



PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT

A Handbook for Teachers, Researchers, Health Professionals and Decision Makers

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Preface

The development of health strategies gained momentum only during the last decade, parallel with the technological advances in indicator-based health monitoring. The build-up of the WHO Health For All Database in Copenhagen and of the EU ECHI System over the last years is serving now as a basis for the analysis of time trends and cross-sectional comparison. This new infrastructure enabled the political decision makers to define meaningfully health targets and to follow-up on progress towards these goals. Public Health Strategies should cover the broad mission, health targets, an action plan and the evaluation. Whereas the action plan and the evaluation rely heavily on the availability of suitable indicators, most of the discussion usually circles around the mission and the targets. It should be well understood that such a debate is crucial: As important as the final formula will be, even more important is the consensus process leading to it. It allows the new ideas and concepts to sink in and to become adopted by all relevant stakeholders. It makes the public aware of some basic common principles and it obliges the executive to perform accordingly.

Especially with regard to South Eastern Europe (SEE) there is an additional aspect to be noted, namely to harmonize the transition of the national health systems from the old state-based structure to an open more cost-effective organization. It is against this background that the book contains as a central part the framework for a public

health strategy for the South Eastern European Region. This approach may complement and support the strife of the countries in South Eastern Europe for accession to the European Union. Furthermore the book contains very relevant contributions on strategy development and implementation as well as a unique collection of case studies from the countries in South Eastern Europe.

This book is not only the first synopsis of its kind in South Eastern Europe, consciously it is written in the format of a teaching book for the new public health curricula introduced in almost all countries in the Region, predominantly in the context of recently established Schools of Public Health e.g. in Belgrade, Sofia or Tirana. The book has been produced by the Public Health Collaboration in South Eastern Europe (PH-SEE), a project of the Stability Pact, funded by Germany since 2000. The authors come from almost all academic and state institutions of Public Health in South Eastern Europe. This constitutes a major step forward towards collaboration and coordination in the Region, however, the implicit heterogeneity also caused considerable problems of mutual understanding and different use of English as a lingua franca for communication.

Finally, as the principle investigators of the PH-SEE project, we have to express our sincerest thanks to the editors and authors for their dedication and patience and an enormous amount of unpaid work, which gave this endeavour a special flavour and unique value. May this cooperative work also serve as an example for a brighter future in a war-torn region and of the re-establishment of cooperation

and peace-building, collegiality and togetherness in the service to the people.

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Chapter 1
INTRODUCTION

PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title:	The Framework of Public Health
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Keywords	Health, health policy, health promotion, prevention, public health.
Learning objectives	After completing this module students will be able to explain, classify and accept the main philosophy and knowledge domains of public health, the principles of public health ethics and the main areas of public health competencies. To meet this objective students will: <ul style="list-style-type: none">• define public health and identify the philosophy and underlying principles with selected unique features of public health• explain different phases in public health development and distinguish the new public health from old public health• accept underlying ethics of public health, values and beliefs inherent to a public health perspective and summarize how public health's legal powers relate to public health ethics, and• describe essential public health functions and their relation to public health practice with public health programmes or domains that create and utilize public health data.

Abstract	Introduction to Public Health is designed to promote the application of public health sciences to a wide range of common problems and issues. The module will portray the philosophy and underlying principles of public health. History, concepts and concerns of public health, public health policy and ethics, essential public health functions will be focus of this module. The sessions are based on the presentations of either historical or contemporary global health problems using a wide range of different types and sources of information. Students will learn to integrate the diverse knowledge and skill requirements of a competent public health practitioner in their approach to problem solving. Each session will include one or more problems which can be used to illustrate the wide range of disciplines applicable (from an evidence based perspective) to the practice of public health.
Teaching methods	<p>The teaching methods will be a combination of lectures, group work, case studies, presentations and discussions in plenary. The main emphasis will be on participatory approaches.</p> <ul style="list-style-type: none">● Interactive presentations in which presentation of content will be supplemented with a variety of questions, interactions, visual aids, and instructional materials.● Small group discussions about public health problems as interactive process in which students will share their ideas, thoughts, questions, and answers in a group setting with a facilitator.● Case studies using realistic scenarios from public health ethics that focus on a specific issue, topic, or problem; students will read, study and react to the case study individually or in small groups.● Brainstorming in which a list of ideas, thoughts, or alternative solutions that focus specific public health topics or problems will be generated to stimulate creativity and active involvement of students.● Essay examination in which an essay question will be written and presented on the subject of local public health challenges to test students' ability to organize and express ideas.

	<ul style="list-style-type: none"> ● Objective written examination will include multiple-choice assessment items linked to the learning objectives. <p><i>Topics for Introductory Lectures :</i></p> <ul style="list-style-type: none"> ● Definitions of Public Health; ● Foundations of the "Old" and the "New" Public Health; ● Public Health vs. Medicine; ● Public Health Ethics; ● Key functions of Public Health. <p><i>Topics for Group Discussions :</i></p> <ul style="list-style-type: none"> ● International developments in Public Health practice: the past and current trends; ● Organization of Public Health Services in SEE countries: the past and current developments; ● Regional collaboration in Public Health training, research, and practice in SEE countries.
Specific recommendations for teachers	<p>This module should be assigned 1 ECTS. Teachers should be familiar to give examples of specific challenges and problems in public health. Teacher should advise students how to use Internet sources in the preparation of an essay.</p>
Assessment of Students	<p>Assessment will be formative based on students' participation (<i>attendance, small group discussion and assignments</i>) and summative based on <i>essay examination with presentation</i> and final exam by <i>multiple-choice questionnaire</i>. <i>Individual assignment</i>: home essay (up to 3000 words, references excluded). Students are expected to provide a comprehensive and coherent literature review on <i>theoretical aspects, core principles, main features, and basic functions</i> of public health.</p>

THE FRAMEWORK OF PUBLIC HEALTH

Vesna Bjegovic, Genc Burazeri

Nowadays, the entire spectrum of public health is enormously complex and public health activities are oriented to many challenges related to health. Evidence from countries in which public health is well developed suggest that it can make an important contribution to the health status of the population. In fact, the health gain of public health activities is far greater than the impact of curative services, although the latter usually consume over 90% of the funds available for health care. However, in the eye of the public and also of many physicians, public health does not have the position it deserves, because it is less “visible”: keeping healthy people healthy is less spectacular than treating the sick (1).

The concept of health very often is still attributed to a medical profession – when people are sick they look for medical care to recover their health. Yet, there is a side of health that many do not see, but are directly affected by – public health. Public health addresses the health of the population as a whole rather than medical health care, which focuses on treatment of the individual disease. It deals with collective problems in society and seeks collective solutions. Today the practical importance of public health is well recognized and presented by fulfilment of the interest of the society in providing conditions in which the people can be and stay healthy (1, 2). For the realization of the public health mission in disease prevention and health promotion, the efforts must be based on the scientific and technical knowledge and the public health activities must reflect the values of the community and rely on the consensus of the same community. In addition, the responsibility for the performance of public health activities is on the government, as on the federal, so is on the republic, regional and the municipal level (3).

The modern concept of public health, the New Public Health, means the efforts on mobilizing thousands of communities, their public health planners and political leaders throughout the world around the programmes of health promotion (4, 5, 6). Health promotion, as the practical implementation of the New Public Health

is “the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. Health promotion is an evolving concept that encompasses fostering lifestyles and other social, economic, environmental and personal factors conducive to health. Health promotion means the techniques that strengthen physical and emotional well-being and prolonging the longevity and the quality of life. It considers the fact, that many diseases are not connected with unknown factors, but with personal lifestyles that can be modified” (7). It is believed that the modification of lifestyles (such as unhealthy nutrition, physical inactivity, unprotected sexual intercourse, lack of prenatal care, not using the safe belt while driving, tobacco, alcohol and drug use) can result in reduction of all causes of acute disability by one third, all causes of chronic disability by two-thirds, and 40-70% of all causes of premature deaths. Many scientists agree that the major gains in health have been attributable largely to the impact of public health interventions during the 20th century (2, 8, 9). The worldwide extension of the average life expectancy at birth is one of the most prominent examples of public health achievements. According to the 2003, UN Human Development Report this indicator exceeds 70 years in almost half of the world countries. However, this and other health gains are not shared equally either within or between countries and within or between different population groups (people living in poverty, refugees, ethnical minorities). Hence, the major global public health challenge in the 21st century will be the application of its knowledge and evidence to effective, safe and affordable interventions, which will have impact at all population levels.

Definitions of Public Health

Definitions of public health vary widely, ranging from the utopian conception of an ideal state of population health to a more concrete listing of public health practices. There were many efforts throughout the history, which tried to capture the entire spectrum and complexity of public health in one definition. As an example of one of the most comprehensive definitions is that one made by Winslow, even in 1920 (10):

“The science and art of preventing disease, prolonging life and promoting physical health and efficiency

through organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure every individual in the community a standard of living adequate for the maintenance of health; so, organizing these benefits in such a fashion as to enable every citizen to realize his birthright of health and longevity”.

It must be noted that, almost 80 years later, the World Health Organization did not depart much from the Winslow’s definition in 1920 (11, 12):

“Public Health is a social and political action aiming at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health interventions”.

One of the most precise and shortest definitions given by Donald Acheson (10a) is what one could call an abridged version of Winslow’s wording:

“Public Health is the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society”.

The Institute of Medicine (IOM), in its important report on the *Future of Public Health*, proposed one of the most influential contemporary definitions (13):

“Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.”

The IOM definition also makes clear that even the most organized and socially conscious society cannot guarantee complete physical and mental well-being. There will always be a certain amount of disease, injury and disability in the population that is beyond the reach of individuals or government. The role of public health, therefore, is to “assure the *conditions* for people to be healthy.” These

conditions include a variety of educational, economic, social, and environmental factors that are necessary for good health. Hence, all contemporary definitions share the principle that the core issue of public health is the health of populations and that this goal is reached by a generally high level of health throughout society, rather than the best possible health for a few. The field of public health is concerned with health promotion and disease prevention throughout society where an essential tool is considered to be a modern approach to health systems development by contemporary methods of public management and health planning. The inherent linkage to an enlightened health policy is apparent.

The Framework – *Old Public Health vs. New Public Health*

Contemporary public health and its complexity can be understood only against the background of history. Looking to the history, it is difficult to select a date for the origins of the field of public health (Table 1). Some authors are beginning with old Egyptians and their efforts to develop a precursor of waterworks system around 2000 BC. Some others cite Hippocrates who describes a number of communicable diseases including mumps and diphtheria with introducing the term “epidemic” and making relations between environmental factors and diseases around 400 BC. The principles and skills of public health were known and applied for centuries, though it is believed that this discipline was created simultaneously with the industrial revolution during the 19th century and that it is particularly developed and improved during the 20th century.

Table 1 Milestones in Public Health History

2000-1000 BC	2000BC	Sewers
		Many ancient Indian cities excavated in the Indus Valley had covered sewers. The city of Kahun in Egypt had sewers to drain water from the streets.
		Public water
		The city of Troy had elaborate systems to bring water to homes.
		Chopsticks
		Eating with chopsticks provided the unintended benefit of preventing illnesses by interrupting the hand-to-

		mouth transmission of germs.
	1000 BC	<p>Diseases</p> <p>American ancient Indian history showed rotation of troops from lowlands to highlands to minimize diseases associated with swamplands.</p> <p>Anthropologists have found evidence of tuberculosis, syphilis, and common birth defects in ancient burial centres.</p> <p>Smallpox stigmata were identified in corpses.</p>
1000-1 BC	400 BC	<p>Communicable Diseases</p> <p>Some of first accounts of acute communicable diseases were described in Thucydides writings on the Peloponnesian Wars (460-404 BC).</p> <p>Hippocrates (b. 460 BC) described a number of communicable diseases including mumps and diphtheria. He also coined the term epidemic.</p>
	100 BC	<p>Hospitals</p> <p>Hospitals were first developed for troops</p>
1-1300 AD	BC/AD	<p>Public Water</p> <p>The Romans since the first century BC built aqueducts to bring water to the city. They also developed a sophisticated plumbing and sanitary drainage system.</p>
	1000 AD	<p>Diseases</p> <p>Many authors wrote about smallpox, and measles was also widespread.</p> <p>Epidemics of – supposedly – Influenza were recorded between 1000 and 1450 AD.</p>
1300-1799 AD	1300	<p>Plague</p> <p>From 1347 to 1352, the plague killed an estimated 25 million people in Europe (one-third of the population) and more than 60 million worldwide.</p> <p>Explorers and traders unknowingly spread diseases--including smallpox, measles, typhoid, diphtheria, influenza, and scarlet fever--, which eradicated up to</p>

		90% of the Western Hemisphere's indigenous people.
	1700	<p>Diseases</p> <p>Malaria is the first human illness attributed to an animal carrier (mosquitoes) in 1717.</p> <p>1796 - Edward Jenner discovered he could make individuals immune to smallpox by injecting them with cowpox, a similar but less deadly disease.</p>
1800-1900 AD	1800	<p>Diseases</p> <p>1847 - Ignaz Philipp Semmelweis identified the cause of puerperal fever in Vienna, comparing women attended by a midwife to those unattended.</p> <p>1854 - John Snow traced a cholera outbreak to a London well contaminated with human sewage. This was the beginning of epidemiology.</p> <p>1862 - Louis Pasteur discovered that heat kills the microscopic germs from air and in liquid, thus preventing bacterial growth and food spoilage.</p> <p>1876 - Robert Koch identified individual types of microorganisms and the diseases they cause, thus discovering the germ theory of illness.</p>
	1900 - present	<p>Ten Great Public Health Achievements of the 20th Century</p> <ul style="list-style-type: none"> • Vaccination • Motor-vehicle safety • Safer workplaces • Control of infectious diseases • Decline in deaths from coronary heart disease and stroke • Safer and healthier food • Healthier mothers and babies • Family planning • Fluoridation of drinking water • Recognition of tobacco use as a health hazard
		<p>Disease Prevention</p> <p>1928 - Alexander Fleming discovered that penicillin mold resists bacteria. Penicillin was developed in the</p>

		1940s and was first used extensively in WW II.
		1946 - The "Communicable Disease Center" opened in Atlanta. This was the beginning of what is now called the Centres for Disease Control and Prevention (CDC).

Source: Modified from NYNJ (PHTC). *Orientation to Public Health*. (Cited: 2005, July 27). Available at URL: <http://www.nynj-phtc.org/orientation/module01/documents.cfm> (14)

The main development of Public Health knowledge and practice could be followed in four main phases (4):

1. hygiene phase,
2. individualistic phase,
3. therapeutic phase, and
4. New Public Health.

The first phase (hygiene phase). The beginning of the development of the discipline of public health is well known as the hygiene phase. At the end of 19th century, this first phase can be understood by the movement for the improvement of the hygienic and sanitary conditions in several European countries that was motivated by the deterioration of the population health due to the industrial revolution (4, 15). In that time, a large amount of people lived in the cities where the basic housing and sanitation problems were not solved. As the results of the epidemics, the mortality increased rapidly. Moreover, the need for efficient measures became mandatory. As an example, in Germany, like in most European countries at the beginning of 19th century, the rapid urbanisation caused the most severe hygiene problems since the middle ages (16). Communal authorities soon appointed physicians to a public office addressed as *medicus civitatis*. These town physicians served as first public health authorities at the community level. Their duty was the surveillance of infectious diseases and the medical care for the poor within the community. A Committee for the Poor was established in 1834 in England, with the mandate to deal with community problems and to propose measures for its solution (17). The committee conducted a research that confirmed the connection between communicable diseases and the non-hygienic environment. Based on this, it was suggested that every administrative community must establish a public health service. The first service of this type was founded by the Association of English Cities for health in 1839. The next step was the

issuing of public health laws, such as the Liverpool Sanitary Act (1846), by which General Health Committee was founded with the task to establish the local public health authorities, later on to provide them with methodological expertise, and to examine sanitary conditions in the community together with them. Henceforward, a whole line of legislative acts was issued, by which waste disposal, water supply, prevention and disease control, inspection of hospitals and chronic patient treatment institutions, birth registration, provision of services for mother & child health care, and other measures were regulated. The activities in Public Health in England had a strong influence on the developments not only in European countries, but also in the USA, where the absence of efficient administrative mechanisms for supervision over community health was noticeable. The first local institution was founded in 1866 in New York, and in 1878 the Public Health department of the state for the USA. Similar activities took place both in France and Germany. The first organized forms of Public Health services in the Balkan region were developed also in the 19th century. They correspond to the first development phase of Public Health (Hygiene phase).

The second phase (immunization, individualistic phase). The development of microbiology and immunology, especially the work of Louis Pasteur, and the discovery of the principle of protection through vaccine, had a significant influence on the work of Public Health institutions. While during the 19th century their activity was limited on the improvement of environmental conditions, during the 20th century, the activities switch to the control of microorganisms as the cause of diseases, and to the immunity mechanism. This second phase of the development of Public health is known as the individualistic phase (4). The measures for the sanitation of the environment and the disease specific protection lead, already in the first years of the 20th century, to improvement of the results in prevention and eradication of communicable diseases.

The third phase (therapeutic phase). The third phase in the development of public health started with the discovery of new therapies such as insulin therapy, and the therapy with the sulphonamide group of drugs in the early 1940s. A significant increase in the individual therapeutic interventions and a search for new technological and scientific approaches began. In that time, as the

consequence of taking control over communicable diseases, the “Old Public Health” lost political attention, and the resources of the state were directed preferably towards hospitals, i.e. the curative services. This domination of clinical medicine, with its large investments and expenses, tended to increase the differences in health between the rich and the poor, the urban and the rural residents. In this phase, good health was primarily considered as a consequence of medical intervention and hospital services. As a consequence, a medical/pharmaceutical industry and powerful medical associations emerged with strong influence on the governments. However, this shift of focus to the curative patient-centred side, also led to a renewed interest in poverty, poor working conditions and unhealthy life styles, such as inappropriate nutrition, alcoholism or sexually transmitted infections. Increasingly, a gap between individual medical interventions with enormous costs and only few effects on the health of the population in general became apparent. The need for a re-orientation of the work of Public Health institutions and their activities was obvious. In consequence, a period of engagement of public health institutions in social actions in the community, in health programmes and health education emerged. Simultaneously, there were efforts directed toward a transnational organization of Public Health that will promote and ensure the health of the population in several countries according to common principles and agreed procedures.

The fourth phase (New Public Health). Thus, in the second half of the 20th century, the fourth phase – the New Public Health emerged, the phase that still lasts. The community is reaffirmed as a focus and relevant setting, because the limited effects of curative medicine, hospital based treatment, one-way doctor-patient relations, and expensive technologies were recognized. Worldwide large numbers of people are affected by poverty, live in remote rural areas or urban slums without provision of the most basic needs, while their communities are characterized by numerous risks that make their health vulnerable (18). These problems are approached by health promotion activities. The development of health promotion, as the implementation on the ground of the New Public Health, had its first cornerstone in the European Strategy Health for All by the year 2000, and in its 38 goals. In this strategy, all member states of the European Region of WHO agreed to develop national health plans (not health care plans) and to contribute to the development of integrated health

promotion programmes (19, 20). The enthusiasm and the dedication to such development of the New Public Health were reflected in the First International Health Promotion Conference held in Ottawa (Canada) in 1986. The most significant achievement of this Conference was the Ottawa Charter for Health Promotion. By the Ottawa Charter, new directions for health promotion actions that could respond to the health problems at the end of the 20th century was set. Since that time, the concept of health promotion has been further developed as the model for the New Public Health movement and provides a strong support for the actions in 21st century.

From the historical overview, it is obvious that the “Old” Public Health culminated at the end of the 19th Century, with Britain (during the “Victorian Era”), France and Germany being examples of excellence in what had been called the “*Public Health Movement*” (21). The Public Health Movement with its emphasis on environmental change lasted until the 1980s and was in time eclipsed by a more individualistic approach ushered in by the development of the *Germ Theory* of disease and the possibilities offered by immunization and vaccination. Thus, the actions to improve the health of the population were shifted towards personal preventive services, such as immunization and later preventive screening. Nevertheless, the accomplishments of the “Old” Public Health, on the whole, have contributed greatly to the decrease in mortality rates and change in the patterns of diseases in Europe and the United States in the early 1900s. The leading causes of death had shifted in the 20th Century from infectious diseases to chronic diseases (what was conventionally referred to as the “*epidemiological transition*”). The population-focus gained even more strength during the first half of the 20th Century through the activities of epidemiologists, sociologists, demographers and economists. Particularly impressive were the public health developments in Germany when Grotjahn inaugurated the concept of Social Hygiene and Gottstein, Schlossmann and Teleky described already in the early 1920s the concept of “*Health Sciences*”, combining medical and social disciplines under this term. These brilliant developments stopped up, however, with the looming of the Nazi regime (22).

After 2nd World War, the “holistic approach” to health services was the cornerstone of what is now referred to as the “New” Public Health (21):

*“The New Public Health synthesizes traditional public health with management of personal services and community action for a **holistic approach**”.*

Thus, comprehensive management of health services with a particular focus on disease prevention and health promotion marked a “new age” for public health. Within this perspective, Frenk (1993) reckoned that:

*“The New Public Health addresses the systematic efforts to identify health needs and to organize **comprehensive health services** with a well-defined population base. It thus includes the process of information required for characterizing the conditions of the population and the mobilization of resources necessary for responding to such conditions. In this regard, the essence of public health is the health of the public; therefore it includes the organization of personnel and facilities for providing all the health services required for health promotion, disease prevention, diagnosis and treatment of illness, and physical, social and vocational rehabilitation”.*

Furthermore, Ncayiyani (1995) deemed that (23):

“The New Public Health seeks to address equitable access to health services, the environment, political governance, and social and economic development”.

Fairly recent (2003), the “New” Public Health was defined as (24):

“Use of theory, experience and evidence derived through the population sciences to improve the health of the population in a way that best meets the implicit and explicit needs of the community (the public)”.

It must be said that, notwithstanding the enlargement of scope and focus over time, the core value guiding the work of public health

professionals has for long remained unchanged to protect the *health of the public*, especially its most vulnerable groups.

The Essential Functions of Public Health

Public health systems provide and support a wide range of programmes and policy interventions. Public health functions are understood as the set of actions that should be carried out specifically to achieve the central objective of public health: improving the health of populations (25). A distinction should be made between **public health functions** and **public health activities**. Public health functions define the major objectives or expected results from the public health sector (what is to be achieved), while the activities describe the means or mechanisms of achieving these expected results. Public health functions define goals and expected results of a sustainable health development relating to the general population and to certain population groups that actively participate in health promotion and improvement of a healthy environment. Beside health status and risk factors assessment, functions of public health also relate to enabling people to take care of health, mobilization of partnership and reinforcement of public health legislation. Special functions of public health are also continuous quality improvement, effectiveness and efficiency as well as availability of health care and finding new approaches to solve community health problems. The operability of a function depends primarily on a sufficient definition of its contents, objectives, and activities and on assigning responsibility for implementing it.

Identifying the functions of public health is a recurring theme around the world, suggesting a need for countries and international health organizations to improve their ability to explicitly identify what they do and how they do it (26, 27). During this process, decision-making is informed by the best available evidence, while evidence-based public health has become increasingly important (28). It refers to using a systematic approach to appraise the quality of the knowledge and the studies that are available on public health interventions. Though the concept and logic of evidence-based public health are similar in many ways to the well-known evidence-based medicine, specific principles of public health should be always

considered taking in mind the complexity of public health and its social and political nature (29).

Over the past decade, many countries have defined core (or essential) functions of their public health systems. Within the set of public health actions and responsibilities, they define more homogeneous specific subsets based on the objectives or tasks needed to achieve the end goal of public health at the local, state and federal levels. In 1988, the Institute of Medicine defined three core functions of public health that help to describe responsibilities of public health agencies (13):

- *"Assessment: assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities;*
- *Policy development: formulating public policies, in collaboration with community and government leaders, designed to solve identified local and national health problems and priorities; and*
- *Assurance: assuring that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the quality and effectiveness of that care."*

Following the three core functions of public health as defined by the Institute of Medicine, one of the first examples in the field is the work done by the Core Public Health Functions Steering Committee, which developed the framework for ten Essential Public Health Services for the USA in 1994 (27). These Essential Services provided a working definition of public health and a guiding frame for the future efforts in many countries (27):

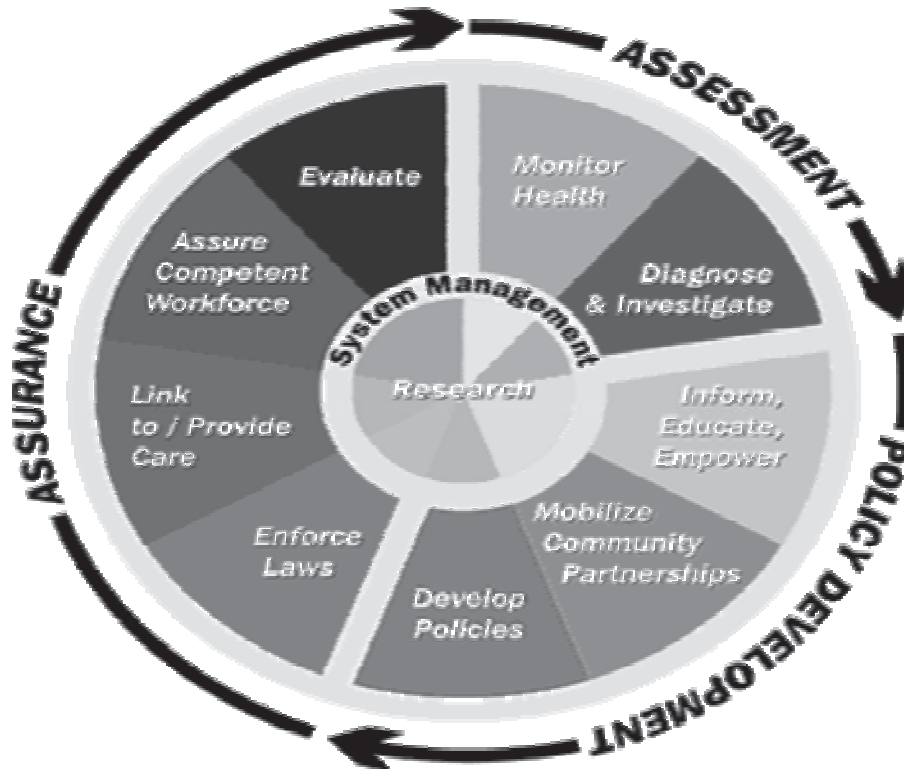
1. "Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety

7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services, and
10. Research for new insights and innovative solutions to health problems”

Very often Public Health is considered to be a part of the medical sciences. If one reflects the array of the essential functions above it becomes clear that the concept of the Public Health extends far beyond the curative medical horizon and rather involves medicine as one of the contributing disciplines in addition to sociology, psychology, economy etc., which enables the implementation of public health interventions.

Later, in order to develop the institutional capacities of health authorities to carry out sound public health practices, the World Health Organization conducted an International Delphi Study, which pointed out the importance of public health management (30). In addition, the Public Health in the Americas Initiative has prepared a list of 11 essential functions by adding a function related to emergencies and disasters in health including prevention, mitigation, preparedness, response and rehabilitation (31).

Figure 1 Essential Public Health Services



Source: Department of Health and Human Services. *Public Health in America*. (Cited 2005, July 28). Available from URL: <http://www.health.gov/phfunctions/public.htm>. (32)

Reviewing the public health literature there are several examples e.g. from Canada, Australia and the United Kingdom which define the core public health functions (27, 31). Inherent in these functions is the recognition that each public health organization would not perform the same amount of each element or the same elements as others; rather performance is determined by the level of responsibility and by a number of forces in the specific community.

Table 2 A Comparison between CDC’s Essential Public Health Services and WHO-PAHO’s Essential Public Health Functions

CDC’s Essential Public Health Services	WHO-PAHO’s Essential Public Functions
1. Monitor health status to identify community health problems	1. Monitoring, evaluation and analysis of health status
2. Diagnose and investigate health problems and health hazards in the community	2. Public health surveillance, research and control of risks and threats to public health
3. Inform, educate and empower people about health issues	3. Health promotion
4. Mobilize community partnerships to identify and solve health problems	4. Social participation in health
5. Develop policies and plans that support individual and community health efforts	5. Development of policies and institutional capacity for planning and managing public health
6. Enforce laws and regulations that protect health and ensure safety	6. Strengthening of institutional capacity for planning and management in public health
7. Link people to needed health services and assure the provision of health care when otherwise unavailable	7. Evaluation and promotion of equitable access to necessary health services
8. Assure a competent public and personal health care workforce	8. Human resource development and training in public health
9. Evaluate effectiveness, accessibility and quality of personal and population based health services	9. Quality assurance in personal and population based health services
10. Research for new insights and innovative solutions to health problems	10. Research on public health
	11. Decreasing emergencies and disasters in health including prevention, mitigation, preparedness, response and rehabilitation

Sources: a. CDC. *The Essential Public Health Services* (Cited 2005, July 20). Available from URL: <http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm> (27)

b. PAHO, WHO, CDC. *Public Health in the Americas*. Washington: Pan American Health Organization 2002. (31)

Ethical Dimensions of Public Health – *Public Health vs. Medicine*

The ethics of public health are concerned with the ethical dimensions of professionalism and the moral trust that society gives to public health professionals to act for the common welfare (2). The ethical principles of public health are born out of the values and beliefs inherent to a public health perspective, in addition to common ethical theories. Since the mission of public health is to achieve the greatest health benefits for the greatest number of people, it draws mainly from the traditions of utilitarianism which in its essence considers those decisions to be ethically right which enhance the benefit of the majority without harming the minority. The public health approach, therefore, differs from modern liberalism primarily in its preferences for community benefits. At the same time, ethics in public health raise the important issue of social justice and have transferred many of the principles of medical ethics to itself. Medical ethics emanate from interactions between a patient and a physician while public health ethics emanate from interactions between an agency, such as the state health department, and the population it serves. In the case of vaccination for an infectious disease such as measles, a physician will consider the autonomy of the patient (people can refuse "required" vaccinations on the basis of religious beliefs or moral convictions). While the director of a public health department will not want to violate an individual's rights, his perspective will extend to a whole population. An ethic of human rights is popular among many in public health. Sometimes one of the most difficult decisions public health professionals have to make, is the one between the protection and welfare of the population and the rights and the perceived benefit of individuals. Often one has to make up one's mind in a rather intuitive and personal way. Some core differences between Public Health and Medicine are listed in Table 3.

Table 3 Key Differences Between the Attributes of Medicine and Public Health

Attribute	Medicine	Public Health
Primary focus of concern	Health of specific individuals	Health of populations/communities

Primary health improvement strategy	Treatment of disease or injury with secondary emphasis on prevention	Prevention of disease or injury
Intervention context and scope	Clinical and surgical encounters and medical/surgical treatment; preventive interventions within the context of each professional discipline (e.g., paediatrics), with focus on one or a few points in the causal chain	Any and all vulnerable points in the causal chains; prevention approach not predetermined by professional discipline, but rather by the effectiveness, expediency, cost and social acceptability of intervention
Operational context	Operation through private practices, clinics, hospitals, with governmental direction primarily in terms of quality assurance	Operation within a governmental context requiring, responsiveness to legislative, regulatory, and policy directives

Source: O'Carroll PW, Yasnoff WM, Ward E, Ripps LH, Martin EL. *Public Health Informatics and Information Systems*. New York: Springer-Verlag 2003. (33)

Public health concerns are not equal to those of medicine, as it focuses more on population than individuals, and more on prevention than cure. Hence, public health has, intrinsically, some unique ethical features, the most prominent being the following (5):

- **Equity and solidarity:** In the European ethical tradition, solidarity with the disadvantaged groups has long been a unique ethical value, which is reflected in the configuration of the modern European welfare states.
- **Sustainability:** refers to the developments, which ensure that the current use of resources does not compromise the health of future generations. This is especially relevant for countries in economic difficulties, such as the case of SEE region.
- **Participation:** community empowerment and participation in the decision-making process is a coherent approach promoted and vigorously supported by the World Health Organization.
- **Efficiency:** even in the richest countries, health care resources are scarce, as modern technologies create new diagnostic tests and new therapeutic procedures with remarkable costs. Consequently, in all countries, there is clear evidence of a (widening) gap

between technological advancements and financial means available. Therefore, any waste i.e. sub-optimal use of resources is deemed unethical.

- ***Justice and peace:*** public health disciplines are all vastly based on a social justice philosophy; social fairness is the cornerstone for avoiding social tensions and, consequently, promoting peace, which in turn is the best prerequisite for a sustainable development.

One of the key problems, which differentiate a new public health ethics from the classical biomedical ethics, is the necessary decision-making on the basis of statistical probabilities. That does not only imply that such decisions can be wrong but that they will not be appropriate for some individuals although they are the best for the majority of a population. Whereas in clinical medicine such uncertainty can be mastered by respecting patient consent, in public health often the rights of a minority have to be suspended as is shown by the classical example of obligatory smallpox vaccination in spite of some serious side effects. To advance traditional public health goals while maximizing individual liberties and furthering social justice, public health interventions should reduce morbidity or mortality; data must substantiate that a programme (or the series of programmes of which a programme is a part) will reduce morbidity or mortality; burdens of the programme must be identified and minimized; the programme must be implemented fairly and must, at times, minimize pre-existing social injustices; and fair procedures must be used to determine which burdens are acceptable to a community (34).

Developments of Public Health in Europe: *East vs. West*

Today, what has emerged as the "New" Public Health is an approach, which brings together preventive measures and health promotion at the community level, environmental changes in a broad sense (taping physical, socio-economic, and psychological dimensions), appropriate therapeutic interventions, as well as a comprehensive management of health services at large. Public health in the West had moved from a *paternalistic, medicalised* model to one that emphasizes *empowerment, community development*, and the ability to make *healthy choices*. On the other hand, in the East few choices were available for most people. Even if the governments in

the East had been aware of developments in the West, the community empowerment was merely irreconcilable with the highly centralized systems consisting of undisputed authority and harsh command, which resulted in an extremely vertical management of health services.

In contradiction to the communist past of Eastern and South-eastern Europe with its mainly vertical structures, in Western Europe differentiated societies of a more horizontal character evolved of which a significant example is the growing role of citizen initiatives, self help groups and non-governmental organizations and a prevailing tendency to decentralize powers which is in line with one of the basic principles of the European Union, namely subsidiarity. Subsidiarity means that whatever can be done by a lower hierarchical level should not be performed at a higher i.e. more central organizational structure, that is activities should preferably be developed bottom-up and be supported only where necessary top-down. The strong environmentalist green movement and the nowadays well-accepted role of self help groups in the health field have created partners for public health institutions and professionals, which in many instances became more relevant than the classical state institutions as there are ministries of health or city governments. Whereas in the early historical development of the later European Union (EU) coal and steel where the main areas of commonality, public health entered the agenda forcefully with the treaties on European Union of Maastricht (1992) and Amsterdam (1997) where in the article 152 (ex 129 Maastricht Treaty) it reads:

Article 152

- 1. A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.*

Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education.

The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. *The Community shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action.*

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.

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Article 152 describes the so-called Public Health Mandate of the European Commission in granting to it the right “to take any useful initiative...”, whereas the organization of the curative medical services remains exclusively a national domain. However, even in this area the decisions of the European High Court on patient mobility have opened new avenues for convergence between the national health systems and insurance. Over the years, one can observe a continuously rising importance of the EU in public health matters, an example having been set by the handling of the Mad Cow Disease around the year 2000. More and more the so-called Four Freedoms of unrestricted movement between the member states of persons, goods, services and finances become valid also for the health sector.

It may be useful here to point to different but overlapping dimensions related to health promotion, namely prevention, health education and health protection as the latter term is mainly used in the EU policy statements.

According to Downie et al (34a) central to *prevention* is the conception of reducing the risk of the occurrence of a disease process, as there are illness, injury, disability, handicap. *Health education* is understood as communication activity aimed at enhancing positive health and preventing or diminishing ill-health in individuals and groups, through influencing beliefs, attitudes and behaviour.

Health protection, comprises legal or fiscal controls, other regulations and policies, and voluntary codes of practice, aimed at the enhancement of positive health and the prevention of ill-health. In other words, it is about making healthy choices easier choices. Examples of legal control include legislation concerning the wearing of seat-belts in cars, the sale of alcohol and tobacco to minors, drinking and driving, the control of communicable diseases, and health and safety at work. Other regulations and policies are also important for health protection, as for example many employers have developed policies to promote non-smoking on their work places. Voluntary codes could also take an important role in this respect. A major barrier to governmental action in favour of health appears to be a failure to look for and give priority to such domains as fiscal policy. Another barrier to health protection is big business, which is in a strong position to oppose pro-health policies in the interest of profit. Ethical considerations include people's freedom of choice even for unhealthy lifestyles.

EU action is to focus on the prevention of illnesses, including drug addiction, by promoting research into their causes and their transmission, as well as health information and education (35, 36, 37, 38). Under Article 152 action towards these ends may involve Community measures, complementing action by the Member States. But the main approach should be to encourage co-operation between the Member States in line with the subsidiarity principle. The institutional arrangements are that the Council adopts incentives and common actions on the basis of the co-decision procedure, while recommendations are adopted by qualified majority on a Commission proposal. The Treaty of Amsterdam especially extends the scope of actions covered by the co-decision procedure to include measures setting high standards of quality and safety of organs and substances of human origin, as well as measures in the veterinary and phytosanitary fields.

