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INVESTING FOR HEALTH

Bolzano, Italy, 13-14 October 1995

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THIRD ANNUAL CONFERENCE OF THE REGIONS FOR HEALTH NETWORK

Bolzano, Italy, 13-14 October 1995

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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 PROMOTION
POLICY MAKING
INTERSECTORAL ACTION
CONGRESSES
ITALY
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Foreword

One evening, on his way home from work, a man sees his neighbour searching underneath a lamppost. "Have you lost something " he asks, beginning to help him search. "Yes, my keys", the neighbour replies. They continue to search but to no avail, and eventually the second man says "Are you sure this is where you dropped them?". "No" replies the neighbour, "but this is where the light is".

Many of us working in the health sector are like the man in the story, looking for solutions in places where we probably will not find them, afraid to break out of traditional ways of thinking and working, or to move away from the familiar light we are comfortable with.

At its third Annual Conference in Bolzano, the Regions for Health Network took the opportunity to shine the light in a different direction and explore ways to bring about a broad based approach to investing in health by putting health at the centre of economic and social development.

Today, European policy-makers must face complex challenges. In the framework of their societal values, they must find the appropriate balance between demands for equity and solidarity, sustainability, efficiency, and accountability. They must make trade-offs between one policy intervention over another, and cope with both long-entrenched and new social problems. To solve many of the problems facing the health sector, health promotion and disease prevention must be high on the agenda of sectors, such as education, transport, social care, and environment. This message underpins the Investment in Health approach, which aims to prioritize the opportunities for health gain; to build organizational, technical, and political capacity; and to generate intersectoral processes for health.

We were delighted that so many regions were able to attend the Conference, particularly those from central and eastern Europe, many of whom are working at the level of regions for the first time. It was most impressive to find that so much intersectoral activity is already happening in regions, for the development of policies which promote and sustain health. In particular, the demonstration projects undertaken by the regions of Bolzano and Trento, in collaboration with the Investment in Health Unit in WHO/EURO proved that the regional level can be an excellent setting for testing the investment for health methodologies, and the tools for implementation. Moreover, for those regions which only now are thinking of embarking on a similar process, the task will not be as uncharted as for these first pilot regions.

We may feel the need for change, or even realize that in order to progress we must change. Once we take that step, and reach out to other groups and sectors, we will find a wealth of knowledge and experience to help us meet the challenges. As with the man in the story, it may be more comfortable in the light of the lamppost, but if, after all, what we really want to find is the key, then we must be prepared to be more flexible, and to shine our lamp in yet unexplored corners.

Anna Ritsatakis, Ph.D.
Regional Adviser for Country Health Policies
and focal point for Equity in Health

1. INTRODUCTION AND SUMMARY

1.1 Purpose of the Third Annual Conference

The Regions for Health Network held its third Annual Conference from 13-14 October 1995. The meeting was organized by the World Health Organization and hosted by the Autonomous Province of Bolzano, Italy.

The theme of the Conference, "Investment for Health", attracted representatives from the Regions for Health Network (RHN), and other European regions. The work of the Conference was dedicated to enhancing the ability of decision-makers to develop investment for health strategies at the level of regions. Its specific goals were to:

- discuss and debate the concepts and principles of investment for health;
- take stock of innovative experiences emerging from the "Investment for health demonstration projects", and from experiences in intersectoral action for health gain accumulated in member regions of the RHN, as these relate to four key principles of investment for health (equity, accountability, sustainability, and empowerment);
- identify facilitating circumstances or obstacles to developing intersectoral policies for health, based on the four key principles;
- explore the capacity of regions to implement investment for health strategies; and
- suggest areas for further work and collaborative efforts to promote the development of investment for health strategies in RHN member regions.

The Conference was arranged in two main plenary sessions, one of which was followed by parallel working groups in which participants were asked to identify the factors, which facilitate and inhibit investment for health. The necessary background information was provided in the plenary session, in the form of case studies from the investment for health demonstration projects carried out in the Italian region of Trentino Alto-Adige (Bolzano and Trento), and the Spanish region of Valencia, (in collaboration with WHO/EURO's Health Promotion and Investment (HPI) unit) and a report on investment for health in the health services in Wales.

1.2 The context of the 1995 RHN Conference

In 1993, the Regions for Health Network held its first Annual Conference in Barcelona, exploring prospects for health gain in its member regions with particular emphasis on the role of health professionals in health promotion. During that meeting, a number of

regions presented their experiences on issues such as the development of overall policies for health promotion; the use of a settings approach involving hospitals, schools, the workplace and the community; as well as the implications for the development of economic and non-economic incentives for health promotion and consumer empowerment. In all cases, an attempt was made to examine the potential role of the thousands of health professionals in Europe, in the new approach to health.

1994 was the year when WHO, in collaboration with the European Commission and the Council of Europe, was to organize a ministerial level conference on health policy (European Health Policy Conference, Copenhagen, 5-9 December, 1994). The RHN, therefore, chose to look at the process of health policy development and the specificity of this for regions, as the theme for its second Annual Conference, held in the county of Bacs-Kiskun in Hungary.

In the meantime, the HPI unit in WHO/EURO had been involved in demonstration projects in regions in Italy and Spain, which focused on the development of methodologies and tools, tailored specifically to the achievement in practice of the principles of health promotion. These methodologies and tools as well as the processes they are designed to set into motion, are subsumed in what has been called the "Investment for health" policy approach.

This approach introduces rigorous and disciplined methods for identifying and prioritizing opportunities for health gain, as well as for building organizational, technical, and political capacity for the implementation in practical terms of a health promoting strategy. At the same time, the application of investment for health principles is intended to generate intersectoral processes that extend across diverse policy sectors and are based on broad community involvement and participation.

In the framework of WHO/EURO's Health for All principles and the 1986 Ottawa Charter on Health Promotion, the HPI unit has identified four key principles[1] upon which the success of an investment for health strategy depends:

i) equity

ii) sustainability

iii) empowerment

iv) accountability

The "Investment for health" theme of the Third Annual Conference of the RHN offered a logical continuity to the numerous issues that were raised and explored in the previous two years.

[1] See Annex I

1.3 Main outcomes

Representatives from 19 European regions took part in the Conference. Most of the delegates were already RHN members, and among them was a strong representation from central and eastern Europe. For the participants from some countries, developing health policies at the level of regions was a new experience and the Conference provided an important opportunity to discuss investment for health strategies and to establish and strengthen links for future exchange of experiences. A number of regions which were not yet RHN members also attended the Conference, and this mix of participants allowed for an interesting and lively exchange of ideas and experiences.

Three case studies on developing investment for health at the level of regions demonstrated that sufficient evidence can be found, reasonably assessed, and presented in a way which allows a transparent discussion of priorities, and consideration of the possible trade-offs which in practice must be made when choices between potential priority areas are made. Participants were given the opportunity to learn about the projects which have focused on the development of methodologies and tools for investment for health, and to explore how they could incorporate the lessons from these experiences in planning their own investment for health strategies. In doing so, they were also able to act as a sounding-board for the host region, offering the reactions of experienced policy-makers, to what was presented to them.

Participants identified facilitating circumstances and obstacles to developing intersectoral policies for health and looked at the challenges to putting investment for health thinking into action. Some of the main concerns included how to achieve a balance between long-term goals and short-term incentives, the need for an ethical framework, the need to make trade offs in policy implementation, and the importance of using the full intelligence of the policy environment.

They agreed that their common goal, both through the RHN and individually, in their own regions, was to **make change happen**, and they offered a number of suggestions as to how this might be achieved. In particular, they identified information and public opinion as important forces for change. They proposed that if intersectoral action is to be achieved, health agencies must initiate that process by being the first to change themselves. Participants suggested a number of ways in which agencies for health could begin the change process.

Linking the work of the RHN Annual General Meeting, which had taken place the previous day, to the work of the Conference, participants also explored the capacity of regions to implement investment for health strategies, with particular reference to how the RHN could provide support in this task. They felt that greater emphasis should be placed on:

(i) expanding channels of information exchange

(ii) improving RHN's knowledge base

(iii) providing training for regional level personnel

(v) building alliances with other networks such as the European Committee of the Regions, politicians, the national and municipal levels, and general public

(vi) marketing the HFA approach more vigorously with local opinion formers.

2. OPENING CEREMONY

2.1 Statements by local hosts and WHO representatives

Dr Di Puppo, Minister for Finance and Vice President of the Region of Bolzano, welcomed participants, and expressed his pleasure that Bolzano was able to host the RHN Conference. He explained that in opening the Conference, he was wearing two hats. Normally, as Vice President of the Region of Bolzano, his role was to oversee matters pertaining to health, but he felt that his capacity as finance minister made it particularly appropriate that he was attending a conference on investment for health. Still wearing his finance hat, he described health as an important "asset" for all communities - a depiction which he felt was particularly appropriate in view of the increasing use of terms such as "optimization" and "health gain" in the health sector.

He stressed that health was an issue of international importance, pointing out that it had the ability to transcend political and geographic borders, and to unite people in the name of the common good. However, Dr Di Puppo felt that a concerted effort was required to overcome some of the challenges posed by the globalization of health, and he referred in particular to the spread of disease as a result of greater travel.

He felt that there was considerable economic advantage to be gained from investment for health. Currently the region of Bolzano spends 25% of its overall budget on health, and although this is a heavy financial investment, he hoped that the investment would pay off in the future. As of yet, it was too early to assess what the actual benefits would be.

Referring to the strategy itself, he explained that the aim in this region had been to "add life to life", as opposed to simply "years to life". Emphasizing that Bolzano had been pleased to have been chosen by WHO for the investment for health pilot project, Dr Di Puppo remarked that the region now looked forward to also becoming a member of the Regions for Health Network. He expressed the hope that the Conference would enrich participants' experience in developing investment for health strategies, and that they would use it as an opportunity to further exchange information and expertise.

Dr Sakellarides, Director, Health Services Department, WHO Regional Office for Europe welcomed participants to the Conference on behalf of the WHO Regional Office for Europe. He began by pointing out that there is sometimes a difference between what those working in the health field would like to achieve, and what is actually feasible and practical for them to achieve.

