



EUR/ICP/HFAP 94 01/CN01 (II)
ENGLISH ONLY

European Health Policy Conference: Opportunities for the Future

Copenhagen, 5-9 December 1994

Volume II

The Policy Framework to meet the Challenges - Intersectoral Action for Health

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World Health Organization
Regional Office for Europe
Copenhagen

1995

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Target 33

HEALTH FOR ALL POLICY DEVELOPMENT

By the year 2000, all Member States should have developed and be implementing, policies in line with the concepts and principles of the European health for all policy, balancing lifestyle, environment and health service concerns

Keywords

HEALTH POLICY
HEALTH FOR ALL
INTERSECTORAL ACTION
EUROPE

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FOREWORD

In 1977, the Thirtieth World Health Assembly laid the foundation for the health for all policy when it decided that

the main social target of governments and WHO in the coming decades should be 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.

At the European Health Policy Conference: Opportunities for the Future, WHO Member States underlined their commitment to health for all in the Copenhagen Declaration, reaffirming that the fundamental principles underpinning the policy remain as relevant for the future as they have proved in the past. One of the fundamental principles is that countries should adopt an intersectoral approach to developing policies for health. This is the subject of this second volume of the five-volume report from the Conference.

Faced with rapid technical innovation, increasingly interlinked economies, widespread social change and the need to make more effective use of available resources, the validity of an intersectoral approach to health is all the more apparent. Pressures for change need to be balanced against ensuring access to the prerequisites for health and protection from risks in the physical, economic and social environment. At the WHO Regional Office for Europe, it is our firm belief that a balance can best be achieved through international cooperation, the development of sound public health structures and the creation of an environment in which the physical, social, economic and psychological factors that influence health are all given due importance. Health must be everyone's business, not just the responsibility of the health sector, but of sectors such as education, housing, transport, agriculture and industry.

Health for all provides a comprehensive yet flexible framework that extends to all sectors of economic and social life and is easily adapted to suit different socioeconomic, political, cultural and administrative settings. We are delighted that so many of our Member States have been encouraged to make the essential links and alliances, by reaching out to new groups and sectors and showing how they can benefit from putting health on their agenda. Already, in a relatively short time, the policy and targets for health for all have become a powerful public health movement in the European Region, inspiring people to think about health in new ways and to work with different partners.

Nevertheless, the objective of achieving a higher level of health for all citizens – in all stages of life from childhood through adulthood to old age – is an enormous task. Fortunately, it is not a task that any international organization working in Europe must tackle alone and, during the Conference, the European Union and the Council of Europe expressed their commitment to intersectoral action for health and to continued pragmatic collaboration both with each other and with the Regional Office. I am delighted to say that, since the Conference, efforts have continued to maintain and develop links with intergovernmental organizations working to achieve better health in Europe. By harnessing our diverse energies, experience and expertise, I am certain that we can create a bedrock for developing the type of intersectoral structures necessary to surmount the challenges and achieve a higher level of health for all Europe's citizens.

J.E. Asvall
WHO Regional Director for Europe

PREFACE

This is Volume II of a report on the third European Health Policy Conference held in Copenhagen, 5–9 December 1994. Volume II reports on that part of the conference which looked at the intersectoral action for health. It gives a detailed account of the plenary session (Plenary B on the Conference Programme) which dealt with this issue and of the six related discussion groups. The full texts of papers presented or prepared as background documentation are included.

The other four volumes report in a similar manner on the plenary sessions and of the work in their related discussion groups. The full texts of the papers presented are also given.

- Vol. I gives an overview of the Conference and reports in detail on the plenary sessions related to the politicians' viewpoint and to the role of the intergovernmental organizations in supporting health policy development. It also reports on the outcome, including the Copenhagen Declaration and briefly on the follow-up since the Conference.
- Vol. III examines the process of health policy developments at national, regional and city level.
- Vol. IV explores some of the main changes in health care in relation to their contribution to health gain.
- Vol. V highlights issues of particular importance to countries of central and eastern Europe and the newly independent states.

1. INTRODUCTION

Since the adoption of the health for all policy and the acceptance of the Ottawa Charter, many effective intersectoral alliances for health have been developed. The benefits of such alliances in terms of increasing health gain and reducing inequities are clear. Much has also been learnt about how actions to promote and protect health can contribute to the achievements of goals of other sectors, in what management experts call a win-win situation.

If intersectoral action is to work clear policy frameworks such as the health for all approach are essential. Some might even have been tempted to believe that, by embracing health for all, Europe had found the consummate answer to its health problems. Unfortunately, today's stringent cost constraints, changing values and pressing short term problems pose new threats and challenges and the temptation to simply react to these, without due consideration for the long-term implications.

Improved channels of communication and intensified efforts to network across Europe have provided opportunities for countries to share experiences on alliance building. International organizations are doing their best to find ways to further strengthen such efforts. This plenary session of the Conference was devoted to exploring ways they could support and promote intersectoral action in the field of health. Representatives from the Council of Europe, the European Commission, and the WHO Regional Office for Europe presented the policy frameworks of their organizations. They described the principles which guide the organization's actions and decisions in the field of health, specific actions which the organization has taken in the field of health and plans for the future.

Mr Goren Dahlgren, Senior Advisor in Public Health Policies at the Swedish International Development Agency, introduced the session. Presentations followed from Dr David McFadyen, Director, Programme Management, WHO, Dr William Hunter, Director, Directorate-General V, European Commission, and Dr Robin Guthrie, Director, Social and Economic Office, Council of Europe.

2. SETTING THE SCENE

2.1 Intersectoral action for health

Mr Goren Dahlgren, Senior Advisor in Public Health Policies, at the Swedish International Development Agency, opened by pointing to some of the basic determinants of health which he classified in three groups. The economic, environmental and health sectors were “the upper strata” and sectors relating to the work environment, housing and social security were classified as “the secondary strata”. Lifestyle factors and characteristics such as age, sex and heredity were in the first strata of determinants of health.

The relationship between economic development and health could be described in two ways - in terms of *the economics of health* and the *health of economics*. Mr Dahlgren explained that the former, the economics of health theory is based on the idea that improvements in health are a prerequisite for economic growth. The theory is underpinned by a strong belief that decision makers can save money through the healthcare system. However, while such an approach may appeal in the short run, Mr Dahlgren proposed that in the long run the *economics of health* theory did not offer the best analysis for the relationship between economic policy and health. A field such as care of the elderly, where measures to improve health status make virtually no contribution to economic gain revealed some of the weaknesses of the theory.

By comparison, the *health of economics* theory addresses the health “effects” of different economic strategies. Taking examples of countries with a similar Gross Domestic Product (GDP), Mr Dahlgren demonstrated that the way resources are distributed actually proves to be a greater determinant of health status, than the level of GDP¹. For example, in countries with equitable income distribution policies, inequities were found to be decreasing, while in countries with inequitable income distribution policies they were found to be rising. Healthy economic strategies could only be developed, if based on an equitable distribution of resources within countries.

¹Japan and Costa Rica perform much better than expected. By comparison, the US performance in health is poorer than its GDP would suggest.

Mr Dahlgren pointed out that fortunately research in this area was growing. A recent WHO publication *Health in Europe* held that inequities in income were responsible for various types of health risks. Strong evidence linked incidences of psycho-social and mental health problems with increased social inequities. In view of the rising inequities in the European region, Mr Dahlgren proposed that decision makers should address social inequities, as a political and as a health issue.

