Ministry of Social Affairs in Estonia and World Health Organization Regional Office for Europe

Joint workshop to share experience in Health Policy development in Europe

Meeting Report

Tallin, 7 March 2006

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1. Introduction

Most European countries have national health policies or health sector development plans that outline their vision of the main goals for the health system in a medium and long term time-line. Health policy documents also specify strategic objectives that need to be achieved in order to attain the broader goals. Health policy development in the European Region has been strongly influenced by WHO's Health For All strategies and the values embedded in it. European States differ in terms of their historical, cultural, political, and socio-economic context, and in terms of the organization and performance of their health systems. Such diversity is naturally reflected on the content of national health policies.

It is fair to say that many European States face common or at least similar challenges including: aging population, increasing burden of non-communicable diseases, unhealthy life-style and environment, growing health care expenditures, scarcity of financial resources to sustain the achievements of health system objectives and adherence to values, etc. These challenges define specific policy objectives for the countries. In order to address these challenges countries resort to various strategies and tools the effectiveness and appropriateness of which have to be evidence-based. Values embedded in health policies provide additional dimension to the interaction between the policy objectives and strategies and tools: values, in addition to scientific evidence, guide the selection of appropriate strategies to address particular policy objective; values affect the perception and interpretation of existing challenges and problems in health system; values influence how the policy objectives will be defined and formulated; and lastly and not least, values have an impact on how the responsibilities for implementing a health policy will be shared and distributed between government and private sector, between society and individual, and between centre and regions.

Health system values are not synonymous to ideological convictions. Values of health system shall be grounded on what is considered to be by the society as desirable outcomes of the health system for an individual as well as for the society in large. The purpose of health policy document is to articulate those values clearly, identify the policy objectives that are best tailored to existing needs, and suggest broad strategic directions that will lead to those policy objectives and goals in such a way that respects the values.

2. Background

The feedback to Estonian draft health Policy Document builds on extensive high level discussions between Ministry of Social Affairs and WHO Regional Office for Europe. The request for WHO support was expressed during the meeting between Dr M Danzon and Mr J Aab in the WHO Regional Committee in September 2005. During a separate meeting the aim of the document and the process of WHO's technical support were discussed between Dr B Shengelia and Dr P Laasik.

To support the further development of the policy paper WHO in collaboration with the Ministry of Social Affairs organised Health Forum in November 2005. During the forum the policy document developed by the Ministry was shared with a wider public. At that stage WHO was evolved neither in the preparation nor in the revision of the document.

During the visit of WHO-EURO's Regional Adviser for Health Policy and Equity, Dr. B. Shengelia in December 2005, the Ministry of Social Affairs requested that WHO organized a workshop were the Ministry would present the document to key health system experts and WHO would provide comments with regard to presented document. Such a workshop would also provide capacity building opportunity to the Ministry of Social Affairs in policy development process.

The workshop organized by the Ministry of Social Affairs and WHO collaboratively on March 7, 2006 with following objectives:

- To strengthen technical capacity of Ministry of Social Affairs and selected local specialists in developing a Health Policy document;
- To give active feedback to the draft Estonian health policy document developed in 2005;
- To share experience and available evidence from Europe and other selected countries in developing, approving and implementing health policy documents;
- To share experience of Europe in value based health policy development, setting targets for health system development, and steering the health system to improve population health

3. Outline of the workshop

The workshop was conducted in a flexible and interactive manner in order to encourage active participation of the audience.

The meeting was opened by Dr Peeter Laasik, Assistant Minister, Ministry of Social Affairs, and Dr Jarno Habicht, Head of Office, WHO Regional Office for Europe. The purpose, scope and expected outcomes of the meeting were discussed.

A number of presentations laid out the conceptual framework for policy development and stewardship. This included both a theoretical background and practical approach with experiences from different countries.

The second section of the workshop focused on the experience of the European countries in the development of the value based health policies based on Health for All revision in 2005. This was followed by health policy examples from different countries.

In the third section of the workshop the findings of recent Estonian health system analysis were discussed and the policy document was presented. This was followed by intensive discussion on the objectives, process and implementation of the policy.

The last section of the workshop was devoted to WHO's feedback and comments on the presented policy document. Summary of the WHO's feedback is outlined in Section 5.

In the end of the workshop, an evaluation was conducted through eliciting feedback from participants with a standard set of questionnaires.

4. Presentations and discussions

4.1 Health policy development and health system approach

Presentation[1]

The presentations on *the stewardship function* and the linkage with the policy making was given by Dr A Duran. The health system perspective and the systematic approach applied since World Health Report 2000 (WHR) was presented. The rethinking of the approach to health system in the report was built on the evidence in past decades pooling together evidence from international organisations as WHO, World Bank and countries. The main difference from past was the functional approach where the previous frameworks based on structural and organisational structures. The need to have clear definitions for health system were highlighted and the boundaries described in the WHR were discussed as well the generic objectives for the health system as health gain, fairness in financing and responsiveness.

The stewardship function as the responsible and careful management of the well-being of the population was discussed in depth. The three main components of stewardship as formulating health policy and setting vision; providing regulation; and creating intelligence were discussed. The need to use the policy for strategising the implementation and plan further actions were discussed in depth, following by other areas of stewardship. The lessons learned from different countries from past decade were shared to support country to think about new approaches and tools for good governance.

The evidence on making health policy happen has shown that the policy papers matter, but it is very important to have well functioning stewardship function that will support change. This is especially true where different targets on effectiveness, safety, accountability, responsiveness, efficient purchasing, equity etc are desirable to be met and different sectoral policies are created – but there is need to coordinate these at health system level. Related to stewardship this should be carried out with transparent way when measuring set targets and achievements.

The second presentation on *health policy experience* stared with the policy definition and experience from different countries where the mix of policy and politics has different form in countries coming from their past. The need to have clear goals, objectives and targets in the policy document was discussed with the emphasis to concentrate to outcomes that are achievable, with clear actions what needs to be done in the given situation in the particular country. Thus health policy should be seen as a set of courses of action intended to achieve the health objectives of a society. Second the policies should be driven from the need assessment to find right actions, where different methods are applied. Third there are many competing objectives for the health system as equity, choice, efficiency and policy development needs to balance them.

The important question in policy development would be whose objectives should be achieved, as naturally there are groups of society who will benefit from the new system. This type of analysis is needed during the policy development process and should inform the policymakers. This would serve the policymakers on different stakeholders and their interests

[1] The presentations are available in the Annex 4

to help design policy objectives that can be reached. Thus the policies should include content (goals and targets), principles (ideology and values), means (legal, cultural, organizational tools), and beneficiaries (supporters). The need to have all these sections in the right balance has shown to be valuable as the content alone can not create change. The policy analysis can serve policy developers on this and further quick overview on framework for policy analysis was presented. This was followed on policy cycle presentation where it has been seen that many policies are staying at problem definition and diagnosis level, and few have reached to policy development, political decision, implementation, and evaluation level. It has noted that the successful policy changes occur when three streams of events come together as: the objective situation (the problem stream); the availability of possible solutions (the policy stream); and the flow of political events (the political stream).

In summary the health policy document should: be reasonable explicit in terms of values; provide a road map for the future; indicate the main trade offs for the stakeholders; give scope for transparent follow up of the proposals; and be useful tool for change. The experience from Europe shows that many Health Policies are eloquent and ambitious but unrealistic – thus not implemented in full scale. This is also dues to fact that important stakeholders have not been taken into account, and less attention is given to implementation and needed changes in the managerial structures compared to the epidemiological descriptions.

Discussion

The discussion on how to measure performance was held where the different countries have various approached. This can be done in way of the national standards, analytical studies, benchmarking services, releasing comparative information to public, inspections and audits etc. There is no one solution available but it is important to decide what combination of different performance measures should be used to steer the health system. The discussion was held on specific capacity indicators at community level, where it was found that this can not serve the whole answer as there are other tools that need to be applied. As well as in the health system where usually only less that five percent is dedicated to public health the performance measurement tools should capture the whole health system with its personal and non-personal services.

The discussion what is policy and what is not was held, where it should be noted that countries have taken different routes. The need to understand the different streams as policy and political development were highlighted and that the documents should be sometimes explicit on value for money.

4.2 Experience of health policy in other countries

Presentation

In the first presentation was given by Dr M Wismar. This concentrated to *the values in the health policy documents in Europe* coming from WHO Health For All review performed in 2005. The different use of values has been noticed where in one end in some policy documents values have been used more as rhetoric, and in another end the values are guiding policies and supporting change. The importance to concentrate to the latter end is important. The criteria used to assess different policies were if they were multisectoral, included clear

values and had targets. Basing on these criteria many countries have national multisectoral health policies available, but notably many have also regional health policies available.

Different values that are included are equity and solidarity; participation and accountability; and health as fundamental health right. From these three sets of values more than half of the policy documents include all of them and additional one third at least two of them. On setting targets countries have different focus, where for example Sweden concentrates on health promotion, Germany on selected priority areas, France on comprehensive set of targets.

The evidence from reviewing different policies has shown that most of the policies are staying at policy formulation level, and few of them have been implemented and influencing the system. The third part of the stewardship as collecting and creating the intelligence has also been under presented.

The second presentation on the *national health policy development in Europe* was presented by Dr M Wismar. The current map of health policy developments in Europe was shared with participants where it needs to be noted that most of the countries have mid-term policies available. The further experience on selected countries as France, Germany and England was shared. All selected countries have had different approach to the policy development and thus were valuable source of information.

The third presentation was made by Dr J Habicht to bring the discussion more close to Estonia and short overview on recent analysis (2005) on *health system strength and weaknesses assessment* was presented. The assessment framework with the goals (health, financial risk protection, consumer satisfaction) and intermediate goals (access and coverage, choice, efficiency, quality and effectiveness) were presented. From another end the analysis took the health system levers as basis for creating change to achieve the goals. In the current health system has many strengths and there are opportunities in wider Europe and particularly Estonia that can be used to create change to improve population health.

Discussion

On values it is suggested to use the values surveys available in Estonia to take into consideration the values of general population and how to ensure that health sector values as health as human right, solidarity, equity and public participation can be promoted in the Estonian context. As noticed during the discussions and presentations these have not been incorporated into the health policy preparation process so far in Estonia.

The discussion on the Swedish experience on the measurement on the capacity indicators for communities was held. Even it is a area of development driven mainly by research institutes these indicators are not informing policy or decisions. It is important that there is step further from the information to the intelligence that can be used to create change and for this evidence based measurement tools should be selected.

The scope of different health policies were discussed as some countries have policies that concentrate only narrowly to the health promotion (Sweden) or public health (United States) and not in the overall health system where health promotion and diseases prevention have its important role. To have overall policy for whole system the stakeholders need to be involved from the beginning as well there is need to explicitly state what the document aims and what sectors it covers.

The need to have clear link between policy targets and allocations of resources was highlighted by the participants. This has been the experience also from other countries in Europe and support the policy implementation.

During the discussion it was noted that the presented health system SWOT analysis was not used to inform the policy development process and rather other documents were informing the process as specific health promotion area strengths and weaknesses analysis that was performed some years ago. This was using other structure as described by participant: legislative, political, structural, environmental and professional development domains. It was noticed during the sicussion by participants that the overall health system approach could also inform the further policy development.

4.3 Estonian health policy document

Presentation

The health policy document[2] overview was given by Dr Ü-K Nurm describing the overall epidemiological situation in Estonia, the scope of the policy document, process in developing the document. It was noticed that this is not a new process for Estonia as such documents have been produced also previously but not reached to Government decision level. Current document emphasis the worse health situation in Estonia and is basing on health determinants approach. The presentation was lively with a number of interruptions and discussions that is available in next sections and feedback to the document as many questions raised by participants coincided with the initial feedback to the document.

The feedback to the policy document is partly presented in the discussions, but more explicitly available in the feedback in section 5.

Discussion

The experts expressed their feeling that the document is very negative where Estonia has developed the health system well compared to other similar countries, and that the document should give credit to the past reforms and support further development.

It was highlighted that societies value highly their health, but more important are the values of the society and different groups particularly. Taking into account that Estonia is young society and development oriented this information should be incorporated to the document. If the document *speaks* on the behalf of the population then it should be tailored to their values as the health sector values can not be imposed to the population groups.

It was discussed that the objectives should have clear and achievable measures that will explicitly guide the health system development.

