- timely publications on key HFA issues to coincide with the expression of concern in Member States.

6. The place of quantified targets

Quantified targets can be seen as attractive as a rallying force, in initiating a programme and demonstrating the need for action. They satisfy the need to know the sense of direction and speed of progress. They can focus discussion on whether a particular action proposal will or will not bring the target nearer. There may, however, be resistance to targets if they are wrongly perceived as normative superimposed values. What is more, there is an obvious need to clarify the role and raison d'etre of European versus national targets. There is a risk that the numerical value of the target obscures the intent of the policy content behind the

target. Other arguments cited against such targets include the lack of knowledge of cause-effect when choosing outcome measures as targets and the difficulty in separating out the effects of the action taken from the effects of other unknown, unplanned or unintended events. This, of course, makes it in any event vital that any indicators chosen to track Targets must cover developments outside the health sector itself. There are also the known technical problems of small numbers when interpreting local area statistics: district populations may be too small for any worthwhile analysis and interpretation to be possible. More philosophically, some of the phenomena central to HFA objectives, such as sense of leading a satisfying life, may be widely thought of as intrinsically unquantifiable. If such technical and conceptual problems are overcome, to proceed to develop the comprehensive information system implied would be very demanding on financial and human resources, and would therefore require a political judgement as a decision. That decision might hinge on the general, political attitude towards targets: whether there is a positive feeling or a sense of anxiety at being committed to an objective, which may prove unattainable. It may well be a recurring issue in Member States that quantified Targets, including particularly those relating to equity and the reduction of inequities, are difficult to establish <u>within</u> Member States. In such cases, targets can be more easily accepted if set externally, i.e. proposed to Member States by EURO through the Regional Committee and cast in European-wide terms. In some cases, scenarios of alternative futures may be more politically acceptable. Nevertheless, despite reservations and problems still to overcome, the Targets and associated indicators developed for the Regional Strategy were to be seen as a reasoned attempt to project levels of attainment based on what appears to be

achievable from present trends and realistic hopes for improvement. They should be a focus to stimulate political, professional and public imagination.

7. Assessing progress and impact of HFA policies

The practice of three yearly HFA evaluations should yield useful information; the interval is short enough to maintain any momentum and long enough to be able to discern changes between evaluations. There were present weaknesses which would need correction such as mapping and assessing the private medical sector or assessing progress at the sub-national level. New direct - or, if necessary, proxy - indicators would need to be developed to assess policy development in terms of HFA principles, (intersectoral action, community participation, primary care focus, etc.). It would be essential that simple parameters were agreed upon which would be suitable at international, national and local level (noting that not all indicators could be equally relevant at all levels). While existing statistical reporting systems should be used wherever possible, it is certain there will be gaps which would need to be filled by periodic sample surveys. Support from academic institutions will be vital in developing methods of measurement and analysis (particularly in support of the sub-national/local level) and in carrying-out studies of the life and health of local populations and studying the formulation, implementation and impact of health policies. Whether information is generated routinely in the systems or by special studies, it is essential that the information gathered and its interpretation is fed back to the people within communities to show what is in fact happening, and to

administrators and politicians at all levels so that they are encouraged to evaluate the trends and the consequences of action taken. It is important that all the interested parties - decision-makers, professionals, public - have the opportunity to discern the reasons for a situation being what it is before going on to consider what might be done. Much of this activity is essentially political - including the choice of what to report and how to interpret - and conflicts will thereby be exposed. It is crucial to sustaining the HFA movement that such conflicts are not automatically handled through confrontation.

8. Further action by WHO

In future, WHO should consider ways of:

- ensuring that reporting and monitoring approaches are modified to give added emphasis to qualitative and basic issues;

- initiating collective discussion within Member States, bringing together representatives from various political-administrative levels, sectors, etc. to join with WHO staff in joint policy assessments (perhaps on the model of OECD missions to countries and other such exercises);

- fostering further contact between Member States where it is clear from prior evaluations that there are sufficient similarities of systems and circumstances to make exchanges mutually beneficial;

- making greater and/or better use of MTP discussions with Member States to focus on HFA issues;

- providing sensitivity training to WHO staff and ensuring that they are fully oriented to the HFA strategy and to the place of their own programme(s) within the strategy;

- showing a clear example to Member States in their own conduct of policy analysis directly related to HFA Strategy, e.g. on the emergent issues cited above and on priority setting;

- engaging with key persons in other sectors in Member States to discuss the health component in policy in those sectors;

- promoting/commissioning action research on reducing health inequities;

- sustaining the initiative of the present meeting to spread awareness of the need for policy analysis with a health problem focus and identifying the required inter-sectoral action.

- promoting training, learning materials, etc. in HFA policy analysis;

- periodically reviewing current research strategies, plans and programmes to ensure their continued relevance to the HFA Strategy and Targets.