He described this scenario in terms of a mask and a face; the mask is what people like to be seen as, the face represents their place in the real world, and the space for change can be measured as the difference between the two. In the case of WHO, Dr Sakellarides proposed that the mask is symbolized by health for all (HFA), while the face represents the real world, with all its various challenges and constraints.

The challenge for WHO is to bring the face and the mask closer together, and to narrow the distance between HFA goals and the real situation in countries. In order to achieve this goal, Dr Sakellarides stressed the importance of developing both conceptual and practical ways of promoting health. He expressed his appreciation to Dr Bianchetti, Dr Martini and Dr Spolaore for sharing the challenge with courage and practicality. He also thanked Dr Erio Ziglio, WHO/EURO for his collaboration, and for making the magic connection between the "health people" and the "finance people".

Pointing out that HFA combines dreams with reality, Dr Sakellarides acknowledged that ideas and goals taken from the text book world of policy-making may seem vague. However, he stressed that beyond the ideas and theory, people are working very hard to bridge the gap between conceptual frameworks and practical action. These were the type of people who gave their input to the Regions for Health Network (RHN), and he expressed his appreciation to the RHN for their considerable efforts over the past three years, and to Dr Anna Ritsatakis and Frances Ingels, who ran the Secretariat for the Network.

Dr Sakellarides pointed out that there was a difficult road ahead both in Member States and in WHO. He stressed that in the future, in order to focus scarce resources effectively on priority areas, WHO intends to be even more explicit about its goals and plans, and that its partners would also need to carefully consider their goals and objectives. Collaboration should then feed into an agreed common initiative, and he hoped that each of the partners would have the courage to live up to the challenges.

Dr Sakellarides drew attention to the RHN's development since it was founded in Düsseldorf in 1992, describing it as a vibrant and effective network with sophisticated ways of communicating and exchanging information. Anticipating its continued growth and development, he expected the Network to become an extremely important force in the future Europe of the citizens.

Expressing his thanks once again to RHN members for their considerable effort, Dr Sakellarides wished them the best in all they were hoping to achieve in the future.

Speaking on behalf of ***the RHN Secretariat, Dr Anna Ritsatakis, Regional Adviser for Country Health Policies and Equity in Health, WHO Regional Office for Europe,*** pointed out that regardless of whether Dr Di Pupo was wearing one hat or two hats, both he and Dr Mario Bianchetti were certainly the right people, in the right place, at the right time. People who were prepared to initiate change were crucial to the process of health policy development, and she felt that in the case of Autonomous Province of Bolzano, the ground had been particularly fertile. Key people had been attuned to the need for change, and more importantly had been ready to make the leap between thinking, and the type of practical action, which makes change happen.

Dr Ritsatakis welcomed participants on behalf of the RHN and emphasized the importance of using the forum of the Conference to share information and practical experiences on developing investment for health strategies at the level of regions, as fully as possible. She informed that participants would be expected to work both in plenary and discussion groups, and that later in the day there would be an opportunity to work with

Mr Laurie McMahon, Director, Office for Public Management in the United Kingdom, who would introduce some innovative ways of facilitating discussion and getting the most out of sharing knowledge and experience.

Dr Ritsatakis explained that working at the level of regions is a relatively new undertaking for the WHO Regional Office for Europe, which has previously worked mainly at the national level, and at the local level through the Healthy Cities project. She pointed out that the regional level was also a new experience for some central and eastern European countries, where new legislation on decentralization was being introduced to establish regional authorities. Describing health as possibly one of the less controversial policy areas, in some respects, she hoped that regions would find it easier to establish commonalties in other areas, if they worked together with health as their focus. They might then be more prepared to develop the thinking, attitudes and practices which are essential for implementing the decentralization processes being formally established through new legislation.

Dr Ritsatakis concluded that the potential for developing health policies at the level of regions and for putting health high on the political agenda, had been considerably enhanced as a result of the recent establishment of the EU Committee of the Regions. She expressed the hope that participants would avail of the Conference as an opportunity to build on this potential by exploring new ways of developing policies and initiating responsible change.

Dr Mario Bianchetti, President of the Fondazione Incontri di Madruzzo, assumed the chair for the first session. He thanked the opening speakers and responded that Dr Ritsatakis was also the right person, in the right place, at the right time.

Introducing the opening speaker, he paid tribute to Dr Ziglio, for his ground-breaking work in developing the health promotion and investment for health strategies in Bolzano and Trento.

3. INVESTMENT FOR HEALTH: the conceptual framework

3.1 The intersectoral framework - concepts and principles

In his presentation, ***Dr Erio Ziglio, Regional Adviser for Health Promotion, WHO Regional Office for Europe*** prepared to address the following issues;

(i) current trends in the European Region, and their implications for health;
(ii) the need to shift from concern about the organization of health services to the development of policies which promote and sustain health; and
(iii) the role of investment for health strategies in developing such policies.

Dr Ziglio proposed that an investment for health strategy can help decision-makers deal in a practical way with the health implications of trends such as economic regionalization, recession, democratization, conservation, popularization, and migration. He stressed the importance of investment for health thinking, emphasizing that in the twenty-first century, health promotion should not be perceived as a "service", but as a decision-making process which is at the centre of economic and social development.

Dr Ziglio introduced participants to a situation where European policy-makers are looking increasingly worried due to the prevalence of many of the above mentioned trends. Rising costs of health care, higher expectations of services, and requirements to achieve more effectiveness and efficiency with less resources are everyday challenges across the European Region. Policy-makers must make complex decisions which involve trade offs between one intervention over another, for instance whether to invest more in high technology or in primary health care. They must cope with increasing levels of migration, marginalization and poverty, and new types of social problems, such as violence, drug abuse, AIDS, and accidents.

All of these are factors which can seriously effect people's chances for health, and Dr Ziglio emphasized that, as a result of such trends, policy-makers were (and should be) putting health promotion and disease prevention higher on their agenda. He explained that many countries were now aiming to change attitudes to health, by encouraging people to avoid health-damaging behaviour such as smoking, and by promoting sensible drinking, eating, and exercise patterns. Dr Ziglio was optimistic that the tools of health promotion could enable policy-makers to achieve this aim, and bring about substantial improvements in health status.

Currently, he felt that policy decisions were overly focused on achieving a balance between financing services and access to health care, and that greater attention should be focused on policies which promote and sustain health.

There were, he felt three basic questions which policy-makers should address when developing such strategies.

(i) Where is health produced and sustained?
(ii) Which investment strategies produce most health gain? and
(iii) Which investment strategies help to reduce health inequities, and are in line with human rights?

In order to increase health gain, he felt that it was crucial for the health sector to work with other sectors, such as education, transport, social care, and environment. This would provide policy-makers with a "map for possible investment" but, before embarking on the journey Dr Ziglio advised careful assessment of the opportunities for health gain, the costs of implementing policies, and the investment trade offs of each initiative. Emphasizing that the map should not be the only signpost which policy-makers use, he stressed the importance of criteria such as equity, sustainability, empowerment, and accountability to guide decisions.

Referring to the two recent investment for health projects, undertaken by the autonomous regions of Bolzano and Trento, he felt that the regional level had proved to be an excellent setting for testing the investment for health methodologies, and also the policy tools for implementation.

Dr Ziglio also referred to an investment for health project being undertaken by the region of Valencia in Spain. The strategy there had involved linking health objectives with the objectives of two of the most important sectors for the region's economic and social development - tourism, and agriculture. The task was for each of these sectors to look at the added value of investment for health, and for the region to create a health strategy which looked beyond health care.

The focus of the project had been to encourage "healthy tourism" in the hinterland of the Valencia Region. It was believed that this would relieve an unhealthy concentration of tourists and workers in the tourist trade on the coast (the health perspective), and to provide some product differentiation for the Valencian tourist industry (the tourism perspective). The initiative was also intended to help prevent rural depopulation (the Department of Agriculture's perspective on the issue).

Dr Ziglio acknowledged that conflicts between sectors can make intersectoral cooperation difficult to achieve with different sectors "rowing" in different directions. However, if the investment for health approach is to succeed, he emphasized that people must "row" together as much as possible.

Although the process is relatively new, he felt that already a strong impact had been made with regard to establishing new political and professional alliances, and achieving effective and far reaching changes in the health care system. Dr Ziglio advised that sometimes the shortest road is not the best. It was, he felt, more important to know the destination than to arrive there quickly, and he strongly emphasized that change and innovation must be managed. He described investment for health as the wide range of levers and supports which were available to policy-makers for that task. Concluding on a sea-faring note, Dr Ziglio proposed that it was more important for decision-makers to know how to trim their sails, rather than which way the wind was blowing.

3.2 Making it happen: an overview

Mr Laurie McMahon, Director, Office for Public Management, London gave a brief overview of what he believed were the essential conditions for bringing about the type of change which facilitates investment for health. He began by introducing participants to the world of the typical policy-maker, a terrain which he felt was very different to the world of WHO and health for all. In fact, Mr McMahon proposed that many policy-makers were not familiar with, nor did they understand, WHO language.

To illustrate this, Mr McMahon sketched a model of the world of policy-making. In this world, each policy-maker presided over a different policy sector, symbolized (in the illustration) by a closed pyramid structure. There were no links between sectors or with the outside world, so essentially, policy-makers were locked into this hierarchical structure and were quite remote from what was happening outside of that world.

Mr McMahon felt that the purpose of the Conference should be to identify ways of breaking up this compartmentalized picture, to build links between the sectors, and promote new ways of thinking. However, he acknowledged that in the real world, achieving intersectoral action would require a fundamental change in the way policy-makers think and work. Although many small investment for health projects were being sustained, he emphasized that they required a disproportionate amount of energy to keep going, and very little was happening on a large scale.

Drawing attention to some of the challenges facing policy-makers, he stressed that sectors have independent and often conflicting policy trajectories, and that this could pose an obstacle to getting sectors to work together in an integrated way. He posed such questions as how could integration be achieved in face of different organizational cultures and ways of working and how could policy-makers overcome the prejudices which prevent them from learning from each other, and share resources and power?