It was noted by participants that the document intends to involve other sectors to develop health and is larger than the health sector itself. It was noted that the benefits of such move should be analysed. It was also highlighted by the policy paper developers that the values of

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[2] The Estonian Health Policy document available in March 2006 is presented in Annex 3

other sectors have not been deeply analysed during policy developing process and there might be some conflicting views that needs to be analysed before starting to develop broader base for policy implementation. At the sometime it was noted that the dialogue with other sectors has started and document will be updated according to the feedback gained.

During the discussion it raised that it is not yet clear what this document serves. As it was noticed that current document is a concept paper rather than policy document. In further discussion it was noticed that this is a political document, where the policy and strategy document will follow after current document is adopted. It was noted by the experts that the scope of the document should be clear and agreed. As well then raises question how many different strategic documents will be produced for the health system, where there are already available many documents that guide implementation for next decade.

After the discussion Ministry of Social Affairs formulated next steps to develop the health policy document further:

- Prepare a health system stakeholder map and analyse different interests
- Analyse the perceptions of the public and society
- Perform policy analysis
- To be more explicit on terms and values
- Include transparent proposals to implement the policy and follow up system

5. Feedback to draft policy document

The draft health policy document is a product of good effort of reviewing the population health challenges and the epidemiological profile of Estonia. It correctly identifies the main threats to the health of the nation and rightly focuses on the prevention of health risks as a cost-effective option to reduce the burden of excess mortality and morbidity. However, despite its merits, the draft document is still far from a solid policy paper that can guide the development of health systems in Estonia.

One of the limitations of the document is that goals and intermediate objectives of the system are rather limited in scope and are not connected with the findings of recent health sector assessments. The main challenges presented in the document are mostly of epidemiological nature with little reference to underlying health system causes. The policy document fails to emphasize the issues identified in the SWOT analysis of the system conducted by WHO and the Ministry of Social Affairs in 2005.

Given that the SWOT analysis clearly illuminates several distinct directions for health sector reforms it is surprising that the policy document identifies only one general objective for the Estonian health system – increasing healthy life expectancy. While health is one of the main intrinsic goals of the health system, there are other goals that the health system should also be concerned about, such as equity, fairness of finance, efficiency of the system, responsiveness to patients' non-medical expectations, quality of care, etc. It is recommended that the health policy document expands its focus on other intrinsic goals of the health system and identifies a set of more specific policy objectives linked to concrete health system issues.

In addition to final health system goals, the policy documents shall also specify intermediate goals with measurable targets. Intermediate goals usually relate to specific to health system

functions and there achievement is a precondition for attaining higher level goals. Such intermediate goals could also include special milestones related to the implementation of health sector development plan.

The policy document, in overall, lacks health system perspective. It is heavily saturated with epidemiological descriptions. The lack of health system perspective results in rather blurred vision of objectives and strategies. Specific objectives resemble wishful expressions without time-bound and measurable targets, road map for achieving them, and clear division of responsibilities among the main constituencies of the system.

Health promotion, without any doubt, should be one of the key areas of investment for the health system. The policy document does recognize this, but naively looks at health promotion as a panacea – the magic bullet that can solve the most of the problems in the health of the population.

Sometimes the policy document creates an impression that the boundaries of the health system are not well understood. Very challenging intentions for socio-economic development and social inclusion are placed on the plate of the health system. The health systems do have a significant role to play in reducing social exclusion but they cannot be held responsible for this, neither for investing heavily in social safety nets. Even thought the social affairs fall under the responsibility of Ministry of Social Affairs, the health policy document has to be placed in the boundaries of the health system recognizing and acting on all existing links that the health system has with other system, and the social systems first of all.

The health policy document in its current form is still not ready to provide good guidance and to the health sector development in Estonia. The document requires further polishing and refinement.

6. Evaluation of the meeting

The anonymous evaluation form was distributed to the participants at the end of the meeting to collect feedback. Half of the participants filled and returned the questionnaires. Additional verbal feedback was collected from some other participants after the workshop. The attendance had various background from research, and policy development and decision making. The option about the workshop is given in following table.

Your opinion of the workshop	average grade, (minimum 1, maximum 5)
Quality of speakers	4.9
Relevance of this workshop to your current work or functions	4.4
Extent to which you have acquired information that is new to you	3.7
Usefulness for you of the information that you have acquired	4.1
Focus of this workshop on what you specifically needed to learn	3.7
Extent to which the content of this workshop matched the announced objectives	4.0
Overall usefulness of this workshop	4.1
Your satisfaction with the venue	4.7
Quality of the administrative assistance provided	4.2
Your satisfaction with the overall logistical and practical arrangement during the workshop	3.7
Degree to which you would recommend workshops to others	4.0

The time allocated to the discussions and interactions between participants were found sufficient by two thirds of those who responded. The depth of the discussions and how the issues were treated were found sufficient by almost all respondents.

The open ended feedback the workshop was found useful, similarly also concrete discussions, with direct and practical comments do develop the policy further. In addition the development of analytical skills was found very useful. There was mentioned some lack of time for discussions and misunderstanding of different concepts of health policy development among the group. The suggestion to involve more specialists was made. The experts provided were found very good.

Annex 1. Workshop objectives and agenda

Workshop to share experiences in Health Policy development in Europe

Ministry of Social Affairs in collaboration with World Health Organization

March 7, 2006,
Tallinn, Estonia

The objective of this workshop is to contribute to the finalisation and implementation of the Estonian health policy document in 2006, by

- Strengthening the technical capacity of Ministry of Social Affairs and selected persons in developing the Health Policy documents
- Giving active feedback to draft Estonian health policy document developed in 2005
- Sharing experience and available evidence from Europe and other selected countries in developing, approving and implementing health policy documents
- Sharing the experience of value based health policies, setting targets for health system development, steering the health system to improve population health

Participants

- WHO Regional Office for Europe, European Observatory on Health Systems and Policies
- 25-30 officials from Estonia (Ministry of Social Affairs, Health Protection Inspectorate, National Institute for Health Development, Health Care Board, State Agency for Medicines, Estonian Health Insurance Fund, University of Tartu, Public Understanding Foundation, Praxis Centre for Policy Studies)

Working language: English

Venue

- The guesthouse of State Chancellery (Vabaduse pst 95)

Agenda

8:30 – 9.00 *Morning Coffee*

Session I: Health Policy Development in Europe
Chair: A Duran (WHO)

9:00 – 9:15

Welcome address from the Deputy Minister of Ministry of Social Affairs and WHO

9:15 – 9:45

The stewardship function – relationships with policy making (A Duran)

9:45-10:15

Health policy –scope and outline; the European experience (A Duran)

10:15-10:30

Values in different European countries and health policy documents in Europe (M Wismar – European Observatory on Health Systems and Policies)

10:30 – 11:00

Discussion

11:00 – 11:15 Coffee Break

11:15 – 11:45

Experience in national health policy development from selected European countries (M Wismar).

11:45 – 12:15

Discussion

12:15 – 12:30

Experience in national health policy development from non-European countries (M Wismar).

12:30 – 13:00

Discussion

13:00 – 14:00 Lunch

Session II: Health Policy development and implementation in Estonia

Chair: Ü-K Nurm (Ministry of Social Affairs)

14:00 – 14:15

Presentation of the recent SWOT analysis of the Estonian health system (J Habicht – WHO)

14:15 – 14:45

Presentation of the draft policy document – goals, objectives, major principles and strategies for implementation (Ü-K Nurm – Ministry of Social Affairs)

14:45- 15:15

Process of developing policy document - how the process was conducted, who participated, what are the main milestones and political commitments (I Normet – Ministry of Social Affairs)

15:15 – 15:30

WHO's comments on the draft policy document (A Duran – WHO)

15:30 -15:45 Coffee break

15:45 – 16:30

Discussion on international experiences and health policy development in Estonia

16:45 -17:00

Next steps and concluding remarks (I Normet – Ministry of Social Affairs, A Duran)

Annex 2. List of participants

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Annex 3. Draft Estonian Health Policy document in March 2006 (from Ministry of Social Affairs)

Population Health Policy
-INVESTMENT IN HEALTH-

Introduction

Health is the most important individual and national resource, and ensuring the prerequisites for attaining the best possible state of health is a part of every person's fundamental rights. Health is a natural precondition for everyday life and an economic resource, which can be developed persistently and systematically. Every person in Estonia must have an opportunity to live in a health-supportive environment and make healthy choices, which is a prerequisite not only for shaping healthy personalities but also for the successful social and economic development of the society.

Health indicators of the Estonian population are alarming. The average life expectancy of Estonian men is approximately 12 years shorter than that of the men living in the old European Union Member States. During the last decade, increasing contrasts in health indicators have occurred between different social groups. Regarding the general average life expectancy, ever-increasing gaps emerge across different educational levels, incomes, places of residence and nationalities. Such great differences cannot be seen in any other Member States.

Contrasts between health indicators result from those economic and social conditions in which people live and work. Healthy people have higher labour productivity; they consume fewer social and health services, and have more opportunities to participate in social, political and economic affairs. Health and economic welfare are correlated. Health investments promote the growth of social and economic welfare and the improvement of people's health and quality of life.

It is possible persistently to develop population health, and to prevent and reduce social inequality in health by the means of planned social, economic, ecological, intellectual and financial resources. Every country, including Estonia, has a responsibility and task to implement measures and make investments in developing the population health potential and reduce inequalities in population health.

The present health policy document is addressed to all the politicians and decision-makers, business people, heads of the local governments and all those, whose decisions influence population health and its development.

Population health can be influenced much more significantly and effectively, if governments at all levels make investments in health and the supporting infrastructure. Clear commitment to health and its development must be the priority and prerequisite for work of each government.

The objective of the health policy is to create preconditions for retaining the nation and for the wellness and quality of life of population by preserving and promoting people's physical and mental health.

The Health Problems of the Population

The health-adjusted life expectancy in Estonia is significantly lower than the average level in the new and old EU Member States. Furthermore, the average life expectancy in Estonia (men 66 and women 77 years) is even lower than the average level of the new Member States. In the average life expectancy, continuously increasing gaps between different social groups emerge. In Estonia, the average life expectancy of men with higher education is up to 13.5 years longer than that of men with basic education. Women with higher education are likely to live 19 years longer than men with basic education. No other European country displays such major differences. There is a pattern that health indicators are characterized by social position – the indicators of people with the highest income and educational level are the best, for those with average income and educational level the indicators are intermediate, and the indicators of people with the lowest income and educational level are the worst ones – and this is also evident in Estonia.

25 % of the population is still living below the absolute poverty line. The health indicators of our socially vulnerable groups are among the worst in the European Union. The most alarming fact is that more than one third of the children up to the age 16 live in families, whose income is below the poverty line. The poverty risk group includes mainly long-term unemployed, low-paid workers, families with many children and single parent families. One fourth of the single elderly is living below the absolute poverty line. The percentage of women among the people living in poverty and in the poverty risk group is higher than that of men; however, 2/3 of the homeless people are male, and this proportion has been constantly increasing over the last 10 years. The percentage of working-age people (in the age of 15-59) with primary education living in poverty is much bigger than that of the working-age people with higher educational level (31 % and 18 %, respectively).

More than one fourth of the households live in lack of privacy, as they are forced to live together with another household. A quarter of households do not have washing facilities or an indoor toilet.

Compared to the average of the old Member States, the rate of preventable injury deaths is 4 times bigger in Estonia. Traffic injuries and deaths, drowning, slaughter and suicide cases are mainly the result of abusing alcohol. In Estonia, the number of up to 14-year-old children dying of injuries and intoxications is bigger than in any other Member State.

The prevalence of mental disorders and addiction problems increases continuously. The use of illegal drugs among the 15-16-year-olds has grown from the 7 % in 1995 to 24 % in 2003. Every third boy and every fifth girl in that age group smokes cigarettes. The consumption of alcoholic beverages increases constantly and has exceeded the amount of 12 litres of absolute alcohol per person from birth to death. Suicide has become the main cause of death among the 15-29-year-olds.
The prevalence of communicable diseases increases steadily – by the end of 2005, there were more than 5000 HIV-positives and as at 2004, 429 people were suffering from tuberculosis. The problem is multi-drug resistant tuberculosis and its rate of prevalence in Estonia is one of the highest in the world. The case rate of tuberculosis among HIV-positives increases, as well as the number of pregnant HIV-positives.
The availability and use of health services is characterized by great regional and socio-economic divergences. Due to urbanization, it becomes more and more problematic to guarantee the availability of health services in thinly populated rural areas.