CONCLUSIONS AND RECOMMENDATIONS

1. Member States' commitment to HFA

The overall pattern of progress since the Regional Committee's acceptance of the Targets Document in 1984 was regarded as very encouraging. In particular, the meeting observed the value attached to the Targets within Member States as a focus for the discussion of health policy and for giving it a sense of purpose and direction. In some cases, it was possible for proponents to exploit HFA as a "contagion" to shape health policy thinking both intra and inter-sectorally. In other cases, it was more useful to exploit it as one among a number of influences on policy thinking: in such circumstances, it was more effective when the HFA Strategy and Targets could be directly related to issues of immediate political and public concern. Pragmatically speaking, disease reduction programmes were likely to gain political support, while programmes which focused on risk factors (rather than disease *per se*) were more likely to be effective in securing inter-sectoral action. In any event, a variety of tools (legislative, financial, organizational, educational, etc.) would be necessary according to particular circumstances, for HFA implementation. It had also

been the case that a major public anxiety (such as that engendered by AIDS) could deflect even a well prepared HFA strategy. This reinforced the value of periodic national and international reporting of the health situation within a Member State and of the trend in its progress in HFA.

2. Key factors in initiating HFA within Member States

2.1 It was readily accepted that there could be no standard strategy: the entry points would be specific to the national or local circumstances and should, wherever possible, be related to expressed concerns and existing policies. However, it was likely that a successful HFA initiative would follow a sequence: first dissemination of the HFA message in digestible local language, then a build-up of awareness within the health sector, extending to other sectors and to the general public, including their political representatives; this increased awareness provides the basis of an informal structured discussion of major policy issues leading to a consensus or at least a broad based coalition of support among those involved in or affected by the necessary action required.

2.2 However carefully the core issues for a national or local HFA policy have been chosen and supported with argument and evidence, it would be naive not to anticipate opposition with either overt or submerged conflict. In order to determine how to handle such situations, it would be necessary to analyse the nature of the opposition. It could find expression in various forms:

- a declared satisfaction with the status quo or;
- decisions on health should be left to the principal groups within the health sector, or;
- HFA is neither scientifically sound nor realistic and feasible.

The opposition may have different roots:

- concrete vested interests may be at stake, or;
- philosophical or psychological rejection of an "ism" - in this case, a "healthism", which asserts "health" as a value above all other values, or;
- institutional or bureaucratic resistance to change (the "do not disturb" syndrome).

4.3 The above consideration made it important to avoid, wherever possible, policy options which were clearly "zero-sum games", so that those whose activities were contrary to the objectives of HFA should be offered some positive encouragement to change. Equally, it was strongly felt that bargaining with interested parties should not go to the extent of jeopardizing health (i.e. HFA) objectives. Finally, it should be understood that the task of starting a HFA initiative implies having a clear idea of how it could be sustained over time, not just in the start-up period, and giving responsibilities to individuals possessing the necessary political and managerial skills.

3. Regional targets

3.1 It was widely recognized that the Targets Document has been crucial in making the Regional Strategy operationally appealing. The Targets had considerable psychological power in defining the magnitude of attainable change and improvement. It was also easier for a national debate to be managed against a background of EURO-proposed targets, than if comparable national targets had been proposed within a Member State. It was generally accepted that quantified targets, other things being equal, gave a sharper edge to policy-making and planning. However, it would not be normal practice for quantitative values to be explicitly included in policy documents which typically indicated the measures proposed by government or parliament to achieve health objectives. But specified targets could be used in planning documents which developed the policies into strategies, programmes and activities with resource implications and time horizons for implementation and achievement. Even so, the targets should not deflect attention from policy or programme content. They should be used as part of the assessment process of policy proposals - "how far will this particular option, if adopted, contribute to the attainment of the Target?".

3.2 With this general assessment in mind, the following particular points were made:

- there is value in quantified trend analysis, including the speed of progress in a desired direction;

- however, if quantified targets were perceived as normative, this could generate resistance which would be counter-productive. The development of scenarios, as used in some Member States, might be an effective alternative;

- the lack of knowledge about some cause-effect chains inhibited the development of targets;

- some phenomena were not convincingly quantifiable;

- even if there were no problems of the kinds just cited, there might be considerable costs of information connection, analysis and presentation. This raised the question of purpose in any information collection (or, otherwise, "How little do we need to know?").;

- in some Member States, particularly at sub-national level, there would be problems with small numbers which would create difficulties in drawing inferences;

- there would be problems of time lag if the choice was for quantified outcome indicators. Preference could be given to process indicators, i.e. "What action has been taken and why, by whom, in what sector?";

- if the problems posed above can be solved, it would be possible to argue more powerfully to have health indicators accepted as social development indicators (analogous to economic indicators);

- from a policy perspective, emphasis on individual targets is not so important as the general tendency of a cluster of related targets, comprising one of the principal thrusts of the Strategy.

4. Policy analysis and policy research

4.1 Having clarified that "policy" was not in reality a unitary concept, but one which was multi-focus, multi-level and multi-activity; and could be defined as decisions shaping purposeful action; and that policy could be reshaped at each stage of the process of formulation and implementation, it was recognized that there was a clear need for better policy analysis and research in support of HFA at all levels, from EURO to the local operational level.

