

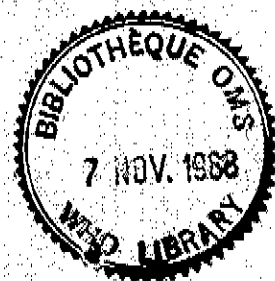


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Health for all
Suzanne*

FRAMEWORK FOR THE ANALYSIS OF COUNTRY (HFA) POLICIES



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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.

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CHAPTER 1

INTRODUCTION

1. The adoption of Health For All

In 1977 the Thirtieth World Health Assembly decided that the main social goal of governments and WHO in the coming decades should be the attainment by all the people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. This goal is commonly known as "Health For All by the year 2000". "Health For All" (HFA) is a process leading to a progressive improvement in health, not a single finite target.^a

A global strategy for health for all was adopted by the World Health Assembly in 1981. It describes the broad lines of action to be taken at policy and operational levels, nationally and internationally, in the health sector and in other social and economic sectors, to attain HFA by the year 2000.

A regional strategy for Europe was approved in 1980, and 38 regional targets were unanimously agreed on in 1984.^b A list of indicators has been drawn up to make it possible to measure progress towards achieving the regional HFA targets^c.

Resolutions urging Member States to formulate strategies in line with HFA have been passed in the policy organs of WHO since the inception of the process, and two rounds of monitoring and evaluation have already been carried out in 1983 and 1985.

The basic policies embodied in the strategy for HFA are that health is a fundamental human right and a worldwide social goal; health is an integral part of development; the existing gross inequality in the health status of people is of common concern to all countries and must be drastically reduced; people have the right and duty to participate individually and collectively in the planning and implementation of their health care; governments have responsibility for the health of their people; countries must become self-reliant in health matters; and fuller and better use must be made of the world's resources to promote health and development.

^a *Glossary of terms used in the "Health For All" series No. 1-8.* Geneva, World Health Organization, 1984

^b *Regional strategy for attaining health for all by the year 2000* EUR/RC30/8 Rev. 2. Copenhagen, World Health Organization, 1982; *Targets for health for all*, Copenhagen, World Health Organization, 1985

^c *Development of Indicators for Monitoring Progress Towards Health for All by the Year 2000.* Geneva, World Health Organization, 1981

Revision of the Regional Indicators for the Implementation of the Regional Strategy for Attaining Health for All by the Year 2000, EUR/RC37/8, 1 October 1987

2. Purpose of this document

The Seventh General Programme of Work (7thGPW) which covers the period 1984-89 and is now being implemented, has as its principal objective to promote, coordinate and support the efforts of Member States individually and collectively in implementing their strategies for health for all. The 8th GPW (covering the period 1990-1995), which is the second of the three GPWs that together will cover the period of the Global Strategy for HFA 2000, reflects WHO's continuing support to that Strategy, particularly its national components, and retains the same principal objective as that stated in the 7th GPW¹.

One of the main roles for WHO/EURO outlined in the 7thGPW is to "act as a catalyst in promoting the formulation of national health policies in line with the principles of HFA", and this will remain for the 8thGPW². This catalytic role of WHO implies greater attention to the promotion of multisectoral collaboration and the integration of health policy in overall socioeconomic development policy.

In the light of the above, the present document prepares a framework for analysing country health policies and country HFA policy documents. It aims at facilitating common understanding of concepts, principles and alternative approaches in HFA policy development.

It will be obvious from the following that a country HFA policy document is in no way considered to be the only legitimate manifestation of HFA in a country, or indeed essential "evidence" of adherence to HFA. Such a document can, however, be a valuable tool for the formulation of HFA policy, or the consolidation of health and other development policies in a HFA framework.

As will be seen below, policies are formulated when there is an awareness of the need for them. The process by which they are formulated and manifested depends on the political, cultural and socioeconomic character of a country. An attempt is made, therefore, to set up a framework in which health policy or policy documents can be seen in their own national setting of socio-economic conditions and prerequisites for health, and with reference to some of the factors which may influence the initiation and formulation of a HFA policy.

This is a first and by no means definitive framework for such analysis. It has been tested, however, by using it for the analysis of a number of HFA policy documents, and consequently is felt to adequately cover the major issues, although this naturally does not preclude future improvements.

¹Eight General Programme of Work (covering the period 1990-1995 inclusive) WHO, Fortieth World Health Assembly, Provisional Agenda item 9, A40/6, 12 March 1987, p.11, p.35

²Regional contribution to the Eighth General Programme of Work (1990-1995) WHO, EUR/RC36/9, 11 June 1986, p.5

The need to develop indicators related to the measurement of progress towards the regional HFA targets is borne in mind, and allowance is made in the framework for the incorporation as far as possible, of some of the information necessary for the indicators which have been designated as essential.

The WHO does not intervene in the political affairs of its Member States, or try to impose a particular way of working. This framework is not presented as a model to be followed by Member States, but rather as a useful checklist:

- to assist countries interested in developing HFA policies of their own
- to be used for the analysis of the HFA policy documents which have already been prepared in some countries, in order to ascertain the main issues covered and priorities set. Such analysis will enrich the way in which implementation of HFA in these countries has so far been examined, and will demonstrate some of what can and is being done in Europe towards the achievement of HFA
- to develop an adequate information base both for the formulation of country programmes, and for the briefing of EURO staff making country visits.

CHAPTER 2

POLICY FORMULATION

1 Definition of policy formulation

In many European languages, only one word is used to translate the two English-language words 'policy' and 'politics'¹. It is considered necessary, therefore, to clarify what is meant by 'policy' in this document.

A policy is a manifestation of goals and objectives to achieve a desired result or change. It can be formulated through a variety of processes, and may be manifested in many ways.

Policy is frequently not explicitly expressed in the form of a particular policy document or text. It may be seen to evolve as the result of incremental administrative decisions, or through ministerial administrative directives. That is, small incremental steps are taken which move towards implicit objectives, what Lindblom has called 'muddling through'².

Policy may be discerned from the provisions of acts of parliament, or from local by-laws and regulations. High court decisions which set precedents may, in effect, become a manifestation of policy, or it may be expressed in answer to demands from opposition parties, interest groups or wide popular movements for a central or local government position on a particular issue.

From this it can be seen that policy formulation is an ongoing government activity. Policies, formal as well as unwritten, emerge continuously from governmental process³.

Obviously, the initiation of policy formulation varies correspondingly to the above. What is common to all types of policy formulation is that policy must be seen to be needed. No matter how urgent the need for new policies, they will not emerge if they are beyond what Vickers has called the 'appreciative setting' of the policy makers⁴.

¹ Heidenheimer, Arnold J. *Politics, Policy, and Policing as concepts in English and Continental Languages: An attempt to explain divergences*

² Lindblom, C.L. "Still muddling, not yet through". *Public Administration Review*, 39, 1979.