The Imperative Needs and Basics of Health Policy

The aggravation of economic and social inequality between different social groups and regions in Estonia is strongly reflected in population health. There are easily vulnerable social risk groups evident in Estonia, who have less favourable living and working conditions, fewer opportunities for healthy choices and poorer access to health and health services, and the people belonging to these groups have usually increased health-damaging risk behaviour. The sharpened social problems and shortages in environmental conditions increase the health damage risk, and the gap between unequal health statuses is continuously and rapidly widening.

The health policy document approved by the Government of the Republic in 1994 and the proceeding practical steps to enhance the health status of population has given desired results mainly among the social groups that cope well. Joining the European Union, challenges resulting from the development of society (decrease in the birth rate, ageing population, changes in traditional family structure, free movement of workers etc), new evidence-based methods and health-promoting movements require a new and integrated political approach, and investments and agreements on developing, promoting, and protecting the population health potential.

Population health policy is based on a constitutional right – the right to the protection of health and to the health development. Population health policy follows the ideas of international initiatives – Ottawa Charter (1986), European Charter on Environment and Health (1989), Jakarta Declaration (1997), WHO policy framework Health for All (1998), Verona Initiative (2000), EU Public Health Programme (2003-2008), Revised European Social Charter (2000), EU Charter of Fundamental Rights (2000), Lisbon Strategy (2000), European Charter of Patients Rights (2002) – and other internationally recognized documents regarding health.

Health Policy Is Based on Values

Human Rights

Health is a person's fundamental right, which means that a community must ensure the preconditions for achieving the best possible state of health for all people. The right to the protection of health, to a physically safer living, working and psycho-social environment is stated in our Constitution, in the Treaty establishing the European Community, in the European Social Charter and in several other international documents. Article 152 of the EU (Amsterdam) Treaty states that a high level of human health protection shall govern all decisions, projects and programmes which might have an impact on human health.

Corporate Responsibility for Health

Every decision (political, economic or other) influences population health and all decision-makers on all levels and in all sectors must assume responsibility for advancing their own and population health when planning their activities. Assuming social and global responsibility is the central subject in the documents adopted in the World Health Forums (Jakarta Declaration 1997, Adelaide Recommendations 1988, Bangkok Charter 2005 etc). Governments and all

other resource administrators are responsible for the consequences in population health resulting from their policy or lack of policy. National health policy obliges the government to measure the impact of political decisions on health and report the results in a language, which is easily understandable to all the members of the community. Responsibility for population health is common responsibility, which comprises all the sectors, organisations, groups and individuals of the community.

Equal Opportunities and Justice

Equal opportunities in health reflect social justice. Social justice prevents systematic and inequity-related differences in the health indicators between social groups. The activity of all the sectors and levels of community to implement the health policy must be primarily aimed at those groups of community who are the most vulnerable, to ensure their access to the necessary health information and to create the prerequisites and conditions for them to fully develop their health potential. Creating equal opportunities in education, housing, work and health services regardless of gender, nationality, social position, and place of living is the prerequisite for the continuous improvement of health and quality of life of the Estonian residents.

Social Inclusion

Social inclusion is defined as an active participation of individuals in making decisions and solving the problems that influence them, their neighbourhood, community life and environment. Inclusion means that every person has an opportunity to participate in community life, including to work and to be economically active. Through social participation, individuals, groups, organizations and communities become more empowered and socially capable of solving their health problems. The development of a health-oriented society, the community capacity, and the increase of social capital, which is the basis of a health-supportive human environment, requires people's active participation in making the appropriate decisions.

Evidence-Based Knowledge

When implementing the course of action of the health policy, we must rely on evidence-based knowledge in order to use our resources effectively and transparently. Scientific studies, including the evaluation of health technologies establish the most effective and cost-efficient approaches to health care services, and they must become accessible to decision makers and be the basis of everyday practice.

General Objective of Health Policy

People stand in the central focus in the health policy and policy is implemented with people. The health policy concentrates on the determinants of the population health. Shaping a secure and health-supportive socio-psychological, socio-economic and physical environment, favourable conditions and motivation for one's own responsibility will be created for every person to make the healthiest possible choices and for the rise in the quality of life.

The objective of the health policy is to create opportunities and preconditions for achieving the increase in health-adjusted life expectancy of Estonian men approximately to 60 and women to 70 years, and the general average life expectancy to 73 and 80 years respectively by the year 2015.

The Main Areas of Investment

The choice of areas of influence is made on the basis of the following major health determinants, through which it is possible to enhance population health and decrease inequality in health. Focusing on strengthening social cohesion, on ensuring the healthy and secure development of children, on health-supportive living and working environment, on promoting healthy choices and on the availability of health services meets the new contemporary challenges.

I Strengthening social cohesion and decreasing health-related inequality

Population health is strongly influenced by the interpersonal relationships in the society and their quality. The concept of social cohesion includes the density of communication networks, the perception of coherence and social support. The planned development of social cohesion brings about both social trust and the growth of social capital, which in turn are very important factors of population health. We regard social capital as social networks, trust and norms, which are measurable and comparable in any society.

Social cohesion can be strengthened through capacity building of individuals, groups, organisations and communities to cope with solving their health problems. The increase in capacity of organisations and communities shall be achieved by activation and mobilization of the communities in the process of solving health problems, developing their competence and skills, and creating a politically and socially supportive environment.

Health is created in the places where people live, play, study and work. Thus, the primary level of health investments is the local level, which is supported by the national level. To obtain permanent changes, it is necessary to have a politically favourable environment. The level of social cohesion is high in those societies, which acknowledge the principles of solidarity and social responsibility.

Various health problems are solved on the local level through co-operation. Different sectors, organisations and associations are involved in analysing the local needs, specifying the priorities and also in the process of interventions, which are aimed at obtaining the optimum health potential of the local residents. The development of the social infrastructure and extensive co-operation directed at attaining good health and better quality of life is the key to reducing social exclusion.

Social capital marks the level of social coherence in a community. It is a process that creates networks, values and social trust, and promotes co-operation in solving common problems and reaching aims.

The stronger these networks and ties are, the higher is the health-capacity of the whole society. In this way the social capital develops health and increases the benefit derived from the investments made in health.

Objective: to achieve the growth of social capital and substantial rise in social inclusion.

In the process of reducing health-related inequality, little attention has been paid to the real needs of the easily vulnerable social groups. The prerequisite for satisfying these needs is guaranteeing the social security and recognition to be equal to the other members of the community, which is attainable by creating social justice and equal opportunities, and involving vulnerable groups in social networks. This means a decrease in the level of long-term unemployment, poverty and exclusion, and improvement of the socio-economic situation. Reaching the objective requires also the justice-based equal access to health services and participation in education and labour market together with social guarantees to all groups of society, improvement of social coping skills, and a social guarantee system, which would ensure that people will not fall below the poverty line that threatens the ability to cope.

II Ensuring healthy and secure development for children and teenagers

There are strong associations between the conditions of development in early childhood and adolescence years, and the economic and social coping skills in adulthood – more advantageous development and living conditions and more supportive and considerate family relations in childhood contribute to a healthier and more productive person in adulthood. Thus, the national policy aimed at supporting families with children in every way is very important from the perspective of population health.

Poverty is the main risk factor when it comes to the causes of health problems. Unemployment as a crucial factor of poverty is often related to the parents' abuse of alcohol, which leads to domestic violence and child abuse. Due to disturbed family relations and insufficient social coping skills, poor families are not able to provide the necessary support for the proper development of children. The childhood family experiences in turn influence the future adult's values, social coping skills and health behaviour. Children from poor families have fewer opportunities to participate in developing activities appropriate for their age and to acquire adequate education. Due to poor social coping and risk behaviour, these children are more exposed to communicable diseases, including HIV-infection, injuries and accidents, which in turn are significantly related to the increasing use of addictive substances (tobacco, alcohol, illegal drugs). The high number of suicides among children indicates the seriousness of the problem.

Similarly to adults, children and teenagers are characterized by little physical activity. Low physical effort in school and leisure time is also reflected in the weakening results of the health and physical performance tests among the youth liable to service in the Defence Forces.

We lack co-ordinated activities between the primary health system, pre-school establishments and parents to ensure the health of pre-school children. This is the main cause of detecting child's development, hearing, visual and speech disorders in a late stage. In turn, the insufficient availability of specialised care (social pedagogues, social workers, psychologists) in schools facilitates the dropping out of children with learning difficulties.

The shortening of the time a newborn child stays in hospital to 2-3 days does not enable to give enough advice to the child's parents on how to evaluate the adaptation and development of the newborn child during the postnatal period and how to take care of the child. Therefore, the number of newborn children needing hospital treatment in their first weeks due to unsatisfactory nutrition and adaptation disturbances has increased. Increasing reluctance of parents to immunize their children is also alarming.

Objective: to create prerequisites and conditions for health-promoting and secure development for children and teenagers.

Families with children, especially families with social problems and lower level of education, where the mortality rate of newborn children and infants is the highest, must have a guaranteed access to medical care, health counselling and social assistance corresponding to the needs of the family. The responsibility of parents is to duly ensure the healthy development of child: healthy nutrition that is proper for the child's age, secure environment, immunisations and medical examination of their child, and the best possible assistance to complete the compulsory school years.

When children go to nursery and school, the local government's responsibility for their health increases and the main issue is to provide a health-promoting environment not only for the children but also for the families as a whole. To guarantee education for all children, we must greatly improve the availability of counselling and supportive services in schools, teach social coping skills, and guide the teenagers in making healthy choices. The state must create more opportunities and conditions for teenagers to acquire working practices and for advancing school sport.

III Ensuring health-supporting and -promoting living and working environment

Both physical and social environment have an impact on health. The most essential components of physical environment that influence human health are air, water, food, and living and working environment. Although in general the pollution level of atmosphere air in Estonia has decreased, the pollution level caused by exhaust gases in cities has increased due to the growth in the number of motor vehicles and their traffic volume. The main causes of indoor air pollution are deficient ventilation, the usage of fossil fuels, building and furnishing materials, consumer product chemicals and synthetic consumables. In cities the spread of street pollution into the interior spaces is a concern. Providing high quality drinking water for the whole population is still an unsolved problem. The main cause of unhealthy drinking water is groundwater pollution resulting from soil damages caused by reckless human activity, and also from damaged and leaky water pipes. The increased risks in food environment are the pollution of foodstuffs by micro-organisms and chemical impurities, and the lack of vitamins and minerals. In working and living environment, the main physical health factors are still noise, unfavourable microclimate, and unsanitary and directly health-damaging working conditions.

The factors of social environment that have an adverse effect on health are psycho-social stress, disregarding of safety requirements in the working environment, place of residence in a rural district and poor living conditions, homelessness, low level of education and income, unemployment. The impact of these factors on health-related inequalities is partially described above. Unfavourable environmental conditions affect mainly men, working-age population and people with active lifestyle.

At the present time the primary health-determining factor is the living and working environment (approximately in the range of 60%). The impact of the surrounding environment is constant and serious. The management of human working and living environment is an important determinant of person's welfare and medical status. In order to preserve and improve health, the environment must be managed so that the injurious effect of risk factors arising from the environment (environmental pollution, noise, spread of infectious diseases) will be reduced or eliminated.

The development of population economic opportunities plays an important role in environmental health. From the point of view of the individual level, the biggest problems are ageing and substandard dwellings (humidity, mould, unhealthy building materials, and poor thermal insulation). Immobile work and life style and increasing work stress have also become a problem. Employers are not motivated enough to make more systematic investments in the recreation and health of their employees. Risk analyses of workplace carried out by employers is a new trend, and the state must also invest in its development through counselling and trainings.

Objective: to reduce the health risks resulting from living and working environment.

To reach the objectives of high-level protection of human health against the possible health-damaging effects of living and working environment, it is necessary to improve the permanent structures engaged in assessing and managing the environmental hazards and ensuring their sustainability and co-ordinated activity. Regarding health protection management on the national level, practically all ministries are engaged in various aspects of environmental health, and the progress of the domain depends mainly on the degree of integration of health protection into various environments and activities, and also on the mutual co-operation in the given domain.

IV Promoting healthy choices and life style

Every day people make decisions and choices that may advance or damage their health. The greatest determinant of human behaviour is the surrounding environment with its environmental, socio-economic and psychosocial effects that shape one's values and life style. Health-related behaviour across social groups differs greatly from that of the overall population in Estonia. Human risk behaviour has become an alarming social problem in our society, increasing health-related inequality and shortening lifespan. The abuse of psychoactive addictive substances (alcohol, tobacco and illegal drugs), unbalanced nutrition, insufficient physical activity, and risk behaviour in everyday life and traffic must be seen as the main behavioural health factors.