Answering some of these issues, he proposed that the first step should be for those working in the health sector to spend more time learning about the objectives of other sectors, and to be more familiar with the political hinterland of other ministries. He felt that this would help to identify possible areas for collaboration, pointing out that particular attention should be given to sectors dealing with areas such as transport, environment, and agriculture. He also advised identifying the incentives and trade offs of different strategies, and assessing the bargaining power of the health sector relative to others.

Mr McMahon was adamant that the proposal would not succeed if the objective were as broad as to work for the common good, or purely an intellectual exercise. Each sector must be aware of the incentives, and in a position to avail of the benefits from investment for health. Initially people tended to work together because of the incentives, but as sectors become more familiar with each other's culture and way of working, he proposed that the dynamics often change. Incentives are then no longer the driver, and instead of being advocates of intersectoral action, policy-makers become real players.

Mr McMahon concluded that in order for large scale institutional change to occur, those responsible for making health policy decisions must look beyond the health plans to develop strategies for change.

3.3 Report from the discussion

In the questions and reactions which came from the floor, one participant made the suggestion to Dr Ziglio that policy-makers cannot create health, but rather that they create the conditions which can sustain and protect health. Dr Ziglio agreed with this interpretation.

Whilst agreeing with Mr McMahon's view of possible conflicts of interest and the inherent difficulties in achieving intersectoral collaboration, Dr Ritsatakis felt that it was also important not to lose sight of some of the recent positive developments in health policy. Emphasizing that considerable progress had already been made in a number of countries, she drew attention to the contribution made by WHO and its Member States in terms of building alliances and fostering cooperation between different groups and sectors. Challenging Mr McMahon's rather negative interpretation of the policy-makers' world, Dr Ritsatakis pointed out that there was a significant lack of reference to "people" in his model. She stressed that frequently, individual people were instrumental in making change happen, when it was the right time, and there was sufficient opportunity. The experience in Valencia had been a good example of this in the past, but in that region as in any other, political and economic circumstances could change, and the new circumstances might not be so favourable to health policy development. The instability of the political environment in some countries was one of the challenges facing RHN, and Dr Ritsatakis emphasized that when opportunities do present themselves, decision-makers must be ready to seize them.

Taking Albania as a recent example, she explained that as a result of the government's plans for overall socio-economic development, interest has been renewed in developing a health for all policy. WHO had seized this as an opportunity to promote intersectoral action for health, and had been looking at the health sector in relation to the development of other sectors, with the aim of building cooperation around common objectives.

Mr McMahon agreed that timing and opportunity were very important and remarked that by knowing which way the wind was blowing, it was possible to sometimes hitch a ride in the right direction.

Participants felt that intersectoral cooperation can be difficult to achieve because policy-makers are reluctant to move resources between sectors. Dr Ziglio proposed that one way the problem could be overcome was by earmarking a certain amount of resources, (perhaps 2.5 - 5%) for work with other sectors. However, he felt that this aspect could only be explored once the basic groundwork for collaboration had been laid down.

Mr McMahon recalled his recent work in Finland where, as part of its economic restructuring, the government had introduced health cuts. Surprisingly he had found that disinvesting from the health sector had actually resulted in some health benefits, giving an indication that economic decline need not always be accompanied by a decrease in health status.

4. INVESTMENT FOR HEALTH: case studies

Dr Weihrauch from the Ministry of Employment, Health and Social Affairs, Northrhine Westphalia and focal point for the region of Northrhine Westphalia in the RHN chaired the second session, which involved presentation and discussion of Investment for health strategies from three regions - Bolzano, Trento, and Wales[2].

4.1. Background to the Demonstration Project in the Provinces of Bolzano and Trento

In November 1993, the Provinces of Trento and Bolzano engaged the support of WHO to establish a demonstration project that would help them think about how the structures, processes, and resources under their control could be better used to promote health. The project was felt to be particularly important in view of the increasing pressures being placed on health services, and the constraints posed by diminishing economic resources. In Italy, as elsewhere in Europe, there was growing recognition that providing better health care was not necessarily the best (or the only) means of ensuring improvements in health.

A number of reasons have been put forward to explain this:

(i) Inequity of access - not all sections of the population benefit equally from health care.

(ii) Demands for and expectations from health care are rising, yet resources to meet these are limited.

(iii) Marginal benefit arising from the money spent on health care is diminishing. Despite the fact that a greater proportion of health care resources is directed towards tertiary and secondary care than towards primary care, there are diminishing marginal benefits to be gained from health care expenditure at the more specialist end of the spectrum. In fact, expenditure on primary care often yields greater health gain per unit of expenditure than secondary and tertiary care. The need to shift the balance of investment from secondary to primary care and to measures for the promotion of health was a particularly important issue for the Provinces of Trento and Bolzano.

(iv) Most health care is reactive in nature, tending to focus more on illness than on promoting health. Typically, preventive measures concentrate on a single risk factor, even though the determinants of health and illness are complex and multifactorial.

[2] Unfortunately, as a result of changes in the Valencia region, Dr Colomer and Dr Alvarez were unable to present the work which had been carried out in their investment for health project

As a result of these limitations, there is greater awareness in European Member States of the need to focus on health promotion, and to develop investment for health strategies which pay social and health dividends both in the short and in the long term.

In the case of Bolzano and Trento, this new awareness gave rise to the "Investment for health" demonstration project, the aims of which were to:

- **develop and test policy tools** to show how current and future investment of public resources can be reoriented to secure improvements in health;
- **strengthen the capacity** of responsible public authorities to support health gain for the population;
- **enable local resources** to undertake and sustain processes of analysis, formulation, and implementation of policies for health.

External support to the project was provided by the Health Promotion and Investment Unit of WHO/EURO, working in partnership with Yale University (a WHO Collaborating Centre) and the Office for Public Management in London. Within the Provinces, the work was led by a Steering Group, with the detailed fieldwork carried out by two Operational Teams and supported by the Fondazione Incontri di Madruzzo.

As a demonstration project, the initiative was not concerned with the implementation phase. It did however enable managers, politicians and others in the two provinces to learn important lessons about how they might implement an investment for health strategy for two specific health issues.

(i) the prevention of injuries from accidents and
(ii) the promotion of healthy aging

The two case studies were presented in the Conference by Dr Paolo Spolaore, Director of the Department of Health, Autonomous Province of Bolzano Alto-Adige, and Dr Giovanni Martini, Director of the Health Planning and Research unit, Autonomous Province of Trento.

4.2 Achieving health gain for specific population groups - the case of healthy youth in Bolzano

Dr Spolaore, Director of Department of Health, Autonomous Province of Bolzano Alto-Adige presented the Bolzano project, which had focused on the theme of accident prevention. He informed participants that the health promotion strategy had its origins in HFA 2000 and the 1986 Ottawa Charter which defines Health Promotion as "the process of enabling people to increase control over and to improve their health".

Promoting health is described in the Charter as requiring action in five specific areas:

- Building healthy public policy;
- Strengthening community action;
- Creating supporting environments;
- Developing personal skills; and
- Reorienting health services.

These five areas for action were also at the core of the "Investment for health" demonstration project.

Dr Spolaore explained that the basis for the strategy was the HFA goal **that everyone should have the level of health which is necessary to lead a productive life.** He pointed out that, in order to achieve this goal, a new interface linking people and health was required, and the project explored some new approaches for taking the concept of promoting health from principle to practice.

Emphasizing that countries have very different health objectives, Dr Spolaore proposed that, in order to overcome the challenges, policy-makers must be determined to achieve their goals. They must also be prepared to develop and use certain policy tools. Through the use of the tools, which can be regulatory, organizational, managerial, or educational, policy-makers can gain a better understanding of how current and future investment of public resources can be reoriented to secure improvements in health. Dr Spolaore proposed that the key to achieving economic and social development was to be found through investment for health.

He felt that already the methodologies developed in the course of the project, had greatly enhanced local capacity for handling complex policy issues. The project had also demonstrated how partnerships could work effectively to secure real improvements in health. However, Dr Spolaore emphasized that it is not always easy to achieve intersectoral action, and he highlighted the importance of taking the priorities and constraints of other sectors into account when developing projects.

Describing the project itself, Dr Spolaore explained that after working through a valuable process of priority definition, the issue selected by the Province of Bolzano had been that of accident prevention - or more specifically, the prevention of the injuries they cause. In Bolzano, as in many other European regions, accidents were held to be one of the leading causes of premature death and disability in young people, and represented a major social loss for the community.

The International Classification of Diseases (ICD) differentiates over 14 causes of "injuries" ranging from motor vehicles to homicide to medical or surgical intervention. In the case of Bolzano, available data did not allow analysis of injury numbers and rates by detailed cause. Therefore, to simplify matters, the Bolzano group agreed that a wide range of interventions to prevent accidents was required. It was intended that these interventions should go beyond traditional health and safety education measures, to include such elements as fiscal incentives, environmental improvements, and workforce training.

Dr Spolaore stressed the importance of choosing the right area for action. With approximately 6,800 accidents recorded in the Bolzano region every year, he felt that there had been considerable room for improvement and a real opportunity for health gain.

In addition to the framework provided by the Ottawa Charter, WHO had specified four criteria which the project should meet; (i) equity, (ii) empowerment, (iii) accountability, and (iv) sustainability. These criteria formed part of the evaluation criteria used in the project.

In describing the methodology which the team had used, Dr Spolaore explained that the project had been divided into three distinct phases:

Phase One involved identifying opportunities for health gain in the population, and gaining support for the project and the approach. This meant mapping the various health issues and opportunities - a potentially enormous task, it could only be successful if tackled in a systematic way. Using a framework developed for the project, entitled the "Health Gain Map", a large amount of information on accidents and accident prevention was collected and collated. The map documented 131 potential causes of accidents, and an equivalent number of actions which could help to prevent them. Examples of these possible actions included;

- Involving workers in identifying ways the work environment could be improved
- Strengthening the role of the Office for Accident Prevention.

Phase Two involved screening investment opportunities more carefully and setting policy priorities, i.e. identifying possible actions for reducing causes of accidents. A variety of tools were used to inform the selection of priorities, and by the end of the evaluation process, the Province of Bolzano had established a small number of sub-projects to investigate further. These included:

- A safety education programme for schools to improve children's road safety awareness and reduce road accidents;

- A home safety programme for mothers of young children to increase awareness of potential hazards in the home and thereby reduce accidents.