³ *Managerial process for national health development*. Geneva, World Health Organization, 1981, p.18.

⁴ a) Vickers, Sir Geoffrey. *The art of judgement*. Methuen, 1965

b) Thompson, D.J.C. *The systems model of decision-making as a useful conceptual framework for considering policy-making in the NHS*. University of Birmingham, Health Services Management Centre, 1975, (mimeograph).

Policy may be formulated from the top down, the bottom up, or a combination of both. At both central and local government level, policy may be formulated in response to the ideological or political beliefs of the party in power, to pressure from popular movements or interest groups, or in response to a particular crisis or contingency.

The level at which policy is formulated depends on the level of authority necessary for its implementation. For example, income tax policy is usually a matter for central government, whereas property or special purchase taxes may be in the sphere of local government policy.

The process by which nations, subnational units and individuals take decisions concerning the various issues with which they are faced vary, but there can be no rational decision-making without some framework of goals and objectives, however indistinctly these may be defined, and whether or not they are explicitly expressed. This is the difference between a decision and an instinctive reaction.

From the point of view of planning, the formulation of a clear policy is one of the basic steps. The goals, objectives and priorities defined in a policy, set up the framework in which operational plans can then be formulated, implemented and evaluated. The clearer the goals and objectives are defined, the more rational and effective the planning process can be, although clear policy formulation does not necessarily ensure successful implementation^a.

Even if planning continues to be of an incremental, muddling through type, when a clear policy has been formulated, the incremental moves can at least be guided in a specific direction^b, rather than constituting disjointed replies to crises.

When broad policy objectives for development are explicitly expressed, they may be defined in comprehensive national plans for socioeconomic development. In centrally planned economies such policies would be prescriptive, whereas in mixed economies they would be prescriptive for the public sector and indicative for the private sector. They may be contained in subnational plans, in sectoral plans, or in party political platforms. However they appear, they are essential to the planning process and health planning is no exception to this.

2. Goals, objectives, strategies and targets

In the relevant literature and most certainly in many policy and planning documents throughout the world, there is frequently considerable confusion in the use of the terms goals, objectives, strategies and targets. The following definitions and examples should clarify the way in which these terms are used in the present document.

^a Elmore, Richard F. "Backward Mapping: Implementation Research and Policy Decisions". *Political Science Quarterly*, vol. 94, No. 4, Winter 1979-80.

^b Hunter, David. 'Planning in an age of uncertainty'. *Health and Social Service Journal*, August 25, 1983.

A goal is a long-term general aim towards which to strive^a. An example of a goal would be to ensure equity in health.

The term objective is frequently used interchangeably with the term goal. In this document the term objective refers to something slightly more specific than a goal, and is an aim which can be partly achieved during the planning period. An example of an objective would be to reduce inequities in the regional distribution of health facilities.

A strategy^b lays down the broad lines of action to be taken to achieve the goals and objectives, and incorporates the identification of suitable points of intervention, ways of ensuring the involvement of other sectors, the range of political, social, economic, managerial and technical factors, as well as constraints and ways of dealing with them.

A target is an intermediate result towards the achievement of the goals and objectives^c. It is more specific than an objective, is usually quantified, and has a time horizon. An example of a target relating to the above objective would be that by the year 1990, in no region of the country should the ratio of inhabitants to physicians be more than 530 inhabitants per physician.

It should perhaps be pointed out that in some cases, quantified targets are also standards, though this is not always the case. For example, a desirable 'standard' of services might be that all elderly persons living alone are contacted by the social services at least once a month. Financial and manpower considerations may, however, dictate that the 'target' set for the development of these services is that x% of the aging living alone are contacted regularly in this way by the end of the planning period. In countries where the targets are approved to become legally binding on the social services, then the target set, in effect, becomes a standard.

^a *Glossary of terms*, used in HFA series Nos 1-8 WHO, Geneva, 1984, p.18

^b *Formulating strategies for health for all by the year 2000*. Geneva, World Health Organization, 1979, p.15

^c *Glossary of terms*, p.18

3. Health policy and HFA policy formulation

As stated by the Executive Board of WHO:

"A national health policy is an expression of goals for improving the health situation, the priorities among those goals, and the main directions for attaining them."^a

Health policy making is nothing new. The first public health acts legislated in Great Britain and Europe during the early nineteenth century to prevent the spread of contagious disease through dirty water and unregulated waste disposal, and the provision for health insurance in 1883 in Germany, were manifestations of health policy. As the world's first socialist nation, the Soviet Union included health care in its first five-year plan launched after the 1917 revolution, in order to implement an explicit policy for state provision of health services, free of charge for all persons.

Neither did HFA policy appear overnight, or even with the 1977 resolution of the World Health assembly, and it most certainly is not a policy formulated in the Regional Office of WHO, to be imposed upon member states, quite the contrary.

Social, economic, cultural and political changes in member states, emerging demands and aspirations, led to a new 'appreciation of the situation' to use Vickers' terminology again, in many countries. These common experiences and developments were brought together in a form which could be discussed and approved at the international level, so formulating a policy which has been labelled HFA.

The way in which health policy and consequently, HFA policy is formulated or manifest in a country will differ mainly according to the country's approach to planning in general. It should be emphasised here that all countries without exception go through a 'process' of planning for health, though not all produce 'a plan' for health - the preparation of an annual budget is part of this process. Roemer has identified, in what he calls an oversimplified manner, five general approaches, linked to five types of countries, which although referring to health care planning rather than health planning, are quite interesting^b:

1. Socialist
2. Welfare state
3. Transitional developing
4. Entrepreneurial developing
5. Advanced free enterprise

^a *Formulating strategies for health for all by the year 2000*. Geneva, World Health Organization, 1979, p.14.

^b Roemer, Milton I. *National strategies for health care organization*. Michigan, Health Administrative Press, 1985, p.393.

Most of the member states in the European Region come under the first two types but with many variations.

Very simply, for socialist countries, health care planning is part of the overall socioeconomic planning process. Under this model, formulated by the Soviet Union soon after its establishment in 1917, the crucial principle is that health services are a government function, provided without charge to all persons. Preventive and therapeutic services are to be integrated, with emphasis on prevention, and deliberate measures are to be taken to achieve equitable distribution of resources. The method is based on a sequence of technical, economic and political decisions. Technical judgements, based largely on empirical studies, are made to determine the nation's ability to produce the needed resources within a certain time. Political decisions finalize the standards to be established for short-term and long-term targets, in light of the competing needs of society^a.

With regard to countries of the welfare state type, the most important common denominator is that, whereas health care receives public economic support, the delivery of care is only partially under public control. Within this very broad definition are countries such as the United Kingdom where the health services are nationalized, Sweden, where health care is very much a regional government affair, or the Netherlands where the private sector plays a very large part. Some of the countries in this group have a long tradition of comprehensive socioeconomic planning, others do not. In some countries health policy is formulated in the light of a strong information base and in others it must be based on commonsense emulation of the health care experience and trends in other European countries.