The Council and the European Parliament meeting in the Conciliation Committee reached an agreement on a 6 year programme (2003-8) of Community action on public health (35). The programme entered into existence in January 2003 with a total budget of 312 million EURO. It replaced 8 existing Community action programmes on health promotion, information, education and training; combating

cancer; prevention of AIDS and other communicable diseases; prevention of drug dependence; health monitoring, injury prevention; rare diseases; and pollution related diseases. The new programme will promote an integrated health strategy through three major objectives (35):

1. Improving information and knowledge relating to public health
2. Enhancing the capacity of public authorities and health systems to respond rapidly to health threats
3. By promoting health and the prevention of disease by addressing health determinants across all policies and activities.

The new strategy will concentrate on three main strands, leaving the organization and delivery of health services and medical care in the hands of national authorities. The priorities in public health of the EU are to establish a comprehensive data system on the major determinants of health, such as the consumption of alcohol and tobacco, ensuring that the union is able to handle international health threats, such as infectious diseases, and identifying the most effective policies for combating disease and promoting health. The new programme marks a deliberate break with its predecessor, which had adopted a fragmented, disease oriented approach in which resources were spread thinly over a multitude of one off projects. Setting health targets (rather than simply providing health services) may be a good way to persuade governments to take health seriously (36). It is stressed that targets must be set at regional and district level rather than national or European level. Also health targeting needed to be seen as a part of a mid to long term strategy to improve health, and targets had to be drawn up with the full collaboration of different partners in the community. The WHO Healthy City and Healthy Regions initiatives suggest that communities have a tremendous capacity to co-operate in public health.

It has been noticed that public health services throughout of EU follow different models specific for each country. However, two basic approaches can be distinguished:

- a) public health services organized with governmental support in collaboration with different public institutions (inside and outside the health sector) and non-governmental organizations at the national and community levels, and

- b) through a network of institutes of public health in collaboration with other partners at the national and local level. Nevertheless, for all countries is typical that an institute of public health at the national level exists though with different scopes of tasks and responsibilities.

In the past decade most of the SEE countries have experienced conflicts and economic collapse, which has impacted the quality and development of public health. In addition, changing disease patterns in SEE region require a public health service to be constantly redefined. At the beginning of 1990s the former socialist countries in the SEE region begun to make radical political and socio-economical changes away from centrally planned economies, towards the development of market economies. The dissolution of the Former Yugoslavia was followed by the appearance of new states. The increasing cost pressure as the result of scarce financial resources moreover forces the public health actors to strive for more co-ordination and co-operation to employ resources as effectively as possible (37). There is a need to strengthen the collaboration between the countries and improve the co-ordination of international co-operation and support for the reconstruction and development of public health in the region. Key areas of collaboration in public health reforms among the SEE countries are: the health information system, training and research, non-communicable disease and public health interventions, migrant health and control of illegal drugs (39, 40, 41). There are several initiatives, which support this. The most important is signed as Dubrovnik Pledge in 2001, by the Ministers of Health from the South Eastern European Region (SEE), who gave political support for improving the health of their populations and particularly of vulnerable groups (39). Priority health issues, policies and future actions for the Region have been explored. In this framework, Stability Pact supports many public health projects. The Council of Europe, together with the World Health Organisation coordinates the activities within the Stability Pact, among others the Initiative for Social Cohesion. A Health Action Plan has been issued in this context with three strategic regional health objectives (37):

- 1. cost-effective reorientation of health service to deliver a high quality of health for all particularly vulnerable groups,*
- 2. restructuring and strengthening of the public health function and infrastructure, and*

3. development of professional capacities.

Underlying the decision was the recognition of health as important determinant of social cohesion and a major factor in peace building, investment and development.

Another important project within the Stability Pact, funded by Germany, is represented by the Programmes for Training and Research in Public Health (PH-SEE), which have been developed through collaborative networks between public health institutions in the SEE Region (<http://www.snz.hr/ph-see>). Regional co-ordinating centre of this project is the School of Public Health “Andrija Štampar” in Zagreb, whereas the international co-ordinating centre is the Section of International Public Health at University of Bielefeld, Germany. Participation in this regional network is a good commencement of the development for public health in the Region. Strengthening public health through collaborative training, research and practice remains the greatest challenge through out the region.

Since the year 2000, this project pursued the development of a PH-SEE Consortium, which is supporting the following developments:

- network of public health institutions and professionals
- internet-based postgraduate training
- support to schools of public health development
- agreement on common minimum indicator set
- common training programmes and conferences
- publish a set of handbooks for teachers and health professionals in the region
- regional mobility of students and teachers
- institution building
- joint public health research
- enhancement of peace and human rights in SEE, and
- development of a common internet-platform.

Until now, more than 1.000 public health professionals from SEE region and EU have participated in different activities. The Stability Pact process is an opportunity to boost public health and health development in the countries of SEE. In addition, important

support is coming from other international agencies (European Agency for Reconstruction, Fund for an Open Society (OSI), Canadian International Development Agency (CIDA), Centres for Disease Control & Prevention (CDC), World Bank (WB), UK Department for International Development (DFID), etc).

Programmes for training and research in public health



New Threats and Challenges of Public Health in South Eastern Europe

Traditionally, some public health activities (by the Sanitary Epidemiological Services) and some personal preventive services (e.g. immunisation programmes) were well developed in countries in South Eastern Europe and other former socialist countries. Public health was more concerned with infectious diseases than with physical and

chemical risk at the workplace and in the environment. The public health services had large networks of laboratories at their disposal and impressive numbers of data were collected. During the nineties, however, the public health services suffered heavily from lack of resources, lack of continuous education and generally from disorientation. It became obvious that a change of emphasis was needed away from the control of infectious diseases (without abandoning this field) towards health problems caused by life style, such as smoking, alcohol abuse, lack of safety consciousness, lack of physical exercise, etc. Many projects in many countries have worked on the development of modern health promotion services, with mixed results. Personal preventive services have also suffered from lack of resources and even the immunisation of small children has deteriorated, leading for example to resurgence of diphtheria in the former Soviet Union (42).

In some countries, either because of scarcity of appropriate skills or organisational weaknesses or lack of funds, public health services are unable to realise their potential. Experience suggests that public health services can be made more effective by developing and/or restructuring their activities in certain areas based on well-evaluated results from other places. For example, in the field of health promotion, restructuring should focus on those interventions that help individuals to make healthy choices, whether by empowering them through advocacy or community development or by encouraging fiscal, regulatory or other means to increase the choices available. While such reorientation should not ignore health services, it should concentrate on the broader determinants of health.

As a first step towards reform in any country, the present situation in public health must be described: health indicators, physical infrastructure, staff, financial and material resources and strategy. Priorities must be set, which can provide most health benefit at the lowest cost and which together fit the presently constrained financial resources. With all choices to be made, the principle of cost-effectiveness is an overriding one. This means that priorities should be based on scientific information as to expected health benefit and costs, although this may be difficult to explain to politicians. Costs are not only financial, but also non-material, such as willingness of

professional staff to adapt to a new system and efforts by the population to change harmful practices (43, 44, 45).

Modern health promotion (health education) will be a key element in a public health reform package, both because it is potentially most cost-effective and because it is relatively new to professionals and the public alike. Smoking, alcohol abuse, STD including HIV/AIDS, and drug addiction are important subjects here (46).

Classical health protection measures cannot be neglected, and should indeed be strengthened and adapted, especially to more environmental determinants of ill-health. The control of communicable diseases should go on unabated, including immunisation programmes, whoever is going to implement them. Rationalisation and upgrading of the public health laboratories usually is part of public health reform projects.

For all forms of public health, educational establishments can play a role. This can already start with health promotion activities in schools, and more specifically with the training of health care professionals in medical schools and nursing colleges.

It is clear that public health reform cannot limit itself to a top-down approach. Indeed, without the participation of citizens and educational establishments, health promotion efforts are doomed to fail, whereas modern health protection activities do not depend so much on community participation, but may come as a cultural shock to the professionals working in this sector. The responsibility for different types of personal preventive care must be clearly established. This is especially true for the immunisation programmes.

The growing relevance of Public Health in the European Union is only one example of a worldwide renaissance in many ways related to the newly emerging global threats to public health in the 21st Century, which include the following:

- proliferation of weapons of mass destruction, and catastrophic terrorism, particularly bio-terrorism.

- emerging infectious diseases, with new pathogenic threats (like SARS), re-emergence of "old" diseases (like tuberculosis), and antimicrobial resistance.
- non-communicable diseases, with the pandemic of tobacco-related diseases and obesity.
- globalization, with its potential for propagation of pathogenic threats, unhealthy lifestyles, and dissemination of terrorism.

The new threats constitute a strong force for closer co-operation globally (World Interior Policy) and even more within the EU where relevant common institutions are already in existence.

Formulation of Public Health Strategies as New Challenge in 21st Century

Reviewing the framework of public health as described above, it becomes obvious that a public health strategy has to draw from the medical paradigm but as well from a social paradigm and therefore is to be multi- and interdisciplinary in nature in terms of the New Public Health. Also a public health strategy cannot be formulated anymore with a national reference alone, given the interrelatedness of local, regional, national and inter- and supranational structures especially in a uniting Europe. For the transition countries in South Eastern Europe, i.e. Albania, Bulgaria, Romania, Moldova and the countries on the territory of the former Yugoslavia, a public health strategy has last but not least also to deal with the common communist heritage. As the similarities between the countries in SEE and their mutual dependency are dominating their public health, a regional strategy is accruing which may find its political structure in the collaboration, which has been established in the health sector by the Dubrovnik Pledge (2001) under the auspices of the EU-Stability Pact, the Council of Europe and the World Health Organization. As the formulation of public health strategies especially at the national level is always subject to political negotiation it constitutes a continuing and never ending debate where the process is more important than the result of the day as it helps to define the common interest in public health and to assume accountability towards the people. To structure this process the Essential Public Health Functions as described above are more and more accepted as a comprehensive guidance.

Exercises

Learning objective:

The purpose of the exercise is to provide students with basic skills necessary to explain, classify and accept the main philosophy and knowledge domains of public health by using different source of information (*publications, online resources and free online journals in the field of public health*), which are listed below.

Task 1. International developments in Public Health practice: the past and current trends

Groups will be formed at the beginning of the module and each group will choose a health problem among those identified as public health problems in the list provided by teacher. The first, students work individually, by writing down their own discoveries in international public health developments regarding selected health problem. They should use different sources of information listed below to gain their personal vision. In addition, their essays should include literature review on theoretical aspects, core principles, main features and basic functions of public health. After this is done, each group will describe the health problem in terms of evidence and importance for public health interventions. The past and current international trends should be listed. Finally each group will present their work using appropriate media. A teacher summarizes reports, which are presented by highlighting the main trends in international public health, while each student's essay is assessed separately.

Time (ECTS): 3 hours under supervision and 10 hours of individual student's work.

Task 2. Organization of Public Health Services in SEE countries: the past and current developments

Students should be informed in advance about the task in order to gain relevant knowledge, which will support their small group discussions. Each group will report the results of discussion by using flip-charts paper to list the past and current public health developments in their countries.

Time (ECTS): 4 hours under supervision and 10 hours of individual student's work.

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Recommended readings

Publications:

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Online Resources:

- Centers for Disease Control and Prevention (CDC). Available from URL: <http://www.cdc.gov>
- European Union. <http://www.europa.eu.int>
- European Health Forum Gastein (EHFG). Creating a Better Future for Health in Europe. <http://www.ehfg.org>
- European Observatory on Health Systems and Policies. <http://www.euro.who.int/eprise/main/who/progs/obs/toppage>
- Health Resources Guide (Eldis). <http://www.eldis.org/health/index.htm>
- Programmes for Training and research in Public Health. Available from URL: www.snz.hr/ph-see
- Public Health and Prevention Resources Centers. <http://www.medscape.com/pages/editorial/public/resourcecenters/index-publichealth>
- Super course. Epidemiology, the Internet and Global health. Available from URL: www.pitt.edu/~super1
- United Nations. <http://www.un.org>
- World Health Organization. <http://www.who.int>
- World Health Organization. Regional Office for Europe. <http://www.who.dk>

Free Online Journals in the field of Public Health:

Annual Reviews Public Health	http://publhealth.annualreviews.org
BM Public Health	http://www.biomedcentral.com/1471-2458/1/
BMJ	http://bmj.com
Directory of Open Access Journals	http://www.doaj.org
International Journal for Integrated care	http://www.ijic.org
Internet Journal of Public Health Education	http://www.aspher.org

PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	The Economics of Evidence in Public Health
Module: 1.2	ECTS (suggested): 0.75
Author(s), degrees, institution(s)	Helmut Wenzel, M.A.S. Milena Šantrić Milićević The first author is health economist. Research Associate of the Section of International Public Health (S-IPH) Faculty of Health Sciences, The second author is Teaching Assistant at the Institute of Social Medicine, School of Medicine, University of Belgrade
Address for correspondence	Helmut Wenzel,, Friedrichstrasse 61, D-78464 Konstanz E-mail: HKWen@aol.com
Keywords	Rational decision-making, evidence, utility, priority setting, information, knowledge
Learning objectives	After completing this module students and public health professionals should: <ul style="list-style-type: none">• be aware of the trade-off between evidence information, its timely availability and its measurability,• understand the concept of medical and economic evidence,• differentiate between data, information and knowledge,• increase knowledge on priority setting options.
Abstract	The notion of "economics of evidence" nevertheless suggests that information on evidence can be obtained in an efficient way. Supporting decision-making therefore means to reduce complexity and to pay attention to the fact that information might be highly uncertain. In other words the deliverables are "actionable information". In the following we will look closer to the available options.

Teaching methods	After introductory lecture students will participate in nominal group technique in order to recognize and to rank the field in the quality of health care where organizational, managerial, or other improvements are necessary, such as waiting lists, admission policy, medical records keeping, patient's discharge procedure, administration of drugs, working in multidisciplinary teams, patient satisfaction, etc. Then they will work in small groups, divided according to country or working place, to discuss the possibilities for improvement in their own environment. The second exercise will be to discuss, within the country (or working place) small groups, the necessary procedure for development of national accreditation system. Teacher will advise them to follow existing models and experience and to highlight their advantages and obstacles in the case of application within the country of SEE region.
Specific recommendations for teachers	
Assessment of students	Multiple choice questionnaire (MCQ), and case problem presentations.

THE ECONOMICS OF EVIDENCE IN PUBLIC HEALTH

Helmut Wenzel, Milena Šantrić Milićević

Introduction

Decision-making in public health occurs at different occasions and at different levels. Independent from the underlying problem the mechanisms or the principles of decision-making should be the same. From the viewpoint of economics and decision theory we assume that this process is rational¹. Homo oeconomicus analyses, selects and evaluates the alternatives in a systematic and rational way in order to get the highest benefit or satisfaction with the least possible effort².

The most important hurdle on this way is the timely availability of information and related uncertainties with respect to options to act, consequences and the likely outcomes of any action. How do people make decisions when time is limited, knowledge imperfect, and the future uncertain? For many economists, the answer is that people behave as if they were optimising under constraints (such as information costs³). For many psychologists, in contrast, the answer is that people commit reasoning fallacies, due to limited cognitive capacities, thus suggesting irrational decisions (1).

Given the fact that human minds are designed to work in environments where information is often costly and difficult to obtain, we should instead expect many decisions to be made based on simple heuristics. This leads to the question whether the outcomes of any

¹ Rational means that an action is suitable to reach a given goal with least possible resources. This is a definition of technical rationality which corresponds with "Zweckrationalität" of Max Weber (2).

² Traditional views of rational decision-making assume that individuals gather, evaluate, and combine all the available evidence to come up with the best choice possible (3).

³ Cost does not necessarily mean money. Cost describes any effort to be made to obtain information. The notion of cost also includes incremental aspects. What is the optimal ratio of cost and information?

decision-making process in a complex environment can really contribute to adequate problem solving and efficient decisions.

The notion of ‘economics of evidence’ nevertheless suggests that information on evidence can be obtained in an efficient way. Supporting decision-making therefore means to reduce complexity and to pay attention to the fact that information might be highly uncertain. In other words the deliverables is “actionable information”. In the following we will look closer to the available options.

The Framework for Decision-Making in Public Health

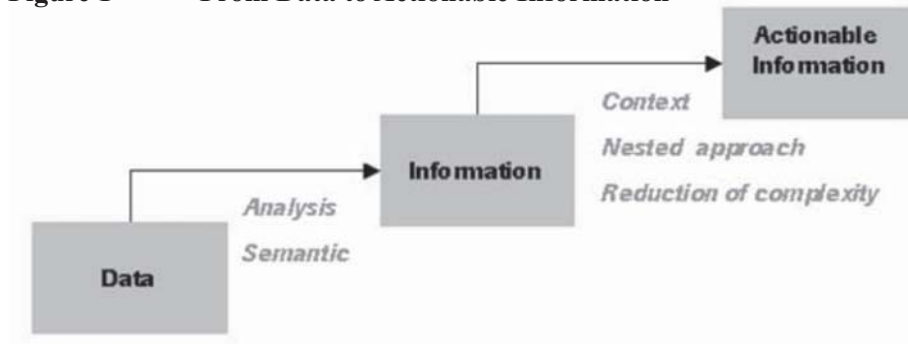
To understand better the general set-up for decision-making and the likely constraints a look on the definition and the content of Public Health is helpful. Public Health “addresses the systematic efforts to identify health needs and to organise comprehensive health services with a well defined population base. The definition thus includes the process of information required for characterising the conditions of the population and the mobilisation of resources necessary for responding to such conditions. In this regard, the essence of public health is the health of the public, therefore it includes the organisation of personnel and facilities for providing all the health services required for health promotion, disease prevention, diagnosis and treatment of illness, and physical, social and vocational rehabilitation”(4). This should be done based on “Use of theory, experience and evidence derived through the population sciences to improve the health of the population, in a way that best meets the implicit and explicit needs of the community (the public)”(5).

Decision-making areas are the description and prognosis of health related issues of a population, the options for change (improvement) and the adequate response in terms of programs and policies. Information is the common denominator of all those different steps. Economics comes in at the “collection” process of information as well as at the description of rational options for recommended policies.

Actionable Information in Public Health

Data are not information. Data are the result of any measurement and represent isolated facts - or more generally spoken - are characteristics of a sector of reality that was under assessment. For further use data have to be interpreted. Consequently, information is data that are linked and have an assigned meaning. Taking into account the context of data collection and reducing complexity, converts and upgrades information into actionable information (see figure 1).

Figure 1 From Data to Actionable Information



Source: Helmut Wenzel, presentation given at the Expert Summer Retreat - National Public Health Strategies in South Eastern Europe and the EU Health Policy, Belgrade, Serbia, 2004 (6)

There exists no clear definition of actionable information at present. A first approach of a definition could be as follows:

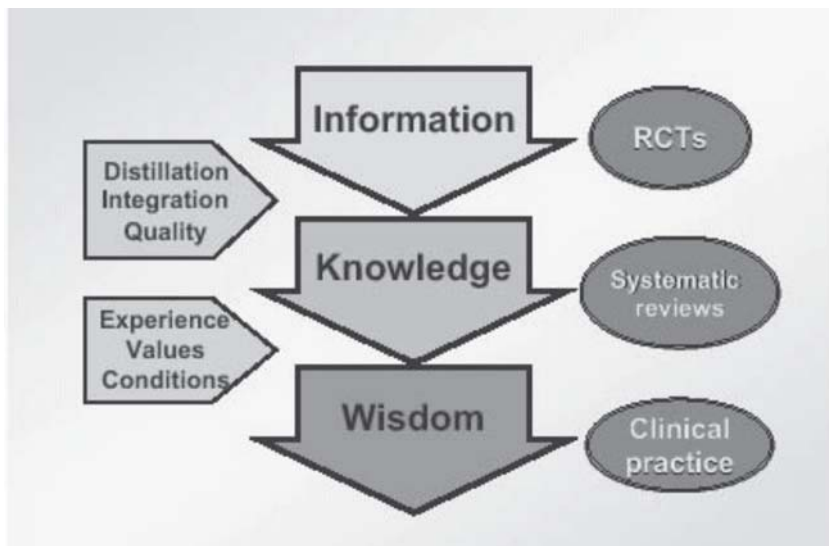
Actionable Health Information supports decision-making (in health care) comprising the continuum from information, knowledge up to wisdom⁴. Closest attention is paid to the empowerment of decision-makers to understand the field (environment) of their decisions but also showing options to act. It is built on high quality requirements related to validity of information (in the sense of evidence based medicine), is easy

⁴It is raining (*collecting data*), the temperature dropped 15 degrees and then it started raining (*analyzing*), if the humidity is very high and the temperature drops substantially the atmosphere is often unlikely to be able to hold the moisture so it rains (*interpreting*), it rains because it rains and this encompasses an understanding of all the interactions that happen between raining, evaporation, air currents, temperature gradients, changes, raining (*understanding*) (7).

to understand, easy to use, reduces complexity, avoids redundancy (nevertheless pays attention to all important facts and issues), is relevant to the present situation and efficient (no unnecessary overload of information).

Actionable information has to be available on time. There is a trade-off between uncertainty, timing and need of information. When information is needed most it is very often highly uncertain. Of course, highest degree of certainty is achieved after things have happened. But then, no decision has to be made anymore. Zero uncertainty has

Figure 2 Data Sources, Processes and Outcomes



Source: Bandolier Extra, Evidence-based health care (8)

no value in this context. From an economic point of view we have to balance out the information cost against the cost of a wrong or delayed decision. Figure 2 shows how data sources, processes and outcomes in terms of actionable information in an evidence based medicine world are linked. Comparable processes have to be set up in Public Health as well.

Evidence in Public Health

Evidence and evidence based decision-making in medicine is discussed widely. The two most commonly cited definitions of Evidence-based Medicine are:

“A new paradigm for medical practice is emerging. Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience and pathophysiologic rationale as sufficient grounds for clinical decision-making and stresses the examination of evidence from clinical research. Evidence-based medicine requires new skills of the physician, including efficient literature searching and the application of formal rules of evidence evaluating the clinical literature”(9).

“Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research”(10).

It is clear from those two definitions that EBM is a tool that was developed to help medical practitioners insure that their patients receive the best possible care. But what about administrators, program managers and policy makers? Are there any evidence-based tools that they can use to make sure that the decisions they make are also in the patients’ best interest? *Doig* therefore defines evidence-based decision-making as:

“The consideration of the evidence when making health care decisions at the level of the process, structure, program or system”(11).

This definition surely is more appropriate from a Public Health perspective as it pays attention to the fact that decisions can be made with focus on structure, processes and/or outcomes. Nevertheless the economic part is not reflected. Taking into account that resources are a prerequisite for creating actionable information a new definition from the viewpoint of Public Health possibly could read as follows:

Evidence-based decision-making is the conscientious, explicit and judicious use of current best evidence about the outcomes

of care⁵ of populations and sub-groups. Health care decisions are made at the level of the process, structure, program or system. The practice of evidence-based public health means integrating medical expertise on a population basis with the best available evidence on resources needed and their efficient use.

Figure 3 gives an overview on the content of this new paradigm. Discussions on evidence, criteria and ways to determine evidence mostly concentrate on medical evidence solely, especially in the context of clinical studies - RCTs (12). This leads to an over-estimation of clinical utility or efficacy data. RCTs as only basis for decision-making are inappropriate - even in pure medical decision-making. There is no clear definition of evidence up to now and consequently a variety of tables exist that try to rank study designs and the outcomes according to the expected internal validity. Some authors therefore point out that those tables “are arbitrary and based on common sense at best” (13). Evidence is any useful information that serves as a basis for decision-making, and evidence is scientific evidence, which means it is experimental. Nevertheless, there is no precedence of prospective studies. Observational and experimental methods can often be complementary. Evidence is research-based and therefore the quality of the underlying research must be appraised. This includes the appraisal of breaking down the study question to an appropriate study design and the possibility of generalising the outcomes.

Level of Utility

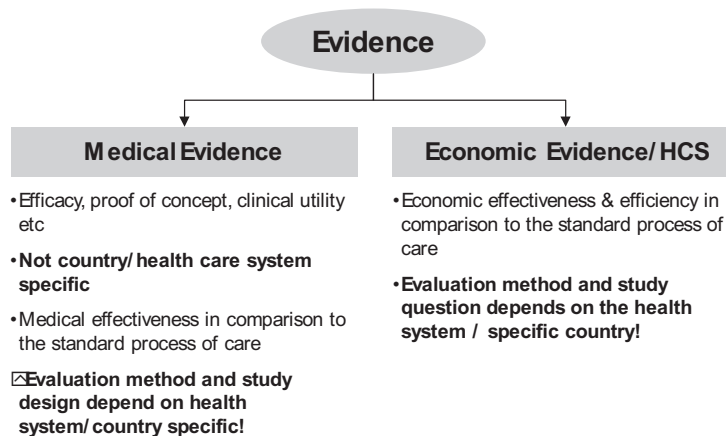
From the viewpoint of Public Health it is effectiveness data that is needed. Effectiveness data only reflect the actual situation in a given population and a given health policy⁶. Evidence in Public Health mostly has to look for high external validity, RCTs provide high internal validity, only. Economics evidence in this connection has to build on population view and effectiveness considerations as well. Data sources are empirical studies, analysis of secondary statistics data and models (disease models, policy scenarios).

⁵ Includes all kinds of prevention, cure and rehabilitation options

⁶ To do nothing is also seen as a policy, here.

Figure 3 The Components of Evidence in Public Health Decision-Making

Evidence Can Be Defined In A Medical And Economic Sense
Definition of Medical And Economic Evidence



Source: Helmut Wenzel, presentation given at the Expert Summer Retreat - National Public Health Strategies in South Eastern Europe and the EU Health Policy, Belgrade, Serbia, 2004 (6)

Economic considerations mostly will have to deal with the description of disease consequences (burden of disease) with and without an intervention. The classical portfolio of methods covers cost-of-illness, cost-benefit, cost-effectiveness and cost-utility analyses. The data can be based on empirical studies (evaluations) as well as on models. In most cases modelling will be the method of choice: e.g. spread of a disease, like HIV, SARS, and TB. Policy recommendations need scenarios (what-if considerations). Taking into account time perspective and ethical issues, mostly no “real life” economic studies can be carried out to show the likely improvements due to policy changes. Quality criteria or criteria to evaluate evidence have to incorporate evidence from a health perspective as well as criteria from the point of view of resources needed.

What are likely Criteria of Evidence?

When we look at different evidence tables like the “Oxford Centre for Evidence-based Medicine Levels of Evidence (Version of April 2001)” (14) or the “Bandolier table” (12) it is all about validity of data. Close attention is given to the fact that “unbiased” data is collected and priority is given to randomized, blinded clinical trials. The Oxford table reflects economics also, but not very extensively. Studies with high

Figure 4 Evidence Criteria from a Public Health Perspective

Evaluation of Evidence *Public Health Perspective*



- | | |
|---|---|
| <ul style="list-style-type: none">• Formal: Stringent causation<ul style="list-style-type: none">– <i>Level of statistical evidence</i>• Content: Appropriate Outcomes<ul style="list-style-type: none">– Linked to final outcomes (<i>Level of utility</i>)• Quality of conducting study• Generalisability<ul style="list-style-type: none">– <i>External validity of medical and economic evidence</i>– <i>Uncertainty of all relevant variables covered</i>– <i>Appropriate reflection of the structure of the health care system</i>• Relevant for decision-making | <ul style="list-style-type: none">• The Three Necessary Conditions for Causation• Researchers must establish three conditions if they are to conclude that changes in variable A cause changes in variable B.• Condition 1: Variable A and variable B must be related ('Relationship Condition').• Condition 2: Proper time order must be established ('Temporal Antecedence Condition').• Condition 3: The relationship between variable A and variable B must <u>not</u> be due to some confounding extraneous or 'third' variable ('Lack of alternative explanation condition'). |
|---|---|

Source: Helmut Wenzel, presentation given at the Expert Summer Retreat - National Public Health Strategies in South Eastern Europe and the EU Health Policy, Belgrade, Serbia, 2004 (6)

internal validity show the proof of principle. For that reason the study population, the medical professionals and the treatment environment are somewhat artificial when we compare it to routine care or Public Health environment. What we need is high external validity, i.e. a study situation that reflects appropriately the situation of a population in a given health care system, this is true for economic evidence, too. From an analytical viewpoint the main components of an evidence ranking should take into account: (1) the degree of stringent causation (internal validity), (2) the appropriateness of outcomes measures (utility or medical aspects), (3) the generalisability (external validity) and (4) the quality of the study design and its realisation. Depending on the decision-making situation not all components are equally important. In effect there is a trade-off between the various components. Figure 4 gives an overview on the suggested features.

Quality Assurance: Evidence Criteria for Critical Evidence Appraisal of Economic Outcomes Studies

Every decision-maker can check the quality of outcomes studies by following the checklist of *M. Drummond*. His “ten commandments” of good appraisal practice suggest judging the following items (15):

- **Was a well-defined question posed in answerable form?** Did the study examine both costs and effects of the service(s) or programme(s)? Did the study involve a comparison of alternatives? Was a viewpoint for the analysis stated and was the study placed in any particular decision-making context?
- **Was a comprehensive description of the competing alternatives given? (i.e., can you tell who? did what? to whom? where? and how often?)** Were any important alternatives omitted? Was (Should) a *do-nothing* alternative (be) considered?
- **Was there evidence that the programmes' effectiveness had been established?** Has this been done through a randomized, controlled clinical trial? If not, how strong was the evidence of effectiveness?
- **Were all the important and relevant costs and consequences for each alternative identified?** Was the range wide enough for the research question at hand? Did it cover all relevant viewpoints? (Possible viewpoints include the community or social viewpoint, and those of patients and third party payers. Other

viewpoints may also be relevant depending upon the particular analysis). Were capital costs, as well as operating costs, included?

- **Were costs and consequences measured accurately in appropriate physical units? (e.g. hours of nursing time, number of physician visits, lost workdays, gained life-years)** Were any of the identified items omitted from measurement? If so, does this mean that they carried no weight in the subsequent analysis? Were there any special circumstances (e.g., joint use of resources) that made measurement difficult? Were these circumstances handled appropriately?
- **Were costs and consequences valued credibly?** Were the sources of all values clearly identified? (Possible sources include market values, patient or client preferences and views, policy-makers' views and health professionals' judgements). Were market values employed for changes involving resources gained or depleted? Where market values were absent (e.g., volunteer labour), or market values did not reflect actual values (such as clinic space donated at a reduced rate), were adjustments made to approximate market values? Was the valuation of consequences appropriate for the question posed? (i.e., has the appropriate type or types of analysis - CEA, CBA, CUA - been selected?)
- **Were costs and consequences adjusted for differential timing?** Were costs and consequences which occur in the future 'discounted' to their present values? Was any justification given for the discount rate used?
- **Was an incremental analysis of costs and consequences of alternatives performed?** Were the additional (incremental) costs generated by one alternative over another compared to the additional effects, benefits or utilities generated?
- **Was a sensitivity analysis performed?** Was justification provided for the ranges of values (for key study parameters) in the sensitivity analysis employed? Were study results sensitive to changes in the values (within the assumed range)?
- **Did the presentation and discussion of study results include all issues of concern to users?** Were the conclusions of the analysis based on some overall index or ratio of costs to consequences (e.g., cost-effectiveness ratio)? If so, was the index interpreted intelligently or in a mechanic fashion? Were the results compared with those of others who have investigated the same question? Did the study discuss the generalizability of the results to other settings

and patient/client groups? Did the study allude to, or take account of, other important factors in the choice or decision under consideration (e.g., distribution of costs and consequences, or relevant ethical issues)? Did the study discuss issues of implementation, such as the feasibility of adopting the “preferred” programme given existing financial or other constraints, and whether any freed resources could be redeployed to other worthwhile programmes?

Quality Assurance: Evidence Criteria for Critical Appraisal of Models

As mentioned above, models are very important means for analysis and prognosis of the health status of a population at risk. To understand the level of evidence delivered by such models is of utmost importance, but there is also a sense of insecurity how to assess the quality⁷. For evaluating the quality of such models a short guidance is given here.

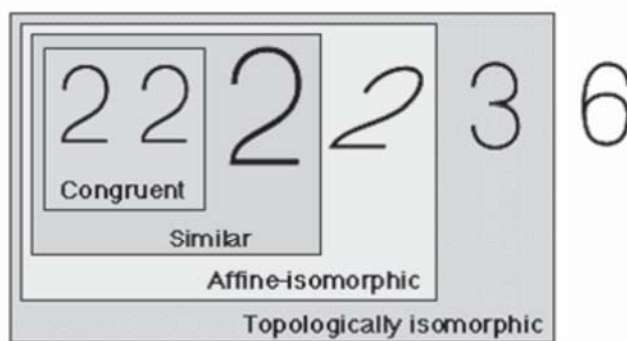
What is meant by model? A model is a picture of the real world which is described with the help of different tools. E.g. data bases are models of the real world, a road map is a model of a country or region. The properties and the “language” used are the tools to describe the relevant part of the real world. A delimited part of the real world which is marked off in such a way that it only describes those parts of the real world that are necessary for the analytical process is called system, then. The model is only valid for the underlying system. Model and system have to be related. The relationship between system and model can be described by the degree of Isomorphism.

The *International Society of Pharmaeconomic Outcomes Research (ISPOR)* uses a narrower definition of a model: “We define a health-care evaluation model as an analytic methodology that accounts for events over time and across populations, that is based on data drawn from primary and/or secondary sources, and whose purpose is to estimate the effects of an intervention on valued health consequences and costs...” (16).

⁷ Providing an all-embracing definition of what constitutes a high-quality model is not possible, but some guidelines are available (20).

Correct models should be realistic and therefore show up a high degree of *isomorphism* (see figure 5).⁸ Which degree would be appropriate, then? Is it congruence, affine-isomorphism or topological isomorphism? This question has to be answered individually at every model appraisal. There is no general rule except the one: the model has to be as complex as necessary and as simple as possible.

Figure 5 Degrees of Isomorphism



Source:
<http://m.iwa.hokkyodai.ac.jp/mathedu/subjects/geometry/isomorph/hierarchy/index.html> (17)

A Conceptual Framework of Validity (18)

All relevant elements and processes should be covered. A very first orientation was given by *Kulla* (19). He suggested the following components of a framework: validity of the structure, validity of the process, empirical validity and pragmatical validity.

⁸ The term isomorphism literally means equality or sameness (iso) of form (morphism). In mathematics an isomorphism between two systems requires a one-to-one correspondence between their elements (that is, each element of one system corresponds to one and only one element of the other system, and conversely), which also preserves structures. Referring to isomorphism as one of the most important and general mathematical concepts, R. Duncan Luce and Patrick Suppes (19) characterize it as “a one-to-one mapping of a system A onto a system B in which the operations and relations of A are preserved under the mapping and have the same structure as the operations and relations of system B.”

To check the *validity of the structure* the formal correctness has to be analyzed. For example is the role of risk factors incorporated sufficiently? Is compliance paid attention to? Is the reduction of risk modified by the fraction of benefit which shows that e.g. the physical change of cholesterol levels is converted into risk reduction with a time lag only. *Validity of the processes* is given when conformity with existing real processes can be shown. This means e.g. patient cases, sequences of clinical interventions and the quantities of resources used are typical for the section of reality to be modelled. Valid processes do not necessarily prove the validity of the model. Different structures and processes can lead to the same result. Therefore it is important to understand the limits of the model, i.e. the boundaries where validity was proven. To give an example, within the boundaries of a model two different formulas will yield the same result for a given variable: Given $u = 1$ then $y = 10$, both with $y = 9u+1$ and $y = 10u^2$. However, for $u > 1$ the results will be very different. For $u = 1$ both modelling algorithms would be acceptable. The conclusion is: (1) without theoretical justification it is hard to decide on the appropriate algorithm. (2) extrapolations outside the system boundaries of the model are not appropriate. *Empirical validity* is the strongest criterion. It describes the similarity of model outcomes with known empirical data. *Pragmatic validity* gives evidence for usefulness in the decision process.

Outline of a Validation Framework:

- A valid model has to be *isomorph* thus representing a *true picture of the structure* of the system to be modelled. The degree of isomorphism⁹ depends on the target of the model, its application and the complexity required. The degree of complexity primarily should be determined by the application and not by the availability of data.
- The degree of isomorphism can be described by means of the underlying structure and processes. This procedure is equivalent to the revision of "*validity of structure and processes*" as recommended by *Kulla (19)* or "*expert concurrence*" according to *Eddy (22)* and "*construct validity*,

⁹ Hierarchy in ascending order: Topologic isomorph, affin isomorph, similar, congruent

face validity and content validity“ used in psychometric scaling validation.