Phase Three of the project focused on building capacity. This meant first assessing the feasibility of the range of potential opportunities, and then identifying the steps necessary for implementation. The team looked in particular at the anticipated benefits of each project. Tools such as questionnaires, interviews, and literature searches to investigate similar initiatives elsewhere, were used to gather this information. Many new ideas were generated, and some new proposals were made on what might be possible steps towards implementation.

By the end of phase three, the team were also able to identify some skills which needed further development in order to make better use of the concepts that they had explored through the "Investment for health" project, particularly in the areas of;

- intersectoral working
- data analysis and interpretation
- decision-making processes.

The project had provided several opportunities for collaboration. Dr Spolaore emphasized that Bolzano had been particularly pleased to collaborate with the region of Trento, who were developing an investment for health strategy on the theme of "Healthy Aging".

Cooperation had also spread further afield, involving collaboration with WHO, Yale University, and the Office for Public Management in London. Dr Spolaore explained that the aim had been to create a new synergy and to facilitate a better understanding of the determinants of health. He felt that the collaboration had proved very beneficial, both on a strategic and on a practical level. A number of policy tools to secure the promotion of health had been developed. The methodology had been documented and those who were involved in the project were now comfortable with using the new tools and approaches.

Dr Spolaore pointed out that Yale University had made a very important epidemiological and statistical contribution to the project, with the calculation of both qualitative and quantitative indicators for the South Tyrol region. The indicators had been based on the HFA targets, and Dr Spolaore informed that a summary report had been produced, and that copies were now available[3].

He concluded with the hope that local authorities would aim to sustain the accident prevention project, particularly now that the strategy seemed to be so firmly on track. Taking the work forward would require concerted action on the part of policy-makers, professionals, the public, and the media to promote health. Dr Spolaore concluded with the hope that the results of the project would very soon translate into practical action, and thanked all the coordinators of the project.

4.3 Achieving health gain for specific population groups - the case of "healthy aging" in Trento

Dr Martini, Director of the Health Planning and Research unit of the Autonomous Province of Trento described the investment for health project undertaken by the region of Trento, which had focused on the topic of promoting healthy aging. In Trento, as elsewhere in Europe, the effects of aging in the population were increasingly being reflected in the changing utilization of health and social care services.

For example, expenditure on residential care had increased significantly. At the same time, the people living in residential accommodation were becoming more dependent than

[3] See List of References

previously. Changes in family structure and the participation of woman in the labour market meant that opportunities for the informal care traditionally provided by families were more limited.

The Trento group felt that there was considerable potential for developing approaches which would promote the health of older people, and which would enable them to maintain their independence.

Like the Bolzano project, the Trento project was also divided into the same three phases, with phase one devoted to identifying investment opportunities and policy priorities, phase two to selecting areas for action, and phase three to assessing the feasibility of potential projects.

In order to reduce the large number of actions to promote healthy aging identified in phase one to a manageable number, the team drew on a variety of tools and techniques. The range of opportunities were evaluated according to the following criteria;

(i) WHO criteria specified at the outset of the project

(ii) Initial suggestions made by Yale University

(iii) Suggestions from the Steering Group.

Dr Martini explained that the criteria used to select the areas for action, were defined both in terms of a single word, and a more specific question. In Trento, for example, they had asked themselves the following questions:

Equity	Does the project enhance an equitable gain in health for the target population?
Empowerment	Does the project enhance the capacity of the target population to self-manage their health effectively?
Accountability	Can the services, which the projects are designed to deliver be evaluated effectively for the achievement of their intended benefits?
Sustainability	Can the services, which the projects are designed to deliver, be sustained by local resources, skills, and managerial capacity?

He also outlined a number of other criteria, which the region had also found to be significant for selecting the projects:

Multisectorality	Does the final selection include at least two projects which would involve multisectoral collaboration?
Cost-effectiveness	Will the projects, when implemented have a positive cost-impact ratio?
Political acceptability	Will the services, which the projects are designed to deliver be acceptable to local people?
Risk effectiveness	Do the projects have a positive risk-impact ratio?
Flexibility	Will the services, which the projects are designed to deliver be characterized by flexibility ?
Speed of implementation	Are the projects capable of being implemented quickly?
Real need	Do the projects demonstrate real need?

By the end of the evaluation process, the province of Trento had established that the following sub-projects should be investigated further:

- The creation of initiatives for the Third Age by encouraging cultural activity and self help;
- Providing support to enable elderly people with dementia to remain in their homes;
- Improving the town environment to enhance the independence and mobility of elderly people.

The third phase of the project was devoted to assessing the feasibility of the range of potential opportunities, and then identifying the next steps necessary for implementation, marking a shift from demonstration to practical action.

In relation to improving the town environment, some of the following steps were proposed;

- pilot projects to test out different methods of improving mobility;
- analyzing the specific problems and needs of urban and rural areas and establishing pilot projects in each area;
- introducing new forms of season ticket to encourage elderly people to use public transport;
- increasing the number of local bus services;
- gradually replacing buses with models designed to enable a wide range of users (particularly those with mobility problems) to get on and off easily.

In order to move from being a demonstration project to practical implementation, support and commitment to the project was required not just from the operations team, but also from the local community. Dr Martini explained how the team tried to ascertain real needs by carrying out a detailed assessment of the local care needs from the perspective of elderly people themselves. The team also carried out an evaluation of the scope and quality of care already available. In this process, the operational team learnt that focusing on the needs and problems as experienced by the recipients of services themselves, offers an effective way of defining and understanding problems.

The Trento group sometimes wondered about the possibilities of carrying out the actions planned in the "Health Aging" project. In answering these questions, a line from a famous song of Bob Dylan "The answer is blowin' in the wind" came to mind. Since then, the wind has blown in the right direction. The Health Plan for 1996-1998 included, among the actions favoring the elderly, a plan of action for the improvement of the town environment to enhance their mobility.

Dr Martini also drew attention to some of the legislative changes that had been brought about as a result of the project. These included (i) the establishment of a "Health Promotion and Education Department" by the Provincial Authority for Health Services, and (ii) the preparation of a draft law on providing incentives to encourage people to care for their elderly neighbours. Dr Martini felt that such initiatives would enable elderly people to remain in their homes for longer.

The tools and techniques used in the Investment for health demonstration project have now been put together in the form of a "tool kit" for the two provinces. As planned from the outset, the methods documented in the "tool kit" are capable of being applied to other health issues, and there is continued interest in developing the skills and competencies with which people became familiar in the course of the project.

The "Investment for health" demonstration project has already generated considerable interest from other regions and WHO Member States in Europe. Fortunately, documentation used in the project is already available to assist other regions in developing their investment for health projects. Dr Martini informed participants that, as well as the final report, plans were already underway for disseminating this information through the Internet*.

4.4 Report from the discussion

Participants were keen to learn about some of the practical action undertaken in the projects. In the case of Bolzano, Dr Spolaore informed participants that detailed statistics had been collected - however, the material must be analyzed before any follow-up action can be implemented. Dr Martini explained that a sample group of elderly people had been interviewed in the Trento region on the subject of accidents, and that the information was currently being used to carry out a health impact assessment.

Participants were interested in the epidemiological system used in the Bolzano project - however in the absence of the responsible epidemiologist, it was agreed that details of the system would be provided later.

* The final report of the project in English, German and Italian is available on HTTP://health.tqs.it/istituzioni/patssp/dipart/invsal/hinvest.htm

Still on the practical theme, participants were interested in how the principles, equity, accountability, sustainability, and empowerment had been translated into action and results. Dr Martini's response was that the intention had not been to translate the principles into practical action but to use them as the criteria by which to evaluate possible trade offs and results. He pointed out that in the case of the Trento project, modification of the urban environment had been a very practical goal, and one where the results could easily be seen.

Participants were informed that the two Italian regions had been able to allocate 25% of their overall budget to health. They felt therefore that these regions were in a very advantageous position and that insufficient funds could pose a real obstacle to developing an investment for health strategy for other regions. As funding was apparently not a problem, participants asked whether Bolzano and Trento had experienced other types of obstacles.

Dr Martini agreed that money sometimes allows people to be more confident than creative. Trento had however experienced other types of problems. In particular, they had been faced with a reluctance to change on the part of the medical professions. Although a shift of power was underway, Dr Martini predicted that progress would be slow, with many doctors continuing to be suspicious of non-health sector groups.

Dr Spolaore also recalled a problem with the medical professions relating to a proposal on reducing the length of hospital stays. At the time, contrary to the view that this would release more funds, the physicians believed more funding would be required to realize this goal. An agreement had eventually been reached, and Dr Spolaore felt that this had entailed a serious cultural change on the part of the medical professions.

The chairperson asked whether health was always the driving force behind intersectoral action, or did other sectors sometimes take the lead. Dr Spolaore replied that the health sector had been the main instigator in Bolzano. He felt that until other sectors became more familiar with the concept of investment for health, the health sector would be required to take the lead role.

4.5 Creating incentives for investment for health within the health services - the case of Wales

Dr Morton Warner, Executive Director, Welsh Health and Social Care Policy Institute also opened with a good sea-faring reference to the dangers of sailing in treacherous winds and waters. He highlighted in particular the challenge that comes from facing your boat into a strong wind. However, Dr Warner emphasized that sometimes just such a crisis was necessary in order to realize change, providing it is possible to weather the storm and eventually emerge into calmer waters.

In an earlier presentation, Dr Martini had stressed the importance of knowing which way the wind was blowing. Dr Warner proposed however that it might sometimes be dangerous to hitch a lift from a wind coming too strongly from behind. The boat could be put in

danger of overturning, as had been the situation in Wales where there had been too little time to plan for all the changing climactic conditions of health care reforms.

Turning to the theme of investment for health, Dr Warner pointed out that in the past, strong territorial claims between sectors in Wales had inhibited intersectoral action. He explained that the situation became more favourable during the late 1980's, and that today there is much greater cooperation between the different sectors.

Dr Warner proceeded to describe the investment for health strategy that had been devised for Wales, pointing out that, at the time, the health status of Welsh people was relatively poor in comparison with other European regions.