Socio-economic indicators, such as education, income and employment, are strongly related to human behaviour. People in a lower socio-economic position are characterized by great extent of health-damaging behavioural risks. The percentage of behavioural risks is essentially higher among men. It is many times higher regarding the use of tobacco and alcohol, and gender inequality in terms of the mentioned consumption types has not notably decreased. The percentage of behavioural risks is higher among men also in terms of the consumption of fresh fruits and vegetables, oral hygiene, adding salt to foodstuff after preparation, fastening seatbelt etc.

The general tendency in the above-mentioned types of behaviour among the adult population during the last decade has been towards a healthier direction, but the inequality analysed on the basis of socio-economic indicators (education, income, employment) has rather increased

than decreased. There is inequality between the urban and rural population: there are more overweight people, alcohol consumers and smokers among the latter. Despite the tragic consequences, there has not been a notable progress in traffic safety.
The positive effect of physical activities and healthy nutrition on preventing various diseases and developing health potential has been amply proved. In spite of this knowledge, the percentage of normal-weight people has not exceeded 60 % for several years and the percentage of physically active people has not reached the level of the year 1990.
Opportunities for well-balanced and healthy nutrition and access to sports and health facilities must be much more available for all Estonian residents regardless of their education, income or place of residence.
The issues of sexual identity, relations with partner, sexual violence and sexual abuse have become major problems not only in Western Europe but also in Estonia. Bearing these circumstances in mind, we need to regard reproductive and sexual health in integrity and in the terms of freedom of choice and human rights.

Objective: to achieve the rise in population physical activity, more balanced nutrition, decrease in using addictive substances, and healthier precautionary behaviour.

To reach the objective that determines the rise in our life quality and healthy life expectancy, it is necessary to implement measures in multi-sectoral co-operation to decrease the demand for and availability of psychoactive addictive substances, to promote safe behaviour in traffic and personal life, to enhance the access to healthy food and physical activity opportunities, and to develop health awareness and culture.

V Developing needs-based, fair and effective health system

The availability and quality of health services is important for every person. Developing health system and ensuring its sustainability is possible when responsibilities are fairly divided between the state, local governments, health service providers, employers and citizens.

All people have uniform rights and opportunities to have an access to health services, regardless of their age, gender, place of residence or social background. Under the circumstances of limited resources, one social group or person can be preferred over the other only on the grounds of the health needs of the person or group.

Inequality between people is mainly related to the level of income. People with higher income have generally better health and easier access to health services than people with lower income, whose health is actually worse and the need for health services is higher. This inequality is increased due to the fact that in case of illness, the level of patient's cost-sharing to cover the costs related to the use of health services is one of the highest in the EU. Studies have shown that the structure of health expenses differs between the poorest and the richest social strata. When the expenditures of the poorest households are mainly made on medicines, then the richest people can spend money also on dental care and other fee-charging services. Vulnerable groups include also persons not covered by health insurance, who form approximately 6 % of the Estonian population (about 80,000 people) and to whom only emergency care is ensured.

Objective: to ensure the availability of high-quality health services to all persons in need of them.

We reach the objective when people receive assistance responding to their needs in optimal time and with optimal resource expenditure. In the health system development process the focus is not only on the availability of medical care, but also on the availability of health-promoting and disease-preventive services and on increasing people's responsibility for preserving their own health. Raising people's awareness about their rights in health system is as important as their knowledge about health system management.

Under the circumstances of limited resources, Estonian priority has been set to organising effective and operational co-operation between different health service providers. The health system management must be based on the concept that first contact health services have a central role. First contact health services are locally available to all people and in addition to medical and nursing care services include to a significant extent also health promotion and disease prevention. If necessary, access to other services is guaranteed by directing those who need them to a specialised medical unit or social welfare service provider. In addition to active treatment, the network of nursing care and rehabilitation services, which is necessary due to the ageing population and increasing spread of chronic illnesses, is also being developed.

Social tax shall cover mainly the expenses related to providing services; expenses related to infrastructure shall be mainly covered through other revenue sources. The responsibility of employers shall mainly increase on account of covering the expenditures related to occupational health and benefits for incapacity for work. People's own responsibility in using health services lies in paying for the services in the amount agreed or making expenditures to preserve health and prevent diseases.

Application and Functions of Health Policy

The effectiveness and efficiency of the application of health policy depends on the co-operation and partnership between different levels of various fields. Agreements that divide roles and tasks clearly, inclusion, activation and empowerment of target groups with investments of all sectors are the key factors in reaching the major objective of the population health policy. Different national and local structures, whose work is co-ordinated, play the central role. Internal and international co-operation and partnership between the relevant research establishments, World Health Organisation, European Commission and other organisations enable to introduce more efficient methods and measures for the co-ordinated implementation of the health policy.

National Level

National health assembly consists of the ministers of governmental agencies involved in developing health, chairmen of the relevant commissions of the Parliament, and other important decision makers.

The implementation of health policy is co-ordinated by the Ministry of Social Affairs, whose task is to advance partnership between different sectors and institution on the national level, to arrange the analysis of the impact of political decisions on health, and to co-ordinate and evaluate the implementation of health policy.

The central organ in county government is the health council, which is summoned by the county governor and composed of the representatives of various sectors, co-ordinators of networks, and experts.

Local level

The best results in the development of population health can be obtained by intervening on the local level, where the activity of the implementation of health policy is directly aimed at the socially vulnerable groups. The most significant role in co-ordinating activities is held by local governments and the convened working groups, where obligations and responsibilities of all involved institutions and organisations have been specified. Larger local governments engage a health promotion specialist. Working groups summoned by local governments establish partnerships for the co-operation between the local and national institution, concentrating mainly on the empowerment and capacity building of local groups and communities. Development plan of a local government includes a health development plan, in the drafting of which participate all networks aimed at health development, and which establishes the objectives and goals to reach the overall objective of the population health policy within the boundaries of the local government.

Civil society and non-profit sector

Non-profit sector and different population groups is a powerful partner in affecting population health. Civil society can involve many target groups in the solving of health problems with purposeful activity by supporting them socially, developing their ability to solve health problems and shaping their environment. Non-profit sector is a valuable partner in the co-operation with organisations, institutions, local governments and national sector.

Health Policy Is Our Unique Opportunity

Health problems of the Estonian population are serious. Health policy is not one choice out of many anymore. It is the responsibility of the entire society, which demands the commitment of every sector and level. Considered health investments and our corporate activities in implementing the health policy can bring about significant positive changes in population health and welfare already in the near future. The wisdom of our decision and our activities today shall be measured by the health and welfare of the future generations.

Estonian population has demonstrated its intelligence, perseverance and innovativeness to solve seemingly insuperable problems by setting and reaching common goals. We have a unique opportunity to prove to ourselves and all countries that with the help of a systematic activity, we are capable of reducing the increasing inequalities in population health. We know how to do it. What we need above all is our will and commitment to achieve positive changes. We have a moral, ethical and social responsibility not to let the future generations down.

Annex 4. Presentations from the workshop

The stewardship function – relationships with policy making

Sharing experiences in Health Policy development in Europe

Workshop, March 7, 2006, Tallinn, Estonia

Antonio Durán, WHO Consultant

Structure of the presentation

- Conceptual issues; an overview

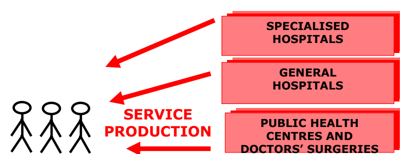
- Stewardship in practice

World Health Report 2000: "Is the health system performing as well as it could?".

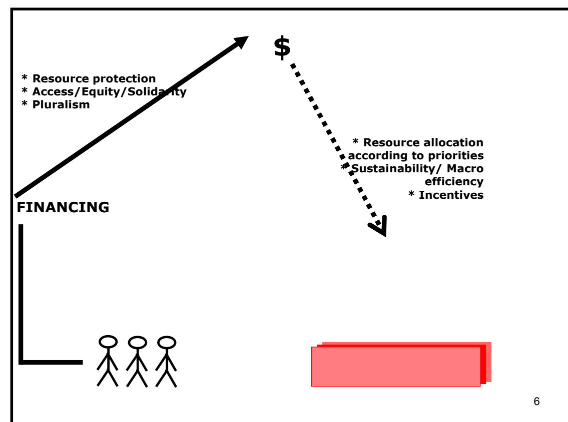
- **Overall health outcomes** (measured by disability-adjusted life expectancy)
- **Inequality in health** (measured by an index based on child mortality)
- **Overall health system responsiveness**, reflecting respect for persons and client orientation (as assessed by a panel of key informants)
- **Inequality in health system responsiveness** (as assessed by the key informants)
- **Fairness of financing** (measured by an index based on the proportion of non-food expenditure spent on health care).

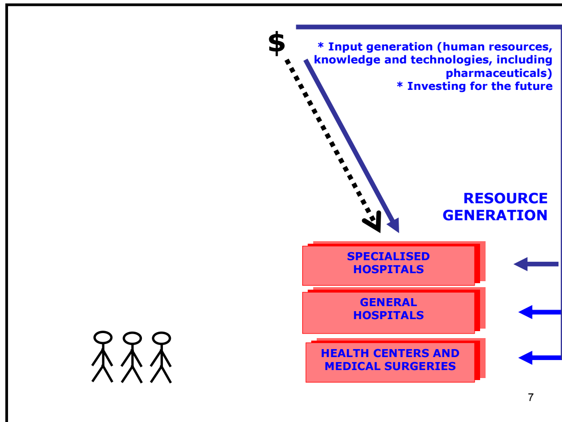
Means and ends

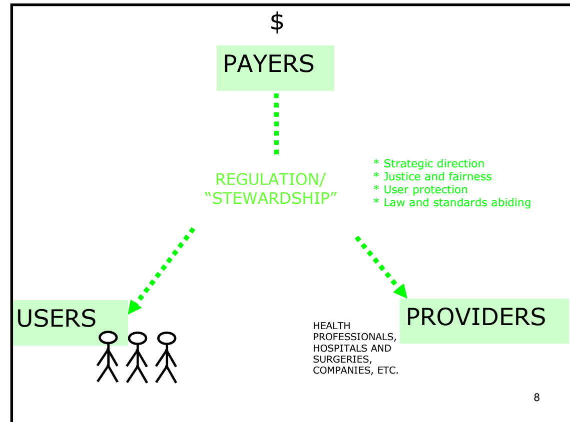
- **The boundaries of the health system:** the *primary intent* criterion: all actors, institutions and resources whose primary intent is to improve (promote, restore or maintain) health
- **Three goals of the health system:** (i) improving health status of the population; (ii) protecting the population against financial risk of health care costs and distributing the burden of health financing fairly; (iii) improving health system "responsiveness"
- **The functions of the health system:** (i) services need to be *produced;* (ii) funding has to be *ensured;* (iii) inputs have to be *"created"*; (iv) the whole thing has to be *governed*



* Use/Satisfaction * Quality * Technical Efficiency/ Productivity







So what is stewardship?

9

(In the health field) "The responsible and careful management of the well-being of the population (the very essence of good government)"

Source: WHO 2000, World Health Report

10

Concept:

"Someone" in the country should be responsible and in charge of the health of the population, while articulating the genuine interests of all other stakeholders

11

A country's government, through its health ministry, remains the "steward of stewards" for the health system, with a responsibility to ensure that they collectively provide effective stewardship.

Travis P, Egger D, Davies P & Mechbal A, "Towards better stewardship: concepts and critical issues", World Health Organization, 2002, Evidence and Information for Policy

12

The "*autoritas*" of the health system

- Steering: focus on vision (health gaining, protecting those in need, etc.) rather than on operations (service delivery)
- Governing: ensuring good use of resources, being fair and transparent, preventing abuse
- Being accountable for outcomes and reasonable in terms of procedural justice

Stewardship's 3 main components

1. Formulating health policy –defining the system vision and direction;
2. Regulating –establishing fair rules of the game;
3. Intelligence –assessing performance and sharing information.

Source: WHO 2000, World Health Report

Policy making has to do with *providing guidance* in a climate of trust and legitimacy while respecting the stakeholders' (and specially the citizen's) perspectives and interests

Critical issue in policy making:

Is the health system's able to *create and sustain (i.e. develop, implement, oversee, adjust…)* a set of effective policies and strategies to improve health

Establishing fair rules of the game

Are there rules that are clear and acceptable for public and private stakeholders, balancing centralization and decentralization and providing channels to allow patients (and especially vulnerable groups) to make their concerns heard?