- This part of the validation is extremely extensive and not necessarily designed for quantification. Here expert opinion plays an important role. The appraisal comprises the selection and processing of data, the mathematical concept that is used (e.g. Markov approaches, deterministic or stochastic methods), the epidemiological and/or economic concepts, the validity of programming languages and programming techniques and software routines. In some cases procedures and methods of modelling that have been proven to be valid can be used for further examination of the validity of the model under evaluation.
- The strongest criterion is *outcomes validity*. This corresponds with *Kulla's "empirical validity"*, with *"prediction validity"* in the opinion of *Eddy* and possibly with *"predictive validity"* in psychometry. Here the similarity of outcomes which are produced by the model is compared with known outcomes. While doing so we have to make sure that possibly no data are used for the similarity checks that were incorporated when setting up the model. Moreover - like in a clinical trial - a study design has to be submitted, describing the selection of the population and the definition of similarity. What differences of the outcomes has to be seen as similar. This decision should not be made on statistical ground, only. It should also depend on intended use of the model and the quality and precision of the input data. In the case of very imprecise input data a small difference as a criterion of similarity makes no sense.
- *"Application validity"* is important as well. Application validity is the ability of the model to meet the needs in the decision-making process. This means to answer the questions: is information produced correctly, on time and in an applicable format?
- **Reliability.** Given the fact that the research setting is the same are results of the model consistent? (comparable to reproducibility and repeatability in diagnostic industry).
- **Objectivity.** Are there any differences in outcomes due to different users of the model? Are there differences in results

and the performance of the model? Are they depending on a specific computer or specific configuration¹⁰.

- **Acceptance by Scientific Community:** Is the model accepted by the scientific community? Was a formal peer-review carried out?

Figure 6 Medical and Economic Benefits

Perceived medical and economic benefits vary between different stakeholders
Overview on benefits for healthcare stakeholders



	Medical benefit	Economic benefit
Government	<ul style="list-style-type: none"> • better health status of inhabitants • Increase of life expectancy 	<ul style="list-style-type: none"> • Overall cost savings within healthcare sector • high productivity of inhabitants
Health insurance	<ul style="list-style-type: none"> • Improvement of current diagnosis in terms of accuracy, efficacy & effectiveness 	<ul style="list-style-type: none"> • Overall cost savings for diagnosis • Less hospital and specialist referrals • cost savings for therapy if used for disease prevention
Hospitals	<ul style="list-style-type: none"> • Improvement of current diagnosis in terms of accuracy & efficacy • Optimization of treatment guidance • Reassured hospital discharge 	<ul style="list-style-type: none"> • Process improvement • Shorter hospitalizations • Cost savings (e.g. material, personnel)

Source: Helmut Wenzel, presentation given at the Expert Summer Retreat - National Public Health Strategies in South Eastern Europe and the EU Health Policy, Belgrade, Serbia, 2004 (6)

Evidence and Priority Setting

Economic evidence has to be communicated on different levels to different stakeholders. Their viewpoints and evaluation criteria are different (see figure 6) and have to be taken into account appropriately. On a macro level e.g. it would have to be shown that improved health is an important prerequisite for a growing economy and can contribute to the prosperity of a nation. On a micro level we rather would show how specific programs or policy recommendations will improve public health and at what cost.

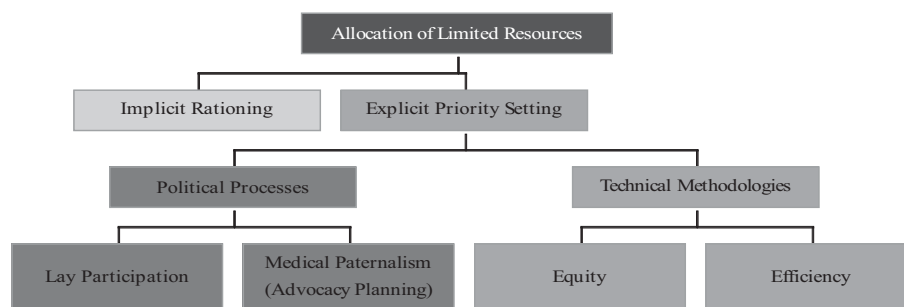
¹⁰ The authors recently found three different results produced by a (commercial) standard software due to using three different computers. All computers were run under windows NT.

The Role of Economics and Economic Evidence in Public Health Decision-making

Decision-making always comes to the same thing: bargaining for resources or budgets and allocation of scarce resources. Priority setting is perceived as an appropriate way to allocate resources. Decision-making will have to be based on perceived needs, options and constraints. If we understand each of those parts as circles which overlap to a certain degree, the sphere of action would be defined by the intersection of the overlapping circles. The portfolio of available actions and the decision that can be made lies within the intersection of the circles, then.

Bandolier correctly states “.. no health care system can satisfy all the possible demands made upon it, so decisions about allocating resources are very important. Resources should be allocated to those things that are effective, and withdrawn from those that are ineffective. The only way of judging effectiveness is through *evidence*” (23). This clearly asks for support from economic disciplines. *Samuelson* once defined economics as “the study of how men and society end up choosing, with or without the use of money, to employ scarce productive resources that could have alternative uses, to produce various commodities and distribute them for consumption, now or in the future, among various people and groups in society. It analyses the costs and benefits of improving patterns of resource allocation” (24).

Figure 7 Alternative Ways of allocating limited Resources



Source: Coast J. et al., in: *Priority Setting: The Health Care Debate* (25)

Rationing is an ethical issue and ought to be based on the principal agreement of a population. In an *implicit* rationing procedure the decisions and the preferences are not revealed. From the viewpoint of modern societies this is not acceptable. *Explicit* rationing is an outcome of political processes where the consent of society could be received by either lay participation in the decision processes or by the anticipation of the citizen needs by experts. In the late sixties this kind of integrating as many citizen and their needs as possible in any planning process was called advocacy planning. The basic idea was that experts (and politicians) should be able to anticipate the problems of those people that have not the ability to take part in political processes in an adequate way (advocacy planning). This approach was not very promising.

From the point of view of health economics it is a second best solution only, because it does not address the problem of wasting resources (inefficient use). Even when we would assume that the political process would be “fair”, there is enough evidence from research in political decision-making showing that lay participation and advocacy planning do not solve the problem of “inefficient” use of resources, and that no transparency of the decision processes is provided. If we look for more objective ways of comparing the alternative use of scarce resources and in reaching the humanitarian goal of equity we need technical solutions, we need evaluation tools (26).

If we agree upon the limited value of rationing, the more appropriate approach is explicit priority setting, which should be based both on efficiency and equity¹¹ considerations. Priority setting based on economic and equity principles should be the target.

¹¹ “Equity is a difficult concept to analyse but it helps if we differentiate between horizontal and vertical equity. Horizontal equity is concerned with the equal treatment of equal need. This means that to be equitable, the health care allocation system must treat two individuals with the same complaint in an identical way. Vertical equity, on the other hand, is concerned with the extent to which individuals who are unequal should be treated differently. In health care it can be reflected by the aim of unequal treatment for unequal need i.e. more treatment for those with serious conditions than for those with trivial complaints, or by basing the financing of health care on ability to pay e.g. progressive income tax” (27).

From the viewpoint of economics there are two key economic principles that should be the basis for priority setting. “The first is that of *opportunity cost*, which carries with it the understanding that in investing resources in one way, some opportunity for benefit, through investing those resources elsewhere, has been lost. One of the keys in setting priorities, then, is to measure or weigh out the costs and benefits of doing one thing vis-à-vis another. The other principle is that of *the margin*, which is about shifting or changing the resource mix. If the budget increases, one could reasonably ask how best the additional resources should be spent. Conversely, if the budget decreases, one would likely want to take resources from areas, which are producing the least benefit. Lastly, if the budget was neither increasing nor decreasing, at least not continuously, the question remains as to whether resources should be re-allocated (with some areas cut back so that others can expand) so as to improve benefit to the population being served. The concept of the margin is crucial to the development of an economic approach to priority setting.

Without explicit adherence to these two economic principles, resources will unlikely be allocated in the best manner possible. For this reason decision makers are not well served when setting priorities on the basis of historical and political allocation processes, and it is on these economic grounds that other approaches, such as needs assessment and defining core services, have been criticised.

A major question, then, becomes whether there is a process for priority setting which responds practically to the dilemma of resource scarcity. Such a process should be conducted in a manner which is as *evidence based* as possible, and at the same time must also encompass a range of challenges, such as incorporating the views of a wide set of stakeholders and operating within the often (and apparent) non-rational context of health organizations. Reviews of various tools for priority setting exist elsewhere in the literature” (28, 29).

One economic based approach to priority setting which obviously has gained attention and attractivity in practice over the last three decades is the so called *program budgeting and marginal analysis (PBMA)*, which has been reported to be used in health organizations mainly in Britain, Australia, New Zealand and Canada. The core of this approach is the principles of classical economic

evaluations (cost-benefit analysis, cost-effectiveness analysis, cost-utility analysis). And like in a cost-benefit analysis the practical problem is the value assignment to activities, the determination of opportunity cost - especially in areas where no market prices exist and the measurement of benefits.

In a perfect market, price would reflect the opportunistic value of a good. Similar difficulties in defining appropriate indicators to measure outcomes and benefits - issues that are discussed intensively in *PMBAs* today - has led to the promotion of cost-effectiveness and cost-utility analyses in the past. So, from a methodological viewpoint it is not really a new way of assessing and ranking options. What is new, compared to the classical economic evaluations, is the integration of budgeting and anticipatory evaluation (what-if scenarios). On the other hand, a forerunner of this analytic concept is the *Planning-Programming-Budgeting-System (PPBS)*, which has been used by American Government since the late sixties, and which integrated cost-benefit-analysis, too. The goal of *PPBS* is improvement of rationality, efficiency, and transparency of political decision-making. The key elements are: functional breakdown of budgets into programme categories and application of cost-benefit analysis to assure efficiency.

Table 1 Changes in resource use from the introduction of a diabetes clinic: cost (and activity)

	Programme budget (cost and activity)	Scenario A*	Scenario A1 (OP visits fall by 62%)	Scenario A2 (35% attendance rate)	Scenario A3 (75% attendance rate)	Scenario A4 (½ of GP visits replaced by clinic visits)
GP consultations	2192 (259)	8816 (955)	8816 (955)	4510 (503)	7160 (781)	7720 (826)
Practice nurse visits	164 (73)	2715 (696)	2715 (696)	950 (244)	2036 (522)	2715 (696)
Hospital admissions	3662 (4)	2715 (3)	2715 (3)	2715 (3)	2715 (3)	2715 (3)
Out-patient visits (diabetes)	55 742 (66)	33 445 (39)	21 182 (25)	47 938 (57)	29 822 (35)	33 445 (39)
Out-patient visits (ophthalmology)	10 583 (66)	10 583 (66)	10 583 (66)	10 583 (66)	10 583 (66)	10 583 (66)
Out-patient visits (dietician)	247 (8)	247 (8)	247 (8)	247 (8)	247 (8)	247 (8)
Prescribing	33 780	33 780	33 780	33 780	33 780	33 780
HBAC1	2111 (352)	4176 (696)	4176 (696)	1462 (244)	3132 (522)	4176 (696)
Full blood count	0	694 (174)	694 (174)	243 (61)	521 (131)	694 (174)
Renal function	0	1044 (174)	1044 (174)	365 (61)	783 (131)	1044 (174)
Liver function	0	1044 (174)	1044 (174)	365 (61)	783 (131)	1044 (174)
Thyroid function	0	1218 (174)	1218 (174)	426 (61)	914 (131)	1218 (174)
Cholesterol	0	696 (174)	696 (174)	244 (61)	522 (131)	696 (174)
Urine	139 (35)	2784 (696)	2784 (696)	974 (61)	2088 (522)	2784 (696)
Total cost	108 620	103 958	91 694	104 803	95 803	102 862
Change in cost		-4662	-16 926	-3817	-13 535	-5758

* One initial, two regular and one annual visit spread throughout the surgeries, assuming a 40% reduction in out-patient visits, a 100% attendance rate and that GP visits generated by the clinic are additional to existing GP visits.

Source: Holm S. *Goodbye to the simple solutions: the second phase of priority setting in health care* (30) (The numbers in brackets are physical units (e.g. number of visits), the cost data are in £)

Typically, a *PBMA* process relies upon an advisory panel which is charged with identifying, for a given budget planning cycle, areas of service growth, and, in order to fund the proposed growth, areas for resource release. Resource releases can come in the form of operational efficiency gains (achieving the same outcomes at less cost) and service reductions or disinvestments (where a service which is effective, but in only a small way, may be 'cut back', at the margin, to release resources for a more effective service development).

Table 1 shows a typical presentation of the outcomes: The resources and activities that are needed or would be needed if one of the scenarios would be put into action. At the bottom of the table the line "change in cost" shows the results of the marginal analysis.

Evidence Appraisal of the PBMA Example

The authors admit different problems, for example when including all cost and valuing all activities properly (administration cost). How would evidence be judged, then? First of all, are we talking about a model? Or is it just "economic calculations" and the appropriate quality check should be done with the economic appraisal criteria only?

The authors claim to contribute to decision-making by means of a scenario analysis where the actual situation is described (modelled) and hypothetical situations are simulated. Actually, it seems to be a kind of a cost-benefit analysis. The analysis describes a system (or a segment of the real world) "diabetes care" with the help of input-output calculations. Therefore the calculation is a model of that picture of the real world and it has to satisfy criteria of good economics as well as criteria of good modelling.

If we look at the good economics criteria of *Drummond* (see above) we have to admit that:

- › not all relevant costs and consequences were included
- › the evidence for the underlying efficacy of the scenarios is not very sound
- › there was no adjustment for different timing, i.e. discounting
- › no sensitivity analysis was performed

Consequently - looking at the model validity now (see above) - we have to say that at least the *application validity* is not very pronounced.

General Critique on Feasibility

Priority setting provoked discussions on feasibility, appropriateness and ethics concerns, also. *Holm* summarizes the different approaches and the most often mentioned arguments:

“The first phase in discussions and reports on health-care priorities was characterised by a search for priority setting systems which, through a complete and non-contradictory set of rational decision rules, could tell the decision-maker precisely how a given service should be prioritised in relation to other services. QALYs, the Oregon approach, the Dutch system (based on a definition of necessary care), the Norwegian system of 1987 (based mainly on the severity of disease), and the Swedish system of 1995 are more or less successful embodiments of this ideal. In such a system a given decision is legitimate because it is made by following the rules of the system, and, since the rules are rational, the decision is also unassailably rational.

The second phase of Scandinavian reports on priorities have shown that systems of this kind run into several kinds of problems, which make it highly doubtful whether they can ever be a rationally compelling way of making allocation decisions.

Firstly, there are practical problems about the amount and quality of information needed to make the systems work and the impartiality of the decision-makers. Experience, especially in Norway, has shown that doctors interpret severity in different ways and that

they are willing to reinterpret their patient's disease state if it will improve the patient's priority.

Secondly, and more damagingly, there are fundamental conceptual problems with allegedly rational decision-making systems. For example, the purpose of a public healthcare system is unclear. It is not there simply to maximise the amount of health in society (however we choose to measure health). It is not there merely to treat diseases (however we choose to define disease). It is not there solely to meet healthcare needs (however we choose to define healthcare needs). And it is not there to ensure equality in health status (however we choose to conceptualise equality).

The goal of a public healthcare system is a complex composite of many goals, including fuzzy goals such as maintaining a sense of security in the population. There is no natural way to balance these goals against each other. We can state that one goal is more important than another in specific situations, but an attempt to raise one goal as the most important in all situations is implausible. This means that it becomes impossible to use a simple maximising algorithm as a basis for priority setting (such an algorithm requires either a single goal or a principled way of balancing a number of goals). This problem can be illustrated by looking at one of the often mentioned allocation criteria: the severity of a disease.

The severity of a disease is open to different interpretations. Whether a disease is lethal or likely to lead to permanent handicap or disability is an aspect of its severity, but severity also includes current state of health (for example, whether there is severe pain or current disability), urgency of treatment, and also the possibility of treating the disease. The severity of the disease thus turns out to be a multifaceted concept; consequently it is a problematical basis for a simple priority setting system”(31).

In the light of this critique of correctly measuring and valuing disease severity an interesting approach for selecting prevention priorities in the Republic of Serbia has to be mentioned (32). Priorities were defined by combining severity measures with the estimated likelihood of preventability. The analysis covered four stages of the priority setting process. In the first stage - in order to define national

health problems - a retrospective trend analysis of a standard set of indicators was done. The indicators covered mortality, morbidity, utilization of health services, absenteeism and disease classification - ICD10th revision. The time series used, covered a time period of eleven years. In the second stage, four different statistical models of selecting priorities were examined and a compilation of models was done. Finally the factorial analysis was chosen as the best alternative. After the ranking of health problems, which was based on the (theoretical) potential for prevention, in the third stage suggestions for decision-makers were made. One important finding was the observation that different indicators lead to different priorities: standardized mortality rates and standardized rates of YPLL indicated injuries and poisonings as priorities in the group of first five. Looking at the morbidity structure with non-hospital services the group of diseases of genitourinary system and diseases of musculoskeletal system are among the five most important diseases. When looking at the hospital morbidity structure and hospitalization rates, complications of pregnancy, delivery and puerperium seemed second important health problems after the circulatory diseases.

Šantrić Milićević concludes that the outcomes of the processes have to be interpreted cautiously due to its dependence on the selection of health indicators and incomplete health indicator data. Nevertheless, the progress has to be seen in the fact that a ranking of priorities based on a measure of importance of a health problem and the likelihood of a successful intervention was analyzed. This is a first step in the direction of looking at efficiency as well.

All the methods used so far to set up priorities did not take into account equity aspects and a possible trade-off between equity and efficiency. How would a population see it? How much efficiency would we be willing to give up for a gain in equity and vice versa? What are the preferences in a population with regard to efficiency and equity? *Mason et al* once stated "Cost-effectiveness estimates could not be used in a mechanistic way: at best they provide a useful aid for decision-making. Other factors, for example equity, legitimately influence decisions" (33).

What importance should be given to the allocation of health resources and health gains between different groups of a population?

Plans-Rubió (34) tried to integrate both aspects by using a combined approach of effectiveness ranking of interventions (relative efficiency) while reducing inequality (aversion of inequality) in Catalonia. He recommends to allocate resources according to the social welfare function^{12,13}. The social welfare function was determined empirically, using a questionnaire. This approach can be interpreted as an attempt to apply the principle of rationality by maximising a social welfare function and taking into account existing constraints.

However, the social welfare function is not constant over time and is depending on the survey population and the “basket” of products offered. A binding set of preferences would have to be defined by a representative sample of a population and - as *Arrows* showed - paradoxical outcomes of such a process could occur. It is an interesting attempt but more practical research is needed.

Conclusion

Evidence in public health decision-making has two dimensions: medical and economic evidence. For each dimension a set of different appraisal criteria are available. Choices always have to be based on a comparison of relative and marginal cost-effectiveness. Evidence of economics is a prerequisite of appropriate proof of economics of evidence. It cannot be discussed separately.

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¹² “In nonutilitarian societies, where individuals have aversion to inequality in the distribution health gains between patient groups, social welfare depends on both efficiency and equity in the distribution”, *ibid* p21

¹³ The social welfare function is an aggregation of individual welfare functions. A prerequisite is the possibility to compare different individual welfare functions and the feasibility to aggregate those functions. Many authors deny the feasibility.

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Providing evidence for high level decision-making <i>Health Evidence Network of the World Health Organization Regional Office for Europe</i>
Module: 1.3	ECTS (suggested): 1,5
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Keywords	Evidence-Based Medicine; Health Policy; Decision Making, Organizational; Public Health; Research;
Learning objectives	After completing this module students and public health professionals should: <ul style="list-style-type: none"> • be aware of definition of evidence for public health; • recognise the importance of research and other factors for policy-making process; • increase knowledge on methodology for providing and using evidence-based advice; and • understand advantages of various sources of evidence for public health, such as Health Evidence Network of WHO Regional Office for Europe.

Abstract	<p>The question of how to create better policies using the best evidence points towards using the best available evidence, not the best imaginable evidence. But studies alone do not produce evidence. Evidence goes beyond scientific research, including professional judgment and common sense. In the complex process of policy-making, other factors are also important besides evidence, or to circumvent the lack of scientific evidence. The need to broaden the evidence-base for policy-making in public health brings forward other sources of information and knowledge, such as case studies and descriptive information. Further attention should be paid to the specific context from which the evidence comes.</p> <p>Several initiatives provide systematic evidence, really useful for decision-making. The Health Evidence Network of the WHO Regional Office for Europe is one of these initiatives. The web-based network has two services.</p> <ol style="list-style-type: none">1. HEN provides a single point for easy access to sources of information, relevant databases containing evidence related to possible health policy decisions, and2. HEN provides answers to questions to support the decision-making process. <p>The information is in English, with summaries in French, German and Russian and access is free of charge. http://www.euro.who.int/HEN</p>
Teaching methods	Lectures, individual work, group work
Specific recommendations for teachers	<p>This module should be organised within 1,5 ECTS, out of which one third will be under the supervision of teacher, and the rest is individual students work. After an introductory lecture the student should become familiar with various sources of evidence for public health, especially with the Health Evidence Network of WHO Regional Office for Europe. By looking for answers to different questions to support the decision-making process, the student can become aware of the usefulness of HEN for her/his field of profession (individual work). Results can be presented and discussed in groups.</p>

Assessment of students	Students will receive a particular policy question and will be asked to find an appropriate answer on HEN site and on the basis of the reports published on HEN to provide specific recommendations.
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PROVIDING EVIDENCE FOR HIGH LEVEL DECISION MAKING HEALTH EVIDENCE NETWORK OF THE WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE

Anca Dumitrescu

Introduction

Policy-making in public health and health care nowadays asks increasingly for health evidence for decision-making. Equally, the advances in science and technology produce more complex information, moving from simple records to information dealing with real context at local or subnational level; moving from vital statistics to evidence on the effectiveness of interventions and policies.

The shift towards an evidence-based approach to public policies has gathered momentum over the past decade. Since 1992, when Sackett and others first formulated the term “evidence-based medicine”, increased attention has been paid to the use of evidence in public health and health care (1).

Researchers and policy-makers alike are looking for strategies to ensure that knowledge gained from the best evidence is actually used in practice. Enhancing the utility of research includes both making research evidence more usable and improving the capacity of decision-makers to use it. Communication between those who produce and those who use research is decisive in integrating research, research utilization, and routine practice for better policy-making (2).

Several initiatives, projects and programmes aim to offer decision-makers in public health and health care the best available evidence for their work. One of these initiatives is the Health Evidence Network of the World Health Organization (WHO) Regional Office for Europe.

Decision-making process and the use of evidence

The recent increase in interest in "evidence-based policy-making" is a response to a perception that governments need to improve the quality of their decision-making in a world of rapid change and scarce resources. However, the mere statement that a particular policy is based on evidence is not enough. In the world of information overload and with the help of 20 000 medical journals, 30 000 new studies every month, thousands of databases and 10 000 related web sites, policy-makers can find arguments for virtually any decision. There is a need, therefore, to filter that enormous amount of information and to distil the best available information that is really useful for decision-making.

When it comes to policy-making, the "evidence" coming from research is not always of the quality one would like; sometimes research may not even be readily available. Many research studies are flawed by unclear objectives, poor research designs, methodological weaknesses, inadequate statistical reporting and analysis, the selective use of data, and conclusions that are not supported by the data provided. These shortcomings are made transparent and analysed in systematic reviews. These are a form of secondary research, with a structured approach to searching of appropriate studies and their critical appraisal, followed by a balanced understanding of what the research evidence is saying and of its strengths and weaknesses (3).

Nevertheless, policy-makers have to take decisions every day in real-life situations and cannot operate with research conclusions stating that "more research is needed". At the same time, the trust of policy-makers in research has been eroded. There are many examples of incidents in recent years. BSE/mad cow disease in the United Kingdom, a tainted blood scandal in Japan, contaminated hepatitis B vaccines in France and the withholding of information on SARS in China are just a few such examples. Highly publicized cases of scientific fraud, misconduct and malpractice have only added to the public's suspicion (4).

As a consequence, other types of information are used in the decision-making process, and other factors influence the decisions,

such as the experience, expertise and judgement of decision-makers, ideology and political beliefs, costs and resources. Decision-makers also deal with pressure from interest groups, opinion leaders, not to mention crises and hot issues. Using all these elements is legitimate, as policy-making can be informed by research, but it must also take into account the specific context. Examples of factors other than evidence influencing the policy making process are shown in Box 1. The challenge is how to balance all these important factors: how to make sure that the available evidence from sound research is known and taken into account; and how to avoid confining decision-making only to evidence that comes in formally organized and structured forms, namely research. Further more evidence does not automatically generate better policies, and this statement is clearly true for public health (5).

Box 1 Factors other than evidence that influence the policy-making process

Experience, expertise and judgement
These factors constitute valuable human and intellectual capital and include tacit knowledge, identified as an important element of policy-making; they may be of critical significance when the evidence from research is equivocal, imperfect, or non-existent.

Resources
Policy-making and implementation take place in the context of finite (and sometimes declining) resources. This requires sound evidence not only of the cost of policies, programmes or projects, but also the cost-effectiveness, cost-benefit, and cost-utility of different courses of action.

Values
Policy-making also takes place in the context of values, including ideology and political beliefs. Political ideology is a major driving force of policy-making and is in no way made redundant by a commitment to evidence-based policy.

Lobbyists, pressure groups and consultants
These factors compete with evidence to influence policy-making and implementation. Think-tanks, opinion leaders and the media are other major influences. The way in which these groups work to influence policy can be under-estimated and misunderstood by proponents of evidence-based policy and practice. The evidence that these groups use is often less systematic, and

more selective, than that used by supporters of evidence-based policy and practice.

Pragmatics and contingencies

Other factors that influence policy-making and policy implementation are the sheer pragmatics of political life such as parliamentary terms and timetables, the procedures of the policy-making process, the capacities of institutions, and unanticipated emergencies and crises. Evidence-based policy and practice should be the first line of response to unanticipated events in the sense of identifying what is already known about the problem and what is not.

Source: Modified from Davies P., 2004 (6)

Definition of evidence and methodology for evidence-based advice

One of the main missions of the WHO Regional Office for Europe is to offer evidence-based advice to its Member States to help them make the best decisions on their health policies. WHO actively promotes evidence-based policy-making to make public health and health care safe and effective, equitable, accessible and of good quality. An important question is what is meant by the term evidence. As shown in the previous section, results of scientific studies and many other forms of information and knowledge, as well as other factors, play a role in decision-making. Different types of evidence are shown in Box 2. Owing to the specific needs of the public health domain, the Regional Office has developed a broader and more operational definition of the concept of evidence. It reads: “Findings from research and other knowledge that may serve as a useful basis for decision-making in public health and health care”.

Box 2 Different types of evidence

Systematic reviews

Systematic reviews provide generalizations, and summarize existing research evidence. They are a form of secondary research that overcome the shortcomings of single studies, which are sample-specific, time-specific, and context-specific, and sometimes of less than optimal quality. Systematic reviews use explicit and transparent quality criteria, and rigorous standards for searching and critical appraisal.

Meta-analyses

Meta-analyses are based on the statistical practice of combining the results of a number of studies, for resolving apparent contradictions in research

findings. Meta-analyses are based on systematic reviews and are usually used for assessing the clinical effectiveness of health care interventions.

Single studies

Single studies are more commonly used than systematic reviews to support government policy and practice. If undertaken to the highest possible standards, single studies can provide valuable and focused evidence for particular policies, programmes and projects in specific contexts. Unlike systematic reviews, however, single studies are less able to say much about the variability of populations, contexts and conditions under which policies might work or not work.

Pilot studies and case studies

Pilot studies and case studies are other sources of evidence for policy-making and policy implementation. These studies use a combination of experimental, quasi-experimental and qualitative methods, as well as case studies.

Internet evidence

The Internet has enhanced enormously the availability of information and knowledge. The European Region has uneven access to these important sources of potential evidence, but in the future they will become more important within governments themselves. The uncertain scientific and political basis of much of the information and knowledge on the Internet makes it difficult to be sure that it meets the required quality to be counted as sound, valid and reliable evidence. This makes it all the more important for the wider public health community, including the Regional Office, to ensure that such information is critically appraised and scientifically assured before it is used as evidence for policy-making purposes.

Source: Modified from Davies P., 2004 (6)

The wide range of types of evidence needed to answer decision-makers' questions calls for different methods for both synthesizing the evidence, and communicating the strength of the evidence supporting a recommendation. The strength of evidence depends on the research method used. The assessment of quality and strength of evidence is an essential element in summarizing the results from the systematic reviews, because policy-makers need to know how much confidence they can place in the policy considerations suggested. Judgements about the quality of evidence require consideration of study design, study quality, consistency and directness of the evidence, reporting biases, strength of associations,

the balance between benefits and harms of an intervention, and translation of the evidence into specific circumstances.

Public health evidence can be graded in a similar way to the grading of clinical evidence, where systematic reviews of randomized controlled trials are considered to be the highest level. A sensible system for grading evidence from systematic reviews and other sources should be applied across a wide range of interventions and contexts. The grading of evidence for policy-making should be complemented with taxonomy to structure 'other' types of evidence as follows:

- descriptive (qualitative and quantitative)
- interpretive (appraisal and assessment)
- evaluative (experimental and non-experimental)
- predictive (modelling and scenario analysis).

A tentative grading scale of evidence from research might look as follows.

Strong evidence. Consistent findings in two or more scientific studies of high quality and/or a reanalysis of existing information or further primary research are unlikely to change the confidence in the result.

Moderate evidence. Consistent findings in two or more scientific studies of acceptable quality and/or a reanalysis of existing information or further primary research could change the confidence in the result.

Limited evidence. Only one study available or inconsistent findings in several studies and/or a reanalysis of existing information or further primary research are very likely to change the confidence in the result.

No evidence. No study of acceptable scientific quality available.

Quantitative evidence should not necessarily be rated to be of higher quality or more relevant than other types of evidence. Both have their use and can be applied in a complementary manner (7).

Experts providing advice should follow all the steps needed for an evidence-based approach in a **systematic** and **transparent** manner:

- defining an appropriate policy and research question

- searching for information
- evaluating and collating all types of evidence
- formulating advice.

Since decision-makers may be interested in evidence-based policy and practice, but operate in the context of national decision-making frameworks, careful consideration of the applicability of evidence in the specific context and of sensitivity to contextual factors in different countries is always needed. Questions remain about the applicability of global evidence to national questions, about the portability of the policy options and conclusions across different national settings. These questions should be explored by maintaining close collaboration between researchers and policy-makers. The different roles should be clearly defined, however: policy-makers asking for policy options should be aware that experts' responsibility is to provide advice, and that their own responsibility is for policy decisions based on that advice. Examples of sources of systematic reviews and secondary research results are given in Box 3.

Box 3 Examples of sources of systematic reviews and secondary research results

Cochrane Collaboration

The Cochrane Collaboration is an international not-for-profit organization that helps people make well informed decisions by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of health care interventions. The major product of the Cochrane Collaboration is its database of systematic reviews. The reviews and activities are supported by staff in Cochrane centres around the world and published in the Cochrane Library. The Cochrane Collaboration addresses national and international decision-makers, health care professionals and the public. Access to review abstracts is free. The web site is in English. <http://www.cochrane.org/index0.htm>

Campbell Collaboration

The Campbell Collaboration is an international, non-profit organization that prepares, maintains and disseminates systematic reviews of studies of interventions in the social, behavioural and educational arenas. It builds summaries, reviews and reports of research trials for policy-makers, practitioners, researchers and the public. It works closely with its sibling organization the Cochrane Collaboration. The web site also contains guidelines for producing high quality systematic reviews, developing

registries and related activities, and links to its coordinating group and similar organizations. Access is free of charge and no password is required. The web site is in English. <http://www.campbellcollaboration.org/>

The European Observatory on Health Systems and Policies

The European Observatory is a partnership between the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics, and the London School of Hygiene & Tropical Medicine. The Observatory focuses on three main inter-related areas of work: country monitoring and information, analysis of health system and policy issues, and engagement with policy-makers. The Observatory produces country profiles (The Health Care Systems in Transition series) that describe and analyse a country's health care system, that is its organization and funding, to facilitate international comparisons. Researchers analyse major health care issues on a multidisciplinary basis, in order to develop policy recommendations. The Observatory organizes focused policy dialogues and workshops that provide a unique opportunity for it to respond to and learn from front-line practitioners. In turn, this practical exchange of information helps to inform countries' decision-making at the policy level. For more information visit: <http://www.euro.who.int/observatory>

Health Evidence Network

As stated earlier, the mission of the WHO Regional Office for Europe is to support decision-makers in the European Region to produce better policies in public health and health care. To increase the use of evidence in the decision-making process for public health, the Regional Office approach is to identify information and evidence needs; to analyse and interpret available evidence appropriately so as to offer viable options for public health decisions; and to present the evidence in a format that is easily accessible and usable.

To respond to these challenges, the Regional Office for Europe has provided a new service, the Health Evidence Network (HEN), since September 2003. This is a web-based information service to provide policy-makers in the WHO European Region with the evidence they need to make key decisions on health. The network makes the overwhelming volume of evidence accessible to decision-makers in a format they can readily use. The information is in English,

with summaries in French, German and Russian and access is free of charge. www.euro.who.int/HEN

The network has two services.

1. HEN provides a single point for easy access to sources of information, relevant databases containing evidence related to possible health policy decisions, and
2. HEN provides answers to questions to support the decision-making process.

Access to sources of information

The HEN web site facilitates access to online resources. HEN provides access to a number of online databases, reports and documents, and networks of experts in the field of evidence for public health and health care. New information is continuously added. From each organization, the relevant evidence and information is selected. The organizations/databases included as of December 2004 are the following:

- Database of Abstracts of Reviews of Effects (DARE)
- PsycINFO
- Medical Literature, Analysis, and Retrieval System Online (MEDLINE)
- National Institute for Clinical Excellence (NICE)
- International Network of Agencies for Health Technology Assessment (INAHTA)
- Campbell Collaboration (C2)
- Cochrane Collaboration
- Food and Agriculture Organization of the United Nations (FAO)
- World Health Organization (WHO)
- WHO Regional Office for Europe
- United Nations Children's Fund (UNICEF)
- United Nations Educational, Scientific and Cultural Organization (UNESCO)
- United Nations Development Programme (UNDP)
- United Nations Economic Commission for Europe (UNECE)

- Joint UN programme on HIV/AIDS (UNAIDS)
- World Bank (WB)
- European Commission Health and Consumer Protection Directorate-General (DG SANCO)
- Organisation for Economic Co-operation and Development (OECD)
- International Agency for Research on Cancer (IARC)
- European Environment Agency (EEA)
- Council of Europe (COE)
- United Nations Population Fund (UNFPA)

For each organization/database, HEN presents a short description of the scope, profile, audience, information available, access to and languages of the web site. In addition, HEN offers links to these organizations and a search function by topic.

Answers to questions

The most innovative aspect is that HEN starts from the question a decision-maker needs to address. From there, HEN provides a synthesis of the relevant evidence and policy considerations or policy options. In response to policy-makers' questions, HEN identifies and reviews relevant online resources and selects information related to public health, such as publications in databases and from networks of experts. HEN then summarizes the best evidence to give policy-makers brief and timely answers.

The WHO Regional Office for Europe has direct and regular contact with decision-makers throughout the 52 Member States of the WHO European Region, which eases the identification of relevant issues. Typically policy-makers ask questions about how to solve the most pressing health and health system problems. Questions arrive from health departments or ministries. National health technology agencies are also interested in receiving neutral, independent and objective evidence collated by an intergovernmental body such as WHO, to check and complete the information they offer to their national decision- and policy-making bodies.

Experts are then commissioned to produce evidence-based, peer reviewed and concise responses. HEN provides information on

what is and is not known about the issue as well as the current debate on the subject and finally sets out the policy options. This gives policy-makers a quick way to obtain evidence to back up their decisions. The synthesis report in English is usually 10 pages long. In addition, a one-page summary is produced and made available in the four official languages of the Regional Office: English, French, Russian and German. It is obvious that with such brevity, some complexity and details may be lost, but this is a requirement from high level decision-makers.

Since the HEN launch in September 2003, much has been accomplished. Each month, two reports are finalized and made available. As of December 2004, 30 answers to questions were accessible at http://www.euro.who.int/HEN/Syntheses/20030820_1:

- What is the evidence on effectiveness of capacity building of primary health care professionals in the detection, management and outcome of depression?
- What are the human health consequences of flooding and the strategies to reduce them?
- What are the most effective strategies for reducing the rate of teenage pregnancies?
- Which are the most effective and cost-effective interventions for tobacco control?
- To what extent does an increase in tobacco prices lead to a significant reduction in consumption? What other possible implications will an increase of tobacco prices have?
- How are hospitals funded - and which payment method is best?
- What is the nature of hospital accreditation in Europe?
- What part does voluntary insurance play in European Union health care?
- What are the most effective and cost-effective interventions in alcohol control?
- What are the main risk factors for falls amongst older people and what are the most effective interventions to prevent these falls?
- How should interventions to prevent falls be implemented?
- Should mass screening for prostate cancer be introduced at the national level?

- What is the effectiveness of home visiting or home-based support for older people?
- What are the equity, efficiency, cost containment and choice implications of private health-care funding in western Europe?
- For which strategies of suicide prevention is there evidence of effectiveness?
- What is the effectiveness of old-age mental health services?
- What are the palliative care needs of older people and how might they be met?
- Which are the known causes and consequences of obesity, and how can it be prevented?
- Are there any effective treatments for obese people?
- How can injuries in children and older people be prevented?
- Are disease management programmes (DMPs) effective in improving quality of care for people with chronic conditions?
- What are the lessons learnt by countries that have had dramatic reductions of their hospital bed capacity?
- How can hospital performance be measured and monitored?
- What are the best strategies for ensuring quality in hospitals?
- Are bigger hospitals better?
- What are the arguments for community-based mental health care?
- What are the main risk factors for disability in old age and how can disability be prevented?
- What is the efficacy/effectiveness of antenatal care?
- What is antenatal (or perinatal) care? What are its boundaries? What are the financial and organizational implications of antenatal care?
- What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services?