He stressed the importance of comparing performance with other countries in order to get a true picture of health status. The yardstick that the Welsh project team used was European countries who were known to have achieved a better health status. They then aimed to take Welsh people into the 21st century, with a level of health which could compare with the best in Europe

Dr Warner explained that the health gain strategy focused on two principal goals, to add years to life, and to add life to years. This was the leading component of the strategic direction which also incorporated the main goals of both health professionals, in terms of providing effective care, and of patients, in terms of improving quality of life. The health care system needed to place more value on people as individuals.

Dr Warner pointed out that, like most of Europe, conserving scarce resources was an important consideration in developing the strategy. The aim was to achieve a balance between meeting the requirements of those who used health services, and making the most effective use of resources. Dr Warner described this as "getting the balance of investment right", and explained how the Welsh authorities had embarked on a systematic process of assessment to achieve this goal.

District Health Authorities carried out community needs assessments, whilst the project team developed "protocols" for a number of selected areas including early child health, respiratory diseases, injuries, physical and sensory pain and discomfort, palliative care, oral health, and mental health. In terms of utilizing resources, the aim was:

i) to identify and promote clinical interventions that have proven their effectiveness, and
ii) to disinvest from those which showed poor health gain.

Dr Warner pointed out that persuading the health services themselves to think in terms of health gain had been quite important. This had been done for instance by introducing measures to improve the hospital environment, or reduce the numbers of injuries related to nursing care and the level of hospital infections.

The strategy also focused on more specific targets in the areas of health prevention and promotion, diagnosis and assessment, treatment and care, and rehabilitation and

monitoring, with timeframes for achieving targets being established in all cases. All health gain targets, of necessity long term in their achievement, were backed up by service targets which act as surrogates in the shorter term and identify management action.

Dr Warner felt that two of the most important elements in the strategy had been the efforts to actively engage health professionals, and the efforts to establish protocols for health gain. He felt that the purchaser/provider split had encouraged the involvement of different professions in the strategy.

Europe faces a future of needing to keep health care costs at a minimum. Dr Warner proposed that a shift from secondary to primary health care could help to conserve scarce resources. He stressed however that the shift should be an equitable one, and he pointed out that population needs are often quite different from what some politicians perceive them to be. While representation of all groups on participatory bodies may be unobtainable, he felt that policy-makers should try to gain greater insight into population needs. By working directly with consumers, he felt that the health sector could obtain a more realistic picture of what people's real needs are.

5. INVESTMENT FOR HEALTH: the wider experience from the Regions for Health Network

5.1 Discussion Groups

In the afternoon session, participants divided into three discussion groups. Mr McMahon explained that the task for each discussion group was to identify the key factors which encourage or inhibit investment for health thinking in health policy development. He distributed transparencies on which the groups were to report back in plenary.

5.1.1. Factors which inhibit the development of investment for health strategies

The groups identified the following factors as inhibitors to developing investment for health strategies;

Group one

- Ignorance of the concept "investment for health"
- Lack of monitoring mechanisms
- Vested interests
- Doctor's knowledge of preventive medicine
- Lack of trained staff
- Policy-practical possibilities

Group two

- No common public interest
- Resources are compartmentalized, and cannot be used flexibly
- All partners are not involved in the discussion process
- More information available on illness rather than on health
- Over concentration on health services rather than on health

Group three

- Politicians do not understand the concept "intersectorality"
- Health professionals are not communicating their message effectively
- Other sectors are not aware of the incentives of putting health on their agenda
- Insufficient information particularly on the outcomes of one intervention over another
- Sectors are compartmentalized
- Health professionals are poorly equipped to understand the political process

5.1.2. Factors which facilitate the development of investment for health strategies

The groups felt that the following factors facilitate investment for health strategies.

Group one

- Public interest in health
- Clear visions
- Creativity
- Agenda setting
- Leadership
- Training of health professionals
- Strong political support
- NGOs' support

Group two

- Shifting resources from hospital to primary based health care
- More information on people and health services
- Changing the medical culture
- Decentralized services
- Commitment to health promotion
- Taking a "settings" approach
- Making processes visible
- Evaluation of outcomes to show what has been achieved
- Link public health science to the practical level

Group three

- Politicians can be motivated by public opinion
- Assessment of outcomes can show the benefits of investment for health, particularly in an area such as accidents
- Timing and opportunity
- Health is a powerful macro-economic issue
- Health professions are becoming more autonomous (e.g. as budget holders)

Following the presentations by the rapporteurs, Mr McMahon facilitated an impromptu brainstorming. Combing the room with his mobile microphone, he sought one suggestion from each participant on how to develop an investment for health strategy. Mr McMahon later mapped the various ideas and trains of thought and presented his analysis of what had been said on the following day.

6. CHALLENGES AND OPPORTUNITIES OF INVESTMENT FOR HEALTH

Based on the comments and suggestions of the previous day, Mr McMahon produced what he humorously described as an "elaborate" overhead[4]. Having carefully plotted and grouped the various ideas, he found that participants had focused their thoughts mainly in a number of different areas. Some of the main concerns in relation to putting investment for health thinking into action included:

(i) **achieving a balance between long term goals and short term incentives;**
Large systems do not usually change rapidly, but in a series of small incremental steps; policy-makers should be aware of this, and remember to have both short and long term goals. Too often, policy-makers tend to go for early wins or the "hanging fruit", and lose sight of the overall vision, or conversely they focus on the long term goals and lose support because they have offered no incentives in the short term. It is important therefore to maintain a balance between long term goals and short term incentives.

(ii) **basing practical action on a framework of values;**
It is also important to establish an ethical framework, such as HFA and to explicitly state what the principles of that framework are. Policy-makers should then aim to bridge the gap between principles and practical action, and to move fluidly from strategic thinking to operational planning. The relationship between strategic plans and operations should not resemble one way traffic, but should involve a reciprocal exchange of information, with decision-makers solving operational problems by strategic thinking.

(iii) **trade offs in policy implementation;**
Although decision-makers may establish their goals with a view to satisfying different principles, often it is not possible to satisfy all the principles to the same degree. For instance, it may prove more realistic to achieve sustainability in a particular project rather than equity. In effect, policy-makers are playing with an abacus of different values[5], and must be prepared to make trade offs of one principle or value in order to achieve the best solution in the long term.

(iv) **using the full intelligence of the policy environment.**
Policy is born out of a series of axiomatic relationships between politicians and other actors, and also between organizations and sectors. Politicians may take the final decisions, but technical experts, and bureaucrats play a pivotal role in amassing the raw material on which they will base those decisions. It is important to target all relevant actors involved in setting and agreeing the agenda, and to exert pressure wherever influence is being wielded.

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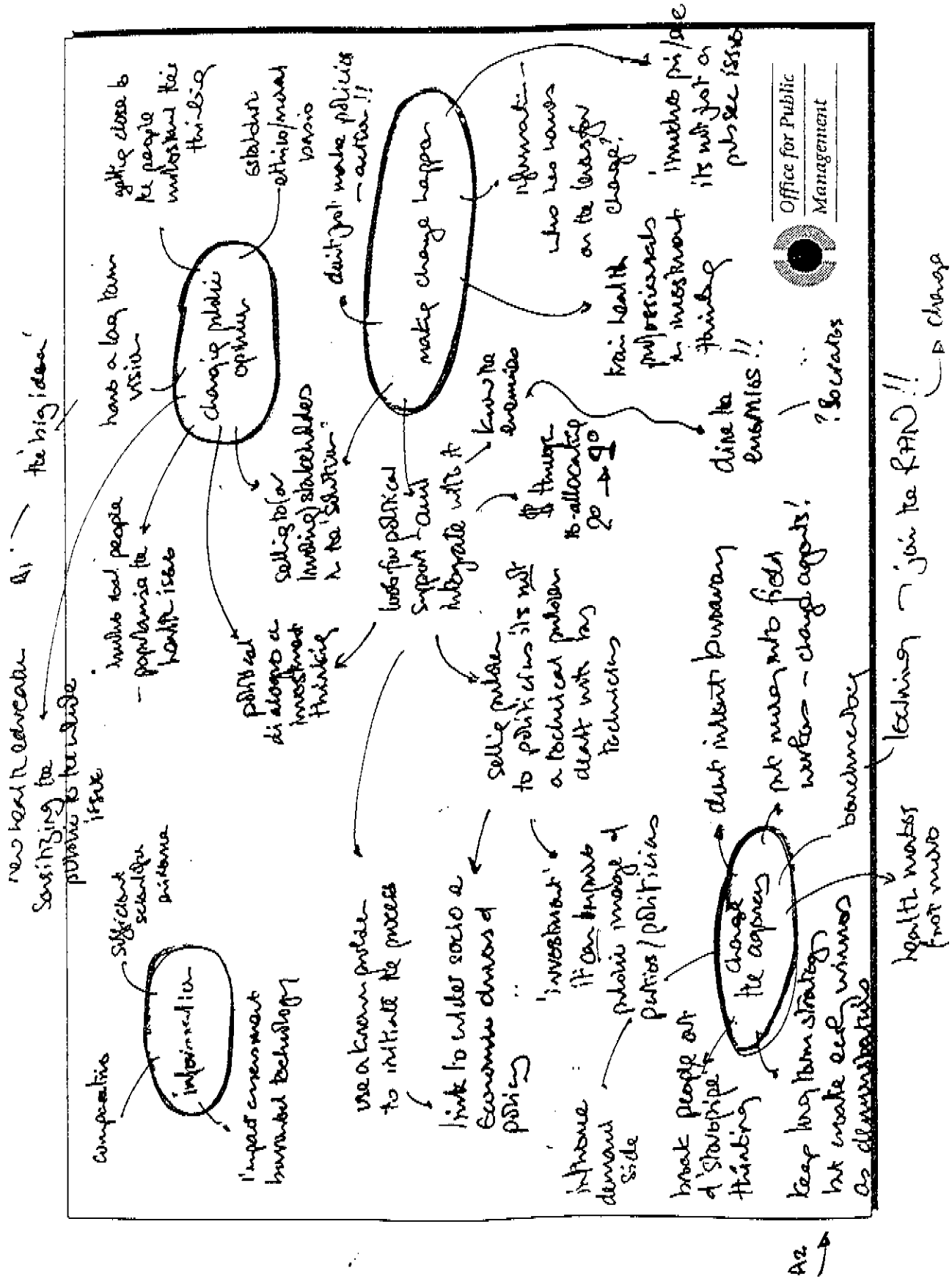
4 See Figure I overleaf

5 See Annex II

Figure I


Office for Public Management
change public opinion
make change happen
change the agenda
information

7. PUTTING INVESTMENT FOR HEALTH THINKING INTO ACTION

Participants agreed that it was important to **make change happen,** by marketing health objectives to politicians, as well as to other sectors. However, this re-packaging of health requires a radical change in thinking on the part of those working in the health agencies. In particular, participants discussed how policy-makers might approach information, and use public opinion to inspire change. The following is a synthesis of the main points.

