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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО



TARGETS FOR HEALTH FOR ALL:

IMPLICATIONS FOR NURSING/MIDWIFERY

*For many nursing care
Midwifery*

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Targets 4 and 5 are to add health to life by reducing disease and disability and by eliminating some diseases (indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis and indigenous malaria).

The last seven targets in this group require action to add years to life. Life expectancy at birth should be raised to 75 years (Target 6). The rate of infant mortality in the Region should be less than 20 deaths per 1000 live births and maternal mortality should be less than 15 per 100 000 live births (Targets 7 and 8). Numbers of deaths from circulatory disease, cancer and accidents, the three main killers in the Region, should be reduced (Targets 9-11), and the current increase in suicide and suicide attempts should be reversed (Target 12).

II. CHANGES NECESSARY FOR HEALTH FOR ALL

Targets 13-31

These targets cover the changes in lifestyles, the environment and health care necessary to achieve the fundamental requirements for health. The completion dates for almost all these targets are 1990 or 1995. Although nurses and midwives will continue to be most closely involved in the targets on appropriate care, they should also help promote lifestyles conducive to health and a healthy environment, thus expanding their caring role.

Lifestyles Conducive to Health (Targets 13-17)

Because lifestyle is closely connected with health, promoting healthy lifestyles is essential to Health for All. The starting point is to recognize that people's health depends to a considerable extent on their political, economic, social and physical environments, which can limit their ability to choose healthy ways to live. Public and corporate policies also influence lifestyles considerably. Thus, these five targets concern essential parts of a strategy to promote healthy lifestyles and suggest policies to make them easier for everyone to attain.

The first three targets in this group aim to give opportunities and strengthen people's capacities for healthy lifestyles through national policies (Target 13), support programmes for families and social groups (Target 14) and programmes for health education (Target 15). Nurses and midwives can do important work in both kinds of programmes and lobby in support of Target 13.

Further, people can actively maintain their health, and Member States should promote positive health behaviour (Target 16) and discourage health-damaging behaviour (Target 17). Because of the social and environmental influences on lifestyle, Targets 16 and 17 require action from all of the five groups responsible for Health for All. These targets aim to change behaviour, but behaviour will change only when the people first change their minds and adopt a positive concept of health as something they can build and maintain. Neither nurses nor midwives can order people to change, but by discussing the issues and supplying people with information, they can help the people choose health for themselves.

Healthy Environment (Targets 18-23)

The environment powerfully affects health, and the next group of targets concerns protecting people from health risks in the environment (Targets 18-23) and improving the places where people live and work (Targets 24 and 25), not only to safeguard people from risks but also to promote their health by improving the quality of life.

Nurses and midwives can make a vital contribution in the community towards a healthy environment, through achieving the goals of Targets 24 and 25. Public health nurses, occupational health nurses and some midwives already work in the community, and more nursing professionals, as givers of primary health care, will do so. Although most of the action for a healthy environment will come from other sectors, nurses and midwives, along with other health professionals, should have an important role.

Health professionals must develop the skills to assess and report environmental risks to health. By talking with people, learning about their problems and advising them on environmental health hazards and what they can do to solve them, nurses and midwives can (and should) be an important channel of communication. Their contribution should include education about risks in the home and workplace and about ways to improve homes and workplaces to promote health.

of work that nurses and midwives do will change. Nurses would be especially valuable in providing home care and rehabilitative care that would allow people (particularly the elderly and disabled) to remain or recover in their own homes. Midwives should expand their role well beyond the traditionally recognized boundaries to include family health, family planning, counselling and sexual health. Nurses and midwives should also contribute to the debate on the quality of services and the appropriate use of technology (see Targets 31 and 38).

Nurses should work also in multidisciplinary research to evaluate health care delivery. Appropriate care means integrated services, and nurses and midwives should help link all levels of care and all the people involved. Again, they would be communication channels, relaying information from users of health services along with their own experiences and helping to plan services and spot problems in the system.

The active participation of people in their own care is essential. Nurses and midwives could do vital work in promoting people's self-determination. They should not merely work for the people, but also with them, helping people to help themselves.

Providers of primary health care

Who will provide primary health care, and how will the providers work together? Primary health care systems should be based on cooperation and teamwork among health professionals, individuals, families and community groups (Target 29).

The people should help provide primary health care; already they provide care for many minor ailments and some major conditions. All health professionals should recognize the value of such care and listen to patients' views about their needs. Nurses and midwives should research the validity of such unofficial forms of care. The goal is to attack health problems with the powerful combination of professional skills and the self-help efforts of individuals, families and community groups.

As well as teamwork with the public, cooperation among health professionals is essential. All health professionals should be open and prepared to change their attitudes, their working methods, and therefore their training. The basic and continuing education of nurses and midwives should train them to be partners, not subordinates, in the health care team. Also physicians' education, planned with the help of senior personnel from disciplines such as nursing and sociology, should include practical training in teamwork and primary health care techniques.