The flow of questions is constant: HEN has received 120 questions, and answers to 40 of them are in various stages of preparation.

Development and presentation of evidence in HEN

The synthesis reports are prepared in a methodical way to ensure the quality and relevance of the final product. This includes steps for the selection and refinement of questions to be answered, methodologies and procedures for the experts who write the syntheses, and several independent peer reviews. The finished synthesis report is then published on the HEN web site. The steps followed in answering questions in HEN are provided in Box 4.

Box 4 Steps in answering questions

Defining the question

The issue, the scope and the context of the problem have to be clearly understood. At a minimum, the questions should be discussed between the policy-makers and the experts, to ensure that the questions can receive a scientific answer. An iterative process that allows a close two-way communication has been demonstrated to increase the use of evidence in policy-making.

Converting a policy question to an answerable question

Policy questions must be specified as and translated into answerable (research) questions, linking the research questions with the aims of an intervention or policy. This requires consideration of the multiple facets of a problem, and a clear description of the different kinds of knowledge (disciplines) needed to develop answers to the questions.

Searching for the evidence

Searching sources of information is done primarily by means of search techniques made available in various databases, including health technology assessment agencies and programmes, the Cochrane Collaboration, and other governmental and private organizations.

Analysing the evidence

A clear and consistent strategy for analysis of the evidence and the use of this strategy in all aspects of evidence-based work must be ensured. Depending on the types of evidence identified, different methods and standards of analysis will be appropriate, including systematic reviews.

Using the evidence to provide recommendations

Advice and recommendations to policy-makers take into account: the best available evidence from scientific research and existing data sources, evidence from a systematic review of benefits and harms (efficacy and safety), the transferability and feasibility within a particular context, and consideration of cost and cost-effectiveness.

Source: Evidence policy for the WHO Regional Office for Europe; 2004 (8)

HEN and the Editorial Board

HEN is conceived as a true network of partners. The members of HEN are:

- 35 government agencies and other public institutions in the field of public health and health care;
- the European Commission;
- United Nations agencies with a mandate in health.

HEN is constantly expanding. All are welcome, assuming that their work meets a high quality standard. The role of the partners comprises: developing synthesis reports (answers to policy questions), collecting questions, identifying possible authors and reviewers, reviewing drafts themselves, and disseminating results. The network's information also depends on that of partner institutions. That means, for instance, that HEN may map out online resources available from partners, which include a content summary to show available public health evidence.

An international Editorial Board ensures that the information provided by HEN is reliable, up-to-date and relevant. The Editorial Board also helps assure the quality of the products, advises on general lines of development and carries out other tasks, such as to help disseminate information about HEN. There are about 25 members on the Board, some representing partners, and others being international experts in such areas as publishing. With the help of the Editorial Board, HEN reviews questions posed by European health care policy-makers and chooses which ones to respond to. The Editorial Board meets annually.

Feed-back from users and the next steps

The service is aimed at the 52 Member States of the WHO European Region, although the questions are often global in relevance. The web site is therefore visited by people from all over the world. Statistics for current use of the web site show that activity on the site is spread over 24 hours of the day, seven days a week.

Countries ask HEN for speedy answers. HEN receives about three questions each week through the HEN e-mail box. These are answered within 1–2 weeks using a basic search strategy. If the HEN team considers the question to be of wide interest in the Region, it will be developed into a full synthesis report, ready in 2–3 months. Countries also ask for the rights to translate the reports into national languages, as they are used in parliamentary hearings and when drafting national legislation.

The next steps in the expansion of HEN are the development of an effective dissemination strategy, including other channels than the web (in 2005, two books grouping reports on mental health and health of the elderly will be produced), and the expansion of the network and of the collaboration with the partners.

Conclusion

The question of how to create better policies using the best evidence points towards using the best available evidence, not the best imaginable evidence. But studies alone do not produce evidence. Evidence goes beyond scientific research, including professional judgment and common sense. In the complex process of policy-making, other factors are also important besides evidence, or to circumvent the lack of scientific evidence. The need to broaden the evidence-base for policy-making in public health brings forward other sources of information and knowledge, such as case studies and descriptive information. Further attention should be paid to the specific context from which the evidence comes.

Several initiatives have operated for some time to provide systematic evidence, with transparent methodologies that distil the best available information that is really useful for decision-making. The Health Evidence Network is one of these initiatives. It will continue to develop further, as the WHO Regional Office for Europe embarks on the journey towards health intelligence, from data to information and evidence. The Regional Office's ambition is to ensure that evidence is an integral component of the decision-making process in public health and health care.

Exercises

Students will be asked to choose few policy problems that might be of utmost importance for the health system in their country and to formulate clear and well focused questions to be submitted to HEN.

Students will be asked to search the answer for specific policy questions on HEN and to discuss the potential impact of the report found on HEN on the policy making process in their country/region.

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Chapter 2
STRATEGY DEVELOPMENT

PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Best Practices of Public Health Strategies: Comparison and Critical Appraisal
Module: 2.1	ECTS (suggested): 0.5
Author(s), degrees, institution(s)	Silvia Gabriela Scîntee, MD, MSc, PhD Public Health Consultant at the Institute of Public Health Bucharest
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Keywords	New Public Health, Public Health Policy, Public Health Strategies, Strategy Implementation
Learning objectives	At the end of this module, students should be able to: <ul style="list-style-type: none"> - discuss the dimensions of public health - make a distinction between health policies, health strategies, health programmes and health plans - make a critical assessment of a public health strategy
Abstract	In order to make a critical assessment of a public health strategy it is necessary to have a good understanding of both notions: public health and strategy. The introduction of these notions, as well as the discussions on some essential aspects of the public health strategies are done through a comparative analysis of public health strategies developed or implemented in different European countries. The comparison focuses mainly on the scope of public health strategies and on some aspects related to the implementation plans, such as: coordination and responsibility, budgets, monitoring and evaluation.
Teaching methods	Lectures, group discussions, group assignments.

Specific recommendations for the teachers	This module takes: 2 hours lecture, 5 hours supervised group discussion on the presented strategies, and 8 hours group work on the assignment. A working group will have no more than 6 students. Each group will have to make a similar critical appraisal and to compare other two public health strategies.
Assessment of the students	Group reports on the comparative analysis of two public health strategies.

BEST PRACTICES OF PUBLIC HEALTH STRATEGIES: COMPARISON AND CRITICAL APPRAISAL

Silvia Gabriela Scîntee

The study of public health strategies requires primarily a good understanding of both notions: public health and strategy. The introduction of these notions, as well as the discussions on some essential aspects of the public health strategies will be done through a comparative analysis of public health strategies developed or implemented in different European countries.

For the present analysis, there have been chosen national documents of 7 countries with different levels of social and economical development and located in different geographical areas of Europe. These are:

- Better Health for a Better Future of Bulgaria - National Health Strategy, Ministry of Health, Republic of Bulgaria (2001)
- Healthy throughout Life - the targets and strategies for public health policy of the Government of Denmark, 2002-2010 (<http://www.folkesundhed.dk/ref.aspx?id=190>) (2002)
- Latvia Public Health Strategy (www.esi-vesels.lv/src/eng/papild/strategija.doc) (2001)
- Romanian National Public Health Strategy - Ministry of Health, Romania (2004)
- Public Health Strategy for Republic of Serbia - Ministry of Health, Republic of Serbia (2003)
- The National Public Health Strategy for Sweden in brief (<http://www.fhi.se/upload/PDF/2004/English/strategy.pdf>) (2003)
- Saving lives: Our Healthier Nation - United Kingdom (<http://www.archive.official-documents.co.uk/document/cm43/4386/4386-00.htm>) (1999)
- Improving our Lives: a focus on Health - Barnet's Local Strategy on Public Health (http://www.barnet.gov.uk/local_democracy/images/health_strategy.pdf) (2000)

Public Health

Public health concept has been repeatedly revised over the time, being defined in broader or narrower ways. In the early 20th century, Winslow provided the most widely accepted definition of public health: "... the Science and Art of (I) preventing disease, (II) prolonging life, and (III) promoting health and efficiency through organized community effort for (a) the sanitation of the environment, (b) the control of communicable infections, (c) the education of the individual in personal hygiene, (d) the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and (e) the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits so as to enable every citizen to realize his birthright of health and longevity" (1).

Despite this comprehensive definition, many policy-makers and even professionals have limited public health to the infectious disease control, environmental health, health care for special groups and health education, not taking into account the social responsibility and the great impact of health care financing and organization on public health.

WHO's definition of public health adapted from the "Acheson Report", London, 1988 is: "... the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society" (2). In order to stress the comprehensive approaches to the description and analysis of the health determinants, and the methods of solving public health problems, WHO made a distinction between *public health* and the *new public health*. Thus, according to WHO "the new public health is distinguished by its basis in a comprehensive understanding of the ways in which *lifestyles* and *living conditions* determine health status, and a recognition of the need to mobilize resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy *lifestyles* and creating *supportive environments for health*" recognizing that: "Such a distinction between the "old" and the "new" may not be necessary in the future as the mainstream concept of public health develops and expands" (2).

Frenk's definition of *new public health* enlarges the scope of public health taking into account issues of health services financing and organization, but outlines the need for action only at the health services level, not including actions that should be taken outside the health sector: "The new public health addresses the systematic efforts to identify health needs and to organise comprehensive health services with a well defined population base. It thus includes the process of information required for characterising the conditions of the population and the mobilisation of resources necessary for responding to such conditions. In this regard, the essence of public health is the health of the public, therefore it includes the organisation of personnel and facilities for providing all the health services required for health promotion, disease prevention, diagnosis and treatment of illness, and physical, social and vocational rehabilitation" (3).

The most recent definition of public health was provided by Heller and collaborators in an article very suggestively named "*Putting the public back into public health*", in which they discuss the narrow focus of public health practice: "The practice of public health has been criticized as being too involved with a narrow, managerial agenda focused on health care rather than the wider horizons of public good. Public accountability is central to the practice of public health, but is not mentioned in current definitions. We offer a new definition that recognizes the centrality of the public, and which should help public health professionals interpret their own role: 'Use of theory, experience and evidence derived through the population sciences to improve the health of the population, in a way that best meets the implicit and explicit needs of the community (the public)'" (4).

The reviewed documents go beyond the definition of new public health. They are not limiting the responsibility and actions to be taken for improving public health to the health services, but involve, either as simple statement or in a detailed plan of action, changes that should be taken at other sectors level, at civil society or even individual level.

Examples:

Better Health for a Better Future of Bulgaria states: "The society is accountable for safeguarding the health of the individuals" (5). For this purpose it calls for partnership and intersectoral

collaboration for implementation of the strategy objectives, defining roles for each national and international partner.

Healthy throughout Life document of Denmark's Government uses the expressions "collective challenges" and "collective responsibility". In the preface signed by Mr. Lars Løkke Rasmussen, the Minister for the Interior and Health, it is mentioned: "The tasks are precisely collective and so is the responsibility. Improving health requires that we all recognize our responsibility and take on our share of the tasks: individuals, families and local social networks; the voluntary sector; child-care centres, educational institutions, the health care system and the like; workplaces; private and public companies; and the municipalities, counties and state" (6). Indeed, the document includes numerous examples of what each individual can do, what communities can do collectively and what the public sector can do.

Latvian Public Health Strategy mentions "involving society as much as possible" as one of the main principles of its formulation and implementation. The strategy itself was developed with the help of the Inter-Sector Co-ordination Commission, established by the purpose of dealing with the public health issues. During the strategy development process different ministries, state institutions, municipalities, non-governmental organizations, professional and other sectors contributed in the consultation process. The strategy implementation will be monitored by the same Inter-Sector Co-ordination Commission which is expected to "keep involved and make responsible for the implementation of the strategy other ministries and institutions dealing with public health issues" (7).

Among the Romanian National Public Health Strategy principles it is mentioned: "Partnership and collaboration for improving health status of the population", having specified that "Public health programmes planning, implementation and evaluation require collaboration of all partners: community, government, non-governmental sector, scientific and health organizations, other sectors, etc. This collaboration should be extended in order to include programmes and policies developed for other sectors, but having impact on public health." As well, among the specific objectives of the Romanian National Public Health Strategy there are: "To sustain collaborations between the health sector and other sectors in order to

take action on the health determinants that are out of the health system control” and “To introduce compulsory application of Health Impact Assessment for policies and programmes developed by other sectors” (8).

Public Health Strategy for Republic of Serbia has among its overall aims: “A re-orientation of the public health infrastructure from a medical top-down approach to a more widely spread responsibility for health, fostering health promotion, intersectoral co-operation, community involvement and individual responsibility” (9). The Serbian Public Health Strategy sees “Partnership for health” as one of the main challenges for public health considering that “Largest number of public health problems is too complicated to be solved by health service alone... solutions of public health problems should be looked for where they arise... Through partnership for health, we could influence on development of healthy public policy, also on changes in human behaviour, and contribute to building such community that support health” (9).

The overall aim of Swedish public health policy is “to create social conditions that will ensure good health for the entire population” (10). To this end the Swedish Public Health Strategy contains eleven general objectives that cover the most important determinants of public health. The responsibility for attaining these objectives is divided among various sectors and different levels in society.

Saving lives: Our Healthier Nation document is based on the facts that “the social, economic and environmental factors tending towards poor health are potent” and “people can make individual decisions about their and their families' health which can make a difference” (11). The United Kingdom Strategy also mentions partnership to improve health. “Our new approach to better health comprises: reorienting local services - including the NHS - to give a high priority to health improvement and local partnerships for health, where organisations and people work together to improve health overall” (11).

Strategy

There are many lectures or written materials on strategy development starting with the well-known dialogue from Lewis Carroll's "Alice in the Wonderland":

- "Cheshire Puss, ... would you tell me, please, which way I ought to go from here?"
- "That depends a good deal on where you want to get to," said the Cat.
- "I don't much care where," said Alice.
- "Then it doesn't much matter which way you go," said the Cat.

This reflects very well the essence of a good strategy, which is about what results should be achieved and in which way. In order to decide upon the way in which the results are going to be achieved it is necessary to know exactly what results are expected.

The Oxford dictionary defines strategy as "planning and directing of the whole operation of a campaign or war; plan, policy" (12). According to this definition, strategy is equivalent with plan and policy. Sometimes the terms are used as synonyms, but it would be a slight difference between them. WHO's definition of "health policy" is: "A formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures" (2).

Planning was defined by WHO as "A process of organizing decisions and actions to achieve particular ends, set within a policy" (13).

Among the numerous definitions of strategy existing in the public health and health management field, Longest and collaborators have provided a short but expressive one: "A long-term major pattern of activity describing the means of accomplishing the objectives" (14).

Thus, policy would be focused mainly on the vision for the future, outlining priorities, setting clear directions and the main objectives and having the role of building consensus and informing

people. Based on the policy framework, health plans, programmes and strategies are further developed outlining the way in which policy objectives will be achieved, establishing deadlines for the short and medium term and setting clear responsibilities for each actor involved.

The reviewed documents are similar, despite the various labels and terms used as title:

- Latvia and Serbia have entitled their documents “*Public Health Strategy*”
- Romania and Sweden named them “*National Public Health Strategy*”
- Bulgaria used “*National Health Strategy*”
- Danish document is entitled “*The Targets and Strategies for Public Health Policy of the Government of Denmark*”
- United Kingdom’s “*Saving lives: Our Healthier Nation*” document is described as “*an action plan to tackle poor health*”

The scope of public health strategies

There is no rule on how extensive should be a public health strategy. International and national practice has shown that public health strategies could be of two main categories:

- *general strategies*, aiming at improving overall health based on a comprehensive approach, such as the Health Strategy of the European Community that has the purpose of raising the level of health protection for its citizens and responding to the main challenges of public health.
- *sectoral strategies*, limited to one or more dimensions of public health and these could address:
 - a specific domain: “*Mental Health Action Plan*” for Europe, adopted at the WHO European Ministerial Conference on Mental Health held in Helsinki, Finland, 12–15 January 2005, that has the purpose to ensure the delivery of mental health activities capable of improving the well-being of the whole population, preventing mental health problems and enhancing the inclusion and functioning of people experiencing mental health problems (15).

- one or more specific diseases: “WHO European Region's Strategy for Elimination of Measles and Congenital Rubella Infection” that includes the strengthening of surveillance and immunisation programmes in collaboration with European specific networks and Member States (16).
- one or more risk factors: “WHO Global Strategy on Diet, Physical Activity and Health” which is based on the fact that a few largely preventable risk factors account for most of the world's disease burden; the overall goal of this strategy is to improve public health through healthy eating and physical activity (17).
- a specific population category: “Tayside Child Health Strategy” a local strategy that aims to improve the lives and health of children and young people in Tayside through the delivery of appropriate, integrated, effective, evidence based and needs led services and to improve the experiences and satisfaction of children, young people and their carers with the services provided for them (18).

Another criterion for classification is the geographical coverage. From this point of view, strategies could be developed at sub-national, national, sub-regional or regional level. Examples of public health strategies of different extent are given beneath.

For *European region* international organizations such as European Community and World Health Organization have developed either general or sectoral public health strategies, such as:

- “Health Strategy of the European Community”
- “European Environment and Health Strategy”
- “Community Strategy on Safety and Health at Work”
- ”WHO Health for All in the 21st Century”
- “WHO Strategy for Children and Adolescents in Europe”
- “WHO Global Strategy on Diet, Physical Activity and Health”

Some strategies are jointly developed by two or more international organizations, i.e.:

- “WHO and UNICEF Global Strategy for Infant and Young Child Feeding”

Besides protecting and promoting the health of the people in the area, regional or sub-regional strategies have the purpose of promoting regional, sub-regional and cross-border co-operation.

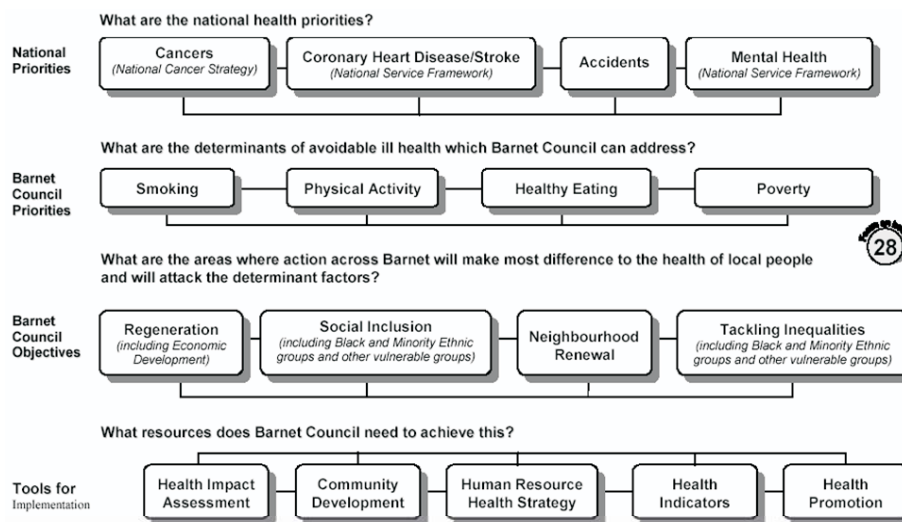
Strategies developed at *national level* are usually based on the priority health problems in a country, but they are also aligned to the regional strategies. A good example is the “Public Health Strategy of Latvia”, which is modelled on the WHO European regional strategy “Health for All in the 21st Century”.

Some national or local strategies are adaptations of international or regional sectoral strategies at the specific country/local conditions, such as “Healthy Cities” or “Health Promoting Schools Programmes”.

Local strategies can be developed at sub-country level in order to endorse the national strategy at local level. An example is Barnet’s Strategy on Public Health - “Improving our Lives: a focus on Health” (19) developed by the Barnet Local Council, which is based on both national and local priorities (Figure 1). National health priorities are described in “Saving lives: Our Healthier Nation” document – the action plan to tackle poor health in United Kingdom. This action plan is focused on four main killers: cancer, coronary heart disease and stroke, accidents, mental illness. Barnet (a district of London) has established its own priorities, focusing on health determinants that should be addressed, in order to improve poor health related to above mentioned conditions. Thus, Barnet Council priorities include tackling poverty to reduce health inequalities, reducing the prevalence of smoking (a major contributing factor to many avoidable diseases), encouraging increased physical activity and better diets for its people.

This local health strategy identifies specific aims and steps towards implementation. These include key linkages with other strategies and plans, in addition to the national action plan. This strategy is also linked to the Health Authority’s Health Improvement Programme and clarifies the council’s contribution to the collective health improvement agenda.

Figure 1 Improving our Lives: a focus on Health - Barnet's Strategy on Public Health



Source: *Barnet's Strategy on Public Health 2000/2005 (19)*

In what concern the focus of the reviewed documents there are two different approaches. While the strategies of western countries aim at improving health of everyone and the health of the worse off in particular being more centred on: health determinants, reducing social inequalities, target groups, and the main “killers”, the strategies of eastern countries have as the main purpose to stop the negative trends or to reach the EU indices and are more focused on improving the public health infrastructure, health care services or the conformity with international standards.

Implementation plans

The successful implementation of a strategy is determined by some aspects related to the implementation plan, such as: coordination and responsibility, budgets, monitoring and evaluation.

What makes a difference between the analyzed strategies in western and eastern countries is the agency that has the responsibility for strategy implementation and the organization charged with coordination of the implementation process.

Usually, in western countries it is the government which has the final responsibility of implementing the strategy, assigning one of its technical institutions with the coordination role. Very often the responsibility is shared between government, other governmental or nongovernmental organizations, communities and individuals:

- “Common responsibility for individuals, for communities and for the public sector” (Denmark) (6)
- “Government in co-operation with local councils, the NHS, and local voluntary bodies and businesses” (United Kingdom) (11)
- “The Swedish National Institute of Public Health coordinates the work and monitors progress of the National Public Health Strategy for Sweden. The Swedish National Institute of Public Health has a central role in coordinating public health work on the national level. The Institute also supports the implementation of the eleven general objectives, monitors and evaluates them and develops indicators to show how well they are being met. Progress is reported to the Government every 4 years in the form of a public health report, which provides the basis of discussions on how successfully the policy is influencing public health.” (Sweden) (10)

In eastern countries the final responsibility is with the Ministry of Health or whatever Ministry is in charge with this sector:

- The Ministry of Health (Bulgaria) (5)
- The Ministry of Welfare (Latvia) (7)
- The Ministry of Health (Romania) (8)
- The Ministry of Health (Serbia) (9)

The explanations could be: the lack of collaboration between sectors, the low priority of health for the governments of these countries, or even weak governments.

However, all strategy documents reviewed mention the involvement of other actors in strategy implementation besides the Ministry of Health, such as:

- other ministries: Bulgaria, Romania, Serbia, Denmark, Latvia
- health insurance fund: Bulgaria, Romania, Serbia

- local authorities: Denmark, Latvia, Sweden, United Kingdom
- NGO's - all
- individuals - almost all

More important than the number or the category of actors involved in strategy implementation is the relationship between them, the degree of communication and the clear definition of each actor's roles and responsibilities. An example of good coordination between national and local levels is UK where local communities have developed their own public health strategies having as starting point the national strategy, as shown in the above example.

The implementation of a strategy can hardly be done without money. Among the analyzed documents we have noticed that only some strategies have allocated a dedicated budget for implementation. Some of them mention that supplementary funds would be necessary, but others do not touch this issue.

In regards with monitoring and evaluation, some strategies contain a list of indicators, others mention the need for developing indicators, but others do not tell how will be monitored and evaluated the strategy implementation. A good example is the Danish strategy "Healthy throughout Life" (6) that contains an indicator programme composed by two parts:

- *Key indicators* - a set of overall indicators that describe trends and results in relation to the overall targets of Healthy throughout Life;
- *A detailed, specific set of indicators* - that describes the trends and results for each priority area in relation to the targets and collective challenges in Healthy throughout Life.

Recommended subjects for group discussion:

- What are the main factors that make difficult the comparisons among strategies.
- How strategy development should be initiated.
- What are the main factors that influence strategy implementation.

Recommended assignments for group work:

Each group will be given two public health strategies and will be asked to make a comparative analysis.

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Recommended readings

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2. World Health Organization, *Health Evidence Network Programme*, <http://www.euro.who.int/HEN>
3. National Public Health Partnership, Australia, *Guidelines for Improving National Public Health Strategies Development and Coordination* (May 1999) <http://www.dhs.vic.gov.au/nphp/publications/strategies/stratguidelines.pdf>
4. American Public Health Association, *Community Strategies for Health: Fitting in the Pieces* <http://www.apha.org/ppp/science/csh.htm>

PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Health21 - The health for all policy framework for the WHO European Region
Module: 2.2	ECTS (suggested): 0.2
Author(s), degrees, institutions	Octavian Eliade Mihalcea, Economist, MPH Institute of Public Health Bucharest
Address for correspondence	Institute of Public Health Bucharest 1-3 Dr. Leonte Street, 050463 Bucharest, ROMANIA Tel: (4021) 3183620 Fax: (4021) 3123426 Email: directie@ispb.ro
Keywords	Framework policy, health strategy, health targets
Learning objectives	By the end of this module the student should be able to: <ul style="list-style-type: none"> • describe the main elements of the WHO Health21 - The health for all policy framework for the WHO European Region; • use the WHO Health21 targets in developing national/local strategies
Abstract	This policy document sets out for the first 20 years of the 21 st century global priorities and that will create the conditions for people worldwide to reach and maintain the highest attainable level of health throughout their lives. The HEALTH21 policy for the European Region of WHO includes: one constant goal, two main aims , three basic values and four main strategies for action . 21 targets have been set for the European Region in order to provide the benchmarks against which to measure progress in improving and protecting health and in reducing health risks.
Teaching methods	Lecture to introduce the strategy, group discussions revealing the key concepts and main conclusions, group exercise.
Specific recommendations for teacher	Copies of the WHO Health21 - The health for all policy framework for the WHO European Region should be made available to students before the module. This module takes 3 hours of lecturing and

	discussions. Another 4 hours will be devoted to review electronic and printed literature in the field. (suggested ECTS: 0,2)
Assessment of students	A short (max. one page) essay developing the main ideas selected during the discussions that may be helpful for the development/improvement of the national health strategy.

HEALTH21 - THE HEALTH FOR ALL POLICY FRAMEWORK FOR THE WHO EUROPEAN REGION

Octavian Eliade Mihalcea

“World Health Declaration” was adopted in May 1998 by the 51st WHO General Assembly. “Health for all in the 21st century” represents the framework policy of the WHO European Regional Committee.

This policy document sets out for the first 20 years of the 21st century global priorities and that will create the conditions for people worldwide to reach and maintain the highest attainable level of health throughout their lives. (1)

The European policy for Health For All (HFA) represents the response to the WHO Declaration’s call for regional and national policies to be developed on the basis of the global policy and is in conformity with the regional HFA plan of action adopted in 1991, which asked for a renewed policy to be presented to the WHO Regional Committee for Europe in 1998 (1).

It is worthy to notice that the arguments contained within this new policy for the European Region demonstrate the essential relationship between health, poverty and social cohesion. These arguments also show how health and health development efforts are now emerging as important factors in contributing to greater social cohesion between and within the populations of the Region.

The HEALTH21 policy for the European Region of WHO includes (1):

- one constant **goal**: to achieve the full health potential for all
- two main **aims**
 - promoting and protecting people's health throughout the course of their lives
 - reducing the incidence of and suffering from the main diseases and injuries

- three basic **values** form the ethical foundation:
 - health as a fundamental human right
 - equity in health and solidarity in action between countries, between groups of people within countries and between genders
 - participation by and accountability of individuals, groups and communities and of institutions, organizations and sectors in health development
- four main **strategies for action** to ensure that scientific, economic, social and political sustainability drive the implementation of HEALTH21:
 - multisectoral strategies to tackle the determinants of health, taking into account physical, economic, social, cultural, and gender perspectives and ensuring the use of health impact assessments
 - health-outcome-driven programmes and investments for health development and clinical care
 - integrated family- and community-oriented primary health care, supported by a flexible and responsive hospital system
 - a participatory health development process that involves relevant partners for health, at all levels - home, school and worksite, local community and country - and that promotes joint decision-making, implementation and accountability

21 targets have been set for the European Region in order to provide the benchmarks against which to measure progress in improving and protecting health and in reducing health risks. These 21 HFA targets represent the framework for developing health policies in the European Region. The European targets reflect the targets set out in the global policy for "Health for all in the twenty-first century". Table 1 presents the 21 targets established for the European region.

Table 1 21 Targets set for the European Region

TARGET	GENERAL OBJECTIVE	SUGGESTED AREAS FOR FORMULATING INDICATORS
1. SOLIDARITY FOR HEALTH IN THE EUROPEAN REGION	By the year 2020, the present gap in health status between member states of the	<ul style="list-style-type: none"> • Mortality-based indicators (e.g. life expectancy) and age-standardized

	<p>European region should be reduced by at least one third.</p>	<p>mortality rates (e.g. maternal mortality)</p> <ul style="list-style-type: none"> • Selected measurements of the incidence and prevalence of disability and morbidity • Estimates of health expenditures and external assistance, whenever such information is available
<p>2. EQUITY IN HEALTH</p>	<p>By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in all member states, by substantially improving the level of health of disadvantaged groups.</p>	<ul style="list-style-type: none"> • Main socioeconomic measurements (e.g. educational levels, unemployment, income) • Differences in broad health status between identifiable socioeconomic groups and genders (e.g. (maternal) mortality, morbidity, disability and access to health care)
<p>3. HEALTHY START IN LIFE</p>	<p>By the year 2020, all newborn babies, infants and pre-school children in the region should have better health, ensuring a healthy start in life.</p>	<ul style="list-style-type: none"> • Mortality indicators related to age groups and causes of death (e.g. perinatal, infant, maternal mortality) • Selected measurements of health status and wellbeing of neonates and infants (e.g. birth weight, congenital diseases, nutrition, immunization)
<p>4. HEALTH OF YOUNG PEOPLE</p>	<p>By the year 2020, young people in the region should be healthier and better</p>	<ul style="list-style-type: none"> • Mortality indicators related to appropriate age groups and causes of

	able to fulfil their roles in society.	<p>death</p> <ul style="list-style-type: none"> Indicators on lifestyles of young people (e.g. smoking, alcohol, drugs, sexual behaviour)
5. HEALTHY AGING	By the year 2020, people over 65 years should have the opportunity of enjoying their full health potential and playing an active social role.	<ul style="list-style-type: none"> Mortality indicators related to appropriate age groups and causes of death Available statistics on morbidity and disability among the elderly
6. IMPROVING MENTAL HEALTH	By the year 2020, people's psychosocial wellbeing should be improved and better comprehensive services should be available to and accessible by people with mental health problems.	<ul style="list-style-type: none"> Suicide rate Incidence and prevalence of mental disorders such as schizophrenia, serious depression, alcoholic psychosis, post-traumatic mental sequelae Statistics on availability and use of mental health services
7. REDUCING COMMUNICABLE DISEASES	By the year 2020, the adverse health effects of communicable diseases should be substantially diminished through systematically applied programmes to eradicate, eliminate or control infectious diseases of public health importance.	<ul style="list-style-type: none"> Mortality indicators related to appropriate age groups and infectious diseases (tuberculosis, respiratory and diarrhoeal diseases, malaria, etc.) New cases of selected communicable diseases, i.e. measles, malaria, diphtheria, tetanus, pertussis, congenital syphilis, congenital rubella, neonatal

		<p>tetanus, rubella, mumps, tuberculosis, hepatitis (A, B, other), syphilis, gonorrhoea, HIV/AIDS</p> <ul style="list-style-type: none"> • Percentage of children immunized against selected communicable diseases, i.e. diphtheria, tetanus, pertussis, measles, poliomyelitis, tuberculosis, <i>Haemophilus influenzae</i> type b, hepatitis B, mumps, rubella
<p>8. REDUCING NONCOMMUNICABLE DISEASES</p>	<p>By the year 2020, morbidity, disability and premature mortality due to major chronic diseases should be reduced to the lowest feasible levels throughout the region.</p>	<ul style="list-style-type: none"> • Mortality from major noncommunicable diseases (cardiovascular diseases, cancer, chronic respiratory diseases, diabetes, others) by age group • Incidence and prevalence of the major noncommunicable diseases listed above, including asthma and chronic rheumatic diseases • Hospital discharge statistics on major noncommunicable diseases • Prevalence of major risk factors in the population, i.e. elevated blood pressure and serum cholesterol,

		<p>inadequate physical activity, smoking, inappropriate nutrition</p> <ul style="list-style-type: none"> • Selected indicators for oral health
9. REDUCING INJURY FROM VIOLENCE AND ACCIDENTS	By the year 2020, there should be a significant and sustainable decrease in injuries, disability and death arising from accidents and violence in the region.	<ul style="list-style-type: none"> • Mortality from main external causes of injury and poisoning • Incidence of injuries due to traffic, home and work-related accidents • Estimates of injury-related disability
10. A HEALTHY AND SAFE PHYSICAL ENVIRONMENT	By the year 2015, people in the region should live in a safer physical environment, with exposure to contaminants hazardous to health at levels not exceeding internationally agreed standards.	<ul style="list-style-type: none"> • Percentage of population with adequate water supply in the home and hygienic sewage disposal • Statistics on microbiological foodborne diseases - outbreaks and persons affected • Statistics on the emission of selected pollutants
11. HEALTHIER LIVING	By the year 2015, people across society should have adopted healthier patterns of living.	<ul style="list-style-type: none"> • National statistics on food consumption and body mass index • Available data on estimates of physical activity and sexual behaviour
12. REDUCING HARM FROM ALCOHOL, DRUGS AND TOBACCO	By the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all member states.	<ul style="list-style-type: none"> • Mortality from alcohol- and drug-related causes of death • Estimates of smoking prevalence in appropriate population groups and national statistics on tobacco

		<p>consumption</p> <ul style="list-style-type: none"> • Estimates of alcohol use prevalence and national statistics on alcohol consumption • Hospital admission statistics in relation to alcoholic psychosis and drug treatment
13. SETTINGS FOR HEALTH	By the year 2015, people in the region should have greater opportunities to live in healthy physical and social environments at home, at school, at the workplace and in the local community.	<ul style="list-style-type: none"> • Incidence and mortality indicators related to home and work accidents and occupational diseases • National housing statistics
14. MULTISECTORAL RESPONSIBILITY FOR HEALTH	By the year 2020, all sectors should have recognized and accepted their responsibility for health.	<ul style="list-style-type: none"> • No statistical indicators; qualitative assessment only
15. AN INTEGRATED HEALTH SECTOR	By the year 2010, people in the region should have much better access to family- and community-oriented primary health care, supported by a flexible and responsive hospital system.	<ul style="list-style-type: none"> • Health personnel resources (e.g. physicians by speciality, nurses, and proportion with occupation within primary health care or hospitals) • Availability of hospital beds by type, and other statistics on health care resources • Indicators of health care consumptions (e.g. hospital admissions, average length of stay, ambulatory care contacts)
16. MANAGING FOR	By the year 2010,	<ul style="list-style-type: none"> • Mortality from

<p>QUALITY OF CARE</p>	<p>member states should ensure that the management of the health sector, from population-based health programmes to individual patient care at the clinical level is oriented towards health outcomes.</p>	<p>selected conditions (e.g. appendicitis, hernia, intestinal obstruction, adverse effects of therapeutic agents and other “avoidable” causes of death)</p> <ul style="list-style-type: none"> • Specific indicators related to the quality of health care (surgical wound infection rates, diabetic complications, autopsy rates, patients- satisfaction estimates, etc.)
<p>17. FUNDING HEALTH SERVICES AND ALLOCATING RESOURCES</p>	<p>By the year 2010, member states should have sustainable financing and resource allocation mechanisms for health care systems based on the principles of equal access, cost-effectiveness, solidarity, and optimum quality.</p>	<ul style="list-style-type: none"> • Health expenditures, total and by component (public, recurring hospital expenditures, capital investment, pharmaceuticals, etc.)
<p>18. DEVELOPING HUMAN RESOURCES FOR HEALTH</p>	<p>By the year 2010, all member states should have ensured that health professionals and professionals in other sectors have acquired appropriate knowledge, attitudes and skills to protect and promote health.</p>	<ul style="list-style-type: none"> • Statistics on health personnel resources by category, as appropriate • Statistics on medical professionals graduating
<p>19. RESEARCH AND KNOWLEDGE FOR HEALTH</p>	<p>By the year 2005, all member states should have health research, information and communication</p>	<ul style="list-style-type: none"> • Expenditure on health research and development

	systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.	
20. MOBILIZING PARTNERS FOR HEALTH	By the year 2005, implementation of policies for health for all should engage individuals, groups and organizations throughout the public and private sectors, and civil society, in alliances and partnerships for health.	<ul style="list-style-type: none"> No statistical indicators; qualitative assessment only
21. POLICIES AND STRATEGIES FOR HEALTH FOR ALL	By the year 2010, all member states should have and be implementing policies for health for all at country, regional and local levels, supported by appropriate institutional infrastructures, managerial processes and innovative leadership.	<ul style="list-style-type: none"> No statistical indicators; qualitative assessment only

Source: "Health 21 - The health for all policy framework for the WHO European Region", Annex 2

Annex 1 in Health21 document describes the relationship between the global and European targets. Table 2 presents this relationship, together with suggested strategies for attaining the targets. Countries, sub-national entities, cities and local communities, etc. in the European Region are expected to adapt these targets to meet their own local conditions, needs and capacities.