In both types of country, socialist and welfare state, while basic policies and goals are established centrally, the implementation of health policy lies to a greater or lesser degree with subnational levels and their part in policy formulation and the manifestation of policy differs accordingly.

It is obvious from the above, therefore, that a country's health policy, or HFA policy, may be expressed in a separate health policy document, be combined with a health programme^b, or a comprehensive overall socioeconomic development plan. This will depend to a large extent on usual practice and tradition in the approach to planning.

^a Roemer, 1985

^b According to the *Glossary of terms* used in the HFA series, the term "country health programme" has "become obsolete since the broader concepts of strategies and plans of action have come into use" (p.22). As noted above, however, the translation of terminology can create difficulties and in reality it appears that countries continue to use the terms "country health plan or programme" or "national health plan or programme".

With regard to HFA policy in particular, it is possible that a country may have an HFA policy without actually naming it as such. Although agreeing with, and approving the HFA strategy and targets, for domestic reasons a country may wish the related policy to appear as a 'national policy', and not refer to it as an HFA policy. This may be part of a quite legitimate desire to appear to be pursuing a national policy and not a policy guided by outside influences. It may simply be considered unnecessary to add a WHO "seal of approval" to a policy which has been readily accepted nationally. The 1985 Swedish Health and Medical Services Act and the supporting HS90 (Swedish Health Services in the 1990s) documentation in Swedish, although closely aligned to HFA, do not refer to it^a. Indeed, work had already been started in Sweden on HS90 before the HFA regional strategy and targets were formulated. The German Democratic Republic has produced evidence that most of the principles of HFA are already embodied in its sociopolitical programme^b.

The preparation of a policy document for HFA can be a valuable starting point for the development and implementation of HFA policy at national or subnational level. Such a document may also be a consequence of vertical or horizontal, ongoing activities related to HFA, at a national or subnational level.

The existence or non-existence of a country HFA policy document, however, tells very little about what is actually happening with regard to the implementation of an HFA policy. It would be possible for a country policy document to be formulated, and for little related change with regard to HFA to actually occur. On the other hand, in some countries there may be considerable activity in the framework of HFA at the national or subnational levels, without a country HFA policy document having been prepared.

It should be stressed here, that for some countries with federal governments, the national level would not be the natural level for an HFA policy to be formulated, since the federal government has authority within a limited field, power for health policy formulation lying at a subnational level.

In a number of countries, there does appear to be considerable HFA related activity at the subnational level, without there being a country HFA policy document. In the United Kingdom, for example, the Nottingham Health Strategy Group has summarized the HFA targets for Europe, presenting them

^a The English-language version refers.

^b *The socioeconomic basis of health protection for all citizens of the German Democratic Republic.* Berlin, GDR Academy for Postgraduate Medical Education, May 1987.

together with their corresponding indicators, and turning the suggests for action in the target document, into questions asking what is actually being done in the area^a. One of the local health districts, Bloomsbury (London), has been particularly active in promoting local action on health for all^b.

Many countries are participating in WHO related activities such as the "Healthy Cities" programme, and the Countrywide Integrated Non-communicable Disease Intervention programme (CINDI).

A major aim of the Healthy Cities project is to move health high on the social and political agenda of cities, i.e. by promoting and ensuring the process of health becomes an explicit consideration in the policies, plans and programmes of not only municipal governments, but of all other significant public and private sectors which affect the health of citizens. Particular emphasis is given to the promotion of healthy environments and healthy lifestyles. Guiding principles for reaching these aims are intersectorality and public participation^c. By mid-1987, cities in nine European countries had already been designated to join the project.

The CINDI project aims at establishing effective collaborative mechanisms and methodologies for integrated, intersectorial prevention and control of major non-communicable diseases, such as cardiovascular diseases, cancer, diabetes, mental disorders and accidents. Priority is given to risk factors, e.g. unhealthy nutrition, alcohol abuse, physical inactivity and psychosocial stress^d. So far, ten European countries are participating in this project, which is a project for both monitoring and intervention.

Nine countries in Europe have recently issued health policy documents (Bulgaria, Finland, Hungary, Iceland, Ireland, Netherlands, Poland, Sweden and Yugoslavia), not all of which are labelled HFA policies, and a further six have started or are embarking on the process of drafting, a national health strategy or overall long-term health policy (Israel, Italy, Malta, Norway, Portugal and Spain).

The process through which these policy documents were formulated, their format and content, differ considerably, reflecting the rich variety in the national backgrounds of the individual Member States of the European Region. It is interesting to note that policy documents have been or are being prepared by Member States from the north, south, east and west of the Region.

^a *A checklist of action in support of health for all*. Nottingham Health Strategy Group, Nottingham, September 1987.

^b See background papers to the First European Congress on Healthy Cities, Düsseldorf, 14-18 June 1987.

^c See background papers to the First European Congress on Healthy Cities, Düsseldorf, 14-18 June, 1987

^d CINDI, Protocol

The way a policy is manifested, the title or format of the document in which it appears are not as important as its content. Even a policy which is not explicit, but which is identifiable, could be said to be an HFA policy if it is in keeping with HFA philosophy and principles, and would therefore be significant. The type of document in which HFA policy is expressed (comprehensive or sectoral plans, national or subnational plans) and its format, can be important, however, with regard to policies which can only be formulated or implemented at a particular level, or which have multisectoral aspects.

It should be borne in mind also, that it is possible that a document may not, in fact, adhere to the essential elements of such a policy. It must be stressed, therefore, that the title, type and format of the policy document are not as important as the policy content. Furthermore, since participation in decision making is one of the basic principles of HFA, not only the content, but also the process of HFA policy formulation and development is crucial.

CHAPTER 3

ANALYSIS OF THE NATIONAL SETTING

1. Methodology for comparative analysis

There does not as yet appear to be an internationally acknowledged methodology for carrying out comparative analysis. This attempt, therefore, in addition to providing a brief, and in some instances, a necessarily incomplete description of the experience of a number of countries, could also form a basis for discussion as to a possible framework for monitoring and comparing the development of national, or suitably modified, subnational HFA policy, through which countries could assess and compare their own progress. As mentioned above, it is not by any means suggested, that there should be a standard model to be followed, for formulating HFA policy. Each country will find its own best road to achieving its objectives. What is suggested here is that there are a number of factors which countries might find valuable to consider and examine.

The national setting in which an HFA policy is defined and developed is of vital importance. It is considered essential, therefore, that HFA policy is seen in the light of a particular context. In this respect, both a situational and an institutional analysis need to be carried out, in order to uncover both the dynamic characteristics of the current circumstances and the more constant features of the organization of policy-making and implementation^a. That is, one needs to examine the situation, past trends, present and expected future developments, and the institutional mechanisms in-place or needed for policy implementation.