The key to adopting a more equity oriented approach lay in developing intersectoral policies for health. Mr Dahlgren pointed out that several sectors had already developed intersectoral policies and there were opportunities for others to follow. Sectors dealing with health and the working environment had been particularly successful, however the high number of occupational accidents and injuries was still a matter of concern and left no room for complacency. He proposed that serious efforts to reduce inequities in the work environment should be made, beginning with staff working in the health sector itself². This could provide lessons on how to reduce social inequities in other occupational areas.

One of the new health hazards of the 1990s is unemployment. A recent Swedish study had shown that increased unemployment will lead to significantly more cases of premature death, suicide and early pensions. Mr Dahlgren proposed that decision makers should give more attention to such statistics when agreeing a trade off between unemployment and inflation policies.

Targets could help address some of the problems particularly in relation to housing, home accidents and social segregation. In some countries, there had been a serious deterioration in co-operation between the health and housing sectors, which had exacerbated problems.

More cooperation between workers in the health sector and workers in other sectors could also lead to improvements in health status. Accidents were one area where there was considerable room for improvement. Mr Dahlgren proposed that greater cooperation between sectors in all stages of an accident, that is from the stage before the crash to rehabilitation, could reduce the number of fatalities and serious injuries by as much as 35%. Similarly, a sector specific health policy for the education sector could contribute significantly to overall health development. Mr Dahlgren identified the Health Promoting Schools project as an impressive example of the type of progress which can be achieved, if people are prepared to work together.

The health effects of the health services are not always widely known. Mr Dahlgren was particularly concerned with some of the recent healthcare reforms, such as the moves towards purchaser/provider systems, DRG prices and privatization in many European countries. Focusing on profitability meant that decision makers were in danger of losing sight of other objectives, such as achieving health gain, or improving the quality of care.

Much of the new market strategy, with its emphasis on profit maximization rather than the provision of appropriate treatment, was incompatible with HFA. To demonstrate the hold

²The comparison between male doctors and hospital laundry workers is particularly revealing.

which such policies had, Mr Dahlgren referred to a recent survey carried out on a sample of Swedish doctors. 58% of doctors said they would prefer to concentrate on those interventions at the more profitable end of the spectrum, rather than on preventive actions such as health education. Basic HFA principles, early intervention and primary health care were seriously under threat.

Assessing patients in terms of whether or not they are “profitable” runs the risk that people will not receive the most appropriate treatment. Mr Dahlgren emphasized strongly that the cost argument alone should not be used as a justification for moving in a particular direction. WHO/EURO had an important role to play in ensuring that cost issues were dealt with in context of the fundamental objectives of the healthcare system. Decision makers must look more closely at the “healthiness” of new reforms and see the health care system as a driving force for HFA and not as a commercial market. (The full text of Mr Dahlgren’s background paper is given in the Annex to this section.)

2.2 Health for all - a framework for action

Dr David Macfadyen, Director, Programme Management, WHO Regional Office for Europe, drew attention to the World Health Organization’s aim to improve the economic, social and health conditions of the human species. This goal had been the dominant motivation underpinning both national and international endeavors during the second half of the 20th century. He pointed out that this marvelous spirit of altruism was embodied in the organization’s plans and visions for the year 2000.

One of the most important words in the constitution of the World Health Organization is the word “all”. The World Health Organization’s main goal is to lead “all” people to the highest level of health. Dr Macfadyen pointed out that this objective had been reaffirmed in the World Health Assembly decision of 1977.

Since 1945, the UN had come a long way in fulfilling its role as a focal point for harmonizing the actions of individual nations. The World Summit for Social Development, scheduled to be held in Copenhagen in 1995, would give an opportunity to renew that commitment and to review the achievements of the second half of the 20th century.

Dr Macfadyen reminded participants that when the global health for all strategy was first adopted, there were just 20 global indicators. These were not just health indicators but related also to determinants of health, such as environmental, social and economic conditions. WHO/EURO has now developed 220 indicators in relation to its own Regional HFA targets and these are closely monitored and reviewed every three years.

Dr Macfadyen emphasized that Europe was undergoing the beginnings of a global social transformation, from an unhealthy to a healthy society. The development of national health policies and the establishment of international structures had contributed to this transformation. They could also be taken as an indication of the progress which had already been achieved.

Many changes have taken place within the health services over the years. Dr Macfadyen pointed to the new emphasis on efficiency and effectiveness in health services. He praised the input of certain individuals responsible for prompting the move from the traditional medical model to one which embraced the wider determinants of health and quality of life. In particular, he commended Dr Michael McGinnis, Deputy Assistant Secretary of Health, Department of Health and Human Services, USA for his work on target setting in the United States and Dr Mark Lalonde, Minister for Health, Canada, for his book, "A new perspective on the health of Canadians". As the first publication to clearly acknowledge the importance of individual needs and social and environmental determinants of well being, the Health of Canadians had been a milestone in the history of health for all.

The European 38 targets were launched as an indication that the WHO Regional Office for Europe had taken a wider perspective on health. The slogans *adding years to life, adding health to life and adding life to years*, encapsulated that perspective, breathing life into the organization's objective to deliver the health for all message to people in Europe, from villages in Tajikistan to housing estates in Glasgow.

Dr Macfadyen pointed out that in practical terms, the Organization has been able to track the progress of health for all via the time series data base and the indicators, which have provided valuable information on differences in health status between European Member States. Monitoring has revealed that some European countries can offer valuable lessons for health improvement. In particular, Dr Macfadyen proposed that the CCEE/NIS could benefit from the successful experience of some of the Nordic countries in relation to reducing tobacco consumption.

The World Health Organization is not the only international organization promoting intersectoral action for health. Dr Macfadyen emphasized that the European Commission and WHO share certain common objectives and had initiated processes in order to achieve these objectives. The Maastricht Treaty had been an important contribution in this respect.

Dr Macfadyen stressed that international organizations and institutions were not operating solely in a strategic sphere, but were working hard to give plans a practical application. The Health Promoting Schools project, organized jointly by the Commission, the Council of Europe and the World Health Organization, was an excellent example of the type of progress which could be achieved.

On a more local level, he praised the stand taken by the East Tenants Group, Glasgow, Scotland, against the ill-effects of chronic housing conditions. This showed the practical application of health for all and could offer valuable lessons for other countries. In some of the CCEE/NIS, the resurgence of TB, partly as a result of poor housing conditions was a matter of grave concern. Dr Macfadyen cautioned against returning to a situation reminiscent of the 1940's, when socioeconomic conditions were a barrier to health, throughout Europe.

However, despite these negative trends, great progress had also been made over the years. Healthier nutrition and lifestyles meant that some southern European countries were now on a par with or even overtaking the traditionally healthier northern European countries.

Dr Macfadyen stressed that improvements in health could be achieved in advance of socioeconomic development, provided countries had a comprehensive policy for health that extended to all sectors of the economy and social life.

Dr Macfadyen concluded with the observation that over the years consensus has been reached in two important areas, health policy and the means for tracking its progress. The WHO Regional Office for Europe provided a forum for people to share their experiences in developing their health policies. People who were familiar with intersectoral action were necessary to bring policies to fruition. It was Dr Macfadyen's hope that such people would leave this conference with a stronger commitment to spread the message of health for all.

2.3 Health Policy in the European Union

Dr William Hunter, Director, Directorate-General V, European Commission, began by referring briefly to the status of the Commission in its context as one of the institutions of the European Union (EU). He emphasized that the EU is neither an intergovernmental organization nor an international organization, but is based upon a sharing of legal and administrative responsibilities between the Member States and the community institutions.

The European Community has extensive powers and Dr Hunter explained that public health, which was made a community competence only in the previous year, is just one of the areas in which the commission has obligations. He pointed out that the potential scope for initiating actions relating to public health is carefully described in the provisions of the Maastricht Treaty.