Particularly important to the expanded role of nurses in working with people and with other health professionals, are research and training (see Targets 32 and 36) to determine what health professionals and health services can and should do. Health professionals should also broaden their view from a focus on the individual health problem to see the whole person in a social, economic and physical environment that promotes or threatens health.

Community resources for primary health care

Community resources in sectors other than health should be organized to work for Health for All. Because health is everybody's business, well-integrated, community-based programmes that combine all aspects of primary health care should be set up in every community (Target 30). All sectors should include health concerns in their planning, and health professionals could do valuable work in assessing economic and environmental problems for health and advocating the needs of the population and its most vulnerable members to planners and decision-makers.

Quality of care

The final part of appropriate care is quality assurance. All Member States should establish ways to ensure the quality of patient care (Target 31). Nurses and midwives should participate in evaluation of care and all health professionals should make such evaluations part of their regular work. Again, a broader view is needed. The effectiveness, safety, efficiency and adequacy of care, along with its acceptability to patients and the community, should be at least as important as the amount and sophistication of equipment and drugs used.

Nurses and midwives need to involve patients in decisions about their care and help them make informed choices by supplying them with necessary information: this is one way of providing better quality, more humanized care. The criteria for high-quality care have not been fully developed. Will nurses and midwives wait to be handed standards of practice from another discipline or will they develop and apply their own?

TARGETS FOR HEALTH FOR ALL:
IMPLICATIONS FOR NURSING/MIDWIFERY

INTRODUCTION

Why should you care about the World Health Organization's goal of Health for All by the Year 2000? What can the 38 Regional Targets for Health for All* mean to nurses and midwives?

The targets are a chance for them to achieve their traditional aims in new, more independent ways, in close reciprocal cooperation with the other health professionals and groups involved in health, and to shape their own future through working for Health for All. Every part of their professional lives will change, beginning with the definition of health.

Health, according to the Constitution of the World Health Organization (WHO), is "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity," and it is "one of the fundamental rights of every human being."

WHO has adopted the goal of "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." Primary health care, with participation by the people, is the key to this goal.

In meetings of the Regional Committee for Europe, the Member States of the European Region of WHO adopted Health for All as their first common health policy, and they endorsed 38 Regional Targets that describe the minimum progress that they must make in improving health and solving problems related to health. The Member States have also agreed to monitor and report regularly to the Regional Committee on their progress.

Several prerequisites are necessary to health for all. Without peace, social justice, enough food and safe water, adequate education, decent housing and a useful role in society and an adequate income for every person, there can be no health for the people, no real growth and no social development. The targets address almost all of these needs. They were adopted because, despite all the money spent and progress made in health, people in Europe are not as healthy as they could be. Also, despite the generally high level of development in the Region, grave inequalities in health still exist. For example, countries at the extremes have a 20-year difference in life expectancy, and rates of infant mortality in the Region range from less than 7 to more than 100 per 1000 live births.

The targets show the improvements that could be expected if all the will, knowledge, resources and technology already available were pooled in the pursuit of a common aim. They should aid the Member States to set their own priorities and goals.

Six themes of the targets

Six major themes run throughout the targets. First, Health for All implies equity, so the present inequalities in health between countries and within countries should be reduced as far as possible.

When people are healthy, they are able to mobilize their physical, mental and emotional capabilities and in this sense, they are able to promote their own health. Emphasis in health care must be on the promotion of health and the prevention of disease.

The people themselves will achieve Health for All. A well informed, well motivated and actively participating community is essential to the attainment of the common goal.

Because the health authorities can deal with only part of the problems to be solved, multisectoral cooperation, involving all sectors of government and society concerned, is the only way of ensuring the prerequisites for health, promoting healthy policies and reducing the risks in the physical, economic and social environments.

*see Annex I

The focus of the health care system should be on primary health care: meeting the basic needs of each community through services provided as close as possible to where people live and work, readily accessible and acceptable to all, and at an affordable cost.

Lastly, some health problems transcend national frontiers; pollution and trade in health-damaging products are obvious examples of problems whose solution requires international cooperation.

Who contributes to Health for All?

The success of the Health for All movement depends on the strong support of five different but overlapping groups of people, each with its own special responsibilities.

First, the people have rights and responsibilities for Health for All. The movement is for their benefit, but it will be a success only with their help and by their participation. Next, the ministries of health and health authorities at all levels in the Member States have the heaviest responsibilities for the action needed to attain Health for All. Sectors other than health, including nongovernmental organizations, must recognize the effects of their activities on health and try to attain their goals in ways that benefit health. Further, United Nations agencies (especially WHO) and other international organizations are responsible for ensuring cooperation among countries on problems that cross national borders. Health professionals, with their expert knowledge and influence with politicians and the general public, can be an important force in mobilizing support and initiating change. Nurses and midwives will be most concerned with the responsibilities of this final group.