From the situational perspective, the analysis could include examination of the following aspects:

- geographic, socioeconomic and political conditions
- health status and the provision and use of health services
- the content of health policies and plans
- views of government leaders and other bodies, including pressure groups
- public discussion, including mass media exposure.

A situation at any given moment, can be affected, for better or for worse, by particular personalities. Although this might be a rather sensitive area, it is worth looking at key officials. A particular person in the position of minister for health, for example, or any other strong cabinet position, or even an official in a key administrative or planning position, can sometimes have a decisive influence on the development of an HFA policy.

From the institutional perspective, the analysis would be looking for certain mechanisms that need to be examined including mechanisms for:

^a Altenstetter, C. *Intersectoral action to aid maternal and child health*. Manual written for the Division of Family Health, Geneva, World Health Organization, January 1985 (EUR/HPP/87.1).

- health situation reporting
- policy-making and planning
- implementation and evaluation
- multisectoral collaboration
- participation and involvement

In the analysis which follows, these factors will not be dealt with in a format which separates the situational from the institutional, since this would divorce them from reality. Rather, they are set-out in the time sequence in which they could profitably be carried out in a country.

It should be borne in mind, however, that planning is a cyclical process. National policies, strategies and plans of action form a continuum, and there are no sharp dividing lines between them. Countries do not always follow a strict order, for example, of first analysing the existing situation and past trends, completing the definition of policies, then continuing with the formulation of strategies and afterwards devising plans of action.³ In reality, different stages of the textbook planning process are frequently being carried out simultaneously.

While recognizing therefore that this cyclical process could, in fact, be entered at any point, an analysis first must be made of the national setting in which the policy document was formulated. This should include an examination of the geography and climate of the country, socioeconomic conditions, i.e. demographic trends and structures, the economic situation, relevant legislation, the level of decentralization in the country, the political situation and the situation with regard to the prerequisites for health. The rationale for this is presented in the following section.

In the following chapter, the health situation is examined, looking at both the mechanisms for assessing and reporting on health in the country, and the coverage of the health situation report, where such documentation exists.

Referring further to the institutional perspective, the mechanisms for health policy-making and health planning are examined in Chapter 5.

Finally, in Chapter 6 a framework is set up for the analysis of a country health policy document, to determine whether or not it contains the essential elements of an HFA policy; what are its strategies and priorities; and whether or not provision appears to have been made for policy implementation and evaluation. Thus, the cycle is completed, so that with the evaluation of a new situation, it may start again, with the reformulation of policy if necessary.

2. Framework for the analysis of the national setting

2.1 Geography and climate

The geography and climate in some countries may not present significant problems. In other European countries, however, the existence of many small islands, or of communities in rather remote mountainous areas can present serious problems of equity in the provision of social and economic

³ *Managerial process for national health development.* Geneva, World Health Organization, 1981, pp. 18-19.

infrastructure. Extreme high or low temperatures can also create serious problems of mobility, particularly for certain groups such as the aging and the handicapped. Such problems need, therefore, to be referred to.

2.2 Demographic trends and structure

A critical element in the formulation and implementation of an HFA policy is the process of demographic change. Health status is closely related to such characteristics as age, sex and social class, as are the need and demand for health services. Future manpower resources both for the health sector and for the economy as a whole will also be partly affected by trends in the age and sex structure of the population.

The geographic distribution of the population and the degree of urbanization are important for the delivery of health services, the urbanization also being important with regard to its effect on health status. The size of the very young and the very old groups of the population is also of particular importance, with regard to the need for health services, self-help and community involvement. In this respect, family size and composition can also have a decisive effect.

It is obvious therefore that this is the essential starting point, and not information which may simply be "useful to know".

2.3 Economic system and situation

A healthy economy is important both for the provision of job opportunities and for the financing of the social infrastructure which is a prerequisite for HFA.

Over the last 30 years, there has been a massive increase in the resources devoted to health in the European Region. However, with the decreasing rates of economic growth after the mid-1970's, many countries in the Region have begun to re-examine their health services, and consider means of containing costs.³

HFA aims at enabling people to take part in economic activity, thus contributing to economic growth. The disease prevention and health promotion components of the policy should lead to a decrease in the need for some types of health care. A shift from expensive hospital care to primary health care might also, to some extent, lead to cost containment.

HFA should not, however, be thought of as an instrument for cutting costs by shifting responsibility for health and health care from the public sector to the individual and families although it does aim at the undertaking of greater responsibility for health by the individual, family and community. The measures needed for the implementation of an HFA policy will require economic resources for health promotion and the reorientation of the health services. Considerable resources in the non-health sectors, such as housing, education and the environment, may also be required.

³ Abel-Smith, B. Cost containment in health care. Occasional Papers on Social Administration, 73, Bedford Square Press, NCVO, 1984

The promotion of changes in lifestyles, including changes in eating habits, and in the consumption of products such as tobacco and alcohol, for example, may necessitate changes in tax and subsidy policies that can have a significant effect on state income, either for better or for worse. There are already signs that economic constraints may delay the achievement of some of the targets. It is important, therefore, to see national HFA policy in relation to possible economic growth, or the lack thereof.

2.4 Legislation

Legislation is an extremely important part of the framework in which any national policy is formulated and implemented, and if it is not in line with the principles of HFA, it can obstruct and delay the development of an HFA policy.

This is not to say, however, that the existence of specific legislation ensures the effective implementation of certain policies. Examples of legislation which are in effect dead-letters, abound throughout the world, for one reason or another.

Legislation can give the individual certain rights and the possibility of taking certain actions under the protection of the State and promoted by it. Legislation protects, defends and preserves the interests of both individuals and communities. Particularly with regard to the field of prevention, the main task of the law is to deal with those phenomena that are beyond the power of the individual to influence.^a

Naturally it would be impractical to attempt a comprehensive overview of all legislation related to health. Reference would need to be made, however, to the basic legislation covering health and health insurance

Reference could also be made to any important social legislation over the last ten years, related to the prerequisites for health, to the protection and assistance of vulnerable groups of the population, and to participation and the balance of power between central and local authorities.

2.5 Administrative structure and the degree of decentralization

The decentralization of decision-making and responsibility to the lowest possible level, which is vital for meaningful participation, will also take place within the constraints of the existing administrative structure and level of decentralization, and this differs considerably between Member States.

Political power and financial resources are largely centralized in some countries, while in others local authorities are much more powerful, mainly due to their ability to raise their own funds.