The European Community has also had a longer and more informal involvement with public health. Dr Hunter referred to the economic objectives of the EC treaty, the safety provisions of the treaty on the European Coal and Steel Committee and the protection provisions of the EURATOM treaty, all of which are based on a fundamental concern with health and well-being. He referred in particular to one of the chapters of the EURATOM treaty, which makes provision for basic standards to protect both workers and the general public from the dangers of ionizing radiation. Dr Hunter emphasized that in the past, the provisions of these treaties and subsequent legal instruments have been used as the basis for action on health in areas such as, environment, research and development, health and safety at work, agricultural policy, information and telecommunications, social security, consumer safety, transport policy, the free movement of goods and overseas aid.

In the field of public health, Dr Hunter referred to some of the specific initiatives which had been undertaken such as the programme on "Europe against Cancer", which began in 1990 and was due to finish at the end of 1995. Dr Hunter emphasized that the cancer programme had been very successful in terms of demonstrating the value of Member States working together in the field of public health. The cancer initiative also paved the way for other specific programmes and actions, such as the programmes on "Europe against Aids" launched in 1991, Action on Drug Dependence and Action on Health Education, which includes the Health Promoting Schools project being undertaken jointly with the World

Health Organization and the Council of Europe³. The Commission had also undertaken specific action in the areas of alcohol, organ transplantation, toxicology, health and environment, blood safety and self-sufficiency, cardiovascular diseases, communicable disease surveillance and cost containment.

Dr Hunter explained that the ratification of the Treaty on European Union had given the Community a specific mandate to act in the area of public health. According to article 129 of the Treaty, Community action on health protection should be focused on the prevention of diseases, particularly the major health scourges, including drug dependence. The Treaty also emphasizes that health protection requirements should be part of other community policies. In relation to the latter, the Commission has set up an inter service group on health to “watch over” policy and to act as a forum for the exchange of information about the type of actions on health being pursued by the Community.

Article 129 proposes that measures should be taken to achieve these aims. Dr Hunter emphasized however, that this could not include harmonizing the laws of Member States. According to article 129, the Community shall foster cooperation with other countries and with the international organizations competent in the sphere of public health. Dr Hunter pointed out that the Commission had a central role to play in implementing article 129, by liaising with Member States in relation to the coordination of their prevention policies and programmes, the investigation and analysis of causes, the modes of transmission of diseases and health information and education.

He drew attention to a communication recently published by the commission setting out a framework for Community action in the field of public health. The communication outlines the context for Community action, the main patterns of mortality and morbidity and the application of the principle of subsidiarity. The communication describes the main health problems faced by member states, particularly those leading to continual increases in health expenditure. Dr Hunter reported that issues of particular significance for most EU countries are the aging population, development of costly new technologies, increasing population mobility, environmental changes, socioeconomic problems particularly social exclusion and rising public expectations of health services. The criteria for establishing priority areas for community action, particularly in relation to the prevention of diseases, are set out in the communication and include the impact of a disease on mortality and morbidity, its socioeconomic impact, how far it is amenable to effective preventive action and how much scope there is for community actions to complement and add value to what is already being done by the Member States.

Dr Hunter informed that a number of priority areas have been proposed for action including, cancer, drug demand reduction, health promotion, education, training and information, AIDS and other communicable diseases, health data and indicators, monitoring and surveillance of diseases, intentional and unintentional accidents and injuries, pollution related diseases and finally rare diseases. The first four of these

³ The programmes on cancer, AIDS and other communicable diseases and on health promotion have now been adopted, and proposals for the health monitoring programme and on a network for the surveillance of communicable diseases have been put forward.

programmes have been submitted for adoption to the European Parliament and to the Council and work is proceeding on the other four. Particular emphasis is being put on health data and indicators, which may be required at community level.

The Community has entered a crucial new phase of public health policy. Dr Hunter pointed out that the objective of the Community's new competence in the field of public health is to contribute to the attainment of a higher level of health protection in Europe. He informed that the Commission would be happy to build on existing pragmatic collaboration with the WHO, the Council of Europe and other international organizations active in the health field, in order to achieve that objective. The Commission would also be willing to provide support for certain activities, as it had done for example in relation to this conference, while still respecting each organization's different framework and perspectives. Dr Hunter hoped that by striving together, real progress could be made towards achieving the ambitious treaty objectives, which were namely to attain a higher level of human health protection for all European citizens.

2.4 The Council of Europe - action for health

Dr Robin Guthrie, Director, Social and Economic Affairs, Council of Europe, began with a brief history of the Council of Europe (CE) and its role as an intergovernmental organization. The Council, established in 1949, was based on ideals and principles relating to human rights, the rule of law and the citizen's right to take an active role in politics. As an intergovernmental organization, the Council aimed to achieve co-operation between governments and worked through discussion, agreements and common action. Dr Guthrie emphasized that unlike the EU, the Council was not a central decision making body. It aimed to achieve greater unity between its members for the purpose of safeguarding and realizing the ideals and principles on which it is based.

Dr Guthrie stressed that the Council of Europe was characterized by having an essentially practical outlook. He described the Council as "pan European". Originally, there were just ten members. Since the political events of 1989 membership had increased significantly and continued to grow. Currently, the Council had thirty three members. Dr Guthrie pointed out that in 1993, European Heads of State and Government re-affirmed the Council's role as the preeminent political institution capable of welcoming the democracies of Europe freed from communist oppression.

He emphasized that to date in the field of health, the Council had concentrated on issues that were essentially ethical and had tried to ensure that its work had a practical application. He referred to some of the ways in which the Council has aimed to achieve this practical impact, such as for example through the drafting of various conventions. Currently, a convention on bioethics was under discussion, with a final draft expected by 1995. The convention on the confidentiality of personal data had already been finalized and was proving to be extremely useful. Conventions, he stressed, were important tools for guiding the operations of governments, intergovernmental organizations, professionals and practitioners and NGOs.

Dr Guthrie described some of the more specific health issues and the Council's ethical concerns in relation to them. He referred in particular to the ethical principles of voluntary donation and self sufficiency which should govern the practice of blood transfusion. In 1983, the Council issued an important Recommendation drawing attention to the potential dangers of transmitting the AIDS virus through contaminated blood donations.

Dr Guthrie referred to a number of other areas in which the Council was involved, beginning with recent attempts to establish a computerized European network for organ transplants. The Council had also taken action on drugs, including controlling the spread of illicit drugs and dealing with the effects of their use. In the field of consumer protection, the Council had been setting standards in food from the earliest stages in the food process through to the final stages of packaging and sale. Dr Guthrie also cited the European Pharmacopoeia which ensures that all medicaments meet agreed scientific standards, as another example of the Council's work in the field of consumer protection.

The Council was particularly concerned with promoting equity and efficiency in health and encouraged its Member States to adopt these principles. Dr Guthrie stressed that although the Council could not in any way determine the health policies of a member state, it could provide a forum in which member states could exchange experiences and learn from each other and develop common policies and, where appropriate, legal instruments.

Although the term "Economies in Transition" was usually reserved for the CCEE/NIS, Dr Guthrie felt that it could be applied just as easily to all the countries represented at the Conference. He proposed that the challenges which these countries were facing today would have surprised previous generations who believed that many of these problems had already been solved. One of the problems currently facing most countries was the shortage of financial resources and Dr Guthrie emphasized that Member States should not undertake the task of re-organizing their health care system alone. Intergovernmental organizations could support countries in this task, for example by acting as a forum for discussion, or assisting them to take a more active role, as in the Health Promoting Schools programme which was run jointly between the WHO, the EU and the CE. Dr Guthrie remarked that the information booklet on the Health Promoting Schools project was the only booklet to carry the emblems of all three institutions. While the programme was important in its own right, Dr Guthrie pointed out that it was also invaluable as a model of how international cooperation can be made to work in practice.