Collectively, health professionals should broaden the traditional framework of health problems to include the psychological, social, economic and environmental determinants of health. They should work more closely with professionals in the fields concerned, and stress the importance of acting on these factors if health is to be improved. They should also publicize them to the people, the politicians and the health authorities. Individually, all health personnel should give higher priority to health promotion, disease prevention, care and rehabilitation. They should try to take a more holistic view of health problems by searching for the potential sources and solutions to many individual health problems in the family and the community.

The quality of health care also depends on health professionals. All health professionals should plan and carry out research to produce a deeper understanding of health problems and to find more effective ways of solving them. This contribution is vital to health for all.

Organization of the targets

The 38 targets fall into three related groups, according to their subjects and dates for completion. These dates reflect the logical order of events necessary to reach Health for All by the Year 2000. Like the stone blocks of a pyramid, each target fits precisely with the others around it, and the highest are the last to be put in place.

The targets do not legally bind any Member State; rather, they are designed to stimulate the governments, professional groups and general public in each country to create the policies and programmes for Health for All that are best for them.

I. HEALTH FOR ALL IN EUROPE BY THE YEAR 2000

Targets 1-12

The first 12 targets describe the fundamental requirements for people to be healthy, which the work of nurses and midwives can help to achieve. Their completion date is the year 2000. First, equity in health must be ensured by reducing the differences in health status between the sexes, social and economic groups and countries (Target 1). The other necessity is to strengthen health; this can be done in three ways.

First, Targets 2 and 3 aim to add life to years by ensuring the full development and use of each person's physical and mental capacities to benefit from and cope with life in healthy ways. Chances for the elderly, the disadvantaged and the physically and mentally disabled to lead socially and economically fulfilling lives are particularly important.

With information from the people and their own assessments, these professionals could point out environmental health problems to the sector of government or society that could solve them, incidentally promoting multisectoral cooperation. The health sector as a whole should also be more involved in community planning. Nurses and midwives, together with other health professionals, should learn more about the effects of the environment on health. They should help set criteria for indoor air quality and standards for health aspects of housing such as hygiene, safety, space, lighting and insulation. They should also advocate to designers the special needs of the elderly and the disabled, as well as the need for homes that foster social interaction and harmonious family life.

Appropriate Care (Targets 26-31)

Despite the impressive progress of recent decades, the health of the people of Europe has not improved as rapidly as might have been expected, probably because of the relative speed of the development of different parts of the health care system and the resulting imbalance, in favour of the hospital, among the different types of care provided. Further, the success of the health care system has created increased demands for support facilities for the disabled, for rehabilitation and continuous care in homes and communities and for terminal care.

What must be done about new health problems, changing expectations, developing capabilities both within and outside the health sector and limited resources? Primary health care is a good answer.

The philosophy of Health for All calls for a reorganization of the health care system. This means a system based on primary health care, with greater emphasis on integration and coordination at all levels, multisectoral work in health promotion, prevention, rehabilitation and care; and formal recognition of the greater role that individuals, families and communities can and should be able to play in health. For nurses and midwives it means great changes and great chances. Primary health care systems will widen the content and locations of these professionals' work, their relations with patients and other health professionals and their ideas and definitions of themselves.

The six targets on appropriate care describe the policies, resources and essential parts of a primary health care system, along with the need to ensure the quality of care. All should be completed by 1990.

Policies and resources for primary health care

First, all Member States should develop health care systems based on primary health care, supported by secondary and tertiary care when necessary (Target 26). Each country should have a national plan, with the help of the community and health professionals, to make primary health care a reality in every community. Primary care would thus replace secondary or hospital care as the focus of the health care system. In making these plans, Member States should have the understanding, support and advice of all health professionals. The starting point should be strong support from authorities at all levels and a reorientation of health professionals' education to fit them to work in primary health care.

If primary health care is to be more than a policy, health care resources must be carefully redistributed, gradually shifted away from the hospital to primary health care. Resources of all kinds (equipment, money and people) should be distributed according to need, to provide services that are accessible and acceptable to all (Target 27). Existing resources should be used in a new, more efficient way to provide primary, secondary and tertiary services in a regionalized system in which individual units with clearly defined roles serve well-defined populations. Thus the recent trends for nurses and midwives should be reversed; they should move out of hospitals to work in health centres in the community, or in homes, schools and workplaces themselves. They should also review their roles and functions, whether they work in primary health care teams or alone.

Content of primary health care

The next three targets concern essential characteristics of a primary health care system. Most preventive and many diagnostic, therapeutic and support services can be offered outside hospitals. All primary health care systems should provide a wide range of health-promotive, curative, rehabilitative and support services to meet the needs of the population and give special attention to the needs of high-risk, vulnerable and underserved people and groups (Target 28). Adequate numbers of nurses and midwives are needed to provide all these kinds of care; thus, also the type

III. SUPPORT FOR HEALTH DEVELOPMENT

Targets 32-38

The last seven targets concern the kinds of support needed to achieve healthy lifestyles, a healthy environment and appropriate care. All should be completed before 1990.