^a Gläss, Klaus, Schmidt, Werner, *Law and health promotion - a comparative research study in Europe*, Dresden, Institute for Health Education of the German Hygiene Museum in the GDR, WHO Collaborating Centre for Health Education, 1986, p. 25

It is not only a question of the power of the purse, however, it is also a question of the elasticity considered permissible at the local level in the implementation of national policies. In the UK for example, the DHSS's consultative document on priorities for the health and personal services which appeared in 1976, gave way to a much less prescriptive, and more flexible approach in the 1977 revision of the document. This was followed in 1981 by a handbook of policies and priorities, the main ingredient of which was a laissez-faire attitude where priority-setting was to be a matter for local decision and local action.^a In other countries, particularly countries of the socialist type in Europe, there is sometimes less flexibility at the local level in implementing national policies.

This question of where the political power lies is extremely important, since the question of who gets what, both within the health sector and particularly between sectors, can be based on technical criteria only up to a certain point. "Indeed, there may well be no expertise when it comes to determining what weight should be attached to different, and perhaps conflicting criteria: technocracy has to yield to a debate about the desirable or tolerable trade-offs between competing social values".^b

Reference needs to be made to the existing structure of power and finance, and to any foreseeable changes. This should include reference to possible conflicts between the principles of decentralization, participation and equity. A real decentralization of political power backed by financial resources can lead to inequities. Decisions at local level may be taken in a very parochial manner, without regard for the needs of a wider region or a neighbouring area.

Some degree of local differentiation may be necessary to meet local needs and preferences. A balance must be kept, however, in order to avoid increasing inequities, the disregard of needs of certain local groups, or over attention to the demands of strong and vociferous groups.

2.6 Political situation

An HFA policy is by nature a long-term policy. Politicians, on the other hand, are not always interested in the long-term, being more concerned with the period up to the next elections. They are sometimes, therefore, not so interested in health as in the more tangible issue of health services. They are not always interested in equity, since there are differing theories concerning the causes of inequity and the feasibility of attacking it.

^a Hunter, David, J., Wistow, Gerald. *Community care in Britain: Variations on a theme*, London, King Edward's Hospital Fund for London, 1987, p. 74.

^b Klein, Rudolf, "The politics of participation" in Maxwell, Robert and Weaver, Nigel (eds), London, King Edward's Hospital Fund for London, 1984, p. 19.

Changes in the political situation can, therefore, have profound effects on the degree of support for the formulation of an HFA policy and on the continuity of such support. Simple reference to the political party/parties in power at the time of the formulation of the policy document is not sufficient. Support for at least certain elements of an HFA policy might cut across a number of parties, or certain parties may be in disagreement with some of the basic principles of the policy, or indeed its whole orientation.

Reference needs to be made, therefore, as to whether or not major political parties were consulted at an early stage of policy formulation, and whether or not there was a consensus of opinion regarding essential elements of HFA, such as equity, decentralization and community participation, and reorientation of the health services.

Possible differences in opinion concerning the manner in which an HFA policy should be implemented, would be of less importance than lack of consensus concerning the basic concepts.

If this is possible, it would also seem to be worthwhile examining which, if any, popular groups appeared to have taken HFA on board, e.g. feminist movements, environmental movements, or special interest groups such as the handicapped, and whether there is strong support or opposition from the professional associations of health care givers. The existence of strong lobbies can cause political parties to rethink their position, either for or against HFA.

Social policies are particularly vulnerable to social unrest. That is, their implementation may be accelerated, delayed or altered in such situations. Social policy statements may even be used by policy makers as a ploy to disperse tension in a critical situation, without there being any real intention of implementation. Reference could be made, therefore, to the existence of conditions of relative stability, or to evidence of unrest, such as successive strikes, etc.

2.7 Prerequisites for health

It is stated in the target document that "without peace and social justice, without enough food and water, without education and decent housing, and without providing each and all with a useful role in society and an adequate income, there can be no health for the people, no real growth and no social development."^a

Peace is not just the absence of war, but freedom from the threat of war.

2.7.1 Nutrition

"To obtain enough food of the right kind is still a problem in various parts of the Region, both affluent and developing. Results of national studies show that there is still under-nutrition in parts of the Region and in some social classes....The deficient diet of many elderly people, particularly those living alone, is of special concern in many countries."^b

^a *Targets for Health for all*, p.13

^b *Evaluation of the strategy for health for all by the year 2000*.
Seventh report on the world health situation, Vol. 5, European Region,
Copenhagen, Copenhagen, WHO, 1986, p.8.

Reference needs to be made to any particular problems of nutrition, especially among children and the elderly.

Outcome indicators such as those relating to nutritional intake, birth weight and anthropometrical studies would be covered under a report on the health situation. As concerns nutrition as a prerequisite to health, reference would need to be made to the proportion of income spent by different population groups on food; to particular problems of domestic food production and self-sufficiency; and to questions of food distribution and safety.

2.7.2 Safe water supply, adequate sanitation, clean air and freedom from noise

Although some countries in the European Region have already managed to provide their total urban population with a piped public supply of water, this is not always sufficient all-year-round, particularly in areas of high tourist influx. There is really insufficient information concerning the quality of water in much of Europe. Water pollution is becoming more complex with the introduction of new toxicants, creating new relations between water and health.

Sanitation remains a problem for most European countries, as do air and noise pollution. Air pollution has reached crisis levels in some metropolitan areas, and noise is a growing problem.

Problems of sanitation, air and noise pollution are frequently found together, in areas inhabited by vulnerable population groups such as the poor, aging and migrant workers. Many countries would need to be aware of such environmental conditions in relation to certain sub-groups of the population, and in different geographical areas.

The availability of a safe water supply and adequate sanitation within the home is important to prevent disease, and for the care of the disabled and the aging in the home. It can be of vital significance for the domiciliary care of the bedridden and particularly of those with problems of incontinence.

2.7.3 Education and the mass media

Education is essential for participation in much of what is satisfying in modern society, and for understanding health and making an informed choice about lifestyle. It is particularly important for both health education and community participation in decision-making.

Literacy rates are almost 100% in the adult population of many of the countries in the Region, but in some there are still pockets of illiteracy, frequently among the aging. Migrants may have difficulty in mastering the language of a country. In countries where illiteracy is still a problem, this will need to be monitored, and where possible, the concept of "functional literacy" should be preferred.

All countries could benefit from monitoring the proportion of the population by sex who have completed primary, secondary and higher education or a certain number of years of education, both as background information for planning health education, and as a first rough estimation of the pool from which manpower of different levels can be drawn in the future.

The availability of reading material and radio and television networks is a prerequisite both from the point of view of increased well-being through cultural and educational enjoyment, and as the essential infrastructure for health education.