Table 2 The relationship between the global and European targets

HEALTH21 – HFA policy framework for the who European region – 21 targets	Strategies for target attainment (highlights only)	HFA in the 21st century – 10 global targets
1. Solidarity for health in the European region	<p>Sharing of vision, resources, knowledge and expertise in Europe</p> <p>More and better coordinated external support to countries in need, in line with their HFA-based development plans</p>	1. Increase equity in health
2. Equity in health	Reduction of social and economic inequities between groups, through policies, legislation and action	
3. Healthy start in life	<p>Investment in social and economic wellbeing of parents and families</p> <p>Access to good reproductive and child health services</p>	2. Improve survival and quality of life
4. Health of young people	<p>Creation of supportive and safe physical, social and economic environments</p> <p>Cooperation of health, education and social services</p>	
5. Healthy aging	<p>Housing, income and other measures to enhance autonomy and social productivity</p> <p>Health promotion and protection throughout life</p>	
6. Improving mental health	<p>Living and working conditions shaped to gain a sense of coherence and social relations</p> <p>Quality services for people</p>	3. Reverse global trends of five major pandemics

	with mental health problems	
7. Reducing communicable diseases	Eradication/elimination of poliomyelitis, measles and neonatal tetanus Internationally agreed surveillance, immunization and control strategies	4. Eradicate and eliminate certain diseases
8. Reducing noncommunicable diseases	Prevention and control of common noncommunicable disease risk factors Healthy public policies, including a Europe-wide movement for healthy lifestyles	3. Reverse global trends of five major pandemics
9. Reducing injury from violence and accidents	Higher priority to safety and social cohesion in living and working environments	
10. A healthy and safe physical environment	National and sub-national action plans on environment and health Legal and economic instruments to reduce waste and pollution	5. Improve access to water, sanitation, food and shelter
11. Healthier living	Actions to facilitate healthy choices regarding nutrition, physical exercise and sexuality	6. Promote healthy lifestyles and discourage health-damaging ones
12. Reducing harm from alcohol, drugs and tobacco	Broad strategies to prevent addictions and treat victims	
13. Settings for health	Multisectoral mechanisms to make homes, schools, workplaces and cities more healthy	
14. Multisectoral responsibility for health	Through health impact assessment, all sectors to be accountable for their effects on health	
15. An integrated health sector	Primary health care for families and communities, with flexible systems of hospital referral	8. Improve access to comprehensive, essential, high-quality health care

16. Managing for quality of care	Health outcomes to drive health development programmes and patient care	
17. Funding health services and allocating resources	Funding systems fostering universal coverage, solidarity and sustainability Sufficient financial resources allocated to priority health needs	
18. Developing human resources for health	Education based on HFA principles Public health professionals educated to act as key enablers and advocates for health from community to country level	
19. Research and knowledge for health	Orientation of research policies to HFA needs Mechanisms to base practice on scientific evidence	10. Support research for health 9. Implement global and national health information and Surveillance systems
20. Mobilizing partners for health	Advocacy, coalition-building and joint action for health Sectors and actors identify and account for mutual benefits of investment in health	7. Develop, implement and monitor national HFA policies
21. Policies and strategies for health for all	HFA policies (with targets and indicators) formulated and implemented from country to community level, involving relevant sectors and organizations	

Source: "Health 21 - The health for all policy framework for the WHO European Region", Annex 2

Most of the European countries have developed national and local health strategies based on the principles, vision, aims and targets included in the WHO Health21 framework policy document.

Exercises

1. Compare the WHO Health21 framework policy and your national Public Health Strategy, if there is one.
 - Discuss the common targets of the two strategies.
2. Set goals and objectives for your national Public Health Strategy based on WHO Health21 targets, if there is not one for your country.

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Millennium Development Goals
Module: 2.3	ECTS (suggested): 0,25
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Keywords	development; social development;
Learning objectives	After completing this module students and public health professionals will be able to: <ul style="list-style-type: none"> • list the millenium development goals • list the health related MDG • describe the work of WHO on MDGs
Abstract	In September 2000, 147 heads of State and Government, and 189 nations in total - the largest ever gathering of Head of State - in the United Nations Millennium Declaration [A/RES/55/2] committed themselves to making the right to development a reality for everyone and to freeing the entire human race from want. They acknowledged that progress is based on sustainable economic growth, which must focus on the poor, with human rights at the centre. The objective of the Declaration is to promote "a comprehensive approach and a coordinated strategy, tackling many problems simultaneously across a broad front."

	This paper describes the 8 MDGs and 16 targets to be reached by 2015 and the work of various international agencies towards meeting these goals. It also presents the prospects of some countries to meet the MDGs
Teaching methods	Teaching methods: lectures, group discussions, seminars.
Specific recommendations for teachers	$\frac{3}{4}$ lectures; $\frac{1}{4}$ discussions. Students will discuss the importance of MDGs, what does it mean and what does it take to achieve them.
Assessment of students	Assessment: seminar paper, case problem presentations, oral exam, attitude test.

MILLENNIUM DEVELOPMENT GOALS

Carmen Ungurean

Table 1 The Millennium Development Goals and targets to be achieved by 2015

Goal	Target
Eradicate extreme poverty and hunger	<ul style="list-style-type: none"> ■ Reduce by half the proportion of people living on less than a dollar a day ■ Reduce by half the proportion of people who suffer from hunger
Achieve universal primary education	<ul style="list-style-type: none"> ■ Ensure that all boys and girls complete a full course of primary schooling
Promote gender equality and empower women	<ul style="list-style-type: none"> ■ Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015
Reduce child mortality	<ul style="list-style-type: none"> ■ Reduce by two thirds the mortality rate among children under five
Improve maternal health	<ul style="list-style-type: none"> ■ Reduce by three quarters the maternal mortality ratio
Combat HIV/AIDS, malaria and other diseases	<ul style="list-style-type: none"> ■ Halt and begin to reverse the spread of HIV/AIDS ■ Halt and begin to reverse the incidence of malaria and other major diseases
Ensure environmental sustainability	<ul style="list-style-type: none"> ■ Integrate the principles of sustainable development into country policies and programmes; reverse loss of environmental resources ■ Reduce by half the proportion of people without sustainable access to safe drinking water ■ Achieve significant improvement in lives of at least 100 million slum dwellers, by 2020
Develop a global partnership for development	<ul style="list-style-type: none"> ■ Develop further an open trading and financial system that is rule-based, predictable and non-discriminatory. Includes a commitment to good governance, development and poverty reduction - nationally and internationally ■ Address the least developed countries' special needs. This includes tariff- and quota-free access for their exports; enhanced debt relief for heavily indebted poor countries; cancellation of official bilateral debt; and more generous official development assistance for countries committed to

	<p>poverty reduction</p> <ul style="list-style-type: none"> ■ Address the special needs of landlocked and small island developing States ■ Deal comprehensively with developing countries' debt problems through national and international measures to make debt sustainable in the long term ■ In cooperation with the developing countries, develop decent and productive work for youth ■ In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries ■ In cooperation with the private sector, make available the benefits of new technologies—especially information and communications technologies
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In September 2000, 147 heads of State and Government, and 189 nations in total - the largest ever gathering of Head of State - in the United Nations Millennium Declaration [A/RES/55/2] committed themselves to making the right to development a reality for everyone and to freeing the entire human race from want. They acknowledged that progress is based on sustainable economic growth, which must focus on the poor, with human rights at the centre. The objective of the Declaration is to promote "a comprehensive approach and a coordinated strategy, tackling many problems simultaneously across a broad front."

The declaration was translated into a roadmap setting out 8 goals and 16 targets (Table 1) to be reached by 2015. The Millennium Development Goals are built on the agreements made at the UN conferences in the 1990s and represent an unprecedented commitment to reduce poverty and hunger and to tackle ill-health, gender, inequality, lack of education, lack of access to clean water and environmental degradation.

The MDGs focus the efforts of the world community on achieving significant, measurable improvements in people's lives by establishing the yardstick for results. They require action not by developing countries but by the industrial countries that must assist in

implementation. The 48 indicators selected by international experts are used to assess the progress over the period from 1990 to 2015. Based on these 48 indicators, aggregated at global and regional levels, the Secretary-General will prepare a report on progress achieved towards implementing the Declaration.

In close collaboration with United Nations agencies and funds, the World Bank, IMF, and OECD, the United Nations Statistics Division co-ordinates data analysis and maintains the database containing the series related to the selected indicators, as well as other background series intended to supplement the basic 48 Millennium indicators, for more in-depth analysis.

Meeting the MDGs means that by 2015 more than 500 million people will be lifted out of extreme poverty. More than 300 million will no longer suffer from hunger. 30 million children will no longer die before the age of 5 and 2 million mothers will be saved from death. Achieving the Goals will also mean 350 million fewer people are without safe drinking water and 650 million fewer people live without the benefits of basic sanitation, allowing them to lead healthier and more dignified lives. Hundreds of millions more women and girls will go to school, access economic and political opportunity, and have greater security and safety (1).

UNDP is the UN's global development network, links and coordinates global and national efforts to reach the Millennium goals. The UNDP Administrator is the coordinator of the Millennium Development Goals in the UN system.

Launched in July 2002, the Millennium Project is an independent advisory project commissioned by UN Secretary-General and supported by the UN Development Group. Working in co-operation with developing countries and other partners, the project has set up an expert task force to prepare strategies to help countries achieve the goals by bringing together the best current thinking and research. Its work includes reviewing innovative practices, prioritizing policy reforms, identifying means of policy implementation and evaluating financing options.

WHO together with UNICEF are the leading responsible agencies to report on child mortality, maternal health, childhood nutritional status, malaria prevention measures and access to clean water, and with UNAIDS on HIV prevention.

Three out of eight goals, eight out of 16 targets and 18 of 48 indicators relate directly to health, which is also an important contributor to several other goals. The MDGs provide a vision of development in which health and education are placed at the centre.

WHO's work on the MDGs

Three principles guide WHO's work on the MDGs:

- working with individual countries to help them develop and work towards a more complete set of health goals that are relevant to their particular circumstances.
- giving special priority to helping countries develop goals and plans to ensure that deprived groups share fully in progress towards the health-related MDGs
- advocating at the global and regional levels, that developed countries live up to their part of the compact, especially by acting on those elements of Goal 8 that are of central importance to the MDGs.

WHO supports national and regional efforts to achieve the MDGs through an extensive body of normative and technical work, through building systems to track progress and measure achievement and to co-ordinate technical collaboration.

WHO works with other organizations of the United Nations system to identify indicators for each health-related MDG and target. WHO also monitors core health indicators, as well as indicators for other areas of public health that help explain progress (or lack of it) in the achievement of specific goals at country level. These include immunization coverage for new antigens, prevalence of risk factors for non-communicable diseases, effectiveness of interventions against these diseases, and impoverishment of households through health payments.

WHO strengthens technical collaboration with countries. Strengthening WHO's presence in countries is a major priority, and collaboration with countries on meeting MDG targets is a central thrust of WHO's commitment to help bring measurable health improvements on the ground. WHO, with the World Bank, coordinates the High-Level Forum on the Health MDGs. The High-Level Forum brings together senior officials from developing countries, ministers of health and finance, economic planning and local government, bilateral agencies, multilateral agencies, foundations, regional organizations and global partnerships. The aim of the High-Level Forum is to provide an opportunity for candid dialogue and identify opportunities for accelerating action on the health-related MDGs (2).

Many countries are on track for achieving at least some of the Goals by 2015. Between 1981 and 2001, according to World Bank estimates, the number of people living in extreme poverty dropped from 1.5 billion to 1.1 billion. Moreover, between 1990 and 2002, child mortality rates fell from 92 deaths per 1,000 live births a year to 73. Life expectancy rose from 62.5 years to nearly 64 years. An additional 10 percent of the developing world's people received access to water. And an additional 14 percent acquired access to improved sanitation services. But progress on the Goals has been far from uniform. (3)

There are huge disparities among and within countries. Some countries are on track to meet most, if not all, of the MDGs and many will reach at least some of the MDGs. Sub-Saharan Africa is the epicentre of crisis, with a continuing rise in extreme poverty and stunningly high child and maternal mortality rates. Asia is the region with the fastest progress, but even there hundreds of millions of people remain in extreme poverty. Other regions have mixed records: in Latin America, the Middle East, and Eastern Europe there has been slow or no progress on some of the Goals and persistent inequalities undermining progress on others (3).

Although WHO recognizes the crucial importance of MDGs, it also warns that they do not say everything that needs to be said about health and development. The MDGs do not specifically refer to the

importance of effective health systems, essential elements to achieve all health goals, or to reproductive health or communicable diseases. While some countries have made impressive gains, many more are falling behind. Progress is particularly slow in many countries of sub-Saharan Africa. Nearly 11 million children under the age of five die every year. Some reduction has taken place but not enough. In 16 countries, 14 of which are in Africa, levels of under-five mortality are higher than in 1990.

More than 500,000 women die in pregnancy and childbirth each year, despite increases in the rate of attended deliveries in South-East Asia and North Africa. Maternal death rates are 1000 times higher in sub-Saharan Africa than in high income countries. The worsening global pandemic of HIV/AIDS has reversed life expectancy and economic gains in several African countries (2)

WHO states that while more resources are needed, they are only part of the picture. Current health spending in most low-income countries is insufficient for the achievement of the health MDGs. Progress will equally depend on getting policies right; making the institutions that implement them function effectively; building health systems that work well and treat people fairly and ensuring there are enough staff to do all the work. (2).

Table 2 Prospects of selected countries to meet the MDGs

Country	MDG1 Poverty	MDG2 School enrolment	MDG3 Equality in school	MDG 4 Child mortality	MDG 5 Maternal mortality	MDG6 HIV/AI DS, TB incidence	MDG7 Water access
Albania		Unlikely	Likely	Unlikely	Likely	Unlikely	Made some progress, but hard to tell

Bosnia and Herzegovina	Inadequate date to predict	Made some progress, but hard to tell	Inadequate date to predict	Likely	Likely	Made some progress, but hard to tell	Inadequate date to predict
Bulgaria	Likely	Made some progress, but hard to tell	Made some progress, but hard to tell	Likely	Likely	Unlikely	Likely
Croatia	Likely	Likely	Likely	Likely	Likely	Made some progress, but hard to tell	Made some progress, but hard to tell
Macedonia FYR	Inadequate date to predict	Made some progress, but hard to tell	Made some progress, but hard to tell	Likely	Likely	Likely	Inadequate date to predict
Moldova	Unlikely	Made some progress, but hard to tell	Likely	Unlikely	Likely	Unlikely	Made some progress, but hard to tell
Romania	Unlikely	Likely	Likely	Likely	Likely	Unlikely	Unlikely
Serbia and Montenegro	Inadequate date to predict	Likely	Inadequate date to predict	Likely	Likely	Made some progress, but hard to tell	Inadequate date to predict

Source: *Achieving the Human Development MDGs in ECA*, World Bank, 2003. (4)

Exercises

1. Small groups discussions on progress of countries progress towards achieving MDGs and plenary presentations.
2. Describe country programmes tailored to meet the MDGs.

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Recommended readings:

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	The public health strategy of the EU
Module: 2.4	ECTS (suggested): 1.5
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Keywords	Public Health, European Union, history, legal basis, policy development, Open Method of Co-ordination (OMC), European constitution
Learning objectives	Applying the content of this module the student will be able: <ul style="list-style-type: none"> • to identify key areas of EU's involvement to complement national policies in the field of public health; • to oversee present developments, such as the implementation of the European constitution and the Open Method of Co-ordination; • to put the own professional field in relation to European fields of action.
Abstract	European activity in the field of public health started late, and the diversity of public health systems makes the development of common strategies more difficult than in other fields. The legal basis of EU's action in the field of health is fairly basic and simple but implies a broad and strong impact not only for health related matters but also for other political fields. EU's activity in the field of health is based on a public health point of view and complementary to national activities. Since its start in special fields it has grown into whole programs but constantly

	limited by member states' responsibility to organise public health systems. The content of the present legal provisions is only marginally changed in the draft constitution. Still, the importance of European health strategies is growing, especially within the framework of the Open Method of Co-ordination which becomes even more important in the light of the enlargement of the European Union.
Teaching methods	Lecture, individual work, group work
Specific recommendations for teachers	This module should be organised within 1,5 ECTS, out of which one third will be under the supervision of teacher, and the rest is individual students work. After an introductory lecture the student should become familiar with information sources of the European Commission at the internet or by ordering through common mail. By looking for related EU legislation the student can become aware of the relevance for her/his field of profession (individual work). Results can be presented and discussed in groups.
Assessment of students	Presentation or essay discussing the national or professional impact of one particular field of EU's Public Health Policy.

THE PUBLIC HEALTH STRATEGY OF THE EU

Thomas Hofmann

Key players and frameworks

From a political perspective the recent years have been very remarkable when looking at EU's public health strategy. For the first time approaches have been taken which go beyond legal and administrative actions. At the same time, health moves away from a marginal position within the various sectors of the EU administration and becomes subject of other interested sectors, especially finance and economy. Debates on values and perspectives have already started. Member States are also struggling in defining their positions somewhere in between appreciating a strong EU policy for the sake of health benefits and protecting national values and sovereignty.

Linked to that is the very confusing relationship between the EU (European Union, based on the treaty of Maastricht in 1993) and the EC (European Community, based on the first treaty in 1952). The creation of the European Union in 1993 did not abolish the European Community, but complemented it. The European Community can only act on the basis of its legislation, the European Union can act upon any kind of agreement between the Member States. The actor of EC's action is the European Commission, the actor of the European Union is the respective member state as presidency. It is clear that strategies can be developed in both ways – administratively or politically.

In the absence of legal and political action, the obvious need for regulations on a EU level created other (third) modes of action. For many years, the European Court of Justice determined some cornerstones of European integration. As this happened without Member States involvement this phenomenon is also called "negative integration". Any other political approach is consequently called "positive integration". But still, legal instruments make up the biggest part among strategic fields in the health sector.

Legal instruments

Going back to the roots of the European Community, the Treaty of Rome in 1952 did not provide any legal basis for public health activities. The first so-called “action plans” started in 1987 on the basis of the Single European Act. Action was taken to prevent cancer, AIDS and drug consumption and trafficking. Still, there was no basis for European legislation in the health sector. Only in 1993, the Treaty on European Union (TEU - the Maastricht Treaty) created the first legal competence for the Community. Article 129 foresees the co-ordination of health programmes and policies of the Member States, a significant focus on prevention of diseases, the obligation to combat major health problems (e.g. drug dependence) and the Community’s co-operation with other organisations. It outlines as well the criteria which allow the definition of priorities of action (1):

- a disease's impact on mortality and morbidity;
- a disease's socio-economic impact;
- how far a disease is amenable to effective preventive action;
- and, of particular importance, how far there is scope for Community action to complement and add value to what is being done by the Member States.

The Treaty of Amsterdam amended and extended the article (now 152 - see table 1) of the EC Treaty. According to the treaty, the protection of human health is now to be ensured in all Community policies and activities, both in their definition and in their implementation. The meaning of the new article also goes beyond the prevention of illness and disease, including the improvement of public health and the obviating of sources of danger to human health. The Community's public health policy is seen as subsidiary to the Member States' effort. At several points, the Article emphasises the Member States' responsibility for organising the delivery of health care, including action in the public health field.

Table 1 Art. 152 Treaty of the European Union

<p>1. The Community shall complement the Member States' action in reducing drugs related health damage, including information and prevention.</p> <p>2. The Community shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action.</p>

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.

3. The Community and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. The Council, acting in accordance with the procedure referred to in Article 251 and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting:

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) by way of derogation from Article 37, measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

(c) incentive measures designed to protect and improve human health, excluding any harmonisation of the laws and regulations of the Member States.

The Council, acting by a qualified majority on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.

5. Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

Source: <http://www.europa.eu.int>

Besides this article which refers exclusively to health, legislation in other fields can be considered as having potential impact on public health. Some examples are:

- Art. 3 (The activities of the Community shall include... "a contribution to the attainment of a high level of health protection".);
- Art. 30 - trade - (Allows member states to prohibit the marketing of products from other EU countries to protect public health, but only where there is scientific evidence in support, and as long as it is not a disguised restriction on trade.);

- Art. 95 (3) - internal market - "The Commission, in its proposals ... concerning health, safety, environmental protection and consumer protection, will take as a base a high level of protection, taking account in particular of any new development based on scientific facts.");
- Art. 174 - health and environment - ("Community policy on the environment shall contribute to pursuit of the following objectives: preserving, protecting and improving the quality of the environment, protecting human health, ...);
- Art. 39 and 46 - free movement of workers -, Art. 137 - worker's health and safety - and Art. 153 - consumer policy -

In the fields of Common Agricultural Policy (CAP) and Common Transport Policy (CTP) health is surprisingly not mentioned.

The draft constitution for Europe

The draft Constitution for Europe of 18 June 2004 is expected to be signed before the end of this year and to come into force in 2006, after ratification through the Member States. A complete different legal system is now being introduced. Health can now be found under the umbrella of social protection, too, especially regarding access to health care (Art. II-34 and II-35). The multi-sectoral aspects of health and social protection are now also mentioned in Art. III-2a. After controversial debates -trade in (health) services- stayed within the Member States' competence respectively under the principle of unanimity (Art. III-6 and III-217). For the first time, co-ordination processes such as the Open Method of Co-ordination (OMC, see 5.) became their formal legitimisation in Art. III-107. For that article a declaration by the Member States has been made that any co-ordination never aims at harmonisation. It is important to note that this formally introduces a new political approach of integration besides the present legislative and administrative approaches provided in the EC treaty, e.g. drafting of directives and recommendations.

The core elements of previous Art. 152 are now included in Art. III-179. Some aspects have been added:

- mental health in addition to physical health (III-179-1);

- the development of standards and indicators, the exchange of best practices and monitoring as possible measures initiated by the Commission (III-179-2);
- shifting more competence to the Commission in the field of quality and safety of treatment based on biological substances donated by others such as blood, tissues and organs (III-179-4a and b);
- pharmaceuticals and medical products are no longer only internal market affairs but also health affairs (III-179-4c);
- cross-border health threats, especially through infectious diseases and bioterrorism, are now shared competence of the Commission and the Member States (III-179-4d);
- strategies to tackle diseases which are of concern of more than one member state, explicitly tobacco and alcohol related diseases, are now shared competence, too (III-179-5).

Objectives of European Commission's health programmes

The European Commission's public health department (Directorate G alias SANCO) with about 120 employees is split into four units and located in Luxembourg. It is integrated into the Directorate General (DG) for Health and Consumer Protection with about 600 employees which is one of 26 DG's. The units show a very slim structure and a strategic organisation (2). In the legislative process the Commission has the monopoly of making proposals like in other fields.

The Commission has several agencies. The most important to be mentioned in the field of health are the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon and the newly created European Centre for Disease Prevention and Control (ECDPC) in Stockholm.

Up until 2000, eight different programmes of Community action in the field of public health were set up. The areas of these action programmes have now been merged to one global action programme from 2003 until 2008 with a financial framework of 312 million Euro. The general objectives of the programme are described as (3):

- to improve information and knowledge for the development of public health (health information);
- to enhance the capability of responding rapidly and in a co-ordinated fashion to threats to health (health threats);
- to promote health and prevent disease through addressing health determinants across all policies and activities (health promotion).

This action programme includes the previous action programmes for health promotion, cancer, AIDS and other communicable diseases, drug prevention, health monitoring, pollution related diseases, rare diseases and injury prevention. Activities such as networks, co-ordinated responses, sharing of experience, training and dissemination of information and knowledge are planned. In order to support the Commission services the High Level Committee on Health has been established as an informal advisory body. It consists of senior officials from the health ministries of EU Member States and Candidate Countries.

Open Method of Co-ordination (OMC)

In 2004, a very outstanding process in the field of health had its start. In April, the Commission submitted a document which introduces the "Open Method of Co-ordination" (OMC) as a measure to support national strategies in health care and long term care. Originally developed in the field of EU's social policy since 1997, OMC has been aimed, after the Lisbon Summit 23 and 24 March 2000, to allow action in the field of health in areas where competence was not clear between the Community and the Member States. Generally, OMC goes in parallel to Commission activities. It ideally promotes the principles of subsidiarity and decentralisation. Without any legal basis it only exists out of the Member States' commitment. OMC's procedure is similar to any benchmarking process. The Council of Ministers decides measures which should be reflected in national policy. The Member States present their efforts in reports to the Council and the Commission. The Council formulates recommendations to be taken into account by the Member States and so on (4).

Any strategy developed within this new framework should respect three principles: access, quality and financial sustainability meaning:

- promoting universal access, adequacy and solidarity, reducing social, ethnical and regional exclusion, developing palliative care and adjusting the supply of qualified health care workers;
- assessing health technology, pharmaceuticals and therapeutical standards, promoting life-long learning, streamlining the co-ordination of administrations and stakeholders in the field of health, determining rights of patients and raising awareness of gender specific needs in prevention and health policy;
- promoting prevention strategies for all age groups, improving co-ordination of health care providers, introducing incentives to reward cost-saving behaviour and developing mechanisms to cope with the financial challenges of an ageing society.

In a first phase the 25 member states should present reports on national challenges until 2005. In a second phase the Commission is going to assist the member states in defining development and reform strategies for the years 2006 to 2009. A first evaluation will be presented in the framework of the report on social protection and social inclusion in 2007. The relevant body for the whole process will be the Social Protection Committee (SPC) (3).

There is apparent need for measurable standards and indicators at the same time. Hence, extensive discussions on methods and fields of indicator development go in parallel. International comparisons in the field of health are a very sensitive issue, all the more as EU indicators are going to be even more relevant for EU Member States than existing indicators published by OECD or WHO. In a first round, the Member States were invited to submit proposals on certain indicators in the above mentioned three fields: access, quality and financial sustainability. The discussions as part of the OMC process will continue on that basis in various bodies.

Perspectives of EU health policy and international co-operation

Despite the limits set by Article 152 the importance of the European Union in the field of health has increased. As health threats are becoming more complex and internationally linked, the need for

strong international action becomes greater. Not only in certain fields but also in international processes and negotiations the European Union has taken an outstanding role.

To achieve international goals, the European Union has cooperated with the WHO both the headquarter in Geneva and the Regional Office in Copenhagen based on a Memorandum of Understanding for many years. Joint strategies in the field of communicable diseases, health information, risk reduction, trade and health, research and health, health and development and environment and health are in the main focus (5).

Also for many years, the European Union is collaborating with the Council of Europe, especially in the fields of: equity in health, health information, the impact of information technologies on health care, the media and health, health promotion, quality and safety of organs and substances of human origin, blood and blood derivatives and drug dependence. A very famous example of this collaboration is the European Network of Health Promoting Schools.

Similar agreements have been made with the OECD in the field of health monitoring and health data collection, since the EU has the unique status of a full participant under the founding convention of the OECD.

At 15 July 2004, EU-Commissioner David Byrne presented a new EU health strategy called "Making health for all possible" as a basis for discussion with the Member States. Doubtlessly, it has its roots in the WHO Health for All and Health 21 strategy. A great emphasis in this new document is put on: partnerships and involvement of citizens, health promotion, health and well-being, economic impact of health markets and population's health status, HIV/AIDS, tobacco-related harm, nutrition, environment, healthy lifestyles and research. The Commission is defined as catalyst for change to achieve better health and as leading actor in the field of health far beyond European borders. In order to be able to fulfil this role, health should move in the centre of EU policy making. The Commission's Public Health Action Programme should more actively be used to gain knowledge and to make policies. Information systems should support the spread of knowledge and best practices (3).

The approach of that proposed strategy seems to be very ambitious. Shared competence between Member States and other international organisations is not defined yet. Regarding the fact that the EU Member States make up half of WHO EURO region, conflicts of interests seem to be obvious, especially in the areas of: infectious diseases, environment and health, macroeconomics and health, preventive strategies and information systems. Member States are very cautious when it comes to duplicative work of international organisations which means the final version of this strategy seems to be far away.

Conclusions

Compared to other policies, health as topic is climbing up in the priority agenda of the European Union, but still with minor regulatory power and far away from justifying enthusiasm. The main part - together nearly 90% - of the EU budget is spent on agricultural policy and so-called structural operations. Remarkably, the Commission's health services are located in Luxembourg away from the more powerful services in Brussels. The OMC certainly helps the EU health strategies to gain attention internally, in comparison to national institutional health services and to the economically powerful national health care systems. But as health grows in importance the conflicts with economic and financial interests are growing, too, and of course vice-versa. Recently, several attempts could be observed where financial and economic services of the Commission tried to determine EU's health agenda. And introducing the OMC the same debates on a national level could be found in the Member States when they defined their positions. Therefore, some experts regard the draft constitution as still being too weak from a health perspective and as economy driven. They are also pointing out that there is ongoing lack of social aspects in the various political fields (6). Some even see the OMC as victory of commercial powers within the Commission as it allows extensive control in the future (7).

Others are more optimistic and regard the present steps which have been taken as being in time (8). They also expect great gains from more co-ordination (9). As European health policy is continuing to be organised according to the principle of subsidiarity it increasingly can discover gaps which can't be filled through national activities (10).

The recently announced new public health strategy although it might be too ambitious can certainly provide some guidance pointing out the need for EU health strategies (11). And this need is continuously increasing, not only in the course of enlargement, but generally in all Member States. Increasing differences in health status and life expectancy between European countries and between population groups within countries can't be neglected. And regarding the fact that the countries with the most expensive systems are not necessarily the ones with good health status of the populations they are made for, call not only for further analysis but for action other than cure. The soft law which is going to be created through OMC is going to play an important role. Soft law in that context can be built out of recommendations and unsolicited agreements which are formally non-binding but create an international and diplomatic pressure to be applied.

Moreover, the development of EU health strategies will always be debated as it interferes with national health strategies and touches national sovereignty (12). But alongside European integration processes concerning trade and internal market affairs, health needs strong mechanisms as well. This led the Member States to their agreement to introduce OMC. In addition, issues such as "trade in services" or "patient mobility" can't neither only be discussed on a national level nor solved with legislative measures at that stage.

It will be a challenge for present and future Member States to draw attention to the specific needs of their regions and to uphold their social values versus economic gains. This very ambitious approach can only be reached in little steps. In pragmatic terms, the Commission and the Member States should further pay attention to the core competence of European health policy when defining their strategies. Among those are certainly the area of research, strengthening regions and creating competence. Arguments that underline the economic benefit of public health strategies need more

scientific evidence and international multi-sectoral approaches. The new EU strategy seems to tackle the poor evaluation of the public health programmes and to underline their focus on the proof of evidence. The interregional networking of research institutes which is required in any of EU's application procedure bears great potential for the international development of public health. By doing so, regions especially in the light of globalisation keep their outstanding role.

Exercises

Search for or order the Draft Constitution of the European Union and discuss the potential impact to the various articles for the public health strategies in your country/region.

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Internet Links

European Union web-based information guide
<http://www.europa.eu.int>

Community Research and Development Information Service:
www.cordis.lu

Enlargement: <http://europa.eu.int/comm/enlargement>

European Monitoring Centre for Drugs and Drug Addiction:
www.emcdda.org

EUROSTAT: <http://europa.eu.int/eurostat.html>

Framework Programme for Research and Development:
<http://europa.eu.int/comm/research>

New EU health strategy (draft by Commissioner David Byrne of 15 July 2004):
http://www.europa.eu.int/comm/health/ph_overview/strategy/health_strategy_en.htm

Regional Policy: www.inforegio.org

Recommended readings

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Public Health Associations and Civil Society's Voice for Public Health
Module: 2.5	ECTS (suggested): 0.5
Author(s), degrees, institution(s)	<p>James Chauvin, MA, MSc. Director, Global Health Programs Canadian Public Health Association</p> <p>Margaret Hilson, RN, MSc. Senior Policy Advisor, Global Health Programs Canadian Public Health Association</p> <p>Chris Rosene Coordinator, Strengthening Public Health Associations Project, Global Health Programs Canadian Public Health Association</p>
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Keywords	Public health, policy making, voluntary health agencies
Learning objectives	After completing this module students and public health professionals should have a greater appreciation for the important role played by public health associations in promoting public health and supporting the formulation of sound public health policy and programs. Students and public health professionals should also be interested in joining a national public health association in their country or, if one does not exist, become involved in the process to establish one.
Abstract	One of the key contributing factors to the

	<p>“health of a nation” is the capacity of a public health system to identify and respond in a timely and adequate fashion to those situations that affect health and well-being. A non-governmental, voluntary membership professional public health association (PHA) is a crucial means of enhancing and reinforcing the capacity of civil society to influence public policy and programs. In Central and Eastern Europe, PHAs are emerging as a credible advocate for public health. But more effort needs to be invested in establishing PHAs where they do not already exist and in nurturing their operational and performance capacities. If national PHAs are to become civil society’s voice for public health, then they must be able to attract and engage members from a broad spectrum of disciplines on a sustained basis.</p>
Teaching methods	<p>This chapter should be accompanied by a discussion about the important role PHAs and other NGOs can and do play in public health development. A set of questions is provided at the end of the chapter as a discussion guide.</p>
Specific recommendations for teachers	<p>Use as a means of generating discussion among students about the role of voluntary professional health associations in policy and program development and public health. This module takes: 3 hours lecture, 4 hours supervised group discussion, and 8 hours group work on the assignment.</p>
Assessment of students	<p>Case problem presentation</p>

PUBLIC HEALTH ASSOCIATIONS AND CIVIL SOCIETY'S VOICE FOR PUBLIC HEALTH

James Chauvin, Margaret Hilson and Chris Rosene

The health of a population is influenced by the political, social, economic, physical and technical environments, personal health behaviour and practices, individual and community coping capacity and skills, human biology, as well as by the availability, appropriateness and quality of health services. One of the key contributing factors to the "health of a nation" is the capacity of a public health system to identify and respond in a timely and adequate fashion to those situations that affect health and well-being. The active participation of civil society in advocating for appropriate and timely policies and programs that have a positive impact on individual, family and community health and well-being is a component of what is termed the "new public health" (1, 2).

A non-governmental, voluntary membership professional public health association (PHA) is a crucial means of enhancing and reinforcing the capacity of civil society to influence public policy and programs. A public health association plays a leadership role in increasing the visibility of public health as an essential component of a nation's health system by galvanizing support through its capacity to convene people and organizations into partnerships for consensus-building and action. It provides a forum for open discussion and debate from a wide range of professional skills and interests, both from within and outside of the health field. It facilitates input from dedicated front line public health professionals and allied workers who wish to have a voice on issues that go beyond their everyday professional lives or for which they are unable to express an opinion in their capacity as an employee. A PHA provides an entry point for a politically non-partisan, credible, independent voice to both the public as well as to key decision-makers by generating scientific, evidence-based knowledge upon which to base advocacy in the health sector.

Advocacy is a core function of a public health association. Advocacy is the process of influencing outcomes, including public policy and resource allocation decisions within political, economic, and social systems and institutions that directly affect people's lives. Advocacy consists of organized efforts and actions that seek to highlight critical issues, to influence public attitudes, and to push for the enacting and implementation of laws and public policies so that visions of "what should be" in a just society become the reality. Advocacy has purposeful results: to enable people and communities to gain access and voice in the decision making process of relevant institutions and organizations; to change the power relationships between these institutions and the people affected by their decisions, thereby changing the institutions themselves; and to bring a clear improvement in people's lives (3). (The Advocacy Institute: <http://www.advocacy.org/>)

PHAs are composed of individuals with substantial experience and knowledge on public health issues in their countries. They have the ability to mobilize the membership and support from key stakeholders. Public health associations also offer a "voice from the community" on important public health issues. The association's membership is the central character of the PHA; it is the driving force behind what the PHA defines as its foci for advocacy and action a PHA is accountable to their members.

I had a vision of a democratic, professional membership public health association well before the demise of the Ceaușescu regime. It was a dream - to create an open forum where public health professionals from across Romania could come together to discuss issues and find solutions to important problems - they were the people of the front lines - they had the information we at the Ministry of Health required to create policies and programs. Looking back over the past 10 years, I believe we made that dream a reality - maybe not a perfect one, but we created an Association that made a difference.

Prof. Dr. Dan Enachescu, founding member and first President of the RPHHMA and former Minister of Health, interviewed in August 2000.

Over the past twelve years, public health associations have been established in several countries in Central and Eastern Europe, parallel with the political and socio-economic transition process. Some

PHAs evolved from already existent “societies of social medicine” while others were founded as new national non-governmental organizations. Some PHAs, such as those in Poland, the Russian Federation and Romania, have existed for several years, gaining considerable experience and being active in policy and program advocacy and public health applied research on particular public health issues; others focus on providing members of the national public health community with information about public health issues through newsletters, workshops and conferences (4, 5). A few PHAs, such as those in Bulgaria and in Serbia & Montenegro, were established recently and are just “getting on their feet”.