Opportunities for change.....

- Health plans are not the goal, move on, and make change happen;
- Health is not just a health problem; open up the issue, in order to open up the discussion;
- Remember! Health is a powerful macro-economic driver, and investment for health is an integral part of socio-economic development;
- Break the tribalism of the medical professions;
- Link up to the private sector;
- Know your possible enemies, and then make them allies - take them out to dinner;
- Use a recognized problem to promote the change process, then target those people who will be particularly frightened or influenced by that problem;
- Don't try to target all and anybody....know who has their hands on the levers of change, and look for political support where political support exists;
- If support is lacking....sell health to the politicians;
- Work backwards, find the problem that needs your solution;
- Remember! Health is a powerful electoral driver!

Changing the agencies.....

- Break people working in health out of "stove pipe" or "pyramid" thinking;
- Aim to decompartmentalize attitudes to health;
- Avoid inventing a new bureaucracy to deal with each newly identified health issue;
- Reward the field work because this is where the change happens;
- Compare performance with other agencies, then use the results. Change must begin in the health sector.

Information as an impetus for change.....

- There is a real need for comparative information but scientific evidence is not always sufficient to provoke change. Sometimes, a leap of faith is needed. Back the leap of faith up with scientific evidence. This will increase your credibility.

Changing public opinion.....

- The public like a "big idea". Politicians need a long-term vision, and short term incentives. However, while early wins are necessary, they should not be at the expense of long term goals;
- To find the big idea, stay close to the people. Know how the people think, and use that information to get ahead of the politicians;
- To know what people expect, encourage public debate;
- Aim to establish a moral or ethical base;
- Involve other stakeholders, and ensure an early participatory process.

Remember! Sensitizing the public to embrace a wider view of health is a political act.

8. IMPLICATIONS FOR THE RHN

The final session, chaired by Dr Morton Warner, was devoted to discussing ways of strengthening investment for health in the regions, and how RHN could provide support. Given that almost all the participants in the RHN Annual General Meeting had stayed for the Conference, this final session was also used as an opportunity to link back to the work of the AGM, particularly as this related to the future development and activities of the RHN.

Participants suggested that RHN should;

- establish a comprehensive information system;
- explore the potential for developing socio-economic indicators in order to support a more equity-oriented approach to health;
- expand the role of sociology/social science in health policy;
- increase toxicological surveillance;
- involve relevant stakeholders in formulating and implementing health policies;
- organize more training seminars on
    - policy-making,
    - problem identification,
    - risk identification,
    - practical application of HFA,
    - working with people at different levels, and other sectors;
- link with other training bodies, i.e. the European Training Consortium;
- market the new health thinking;
- identify problems which can be solved by using WHO targets;
- involve politicians in order to gain political support for RHN;
- disseminate information about RHN programmes/processes, and activities;
- establish links with the European Union e.g. the current information project is one such opportunity for collaboration;
- use established programmes in EU priority areas e.g. Cancer/Drugs/Aids as a basis to build links;
- use the media more;
- encourage the media to adopt a more systematic approach to health

9. CONCLUSION

Over the past decade health reforms in most countries have been dominated by economic issues and driven by efforts to contain costs. Member States are looking to find more effective and efficient ways of delivering health care, and the Conference proved to be of major benefit in identifying practices and intervention, which could help countries to achieve these goals.

Despite the economic constraints facing most European countries, the experience of the regions of Bolzano and Trento demonstrated that money is not always a sufficient impetus for change. Many other factors are also important, such as openness to investment for health thinking and health promotion, good communication between policy sectors, and a strong basis of public and political support. If these mechanisms are in place, it is an indication that sectors are open to change, and willing to work with others.

Unfortunately, however, policy sectors are not always open to the type of change which is needed in order to put investment for health thinking into action. Mr McMahon's sobering account of the world of policy-making revealed a closed and hierarchical system, where it was unlikely for sectors to practice openness either within their own component parts, or with other sectors. This criticism has been leveled in particular at the health professions - a feature which one participant described as "tribalism". How to break people out of these boxes and heal the divisions, so as to achieve a more integrated approach to health policy development was one of the central questions of the Conference.

Participants made a number of proposals on how intersectoral cooperation might be achieved. A strong ethical framework, such as that provided by HFA, was identified as one of the prerequisites for success. It was also felt that strategic planning should encompass both short and long term goals, and should be firmly linked to practical action. There was a strong emphasis on incentives, with the artful suggestion that one should know their enemies and then invite them to dinner, tying in nicely with the idea that incentives must be put firmly on the table, if the support of other sectors is to be achieved.

RHN has an important role to play in facilitating regions to develop investment for health strategies, and some of the main messages from participants included the need to:

(i) improve RHN's channels of information exchange;
(ii) improve RHN's knowledge base, particularly the need for assessment by regions of appropriate indicators for determining possible inequities in health (including sociological and qualitative indicators);
(iii) provide training for regional level personnel to improve information for policy development;
(iv) improve the presentation of information to influence different target groups (local politicians, other sectors, health professionals, NGOs, the public), and use of expanding field of telecommunications;

(v) build alliances with other networks such as the European Committee of the Regions, politicians, the national and municipal levels, and general public;

(vi) improve marketing of the HFA/new public health approach (including for example, developing a European media strategy for regions, mapping mass-media outlets available to regions, articles to journals, workshops with mass media.

Much progress has already been made. WHO has played an important role by mobilizing a wide variety of groups and sectors, and building and sustaining alliances for health. Now that participants are back in their regions, the task is to find ways of putting into practice the investment for health principles, and channeling some of the energy from the small scale initiatives into investment for health on a larger scale.

As RHN moves into a new biennium, it aims to take on board many of these issues, by supporting members in developing policies which sustain and promote health. Despite our distinctive political and cultural traditions, the Conference revealed that we can learn from each other and find commonalties, provided that we are able to exchange experiences and willing to adapt to new ideas. This is the spirit in which the RHN tries to work; it is also the spirit which must prevail between health and other policy sectors. If we are to achieve that essential added value and progress together, there must be understanding of how other sectors work and what they hope to achieve.

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Annex 1

Glossary:
the four key principles associated with Investment for health

According to the Health Promotion and Investment Unit of WHO/EURO, "Investment for health" projects should be:

- **equitable**

The outputs should meet the needs of all **relevant** sections of the population who can benefit.

- **sustainable**

The outputs should have the potential to be self-generating without continued "artificial" stimuli such as external funding or reliance on external expertise.

- **empowering**

The process should enhance the capacity of the relevant population to decide, choose, evaluate, manage or apply a particular action. This means that they must identify with the way in which a problem is defined and with the proposed solutions.

- **accountable**

Accountability is the result of the process which ensures that decision-makers at all levels actually carry out what they are obliged to do, and that they are made answerable for their actions.

Annex II

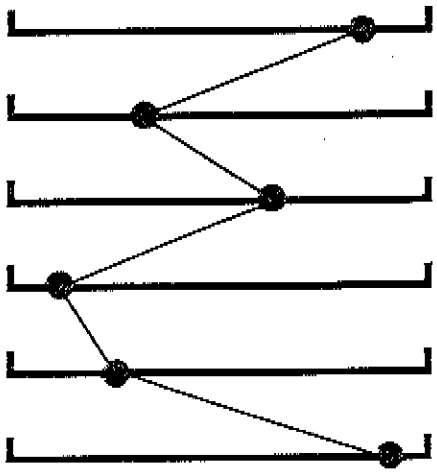
HEALTH ABACUS

VALUES ON THE HEALTH ABACUS

- Effectiveness
- Equity
- Efficiency
- Appropriateness
- Accessibility
- Responsiveness

HEALTH ABACUS

THE HEALTH ABACUS



HEALTH ABACUS

Annex III
Investment for Health in the regions

Prior to the Conference, each region was asked to submit a brief description of ways in which they felt they were investing for health. The following are the examples some of the members gave, and are indicative of the wide variety of experience in the Network. If you are interested in learning more about any of these initiatives, please contact the focal point of the relevant region.*

*Catalonia, Flemish Community, Gyor-Moson-Sopron, Katowice, Northern Moravia, North Rhine Westphalia, Ticino, Östergötland

Investment for health in Catalonia

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Investment for health demands a knowledge of the problems to be tackled and the resources available (assets), but also ideas on what are the best ways of intervening (investing). In Catalonia, we started by clarifying this in the general "Health Plan for Catalonia" (1990) which examines how investment in health principles such as equity, accountability, sustainability, and empowerment can be practically achieved.

The plan sets out clearly defined health goals and targets, which were endorsed by the Autonomous Government of Catalonia and by parliament. In this way, the Minister of Health has made a public commitment to achieve the Plan's objectives, and is *accountable* to parliament and the public.

The Plan aims to promote *equity* by guaranteeing universal health care coverage, free of charge at the point of use, for the whole population; by targeting the needs of specific groups, by and providing high quality health services to everyone. In the early stages of the policy formulation, health promotion and disease prevention were recognized as important instruments for promoting equity in health. This means that health promotion and disease prevention measures, particularly measures such as selected vaccinations, screenings, and health counselling, should be integrated into the primary health care services and accessible to all.