2.7.4 Housing

The quality of housing is of considerable importance with regard to disease and stress prevention, and can be a decisive factor with regard to home care or the independent living of the chronic sick, aging and disabled. "All Member States have legislation for the planning and control of housing. In the majority of cases, this is of long standing, and the regulations cover structural safety, ventilation, noise, sanitary requirements, etc. A number of Member States have specific regulations concerning accessibility for the handicapped."³

"Despite great improvements during the last three decades, the housing situation is far from satisfactory in the European Region. Many rapidly growing cities are marked by overcrowding, by substandard dwellings and sometimes even by shanty towns.... there are still many old dwellings that fail to meet housing hygiene standards. Furthermore, towns and cities are often far from having enough areas for recreation and green space."³

In certain cities, the homeless, although numerically not a very large group, would constitute one of the extremely high risk groups judged by HFA criteria. It is also worth mentioning that in some countries the housing standards of those in residential care, whether these are the responsibility of the health system, the welfare system or the penal system, are woefully below those of the general population.

It is not necessary for the purposes of HFA policy formulation to make a detailed analysis of the housing situation, this is the responsibility of planners in the housing sector. The HFA policy maker must be aware, however, of the general situation concerning housing facilities, overcrowding, home-ownership and the proportion of income spent on housing. Such information is usually available from population and housing censuses, or family budget surveys.

A dwelling is not simply four walls and a roof, but also the environment in which it is situated. Even a broad analysis of the housing situation should, therefore, include information on the accessibility of social, commercial and cultural facilities in residential areas, and particularly of open green spaces. Such information does not appear to be readily available in most countries.

Particular attention needs to be given to the housing situation of vulnerable groups such as children, the aging and the disabled.

2.7.5 Income

An adequate income is frequently the key to many of the prerequisites for health and to some aspects of health promotion. The proportion and characteristics of those living on or below the poverty line, or who are included in the lowest socioeconomic group, and the territorial distribution of such people, needs to be examined.

³*Evaluation of the strategy for health for all by the year 2000.* Seventh report on the world health situation, Vol. 5, European Region. Copenhagen, World Health Organization 1986, p.45.

This also implies an estimation of the adequacy of income support, including disability and retirement pensions and family allowances.

2.7.6 Employment

Employment is important not only for the income it earns, but as a satisfying occupation, and for the social network it provides. Since some kinds of employment can constitute a health hazard, the BFB policy maker also needs to know about the type of occupation in which large groups of the population are engaged.

Recent research has shown the ill-effects that unemployment, particularly long-term unemployment can have on health. Enforced retirement without adequate preparation can also adversely affect health.

Women are the main providers of self-care and informal health care. If their participation in the labour force is not taken into consideration, plans for increased self-care and community involvement, which usually means the involvement of women, could either be unrealistic, or impose an intolerable burden on some women.

In many European countries, the health services are one of the largest employers, and the impact of a reorientation of the health services on local employment, particularly the employment of women, can be quite serious.

As a minimum, therefore, the type of information necessary would include:

- employment by sector of activity;
- unemployment rates by age and sex, and the characteristics of those suffering long-term unemployment;
- participation of women in the labour force;
- institutional constraints to employment (age limits for employment and for training schemes, etc);
- the health sector as a source of employment.

2.7.7 Provisions for physical activity

Health education promoting increased physical activity, will have little effect if the necessary infrastructure to facilitate this is not available.

The minimum information necessary in this respect would be trends in the provision of indoor and outdoor facilities for gymnastics and sports, throughout the general and special education system, in residential care and for the general public, and in the improvement of enabling facilities for walking and cycling (footpaths and cycling paths, car parks to leave vehicles out of city centres, etc.).

CHAPTER 4

HEALTH SITUATION

As mentioned previously, it is important to make not only a situation analysis, but also an institutional analysis. Countries will need, therefore, to refer to epidemiological data and data on health service delivery and utilization, and also to the mechanisms, or lack of them, for reporting on health. Such reporting can influence the political climate and contribute to informed participation in decision-making, both by political leaders and the public.

1. Preparation and presentation of health report

The type of questions that will need to be asked might include the following:

- Is there a recent health report?
- Are regular health reports made, and at what intervals (every year, every two years, every five years, etc.)?
- Is the health report a separate document, or is it incorporated in an HFA policy document, a health plan, or some other document?
- Are the health reports presented by: minister of health, health council, regional/local council, or others?
- Is there any provision for public participation in the preparation of the report?
- Are the health status reports presented for discussion to: central government organ (cabinet, etc.), parliament, other central level organ (health council, etc.) regional or other level authority, professional associations, trade unions, general public and the mass media?

2. Coverage of the health report

The more traditional epidemiological data would cover a number of the indicators which have been proposed as being essential for monitoring and evaluating progress towards achievement of the regional HFA targets. These would include:

- Life expectancy at birth, at 1, 15, 35 and 65 years, by sex.
- Infant mortality, the perinatal and maternal mortality rates.
- Main causes of death (mortality rates from cardiovascular diseases, cancer and accidents).
- Suicide.
- Percentage of newborn with a birth weight of at least 2500 g.

- Percentage of children having a weight for age corresponding to reference values.
- Incidence of main chronic diseases and disability.
- Incidence of the specific diseases which have been targeted for elimination.
- Ratio of abortions to live births.

In addition, an HFA health report would need to cover the situation with regard to the prerequisites for health as outlined above, and as concerns lifestyles and health hazards.

The minimum information necessary would refer to the consumption of tobacco and alcohol, drug abuse, the incidence of homicide and other violent behaviour, and the daily intake of calories, proteins, lipids and carbohydrates.

Both with regard to the above information and with regard to information on service utilization, which is referred to below, it is vital to ascertain whether or not this reflects possible inequities due to sex, age, financial status, occupation or area of residence.

With regard to the provision and utilization of health services, the minimum information needed here would be:

- the percentage of gross national product (GNP) allocated to health services; per capita expenditure on health;
- the type of system (national health service, mixed, private, etc.); and the mixture of public/private financing, showing where financial resources come from and how they are distributed;
- responsibility for planning and delivery (central, local, municipal, etc.);
- provision of health care by geographic region, showing the PHC/hospital care mix;
- provision of residential care and support services for the chronically sick, handicapped and aging;
- remuneration for PHC physicians (whether they are mainly salaried, paid by fee-for-service, per capita, etc.);
- utilization of services.

CHAPTER 5

MECHANISMS FOR HEALTH POLICY-MAKING AND PLANNING

1. Health policy formulation

Naturally, responsibility for national health policy formulation lies with the government. The government may, however, be assisted in the formulation of health policy by the ministry of health, health councils, a comprehensive central planning unit, ad hoc committees, subnational organs, etc.

An organizational chart of the Ministry of Health (or a corresponding body) can be helpful, since the place of departments in such charts can to some extent shape their activities,¹ and their role in policy-making and planning. The place of PHC and of health promotion in such charts would be of interest.

If the government is assisted by a health council, an ad hoc committee, or other advisory bodies the sectors or agencies/services represented on the council or committee should be stated, in order to assess whether these bodies are multisectoral and multidisciplinary, and perhaps even inter-party.

The mechanisms for ensuring an input from subnational level needs to be referred to, since a policy imposed from above will have less chance of success than one which has been discussed and at least partially agreed up to the local level.