Regulation works when:

- is focussed on performance improvement,
- is responsive, proportionate, cost-conscious,
- its methods are rigurous and robust,
- it balances flexibility and consistency,
- arrangements are open and transparent,
- there is a wide range of enforcement strategies,
- the regulatory agency is accountable and independent and
- when regulators are committed to continuing evaluation and review

Walshe, Kieran, 2003, "Regulating Health Care", Open University Press, Buckingham,

An appropriate balance is needed between pro-entrepreneurial regulation (stimulating) and regulation that sets boundaries (restricting) to individual entrepreneurial behavior to ensure the achievement of health system objectives.

Figueras J, Saltman R and Busse, R (eds) 2002, "Regulating Entrepreneurial Behaviour in the Health Sector", Open University Press, Buckingham , p 51-74

Generate relevant intelligence

- Intelligence scope: reliable?, comprehensive?, does it include needs' and demands' analyses?...
- Available to national decision makers and to the general public?
- Health & health system performance monitoring (routine/surveillance systems; surveys; interest groups; opinion polls etc)?

"More than" information…!

It is about identifying, getting, using and interpreting knowledge for decision making from formal and informal sources – management, the media, opinion polls, pressure groups, research…

Data can help move the debate to a more honest and consensual understanding of the options available, so that myth, ideology and group interests will not dominate and drive the debate

… But data or information alone cannot reconcile conflicting positions based on genuine value differences

Roberts M, Hsiao W, Berman P and Reich M. 2004, "Getting Health Reform Right", Oxford University Press, p. 25

Specific stewardship problems

- Health ministries' myopia
- 'Cheshire cat syndrome' (conflict in timing?)
- The 'command and control chip'
- Selective eyesight
- Insufficient technical skills
- Decentralisation as specific additional problem
- Lack of tradition of dialogue with professionals
- Lack of public communication strategy

Modified from World Health Report 2000, WHO, Geneva

Lessons from the 1990's: 1/3

Modern stewardship requires a new approach and new tools

- Ensuring accountability
- Ensuring tools for implementation: power, incentives and sanctions
- Ensuring a fit between policy objectives and organizational structure and culture

Travis P, egger D, Davies P & Mechbal A, "Towards better stewardship: concepts and critical issues", World Health Organization, 2002, Evidence and information for policy

Lessons from the 1990's: 2/3

Never destroy a broad integrated regulatory framework (de-regulation) without an alternative at an adequate level of complexity and detail (simultaneous re-regulation)!

Lessons from the 1990's: 3/3

Improved stewardship is one of the keys to health system reform!...

But how could stewardship be "measured" in a reliable and comparable way?

A lot of operational research is needed

- A clear conceptual framework;
- Careful attention to detailed design of data sources and individual indicators;
- Extension of data collection to "hard to measure" domains;
- Careful development of analytic devices to help understand the data (e.g. risk adjustment);
- Mixture of top down (for accountability of institutions) and bottom up (for professional improvement);
- Enhancement of local incentives and capacity to respond to performance measures;
- Central involvement of clinical professionals at all levels, through clinical networks etc;
- Proper evaluation of performance measurement instruments put in place.

Peter C. Smith, 6 february 2003, Conference *Health care coordination in decentralized countries: implications for Spain*, Madrid

Need different approaches for ...

- Effectiveness
- Safety
- Accountability
- Responsiveness
- Efficient purchasing
- Equity

- Encouraging continuous improvement
- Clinical benchmarking
- Professional learning
- Incentives

Where can WHO be of most help? ...

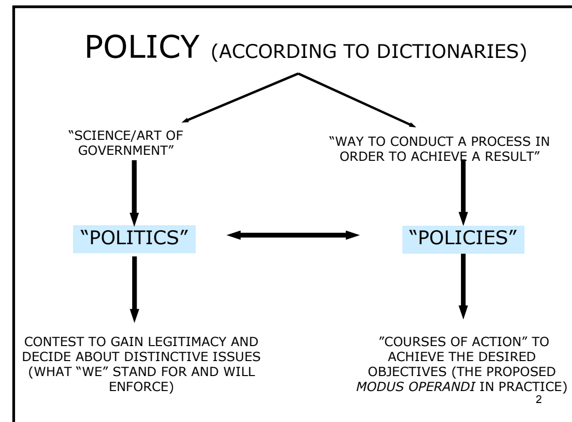
Health policy –scope and outline; the European experience

Sharing experiences in Health Policy development in Europe

Workshop, March 7, 2006, Tallinn, Estonia

Antonio Durán, WHO Consultant

1



2

Health policy is a set of (hopefully evidence-based or at least experience based) courses of action intended to achieve the health objectives of a group, society, etc.

3

GOALS, OBJECTIVES, TARGETS

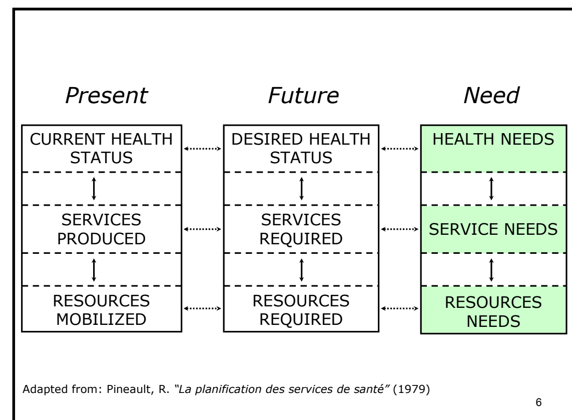
"Preferred outcomes in a given situation"

Beishon J and Peters G (1981). *Systems Behaviour*, 3rd. Edn. Open Systems Group for Open University, Harper and Row

4

For many "WHAT SHOULD BE ACHIEVED?" is the only question to ask

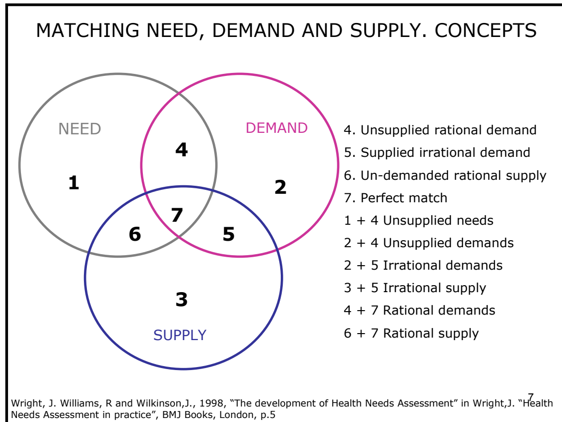
5



Adapted from: Pineault, R. *"La planification des services de santé"* (1979)

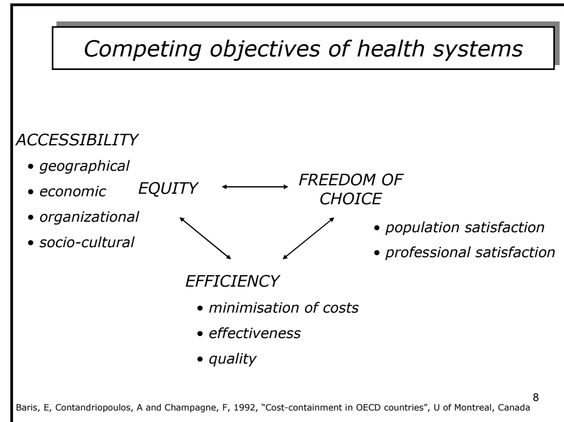
6

MATCHING NEED, DEMAND AND SUPPLY. CONCEPTS



Wright, J. Williams, R and Wilkinson,J., 1998, "The development of Health Needs Assessment" in Wright,J. "Health Needs Assessment in practice", BMJ Books, London, p.5

Competing objectives of health systems



Baris, E, Contandriopoulos, A and Champagne, F, 1992, "Cost-containment in OECD countries", U of Montreal, Canada

In democratic societies, the key question is: *WHOSE* OBJECTIVES SHOULD BE ACHIEVED?

POLICY AGENDA:

"The list of subjects or problems to which government officials, people outside the government closely associated with those officials and society at large are paying some serious attention at any given time"

Kingdon, in Walt G 1994, "Health Policy; an Introduction to Process and Power", Zed Books Ltd, London, p 53

The actor(s) who manage to be seen as asking the 'right question' (that is, he or those who would "define the problem") will have the upper hand in suggesting the solution

POSSIBLE INTERPRETATIONS OF A REGION-WIDE ECONOMIC DOWNTURN IN A MIDDLE-INCOME COUNTRY

1. MINISTRY OF FINANCE: "The health sector is consuming too much of the government's limited budget"

2. MEDICAL ASSOCIATION: "Quality of care is suffering because physicians' salaries are not keeping up with inflation"

3. SOCIAL INSURANCE MANAGERS: "The problem is that the government is failing to pay its shares for the premiums for retirees"

4. HOSPITAL DIRECTORS' ASSOCIATION: "The real problem is the lack of capital investment to buy the necessary new technology

Roberts M, Hsiao W, Berman P & Reich M 2004 "Getting Health Reform Right" Oxford University Press p 22

Any policy thus has:

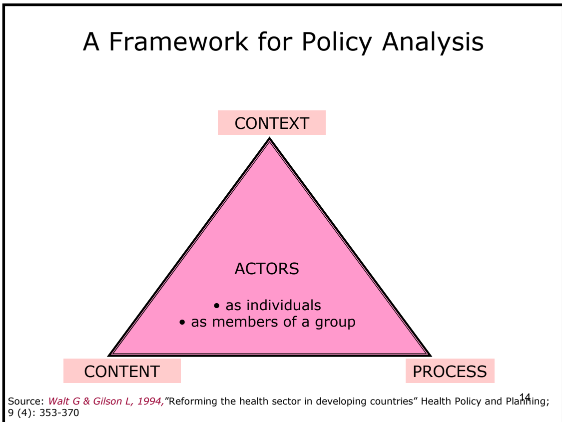
CONTENT → Goals and targets

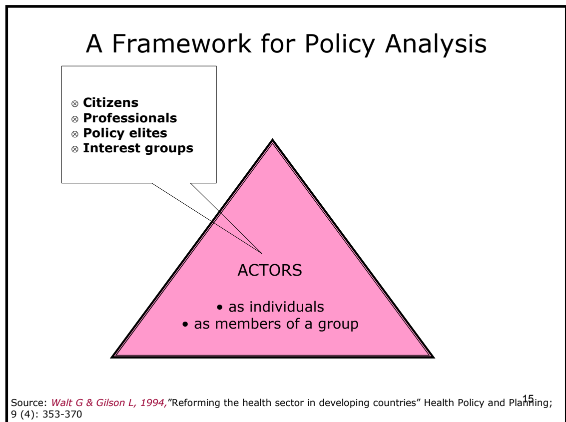
PRINCIPLES → Ideology, values

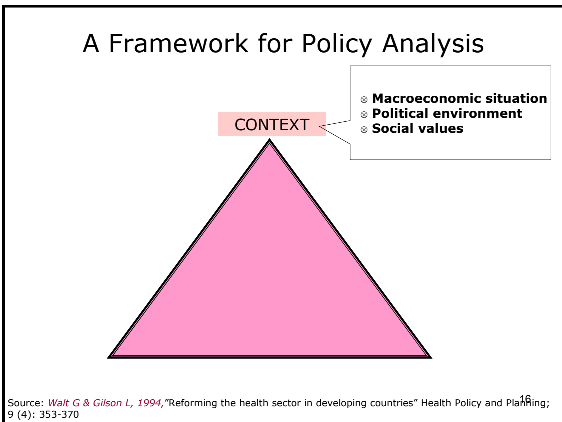
MEANS → Tools

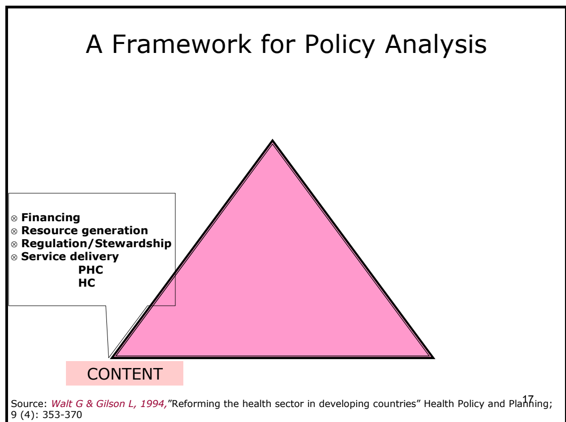
- Legal
- Cultural
- Organizational

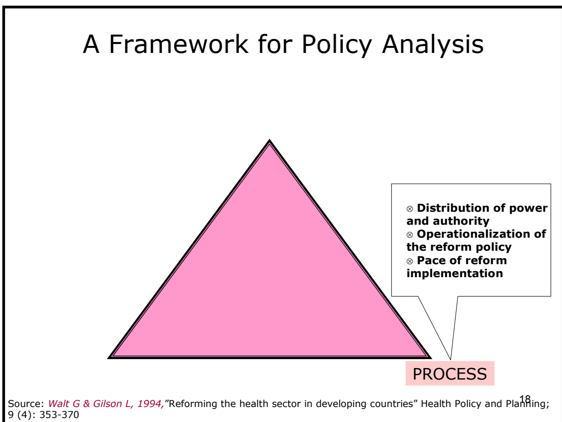
BENEFICIARIES → Supporters











A very similar framework: “Four P’s”

- Players (who’s who?)
- Power (how many “resources”?)
- Position (who defends what?)
- Perception (how felt by the public?)