Many of the PHAs in Central and Eastern Europe reach beyond the traditional fields of “social medicine” and “sanitation and hygiene”. They are neither unions nor syndicates, nor do they represent the professional interests of any particular health sciences speciality. The new PHAs transcend conventional disciplinary boundaries, bringing together professionals and allied workers from a wide range of health sciences fields and as well from non-medical disciplines. They reach out to and create coalitions and alliances with other organizations and sectors, such as housing, employment, agriculture and industry, education, and transportation, as a means of dealing with a wide range of health determinants, many of which are beyond the influence of the “health system”. They are also linked and active in regional and international public health networks, such as the European Public Health Association (EUPHA) and the World Federation of Public Health Associations (WFPHA) (6).

Since 1985, with financial assistance from the Government of Canada, the Canadian Public Health Association (CPHA) has helped establish and provided technical assistance and support to almost 30 public health associations around the world. In Central and Eastern Europe, CPHA carried out projects in the Russian Federation, Romania, and most recently in South East Europe (Serbia & Montenegro, Bosnia & Herzegovina and the UN-administered province of Kosovo). Through these projects, local public health communities succeeded in establishing national public health associations that contribute to the development of policies and strategies for the improvement of the public’s health on several important issues, such as mother and child health, sexual and

reproductive health, tobacco control, ethics and human rights/patients rights, HIV prevention and AIDS care and support, essential public health functions, globalization and health, and community-based primary health care services. The public health association partners contribute to the development of frameworks for new public health policy and programs, and as well to intersectoral and inter-institutional approaches and action to address public health issues. They also serve to demonstrate the important and critical role that civil society can and should play in advocating for sound public health policy and programs.

There are several key lessons that can be drawn from this collaborative experience about the factors that affect the capacity of national public health associations to sustain their leadership role in public health:

1. A PHA does not replace government ministries or institutions

The Indonesian Public Health Association was founded in 1974. Early on in its organizational life the IPHA established a constructive relationship with the Ministry of Health. The IPHA became a member of the Ministry's public health leadership development team, the country's only professional organization to be invited to do so. The IPHA also advised the Ministry and the National Planning Board on the contents of the national health budget. The IPHA became a permanent member of the Consortium for Health Sciences convened by the Ministry of Education, responsible for the planning, standardization and evaluation of health science education.

Report by IPHA President Alex Papilaya to the Partners Around the World Workshop, 1994

The objective is not to diminish or replace government's important leadership role in public health. Governments should play the lead role, defining the public policy that supports the

attainment and maintenance of the "nation's health", enacting and applying appropriate legislation and regulatory frameworks, and delivering essential public health services and functions that protect the health of the country's people. But the role that government can or should play can often be constrained by political and other considerations.

The role of the PHA is to advise government as to what sound public policy, programs and best practice should be. Working from the basis of the “determinants of health”, a PHA brings to the attention of decision-makers the voice from the public health community. A PHA can become engaged on public health issues and subjects that may be too politically sensitive for the Ministry of Health. It can mobilize its members, who represent a variety of opinions and perspectives, to prepare credible and relevant information upon which government can base its decisions. This does not mean that a PHA does not challenge government about policies and programs. But it does so through constructive dialogue and credible evidence rather than through confrontation.

2. Credibility, truthfulness, and relevance are keys to creating a persuasive voice for civil society

The PHA has to develop its capacity to respond on a timely basis with factual, useful information, and to develop its readiness to act when called upon to assist with various initiatives. It develops a “sense” of what the issues are and is politically sensitive to the needs of the Ministry and the population. PHAs conduct “environmental scans” about public health issues and situations in their locations, to determine what is being done/not being done, by whom and with what resources. It also has to be sensitive to and realistic about its own institutional capacity, to understand what it can “take on” at any one time in order to provide scientifically-grounded and relevant information.

3. Volunteerism is important, but not a panacea for success

The Uganda National Association for Community and Occupational Health, founded in 1987, identified membership engagement as a major challenge. By creating committees and working groups, and by providing members with both the responsibility and the authority for decision-making, the Association was able to recruit and retain and active membership.

By their very nature as membership-based organizations, national public health associations depend on the voluntary, in-kind contribution by their

members. This is the driving force of a PHA. Participation goes beyond volunteers sitting on a Board; it implies the active participation of members in all aspects of the Association's life. They provide operational support, sit on working groups and task forces, prepare position papers, and identify sources of in-kind and financial contributions in support of activities. Even if a PHA is "cash-poor", the dynamism of its membership will support its "sustainability".

But complete reliance on volunteerism is not sufficient for "sustainability". There is a need for paid staff dedicated to managing the operations of a public health association and to put into place a practical marketing and fund/revenue generating strategy for the public health association. A PHA has to raise sufficient income to support staff salaries and functions once initial external support for core functions ends. It also has to demonstrate the "value added" of a small efficient and effective secretariat, as an essential component for successful public health programs.

4. High visibility and recognition of the leadership role of a public health association is critical to ensuring its relevance and sustainability

Developing leadership within a PHA is very important. The PHA has to demonstrate its capacity to assume leadership on specific public health issues when the opportunities arise. Developing and nurturing its capacity to prepare scientifically-based credible responses to existing and emerging public health situations that provide information relevant to policy and decision-makers within the Ministry of Health and for other health sector stakeholders is very important. PHAs can accomplish this by publishing timely health sector issue papers and convening scientific conferences. The establishment and operations of public health resource centres, as sources of up-to-date, accessible information on public health, have also served to improve the visibility and relevance of national PHA (7).

A PHA is not the same as other health sector professional organizations. It does not carry out the functions of a nursing or medical association which, in most countries, act as registrars and licensing bodies, and protect and defend the work-related and

Although direct financial support from the Canadian Public Health Association ended in 2000, The Russian Public Health Association, founded in 1993, continues to be actively engaged in public health policy and program issues. It chose to focus its efforts on one priority public health issue: tobacco control. Over the past several years, it has established itself as a credible advocate and important national resource on this issue. It implemented the country's first Global Youth Tobacco Survey in Moscow, and in 2003 conducted a qualitative survey of youth with respect to attitudes and behaviours around tobacco and smoking. The results of these two surveys have been used to advocate for stronger youth-oriented tobacco control policies and legislation. The RPHA convened the first Conference on Tobacco Control in Russia in May 2004 and the first Conference on Tobacco Control among the Russian Military in December 2004. The RPHA's advocacy efforts also contributed to the decision by the Government to ratify the FCTC.

professional interests of a specific member group. PHAs are not "unions" for public health workers. Rather, the PHAs represent a broad-based

membership of people interested in public health. PHAs act as advocates providing a powerful voice and organizational structure for the advancement of measures for the promotion and protection of health and the prevention of disease.

A PHA has to demonstrate its "value added" and comparative advantage vis-à-vis other health sector organizations. It does not "deliver" public health services; but it does pave the way for sound public health policy and programming decisions that support such services. A PHA also contributes to creating the building blocks of an effective, comprehensive and responsive public health system, which forms a cornerstone for effective, accessible and good quality primary health care and curative health services. Developing a practical PHA business/marketing strategy is very important (8).

5. Public health associations have to provide a real benefit to their membership in order to retain and attract new members and to promote and sustain their volunteerism

A PHA's membership is its most important resource. The membership is involved actively in decision-making about PHA

policy and programs. As with most membership associations, the members perceive benefits from their association with the organization. The PHA gives them prestige, access to information, new knowledge and skills and continuing education, and also provides them with a forum for raising public health concerns and issues that affect their local communities, as well as their region or country.

It is therefore critical that each PHA is able to deliver tangible “benefits of membership” that are valued by the members. Otherwise, the PHA runs the risk of losing membership and not attracting new members and the relevance of the PHA is put into question.

6. It is difficult to advocate all alone; creating a collective voice is very important

The Public Health Association of Turkey realised that, on its own, it would have a limited impact on influencing health policy. It organized a consultative meeting and asked each NGO to complete a questionnaire about their respective interests in public health. Participants from twenty three organizations discussed priority public health issues and areas for potential collaboration. As a result of this meeting, a national coalition for tobacco control was formed, which has since had a major influence on tobacco control policy and

Building advocacy capacity is a labour-intensive process. Building and nurturing a credible, constructive engagement and dialogue requires patience, pragmatism,

diplomacy, and evidence-based information. By building consensus on issues, PHAs can nurture coalitions and alliances with other like-minded organizations. A united “voice of many” is stronger than a single voice.

7. Organizational capacity development takes time

Legally establishing a PHA is only one step in the process of contributing to the creation of a “civil society voice” in public health. Setting up a democratic, transparent and accountable governance structure and process, policy and procedures/practices takes considerable time and effort. Creating and maintaining an active,

engaged and supportive membership base also requires considerable effort and time. Creating a “culture of engagement” demands concerted effort. Moving away from a didactic approach at conferences and workshops to a “knowledge generation and learning” mode requires a new approach to “thinking and acting differently”.

Although the path of institutional development and capacity building is neither linear nor steady, they are complementary. Progress may be uneven, due to the context within which the PHA exists. Many external and internal factors affect the rate of achievement of the PHA’s objectives and its capacity to function effectively. PHAs need to be realistic about the situation within which they exist and the constraints that they face.

8. Linking with the global public health community contributes to making a national PHA visible and vibrant

Becoming involved in regional and global public health issues is one means of strengthening the capacity of a national PHA to influence domestic issues. In the case of PHAs in Central and Eastern Europe, membership in and active participation within the European Public Health Association and the World Federation of Public Health Associations can benefit it on the national front. For example, the WFPHA played a leadership role in advocating for support of the WHO’s Framework Convention for Tobacco Control (FCTC). Through its global affiliation, the WFPHA galvanized its members (national PHAs) to become strong advocates for the signature and ratification of the FCTC in their respective countries. At the same time, national PHAs in many countries exchanged information about tobacco control strategies. In some cases, for example, through CPHA’s *Strengthening Public Health Associations Program*, PHAs received technical and financial support to enhance their capacities to design and implement tobacco control advocacy strategies. Through advocacy at both the “macro” (international) and the “micro” (national) levels, the WFPHA and many national PHAs succeeded in successfully advocating for government support of the FCTC.

National public health associations play a very important role in building civil society’s voice in public health and for advancing thinking and action on public health issues, whether at the national,

regional or global levels. In Central and Eastern Europe, PHAs are emerging as a credible advocate for public health. But more effort needs to be invested in establishing PHAs where they do not already exist and in nurturing their operational and performance capacities. If national PHAs are to become civil society's voice for public health, then they must be able to attract and engage members from a broad spectrum of disciplines on a sustained basis.

Discussion guide questions

What do you think is the most important role that a national public health association can play in your country?

What would you identify as the principle areas for action/issues that should a public health association in your country be engaged in?

What would be the key challenges facing a national public health association in your country?

What would be the key opportunities and supportive factors for a national public health association in your country?

What do you see as your role within a national public health association?

Are you a member of a public health association? If so, why? If not, why?

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT	
A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Components of a Public Health Strategy
Module: 2.6	ECTS (suggested): 0.5
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Keywords	Health strategy, situation analysis, health status, health determinants, priority setting, action plan
Learning objectives	At the end of this exercise, students should: <ul style="list-style-type: none"> - be able to document a public health strategy - be able to draft a public health strategy - be able to design an action plan
Abstract	<p>Generally, the Health Policy provides the foundation for the Health Strategy. The Public Health Strategy provides a framework for planning and strengthening public health activities, programmes and services. It guides in working with the community, non-government agencies, local government councils and other government departments. The Public Health Strategy sets the platform for the Governments' action on health. It identifies the priority areas and aims to ensure that health services are directed toward those areas that will ensure the highest health benefits for the population.</p> <p>There is no general template to fill-in to facilitate the development of a public health strategy. However, there are some common components that can be noticed in almost all health strategies at European level:</p> <ul style="list-style-type: none"> • review of international and national health policies • situational analysis • goal and objectives (general and specific)

	<ul style="list-style-type: none">proposed action plan (activities, responsibilities, budgets, timeframe, expected results and follow-up indicators for each objective)
Teaching methods	Lectures, group discussions, group assignments.
Specific recommendations for teachers	This module takes: 3 hours lecture, 4 hours supervised group discussion, and 8 hours group work on the assignment. A working group will have no more than 6 students.
Assessment of Students	Each group will present the draft of a public health strategy.

COMPONENTS OF A PUBLIC HEALTH STRATEGY

Adriana Galan

There is no general template to fill-in to facilitate the development of a public health strategy. However, there are some common components that can be noticed in almost all health strategies developed at European level:

- review of international and national health policies
- situational analysis
 - › population health status assessment (non-communicable and communicable diseases, maternal and child health, environmental health, main health determinants, etc) ⇨ **list of health problems**
 - › health system status assessment (organisation, financing, existence of health insurance system, workforce, etc) ⇨ **list of critical issues**
 - › discussions on alternative dimensions for target-setting - such as diagnostic groups, determinants of diseases, target groups and arenas for action
 - › evaluation of available resources (managerial, technical, financial, political, mechanisms of inter-sectoral co-operation at national, regional and international level)
 - › guiding ethical values and principles (solidarity, universality, subsidiarity, equity, quality etc.)
 - › political will and support, driving forces (national policies and legislation, external support)
- goals and objectives (general and specific)
- proposed action plan (activities, responsibilities, budgets, timeframe, expected results and follow-up indicators for each objective)

Proposals for a health strategy produced by expert groups are not political documents and need to undergo a process of political

negotiation and public debate, which often results in substantial revisions of the original document or rejection of the proposals altogether.

The success of any public health strategy depends greatly on the process by which it has been developed (1). The process leading to the establishment of national goals is just as important as the goals by themselves. It is crucial for a successful strategy to be formulated through a democratic process, involving a continuous dialogue with those who will be subject to the strategy as well as those who will have responsibility for its implementation.

Review of international and national health policies

Achieving good health is not an issue for Health Ministers and health specialists alone. Health is closely interconnected with economic growth and sustainable development.

European Union recognised that it is time now for health to be put at the centre of EU policy making. Health should be considered as the driver of competitiveness and sustainable development, and positioning health as a driver of economic development is part of this process. With an enlarged EU of 25 Member States there are even clearer health and economic inequalities that must be urgently addressed (2).

In June 2000, the European Commission presented a communication on the health strategy of the European Community. This new strategy contains three main strands:

- improve health information for all levels of society
- create a mechanism for responding rapidly to major health threats
- address health determinants, notably harmful factors linked to lifestyle (3)

The Community action programme for 2003 - 2008 in the field of public health represents the cornerstone of the strategy, being an essential component of the European Community's health strategy.

Reviewing the documents elaborated by the European Commission, it is worthwhile to notice that generally, at European

level, a strategy in the field of Public Health should rely on some global approaches deriving from the new public health concept:

- develop and disseminate a system-oriented approach
- partnership-oriented approaches
- tailor interventions to the specific needs of communities
- integrate a policy orientation into public health practice
- apply a comprehensive strategy across diverse issues
- foster cross-disciplinary collaboration and strategy
- advocate for solutions that address multiple problems
- train and support the next generation leaders

Why is action needed at European level? There were depicted some overall dimensions characterising the European Community, claiming for urgent action (4):

- the growth of epidemics (AIDS, SARS, global obesity/tobacco, increasing risk factors, the threat of bio-terrorism, etc)
- the lack of sustainable health systems (lack of health care coverage of the poor, insufficient national capacities for public health in rich and poor countries, the dramatic fall of investment in universal health systems, lack of human resources)
- the socio-economic-political context (unstable world, new emerging poverty, people massive movement, negative impacts of globalization)
- the values (lack of value attached to human lives, lack of support for strong public systems, lack of support for new global financing mechanisms)
- the international actors (an ever denser network of actors with lack of transparency, increasing lack of accountability)
- health systems problems (focus on disease, a world of vertical programs and quick fix solutions, a tendency to invest in technologies and drugs and not in social protection, health systems and people)
- specific problems in new member states and accession countries (fewer resources to spend on health, serious health status problems - communicable, cardiovascular diseases; quality assurance and surveillance systems - e.g. blood,

pharmaceuticals, food and product safety; impact of free movement - health professionals, services, etc) (5)

Apart from the above-mentioned health strategy of the European Community, there is also the framework policy of the WHO European Regional Committee, Health21. The 21 Health For All targets set up by this policy document (6) represent the framework for developing health policies at national level in the European Region. Health21 also suggests strategies for attaining these targets. European countries are expected to adjust these targets in order to meet their own local conditions, needs and capacities. Many European countries have developed national health strategies based on the principles, vision, aims and targets included in the WHO Health21 framework policy document.

National health policy also provides the foundation for the national health strategy. The Public Health Strategy provides a framework for planning and strengthening public health activities, programmes and services. It guides in working with the community, non-government agencies, local government councils and other government departments. The Public Health Strategy sets the platform for the Governments' action on health. It identifies the priority areas and aims to ensure that health services are directed toward those areas that will ensure the highest health benefits for the population.

Situational analysis

Besides the review of international and national health policies, situational analysis represents an important step of the pre-planning phase for strategy development. It consists of an assessment of the profile of a population's health situation (can be a "target" population) and of the health care system in relation with the internal and external environment. The assessment can be done if there is available an appropriately defined and maintained set of health indicators.

The main goal of this step is to identify priority health problems based on valid criteria. Another important goal is to provide data and information necessary to design goals and objectives for the

strategy. Data and information collected during this step cover the following domains (7):

- assess the internal and external environment (review of economic, social and health objectives and policies) - SWOT analysis (see Framework for a common public health strategy of SEE)
- health status and related determinants assessment (mortality and morbidity rates, disability, burden of disease, life expectancy, lifestyle indicators, trends etc.)
- health system assessment (public/private institutions, accessibility for health care, population coverage with services, patient flow within the health care system, etc.)
- resources - human, material and financial

Table 1 presents a very suggestive proposal for a comprehensive health situation analysis. This method of assessment is used by Pan American Health Organization/WHO (8).

Table 1 **Examples of indicators used for the health situation analysis**

Environmental determinants	Health status indicators
<i>Indicators include:</i> population with access to services such as potable water, sewerage and excreta disposal, % of acceptable water analysis...	<p><i>Perceived health</i></p> <ul style="list-style-type: none"> • Satisfaction: % of the population 15 and over that report being dissatisfied with their social life • Quality of life: % of the population that report perceiving themselves in fair or poor health <p><i>Objective health</i></p> <ul style="list-style-type: none"> • Mortality Maternal mortality, infant mortality, mortality rates from communicable/non-communicable diseases..... • Morbidity AIDS annual incidence rate,
Social determinants	
<p><i>Demographic indicators</i> Population by age and sex, crude birth rate, fertility rate, urban population, life expectancy at birth....</p> <p><i>Socioeconomic indicators</i> Literate population (15+ years old), annual GDP growth rate, highest 20% / lowest 20% income ration, calories availability.....</p>	
Behavioural Determinants	

<p><i>Indicators include:</i> proportion of regular smokers, contraceptive use.....</p>	<p>cancer incidence rate, measles incidence rate.....</p>
<p>Health system-related determinants</p>	<ul style="list-style-type: none"> • Disability
<p><i>Indicators include:</i> human resources per 10,000 population, immunisation coverage in infants under 1 year old (%)......</p>	<p>Prevalence of different types of disability in a given population, average number of days per year lost to school, work, homemaking for a defined population.....</p>

Source: *Epidemiological Bulletin / PAHO, Vol. 22, No. 4 (2001) (9)*

If there is a functional and valid information system, health indicators constitute a fundamental tool that generates evidence on the status and trends of the health situation in the population. This means also documentation of inequalities in health, which may - in turn - serve as basis for the determination of population groups with the greatest health needs and identification of critical areas. If existing, health indicators facilitate further monitoring of health objectives and goals set up by a strategy or program.

The main output of this step is represented by a comprehensive background to document the strategy, offering a comprehensive picture of the existing situation. Data obtained through the situation analysis also provide a benchmark against which to measure future trends.

There are several methods described in the literature for problem identification. R.Pineault (7) has described three categories of approaches:

- based on existing health system indicators
- based on special surveys
- based on consensus research

In order to judge the identification of one problem, several criteria can be used:

- *problem's dimension* (usually its frequency within a population)
- *problem's severity* (usually measured by premature deaths, potential years of life lost, disability)

- *trends*

Priority setting process

Priority setting builds on the foundation created by the situational analysis and means to select those identified problems that can be the object of an intervention. It is actually a process of comparisons and decision-making, based on special methods and techniques for ranking the identified problems according to their importance. Limited resources require priority setting to address competing demands across health system

Three main criteria are commonly used in order to prioritise the identified problems:

- *problem's dimension* (incidence/prevalence, premature deaths, avoidable deaths, burden of disease, the size of the population at risk, the impact on medical services, family, society, etc.)
- *intervention capacity* (knowledge on the disease/associated risk factors, prevention possibilities)
- *existing resources for intervention* (existing services, qualified personnel, population accessibility to health services)

R.Pineault has grouped the priority setting (ranking) tools into two categories (7):

- ***specific methods for health planning***
 - › Grid Analysis
 - › Hanlon Method
- ***general ranking methods***
 - › Anchored rating scale
 - › Paired comparison
 - › Pooled rank

Goals and objectives

According to European Observatory on Health Systems and Policies, a goal represents a general aim towards which to strive; a statement of a desired future state, condition, or purpose (10). A goal have usually a broader deadline, and generally being long-range rather than short range. A goal should really represent the solution to an identified problem, being realistic at the same time. Goals should be

directed toward the vision and principles generally accepted; something the health system wants and expects to accomplish in the future.

According to the same European Observatory on Health Systems and Policies, an objective is: a measurable condition or level of achievement at each stage of progression toward a goal (10). Objectives carry with them a relevant timeframe within which they should be met.

If goal statements are generally vague, a well-designed objective will be Specific, Measurable, Attainable/Achievable, Realistic and Time-bound (SMART):

- **Specific** - an objective should address a specific target or accomplishment
- **Measurable** - a metric (usually an indicator) should be established to indicate that an objective has been met
- **Attainable/Achievable** - if an objective cannot be achieved, then it's probably a dream
- **Realistic** - limit objectives to what can realistically be done with available resources
- **Time-bound** - achieve objectives within a specified time frame

Further details and examples for situational analysis, priority setting process, goals and objectives can be found in the Chapter 2.11 "Project Management" of the Handbook for Teachers, Researchers and Health Professionals "Health systems and their evidence based development" (see Recommended Readings).

Action Plan

The Action Plan sets out the strategic direction and actions for improving (health) outcomes. The action plan contains besides goals and principles, specific objectives and appropriate actions. It also includes an appendix with a description and assessment of general instruments that can be used, such as administrative system structure, regulations and supervision, monitoring, advisement, economics, etc. The plan also includes areas of common interest to the health and other authorities, and where better integration or co-operation is needed.

An Action Plan is a written outline that defines:

1. What needs to be done
2. What resources are necessary to achieve the stated goals and objectives
3. Who needs to do what
4. A timeline for accomplishing the goals
5. Estimated budgets

Exercises:

1. The students will work in small groups (4-6 students). They will review their national public health / health reform strategy and discuss what are the common components described into the present paper and what are the original components they can find out. Written conclusions will be presented by the whole group.
2. The students will work in small groups (4-6 students). They are asked to develop a draft of a public health strategy, based on the knowledge they have gained during this module.

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Recommended readings

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Summary Measures of Population Health and Their Relevance for Health Policy
Module: 2.7	ECTS (suggested): 0.75
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Keywords	Summary Measures of Population Health (SMPH), DALY, cost effectiveness, health priorities, health policy, Burden of Disease (BoD) Studies
Learning objectives	After completing this module students and public health professionals should: <ul style="list-style-type: none">• Recognize the value of the SMPH, specially DALY, as a tool for health policy and planning purposes;• Be aware of cost-effectiveness as a key health research priority worldwide;• Recognize the limitations of SMPH in priority setting in the health sector;• Draw the conclusions from the results of Burden of Disease studies directed toward health strategies.
Abstract	Measurement of population health, its causes, and its distribution is fundamental to the development of evidence for health policies and for the planning and evaluation of intervention programs. Population health status has many dimensions, classifications and measurements, as well as interactions between these, that pattern and trends often cannot easily be identified. Thus the need for comprehensive population health measures and standardization of data collection is obvious and

	<p>longstanding. Summary measures of population health (especially DALY – Disability Adjusted Life Year) have been proposed and developed as useful analytical tools for health policy-makers and analysts. The feasibility and cost effectiveness of interventions are additional considerations to set priorities for the organization and delivery of health care services, and play a crucial role in the minds of policy makers in determining which causes of the disease burden are targeted by the health care delivery system and which are the subjects for further research. The examples of burden of disease use as policy support in Australia, Uganda, and Serbia are shown.</p>
Teaching methods	<p>Teaching methods include lectures and small group discussion. Guided discussion on case problems and previously prepared seminar paper. Preparing a report (in small groups - up to five students) on one case problem.</p>
Specific recommendations for teacher	<p>It is recommended that the module should be organized within 0.75 ECTS credit, out of which 0.25 of ECTS credit will be done under supervision, while the rest is individual student's work.</p> <p>Teacher should be aware that prerequisites for this module are the following two modules: <i>Disability-Adjusted Life Years: A Method for the Analysis of the Burden of Disease</i> and <i>Calculating the Potential Years of Life Lost</i>, as well as a basic knowledge about health strategy and health policy.</p>
Assessment of students	<p>Multiple choice questionnaire test and case problems presentations.</p>

SUMMARY MEASURES OF POPULATION HEALTH AND THEIR RELEVANCE FOR HEALTH POLICY

Slavenka Janković

Introduction

Measurement of population health, its causes, and its distribution is fundamental to the development of evidence for health policies (1) and for the planning and evaluation of intervention programs (2). Issues of conceptualization and of valid and comparable measurement of population health are of increasing international policy importance (3).

Population health status has many dimensions, classifications and measurements, as well as interactions between these, that pattern and trends often cannot easily be identified. Thus the need for comprehensive population health measures and standardization of data collection is obvious and longstanding (4).

The Global Burden of Disease (GBD) Study has pioneered new approaches to health priority setting since its findings were first published in the World Bank's World Development Report 1993: *Investing in Health* (5). A fundamental outcome of this research has been a change in the paradigm for health accounting, from measuring death to measuring population health, using a new single time-based metric, the Disability Adjusted Life Year (DALY) - to quantify the burden of disease and to compare disease burden across a range of diseases, injuries and risk factors. The use of DALY allowed researchers to combine in a single indicator years of life lost from premature death and years of life lived with disabilities (6, 7).

Summary Measures of Population Health

Summary measures of population health (SMPH) are measures that combine information on mortality and non-fatal health outcomes to represent the health of a particular population as a single number.

Summary measures may be divided into two broad families: health expectancies and health gaps. There are many different measures within each family and all of them use time (lived in health states or lost through premature death). Key issues in the design of summary measures of population health are: calculation methods, the definition and measurement of health states, the valuation of health states and the inclusion of other social values (8).

Health expectancies are population indicators that estimate the average time that a person could expect to live in a defined state of health. As summary measures of the overall level of health of population, health expectancies have two advantages over other summary measures: they are measured in time units (expected years of life), and it is relatively easy to explain the concept of an equivalent healthy life expectancy to an audience.

Examples include:

DFLE (Disability Free Life Expectancy) – time spent in any health state categorized as disabled is assigned arbitrarily weight of zero (equivalent to death). This means that the summary indicator is not sensitive to changes in the severity distribution of disability within a population.

HALE (Healthy Adjusted Life Expectance) – expected years of life. In contrast to previous indicator, this summary measure is sensitive to changes in the distribution in health states, and

DALE (Disability Adjusted Life Expectancy) – like HALE, this indicator is sensitive to changes. DALE adds up expectation of life for different health states with adjustment for severity weights (9).

Health gaps measure the difference between actual population health and some specified norm or goal. The best known of the health gaps, developed for use in burden of disease studies is:

DALY (Disability Adjusted Life Year) – DALY is a health gap measure that extends the idea of potential years of life lost due to premature death, to include equivalent years of “healthy” life lost to poor health or disability (9). It measures the gap between current health and an ideal situation where everyone lives to old age, free of disease and disability. To calculate DALYs for a disease or injury cause in a population, the years of life lost due to premature mortality (YLL) from the cause are added to the number of years lost due to

disability (YLD) from incident cases of the disease of injury: $DALY = YLL + YLD$. One DALY is equivalent to the loss of one year of “healthy” life (9).

Uses of Summary Measures with Special Emphasis on Policy Application

The design of a SMPH may depend on its intended use. Some potential applications are:

- Comparison of health between two populations
- Monitoring changes in the health of a given population
- Identifying and quantifying overall health inequalities within populations
- Providing appropriate attention to the effects of non-fatal health outcomes on overall population health
- Informing debates on priorities for health service delivery, planning and research
- Improving curricula for professional training in public health
- Analysing the benefits of health interventions for use in cost-effectiveness analyses (8)

The value of SMPH as a tool for health policy and planning purposes has been increasingly recognized (10). They are relevant for three levels of health policy (4):

1. The first level is general socioeconomic policy, which is not often seen as health policy, but as long as poverty is still the major predictor of health, it should be. The systematic presentation of the distribution of health within populations and between them should form an important input for socioeconomic policy.

2. The second, health policy level focuses on the elimination or reduction of specific diseases or risk factors. The incidence- and mortality-oriented SMPH will be particularly helpful for the planning of programmes for health protection and health promotion and for evaluation of such policies.

3. The third level of health policy is specifically directed to health services. SMPH directed at informing this type of policy-making will focus more on prevalence measures and use weights that draw more attention to the effects of non-fatal health outcomes.

Informing debates on priorities for research and development in the health sector can be considered as policy-directed application of SMPH (4).

Advantages and Disadvantages of Summary Measures

SMPH are useful analytical aids to priority setting in the health sector, but their limitation should also be recognized. It is sometimes believed that understanding the composition of disease burdens and identifying the main causes of illness are all that is required for priority setting. Faced with disease burden estimates, people recognize the main causes of illness and develop motivation to reduce them. However, feasibility and cost effectiveness of interventions are additional considerations to set priorities for the organization and delivery of health care services, and play a crucial role in the minds of policy makers in determining which causes of the disease burden are targeted by the health care delivery system and which are the subjects for further research (11).

A principal advantage of burden of disease approach is that it entails a data “audit”, whereby the completeness and reliability of routinely collected health data are assessed, and critical gaps in data collection are easily identified. One implication is that periodic quality assessment of routine data ought to be done to ensure their relevance and reliability for public policy. Another might be a need for a more rational assessment of priority data for the healthcare sector, placing greater emphasis on data collection from surveys and longitudinal studies, rather than on routinely collected data of limited public health relevance (12).

Cost-effectiveness Analysis

Among the major research outcomes of the World Development Report 1993 were packages of interventions to optimize health in populations (5). Subsequently WHO identified evidence of cost-effectiveness as a key health research priority worldwide. The findings of one of the largest research projects ever undertaken by the WHO of cost-effectiveness of 170 interventions, primarily to reduce health hazards from underweight, unsafe water and hygiene, unsafe

sex, tobacco use, and high blood pressure and cholesterol were reported in 2002 (13).

Cost-effectiveness analysis arguments are ratios based on differences in outcomes divided by the difference in costs observed among two alternative programs. They can be used to define a minimum package of essential health services, optimize the allocation of existing resources, direct new health investments, avoid spending resources on small health gains, etc. Despite several weaknesses cost-effectiveness analysis techniques have been and continue to be used to set health priorities.

As demand for healthcare grows and resource constrains, decisions about resource allocation and priorities for the healthcare sector will fall under increasing scrutiny (12). That's why reliable and useful evidence about population health problems and cost effective measures to address them are required.

Burden of Disease studies - Methodology

Initially promoted by the World Bank, national burden of disease (BoD) studies are now being strongly encouraged and supported by World Health Organization. Since 1993, when the study in India started (14) a number of national burden of disease studies have been undertaken (15, 16, 17). The majority of BoD studies are largely based on the methods developed for the GBD Study (6). The method allows the quantification of all states of ill health into a universal indicator, the Disability Adjusted Life Years (DALY). The DALY combines a measurement of premature mortality and disability. This indicator is the aggregation of Years of Life Lost and Years Lived with Disability at the population level and thus reflects the "burden of disease" in population. Life expectancy determines the stream of life lost, or Years of Life Lost (YLL), for each premature death. Likewise, the disability arising from disease or injury is measured as the duration spent in state of ill health weighted for severity. This is referred to as the Years Lived with Disability (YLD). The DALY expresses years of life lost due to premature death together with years lived with disability of specified severity and duration. One DALY is thus one lost year of healthy life.

The disability weights used in DALY calculations represent societal preferences for health states. The majority of BoD studies used actual or derived weights from both, the GBD (18) and the Dutch study (19). In particular, the DALY measures the gap between a population's actual health status and some 'ideal' or reference status.

GBD study weighted a year of healthy life lived at young ages and older ages lower than for other ages. This choice was based on a number of studies that have indicated there is a broad social preference to value a year lived by a young adult more highly than a year lived by a young child or at older ages. However, age-weights were not used in all BoD studies (17).

YLD are calculated by estimating the incidence (or prevalence where the former was not possible) of each condition, the average duration of each incident case (or, more precisely, of the associated disability until death or recovery), and the average severity of the associated disability (the average disability weight). For most conditions this involves calculating a weighted average, across all stages, sequelae or complications of the condition, for both duration and disability severity. Furthermore, both duration and disability distribution need to be adjusted for the effectiveness and coverage (access) of currently available interventions.

Although the majority of BoD studies have followed the methodology initially proposed in GBD study (6), they are not totally comparable to each other, because of important modifications to the original procedures (9).

Use of BoD Studies as Policy Support – Examples from Different Countries

Example 1: Australia

Between 1997 and 1999, two BoD studies were undertaken in Australia. The first one was a national study: *The Burden of Disease and Injury in Australia* (17) and the second one was a separate study for state of Victoria: *Victorian Burden of Disease Study* (20, 21).

The two studies used methods employed by the GBD study to quantify the loss of health from a comprehensive set of 176 causes of

disease and injury and for 10 major risk factors in 1996, departing from GBD methodology in some areas (use of uniform age weighting, 1996 Australian cohort life expectancy, Dutch disability weights for most conditions, and adjustments for co-morbidity). The Victorian study also projected the burden of disease to the years 2006 and 2016.

Both studies constitute the first comprehensive assessment of mortality and non-fatal outcomes in Australia. Information about the ranking of the magnitude of health problems has been of interest to health planners and policy makers at central and regional level in Department of Human Services and Local Government Areas. The large size of burden due to mental health disorders (30% of the national disease burden) and the projection of a rapid increase in heroin dependence and overdose deaths have attracted attention. The development of Australian mental health policy has been strongly influenced by the results of BoD studies which illustrated an escalating need for appropriate and accessible mental care in Australia.

Cost-effectiveness analyses using DALY as a measure of health outcome will greatly add value to the burden of disease results in informing policy decision-making. This will be illustrated by example concerns a comparison of targeted cholesterol-lowering treatment in the primary prevention of coronary heart disease and a nutritional education intervention to reduce cholesterol levels in the general population. The nutrition intervention is more favourable in terms of cost per DALY than the cholesterol-lowering treatment even if targeted at the highest percentiles of risk. However, the cholesterol-lowering treatment is expected to have a much greater impact on the burden of heart disease than the nutrition intervention.

Example 2. Uganda

According to the BoD conducted by Ministry of Health in Uganda in 1995, over 75% of the life years lost due to premature death were due to ten preventable diseases. Perinatal and maternal conditions (20.4%), malaria (15.4%), acute lower respiratory tract infections (10.5%), AIDS (9.1%) and diarrhoea (8.4%) together account for over 60% of the total national death burden. Others at the top of the list include tuberculosis, malnutrition, trauma/accidents and measles. The burden of disease mentioned above is partly due to ear

infections, which are among the major causes of hearing impairment and deafness – the largest disability problem in Uganda.

Apart from the heavy burden of infectious disease, Uganda is also simultaneously experiencing a marked upsurge in the occurrence of non-communicable diseases such as hypertension, cancer, diabetes, mental illness and chronic heart disease. Uganda has therefore, already entered the early phase of the epidemiological transition.

Burden of Disease results from Uganda have been used to form the basis for the national health policy, for advocacy and resource mobilisation, providing criteria for priority setting, resource allocation and strategic planning. Limitations to utilisation included inability of methodology to capture key non-economic issues (22).

Example 3. Serbia

The Serbian Burden of Disease Study (SBDS) is an European Union funded project undertaken between October 2002 and September 2003 (23).

This study has provided an assessment of the health status of the Serbian population through estimates of contribution of fatal and non-fatal health outcomes to the total burden of disease and injury in Serbia without Kosovo and Metohia in 2000. It is largely based on the methods developed for the GBD study. Deaths and estimates of YLL have been obtained for 135 conditions, including over 500 stages or sequelae, and estimates of YLD, YLD/DALY ratio and DALY for 18 conditions, including over 100 stages or sequelae in different age groups. Mortality, morbidity and disability arising from different diseases, injuries and risk factors were measured using a common metric, DALY.