How international organizations could work more efficiently, effectively and equitably together was a question that was likely to gain momentum as the conference went on. Dr Guthrie emphasized that while joint actions such as the programme of Education for Health were often called for and could prove extremely effective, there were also occasions when it was more effective for one organization to take responsibility for a specific task. He concluded by stressing that all international organizations should strive for economy, effectiveness and efficiency in their work in relation to each other. This was crucial if they were to continue to serve the people living in their member states.

THE NEED FOR INTERSECTORAL ACTION FOR HEALTH

Mr Göran Dahlgren
Senior Advisor in Public Health Policies
Swedish International Development Agency

Introduction

The concept of health development bears many similarities to that of economic development. Both result from activities involving most sectors of our society, as well as the population as a whole, through individual and collective decisions and actions. In spite of this, there are very few, if any, comprehensive strategies for health development. There is no doubt that this drastically limits our possibilities to reduce preventable diseases and early deaths.

Consequently a major policy issue within the health for all (HFA) strategy as developed by WHO and adopted by its Member States is how to strengthen intersectoral actions for health.

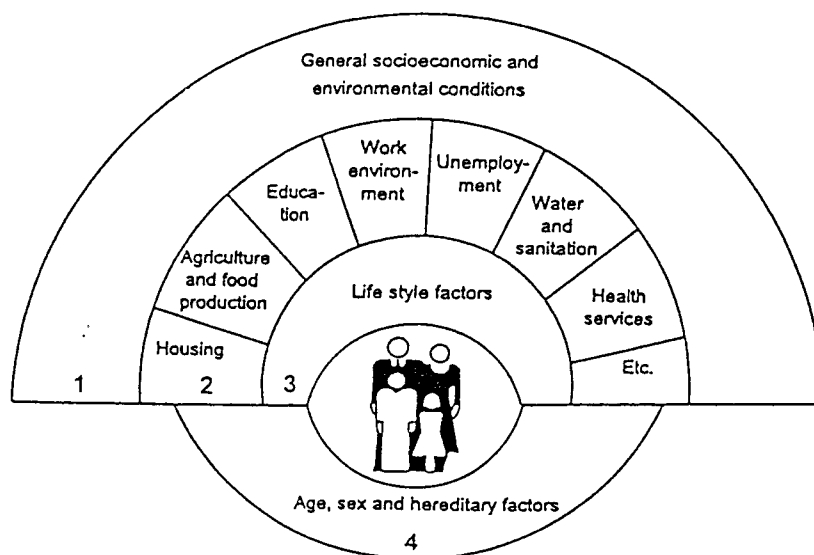
“Health for all requires the coordinated action of all sectors concerned. The health authorities can deal only with a part of the problems to be solved and multisectoral cooperation is the only way of effectively ensuring the prerequisites for health, promoting healthy policies and reducing risks in the physical, economic and social environment.” (1)

The purpose of this paper is to briefly highlight and discuss some concepts and policy issues regarding the further development of intersectoral actions for health within the framework of the HFA strategy.

Conceptual framework

The main determinants of health are related to living conditions, environmental factors, lifestyles and biological factors such as age, sex and heredity. The conceptual framework for analysing the importance of and interactions between, these factors can be illustrated by the following figure (2).

Fig. 1.
Conceptual model for the main determinants of health



The importance of analysing health problems (both for communicable and noncommunicable diseases) within a social and environmental context has been noted by bodies such as the WHO European Advisory Committee on Health Research. The Committee pointed out that the most important medical advance of the nineteenth century was the discovery that infectious diseases are largely attributable to environmental conditions and can often be prevented by controlling the causes; the most significant advance of the twentieth century is the recognition that the same is true of many noncommunicable diseases. The term “environment” is used here in its widest sense, to include socioeconomic, physical and psychosocial factors.

The theoretical base for health development is however quite limited. Few, if any, comprehensive theories exist as regards alternative intersectoral strategies for health development. This seems to be a “no man's land”. Against this background, the HFA strategy (which sets out specific health targets for the population) is quite unique in that it provides a population-based framework (or ideology) for health development. The possibilities of relating comprehensive strategies for health to specific targets for health are however still quite limited.

This state of the art calls for a fairly pragmatic approach to health development, based on the interrelationships between input (changes in the determinants of health) and output (changes in the health status of the population). These interrelationships can be illustrated using a “health policy matrix”. This type of matrix relates the external determinants of health (circles 1-3 in Fig. 1) to various types of health targets.

Applied to the general health targets, (targets 1-8) in the HFA strategy, these interrelationships can be illustrated as shown in Fig. 2 (a small “x” indicates a causal relationship, a big “X” a very strong and dominant relationship).

The aggregated character of the general health targets in the HFA strategy clearly indicates that a comprehensive policy for health development must be truly intersectoral, involving such sectors as those responsible for finance, the environment, employment policies, the work environment, housing, traffic, education, agriculture, health services and social security. Furthermore it must be recalled that so-called

lifestyle factors also are directly influenced by actions - and lack of actions - in such fields as legislation, marketing and pricing policies for food, tobacco and alcohol.

Fig. 2. Health policy matrix for the general health targets in the HFA strategy

	<i>Target 1</i>	<i>Target 2</i>	<i>Target 3</i>	<i>Target 4</i>	<i>Target 5</i>	<i>Target 6</i>	<i>Target 7</i>	<i>Target 8</i>
Main determinants of health	Reduce inequities in health	Develop health potential	Better opportunities for disabled	Reduce disease and disability	Elimination of measles, polio, neonatal, tetanus etc.	Increase life expectancy	Reduce IMR	Reduce MMR
A. Strategies for economic development	X	x	x	x		x	x	x
B. Environment (air, water, etc.)	x	x		x	x	x	x	
C. Working conditions	X	x	x	x		x		
D. Employment	X	x	X	x		x		
E. Housing	X	x	X	x		x		
F. Traffic systems		x	X	x		X		
G. Education	X	X	X	X		x	x	x
H. Health services	x	x	x	x	X	x	X	X
I. Social security (financial)	X	X	X	x		x		
J. Social support	X	x	X	x		x		
K. Sexual relations (including family planning)		x		x	x	x	x	x
L. Food	x	x		X		X		
M. Exercise	x	x		x		x		
N. Alcohol	X	x		X		X	x	
O. Tobacco	X	x		X		X	x	

This can be further and more specifically illustrated by the next health policy matrix (Fig. 3), which shows the interrelationships between the disease-specific targets in the HFA strategy (targets 9-12) and targets related to various determinants of health.

Fig. 3.
Health policy matrix for the disease-specific targets in the HFA strategy

	<i>Target 9</i>	<i>Target 10</i>	<i>Target 11</i>	<i>Target 12</i>
Main determinants of health	Cardiovascular diseases	Cancer	Accidents	Suicide
A. Strategies for economic development Target 15				
B. Environment (air, water, etc.) Target 18,19,20,21,22,37		x		
C. Working conditions Target 18,25,37		x	x	
D. Employment	x			x
E. Housing Target 13,24,37		x	x	
F. Traffic systems Target 15,17,24		x	x	
G. Education Target 15,16,37	x	x	x	x
H. Health services	x	x	x	x
I. Social security (financial) Target 37				
J. Social Support Target 14			X	x
K. Sexual relations (including family planning)		x		
L. Food Target 16,18,22,37	X	X		
M. Exercise Target 16	X	x		
N. Alcohol Target 16,17	x	x	X	x
O. Tobacco Target 16,17	X	X		
P. Drugs Target 16,17			x	x

The interrelationships illustrated are well known and it is of course no surprise that most of the factors promoting or threatening the health of a population are found outside the health sector. Nonetheless, there is a need to repeat these “facts of life” because:

- there is still a tendency within the health sector to medicalize - or neglect - the many external causes of poor health and the role of other sectors in promoting health and preventing diseases;

- the health effects of environmental, social, agricultural and economic policies and programmes are still often neglected (or not made explicit) by the responsible professional groups;
- there is an urgent need to strengthen and coordinate health development at international, national and local levels.