Target 32 concerns the need for research to support Health for All. Nurses and midwives should do research to provide such support and benefit their professions. Research has already been mentioned as an important part of Targets 24 and 25 (healthy homes and workplaces) and Target 28 (the content of primary health care). Knowledge to support Health for All is needed in six areas:

- descriptions of the health of the population;
- biological factors that determine health;
- effects of lifestyle on health;
- effects of the environment (and the prerequisites for health) on health;
- ways to give appropriate care; and
- improvements in policy-making, planning and management for Health for All.

Because of their work in the community, nurses and midwives are well placed to conduct much of this research. They also have a wealth of professional knowledge and expertise to contribute. Research is not just wise but essential if nurses and midwives are to develop their professional identities and specific contributions to reaching Health for All. Higher education will be needed to give them the necessary research skills. In this connection, the challenges of time, money and negative bias will have to be addressed.

Target 33 discusses the necessity for national Health for All policies in each Member State, backed up by laws and regulations. Each country also should have managerial processes for Health for All, involving communities and other sectors and allocating sufficient resources for health development (Target 34). Health information systems that support national strategies for Health for All are necessary too (Target 35). Nurses and midwives should do more than carry out health strategies; they should also work in planning them. This has already been done in some countries through collaborative programmes with the Nursing Unit of the WHO Regional Office for Europe.

The increased roles of nursing personnel in Health for All require a new outlook and new skills, along with the use of traditional skills in new settings. Education is a key to appropriate care and the future for nurses and midwives. Target 36 concerns the planning, training and use of personnel in accordance with Health for All policies and with emphasis on primary health care. All health professionals should have training in teamwork, communication and primary health care techniques, but nurses and midwives should also develop new skills in assessment, planning, decision-making, research and epidemiology.

Nurses and midwives should adopt a broader definition of health and recognize the benefits and opportunities in Health for All and primary health care. Then they should be trained in the skills they will need as partners in the Health for All movement. The choice must be available for those nurses who wish to seek higher education in nursing at the university level. Any discipline must create its cadre of leaders, researchers, administrators and practitioners. This is also true for nursing and midwifery. Both nurses and midwives, who are struggling to maintain their traditional autonomy, should have training that fosters the independence they will need in the future. This training should be supported by appropriate legislation so they can practise what they learn.

Target 37 concerns education for people working in sectors relevant to health to win their support and work for Health for All. Just as they should foster teamwork among health professionals by being involved in planning physicians' training, nursing professionals should promote multisectoral cooperation through involvement in the education of people in other sectors.

The last of the Regional Targets for Health for All concerns the appropriate use of technology (Target 38). Member States should establish ways systematically to assess health technology. Effectiveness, safety, efficiency and acceptability should be assessed and national policies and economic constraints considered. This target is closely related to Target 31 (the quality of care)

because providing the best care does not necessarily mean using complex machines. Some nursing personnel are already involved in testing and evaluating technology in hospitals, but they should also help determine the appropriate use of technology in primary health care. Nurses and midwives should help assess needs for equipment in the home to avoid merely moving the hospital into the home.

CONCLUSION

The Regional policy of Health for All and clear targets for attaining it can create a valuable legacy for the future. The European Region has the people, the knowledge and the resources necessary to reach the targets that have been set: the greatest need now is the will to use these assets more effectively to solve health problems.

Today the future of nursing and midwifery is uncertain. However, the Regional strategy and targets for Health for All offer nurses and midwives a chance to shape an exciting destiny for themselves through work for Health for All. What will they choose to do?

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Target 7 BY THE YEAR 2000, INFANT MORTALITY IN THE REGION SHOULD BE LESS THAN 20 PER 1000 LIVE BIRTHS.

This target could be achieved: if, by the year 2000, no country or group within a country has an infant mortality rate of more than 40 per 1000 live births; if countries with a rate below this level in 1980 have a rate below 15 per 1000; if all countries attempt to reduce significantly the difference between geographical areas and socioeconomic groups.

Target 8 BY THE YEAR 2000, MATERNAL MORTALITY IN THE REGION SHOULD BE LESS THAN 15 PER 100 000 LIVE BIRTHS.

This target could be achieved: if, by the year 2000, no country or group within a country has a maternal mortality rate of more than 25 per 100 000 live births; if countries with a rate already below 25 in 1980 have a rate below 10; if all countries have reduced significant differences between geographical areas and socioeconomic groups.

Target 9 BY THE YEAR 2000, MORTALITY IN THE REGION FROM DISEASES OF THE CIRCULATORY SYSTEM IN PEOPLE UNDER 65 SHOULD BE REDUCED BY AT LEAST 15%.