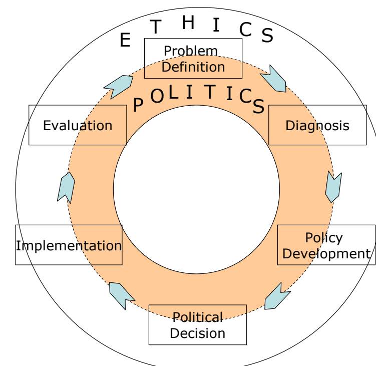
Roberts M, Hsiao W, Berman P and Reich M. 2004, “Getting Health Reform Right”, Oxford University Press, p. 67

A GOOD HEALTH POLICY SHOULD:

- Be reasonably explicit in terms of values,
- provide a road map for the future,
- indicate the main trade offs for the stakeholders
- Give scope for transparent follow up of the proposals
- Be useful as a tool for change

“Policy will” and “policy skills” are two quite different things.

THE “IDEAL” POLICY CYCLE



Roberts M, Hsiao W, Berman P and Reich M. 2004, “Getting Health Reform Right”, Oxford University Press, p. 22

"Power is the ability to make others do what you want them to do"

(J. K. GALBRAITH, 1983, "The anatomy of power" Boughton Mifflin. [Also in lukes, ed. (1986)]

Sources of Political Power

TANGIBLE	NON TANGIBLE
Money	Information
Organisation	Access to leaders
People	Access to media
Votes	Expertise
Equipment	Legitimacy
Offices	Skills

Roberts M, Hsiao W, Berman P and Reich M. 2004, “Getting Health Reform Right”, Oxford University Press, p. 72

POLITICAL SYSTEM:

ensemble of institutions and processes involved in the “authoritative allocation of values for society”.

Easton 1965, cited in Walt G (1994), Health Policy: an Introduction to Process and Power, Zed Books, London, p.16

Successful policy change occurs when 3 streams of events come together:

1) the objective situation (the problem stream)

2) the availability of possible solutions (the policy stream)

3) the flow of political events (the political stream)

Kingdom, J (1995) “Agendas, Alternatives and Public Policies”, 2nd Edition, Harper Collins, New York

3 key factors to be considered in any change of policy:

1.Path dependence (“the inertia” from the previous policy)
2. Government capabilities (to “negotiate” new roles)
3. Technical feasibility (“technical requirements” of the new scheme)

Bonoli G, 2000 “The politics of pension reform; institutions and policy change in Western Europe”, Cambridge

Economists “suffer from a peculiar psychological disorder known as ‘physics envy’ ... We would love to have three laws that explain 99% of economic behaviour; instead, we have about 99 laws that explain perhaps 3% of economic behaviour. Nevertheless, we like to talk as if we are dealing with physical phenomena”

Andrew Lo, Massachussets Institute of Technology, in The Economist, “A Survey of International Finance”, 18 May 2002, p17

Many Health Policies in Europe are eloquent and ambitious but unrealistic. They are aspirational in nature, long in rhetoric but short in delivery

Most suffer from implementation void and lack of attention to managerial implications

The worse feature is the gap with purchasers and sickness funds and the little acceptance by other stakeholders

Public health experts we often suffer also from ‘physics envy’!

Values and Health Policy Documents in Europe

Dr Matthias Wismar
Health Policy Analyst

European Observatory on Health Systems and Policies

Introduction: values do play a role…

- There is scarcely any country in the WHO European Region where it would be accaptable or expedient for a national health authority to declare that it did not stand for justice, equity, solidarity or widespread participateion [...] (WHO 2005 HFA update).

European Observatory on Health Systems and Policies

... but what role?

- Values as lip-service
- Values express what is already under way
- Values guide policies and change

European Observatory on Health Systems and Policies

Overview

- Introduction
- The current situation: Health for All values in Europe
  - Countrieswith value driven policies; Values in the policies; commonalities in values differences in focus
- Some lessons learned
  - It is difficult what values may mean; Values serve as a lynchpin for policy quesionts; cross-fertilization of other policies and laws
- Some concluding remarks
  - Values require debate, values require strategies and tools for implementation

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Current situation

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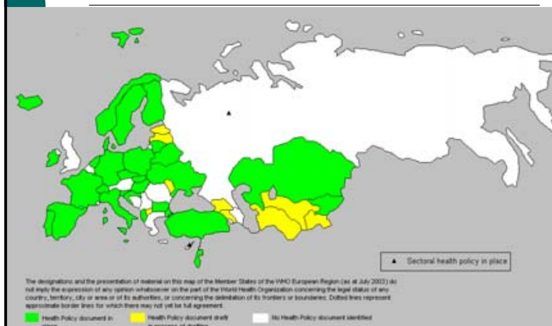
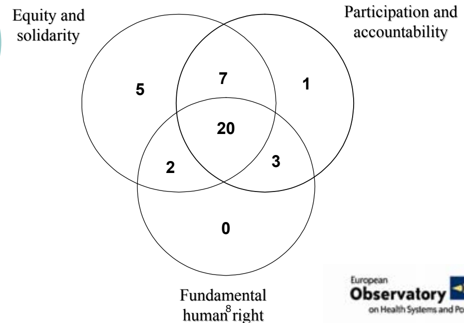
Countries with value driven policies: HFA-policies across the WHO European Region (31 Dec 2004)



Countries with value driven policies on the sub-national level: HFA-policies across the WHO European Region (31 Dec 2004)

Commonalities in value orientation



Marked differences in focus

- **Health determinants (Sweden)**
  - 11 targets
- **Health promotion and prevention (US)**
- **Selected priorities (Germany)**
  - Tobacco control, diabetes, breast cancer, child health (nutrition, physical activity and stress relive), patient concerns, depression
- **Comprehensive (France)**
  - 100 targets

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Some lessons learned

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Clarify the purpos of policies and values

- **Aspirational**
- **Allocative**
- **Managerial**

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Embedded values and policies in the stewardship function

Formulating Health Policy	Exerting influence	Collecting and using intelligence
• Policy analysis • Policy formulation with involvement from stakeholders and civil society groups • Development of an over-arching national health plan • Defining a vision for health • High-level investment and resource allocation decisions • Establishing shared values and the ethical base for health action • Policy evaluation and correction	• Consensus building inside and outside the health sector • Synchronisation of health players • Strategic institution building • Regulation and enforcement • Promulgation of an over-arching national health plan • Promoting a vision for health • Promoting and strengthening shared values and the ethical base for health action • Creating incentives • Consumer education • Establishing and institutionalising transparency in management • Advocating for healthy public policies in other sectors	• Intelligence gathering • Monitoring and evaluation of public health • Encouraging dialogue between communities and the health system • Communication

Establish a common understanding on what a specific value may mean

- Defintion of equity, solidarity and participation
- Process versus outcome
- The system context
- The political contexts

A common understanding on the values require constant and intense debate!

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Consider values as lynch pin in policy formulation

- The Norwegian policy and its values
- The Canadian policy

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Experiences in National Health Policy Development from selected European Countries

Dr Matthias Wismar
Health Policy Analyst

European Observatory on Health Systems and Policies

Overview

- Introduction
- Policy formulation is an ongoing activity in many countries
- Some health policy developments
  - France
  - England
  - Germany

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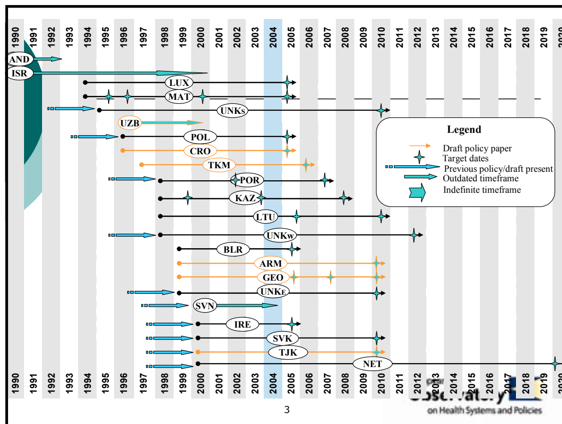

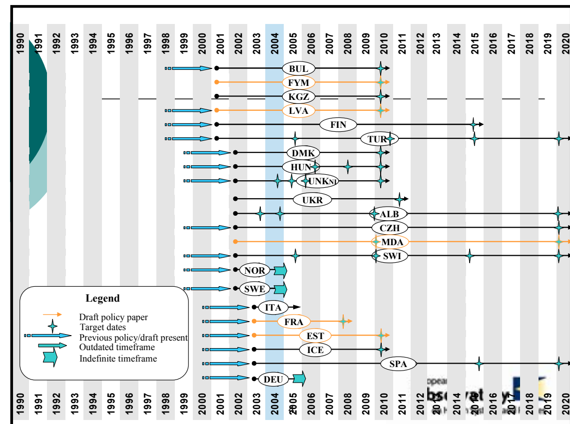

Reform Example France: Challenges and Rational

- Fragmentation of the Public Health System
  - Expertise
  - Medical safety
  - Accoutabilities on the sub-national level
  - Capacities for implementation
- Insufficient co-ordination
- Public health information not sufficiently standardized
- Public health training not standardized

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Reform Example France: Reforming Public Health Services

- Public Health Act (2004)
  - Five-year policy based on 100 targets
  - Determins the tools for implementation
  - Focusses government accountability and reporting to the parliament
  - Supports public engagement
- Implementation of targets so far...
  - Cancer related targets are making good progress, others are delayed due to methodological problems and capacity shortages

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Reform Example England Challenges and Rational

- Governance
  - Long standing experiences with Public Health policy and health targets but little effect on service provision
- Health intelligece
  - Long experience with health reporting but limited use for planning and monitoring and evaluation
- Finance
  - Money does not follow targets and priorities
  - Underfunded

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Reform Example England: Reforming Public Health Services

- Health services become the basis for health promotion delivery
- Linking health targets to public health services (and managers performance)
- Regionalization of Pubich Health Intelligence: the Public Health Observatories

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Reform Example Germany: Challenges and Rational

- Health promotion
  - Insufficient policy orientation (unfocused spending of scarce resources)
  - Insufficient coordination
  - Insufficient information
    - Ca. 2.700 health promotion programmes and projects focussing on equity across Germany
  - Insufficient quality
  - Insufficient and fragmented finance
- Some government agencies and NGOs try hard to make the best out of the given situation…
- …however the health system for health promotion in Germany needs to be modernized and enhanced

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Reform Example Germany: Reforming Public Health Services

- "Prevention Act"
  - Setting up a Prevention Foundation
  - New pooling mechanism
    - € Mio 250 a year
    - Sickness funds, social pension insurance, accident insurance
  - New allocation mechanism
    - 20% national level (campaigns), 40% social insurances, 40% states (Länder)
    - Allocation and purchase of services according to national health targets
  - Delivery
    - Common quality standards
    - Reach
- First attempt to introduce bill failed due to the advanced general election 2005, second attempt planned for 2006

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Reform Example Germany: Regional and local Public Health Services

- All 16 states reform have reformed their public health laws between 1994-2006
  - Adapt to new challenges
  - Adopt new services
- Example North Rhine Westphalia
  - State health conference
  - Local coordination
  - Health policy and health targets
  - New role of State Public Health Institute
  - Monitoring and Evaluation