It is against this background that the World Health Assembly in 1986 unanimously adopted a resolution (WHA39.22) calling on Member States “to identify and develop health objectives as an integral part of sectoral policies for agriculture, the environment, education, water, housing and other health-related sectors and to include health impact analyses in all feasibility studies of health-related programmes and projects”.

Some possibilities of - and constraints on - developing healthy public policies of this kind are briefly illustrated below.

Healthy public policies

Healthy economic policies

The relationship between economic development and health can be described in terms of both “the economics of health” and “the health of economics”.

“The economics of health” perspective focuses on the effects of poor health and early deaths on economic development. This is by no means a major area of economic research, in spite of the importance of adequate human resources for most economic strategies. The productivity losses caused by ill health - as well as the marginal attention paid to these effects from a macroeconomic point of view - can be illustrated by the following example from England (3): “Over the last decade (the 1970s) an average of 13 million working days have been lost each year through strikes. Consider how much attention is given to these strikes and even threats of strikes as imperiling our national well-being, through lost working days. ... But where is the headline and the leader column concerning tooth decay which accounts for an average of four million lost working days a year and is entirely preventable? Where is the special report on the causes of back pain, which accounts for about 18 million lost working days a year? And where is the article on work injuries, which account for an estimated 48 million lost working days a year?”

In spite of the fact that these lines were written nearly fifteen years ago and the HFA strategy has since been adopted, most countries are primarily concerned with the financial costs of health services and social security schemes, rather than with the full costs of diseases and premature deaths to society and individuals. Concern is growing rapidly, however, in the business world about the direct and indirect costs associated with high levels of sick leave and staff turnover rates. Employers considering the economics of a healthy workplace may very well prove to be an important professional group for promoting health and preventing work-related diseases. It is even more likely that the economics of a healthy workplace will facilitate efforts by labour unions, for instance, to reduce or eliminate avoidable health hazards.

“The health of economic strategies”, on the other hand, focuses on the health effects of different economic policies. This perspective is even more relevant than the previous one, since improved health is a major goal of development in its own right. In fact, it constitutes one of the most important determinants of quality of life. The major criterion for judging the health effects of different economic policies is how they affect disadvantaged groups. The magnitude of economic inequalities and the type of living conditions associated with different income levels are also important determinants of health in rich

countries, as has been illustrated by various analyses of the causal relationship between income levels and health status.

Economic and social policies which reduce poverty-related diseases and early deaths are an important component of the European HFA strategy: "Social deprivation is not uncommon even in some of the more developed countries of the European Region: even in the most highly developed countries seven years less life expectancy and two and a half times as much infant mortality have been found among the lowest social class compared with the highest. A major task in any national health for all programme must therefore be to establish a consistent and long-term policy capable of radically reducing the present social inequity in income, housing, etc." (1).

Within this context, the health effects of alternative economic strategies should be assessed as thoroughly as possible. Such analyses could reveal for example the difference a dollar earned by a disadvantaged family and one earned by a rich family makes, in terms of health, even if this difference is not reflected in their respective direct contributions to economic growth.

Environmental health policies

The greenhouse effect, acid rain, pollution and other environmental issues are high on the political agenda in most, if not all, European countries. The effects on flora and fauna are being studied by an increasing number of experts and long-term strategies to cope with these problems are gradually being developed. The effects on human health of these threats to our natural surroundings are however rarely focused on. The main reason for this is probably that medical professionals are not able to trace a direct relationship between the low-dose exposure experienced and manifest diseases.

There are however good reasons to question whether the traditional medical approaches to environmental health hazards are enough to create early warning systems for environmental health hazards. It can be argued that we cannot wait until scientific proof of the relationship between specific risk factors and health is obtained. On the other hand, there are also very good reasons to reject an approach that is based on the assumption that most environmental hazards are also direct threats to human health. An approach based on specific tracers or combinations of indicators known to give an early indication of an increased risk to human health is needed. In these cases, a wise policy may be to turn the argument around, that is to demand an in-depth analysis showing that specific environmental agents are not a threat to human health. Pending receipt of these results, the assumption is that these risks should be considered potential health hazards.

An ecological health policy should - against this background - include efforts to reduce both known and potential health hazards as related to biological and chemical threats to our environment.

Working conditions

The health effects of physical health hazards are quite well known in most European countries and specific programmes have been initiated to reduce these work-related diseases and early deaths. The key actors in occupational health are - in addition to medical professionals specializing in this particular field - often labour unions and other organizations with a particular concern for the health of employees.

The costs of sick leave and high staff turnover rates are also becoming increasingly important for employers; this is, of course, an additional reason for intensifying efforts to improve the work environment. The effect of these efforts, for instance in terms of reducing the number of serious accidents at the workplace, have often been quite impressive. But the efforts - and results - in tackling psychosocial problems as related to the working situation are less impressive. There is thus a need to further develop this dimension of occupational health.

Another area that needs to be further explored is the effect on workers of having to repeat certain movements, for example, the arms on assembly lines in various types of industries. Diseases in the locomotive organs, particularly among women, signals the need for intensified efforts to reduce and whenever possible eliminate, this particular type of health hazard.

Unemployment and health

There is increasing evidence that long-term unemployment can be a health hazard. In countries with poor social security and welfare systems, the lack of financial resources can be a health hazard, as it influences people's possibilities of enjoying a healthy diet, adequate housing etc. These poverty-related diseases are eliminated in countries with a reliable financial support system for the unemployed. Even in these countries, however, unemployment is a threat to the health of those who are not able to find a job: the stress and stigma of not being accepted or needed increase the risk of contracting psychosocial diseases, including cardiovascular diseases and mental problems. Those unemployed, who are in the weakest position on the labour market are at particular risk of experiencing these effects.

A healthy employment policy should thus ensure that special steps will be taken to find jobs for those at greatest risk of being unemployed and to strengthen the social network, whenever needed, of those who are long-term unemployed; it should also ensure an adequate financial support system.

Considering the magnitude of structural unemployment in many European countries (in particular among young people and immigrants), the health effects of alternative labour market and employment policies are an important dimension of a healthy public policy.

Healthy food policies

Food habits are increasingly considered to be major determinants of health in the European Region. Nonetheless, only a few countries have developed an explicit health policy that is an integrated part of their food production systems.

One exception is Norway, where in 1975 the parliament adopted a comprehensive food policy which includes explicit health targets such as a decrease in the proportion of fat in the diet to 35% of the total energy intake and an increase in the intake of starchy foods (primarily cereals and potatoes).

The main areas for intervention were: "agricultural policy, including fisheries; pricing policies and consumer subsidies; food processing, import, marketing and sales; public information and education; legislation and regulations on food composition and contents; mass catering as a channel for improved nutrition; and research."