This target could be achieved by a combination of preventive and treatment methods that would reverse the trend in countries where ischaemic heart disease mortality is increasing or stable and accelerate it in countries where the mortality is decreasing, thereby contributing to the current decline in cerebrovascular mortality in all countries.

Target 10 BY THE YEAR 2000, MORTALITY IN THE REGION FROM CANCER IN PEOPLE UNDER 65 SHOULD BE REDUCED BY AT LEAST 15%.

This target could be achieved: if tobacco-related cancers are reduced as a result of a major decrease in smoking and cervical cancer following the establishment of screening programmes; if current methods in early diagnosis, treatment and rehabilitation are applied in an appropriate way to all cancer patients.

Target 11 BY THE YEAR 2000, DEATHS FROM ACCIDENTS IN THE REGION SHOULD BE REDUCED BY AT LEAST 25% THROUGH AN INTENSIFIED EFFORT TO REDUCE TRAFFIC, HOME AND OCCUPATIONAL ACCIDENTS.

This target could be achieved: if, by the year 2000, no country has a mortality rate from road traffic accidents of more than 20 per 100 000; if countries below that level reduce it to less than 15; if all countries reduce the differences between the sexes, age and socioeconomic groups; furthermore, if the occupational accident mortality in the Region is lowered by at least 50%; if the mortality from home accidents is significantly reduced.

Target 12 BY THE YEAR 2000, THE CURRENT RISING TRENDS IN SUICIDES AND ATTEMPTED SUICIDES IN THE REGION SHOULD BE REVERSED.

This target could be achieved: if improvements are made with regard to societal factors putting a strain on the individual, such as unemployment and social isolation; if the individual's ability to cope with life events is strengthened by education and social support; if the health and social service personnel are better trained to deal with persons at high risk.

Target 13 BY 1990, NATIONAL POLICIES IN ALL MEMBER STATES SHOULD ENSURE THAT LEGISLATIVE, ADMINISTRATIVE AND ECONOMIC MECHANISMS PROVIDE BROAD INTERSECTORAL SUPPORT AND RESOURCES FOR THE PROMOTION OF HEALTHY LIFESTYLES AND ENSURE EFFECTIVE PARTICIPATION OF THE PEOPLE AT ALL LEVELS OF SUCH POLICY-MAKING.

The attainment of this target could be significantly supported by strategic health planning at cabinet level, to cover broad intersectoral issues that affect lifestyle and health, the periodic assessment of existing policies in their relationship to health, and the establishment of effective machinery for public involvement in policy planning and development.

Target 14 BY 1990, ALL MEMBER STATES SHOULD HAVE SPECIFIC PROGRAMMES WHICH ENHANCE THE MAJOR ROLES OF THE FAMILY AND OTHER SOCIAL GROUPS IN DEVELOPING AND SUPPORTING HEALTHY LIFESTYLES.

The attainment of this target could be significantly supported by establishing close intersectoral links between health and social welfare programmes, primarily in the localities, and by securing funds for projects that enhance joint community action.

Target 15 BY 1990, EDUCATIONAL PROGRAMMES IN ALL MEMBER STATES SHOULD ENHANCE THE KNOWLEDGE, MOTIVATION AND SKILLS OF PEOPLE TO ACQUIRE AND MAINTAIN HEALTH.

The attainment of this target could be significantly supported by ensuring an adequate and effective infrastructure and funding for health education programmes at all levels.

Target 16 BY 1995, IN ALL MEMBER STATES, THERE SHOULD BE SIGNIFICANT INCREASES IN POSITIVE HEALTH BEHAVIOUR, SUCH AS BALANCED NUTRITION, NONSMOKING, APPROPRIATE PHYSICAL ACTIVITY AND GOOD STRESS MANAGEMENT.

This could be achieved if clear targets in these areas are set in each Member State, e.g. a minimum of 80% of the population as nonsmokers and a 50% reduction in national tobacco consumption - and if steps were taken by WHO and other international organizations to promote cooperation in health promotion activities throughout the Region in order to make a wider impact on basic health values.

Target 17 BY 1995, IN ALL MEMBER STATES, THERE SHOULD BE SIGNIFICANT DECREASES IN HEALTH-DAMAGING BEHAVIOUR, SUCH AS OVERUSE OF ALCOHOL AND PHARMACEUTICAL PRODUCTS; USE OF ILLICIT DRUGS; AND DANGEROUS CHEMICAL SUBSTANCES, DANGEROUS DRIVING AND VIOLENT SOCIAL BEHAVIOUR.

The attainment of this target could be significantly supported by developing integrated programmes aimed at reducing the consumption of alcohol and other harmful substances by at least 25% by the year 2000.

Target 18 BY 1990, MEMBER STATES SHOULD HAVE MULTISECTORAL POLICIES THAT EFFECTIVELY PROTECT THE HUMAN ENVIRONMENT FROM HEALTH HAZARDS, ENSURE COMMUNITY AWARENESS AND INVOLVEMENT, AND EFFECTIVELY SUPPORT INTERNATIONAL EFFORTS TO CURB SUCH HAZARDS AFFECTING MORE THAN ONE COUNTRY.