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Experiences in National Health Policy Development from selected non-European Countries

Dr Matthias Wismar
Health Policy Analyst

European Observatory on Health Systems and Policies

Overview

- United States
- Canada
- Australia

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United States

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The policy development

- ***Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention.*** **(U.S. Department of Health and Human Services 1979)**
- **Healthy People 2000**
- **Healthy People 2010**

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The policy contents

- **Overarching goals (values?)**
  - (1) increase the span of healthy life;
    (2) reduce health disparities; and
    (3) achieve access to preventive services;
- **To help meet these goals more than 300 measurable objectives were developed**
- **Focus is largely on health promotion and prevention**

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Instruments for implementation

- **Federal budget line supports the adoption of targets by the states (Mio $ 150-170)**
- **Private initiatives**
- **Civil society alliances**

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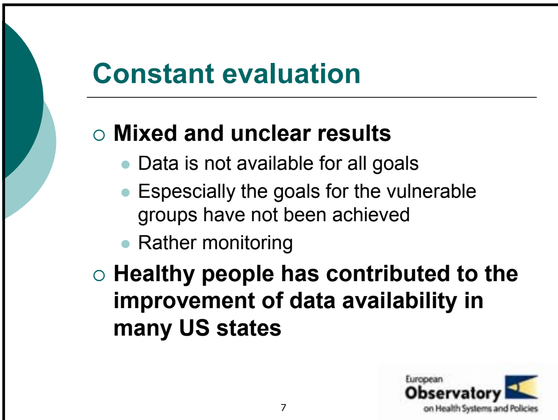
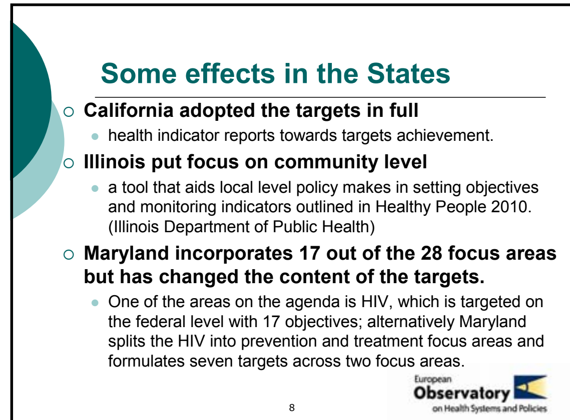
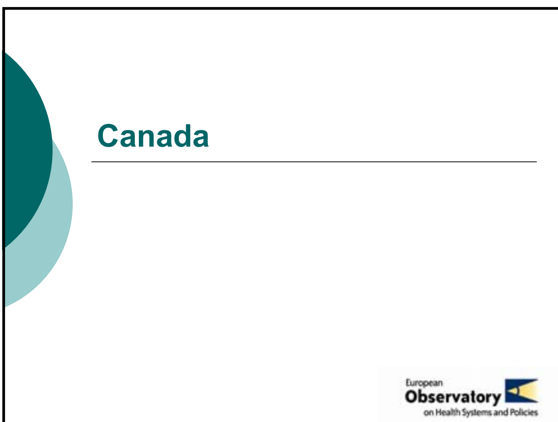

Constant evaluation
Mixed and unclear results
Data is not available for all goals
Especially the goals for the vulnerable groups have not been achieved
Rather monitoring
Healthy people has contributed to the improvement of data availability in many US states
European Observatory on Health Systems and Policies
7


Some effects in the States
California adopted the targets in full
health indicator reports towards targets achievement.
Illinois put focus on community level
a tool that aids local level policy makes in setting objectives and monitoring indicators outlined in Healthy People 2010. (Illinois Department of Public Health)
Maryland incorporates 17 out of the 28 focus areas but has changed the content of the targets.
One of the areas on the agenda is HIV, which is targeted on the federal level with 17 objectives; alternatively Maryland splits the HIV into prevention and treatment focus areas and formulates seven targets across two focus areas.
European Observatory on Health Systems and Policies
8


Canada
European Observatory on Health Systems and Policies

The policy development
A New Perspective on Health Promotion (1974 Lalonde)
Health determinants based:
human biology
health care organization
environment and
Lifestyle
Strengthening of regional and local health planning
Federal Health Planning abandoned in the 1990ies
European Observatory on Health Systems and Policies
10

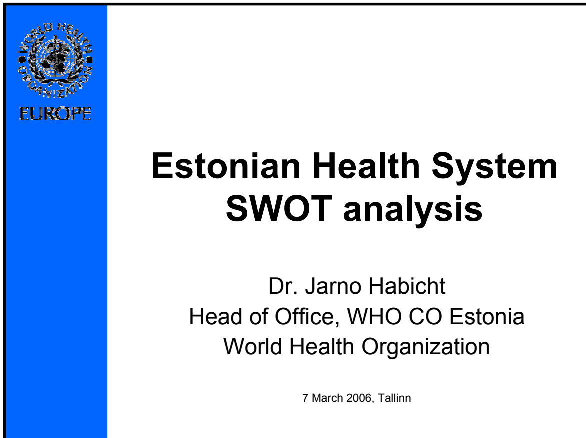
Australia
European Observatory on Health Systems and Policies

Policy development
In 1988, the Health for All Australians report was published identifying five national health priority areas and several measurable targets.
1994 Better Health Outcomes for Australians
cardiovascular disease, cancer, injury and mental health
National Health Priority Areas (NHPA)
European Observatory on Health Systems and Policies
12

Policy formulation and implementation

- 1985 with the establishment of the Better Health Commission. The Commission was formed in response to the publication of the World Health Organization's *Global Strategy for Health for All by the Year 2000*.
- There is a financial mechanism that allows the states to finance policy related activities
- Too many indicators; thus making goals and targets too complex and difficult to implement (National Health Priority Action Council report 2002

European Observatory on Health Systems and Policies



Health system SWOT analysis

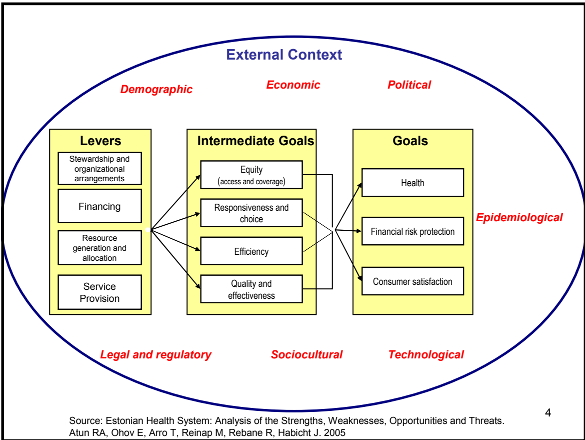
- **Objective** – to provide the framework for the health sector SWOT analysis and support Ministry of Social Affairs in conducting analysis in 2005
  - ... to plan strategic investment from EU Structural Funds 2007-2013
- Different approaches used to
  - ... define areas of further investments, that would allow foster economic growth in Estonia and create competitive advantage in EU
  - ... support further health system development building to existing structures

2

Preparation of the report

- WHO expert (Dr B Shengelia, Dr R Atun) visit to agree framework and meet selected stakeholders
- Further health system analysed
  - Health as investment and relations to other sectors (contribution to economic development, competition, further investments, innovation)
    - DEPLEST, brainstorming, scenario building, dynamic mapping, benchmarking etc
  - Health and health system contribution to production of health
    - levers to manage health system, health system functions and goals (WHO framework), balancing different intermediate goals
- The work has been done in close collaboration with Ministry of Social Affairs where specialists have considerably contributed to the preparation of the report

3



Source: Estonian Health System: Analysis of the Strengths, Weaknesses, Opportunities and Threats. Atun RA, Ohov E, Arro T, Reinap M, Rebane R, Habicht J. 2005

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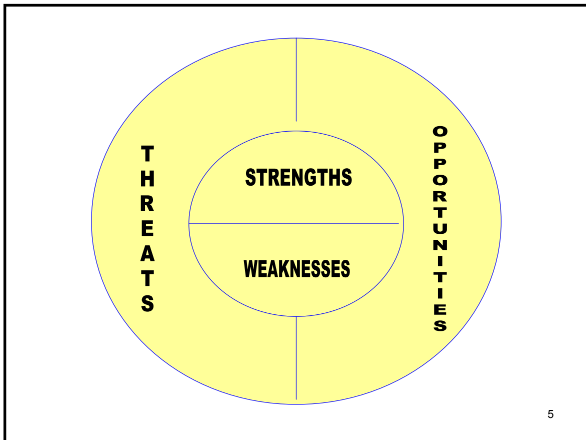


5

Strengths

- Qualified staff and experienced managers
- Comprehensive set of documents in health sector
- Well developed primary health care already accepted by stakeholders
- Rationalised hospital system
- Will to improve leadership in Ministry of Social Affairs
- Transparent public health and health care service purchasing
- Balanced finance in the health sector
- Strong IT development

Source: Estonian Health System: Analysis of the Strengths, Weaknesses, Opportunities and Threats. Atun RA, Ohov E, Arro T, Reinap M, Rebane R, Habicht J. 2005

6

Weaknesses

- No clear, widely shared goals for the system
- Difficulties with continuity of care (leading to frequent cases of patients lost in system)
- Poor intersectoral linkages between health care, public health and social care
- Raising cost sharing (as an expression of inability to cope with cost increases)
- Unsustainable revenue base
- Lack of sustainable training and management skills
- Low ability to retain the professionals
- Unfavourable ratio of different competences

Source: Estonian Health System: Analysis of the Strengths, Weaknesses, Opportunities and Threats. Atun RA, Ohov E, Arro T, Reinap M, Rebane R, Habicht J. 2005

Opportunities

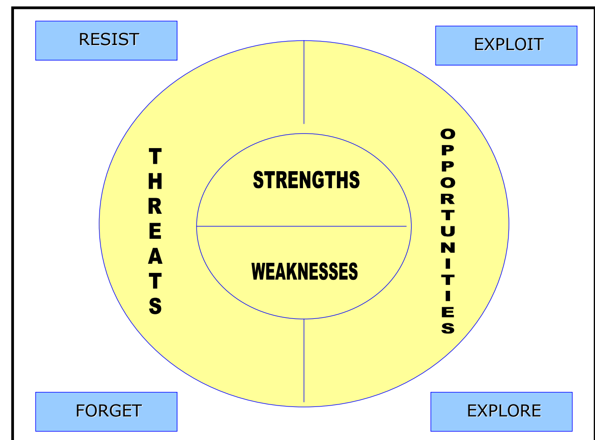
- Societal changes
- Economic growth
- Free movement of goods, services, labour
- Technological development
- EU support for foster development
- Empowerment of citizens and their greater engagement

Source: Estonian Health System: Analysis of the Strengths, Weaknesses, Opportunities and Threats. Atun RA, Ohov E, Arro T, Reinap M, Rebane R, Habicht J. 2005

Threats

- Demographic change and ageing
- Existing and widening income inequalities
- Ecological and public health threats
- Missing the security net?
- Raising population expectations to health system

Source: Estonian Health System: Analysis of the Strengths, Weaknesses, Opportunities and Threats. Atun RA, Ohov E, Arro T, Reinap M, Rebane R, Habicht J. 2005



Issues to reflect on

1. Health promotion and disease prevention
   - strengthen current public health programmes (HIV, TB, cardiovascular diseases) and broaden the further programs to areas such as injuries and mental health - to reduce premature mortality
   - increase the competences and human resources available in public health sector to implement community level actions
2. Preparedness for epidemics, control of infectious diseases and management of environmental health threats
   - strengthen the infrastructure
3. Access to efficient health care services
   - develop infrastructure to strengthen primary health care and increase efficiency in hospital sector
   - invest to human resources and exercise new role allocations among health care workers
4. e-health and IT-systems
   - develop e-health services to support integrated service delivery models

Source: Estonian Health System: Analysis of the Strengths, Weaknesses, Opportunities and Threats. Atun RA, Ohov E, Arro T, Reinap M, Rebane R, Habicht J. 2005

So what is next ?