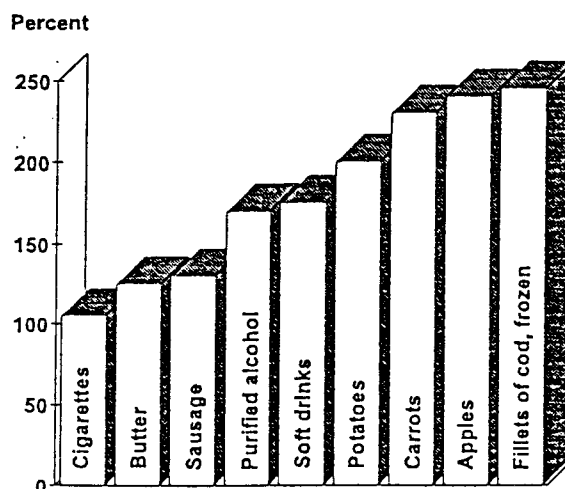
The following results were noted: "Although consumption of whole milk, cereals and margarine seems to follow recommended policy, it has not yet been possible to significantly change trends in sugar and potato consumption. Ten years after the Norwegian Parliament adopted the food and nutrition policy the conclusion seems to be: it works - but slowly" (4).

Many countries have developed their nutrition policy as an independent health policy, rather than directly integrated with such elements as pricing policies. This has been the case in Sweden, for example, where the nutritional changes aimed at include increased consumption of bread, cereal products and vegetables and reduced consumption of fat, sugar, cigarettes and alcohol. The pricing policies for these products are not - as illustrated below - very healthy.

The fact that prices of cigarettes as well as of butter are to a great extent directly controlled by political decisions (taxes and subsidies) makes the need for a multisectoral health policy even more evident.

The marginal effects of price changes on consumption patterns are furthermore likely to be greater among low-income than among high-income groups. Consequently, a healthy pricing policy - combined with health education - is important from the viewpoint of equity in terms of food-related morbidity and mortality.

Fig. 4.
Price increases for various products, 1970-1981 (5)



During the past decade, however, there has been increasing awareness of the health effects of different food policies. The impact of such health goals can be clearly seen in relation to the argument for reducing certain subsidies, such as those on products with a high fat content, as a way of achieving improvements in health. The healthy policy approach is not so evident, however, when there are calls for additional funds or implications of reduced revenue. Thus most countries still have to develop a comprehensive health policy that is integrated with agricultural and food production policies.

Healthy educational policies

Healthy educational policies can imply a number of things:

- that education for health is fully integrated in the regular curriculum from kindergarten to university level (special attention is then paid to attitudes towards different lifestyles);
- that health education for adults constitutes an integral part not only of the health services provided but also of social programmes, adult education, the mass media, etc. (the possibilities of reaching those at particular risk should then be given the highest priority); and
- that the training of professionals to work in health-related sectors should include in-depth training in how to promote health and avoid preventable diseases and early deaths within their sphere of professional competence.

The impact of healthy educational policies such as these should be monitored, both in terms of better knowledge of the major causes of various diseases and so far as behavioural changes as related to lifestyle are concerned. Since most health education programmes are more likely to reach and influence primarily middle- and high-income groups, it is extremely important to develop healthy educational policies which are also likely to benefit disadvantaged groups.

Healthy health service policies

The health effects of health services are usually not well known, nor is information about this requested by policy-makers. There seems to be a general assumption that health services “produce” health. The contribution to improved health in a population from a well developed health service system is sometimes estimated at 10%. At the same time, health services are still often considered a major determinant of health. At the extreme end of the scale, it is sometimes argued that modern health services might even make a negative contribution to health.

Considering that more and more efforts are being made to identify and analyse the health effects of sectors other than that of the health service, it seems logical to step up efforts to study the health impact of health services, too, in terms of:

- added years to life
- added health to years
- added life to years.

Particular attention should be paid to the balance between the strategies - and investments for attaining these objectives. The general tendency seems to be to give “adding years to life” very high priority as compared with the other two objectives. This is to some extent also reflected in the present HFA strategy, which has disease-specific targets only for fatal diseases such as cancer, cardiovascular diseases, accidents and suicide. Including disease-specific targets for diseases such as senile dementia (including Alzheimer's disease), mental disorders, diseases of the locomotive organs and allergies could be an important step - also from a health service point of view - towards encouraging a discussion of priorities within the health services. The need for this type of discussion is very likely to increase during the next decade, as many countries will introduce new types of competition between public health institutions. One such model entails hospital services being bought in by the primary health care system.

In such a competitive system - and with increasing financial constraints - particular attention must be paid to access to good quality care for people such as the elderly, those with mental disorders and those with allergies and diseases of the locomotive organs. In non-competitive systems these groups are already very weak and the cure and care they need is often time-consuming and thus costly.

Consequently it is of the utmost importance to assess - and monitor - the health effects of different strategies for funding public health services, both among various socioeconomic groups and in groups suffering from certain long-term nonfatal diseases.

In this context, attention should also be focused on the appropriate balance between private and public health services in terms of geographical, economic and cultural access.

The financial crises being experienced in most health service systems, in developed as well as developing countries, can thus be tackled in a cost-effective manner only if the health effects (in terms of reduced mortality and morbidity, as well as improved quality of life) are explicitly considered and analysed.

If this approach is not given due consideration, efforts to reduce the costs of health care may very well result in the promotion of an “unhealthy” health services policy in the name of a more “efficient” health system.

Lifestyle factors

Smoking cigarettes, drinking alcohol and giving preference to the armchair in front of the television over the jogging track around the park are often described only in terms of individual lifestyles. In this perspective, it is the choice of the individual that matters. It is assumed that, given adequate knowledge

Unfortunately, the approach adopted is then often to inform people what they should not do. Experience indicates that this is not a very effective way of bringing about changes, despite the fact that the actual knowledge about various hazards to health is improved.

An alternative approach is to focus on how to increase the perceived freedom to choose the healthier alternatives. In a class of underprivileged schoolboys very likely to start smoking, this may imply giving training in life skills and self-esteem rather than lectures on the relationship between smoking and - 20-30 years later - lung cancer. This is simply because one reason for smoking is often to compensate for assumed shortcomings in those human qualities. The perceived possibilities of making choices are obviously greater if the need for this type of compensation is reduced.

Intersectoral actions for health also have an important role to play in - as the WHO slogan rightly says - "making the healthy choice an easy choice".

In view of the above, it is evident that "enabling" intersectoral actions are also of critical importance with regard to changes in so-called lifestyle factors.

Measures to facilitate intersectoral actions for health

The specific actions that need to be taken to ensure that the health policy dimension is fully recognized in a comprehensive approach to development planning can only be determined in a country-specific context. There are, however, some general measures or policies which are likely to facilitate intersectoral actions for health.

Recognizing this the World Health Assembly in 1986 adopted a resolution (WHA39.22) which calls on Member States to - as stated above - identify and develop an integrated and explicit health policy within all health related sectors.

This is the very foundation of a comprehensive approach to health development. The main responsibility for formulating and implementing health policies on economic growth, housing, work, employment, agriculture, the environment, health services, etc., must of course lie with officials in the responsible sectors. In most cases, however, the work can be greatly facilitated if they cooperate with other professionals, for example epidemiologists and public health specialists, within the health service.

It is equally evident that the health policy of the health service sector can only - as illustrated below - be developed in close cooperation with other sectors that have the power to influence various risk factors.

In order to promote and facilitate this type of intersectoral action for health, the World Health Assembly also called on Member States to take a number of steps. These are outlined below.

Box 1

"To include in their health for all strategy specific equity-oriented targets expressed in terms of improved health among disadvantaged groups such as women, the rural poor, the inhabitants of urban slums and people engaged in hazardous occupations"

Unacceptable inequities in health between different socioeconomic and occupational groups exist in all countries for almost all diseases. There are even clear indications in many countries (including England and Sweden) of increasing inequities in such conditions as cardiovascular diseases. These social inequities in health are to a large extent directly or indirectly related to differences in living conditions,

including education and perceived possibilities of choosing a healthy lifestyle. Consequently, intersectoral actions for health are even more essential for reducing social inequities in health than for bringing about improvements in general health status.