The achievement of this target will require: the acceptance by all governments that well-coordinated multisectoral efforts are needed at central, regional and local levels, to ensure that human health considerations are regarded as essential prerequisites for industrial and other forms of socioeconomic development, including the introduction of new technologies; the introduction of mechanisms to increase community awareness and involvement in environmental issues with potential implications for human health; the development of international arrangements for effective control of transfrontier environmental health hazards.

Target 19 BY 1990, ALL MEMBER STATES SHOULD HAVE ADEQUATE MACHINERY FOR THE MONITORING, ASSESSMENT AND CONTROL OF ENVIRONMENTAL HAZARDS WHICH POSE A THREAT TO HUMAN HEALTH, INCLUDING POTENTIALLY TOXIC CHEMICALS, RADIATION, HARMFUL CONSUMER GOODS AND BIOLOGICAL AGENTS.

The achievement of this target will require: the establishment of well-coordinated monitoring programmes with clearly defined objectives; the development of methodologies and health criteria for the assessment of data in relation to control procedures; the investment of adequate levels of funding for control measures, and their introduction and maintenance; the training and utilization of sufficient numbers of competent personnel for all aspects of environmental health protection.

Target 20 BY 1990, ALL PEOPLE OF THE REGION SHOULD HAVE ADEQUATE SUPPLIES OF SAFE DRINKING-WATER, AND BY THE YEAR 1995 POLLUTION OF RIVERS, LAKES AND SEAS SHOULD NO LONGER POSE A THREAT TO HUMAN HEALTH.

The achievement of this target will require: in the less developed countries of the Region, the investment of higher levels of funding for the construction and maintenance of drinking-water supply facilities, with the appropriate mobilization of international and bilateral assistance to reinforce national endeavours, and with the training and utilization of adequate numbers of competent personnel; in all countries of the Region, the introduction of effective legislative, administrative and technical measures for the surveillance and control of pollution of water surface and groundwater, in order to comply with criteria to safeguard public health.

Target 21 BY 1995, ALL PEOPLE OF THE REGION SHOULD BE EFFECTIVELY PROTECTED AGAINST RECOGNIZED HEALTH RISKS FROM AIR POLLUTION.

The achievement of this target will require the introduction of effective legislative, administrative and technical measures for the surveillance and control of both outdoor and indoor air pollution, in order to comply with criteria to safeguard human health.

Target 22 BY 1990, ALL MEMBER STATES SHOULD HAVE SIGNIFICANTLY REDUCED HEALTH RISKS FROM FOOD CONTAMINATION AND IMPLEMENTED MEASURES TO PROTECT CONSUMERS FROM HARMFUL ADDITIVES.

The achievement of this target will require: the introduction of effective legislative, administrative and technical measures for the surveillance and control of food contamination at all stages of production, distribution, storage, sale and use; the implementation of effective measures to control the use of harmful food additives.

Target 23 BY 1995, ALL MEMBER STATES SHOULD HAVE ELIMINATED MAJOR KNOWN HEALTH RISKS ASSOCIATED WITH THE DISPOSAL OF HAZARDOUS WASTES.

The achievement of this target will require: the introduction of effective legislative, administrative and technical measures for the surveillance and control of hazardous wastes; the introduction of effective measures to eliminate health risks due to previously dumped wastes.

Target 24 BY THE YEAR 2000, ALL PEOPLE OF THE REGION SHOULD HAVE A BETTER OPPORTUNITY OF LIVING IN HOUSES AND SETTLEMENTS WHICH PROVIDE A HEALTHY AND SAFE ENVIRONMENT.

The achievement of this target will require: the acceleration of programmes of housing construction and improvement in order to replace substandard property and to reduce overcrowding; the development, where they do not already exist, of international health criteria for the public aspects of housing, such as space, heating, lighting, disposal of wastes, noise control and safety, while taking into account the special needs of groups such as young families, the elderly and the disabled; the introduction of effective legislative, administrative and technical measures to comply with such criteria; the improvement of the quality of community planning in order to enhance health and wellbeing by such measures as improving traffic safety, providing open spaces and recreational areas, and facilitating human contact and interaction; the equipment of all dwellings with proper sanitation facilities and the provision of sewers and an adequate public cleansing and wastes collection and disposal system in all human settlements of sufficient size.

Target 25 BY 1995, PEOPLE OF THE REGION SHOULD BE EFFECTIVELY PROTECTED AGAINST WORK-RELATED HEALTH RISKS.

The achievement of this target will require: the introduction of appropriate occupational health services to cover the needs of all workers; the development of health criteria for the protection of workers against biological, chemical and physical hazards; the implementation of technical and education measures to reduce work-related risk factors; the safeguarding of specially vulnerable groups of workers.