4.2 Policy analysis starts with the recognition that the traditional academic and professional disciplines into which knowledge and skill are traditionally divided are too narrow in scope and form to be helpful by themselves in addressing policy issues. Policy analysis argues for going beyond even a multi-disciplinary frame of study, to an inter-disciplinary frame, i.e. consciously bringing disciplines together to work on the same problem. In its most developed form, it can be described as "meta-disciplinary" - a new

approach created out of the synthesis of the old disciplines. Policy analysis is focused first on a problem to be analysed in its various dimensions (technical, legal, social, economical, organizational, etc.), including an estimate of the consequences if no corrective action is taken. Secondly, it then develops policy options, identifying the intended benefits which would flow from their adoption. And thirdly, it proposes criteria for choosing between alternatives ("a reality test").

4.3 While there was encouraging progress being made in some Member States in promoting and using policy analysis in the health policy process, and in commissioning and using policy-related research, much more needed to be done:

- in promoting training programmes in policy analysis;
- in introducing trained policy analysts in health policy units in ministries and other agencies;
- in familiarizing civil servants (and others in comparable, non-governmental bodies) with the approaches and objectives of policy analysis and how policy analysts can best be used;
- in improving contact and working relationships between ministries and the research communities;

- in identifying ways in which analysts and researchers can help at the local, operational level;

- in encouraging Member States to develop and implement policy-oriented HFA research plans, giving responsibility for such research to the most prestigious location possible;

- in emphasizing the validity of flexible, pragmatic, less sophisticated approaches to policy analysis in Member States with less-favourable circumstances (e.g., the range and quality of information available, problems in mounting population surveys, etc.);

- in devising EURO-level policy analysis studies, whereby it is established what EURO needs to know about circumstances within Member States; and how to make the most constructive presentations of study results to Member States.

5. Emergent issues

It was noted by the meeting that health, and specifically HFA, policy was not, and could not be, developed and implemented in a vacuum. There were likely to be ideological values and other factors, as well as concerns generated within the health sector, which could be significant influences on the HFA agenda. The meeting thus drew attention to a number of these. It was noted that some of them could have specific content, while others might be

slogans capable of varying interpretation or of being used as a cover for some other political objective (e.g. the rhetoric of decentralization being used while administrative developments actually increased central control). Yet others might be in conflict with each other (e.g. equity and decentralization):

- privatization; de-regulation;
- decentralization - structural _devolution_ in pluralist or federal structures; administrative _delegation_ in unitary structures;
- equity - life/health chances;
- access to medical care;
- information - for policy-making and management; health indicators; resource indicators;
- resource control - manpower utilization; drug prescribing;
- infinity of need/demand - minimum acceptable public provision of services or level of environmental controls.

6. Future action by EURO

6.1 The meeting reaffirmed EURO's role as catalyst for HFA in supporting and encouraging their counterparts and other key figures within Member States. This, in turn, highlighted the value of EURO's sensitive monitoring of health

and HFA developments in Member States and reflecting these back to countries in such a way that they stimulated a national evaluation of policies and their impact, and perhaps comparisons with other Member States sharing certain similar characteristics.

6.2 The above implies certain specific developments by EURO:

- harnessing (and subsequently publicizing) all valid defensible arguments and evidence from relevant fields (in and outside the health sector) to support HFA objectives, i.e. to convince major target audiences (politicians, professionals in all sectors, the general population);

- developing "problem centred" case studies (in collaboration with Member States) to highlight HFA issues and potential action strategies;

- reorienting, or at least supplementing, present forms of monitoring of Member States, by a more qualitative approach involving a jointly agreed agenda with a Member State, identifying the key issues to be covered;

- sensitizing all EURO staff members prior to duty travel to Member States, so that individual programmes (targets) can be discussed in the framework of the Strategy as a whole, at the same time acting with a flexibility appropriate to the circumstances of the Member State;

- as far as possible, monitoring should be framed within a mission to the Member State (as practised by other intergovernmental organizations, e.g. OECD); discussions with Member States over their MTP plan of cooperation should be within an HFA framework;

- bringing together (as already practised) Member States from the same part of the Region with similar circumstances for the exchange of ideas and experience;

- encouraging and coordinating policy and action-oriented research, e.g. although equity is self-evidently central to a Health for All strategy, there are problems in practise in addressing and analyzing health inequities within a Member State; EURO sponsored action research projects to reduce inequities could be a practical approach to the problem;

- taking all responsible steps to ensure EURO establishes and strengthens contacts in non-health sectors in Member States to establish an action agenda on health (not health service) problems;

- undertaking, as a matter of urgency, a consultation on training in skills for policy analysis and policy research studies;

- clarifying and establishing consistent use of related concepts and terms (health policy, healthy public policy, HFA policy, health policies, etc.).