Key findings of SBDS:

- Cardiovascular diseases (CVD), cancers and injuries were responsible for 80% of the total mortality burden.
- Injuries are the main cause of lost years of life in young adults and children aged 5-14, and neonatal conditions are the main cause in children aged under five.
- In general, the total burden of 18 selected diseases and injuries in Serbia in 2000 was estimated to be 621 993 DALYs or 82

DALYs lost per year per 1,000 population. There were more relevant YLLs lost for observed disorders than YLDs (78% vs. 22%) with the exception of non-fatal health outcomes (unipolar depressive disorders, and hearing and vision loss), and low birth weight and asthma, the burden of which was mainly caused by lengthy period of disability. For HIV/AIDS contribution of YLL and YLD in DALYs was almost the same. These 18 selected conditions caused 484 995 YLLs or nearly 60% of the total mortality burden in Serbia (Table 1).

Table 1 Total years of life with disability (YLDs), disability adjusted life years (DALYs) and YLD/DALY ratio (%) for Serbia without Kosovo and Metohia, 2000

Rank *	Disease	YLDs	DAL Ys	YLD/DAL Y (%)
1	Ischaemic heart disease	14 735	150 886	19.8
2	Cerebrovascular disease (Stroke)	13 920	136 090	10.2
3	Trachea, bronchus and lung cancers	2 654	59 088	4.5
4	Unipolar depressive disorders	52 901	52 901	100
5	Diabetes mellitus	16 615	37 336	44
6	Road-traffic accidents	13 235	30 468	43.4
7	Self-inflicted injuries	1103	27 938	3.9
8	Colon and rectum cancers	1 785	26 007	6.9
9	Breast cancer	2 134	23 868	8.9
10	Stomach cancer	584	16 487	3.5
11	Nephritis and nephrosis	1 380	14 215	9.7
12	Birth asphyxia and birth trauma	610	13 520	5
13	Asthma	8 093	12 988	62.3
14	Cervix uteri cancer	529	8230	6.4
15	Low birth weight	3 282	4 759	69.0
16	Tuberculosis	388	3 236	12.0
17	Vision and Hearing Loss	2 236	2 236	100
18	HIV/AIDS	817	1 742	46.9

* According to DALYs

Source: *Serbian Burden of Disease and Injury in Serbia (23)*

- In terms of specific conditions, the ranking of the total burden in Serbia was highest for ischaemic heart disease, followed by cerebrovascular diseases (stroke), lung cancer and unipolar depressive disorders at the fourth place.
- The importance of unipolar depressive disorders, even if it doesn't generate deaths in Serbia, was one of the key findings of this study, like to similar studies worldwide (17).
- For the group of conditions selected in the SBDS mortality was the main contributor to the burden due to smoking, physical inactivity, inadequate intake of fruits and vegetables, hypertension and high blood cholesterol, because the diseases connected to these risk factors are characterized by high mortality. The greater proportion of disability in our study has been found with regard to the burden due to alcohol and obesity. The disability associated with alcohol dependence and abuse is responsible for the YLDs of alcohol harm, while negative values of YLDs for low regular alcohol intake with its positive effects on cardiovascular diseases produced the final alcohol benefit.
- SBDS also presented an example of cost-effectiveness analysis of the management of Diabetes Mellitus type 2 pointed the advantages of guidelines application in the clinical practice as well as preventive programmes for reduction of physical inactivity and obesity.

It is early to comment on the policy impact of the study's results. However, it is important to note that Ministry of Health of the Republic of Serbia supported this study. Also, a wide range of opinion leaders among clinicians took part in repeated consultations particularly concerning the estimates of the burden due to non-fatal diseases and injury. As a routine tool for present and future policy makers in Serbia, the SBDS will be judged by its impact in making a difference in terms of health policy and the pattern of health service delivery. The analysis of cost and effectiveness of the management of Diabetes mellitus type 2 should clarify, whether the nationwide application of recently developed guideline would save a relevant amount of Disability Adjusted Life Years and reduce the medical cost of diabetic patients' treatment as compared to the present situation in Serbia.

Conclusion

Precise information about diseases and injuries, their incidences, their consequence, their causation and their trends is more than ever necessary to inform policy-making (9). While the public has growing expectations of health services and the repertoire of health services to respond to these demands is expanding, governments are under pressure to allocate and justify their health resources. Decision-makers are increasingly required to evaluate the impact of health policies, to justify the adoption of new ones and to ensure that information is available for inter-programme comparisons.

The use of SMPH, such as the DALY for burden of disease analysis, measurement of clinical outcomes, and cost-effectiveness analyses allows existing or prospective interventions to be judged both in terms of cost-effectiveness, and their relative impact in reducing the burden of disease and ill-health.

SMPH have been proposed and developed as useful analytical tools for health policy-makers and analysts. However, the usefulness of burden of disease assessments for policy makers and health planners still remains to be fully evaluated. The burden of disease approach, i.e. DALY approach, combining data on weighted morbidity and mortality into one measure, is a useful starting point for public policy prioritization, which need to be followed by information on possible interventions and their cost-effectiveness. A major advantage of the approach is that it makes explicit what is valued in public health and enhance inform debate on the social values that influence resource allocation in health systems. It is important to mention that DALY provides unique and desirable health information on non-fatal health outcomes that is essential for determining appropriate health research priorities as for all indicators the use by policy makers may be the final proof of the significance of DALY's (24).

Exercises

Exercise No 1. Students are requested to use results (key findings) of SBDS for setting health priorities and health policies in Serbia, and then for their own countries (applicable to SEE region).

Examples:

1. In terms of specific conditions, the ranking of the total burden in Serbia 2000 was highest for **ischaemic heart disease**, followed by **cerebrovascular** diseases. The incidence of these diseases is underestimated. The following should be done:

- A preventive programme may achieve risk factors (smoking, physical inactivity and obesity) reduction resulting in a number of quality adjusted life years saved through the prevention of cardiovascular diseases.
- Strengthening the quality of data on morbidity of ischemic hart disease
- Improving the therapy.

2. The result of SBDS found **depression** as the leading cause of non-fatal disease burden in Serbia 2000 and put it into priority area for policy makers and health care providers. Depression, once considered to be of little importance to policy makers has now become an area of national concern. The following should be done:

- The mental health of communities should be monitored including mental health indicators in health information and reporting systems.
- Scientific research on mental health epidemiology, services, treatment, and prevention in Serbia is an urgent need.
- Development of national mental health policy (promotion of mental health of Serbian community; where is possible, prevention of mental disorder development; reduction of the impact of mental disorders on individuals, families and the community; and mental health services improvement) should be the next step.

3. The burden of **Diabetes mellitus (DM)** and risk factors connected to DM, as well as cost-effectiveness analysis of the management of this disorder in Serbia in 2000 pointed out:

- The implementation of the National Serbian Guideline for diabetes mellitus in clinical practice bears an enormous potential not only in saving lives and lowering the years lived with reduced quality of life, but in addition it may reduce clinical costs by as much as about a quarter.
 - A preventive programme with a relatively small budget may achieve risk factors (physical inactivity and obesity) reduction resulting in about the same amount of quality adjusted life years saved through the prevention of diabetes and other diseases.
4. The combination of seven selected **risk factors** (smoking, physical inactivity, obesity, alcohol intake, inadequate intake of fruits and vegetables, hypertension and high blood cholesterol) is responsible for about 45% of the mortality burden in Serbia 2000. Tobacco smoking is the risk factor responsible for the largest burden, followed by hypertension, physical inactivity and obesity.
- Although Serbia faces some common, large and certain risks to health, effective and affordable interventions are available. Very substantial gains can be made for relatively modest expenditures, but government bold policies will be required. The government should prioritize the most important risks and shift the main focus to include preventive measures that can be applied to the whole population (for example, to increase taxes on tobacco, to develop legislation to reduce the proportion of salt in foods, to provide strong health promotion and health safety campaigns).

Students are required to continue and draw more conclusions from key finding of SBDS, directed towards their relevance for health policy (to recognize some other health problems in Serbia 2000, like cancers, injuries, etc. and recommend preventive programmes and health interventions).

***Exercise No 2.* Students will discuss some examples from both developed and developing countries of how the Burden of Disease methodology has been used in planning or setting health policies.** (Details of the conducted BoD studies in different countries can be found on the International Burden of Disease website at <http://www.ibdn.net>)

National Health Plans:

Australia
Indonesia

Sub-National/Local Studies:

Victoria – Australia
Los Angeles – United States of America

Risk Factors Analysis:

Europe

Cost Effectiveness:

United Kingdom:
Tanzania

Projections:

Victoria – Australia

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Setting community health priorities
Module: 28	ECTS: 0.5
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Keywords	Setting priorities, community health, health priorities, priority selection models and criteria.
Learning objectives	After completing this module students and public health professionals should: <ul style="list-style-type: none"> • Understand the basic steps and components of setting priorities process; • Be aware of the inclusion criteria and arguments for each step of the process; • Differentiate selection models for prioritisation process; • Identify effects, advantages and disadvantages of prioritisation in community health
Abstract	Setting priorities in public health is a necessary and inevitable process when community resources for health are limited or scarce. Prioritisation implies that many citizens' needs are not considered as priorities at a certain point in time, and are not going to be addressed right away. Having that in mind,

	<p>the transparency of decision-making process, as well as explicit community resource allocation are preconditions of success in community health attainment. The course will cover: definitions and concepts, basic steps and components of setting priorities process, actors, criteria, selection models and ranking. Recommended readings and discussion topics are also given. At the end of the course, a Since to gain benefits for the wide circle of community partners is preferred, social control mechanisms over the individual pressure or other influences on decision making process might be helpful. Advisable is to avoid one-side decisions and asymmetry in information flow on needs and desirable outcomes. Students should propose model of setting priorities in community health.</p>
Teaching methods	<p>Teaching methods include introduction lectures on prioritisation in public health, interactive group discussions and individual work on the model for setting community health priorities.</p>
Specific recommendations for teachers	<p>It is recommended that this module is organized within 0,50 ECTS credit, out of which one part will be done under supervision (lectures and discussion) and the other part will be individual students' work. Practical work should consist of discussion under supervision in groups of 6-8 students, and individual work on proposed method for setting community health priorities. Clear method has to be based on knowledge attained during the course with details like: whose priorities are to be analysed and whose decisions, what evidences and how many of them, sources, arguments, criteria, steps in prioritisation, definition and suggestions.</p>
Assessment of students	<p>Assessment should be based on students activities during the module and on quality of proposed method for setting community health priorities. Proposed target groups include professionals from all sectors interested in health policy issues.</p>

SETTING COMMUNITY HEALTH PRIORITIES

Milena Šantrić-Milićević

Basic premises for priority setting

During transition period, community health of many countries is beset with problems and is facing “bottlenecks”^{*} in financing area. Within health system reform efforts setting priorities seemed inevitable in every community, and in countries with limited financial resources it was expressed as moral obligation towards citizens’ health. Public society and various professionals questioned whether the prioritisation in health is necessary, whether the clearness of decision making process in public health is what we need, whether the priorities are ethical based and plausible, how much rationalization we can afford, etc.

The term *priority* is commonly used to define the feature claimed to be precedence, basic, primary, and imperative. Priorities in community health usually imply first and foremost priorities for resource allocation, and afterwards health needs priorities, health problems priorities and priorities in health care services delivery (1). The list of priorities in public health comprises also the priorities in population groups, among users, priorities in organization and management, in prevention, research work, and education. World Health Organization emphasizes that selection of priorities does not consider the «simplest and basic services for poor, but, providing the necessary and high quality health care, defined by certain criteria» (2).

Setting priorities in public health belongs to health policy domain and it is the second part of policy cycle formulation, consisting of different types of decisions, starting from defining health

^{*} Many of the functions of health care systems depend on adequate financing. World Health Organization is proposing tools for removing some obstacles and loosens the system bottlenecks that make it difficult to translate more money into better health outcomes. The World Heart Report 2003: Shaping the Future. Geneva: World Health Organization 2003

problems to decision making on strategies for solving priorities. The most critical choices that have to be made will address the priorities among health services, programs and interventions and should assure improvements in the community health (1). Health policy priorities are expression of conceived consensus between different partners' concepts and strategies. They act as leading criteria in the community health resource allocation, so, they should be provided foremost. Besides a positive attitude in setting priorities, when is the question what is the most important to be answered promptly, there is also a negative attitude, when decisions are made to what is not important at that time, and therefore, may be delayed in favour to more important problem settlement.

There is lots of prioritisation in health going on, but not one example was simple (3). The reasons for complexity of the issue are many. Priorities should be set for a certain time period and adequately monitored as they are supposed to pace with health and community development dynamics. Contradictory, setting priorities procedures need and take lot of time to reconcile strong influence of powerful factors like, budget allocations, financial flows and fails, regulations, ethics, patient's demands, politicians interests, international pressures, economic principles and community values as well as other different organizations programs. In addition, there are parallel trends in population like ageing, fertility and reproduction changes, migrations and high technology medicine development. Often when authority solutions do not seem adequate to community expectations, then transparency and methodology of the decision-making process were deeply criticized and not valued afterwards (3, 4).

Depending on the level of decision - making and on the authority, Klein defines five levels at which priorities are set in practice (1):

- First level, decisions for resource allocation to the health sector as a whole;
- Second level, decisions for resource allocation between geographical areas and services;
- Third level, decisions for resource allocation between particular forms of treatment,
- Fourth level, decisions for resources allocation between types of patients; and,

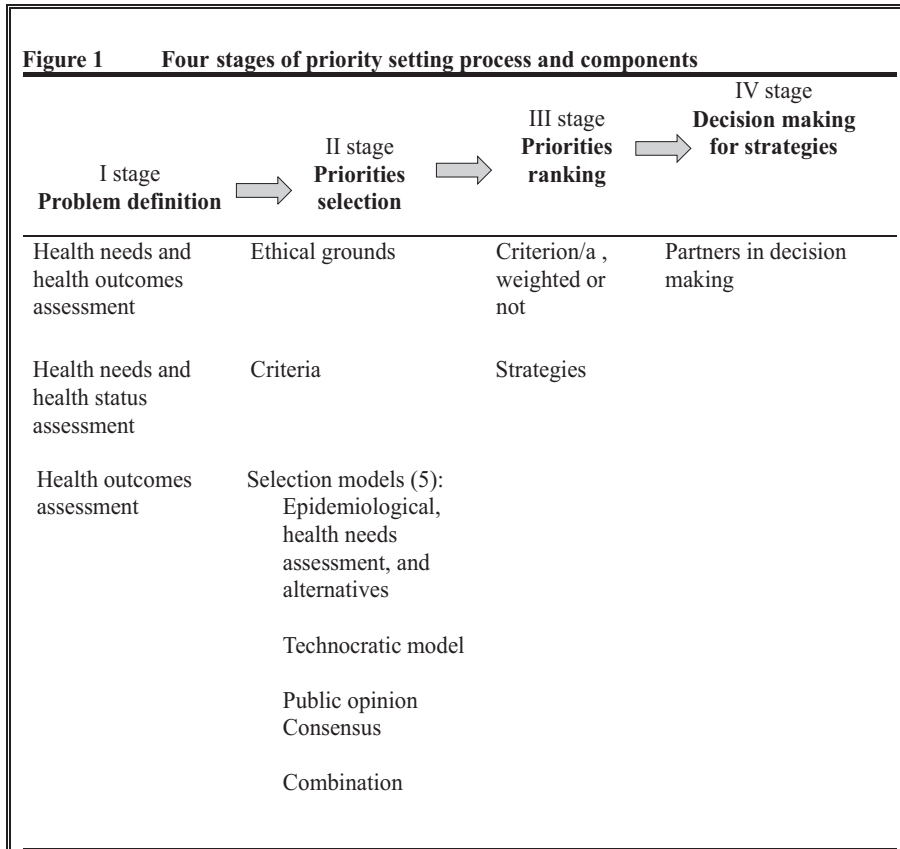
- Fifth level, decisions on how much to spend on individual patients.

At the first level, tasks will include planning and programming the budget, and it is mostly a political decision on budget percentage for health care according to the macroeconomic principles of allocation. Decisions on at other level s should be ethically and socially justified, besides economically approved.

Priority setting process and components

At all levels defined by Klein, the process of setting priorities involves stating priorities and taking strategic decisions for their solving. In the Figure 1 setting priorities is illustrated like a four stage process: defining the health problems, selection of priorities; priorities ranking and decision making for solving strategies. Stages are linked one to another by the previous stage results. Every stage results might be (re) assessed in the light of their values, evidence reliability and transparency, as well as questioned who did the research and analysis in each stage.

In the *first stage of setting priorities process*, the best way for defining the health problems in community will be to apply a comprehensive approach regarding health needs and health outcomes, contrary to focus on health needs and health status or on health outcomes assessment only. Examples of those far-reaching approaches are PRECEDE-PROCEED model for planning community health, "Planning Approach Community Health – PATCH", and "Choosing Health Plans All Together - CHAT" (5, 6, 7). A well known such example of setting priorities is the Oregon experiment, conducted in early 1990s, for Medicaid program. Primarily, the population was questioned on the number and type of services to be covered by the programme, then the expert's opinion was asked and an economic analysis was performed (8). Underlying principles for the concept of coincident measurements of population needs and preferred health outcomes are equity, justice and solidarity.



Source: Santric Milicevic M. *Setting priorities in disease and injuries prevention at the national level. Master of Science Thesis. Belgrade: School of Medicine, University of Belgrade 2000 (in Serbian)*

However, very often it is the case that health priorities are based on health status epidemiological analysis done by health professionals, but not so frequently, the list of priorities resulted from community based health needs surveys. Various techniques for *needs assessment* are starting with the definition of need. Bradshaw taxonomy of needs can be of assistance for decision on how to measure needs: normative, felt, expressed needs as demands and comparative needs (5). By this classification, normative needs are professionals' formulation, based either on epidemiological analysis and literature review, or on expert panel opinion and formal consensus methods. Needs assessment based on epidemiology of population health, actually provides information on needs for health care.

Ghana Health Assessment Team, at the end of 1970's, pioneered the application of explicit criteria in setting priorities by calculating the number of healthy days of life lost to assess the impact of diseases on population health (9). Recent progress in the development of indicators and methods for measuring health status are introducing the composite measures of population health, like Disability Adjusted Life Years (DAL Y), Potential Years of Life Lost (PYLL), and Quality Adjusted Life Years (QALY), and Health Adjusted Life Years (HALY) instead of standard measures of mortality and morbidity (10, 11, 12, 13). Felt needs, whether or not expressed and demanded, can be assessed also in many ways for public involvement in decision-making, like focus groups discussions, surveys, interviews or boards memberships (14, 15). Comparative needs are related to the level of provision for different populations, and they express the differences in normative and felt needs between geographical areas (5). To evaluate these differences, standardization method of the indicators is commonly used.

Mostly, to evaluate effectiveness of allocated resources to health care sector, an approach for defining health problems in community based on calculation of *health outcomes estimations* is used, and it comprises numerous different activities (16, 17). Depending on the definition of preferential health outcomes, there are available different instruments for their measurement and calculation (16). Health outcomes might be defined like improvements in health status or in patients' quality of life, like lifespan prolonging and surviving time, disease eradication, etc. Health outcomes measurements are possible at different levels for example: at individual level for health interventions effects assessments, at population level for estimating the health interventions benefits, at health system level for evaluation of the quality and efficiency of the primary or secondary health care (17, 18).

At the *second stage of setting priorities*, defined problems in community health are reviewed systematically, following up some normative and technical rules. Ethical principles must be considerate while introducing criteria and models for selection of priorities. Ethical grounds of priority selection process like: egalitarian ideology, objective or subjective doctrine for maximizing the utility, liberality principle, medical ethics or community "claims" should be clearly

made in advance, to assure transparency of the process and acceptability of the decisions (19, 20, 21, 22).

Criteria in selection procedures have to be sufficiently arguable, including their quality revision, update availability, and possibility for ease and repetitive measurements and monitoring, at least. Small set of criteria is preferable than the large one, with maximum six of them (23). In the literature, over two hundred criteria are mentioned, and in the Table 1 frequently used criteria are listed (23).

Table 1 Frequently used criteria in selection of priorities models

Case fatality	Utilization of health services	Individual responsibility
Urgency	Disability,	Priority level (e.g. national)
Preventability	Resources	Ethical principles
Premature mortality	Costs	Political adequacy
Disease frequency and severity	Evidences of effective diagnostics and treatment	Health care programs and experiences
Morbidity and mortality trends	Quality of life	Social preferences

Source: *The Ethics of Rationing. Newsletter: European Partnership on Patients' Rights and Citizens' Empowerment* (23)

There are various models for selection of priorities (24). Some of them are built on epidemiological models based on population health status estimates. Others, partly rely on health needs assessment and epidemiological criteria, and whenever possible, on economical evaluation of health outcomes. In addition, models of selection are more or less objective, and some include public participation, SWOT analysis, willingness to pay techniques, but others don't (25).

Very important question is how criteria should be applied against the priorities. There are three common applications of the criteria in models for selection of priorities: to use all criteria simultaneously; to apply them as successive sieves; or to rate the community health problems according to each criterion. The simultaneous application of all criteria against all community health problems is very difficult especially if the differential weighting for

criteria is used. Weights are based on actual information, but since there is limit to the number of information that can be processed at any one time, they will still require review and refinement. Sequential application of criteria is generally preferred model of selection, as that remaining after the final criterion is applied will then be considered as the priority. In this procedure, the most important step that all partners should agree on is the order in which criteria are used as sieves. The third option is to rank each community health problem against of all the selected criteria. Then, to come up with an index or composite score it is necessary to combine the ranks on each of the criteria. Variations of the above models of selection exist. They are more therefore, complex and more systematic approaches, which sometimes include paired comparisons of criteria, weighted voting and ranking. To avoid rigidity in the process output, priority areas in community health are more likely grouped in the groups of low, medium or high priority categories than lined in the list of priorities.

The most recommended model for selection of priorities was the technocratic model, tested in Oregon (8). It consisted of three subsequent phases: in the first one, the quantitative analysis of burden of disease was done, in the second phase, economic evaluation of alternative health interventions cost and outcomes was proceeded, in the third phase the list of paired disease and interventions is formed, framed by budget limits of Medicaid health care program. In Netherlands, priorities selection model consisted of four criteria, subsequently introduced like sieves: necessity, efficiency, effectiveness and, individual responsibility (27). In Sweden, the committee for prioritisation used a two far steps model of setting priorities: first step was personal interviews with politicians, high administrative personnel and senior medical doctors with the aim to affirm previous prioritisation activities and influences and in the second step selecting priorities was done by scaling up – exclusion model (28). Diagnoses and treatments were modelled and ranked from 1 to 10 with consideration of health-gain, usefulness, medical result, risk, cost/resources, quality of life and evidence. The lowest pairs of diagnoses and treatments were excluded (28).

In the *third stage of setting priorities*, if the priorities were previously selected in certain categories (for example: the most important, important, not important) or priority areas in community

health, the ranking might be valuable to specify priorities for strategy proposals. Criteria for ranking should reflect practicability of the strategy proposals, their achievability under financial constraints, and their viability in community.

In the *fourth stage of setting priorities*, when priorities are ranked, decision makers should agree on solving strategies. The basics of this stage are partners and strategies. Responsibility for health is beyond health systems and individual potentials, laying on the whole society. Everyone in community has its role, e.g., health professionals should decide on technical aspect of health care prioritisation, economists and insurance funds representatives should provide economic aspects, but community members are those whose health issues are questioned. Social control mechanisms over the individual pressure or other influences on decision-making process might be helpful, if benefit for the wide circle of community partners is preferred. Especially advisable is to avoid one-side decisions and asymmetry in information flow on needs and desirable outcomes.

Partners in community health decisions are always health authorities, providers, and insurers. Community participation is recognized as important, though not so much practiced, but seems inevitable for big reform strategies and all radical changes. International bodies, such as World Health Organization, World Bank and other EU regional offices, non - government organizations and funds act as necessary partners in strategy decisions and health policy evaluation. International health organizations may help to define their country partners' health policy and support efforts in attaining goals and tasks. World Health Organization defined three overall goals of health system performance: good health, responsiveness to the expectations of the population and fairness of financial contribution (2). Furthermore, World Health Organization emphasizes *goodness* of good health, "as the best attainable average level" and *fairness* of good health, "as the smallest feasible differences among individuals and groups". Although they were set as goals of health system performance, they are reflecting the priorities of overall community, for attaining and improving public health goals and equity.

Whether or not explicit, strategy decisions are used on demand side and on supply side, in the same time (24). Some are monetary,

with limitations, restrictions and exclusions, and others are indirect or not monetary strategies, like services access, regulations, waiting lists, etc. Table 2 presents some types of solving strategies examples by countries (17, 27, 28, 29, 30).

Table 2. Types of solving strategies: examples by countries

TYPE	SOLVING STRATEGIES EXAMPLES	COUNTRY
Monetary	Health services restriction	Great Britain
	Basic package of services and exclusions	SAD
	Limited budget	Countries in transition
	Cost-containment	USA, Germany
	Patients payment ability	USA
	Health insurance premium	USA, Canadian provinces
Non monetary	Open market competition of health care services	Developed countries
	Limited access to some services	Netherlands
	Human resources allocation	Former Soviet Union countries
	Capital resources allocation (health centres etc)	All
	Clinical licensing and regulations	England
	Work conditions by the health Lows	All
	Guidelines	New Zealand, Australia
	Vulnerability priority (age and reproduction period)	Eastern Europe countries
Waiting lists	Canada	

Source: see References (17, 27, 28, 29, 30)

Setting community priorities within project management

For community health improvement, knowledge and skills of project management are necessary. Regardless the type of projects there are common phases of their development and techniques and tools applied, like priority setting (31). One of the very often used methods for priority-setting within community health projects is the Basic Priority Rating System or BPRS. Method was developed by two well-recognized public health academicians: John J. Hanlon and

George Pickett, hence, it is also known as the Hanlon/Pickett Method (31, 32). This method compares health problems in a systematic way and helps us to make decisions that are not influenced by emotion or individual preferences. This method is based on a mathematical equation, but it is not based on rigorous scientific investigation (32). It is not intended to be applied as an absolute method for setting priorities. It is a process that helps programs with competing individual priorities to decide which health problems to address. It will help us to: identify explicit factors to be considered in setting priorities, organize the factors into groups that are weighted relative to each other, modify the factors as needed, and score each individually. Hanlon and Pickett, as they reviewed studies that were designed to identify priorities, recognized a consistent pattern of selection criteria and incorporated them as the components of the BPRS equation (32):

$$\text{BPRS} = (A + 2B) \times C$$

Where A = Size of the health problem

B = Seriousness

C = Intervention effectiveness

Notice that a consensus is required to assign choice, definition, and relative weights to the components. Ratings are based on the judgments of the individuals doing the rating. They translate into a formula that generates a numerical score, which can be used for ranking the priority of health problems. The problem with the highest score is ranked as the top priority. A scientific-type control, however, is achieved by precisely defining terms and using exact rating procedures and statistical data, to the extent that data are available (32).

Component A – Size of the Problem

The scoring for the size of the problem is based on how much of the population is directly affected. This may be considered either in terms of the entire population or a selected target population. Each problem is assigned a numerical rating on a scale of zero (0) through 10, which reflects the proportion of the population affected. The more people affected, the larger the numerical rating. When we decide that size of problem is result of rating percent of population with the health problem, for example, we assign zero if less than 0.01% of population is with that health problem, than we assign 1 or 2 when 0.01% to

0.09% of population is with that health problem; 3 or 4 for 0.10% to 0.99%; 5 or 6 for 1.0% to 9.99%; 7 or 8 for 10% to 24.9%; 9 or 10 for 25% or more.

Component B – Seriousness

In the BPRS system, the seriousness of a health problem is considered more important than the size of the problem. You will also need to establish factors to score seriousness. The number of factors should be few; probably no more than four (e.g., urgency- very high death rate; premature mortality-Years of potential life lost, great impact on others, economic losses to the community, disability etc.). The seriousness of health problems is also weighted between 0 and 10 - the more serious the problem, the higher the number. For example : 0, 1, or 2 - not serious; 3,4, or 5 - moderately serious; 6,7 or 8 - Serious; 9 or 10 - very serious. In the final calculation, the score assigned to seriousness will be multiplied by two.

Component C – Effectiveness of Intervention

Effectiveness is the most important component in the BPRS. A score of zero results in a score of zero for the overall rating, which most likely means that the program must be abandoned. Because precise estimates of the effectiveness of interventions are not possible, it is helpful to establish a general range of effectiveness for each category and assess each intervention according to that general range (e.g., 80% to 100%). When discussing the effectiveness of interventions for the BPRS, you are considering the overall combined effectiveness of known interventions for that health problem. For example, we know that in general, established interventions for vaccine preventable diseases are more effective than interventions for health problems related to individual health behaviour choices (0 almost entirely ineffective <5%; 1 or 2 relatively ineffective; 5% to 20% effective, e.g. as smoking cessation is ; 3 or 4 moderately effective; 20% to 40% effective; 5 or 6 effective; 40% to 60% effective; 7 or 8 relatively effective; 60% to 80% effective; 9 or 10 very effective; 80% to 100% effective, e.g. as vaccine is).

Here is one example of BPRS (32): Lung cancer (or heart disease, or HIV/AIDS) is our consideration. Although its incidence is growing rapidly, lung cancer presently affects a fairly small proportion of our people, and so it receives a “5” for size. We give it

an “8” for seriousness - it kills most of the people it strikes and the cost of health care and loss of productivity is devastating. Urgency is also a factor here - given that over 70% of the adult males in our country smoke, a lung cancer epidemic in the future is likely. Another group of individuals might have come up with a different determination. What’s important is that this group will be committed to this priority. Important advice is to follow the steps of BPRS method: at first each member of the team will individually rank each health problem for:

- a. Size of the Problem
- b. Seriousness of the Problem
- c. Intervention Effectiveness

Then, as a team, discuss and reach a consensus on ratings of the health problem in terms of size, seriousness, and intervention effectiveness. Be sure to agree upon the criteria the group will use for rating size, seriousness, and intervention effectiveness.

So, once the Basic Priority Rating has been established, health problems and programs should be assessed in terms of the other important factors, referred to as PEARL (acronym of P – Propriety: Is it your responsibility? E – Economics: Does it make economic sense? A – Acceptability: Will the community accept it? R – Resources: Is funding available? L – Legality: Is the program legal?) (32).

PEARL method of setting health problem and intervention priorities allows us to examine the feasibility of taking action based on outside factors. PEARL helps us to examine our choices in real-world terms to see if they fit. If they do, we move forward with them. For example, when we consider lung cancer (or heart disease, or HIV/AIDS) prevention we decide:

“P” -for propriety: if *lung* cancer (or heart disease, or HIV/AIDS) prevention is part of the responsibility of our agency? Then,

“E” - for economics: Does it make economic sense to address lung cancer? The interventions available to prevent lung cancer are inexpensive compared to the cost of the problem.

“A” - for acceptability: Will your community accept a lung cancer prevention program? The information we have indicates that people in our country are more receptive to education concerning lung

cancer prevention than previously thought. We have to make it acceptable.

“R” - for resources: Are they available? Yes, we have the people, the technology, and the funding to implement a program.

“L” - for legality: Do current laws allow this problem to be addressed?

When we eventually devise an intervention plan, this question will have to be considered again, but in general terms, the answer is “yes.” If the answer had been “no” to any one of these questions, we would have had to stop and rethink our priority. Use judgment to decide when to apply PEARL. PEARL is well suited to situations where your group is making long-range planning decisions and where priorities are not immediately obvious. In times when a health problem is a clear and present danger, it may not be appropriate. This approach can be useful when you assemble a group to develop your plans for the next 2 to 5 years. But when you are faced with a cholera outbreak, taking time to gather people to apply a formula like PEARL may consume valuable time. In other words, PEARL is used when you have a situation where your group needs to choose among competing priorities (32).

Conclusions

There is no golden formula for setting priorities in community health. In spite of so many information, concepts, knowledge and experiences, priority setting still seems to be lacking of their practical implications. Complexity of the process is partly due to immediate need for explicit health decisions, in short period of time and partly due to authority privilege for discretion versus community rights of transparency in decision-making process. Each community with its own characteristics makes the prioritization procedure specific and contributes to (un) success.

Exercises: Setting community health priorities

Task 1. For this task students should be divided into small groups of maximum six persons. Groups should discuss questions:

- Who decide on community health priorities in your community?

- What do decision makers want to know for setting community health priorities?
- What arguments, information and evidences are needed and available for health decision makers?
- What does the social preferences entail in real life for setting community health priorities?
- Does the alternative for prioritization in community health exist?

At the end or at the start of the discussion, students will be asked to give an example on setting health priorities they are aware of.

Task 2 . Developing skills for setting community health priorities

Individual work is recommended. Prepare the following:

- Community description
- Prioritization level definition
- Arguments for suggested approach for defining the community health problems
- Arguments for suggested criteria and model for selecting the community health priorities and ethical justification for selection
- Arguments for suggested criterion/a for ranking the community health priorities/ or arguments for omitting the ranking stage
- Suggest partners
- Suggest prioritization strategies regarding feasibility

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title:	The Role of Public Health Services
Module: 2.9	ECTS (suggested): 0.25
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Keywords	Public Health Service, health policy, public management, task profile, health conference
Learning objectives	At the end of the module, students should be able to: <ul style="list-style-type: none"> • define the mission of public health institutes; • identify the main tasks; • describe the organization and intersectorality • understand the concept of health conferences • discuss the link to public health education;
Abstract	In addition to treating diseases, all health systems have to take measures which go beyond the provision of medical services for the individual patient. A few countries have developed effective mechanisms to design and implement appropriate policies but, in many countries, the public health community is weak. In particular, public health has largely failed in its role as an advocate of the health of the population. Although many policies that relate to public health still bear little relation to evidence, there is a growing recognition throughout Europe that policies need to change, incorporate prevailing values and political decisions and should take account of the local context. Moreover, in the environmental and social

	<p>sector conditions have to be created which allow the individual citizen to maintain or to improve his health. Equity must be its calling card. Building of new healthy communities is a leading goal of modern health systems. It recognizes the importance of ill health prevention through the development of healthy lifestyles and healthy environment in the community. The work in the health departments of the public health service is performed by multi-professional, multidisciplinary teams. Today's public health service has above all been charged with preventive and population-related medical tasks in the field of environmental protection. As medical training traditionally paid little attention to preventive medicine, poverty related diseases and communication and management skills, it is the main tasks of Schools of Public Health to prepare the public health professionals for this mission. The State Health Conference advises on health matters of fundamental importance with the objective of co-ordination and, if necessary recommendations. Those participating in the Conference commit themselves to the implementation of these.</p>
Teaching methods	<p>Lectures and Group Discussions:</p> <ul style="list-style-type: none"> • The mission of the public health service • European public health policies • Public health as a societal advocate • Inter-sectoral cooperation • The organization of the public health service • Areas of activity • The concept of health conferences • Inter-country comparisons (Internet search)
Specific recommendations for teachers	<p>This module should be assigned 0.25 ECTS.</p>
Assessment of Students	<p><i>Individual assignment:</i> take home essay (up to 3000 words, references excluded). Students are expected to provide a comprehensive and coherent review of the public health service in their country.</p>

THE ROLE OF PUBLIC HEATH SERVICES

Wolfgang Mueller

Introduction

In addition to treating diseases, all health systems have to take measures which go beyond the provision of medical services for the individual patient. So, for example, health care services for the overall population have to be ensured by proper planning and services in the field of health promotion and protection such as ensuring the supply of clean drinking water or the protection against communicable diseases to be provided.

Coker et al. (1) annotate that any attempt to describe (the challenges and problems of) public health (services) in Europe faces the twin problems of defining Europe and of dealing with the diversity of health and health systems it contains. For example the health status varies considerably between countries. In some, health is improving, with substantial decrease in heart disease in many western and central European Countries. In others, especially in the former Soviet Union, there is concern about the rapid increase in tuberculosis and AIDS/HIV. The scale of the communicable diseases challenge can be illustrated by the rise in tuberculosis; according to official Russian notifications, incidence almost tripled in the decade after 1991, climbing from 34 in 100000 to 92 in 100000. Social breakdown has contributed to both the generation and spread of disease. Poverty and weakening social ties have fuelled an increase in crime that, together with a harsh criminal justice system, has led to massively overcrowded prisons (and pre-detention trial centres) that act as incubators for infections, in particular tuberculosis and AIDS/HIV (1).

A national analysis does, however, conceal a substantial variation within countries, between regions, and between social classes. The responses to these threats to health are also diverse. A few countries have developed effective mechanisms to design and implement appropriate policies but, in many countries, the public health community is weak. In particular, public health has largely failed in its role as an advocate of the health of the population. There

are, however, many encouraging signs that this may change in the future.

An exploration of public health issues in Europe is difficult. Countries and regions within countries have many languages, prevailing values, and political systems. Even the term “public health” has many different interpretations, with some languages using several words, each with subtly different meanings. Attempts to define the term are difficult because many of the other words required, are also understood in other ways in different countries.

It is even difficult to agree a definition of Europe. The European Region of WHO extends from Iceland to the Pacific and includes a population of 870 million people.

Within WHO’s definition of Europe, there is enormous diversity in the basic determinants of health, contributing in part to major health inequalities between countries.

Whereas the inequalities are apparent at the level of global indicators – such as life expectancy – for individual causes of death the contrasts are even starker. Deaths from injuries among children are almost five times as common in the countries of the former Soviet Union than in those of the European Union. Deaths from ischaemic heart disease among men are almost four times higher in Ireland than in France.