Target 26 BY 1990, ALL MEMBER STATES, THROUGH EFFECTIVE COMMUNITY REPRESENTATION, SHOULD HAVE DEVELOPED HEALTH CARE SYSTEMS THAT ARE BASED ON PRIMARY HEALTH CARE AND SUPPORTED BY SECONDARY AND TERTIARY CARE AS OUTLINE AT THE ALMA-ATA CONFERENCE.

This could be achieved by: clear statements from the highest national authorities and political leaders of all levels of authority in the health field, backed by effective legislation, regulations and plans, making primary health care the hub the health care system, with secondary and tertiary levels in a supporting role and only carrying out those diagnostic and therapeutic functions that are too specialized to be carried out at the primary health care level; the establishment of effective ways and means of bringing consumer needs and interests to bear on the planning and delivery of primary health care; free discussion with all groups of health personnel, supported by appropriate modification of health manpower policies and programmes, to obtain their full commitment and support for carrying out this policy in their daily work. Such developments should take due account of the constitutional provisions of each Member State.

Target 27 BY 1990, IN ALL MEMBER STATES, THE INFRASTRUCTURES OF THE DELIVERY SYSTEMS SHOULD BE ORGANIZED SO THAT RESOURCES ARE DISTRIBUTED ACCORDING TO NEED, AND THAT SERVICES ENSURE PHYSICAL AND ECONOMIC ACCESSIBILITY AND CULTURAL ACCEPTABILITY TO THE POPULATION.

This could be achieved by: a combination of planned development and a wide range of carefully designed incentives to direct the necessary health care resources to the primary health care services in order to ensure that the distribution of the services and the care they provide correspond to the needs of the population; by similarly gradually readjusting hospital resources, wherever necessary, to form a system whereby secondary and tertiary care resources are distributed in the regionalized system according to the needs of the population.

Target 28 BY 1990, THE PRIMARY HEALTH CARE SYSTEM OF ALL MEMBER STATES SHOULD PROVIDE A WIDE RANGE OF HEALTH-PROMOTIVE, CURATIVE, REHABILITATIVE AND SUPPORTIVE SERVICES TO MEET THE BASIC HEALTH NEEDS OF THE POPULATION AND GIVE SPECIAL ATTENTION TO HIGH-RISK, VULNERABLE AND UNDERSERVED INDIVIDUALS AND GROUPS.

This could be achieved by: establishing clear policies in all Member States with a description of the full range of services that the primary health care system should provide, based on the principle that most preventive, diagnostic, therapeutic and care services and activities could be provided outside hospitals and other institutional settings; modifying basic and continuing education programmes for health personnel to ensure their active support for this development; reviewing planning, referral and incentive systems to ensure that they support these policies.

Target 29 BY 1990, IN ALL MEMBER STATES, PRIMARY HEALTH CARE SYSTEMS SHOULD BE BASED ON COOPERATION AND TEAMWORK BETWEEN HEALTH CARE PERSONNEL, INDIVIDUALS, FAMILIES AND COMMUNITY GROUPS.

This could be achieved by: policies in the countries that clearly define the role that different categories of health and social personnel should play in health care; basic, specialist and continuing education programmes for health personnel that provide insight, motivation and skill in interprofessional teamwork and in cooperation with individual families, groups and communities; health education programmes that provide a realistic picture of what services can be expected from health professionals and give help in developing lay care skills.

Target 30 BY 1990, ALL MEMBER STATES SHOULD HAVE MECHANISMS BY WHICH THE SERVICES PROVIDED BY ALL SECTORS RELATING TO HEALTH ARE COORDINATED AT THE COMMUNITY LEVEL IN A PRIMARY HEALTH CARE SYSTEM.

This could be achieved by: recognizing the responsibility of the primary health care sector to determine what matters require special attention, change and reorientation, and to coordinate efforts in those directions; establishing a permanent structure, e.g. a health council, in each local community, where representatives of the community itself, health and other sectors can make joint analyses of local health plans and determine what contributions each sector should make to improving the health in the community. Such mechanisms should be developed with due regard to the constitution provision of each Member State.

Target 31 BY 1990, ALL MEMBER STATES SHOULD HAVE BUILT EFFECTIVE MECHANISMS FOR ENSURING QUALITY OF PATIENT CARE WITHIN THEIR HEALTH CARE SYSTEMS.

This could be achieved by: establishing methods and procedures for systematically monitoring the quality of care given to patients and making assessment and regulation a permanent component of health professionals' regular activities; providing all health personnel with training in quality assurance.

Target 32 BEFORE 1990, ALL MEMBER STATES SHOULD HAVE FORMULATED RESEARCH STRATEGIES TO STIMULATE INVESTIGATIONS WHICH IMPROVE THE APPLICATION AND EXPANSION OF KNOWLEDGE NEEDED TO SUPPORT THEIR HEALTH FOR ALL DEVELOPMENTS.