An attempt was made therefore to involve the health professionals, administrators and managers who would be asked to implement such an approach, in a further elaboration of the Health Plan, as this related to Primary Health Care. Broad discussion was initiated to reach consensus on which activities were most appropriate to the primary health care setting. The results of this consultation process were published in a document entitled "*White Paper on Basis for the Integration of Prevention in Health Care Practice*.

A further effort was then made to spread the contents of both the Health Plan and the White Paper throughout the health professions, mainly through a process of training the trainers. A number of scientific societies were financed to carry out this activity. It was intended that the new practices involved would be absorbed by health professionals in a natural way, and would therefore become part of a *sustainable* process.

As a model for future initiatives, the project revealed that a participatory process was an excellent way of working, and even more importantly that consensus could to some extent be reached. This had an *empowering* effect for all those involved. Empowering individuals, both those working in the health care sector and the general public was important for *sustaining* the project in the long term. Once people felt that they had a part in the decision making process, they were more likely to strive for the objectives.

Improved information and awareness of positive health behaviour, is also encouraging people to demand preventive health care.

Until now, the development and promotion of the White Paper has been financed from the budget for public health, not from the health services themselves. This "seed money" has been important for initial development, in the future however, it is hoped that the plan will be self sustaining.

Some of the difficulties faced were: incomplete epidemiological data, some problems in involving health professionals and achieving consensus, economic constraints, and a need for improved evaluation.

The Flemish Community focuses on drugs prevention in schools

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Ministry of the Flemish Community

The Flemish Community has developed a drugs prevention programme, specifically targeted at secondary schools, which aims at achieving *sustainability* by encouraging schools to develop their own policies. The approach has three components:

- **a policy or plan** including a set of agreements and rules on alcohol, tobacco, medication and illegal drugs at school;
- **education** through which specific projects and activities related to drugs prevention and health education are developed in a "coiled curriculum" the hidden agenda of which deals with the school environment and structural health promoting aspects "life at school";
- **an intervention strategy** which provides for the counselling and support of youngsters (and teachers and other staff) when alcohol or drug related problems do occur.

The programme has been developed with the four key investment in health principles in mind, equity, accountability, sustainability, and empowerment.

It has the support of the ministers for education and health in Flanders. A steering group, which includes representation from educational and health services has also been established to oversee the administrative aspects of the project, to build awareness, and in particular to provide stability in the initial stages. The school principal is also seen to be an important actor as without their support it would not be possible to achieve *accountability.*

Four publications have been developed to assist the schools: a discussion text; a guidance map; a screenplay, and an inventory. These were developed following continuous consultation in the field. However, no "model" of a policy is provided. Each school must develop its own unique programme, and this involves participation by a broad range of groups and individuals including school principals, teachers, guidance councillors, units responsible for medical supervision at school, pupils and parents. They must participate as equal partners in the formulation and implementation of the project. This participatory process is a key element providing a learning experience for those involved, and provides valuable lessons on team-work, decision-making, and consensus building. Teachers, pupils, and parents have a strong sense of ownership which *empowers* and also helps to *sustain* the initiative in the long-term. It is a continuous process of considering policy options.

In January 1995, a platform was established to evaluate the programme, to identify obstacles or problems in implementation. All the various partners (school principals, teachers, parents, pupils, the educational and medical services and the ministers involved) are included in the platform. Currently the data from this evaluation is being analysed and it is hoped that very soon, based on the findings there will be some recommendations on how the schools can be further supported in their efforts.

Health care in Northern Moravia

Dr J. Volf
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Ostrava

Health care in the Czech Republic is undergoing radical change during this transition period in relation to the organization and financing of health care services. Part of this change is that there has been a shift to General Health Insurance. A "point system" has been introduced, according to which insurance companies are paid for various interventions on the basis of their assigned "points". Two of the main problems being faced in relation to the new system. On the one hand there is less interest in disease prevention programmes, and these issues are being taken up mainly by voluntary organizations which seek financial support from the ministry of Health. On the other, although the cost of investment and maintenance is supposed to be included in the point system, in reality, the costing of investment in buildings and equipment is difficult and uncoordinated, with the result that again demands are made on the government budget, as is the case of the Teaching Hospital in Northern Moravia.

Recently, the municipality of Ostrava and other big cities have been trying to secure more investment for purchasing equipment and rebuilding hospitals. Over the last three years many hospitals in the region have been equipped with CT, magnetic resonance, new incubators, ventilators, ambulances. services. In the primary health care sector, the network of General Practitioners and other specialist in ambulatory care is growing, but unfortunately not fast enough to meet local demands. The chances for receiving high quality care have been greatly improved, and as *equity* is guaranteed under the constitution, everyone is can demand access to hospital and primary care services seems.

It is too soon to say how equity in access to care has been affected by these changes. Furthermore, as the new health care system is in the very earliest stages of transition, it is too soon to evaluate whether it will be *sustainable* in the long term. It is also difficult to assess at this stage the effectiveness of mechanisms designed to promote participation, *empowerment* or *accountability*, particularly since the legislative responsibility for health care is still not clear.

One of the methods currently being used to make health investment decisions, is that of *health risk assessment*. An good example of this is that the municipality of Ostrava asked the Regional Institute of Hygiene for an estimation of the current health risk caused by four coke oven plants located close to the city. The project team were also asked to predict levels of the future risk for 1999, following the adoption of various ecological options..

Through the use of an air dispersion model the individual cancer risk for the inhabitants of Ostrava was estimated. This information has helped to build awareness among the local people and business community, and has led to the direct financial support of measures to reduce pollution and encourage more responsible behaviour. The project is an important example of how health risk assessment can be used to determine which are the most effective areas for investment in the health and the future of the people of Ostrava.

Networking in North Rhine Westphalia (NRW) - a pilot scheme for local coordination of health and social care.

Dr Birgit Weihrauch
Ministry of Employment, Health and Social Welfare
of North Rhine Westphalia

The traditional sectoral approach is no longer adequate to make effective use of resources and meet health care needs, at the local level - a cooperative and integrative approach is essential. Recently, NRW introduced a pilot scheme with just this aim in mind. The scheme is designed to achieve coordination of activities between sectors, and aims to create an efficient and effective infrastructure for health promotion and health and social care at the local level. Through this scheme, *equity in health* is promoting by improving quality, effectiveness and efficiency of health and social care, and *sustainability* by initiating an innovative approach to planning at the local level. This decentralized approach aims for greater *empowerment* of all the partners involved, and increased *accountability* by putting those responsible for local policy development in a position where they have to explore innovative ways of doing things.

The project aims to;
(i) optimize care of those who are ill and in need of nursing by ensuring: a fair coverage of needs; accessibility, and sensitivity to the felt needs of the people
(ii) develop models for effective participation, cooperation, information and coordination, and
(iii) identify new and flexible approaches providing health and social care at the local level.

This State wide pilot scheme is supported by the State Ministry of Employment, Health and Social Affairs and involves 27 (out of a total of 54) cities and counties. A unique feature of the project has been the establishment of local panels involving all partners in each participating city/county called "Round Tables".

The specific topics which the Round Tables were asked to examine, included for example, health promotion; implementation of the new law on nursing insurance; the gradual building up of care networks for geriatric and psychiatric care; new approaches to local authority public health care, and for the local districts whose boundaries meet those of other countries, questions concerning their relationships to other Member States of the European Union.

The Round Tables also set up working groups to examine specific topics including the health promotion of special groups such as the elderly, children and young people, and disadvantaged social groups. Other topics included early rehabilitation during hospital care, care of AIDS patients, drug addicts and those suffering from stroke etc.

The responsibility for organizing the Round Tables was clearly given to the political representatives of cities and counties, thus assuring greater *accountability*. Broader *participation* was assured by involving a wide variety of partners, including medical

associations, health insurance companies, nursing institutions, hospitals and patients' organizations.

The counties participating in the pilot scheme are administratively supported by a central project management team from the State Institute for Public Health in NRW, a data and information management team offering support for data analysis and planning; and a consortium for scientific evaluation, which will monitor progress in the achievement of the targets set.

To ensure a cross fertilization of ideas throughout the State, the regular exchange of experiences between the participating districts as well as with those supporting the process on the state level is being organized.

Katowice invests in the future

Dr Malgorzata Kucytowska
Provincial Methodical Centre for Health Care
Katowice

Poland has recently adapted the manual "Promoting the Health of Young People in Europe". The manual is seen as an important resource for the development of teacher training programmes in health promotion.

In Katowice as in other parts of Poland, there is a strong focus on investment for health among certain target groups of the population, such as children. Programmes aimed at improving the health status of school children have been running for the past three years. The programmes have two principal goals, (i) improving children's health information and changing individual behaviour patterns among young people, and (ii) improving the professional qualifications of nurses working with school children.

A health promotion team consisting of representatives from the local authorities, institutes for medical care, education bodies, and the regional press has been established. Programmes and activities relating to health promotion activities are generally coordinated by the Provincial Doctor.

To encourage children to start thinking about health in a new way, the health promotion team organized a series of competitions at the school, town, and provincial levels where children could demonstrate their knowledge of health issues. Because the initiative had both an educational and a fun element it perhaps appealed to children more than traditional teaching methods. Building awareness was seen as a crucial step in changing young people's attitudes to health, limiting self harming behaviour, and promoting healthy lifestyles.

To improve the skills of nurses working in the school environment, Katowice has initiated regular training workshops. These workshops focus on topics such as;

- preventing disease of the circulatory system
- prevention of dental caries
- stress management
- addictions
- food and nutrition

Nurses use the material from the training workshops to promote healthy lifestyles in the school. The information is usually disseminated through lectures, although nurses also advise individual pupils on how they can cope with particular health problems. A series of nutrition workshops organized for day and boarding schools has proved to be particularly successful, and many schools are now working to ensure that children are "eating healthy".

The media is often perceived as an important partner in health promotion. In Katowice, many attempts have been made to engage the media more actively in youth health promotion. However, progress tends to be slow with only spasmodic interest from the media on most health issues. It has not yet proved possible to engage the mass media on a longer term basis.