A strategy to combat social inequities in health must thus be developed as an integral part of each sectoral policy as it relates to health. Targets set for specific risk reductions should include levels to be achieved among those at particular risk.

Box 2

“To use the health status within the population and in particular its changes over time among disadvantaged groups, as an indicator for assessing the quality of development and its impact on the environment”

In recent decades, many efforts have been made to develop different types of indicators to enable us to monitor social development in the same quantified manner as economic development. Difficulties in agreeing on the elements to be included in such an index of social development, as well as disagreements about the weights to be used for each element, have caused considerable problems.

Since country-specific health indicators are highly sensitive to changes in living conditions and lifestyles, they can however provide valid indicators of social progress. The reason for this is that socioeconomic conditions as experienced by various groups in society are often directly linked to their health status.

Governments should thus be urged to monitor social development by means of country specific health indicators that are sensitive to changes in living conditions within different social and occupational groups. These indicators of social development should furthermore be used in the same manner as GNP, for instance, as an overall indicator of economic growth.

Box 3

“To encourage and support action-oriented multidisciplinary research focusing on socioeconomic and environmental determinants of health, in order to identify cost-effective intersectoral actions improving the health status of disadvantaged groups”

Traditional medical research is often weak on analysing the socioeconomic determinants of health. Greater efforts must therefore be made to develop a macro-theory of health development involving such professionals as economists, sociologists, public health specialists and epidemiologists. The focus of this research should not only be on the potential effects of a specific social, economic and/or environmental risk factor; it should also include analysis of the cumulative effect of several risk factors.

This is of crucial importance for understanding the forces behind social and occupational differences in health, since underprivileged groups are usually exposed not just to one particular risk factor but to many of the factors associated with poor living conditions and an unhealthy lifestyle. In such situations, it seems very likely that cumulative effects increase the relative risk far above those of each factor considered separately (“1 + 1 equals 32”).

Equally important is research focusing upon why certain groups - despite being exposed to various known health hazards - do not develop the disease others contract from the same type of exposure. How is it, for example, that two thirds of all smokers do not get lung cancer?

This type of research has so far been neglected by medical scientists, because they are primarily interested in the determinants of specific diseases, rather than in the determinants of health. There is thus an urgent need to focus also on those factors which may increase people's ability to remain healthy in an unhealthy environment. Within this context, the quality and strength of social networks is of particular interest, given the greater knowledge we now have of the links between "social relations" and health.

Box 4

"To review the training of economic planners, agricultural extension workers, water engineers, teachers, environmental specialists and other professional groups who are to work in health-related fields, in order to secure an adequate understanding of intersectoral relationships with health within their sphere of competence"

Many professional groups are not yet fully aware of their professional role as related to health promotion and disease prevention. An economist presenting a proposal for reducing subsidies on agricultural products or a draft of a tax reform may realize only vaguely - if at all - that he or she is also dealing with a health policy issue. At the same time there are professional groups, such as road engineers, who have a long tradition of assessing such aspects as the risk of accidents on different types of road.

An intersectoral approach to health development must therefore also include adequate training for those who are responsible for various types of health impact analysis within their professional field. This does not imply that each professional group must be able to carry out these assessments alone, but that they have been trained to know when a health impact analysis should be carried out and how to collaborate with other professional groups in order to perform this task.

Box 5

"To strengthen the capacity within the health sector at national and local levels to assist other health-related sectors to formulate and evaluate intersectoral actions for health"

Collaboration between the health sector and other health-related sectors is usually very limited. This can be a serious constraint on health development, since only the health sector has full access to existing health information systems. Furthermore, there is a unique professional competence within the health sector as regards the aetiology of various diseases; this can be of critical importance for the work to be carried out in other sectors to promote health and prevent disease.

It is thus of the utmost importance to strengthen the capacity within the health sector to assist other health-related sectors in formulating and evaluating intersectoral actions for health.

The organizational set-up for facilitating this type of collaboration has to be highly country-specific (see box 7, below). The main problem is not, however, to find an appropriate organization, but rather to create an awareness within the health sector of its potential role in promoting health not only through direct preventive and curative services but also together with professional groups in other health-related sectors. Specialists in public health, occupational health and community medicine, epidemiologists and health planners with professional training in economics, management or sociology are likely to play an important role in this work. The concept of intersectoral action for health, as well as the concern for health development in general, must however be fully integrated in all branches of the health services. If this is not the case, there is an obvious risk of sub-optimal use of existing resources both within the health sector and in other sectors.

Even more importantly, this lack of cooperation without any doubt increases the risk of “unnecessary diseases”.

Box 6

“To ensure that the training of health professionals at all levels encompasses an adequate awareness of the relationships between environment, living conditions and local health problems in order to enable them to establish a meaningful collaboration with professionals in other health-related sectors”

The medical approach is usually reductionist rather than holistic, focusing on diagnosis and treatment of sick individuals rather than on how changes in the risk panorama may influence the health status of various groups in the population. Furthermore, there is a tradition of limiting the analysis of health development to historical data; thus very few, if any, attempts are made to analyse the potential effects, in terms of reduced mortality and morbidity, of various types of investment in health.

Consequently most physicians and other health professionals are likely not to include collaboration with other sectors in their professional role. Neither are they likely to become a real pressure group for reducing health hazards related to such factors as poor living conditions. Even in their daily contact with patients they might not include discussions about working conditions, employment status and family situation, even though they are known to cause specific health problems. This type of “medical cocooning” impedes intersectoral action for health and increases the risk - from the health service point of view - of medicalizing social problems.

It is thus of crucial importance that the training of health professionals - in accordance with the resolution adopted by the World Health Assembly - includes adequate knowledge of the social, economic and environmental determinants of health. This is essential for making the health sector better able to identify vulnerable groups, assess health hazards as experienced by different groups and assist other health-related sectors in formulating and evaluating intersectoral actions for health.

Box 7

“To develop appropriate mechanisms within the overall development process to promote intersectoral action for health at national and local levels, in order to facilitate efficient use of existing resources for achieving multisectoral health for all target”

The organizational set-up for intersectoral action for health is often considered to be the key for making progress in terms of more comprehensive planning for health development. Experience indicates, however, that the formal organization created for intersectoral collaboration is far less important than the interest and willingness of the groups concerned to tackle problems of common interest and formulate goals for joint ventures. Thus there are many examples of highly informal and flexible organizational structures - in particular at the local level - within which various intersectoral actions are carried out. At the same time there are formally created bodies with representatives from various health-related sectors which primarily discuss the possibilities for and constraints on collaboration but which have very limited impact in terms of practical achievements.

One lesson to be learned from this experience is that intersectoral action for health should never be seen primarily as an organizational issue. It is of the utmost importance not only to permit but also to stimulate cross-sectoral collaboration, even if no formal structure exists for this type of collaboration.

In addition to these informal action-oriented initiatives it is often useful, however, to have a fairly small and high-powered body for promoting and facilitating intersectoral action for health. At local level this type of health council could be created in each district, commune, etc., with members drawn from those responsible for areas such as primary health care services, environmental issues, housing, social services, finance, education and labour market issues. The sectors represented at this level will depend of course, on the administrative and political organization in each country. The chairperson of the local health council should, however, be someone with overall responsibility covering most of the sectors involved.

The same type of set-up can be applied at national level, with senior representatives from various health-related ministries and public agencies, including ministries of planning and finance. The chairperson of this national health council should ideally be at the level of head or deputy head of state.

The institutional set-up for intersectoral actions for health can thus be created within the existing organizational structure and without changing the responsibilities at present assigned to various sectoral bodies/organizations. This is likely to facilitate cooperation as compared with the situation where a more comprehensive approach to health development requires major shifts in duties and funds.