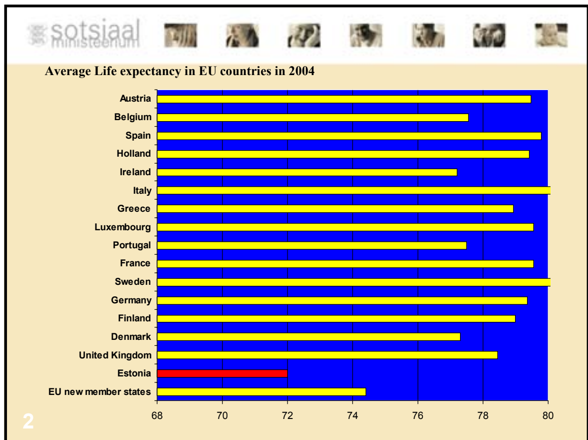
- The production of a policy document offers an excellent opportunity for the Gov and all concerned stakeholders in the health sector to provide a sense of strategic direction
- It is not up to WHO to lead but rather to support the national institutions in this process

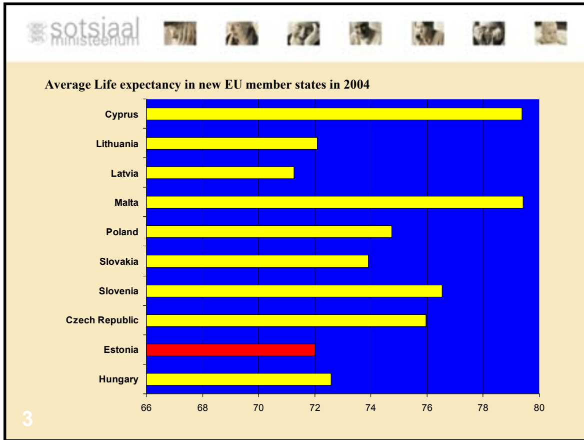
Population Health Policy
INVESTMENT IN HEALTH

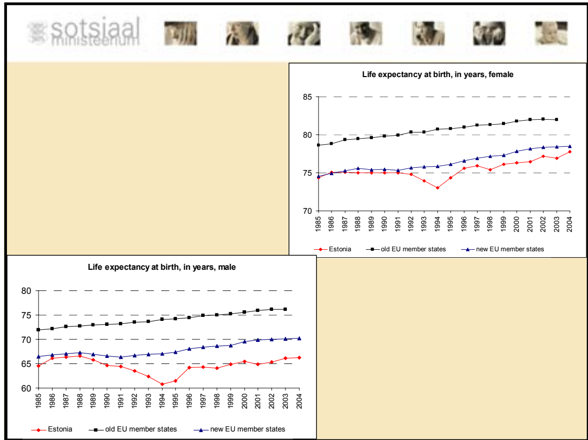
Ministry of Social Affairs
07.03.2006, Tallinn

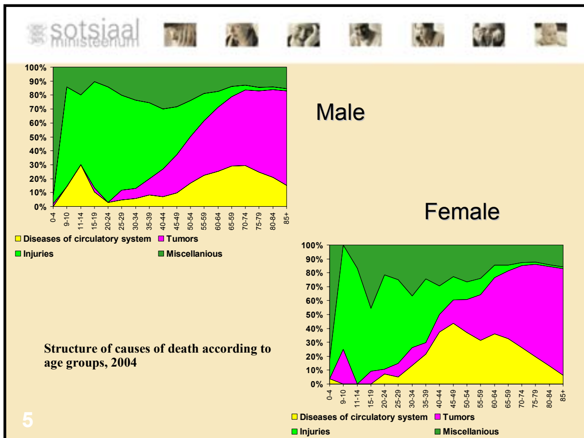
ÜLLA-KARIN NURM
Head of the Public Health Department

sotsiaalministeerium









sotsiaalministeerium

General objective of Health Policy

to create opportunities and conditions for achieving the rise in healthy life expectancy of Estonian men approximately to 60 and women to 70 years, and the general average life expectancy to 73 and 80 years respectively by the year 2015.

Health policy is based on values:

- Human rights
- Common responsibility for health
- Equal opportunities and justice
- Social inclusion
- Evidence-based knowledge

sotsiaal ministeerium

Main areas of the health policy

- Strengthening social cohesion and decreasing health-related inequality
- Ensuring healthy and secure development for children and teenagers
- Ensuring health-preserving and development-fostering living and working environment
- Promoting healthy choices and lifestyle
- Developing necessity-based, fair and effective health service system

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Strengthening social cohesion and decreasing health-related inequality

To achieve the growth of social capital and substantial rise in social inclusion

Measures:

- improvement of the socio-economic situation
- decrease in the level of long-term unemployment, poverty and exclusion
- existence of a social guarantee system, etc.

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Ensuring healthy and secure development for children and teenagers

To create prerequisites and conditions for health-promoting and secure development for children and teenagers

Measures:

- Ensuring secure environment
- Ensuring social and health services
- Completion of compulsory school years
- Teaching teach social coping skills
- Guidance in making healthy choices (nutrition, working habits, sports, etc.)

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Ensuring health-preserving and development-fostering living and working environment

To reduce the health risks resulting from living and working environment

Measures:

- Assessing and managing the environmental hazards both from the physical (air, water, food, working and living environment) and social (human relations) aspects

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Promoting healthy choices and lifestyle

To achieve the rise in population physical activity, more balanced nutrition, decrease in using addictive substances, and healthier precautionary behaviour

Measures:

- Decreasing the demand for and availability of psychoactive addictive substances
- Prevention of injuries (safe behaviour)
- Enhancing the access to healthy food and physical activity opportunities
- Developing health awareness and culture

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Developing necessity-based, fair and effective health service system

To ensure the availability of high-quality health services to all persons in need of them

Measures:

- Development of primary health care services, specialised medical care, long-term care and rehabilitation medicine services
- Ensuring financial protection for people

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Time schedule of the Health Policy Process

- Elaboration of the Draft Health Policy Document
July 2005 – December 2005

- Public discussions of the Draft Health Policy Document
February 2006 – May 2006

- Discussions of the Draft Health Policy Document in the Government of the Republic
June 2006

- Elaboration of health strategy(ies) and action plan(s)
2006 II part → achieving the aim of the Health Policy

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Regional discussions (March-April)

Target group:
- health councils of counties
- local governments

(questionnaires to establish the general opinion on the draft document)
- local stakeholders
- local media

Discussion leaders:
Public Understanding Foundation
- Conclusion of the round table series "Good Health" ("Hea tervis")

Ministry of Social Affairs
- Introduction of the Draft Health Policy Document

Regions
1) Tallinn
2) Tartu, Võru, Valga and Põlva Counties
3) Järvamaa, Jõgeva ja Viljandi Counties
4) Saaremaa, Pärnu, Läänemaa, Hiiumaa Counties
5) Ida- and Lääne-Virumaa Counties
6) Harjumaa and Rapla Counties

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Public discussions at state level

Target group
- other agencies, Chancellor of Justice, State Audit Office, members of the Riigikogu
- Association of Estonian Cities, Association of Municipalities of Estonia
- national organisations of stakeholders
- foreign experts
- media

Responsible party
- Ministry of Social Affairs (March-April 2006)

Final seminar of the inclusion process in May 2006

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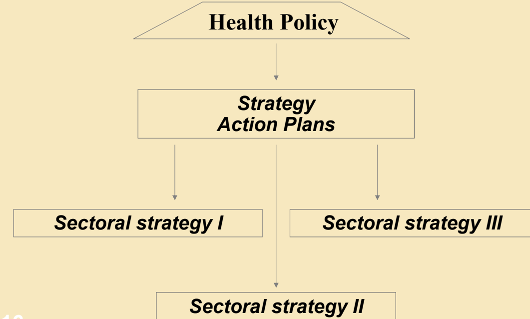

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Implementing acts of the Health Policy

- Child Rights Protection Strategy
- National Programme of Research and Development in Public Health for the Years 1999 - 2009
- National Tuberculosis Control Programme 2004 – 2007
- National HIV/AIDS Prevention Programme 2020
- National Strategy on the Prevention of Drug Dependence 2012
- National Heart Disease Prevention Strategy 2005-2020
- National Cancer Strategy (under preparation)
- Development Plan "Estonian Food" („Eesti toit", under preparation by Ministry of Agriculture)
- Physical Activity Strategic Governmental Action Plan 2006-2010 (under preparation by Ministry of Culture)
- National Sustainable Development Strategy
- Environment Strategy 2030 (under preparation by Ministry of Environment)
- Chemical safety strategic action plan (under preparation)
- Mental Health Policy Basic Document
- Primary Health Care Development Plan (under preparation)
- Hospital Master Plan
- Estonian Long-term Care Development Plan 2004 - 2015
- Rehabilitation Medicine Development Plan
- Medical and Nursing Specialities Development Plans
- Estonian Emergency Services Development Plan 2000-2010
- National Action Plan for Social Inclusion 2004-2006
- Action Plan for Growth and Jobs 2005-2007
- Implementation Plan of the Lisbon Strategy

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Thank you for your attention!

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(Some) Comments on the draft policy document

Sharing experiences in Health Policy development in Europe

Workshop, March 7, 2006, Tallinn, Estonia

Antonio Durán, WHO Consultant
Bakhuti Shengelia, WHO Regional Advisor on Health Policy

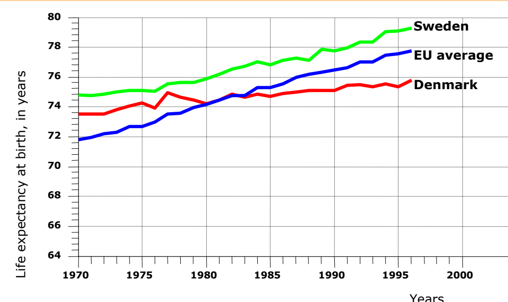
The document is obviously the product of a conscientious effort. This deserves credit to all the authors

However, it would benefit from some changes in its content and presentation

Aims: why "all or nothing"?

- The only general objective is related to healthy life expectancy
- Other intrinsic goals which should be there given the current performance of the health system are missing (e.g. goals related to equity, quality of services, efficiency and sustainability of the system, etc.)
- General objective(s) shall be presented as goals under which intermediate goals and objectives would be placed

LIFE EXPECTANCY AT BIRTH, SELECTED EUROPEAN COUNTRIES, 1970-99



Source: WHO Health For All Database 2000

Some specifics: Main Areas of Investment

- The section is dominated by descriptive epidemiological reviews
- Investment options are not clearly identified
- Objectives are not measurable and time-bound
- The objectives are not linked to specific actions and strategies
- Not clear who is responsible for what

Some specifics:
Strengthening Social Cohesion

- Strengthening Social Cohesion and Decreasing Health-Related Inequalities - HOW to do this is missing…
- The development of the social infrastructure and extensive co-operation directed at attaining good health and better quality of life is the key to reducing social exclusion – what does it mean in operational terms?
- Confusion in the relationships between the agenda for socio-economic development and the health system

Healthy and Secure Development for Children and Adolescent

- The demarcation line of the roles and responsibilities between the state and the individual, between the health system and other systems is blurred.
- Reference to the short hospital stay does not fit with the main issues raised in the section
- In- hospital stay is not necessary to provide advice to parents (this can be done at home too!)

Ensuring Health-Supporting and Promoting Living and Working Environment

- The statement about the magnitude of the expected contribution of the working and environmental factors in the production of health requires credible reference
- Risk reduction is everybody's whish? – But who should do it, how, to what level, and when?
- Does not joining the EU has any implications in this area? No reference to the new context?

Promoting Healthy Choices and Life Style

- Over-simplistic view about how to tackle an immensely complex set of issues
- No clear objectives identified
- No actions and strategies suggested
- Health promotion ideas seen as a panacea?

Developing Needs-Based, Fair and Effective Health System

- "All people have uniform rights and opportunities to access health services regardless age, gender, place of residence or social background" – if that is so, then what is the problem? This statement contradicts with the rest of the arguments
- "First contact health services are locally available to all people … Access to specialist services are guaranteed"- then what is left to be done?
- The objectives sound a bit like slogans

Summary of drawbacks (I of 2)

1. The paper is rather locked in the present and does not provide a clear outlook of the future
2. Epidemiological explanations prevail over feasible solutions
3. Wishes are confused with goals; objectives are not identified clearly
4. Focus on a limited set of health determinants (Iceberg view – focuses on the tip of the problems and does not address the root causes)

Summary of drawbacks (2 of 2)

5. No clear vision of how health system should deal with challenges. Health system perspective is lacking ("ideological" vision of health promotion)
6. Standpoint values, roles and responsibilities of stakeholders not properly addressed
7. No clear time-lines identified, no sense of process, no targets, road map obscure

Final Remark

With due respect, the document requires extensive work, addressing the main issues criticised in this presentation if it is to be really able to reach for a wide audience