"Investment for health"- Experiences in Györ-Moson-Sopron Region, Hungary

Dr Peter Abraham
Medical Officer of Health
Gyor

Health promotion and disease prevention are important in Hungary, at least in current policy documents for 1994-98, they are given priority status. In reality however, for many and complex reasons preventive medicine is not so widely practised. Poor socio-economic conditions mean that fewer resources are being allocated to health, and this policy environment does not appear to be conducive to investment for health. Disease prevention may be a declared goal at the national and regional level, but the main priority, both for politicians and health professionals, is the reconstruction of the hospital care structure. Proponents of public health find it difficult to build support for investment in health and health promotion is very difficult in the current environment.

Nevertheless, despite the obstacles, there have been some important recent developments. Hospitals are undergoing reconstruction, and funds have been allocated to purchase new equipment. At the same time, some screening programmes have been started at the county level, such as those related to cardiovascular care, prostate cancer, cervical cancer, and blood sugar levels, and programmes aimed at specific population groups such as screening for hepatitis B in pregnant woman.

The county level self-government has provided funds for activities to maintain health and improve lifestyles. Applications for such funds have come from schools, youth associations and also General Practitioners among others.

A number of programmes have been initiated in the areas of mental health and drug addiction. In 1995, the government established a national mental health network with participants from the county level. The aim of the network is to improve the mental health status of the population, and to prevent drug, alcohol, and tobacco addictions. Besides government initiatives such as this one, programmes may also be initiated by health insurance body. However, such programmes are not always as comprehensive as government initiatives, and do not necessarily strive to achieve the investment in health principles of equity, sustainability, empowerment, and accountability.

Typically, at the present time the features which characterize health development in Hungary are the "ad hoc" nature of programmes, the low level of funding, and inefficient methods of allocation. Despite these features, the County Public Health Institution submits applications for funding regularly, and modestly funded programs continue to be organized by the Health Promotion Department. Programmes supported by the County Department include:

- health education summer camp for future teachers
- health education summer camp for students
- managing self-help clubs
- tobacco use prevention programme, including a programme for kindergartens
- health programmes for youth and children's groups
- sports groups, and the development of a physical activity culture
- sociological and lifestyle surveys at local level
- "healing plans" for local communities, which provide a link between the public health professionals, the population and decision makers

Continuity and realization of the programmes have been hampered by the lack of regular funding. Money, however, is not the only resource and the voluntary contribution of health professionals committed to achieving improvements in public health should not be overlooked. Unfortunately, reductions in the number of health professionals mean that fewer people are available to undertake this task, and public health workers are becoming more overburdened.

Investment for health in Östergötland - with the help of "Health facilitators"

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Linköping

Recently, Östergötland County Council has initiated a project which indicates its interest in investment for health. "Health Facilitator" posts have been funded in four of the most disadvantaged housing districts in Östergötland.

The appointment of the health facilitators was based on the premise that;

1) the local public health services would establish a local health group with representatives from both the public services and local voluntary organizations of the area. The purpose of the group was to map and analyse local health problems, and identify ways of improving the health status of local people.

2) the analysis made by the group was to be the basis for the health activity plan for the area.

3) activities were to be successively more integrated into the everyday life and activities of the people and of the NGOs, so that they would become part of a *sustainable* process.

The project has been running for two years already, and the County Council considers it an important investment in health. The main strength of the project has been the mobilization and engagement of local people in the main body of health activities for the area, of supported by just one health professional.

A knowledge of local health status and local health conditions and risks, and the willingness of local groups to bring about change have encouraged a wide variety of activities. Some examples from one of these four areas will demonstrate this:

- establishment of "fathers' groups" headed by an experienced father
- arrangement of a meeting place for young mothers and unemployed
- advertisements in local papers for "extra or adoptive grannies" and supportive grown ups for young families in need
- making sure that local voluntary associations arrange more activities for unorganized youth
- encouraging adults to take greater responsibility for children and young people in their neighbourhood, both their own and other people's (including daring to say NO when things are going wrong)
- engaging sober alcoholics to inform about alcohol problems, in schools and other places where young people meet
- arranging walking groups for the elderly

What has been achieved so far? This process is to be evaluated soon and the County Council will be particularly interested in such factors as:

- amount of activities started
- population's awareness of the project
- participation from different groups
- self perceptions of health, well-being and self-esteem
- how the process has spread from the "health facilitator" to other professionals, organizations and inhabitants in the area.

In due course it should be possible to assess the project in terms of its more concrete impact on health gain. For now, it is believed that the best way to achieve health gain is through citizen's participation, population empowerment, feelings of meaningfulness and self esteem in the population.

What will happen after evaluation? One of the main hopes is that funding will become available to finance similar processes in other areas. Hopefully, not only County Councils will finance the services of Health facilitators, but they will also be supported by municipalities, other official organizations, local trade and others. That at least is the aim of the County Council, thus making Health Facilitators truly anchored in local society.

INVESTMENT FOR HEALTH IN TICINO

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One of the main features of the approach in Ticino is that of *empowering* the public to take responsibility for decisions concerning their own health. Previous examples from Ticino which have been discussed in the RHN related to healthy eating and the mobilization of local chefs, restaurants and the public, and to asking for a second opinion before deciding on elective surgery. The example given here relates to empowering the public to recognize quickly the symptoms of a heart attack.

AREA: Canton of Ticino, Switzerland (280 000 inhabitants)

PROJECT: Ticino Project Prevention of Cardiovascular Diseases [6]

ACTION: Early recognition by the public of the symptoms of heart attack (myocardial infarction (MI)) and knowledge of what to do

GOAL: Shorten the time lag between the onset of pain and admission to hospital

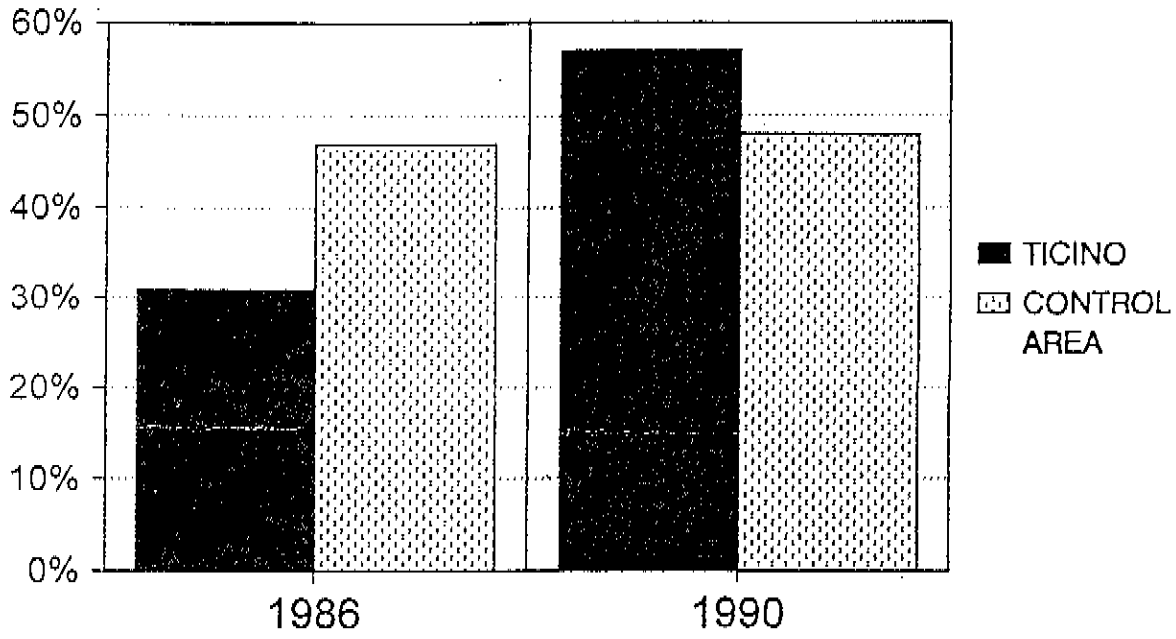
MEANS: From January to December 1989 public information campaign by the media; distribution of 50 000 informative leaflets and 150 000 "credit cards";

regular diffusion (weekly, monthly) of TV and cinema sports on early recognition of symptoms, and what to do (bi-monthly "input" after 1990)

[6] Domenighetti G., Casabianca A., Villaret M., et al. The Ticino Project, first assessment of cardiovascular disease primary prevention programme. Can.J.Cardiol. 1993, vol 9. Suppl. D, 17-18
Domenighetti G., Casabianca A., Villaret M., et al. Prevention des maladies cardiovasculaires, première évaluation du programme du Canton du Tessin (1984-1989). Cahiers médico-sociaux, 1991, 35, 293-309

RESULTS Changes in the time lag between onset of pain and the arrival in hospital was evaluated for the period 1986-1990, by comparing the percentage of cases of "certain MI" hospitalized within four hours in the Ticino Region (intervention) with that of the control region (Cantons of Vaud and Fribourg) where no specific information was given to the public.

Percentage of cases admitted to hospital within 4 hours (diagnosis of "certain" myocardical infarction - MI)



SOURCE: WHO MONICA PROJECT SWITZERLAND

The results confirm the success of the action in empowering the public about the awareness of the early symptoms of a heart attack, and what they should do about it (reduction of the delay).

The main problems related to issues of equity and coordination of the services:

PROBLEMS

- Achieving "high" impact levels for different target groups: old people, groups with a low level of education, young people as "first aid".
- Coordination (professional and educational levels) with emergency services (ambulances, hospitals, physicians) and other actors should have required more attention.

Annex IV

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Annex V

LIST OF MEMBER REGIONS 1996

Country	RHN member regions
Belgium	FLEMISH COMMUNITY
Czech Republic	NORTHERN MORAVIA SOKOLOV NORTHERN BOHEMIA
Estonia/Latvia/Lithuania	BALTIC REGION
Germany	NORDRHEIN-WESTFALIA NIEDERSACHSEN
Hungary	GYOR-SOPRON (N.W.) BACS-KISKUN (CENTRE) SZABOLCS-SZATMAR (N.E.)
Poland	KATOWICE
Spain	CATALONIA VALENCIA EXTREMADURA
Sweden	ÖSTERGÖTLAND WESTERN COUNTIES
Switzerland	CANTONS OF GENEVA & VAUD CANTON OF TICINO
United Kingdom	N.H.S. WALES NORTH WEST ENGLAND