Health development and democracy

A few concluding remarks

Descriptions of various types of intersectoral action for health sometimes give the impression of being an advanced form of “health engineering” performed by different professional groups. In order to avoid this type of “instrumental” view, it may be useful to recall that the real key issue is not what technically **can** be done in order to reduce various risk factors but what we as individuals and society **want** to do.

A healthy public policy must therefore, primarily be based on either the choice of individuals, or decisions taken within the democratic process. In this perspective, intersectoral actions for health often constitute the best - and sometimes indeed only - tool for **increasing the possibilities** of avoiding unnecessary health hazards.

No one wants to live a life where all risks are minimized. It can never be a rich life. We all want to live with certain risks, simply because there is a positive trade-off in terms of other benefits. This is obvious as regards many lifestyle factors, be it the food we eat or the sports we enjoy.

It is equally clear that trade-offs between health and other benefits must be considered in all health-related sectors, e.g. as regards road safety, agricultural policies and city planning. A healthy public policy should then as far as possible be one of influencing people's points of view within the democratic process.

This may seem self-evident, yet the history of health promotion and disease prevention is full of examples where the health policies introduced were perceived as “big brother” telling people what should be done and where regulations in the name of “health” were seen as limiting the freedom of the individual.

Following this line of thinking about “health hazards” as isolated entities, some professionals - often with a medical background - find people highly irrational in being extremely concerned about health hazards at work but ignoring much greater risks as related to their lifestyle. Seen in this perspective, the solution is better information about the magnitude of various health hazards. From the individual's point of view, looking at life as a whole, it is however very logical to focus on avoidable health hazards at work, which

generate nothing but unnecessary diseases, while regarding the benefits of certain eating habits as greater than the increased risks involved from a health point of view.

This authoritarian and technocratic approach to health development is doomed to fail in societies where an increasing proportion of well educated and concerned citizens want to increase their possibilities of choosing the life they want to lead.

The very base for health development must thus be the will of the people as expressed in individual choices and within the democratic process. In order to facilitate this, real options and alternatives must be available not only to the few - the privileged - but to all. This implies that special attention must be given to groups at particular risk. In a European context, the most vulnerable groups in terms of poor health and early death are usually found among people living in poverty, unskilled workers, the unemployed, migrant families, certain ethnic minorities, one-parent families and children of parents with low incomes and social problems.

The typical pattern found is thus an inverse relationship between poor living conditions and good health. In other words, as stated in the European HFA strategy, "most of the present differences in health status are determined by living and working conditions". Consequently, intersectoral actions for health focusing on healthy public policies are of particular importance for disadvantaged groups.

In operational terms, an equity-oriented intersectoral approach to health development may include action aimed at goals such as reducing existing inequities in income and other material resources, within the context of:

- a strategy for economic growth (the success of this approach is seen in Japan, for instance, where health conditions among less privileged groups have improved faster than among the rest of the population, resulting in the healthiest population in the world);
 - stricter legislation to reduce the risks of work-related diseases;
 - a healthy price structure for agricultural products;
 - social renewal programmes for deprived urban housing areas;
 - a healthy school policy, including special efforts to support children from underprivileged families; and
 - access to health services according to need, regardless of ability to pay.

Stated in terms such as these, it is obvious that a healthy public policy must be fully integrated with general strategies for social and economic development. It is equally evident that issues related to health development must also be analysed from a financial point of view. The present tendency to discuss healthy public policies in a financial vacuum is doomed to fail. A major step forward would thus be to introduce explicit health budgets within all health-related sectors, to be used whenever possible to "tip the balance" in favour of a healthy public policy.

Furthermore, there is an urgent need for action-oriented research which tests the effectiveness of alternative intersectoral actions for health. Usually, pilot programmes of this type cannot be financed either from an ordinary sector budget or from research funds. In order to facilitate such intersectoral health programmes, national as well as local funds for health development could be established. The governing bodies for these funds could be the national and local health councils, respectively (or similar coordinating bodies).

Particular attention should then be paid to the process of implementing and managing intersectoral action for health. The main problem is not to identify "what to do" but "how to get it done". The WHO Regional Director for Europe has expressed this in the following words: "Despite widespread consensus on the importance of intersectoral action there is, however, still relatively little knowledge of how best to

Particular attention should then be paid to the process of implementing and managing intersectoral action for health. The main problem is not to identify "what to do" but "how to get it done". The WHO Regional Director for Europe has expressed this in the following words: "Despite widespread consensus on the importance of intersectoral action there is, however, still relatively little knowledge of how best to implement it. Challenges which need to be overcome for its successful application include such things as competition for resources and power, lack of understanding of other groups' vested interests, minimal horizontal thinking in management processes and the perceived need for short-term political gain over long-term social benefit." (6)

In spite of the problems encountered, there is no doubt that intersectoral action for health is the only viable approach to health development in general and to reducing social inequities in health in particular. No other approach is feasible, given that the main determinants of health are to be found within almost all sectors of a modern society. The real choice is then to decide whether the health consequences - positive as well as negative - should be explicitly considered or not. The answer may seem to be obvious from a health policy point of view.

The present state of the art is however that many, if not most, intersectoral health policies are implicit rather than explicit. This often implies that negative consequences are not discussed and that positive effects may be unnecessarily attenuated. Furthermore, this implies that the possibilities of influencing important health policy decisions within the political democratic process are very limited. This is probably the greatest threat to the gradual development of an equity-oriented health policy.

REFERENCES

1. Targets for health for all, Copenhagen, WHO Regional Office for Europe, 1985 (European Health for All Series, No. 1).
2. Developed from figure in Haglund & Svanstrom. *Samhällsmedicin - en introduktion* [Community medicine - an introduction]. Stockholm, Studentlitteratur 1983 (p.63).
3. Kennedy, I. The Reith Lectures. *The Listener*. 20 November 1980.
4. *Intersectoral action for health*. Geneva, World Health Organization, 1986.
5. *Hälsa och sjukvård inför 90-talet* [Health and health policy for the 1990s].
6. Stockholm, Ministry of Health, 1984 (p.44).
7. Asvall, J.E. In: Taket, A.R., ed. *Making partners: intersectoral action for health*. Rijswijk, Netherlands Ministry of Welfare, Health and Cultural Affairs, 1988.

3. THE DISCUSSION GROUPS

The purpose of this set of discussion groups was to present and distill the key issues relating to intersectoral action for health. Links between the health sector and sectors dealing with social issues, the environment, finance and trade, housing and the living environment, agriculture and the food industry and education were examined and participants identified some of the challenges and opportunities for different sectors to work together.

Each of the discussion groups had a chair, rapporteur and facilitator and guidelines were issued to assist those responsible for running the groups. Participants were free to join the group of their choice. However, this was determined to some extent by the availability of simultaneous translation in certain groups. Each group was asked to report back to the Steering Committee in writing and this provided the material to be included in the "9 o'clock news" read by Claire Klausen each day. (See Volume I for a detailed account of this innovative means of reporting back to plenary).

Groups heard presentations of different country approaches and experiences and identified ways Member States could initiate change and how they could be supported in this task. On the basis of their discussions, the groups made a number of recommendations on how interventions by WHO, other IGOs, Member States, NGOs and the mass media could support intersectoral action for health.

In advance, the groups had been issued a set of questions or problems to help guide the discussion. This was intended as a loose framework rather than a rigid agenda. The groups were essentially free, under the heading of the main topic, to pursue the issues they themselves felt were most important. As a result, the key issues raised in the discussions did not always correspond to the guidelines. Many valuable points were raised however and a wealth of knowledge and practical experiences shared.