This target can be achieved if Member States establish machinery to: ensure effective application of new knowledge in the development of health policies and programmes; determine what gaps there are in the knowledge needed to support the health for all strategy and set research priorities accordingly; ensure a balanced representation of all academic disciplines relevant to health and of providers and users of health services as well as health policy makers, in the planning and coordinating of health for all research and make the research community an active contributor to the development of health for all; stimulate relevant multidisciplinary research; allocate sufficient resources to conduct the research needed, giving preference to aspects that have not received the support they deserve.

Target 33 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.

This could be achieved if all countries were to make a systematic review of their health policies and health legislation as compared with the regional health for all strategy and targets, at the same time developing health for all strategies and targets and amending or extending their health legislation accordingly, taking due account of the specific legal, political and structural conditions in each Member State.

Target 34 BEFORE 1990, MEMBER STATES SHOULD HAVE MANAGERIAL PROCESSES FOR HEALTH DEVELOPMENT GEARED TO THE ATTAINMENT OF HEALTH FOR ALL, ACTIVELY INVOLVING COMMUNITIES AND ALL SECTORS RELEVANT TO HEALTH AND, ACCORDINGLY, ENSURING PREFERENTIAL ALLOCATION OF RESOURCES TO HEALTH DEVELOPMENT PRIORITIES.

Such a process should cover the systematic planning, monitoring and evaluation of health for all activities, with due regard to the specific legal, political and structural characteristics of each Member State.

Target 35 BEFORE 1990, MEMBER STATES SHOULD HAVE HEALTH INFORMATION SYSTEMS CAPABLE OF SUPPORTING THEIR NATIONAL STRATEGIES FOR HEALTH FOR ALL.

Such information systems should provide support for the planning, monitoring and evaluation of health development and services, assessment of national, regional and global progress towards health for all and dissemination of relevant scientific information; steps should be taken to make health information easily accessible to the public.

Target 36 BEFORE 1990, IN ALL MEMBER STATES, THE PLANNING, TRAINING AND USE OF HEALTH PERSONNEL SHOULD BE IN ACCORDANCE WITH HEALTH FOR ALL POLICIES; WITH EMPHASIS ON THE PRIMARY HEALTH CARE APPROACH.

This can be achieved if all countries analyse their needs for the different categories of health manpower required to implement their health for all policies, adopt suitable health manpower policies, and decide on the numbers and educational qualifications required for each category of personnel.

Target 37 BEFORE 1990, IN ALL MEMBER STATES, EDUCATION SHOULD PROVIDE PERSONNEL IN SECTORS RELATED TO HEALTH WITH ADEQUATE INFORMATION ON THE COUNTRY'S HEALTH FOR ALL POLICIES AND PROGRAMMES AND THEIR PRACTICAL APPLICATION TO THEIR OWN SECTORS.

This could be achieved if public policy stressed that health protection is also a key concern for sectors other than health, and if training programmes for personnel in such sectors stressed the reasons for actively supporting health for all activities.

Target 38 BEFORE 1990, ALL MEMBER STATES SHOULD HAVE ESTABLISHED A FORMAL MECHANISM FOR THE SYSTEMATIC ASSESMENT OF THE APPROPRIATE USE OF HEALTH TECHNOLOGIES AND OF THEIR EFFECTIVENESS, EFFICIENCY, SAFETY AND ACCEPTABILITY, AS WELL AS REFLECTING NATIONAL HEALTH POLICIES AND ECONOMIC RESTRAINTS.

This could be done if governments adopted a clear policy for systematic and comprehensive assessment of all new technical devices designed for use in the health field, to be carried out in a manner suited of the characteristics of their countries and if an international system for the exchange of information on this subject were set up.

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Further reading

This document is a brief look at the Regional Targets for Health for All and their meaning for nurses, midwives and medicosocial workers. If you would like to learn more about the European targets, the problems they are to address, the solutions suggested and the people involved in achieving them, you can buy the complete book Targets for health for all (Copenhagen, WHO Regional Office for Europe, 1985, price: Sw.Fr.20) from your bookseller or national WHO Sales Agent. If you have difficulty getting it, write directly to the Distribution and Sales Service, World Health Organization, CH-1211 Geneva 27, Switzerland. They can also provide Global strategy for health for all (Geneva, World Health Organization, 1981, ("Health for All" Series, No.3), Sw.Fr.6) and a full catalogue of WHO publications listing other books about nursing and Health for All. You may wish to use the order form on the next page.

Other interesting books include:

O'Neill, P. D., Health Crisis 2000 London, Heinemann, 1982. £4.95p

Alma-Ata 1978: primary health care. Report of the International Conference on Primary Health Care. Geneva, WHO, 1978 ("Health for All" Series, No.1). Sw.Fr.5.

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William Heinemann Medical Books Limited, Bedford Square, London WC1, United Kingdom.