It will also be necessary to refer to the formal channels of and enabling mechanisms for participation of the suppliers of health services, (professional associations, insurance funds, private voluntary or entrepreneurial organizations, where this is relevant), the users of health services (special interest groups, patients and their families) and the general public.

The data base necessary for informed policy formulation also needs to be referred to. Are social, epidemiological data, health service provision and utilization data readily available and analysed by region, small areas, age, sex, socioeconomic group, occupation, and insurance coverage, if this is relevant?. Is health research geared to the needs of HFA policy formulation?

¹ *Strengthening Ministries of Health For Primary Care.* WHO, Offset Publication No. 82, Geneva, 1984, p.49.

2. Health planning

If a policy is not to remain simply a statement of wishful thinking, or even window-dressing for domestic or international consumption, it must at some point be translated into specific action.

Again, it is not always essential to have an HFA plan document. An HFA policy may be translated into specific action through ministerial directives or the promotion of acts of parliament, for example, without an actual planning document.

The existence of a planning document, however, can be extremely useful as an instrument for policy implementation. It is in such a document that responsibilities for action could be designated, as this is often one of the crucial points for achieving action, provisions for multisectoral collaboration be made, financial and manpower resources be allocated, and specific legislature for institutional changes be outlined.

A health plan could be incorporated in the same text as a policy document. It might be a separate sectoral planning document, part of an overall comprehensive socioeconomic plan (i.e. a chapter in a five-year development plan), or a separate document coordinated with an overall plan. The incorporation of a health plan in a socioeconomic development plan, if it is really integrated, would be important for multisectoral planning.

It would be important to know, therefore, whether there is an HFA planning document, what period it covers, and at what level (national or subnational) it is prepared.

What is of vital importance is that a plan should not be couched in the general and sometimes vague terms of a policy document, but that it should make specific provisions for action.

Many years ago Waterston^a suggested that one of the main obstacles to the implementation of development plans is the lack of the necessary institutional structure. It is important to ask whether the health plan makes specific provisions for implementation through:

- designation of responsibility (who should do what);
- securement of financing;
- manpower resources;
- legal or institutional changes.

Reference should also be made to specific provision for assessment of the progress of plan implementation, and for evaluation of the plan in relation to the results achieved.

^a Waterston, Albert *What do we know about planning?* *International Development Review* Vol. VII, p.4 December 1965

As mentioned above, health policy is not always implemented through a "plan". It must, however, go through a planning phase, in whatever way this is manifested.

It is at this stage that policy objectives need to be translated into planning targets. With the setting of targets, a time horizon is given to the goals and objectives, and in as far as this is possible, they are quantified.

The setting of quantified targets is particularly important in that in this way policies are translated into the practical realities of the conflicting demands of all sectors of society for limited resources. Possible constraints and impracticalities can then be highlighted.

Quantified targets corresponding to all the objectives of a policy are not easy to set, and their absence does not therefore necessarily indicate a lack of political will, nor does the existence of a quantified target indicate priority. In some cases it may be technically easier to set quantified targets for issues which are of lesser importance. On the other hand, quantified targets are sometimes avoided in planning documents, particularly when prevailing conditions and trends are so uncertain as to cast some doubt as to the feasibility of target achievement. Where plans are legally binding, failure to achieve quantified targets would need to be accounted for. Care needs to be exercised, therefore, in examining a plan document for the existence or non-existence of quantified targets.

CHAPTER 6

ANALYSIS OF (HFA) POLICY DOCUMENT

1. Document to be analysed

A clear description must first be given of the document to be analysed, including its title, whether or not it is published or is in a prepublication form, preliminary or final draft, etc. It should also be stated, whether or not the document used is the original official document, a direct translation, a summary, or popular version of it.

The question should also be asked whether the policy document has been discussed and/or approved at cabinet level, in parliament, by regional/local authorities, etc. It should also be determined whether the document has been circulated for general, rather than formal discussion.

2. Essential elements of a HFA policy

The only acceptable basis for assessing whether or not a health policy is indeed a HFA policy, would be on the basis of the criteria outlined in the relevant WHO documentation. The country documents to be analysed should, therefore, be examined with reference to these criteria, to ascertain whether or not they are in keeping with the HFA philosophy and principles as outlined in the regional strategy and targets.

The essence of an HFA policy should be expressed in terms of the following criteria being fulfilled.^a

- Does the policy have a long-term strategic perspective?
- Is it health oriented and comprehensive in the sense of going beyond the provision of health services and covering all the major approaches entailed in the regional strategy and targets, i.e. lifestyles, environment, healthy public policies and reorientation of services?
- Does it address the relevant equity issues in the country?
- Is there a comprehensive and balanced system of health services, with due attention to the importance of primary health care?
- Are health promotion and disease prevention given clear priority?
- Does it identify where intersectoral action is required?
- Does it acknowledge the need for and promote community participation in decision-making at all political and administrative levels, and community involvement?
- Does it recognise the need for and promote international cooperation?

^a Report on consultation for national HFA policy development. Copenhagen, 8-9 September 1986 (draft 4277d)

In addition, as an assurance of the real political will to implement the policy, the following criteria should also be met:

- The instruments for policy implementation should either be in place or provided for (i.e. necessary legal and organizational framework, managerial and manpower resources, political and other influence networks).
- There should be a built-in monitoring and evaluation process to compare the baseline situation with progress towards HFA objectives.

Obviously the answers to all these questions may not always be clear cut, and a certain amount of judgement must be used. They do, however, constitute a useful checklist.

3. Specific strategies

A policy can direct attention toward a problem, but it cannot solve the problem. A policy which is intended to result in action, therefore, needs a strategy for its implementation.

The country policy document needs to be examined to ascertain whether or not specific strategies are outlined, covering in some measure all the essential components of an HFA policy. Naturally, the emphasis given to different issues will differ between countries, depending on the problems they are facing.

To obtain a clearer idea of the provisions of the policy document, and how far it can be considered an HFA document, the following checklist is suggested.

Specific strategies designed to deal with the problems of:

- Equity;
- Health promotion and disease prevention; through strategies designed to promote and enhance behaviour which is positive for health and to alter behaviour which is negative for health, including issues of:
 - nutrition
 - tobacco
 - alcohol and drug abuse
 - accidents
 - physical activity
 - personal relationships
- Environmental issues, including:
 - safe water and sanitation
 - air pollution
 - water pollution
 - noise pollution
 - home environment
 - work environment
 - leisure environment
 - educational environment

- Participation and involvement
- Multisectoral collaboration
- Reorientation of health services ensuring an appropriate balance between efficiency, financial resources, quality of services, appropriate technology, management and research, with due attention to the vital role of primary health care
- International cooperation

A note of warning needs to be sounded here, in that some short-term strategies which do not appear to fall into the HFA framework, may in fact be small, incremental steps towards a long-term HFA objective. Sometimes small steps or even what appear to be diagonal steps, may be appropriate until the time and conditions are right for larger and more direct steps.

4. Provisions for implementation

What are the main instruments designed, or already in place, for policy implementation, and do these include:

- broad public discussion;
- designation of responsibilities (i.e. Ministry of Health, other central organs, multisectoral organ, local authorities, etc.) and is provision made to equip them for their designated tasks?;
- preparation of HFA plan at national level and/or subnational level;
- manpower preparation and motivation (planning, administrative and health manpower);
- securement of financing;
- manpower planning for the health sector;
- legal or institutional changes;
- appropriate technology.

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5. Specific provisions for monitoring and evaluation

The existence or not of specific provisions for monitoring and evaluation is quite a good indicator of the seriousness of purpose behind the document.

Provision for monitoring and evaluation might be made specifically for the HFA policy document, or might be covered by general planning legislation.

Such provisions would include designation of responsibility for monitoring and evaluation, the progress of implementation according to a specific time-schedule, and for evaluating implementation in terms of the achievement of HFA objectives. Relevant provisions would also include the development of an information system and the necessary indicators for evaluation, research into outcomes and effects of policies, and provision for community participation in evaluation.

6. Summary and conclusions

A brief summary indicating the main priorities, any unusual or innovative features, and possible weak points or underemphasised aspects would give a valuable bird's-eye-view of country situations with regard to HFA policy implementation. This should also include reference to the main gaps in the information base.

Already from the country analyses which have been carried out using this framework, it appears that WHO/EURO and possibly country health sectors themselves, do not have an adequate data base concerning the prerequisites for health. Information is also sparse regarding the political situation in which HFA policies are formulated, the main actors in the process, and the reaction of public administrators, important interest groups, and the general public to the policy outlined.

Bibliography

A checklist of action in support of HFA. Nottingham Health Strategy Group, Nottingham University, September 1987.

Checkoway, Barry (ed.). *Citizens and health care. Participation and planning for social change.* Pergamon Press, N.Y., Oxford, Toronto, 1981.

Cooke, B.R.B. et al (eds.). *Health for all by the year 2000.* Proceedings of two conferences organized by the Faculty of Community Medicine, June 1984, February 1985, Department of Epidemiology and Community Medicine, University of Wales, College of Medicine, Cardiff, 1985.

Demographic trends in the European Region. WHO Regional Publications, European Series No.17, Copenhagen.

Development of indicators for monitoring progress towards health for all by the year 2000. World Health Organization, Geneva, 1981.

Dignan, Mark B. & Carr, Patricia A. *Introduction to program planning: a basic text for community health education.* Lea and Febiger, Philadelphia, 1981.

Eight general programme of work (covering the period 1990-1995 inclusive). Fortieth World Health Assembly, Provisional agenda item 19. WHO A40/6, 12 March 1987.

Elmore, Richard F. "Backward mapping: implementation research and policy decisions". *Political Science Quarterly*, vol.94, No.4, Winter 1979-80.

Evaluation of the strategy for HFA by the year 2000, vol.5. European Region, World Health Organization, Copenhagen, 1986.

Flahault, D. & Roemer, M.I. *Leadership for primary health care.* World Health Organization, 1986.

Formulating strategies for health for all by the year 2000. World Health Organization, Geneva, 1979.

Fry, John & Hasler, John C. *Primary health care 2000.* Churchill Livingstone, Edinburgh, London, Melbourne, N.Y., 1986.

Global strategy for health for all by the year 2000.

Glossary of terms used in HFA series No.1-8. World Health Organization, Geneva, 1984.

Hagman, Erik & Rehnström, Thomas. "Priorities in primary health care - views of patients, politicians and health care professionals". *Scandinavian Journal of Primary Health Care*, No. 3, 1985.

Health programme evaluation, guiding principles. World Health Organization, Geneva, 1981.

Health Services in Europe, vol.2. Country reviews and statistics. World Health Organization, Copenhagen, 1981.

HFA2000 charter for action. Faculty of Community Medicine, London, 1986.

Heidenheimer, Arnold J. *Politics, Policy and Policity as concepts in English and Continental Languages: An attempt to explain divergences*

Hunter, David. "Planning in an age uncertainty". *Health and Social Service Journal*, 25 August 1983.

Hunter, David J. & Wistow, Gerald. *Community care in Britain: variations on a theme.* King Edward's Hospital Fund for London, 1987.

Kleczkowski, B.M. et al. *National health systems and their reorientation towards health for all.* Public health papers No. 77, World Health Organization, Geneva, 1984.

Kleczkowski, B.M. et al. *Health system support for primary health care.* World Health Organization, 1984.

Managerial process for national health development. World Health Organization, Geneva, 1981.

Maxwell, Robert & Wearer, Nigel (eds.). *Public participation in health.* King Edward's Hospital Fund for London, 1984.

McLachlan, Gordon & Maynard, Alan (eds.) *The public/private mix for health.* The Nuffield Provincial Hospitals Trust, 1982.

Nutt, Paul C. *Planning methods for health and related organizations.* John Wiley and Sons, N.Y., Chichester, Brisbane, Toronto, Singapore, 1984.

Patterns of community participation in primary health care (compiled by Hannu Vuori & John Hastings). World Health Organization, mimeograph, ICP/PHC 301/s01.

Primary health care. Report of the International Conference, Alma Ata, 6-12 September 1978, World Health Organization, Geneva, 1978.

Regional strategy for attaining health for all by the year 2000. World Health Organisation, EUR/RC30/8 Rev.2.

Revision of the regional indicators and plan of action for the implementation of the regional strategy for attaining health for all by the year 2000, EUR/RC36/10, 16 June 1986.

Roemer, Milton I. *National strategies for health care organization - a world overview.* Health Administration Press, Ann Arbor, Michigan, 1985.

Shortell, Stephen M. & Kaluzny, Arnold D. *Health care management.* John Wiley and Sons, N.Y., Chichester, Brisbane, Toronto, Singapore, 1983.

Strengthening Ministries of Health for primary health care. World Health Organization, Geneva, 1984.

Targets for health for all. World Health Organization, Copenhagen, 1985.

The 1990 Health objectives for the nation - a midcourse review. Public Health Service, U.S. Department of Health and Human Services, November 1986.

EUR/HPP/87.2

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Thompson, D.J.C. *The systems model of decision-making as a useful conceptual framework for considering policy-making in the NHS.* University of Birmingham, Health Services Management Centre, Birmingham, 1975 (mimeograph).

Townsend, P. "Trends in inequalities in health; the need to develop a theory" in Lagergren, M. (ed). *Hälsa för alla i Norden år 2000.* Report of a conference, 7-10 September 1982, published 1983.

Waterston, Albert *What do we know about planning ? International Development Review* Vol VII, p.4, December 1965