As McKee and Jacobson (2) conclude, this situation is changing as old threats to health disappear and new ones emerge, with some old diseases now reappearing. Rates of coronary heart disease are falling rapidly in countries such as Finland and Poland, but cases of syphilis and AIDS/HIV infection are increasing exponentially in some parts of the former Soviet Union.

European public health policies need to change

Public health responses vary enormously. The organisation of public health activities, such as what is regarded as public health or not, and whether it is based on a predominantly medical or multidisciplinary notion or a unisectoral or intersectoral model, shows

the complex mixture of cultural norms. The strong sense of individual responsibility for health in Denmark contrasts with the much greater acceptance of a role for the state in Sweden. Abuses by the pre-war German public-health system gave rise to the constitutional limitation on the uses of health-related data, seriously inhibiting the development of population-based registries. In parts of Eastern Europe the prevailing public health model retains many features of the Soviet system.

The increasing international dimension to public health creates an added complexity. In the east, there is extensive western input into health care reform. In the west, the European Union is an increasingly important player, whether as a source of funding for international collaboration and legislation with implications for public health, or as a participant in the international exchange of information (2).

Although many policies that relate to public health still bear little relation to evidence, there is a growing recognition throughout Europe that policies need to change, incorporate prevailing values and political decisions and should take account of the local context. The International Cochrane Collaboration, in which many public health professionals have been actively involved, has been an important driving force in this process.

There are also an increasing number of international initiatives designed to promote effective policies. Examples include the Smoke-free Europe programme and the European Charter on Alcohol.

Within the European public health community there is a widespread recognition of the importance of intersectoral action.

At an international level, WHO's Health For All strategy has been replaced by Health 21, containing 21 targets aimed at achieving full health potential for all. In the European Union, the Amsterdam Treaty introduced a requirement that health protection be incorporated into all European legislation at its inception (2).

The general objectives of the actual EU programme are:

- to improve information and knowledge for the development of public health

- to enhance capability of responding rapidly and in a coordinated fashion to health threats
- to promote health and prevent disease through addressing health determinants across all policies and activities

Public health as a political and societal advocate

We can conclude that many health problems in human populations are associated with problems of public health and especially of public health services. The challenge for public health services is to set priorities and to improve inequalities in health. Therefore the network of all different institutes of public health in nearly all states needs improvements in operations, in financing and in human resources.

The appropriate division between national and supranational responsibilities is not always clear-cut. However, there are many supranational issues that could be actively targeted and promoted, also on a political level, by European-wide public health initiatives, such as vaccination coverage, health care provisions for the elderly, the influence of poverty on health, and health care for asylum seekers.

In fact health issues are more global than ever before. Moreover, in the environmental and social sector conditions have to be created which allow the individual citizen to maintain or to improve his health. Equity must be its calling card.

Poverty not only excludes people from the benefits of health care systems but also restricts them from participating in decisions that affect their health. The resulting health inequalities are well documented, and the search for greater equity attracts many concerned players and initiatives. Fundamental to the success of these efforts, however, is the need for people to be able to negotiate their own inclusion into health systems and demand adequate health care. This calls for a restatement of the centrality of people in public health and its practice. New forms of communication and cooperation are required at all levels of society, nationally, and internationally, to ensure equitable exchange of views and knowledge to formulate appropriate action to redress inequalities and improve people's health and wellbeing.

McFarlane et al. (3) show that some developments in the collection and analysis of comparative data worldwide have increased awareness of the complicated health scenarios that face communities and public health practitioners in poor countries. Substantial numbers of deaths result from infectious diseases (malaria, AIDS/HIV, tuberculosis etc.). These – together with non-communicable diseases such as cancer and diabetes – make up the double disease burden of many developing countries. To these must be added threats related to risk-taking behaviour – particularly among adolescents – violence, road traffic accidents, and psychological distress. There are widespread inequalities in health status, life expectancy, and in access to health care between rich and poor countries, between rich and poor people, and between poor men and women everywhere. Women suffer disproportionately and, together with their children, have most to gain from improved health care.

Mackenbach and Bakker (4) are also detecting that during the past decade, socio-economic inequalities in health have increasingly been recognised as an important public health issue throughout Europe. While the emphasis of academic research has gradually shifted from description to explanation, policymakers and practitioners have begun to search for strategies to reduce these inequalities. A wide range of possible interventions and policies has been proposed, and sometimes implemented, in several European countries.

Whether it will actually be possible to substantially reduce socio-economic inequalities in health remains an open question. European trends in inequalities in mortality during the last decades of the 20th century have generally shown a widening of the gap in relative terms, and at best a stable situation in absolute terms. The good news is that during the 1990s, a great amount of progress was made in development of policies and interventions, putting us in a better position to reduce socio-economic inequalities in health in the coming decades. For several innovative approaches there is at least some evidence of effectiveness, and although evidence might not fulfil the highest scientific standards, better evidence is unlikely to become available unless these approaches are introduced on a wider scale, accompanied by continued evaluation efforts.

No one country has the capacity to contribute more than a fraction of the necessary knowledge. This matter is one of not only restricted manpower or financial resources for research but also restricted opportunities for implementation and evaluation of policies and interventions. Some policies can be applied and assessed in some countries and not in others, either because they have already been implemented or because they are practically or politically less feasible. International exchange, preferably among more countries than included in the present analysis, is therefore necessary to increase learning speed (4).

Joint activities between different sectors and organizations

Since public health comprises health promotion and disease prevention through the organized efforts of the society, it requires health promotion through intersectoral activities. Cooperation with many sectors together with inclusion of the general public has a key role in future tasks defined in this strategy. Sectors that are exceptionally significant and relevant, in addition to the health sector are: economical sector, educational sector, sector of agriculture, transport sector, ecology, social, culture and many other sectors. Voluntary, non-governmental, professional, business, sport organizations, as well as those that include work force (trade unions) will be key partners together with all levels and types of governmental organizations. In addition to these organizations, representatives of different interest groups that gather people with different problems and special needs are significant partners in implementation of roles and tasks of institutes of public health services. In this way, local community should in the best available way be presented in all health promotion activities.

Building of new healthy communities is a leading goal of modern health systems. It recognizes the importance of ill health prevention through the development of healthy lifestyles and healthy environment in the community. This strategy, compulsorily considers the community support, recognizing that population health is determined by numerous factors outside medical care and that these factors may be controlled by community itself, through its cooperation

with the above mentioned other sectors, such as sector of agriculture, water supply, education.

Therefore, the mission of public health services should be based on an integrated approach of the so-called old and new public health, ensuring that all public health services on all administrative levels are orientated towards promotion of public health strengthening the community in assuming the responsibility for its own health and support to the individuals to make choices that preserve and improve health and reduce risky behaviour.

General goal of public health services is to improve the quality of life of the population, especially of vulnerable groups. For the implementation of this general goal - as said before - we find in Europe on different levels – national policies, policies of the European Commission and WHO Europe, it is mainly the public health service who is in charge to implement in real life the written policies

National public health institutions

In all countries if there are organized federally or centrally we find highly specialized health institutions on the national level. Their tasks are different according to the legal organization of the health care system and the size of the country. Generally speaking, they have to monitor and study health status of the population, the epidemiological situation and hygiene conditions, the surveillance of communicable and non-communicable diseases.

These public health institutions – as part of the public health service – have developed and are continuously developing:

- national monitoring of risk factors (social, behavioural and environmental factors)
- monitoring of communicable diseases
- monitoring of chronic mass non-communicable diseases
- support to development of preventive services within the framework of primary health care
- development of health management, health care quality control and programs of continuous improvement of health care quality
- initiation and participation in development of the health information system

In some European states we find on the central level public health laboratory institutions, proving the health measures and services, for example:

- examination of medicaments quality
- virus and microbiology analysis
- complex bacteriological and chemical analysis,
- complex immunology analysis
- allergology-immunology diagnostics.

These laboratory services may control and monitor other laboratories' work, private and state owned it may be part of an accrediting system in compliance with European Union standards.

To summarize, the roles and tasks of central or national public health institutions can be:

- development of capacities for collection and analysis of relevant health data, by using minimum indicator set recommended for the Balkan region
- improvement of skills for development of health policy, which includes routine reporting on health status, estimation of future trends of health problems, economical assessments, instructive reports that will help in adoption of decisions on different levels of the health system
- development of capacities for improvement of system for health care quality control
- improvement of research skills, especially in studying the effectiveness of community based health promotion interventions (health promotion and disease prevention programs, detection of risk factors in population)
- development of information and communication services
- development of employees' abilities to assess the cost-effectiveness of curative and preventive services

and so on.

Local health departments

But all this expertise remains academic without a continuous transfer and implementation to the population as a whole, to defined groups of the population and even to individuals. This has to be done by a lot of different institutions; one corner stone is the public health

service. The public health service in the institutional setting of a local health department offers to the individual citizen personal advice and help.

Whether they contact their local health departments in connection with school entrance examinations or want to procure an expert opinion, whether they seek advice from a health department when trying to find out the address of a local self-help group or contact their local health departments for fear of health impacts from environmental pollutions.

There is a great variety in Europe about what a local health department is, what its responsibilities and functions are, how it is equipped, what human resources it has, for how many people it has to look for. It can be totally integrated into the local municipally or it may be organized in a direct line within the health sector administration.

What is getting more and more common in Europe?

The work in the health departments of the public health service is performed by multi-professional, multidisciplinary teams. At least 10 to 15 different professions are working in most big health departments, with the subject of health not only restricted to purely medical aspects but also comprising social education, engineering, biology, psychology, health sciences and social sciences.

- ➔ Selected tasks of a Health Department
(they may vary from country to country; there is an enormous variety in organization, structure and function in public health departments within European countries)

The following central functions are performed by health departments in general:

- medical supervision of health professions and institutions
- medical hygiene and health protection including modern environmental protection
- health promotion and health care as well as health services
- drawing up of expert reports

- food and drug safety and control
- epidemiology and health reporting/health planning
- quality assurance

In the following some of these tasks are shortly described (for more details see Brand et al. (5)).

➔ Medical Supervision

In some European states the medical supervision of the health professions was transferred to the corresponding medical chambers, in most countries the health departments are still responsible for other professions such as non-medical practitioners.

➔ Infectious Disease Control and Health Protection

A conventional field of activity for a health department is the infectious disease control. Whereas formerly tuberculosis and other infectious diseases were the main reasons for illness and death, we are now witnessing an increase in chronic diseases in the EU. Correspondingly, in connection with controlling tuberculosis, health departments have above all been charged with the combating of small-scale epidemics and controlling of viruses. The development of the immune deficiency syndrome AIDS has however shown that infectious diseases have not been eradicated. This disease constitutes a new challenge for the health departments because here the traditional instrument of infectious disease control does not work.

The political transition led to striking declines in gross domestic product (GDP) in the former communist countries, with increases in unemployment, widening income inequalities, and an expansion in informal and criminal economies (1) Transition has had many consequences for health, with increases in sexually transmissible diseases and tuberculosis accompanied by growing rates of teenage suicide and alcohol-related death. For example Romania has not only the highest incidence of HIV/AIDS among the candidate countries for EU accession, is it also the only country in which most people with HIV/AIDS are children. Clearly, public-health issues will become even more diverse than they already are now in an enlarged EU (6).

The European Union will have its own centre for disease prevention and control from next year after the European parliament gave the go-ahead for the initiative on 10 February. The centre will tap into the expertise that already exists in national public health institutes. It will take over management of the European communicable disease network that has operated since 1999 and become closely involved in the EU health security task force's work in monitoring and planning against bioterrorist attacks (7).

As regards the preventive task of inoculations, health departments used to hold a monopoly position in most European countries. Now that this task has been taken over in many countries by the health insurances and is thus performed by general practitioners, health departments have been charged with the task of determining and closing inoculation gaps among children and adults – besides monitoring the rate of immunisation.

Regarding the monitoring of hygiene in hospitals, health departments have to cope with more and more demands, especially in the field of cooperation with hygiene experts and hygiene commissions in hospitals. Also the question of hygiene in canteen kitchens and old people's homes is a problem which health departments have to tackle.

Today's public health service has above all been charged with preventive and population-related medical tasks in the field of environmental protection. Its practical work is aimed at the early detection of dangers caused by the environment, by registering health relevant pollutions or environment-related health disturbances. In addition, it evaluates the health impact of environment-related risks and dangers for the citizens and population.

At state level, the basic conditions for an effective health protection are created. For this purpose limits and guidelines as well as recommendations for action are developed.

The tasks in environmental health protection are often performed in cooperation and coordination with other local and national institutions, e.g. environmental authorities and factory

inspectorates. Current fields of activities are for instance the hygiene of drinking and bathing water. As far as internal air hygiene is concerned (e.g. Sick-Building-Syndrome) the public health service is charged with the task of contributing to healthy living and working conditions.

In addition to the traditional activities, new tasks are becoming important. Citizens show more and more interest in environment-related health information, especially on the health impact of pollutants. In this respect, the public health service often performs the function of risk communication with the citizens. Assessing the risks caused by expositions, e.g. after having attended an asbestos-polluted school, makes high demands on public health officials. In addition to medical questions concerning the actual health risks caused by expositions and the necessity of redevelopment measures, psychological problems, e.g. addressing the fears of the population, transparency of information or making sure that those concerned are involved in the finding of solutions have to be dealt with. Due to the wide range of problems in this area, some health departments have set up advice centres for environment-related medical problems which in addition to rendering advisory services for the general public also clarify medical problems of the individual citizen in cooperation with other areas of the health care sector. In view of the poor knowledge we have on the correlation between anthropogeneous pollutants in low-level doses and special symptoms it is difficult to answer whether complaints or diseases mentioned by the citizens are really caused by pollutants.

The performing of advisory functions and the drawing up of expert reports for planning tasks by the local communities, by local politicians and citizens' initiatives should also be mentioned in this context. So for example health departments are involved in statutory tests to prove the ecological harmlessness of certain products or substances. There are also initiatives for the introduction of a test to prove the harmlessness of certain products or substances for health which could provide the public health service with better information for its expert reports.

➔ Health Promotion

Health promotion is of major importance in today's public health services.

In the field of health promotion the public health service has an initiative function at local level. Health promotion aims at health gain. This is to be achieved by healthier living and environment conditions which allow and facilitate healthy ways of living as well as by health information and education (information transfer, health campaigns) which are intended to motivate people to lead a healthy way of life. This is a cross-sectional task which also incorporates other sectors of the public health service. It goes far beyond the medical task and stretches into the field of health policy.

Main task of the public health service should be the coordination of the many actors in order to achieve a continuous process of health planning and health education in a local community.

What is also important is the influence on health-relevant areas of policy, programmes and planning initiatives (e.g. traffic and town planning) with which health departments try to enforce health targets and priorities.

In addition to the traditional health advisory services for the general public, the promotion of self-help movements and social networks becomes more and more important. Today already, health departments often perform the function of coordinating offers or providing the infrastructure or technical equipment. The cooperation with contact and information agencies on self-help offers should also be mentioned in this connection.

➔ Social medicine

Among its variety of tasks the public health service attaches special importance to preventive measures and health maintenance for pregnant women, infants, small children and young people. Over a long period of time the successes achieved in perinatal and neonatal medicine have concealed the fact that social indicators and factors play an important role for the healthy development of children and infants. But particularly these factors can hardly be influenced by the traditional out-patient service provided by general practitioners,

because for different reasons socially disadvantaged people tend to see their doctors less often than the well-to-do. A public health service which goes to those in need could achieve further successes in this field.

An important task to be performed by the paediatric medical services is the work in schools and kindergartens. Here the public health service fulfils its independent function of a „works medical doctor“ for children.

This function also applies to the paediatric dental services, a public health service, which shows a great variety in the European countries.

Multi-professional teams referred to as socio-psychiatric services which take care of people with serious and chronic psychic diseases have been established in the local setting.

Main tasks of the socio-psychiatric services are:

- interest-free advising and support in cases of disturbed behaviour by people asking for help
- actively visiting and motivating care in cases of disturbed behaviour by people asking for help
- rehabilitative long-term treatment if not guaranteed by others, including practical support and offers of socio-therapeutic groups
- coordination of individual support when various institutions are involved, especially at links between intra- and extramural health care measures
- expert opinions in affairs concerning public administration and non-contentious judiciary
- initiation and coordination of the regional psycho-social health care

In all societies, immigration entails specific health problems. Supported by corresponding recommendations in the different countries, health departments react to the increasing number of people seeking political asylum and emigrants at first above all with a screening of (infectious) diseases and general pieces of advice.

➔ Epidemiology and Health Reporting

In addition to health reporting at state, national and European level an independent form of health reporting is developing at local level. The idea is that for analysing needs, for evaluating the political situation and for defining priority deficits in the health sector corresponding local analyses have to be carried out. It is only then, that local priorities and health targets can be fixed, programmes or planning tasks be initiated and later on evaluated correspondingly. So we can find now more Public Health professionals in several countries who publish regular reports on the health of their populations, comparing them with neighbouring regions, examining changes over time, and making recommendations for action. Such reports generally take one of two approaches. Some are used as means of proclaiming governments or health authorities whereas others are written from the perspective of the community, drawing attention to failings and challenging the authorities to act.

The tasks of local health reporting include the following:

- information and orientation of politicians and the public
- monitoring
- motivation of decision makers and citizens' groups
- evaluation and
- co-ordination of appropriate measures.

Health departments are well suited for the drawing up of regional health reports because they hold a neutral position. They neither depend on memberships as the health insurances do nor on medical insurance record cards as doctors and unlike hospitals they are not interested in competing for patients or, as in the case of welfare associations or independent organizations, in getting allocations.

Issues to be dealt with by health reporting mostly result from existing problems of the local health policy. Since relevant information on the health status of the population or health care situation is only to some extent provided by the public health service itself, it is necessary to prepare and analyse the necessary information on a cooperative basis.

What is decisive for the future of health reporting is the question as to whether it will be possible to make local health politicians and the public aware of the results of health reporting so that based on these reports concrete measures will be taken.

In very few countries, local health reporting is presently based on a modern statutory basis. Hence workable results can only be achieved in consensus with all participating parties, e.g. at local health conferences. In this context health departments do not have to carry out necessary actions by themselves but to use their influence so that corresponding institutions implement the relevant measures.

Health Conferences

In 1991, the State of North Rhine-Westphalia (Germany) established the NRW State Health Conference to pave the way for a new Culture of joint actions in the health care sector. Against the background of different responsibilities, diverging priorities and increasing competition between the various actors' agreement and co-operation, the further development of health monitoring activities, joint definition of targets, continuous cross-sectoral provision of health care are just some of the concerns of this innovative political forum. With the NRW Act on the Public Health Service (ÖGDG) both the State Health Conference and the local health conferences have been put on a legal footing.

The State Health Conference advises on health matters of fundamental importance with the objective of co-ordination and, if necessary, makes recommendations. Those participating in the Conference commit themselves to the implementation of these. The State Health Conference meets at least once a year. It is chaired by the Ministry responsible for health. An important aspect in this context is the specific coordination on the local level. (for details see: Ministry for Women, Youth, Family and Health (8)).

An existing and working example for this structure is the "Local Health-Conference" in North Rhine-Westphalia. It is a "round table", in which efficient forms of participation, co-operation, information and agreement as well as flexibility to ensure open

structures of the health care system are to be developed which lead to common recommendations for action. On average one local health conference, administered by the local health department which is a part of administration of the municipality, is responsible for about 300000 inhabitants in North-Rhine-Westphalia.

Schools of Public Health

The public health service will increasingly take over health promoting and preventive functions at the local level. In connection with its advisory and services functions, the public health service will more and more act as an advocate of the health concerns of the citizens. For this mission a highly skilled staff is absolutely crucial. As medical training traditionally paid little attention to preventive medicine, poverty related diseases and communication and management skills, it is the main tasks of Schools of Public Health to prepare the public health professionals for this mission. There should be a common understanding of the schools to be a part of the public health service, or at least a reliable partner, including the fact to establish an integrated training and continuous training for undergraduate and graduate professionals. It is claimed that in the local health departments multi-professional co-operation is the basis of effective work – but where is this competence taught and learned if not in the school of public health? In my opinion schools which concentrate only on post graduate training can't support the integrated approach in the best possible way.

The Public health services and Schools of Public Health have to overcome different problems:

In many countries in Europe there are certain unresolved tensions within public health. One is the link between practice and academe. Close links between practice and academe can bring many mutual benefits. Practitioners can contribute to setting the research agenda and researchers can ensure that their findings are translated into practice. In practice, these links are weak in many countries. One reason is the division, in some countries, between public health training and research that could be regarded as addressing public health issues is undertaken in university departments of epidemiology or social sciences, whereas training takes place in separate schools of

public health. Public health practitioners may have little personal contact with the leading researchers in their countries during their training or afterwards (2).

Numerically, some countries produce more health workers than they need whereas others do not produce enough. Qualitatively, there are often inconsistencies between level of training and the needs of the job. In addition, there are serious problems of inequity in the distribution of health workers by geography and institution. Development of human resources is fundamental to the response. It is the greatest asset of any health system – the Public Health Service is as well part of the health system as part of the Civil Service, with all its advantages and disadvantages. Yet an underpaid, poorly motivated, poorly organised and increasingly dissatisfied workforce also poses the greatest threat to any service. Not all can be done by schools of public health, but they are as part of public health service a cornerstone in the reform of the service for the coming decade and the ongoing challenges (3).

For the improvement of the performance the extensive management training for all managers in public health on all levels is needed.

Beside training activities the Public Health Services has to have – as well as the Civil Service in whole – a reliable, ongoing and sufficient financial basis. The money may come from local municipalities or from regional or national state budget. If this crucial condition is fulfilled, the Service itself can convince the citizens by action, intelligibility and results, that the citizens' taxes to pay the service are a good investment for individual and public health.

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Chapter 3
STRATEGY IMPLEMENTATION

A PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Public Health Planning: From Recommendation to Implementation
Module: 3.1	ECTS (suggested): 0.3
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Keywords	Rational decision-making, System Analysis, efficient implementation of policy recommendations
Learning objectives	<p>After completing this module students and public health professionals should understand how:</p> <ul style="list-style-type: none"> • an implementation of projects and solutions are done within complex social systems, with many interdependencies of interests and motives, when planning takes place at different levels and in different organisational structures of a country or region, • one has to distinguish between rejection or delay of a decision due to real feasibility hurdles or politically correct but disguised refusals. • to identify and analyse the rules of the game in the corresponding "fields of force" and to set up models for simulating qualitatively

	possible interventions.
Abstract	<p>Every analysis of the reality of planning has to take into account that planning takes place at different levels and in different organisational structures of a country or region. Such a plurality of planning authorities and corresponding values can lead to conflicts and - in the worst case - to stalemate. It is also important to really understand the meaning of a possible rejection or delay of a decision. Therefore it is vital to understand the motives and interests of involved stakeholders, the connectivity of goals, and the interrelationship of organisations. Furthermore, the likely outcomes of any suggested strategy have to be evaluated from the viewpoint of the stakeholders, qualitatively and where possible also quantitatively. This helps to understand which stakeholder would be supportive, indifferent or possibly against a plan. Social systems are very complex systems with many elements and processes. They are regulated by positive and negative feedback loops. The relatively high number of feedback loops that act with different speed, strength of impact and direction (supporting or weakening) makes it impossible to predict actions or reactions of a system when introducing new activities. Systematic description and simulation of such systems is needed.</p> <p>Two approaches are introduced to simulate the possible behaviour of stakeholders.</p>
Teaching methods	<p>After introductory lecture on network thinking, students will participate in working groups. They will analyse the social system in which a concrete public health recommendation should be implemented. They will have to decide which of the two tools offered they find most appropriate to use. Based on that decision they have to follow the steps recommended in the chapter. The final outcome is an analysis of the social system and a plan for interventions.</p>

Specific recommendations for teachers	Introduction of cybernetic approaches as a basis for planning
Assessment of students	Multiple choice questionnaire on network thinking (MCQ), and case problem presentations.

PUBLIC HEALTH PLANNING: FROM RECOMMENDATION TO IMPLEMENTATION

Valeriu Sava, Helmut Wenzel

*To know one's ignorance is the best part of knowledge
Lao Tzu, The Tao, no 71*

Introduction

Life is full of uncertainties. The previous chapters dealt with different problems and aspects of uncertainty and tools for creating a scientific basis for analyses and policy recommendations. Successful implementation needs to go beyond pure recommendation. In this context planning, strategic planning becomes an issue. If someone wants to reach a specific goal he ought to:

- Determine the likelihood to reach that goal with a given set of resources.
- Anticipate and identify undesired side effects that might occur due to the goal to be reached and the potential use of available resources. This has to do with the complexities of the system where the action takes place.
- Balance the value of the goal against the undesired side effects, and
- Analyse the cost (opportunity cost) with respect to forgone possibilities when using the resources for other purposes or projects.
- Thus evaluate the relative importance and relevance of the goal with respect to all other personal values.

This can be called the fundamentals of any planful activity. As any kind of planning takes place in an organisational and political context, it is important to understand the rules of the game in the corresponding "fields of force". The goal of this chapter is to describe opportunities to cope with uncertainties in the political decision making arena and improve the probability of successful implementation.

Every analysis of the “reality of planning” has to take into account that planning takes place at different levels and in different organisational structures of a country or region. Such a plurality of planning authorities and corresponding values can lead to conflicts and - in the worst case - to stalemate. It is also important to really understand the meaning of a possible rejection or delay of a decision and to distinguish between real feasibility hurdles - such as lack of resources etc - and politically correct but disguised refusals in the “garment” of specific circumstances which make it impossible to implement a project (so called inherent necessity).

It is therefore vital to understand the motives and interests of involved stakeholders, the connectivity of goals, and the interrelationship of organisations. Furthermore, the likely outcomes of any suggested strategy have to be evaluated from the viewpoint of the stakeholders, qualitatively and where possible also quantitatively. This helps to understand which stakeholder would be supportive, indifferent or possibly against a plan.

All those analyses try to describe or to understand social systems. Social systems are very complex systems with many elements and processes. They are regulated by positive and negative feedback loops. The relatively high number of feedback loops that act with different speed, strength of impact and direction (supporting or weakening) makes it impossible to predict actions or reactions of a system when introducing new activities. Systematic description and simulation of such systems is needed.

In principle two different approaches can be used:

- A system analysis approach where a network of influences (influence diagram) is depicted. This can be supported by a professional software tool like GAMMA[®].
- A form of Computer-Assisted Political Analysis (CAPA) like PolicyMaker[®]. The software can be applied to any policy problem that involves multiple players with diverging interests. It primarily uses meta-information on the motives and interests of stakeholders involved which implies a database with all the information mentioned.

The system analysis approach

In Western cultures linear cause-relationship-thinking is very common. In combination with the fact that social systems - the arena of decision-making - are very complex, this fosters simplified views of "reality". In fact, our reality is determined by the concurrence of elements rather than by their isolated function and performances (individuals, organisations etc.). Influencing factors are linked and evolve dynamically over time. Therefore it is needed to think in terms of cycles and interrelations (feedback loops). This enables the analyst to follow the dynamics of a system and to identify undesired (unintended) side effects and feedback effects. Very often, surprisingly very faint feedback loops, easy to overlook, can have a higher impact on the course of a process than overt and direct interdependencies.

In this context the "nested thinking approach" was promoted. It understands problems as a dynamic network of influencing factors, target parameters and impact parameters. Including all relevant associations into the analysis is a prerequisite for appropriate problem solving and anticipating the likely outcomes of an intervention.

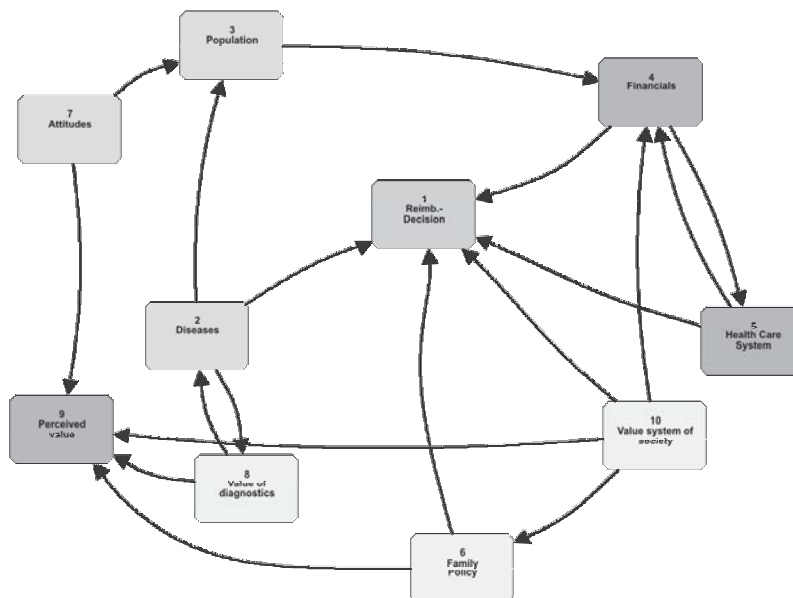
The blueprint for a system analysis

Four steps are recommended (1). Ideally this process should be done in working groups. This modelling approach is rather qualitative, so no algorithms are needed. The information used can be intuitive or – in the best case – be empirical. The engine of the model is transparent, the mathematics is basic calculations like adding up and multiplying numbers, no black box is used, no mystic expert knowledge is hidden somewhere. The expertise is within the group, the members are the experts.

1. Definition of the system to be analysed. Here we describe the field of action or the research area and define the goals of the analysis. All the relevant elements and processes of the system under survey have to be listed. Exclusion of all elements that have not to be considered is a cross-check of that step and helps to define the boundaries of the system (see example).

2. Modelling phase. The elements of the system will be connected by lines symbolising the influence by strength, direction (causality) and time aspects. Very often those lines can be understood as processes. As a result of this step the complexity and the interdependencies are shown. This visualisation is the basis for consensus building in the group: Do we have the same understanding of the boundaries, the elements and the processes of the system we should look at?

Figure 1 Influence Diagram



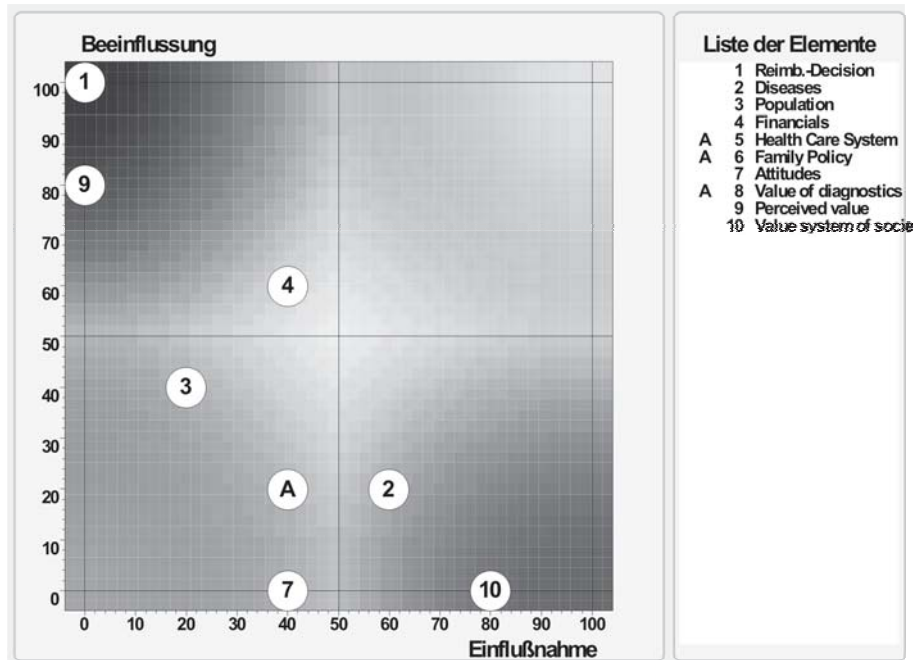
Source: H. Wenzel, Elements that influence Reimbursement Policies, Presentation given at the Annual ISPOR Meeting in Barcelona, 2003 (2)

3. Learning phase. Basic analyses are carried out to understand the dynamics of the system. The simplest analytical step is a portfolio analysis dividing the elements according to the influence they receive or the influence they have on other elements into active and passive elements (see example). In a more sophisticated step the speed of influences and feedback loops are analysed. As prerequisite processes have to be evaluated by their level of strength and the speed of influence (speed can be measured in

terms of hours, days or years it depends on the system and the time horizon). In this case it can be graphically shown how influences are evolving (see example). Again this can be used also to build consensus on the dynamics and behaviour of the system under consideration.

2. Strategy phase. First of all, the possible options for interventions (or changes) have to be listed. Most preferably this could be done alongside the model structure. This prevents overlooking of important options. In a next step the consequences of interventions are simulated. Based on the learnings the desirable activities are listed, maybe resources needed are estimated and responsibilities for the actions are agreed upon.

Figure 2 How to understand the Analysis



Source: H. Wenzel, Elements that influence Reimbursement Policies, Presentation given at the Annual ISPOR Meeting in Barcelona, 2002 (2)

The quadrant on the lower right side shows the elements with the highest influence within the system under analysis: the value system of the corresponding society (#10) and the spectrum of diseases in a country (#2). Those elements are targets for *efficient actions*. Elements in the upper left quadrant have no or nearly no influence (#1, #9, #4). Any measure taken here to change the system is *inefficient*. Elements in lower quadrant on the left side (#3, #5, #6, #8) are inert. They are behaving like buffers and are inefficient for actions, too. Elements in upper right quadrant are critical, mostly due to feed-back loops. It is hard to predict what will be the likely consequences or outcomes of any intervention here.

A form of Computer-Assisted Political Analysis (CAPA)

General remarks

Managing the policy-making process is a difficult task. Politics affects all aspects of public policy: what gets on the agenda; that supports an issue; who opposes an issue; whether an issue receives official approval, and whether the official policy is implemented. The political processes are important in health policy reform because the proposed changes in the health system seek to redistribute resources with new benefits for some groups and new costs for others. Successful health reform requires adequate political management and reformers must be able to assess the political feasibility of a policy, manage the processes of policy design and acceptance, and create strategies for implementation. Reformers need political strategies to manage the interest groups, the bureaucracy, and the technocrats, and often in developing countries, to manage the international agencies. There are different methods for assessment of the stakeholders and their relationships and for identification of the opportunities and obstacles to change. One of them is a computer-based policy analysis tool, which can provide rapid assessment procedures to probe the political dimensions of policy-making and helps the reformers to analyze systematically who are supporters, why the policy may face opposition, and what strategies might help to be more effective.

The *PolicyMaker* is a Windows-based software program for Computer-Assisted Political Analysis (CAPA) that serves for such tasks and can be used as a tool for strategic planning among key advisors, or as an instrument for seeking consensus or agreement among different players or as a policy advocacy or lobbying tool. The

software is a rapid assessment method for analyzing and managing the political analysis of public policy and makes it both accessible and enjoyable. *PolicyMaker* was developed by Michael R. Reich and David Cooper (1995 – 1997), is applicable to policy issues in the public domain (such as the mega-policies of national economic policy and health policy) and also in the private sector (such as the corporate policies of re-engineering and downsizing). *PolicyMaker* has been used around the world by government officials, advocacy groups, private companies, international agencies, and the faculty members of major universities. It was tested and applied for health sector reform issues at the national level in Latin America, Europe, Asia, and Africa; for municipal health policy in the United States; for training health professionals in applied political analysis at institutions in Africa, Latin America, the United States, and Europe. These experiences demonstrate that *PolicyMaker* is an effective tool for describing the political processes involved in public policy, for explaining how past decisions were made, and for proposing strategies to manage the political dynamics of policy decisions.

The role and objectives

PolicyMaker (3) is a practical tool that guides the user through a professional analysis and can be applied to any policy problem, including health policy that involves multiple players with diverging interests. The program is intended to help policymakers manage the processes of reform - to improve the political skills of the reform team and enhance the political feasibility of policy reform. *PolicyMaker* provides what a policymaker and a policy analyst need: a logical and formal procedure to analyze the political dimensions of policy change and a systematic method to design effective strategies for managing the politics. When used creatively, *PolicyMaker* can help promote strategic programming as well as strategic thinking. It can help to describe the political dimensions of a policy decision, explain how a policy decision was made in the past, and design effective strategies for influencing a policy's feasibility.

As a *descriptive* tool, *PolicyMaker* provides a method for collecting and organizing important political information about a policy. Many policy problems involve a degree of complexity that can overwhelm the user's capacity to keep the issues well organized in his

mind. *PolicyMaker* serves as a database for assessments of: the policy's content, the major players, the power and policy positions of key players, the interests of different players, and the networks and coalitions that connect the players. The software also assists the user in identifying opportunities and obstacles to policy change. In many situations, this political information may be well known to people involved in a policy, but the data are rarely collected or organized systematically. *PolicyMaker* provides a set of techniques for deciding on the information to collect and for displaying that information in ways that are analytically useful, visually pleasing, and easy to manipulate.

As an *explanatory* tool, *PolicyMaker* can help explain how a particular policy was decided in the past and which strategies were effective in a particular political environment. *PolicyMaker* incorporates political mapping and political risk analysis models to explain policy-making processes in a real world setting based on an assessment of influence of supporters versus opponents, and the impacts of political strategies adopted by both sides. The *PolicyMaker* model proposes that policy feasibility is a function of three main factors: *the number of players mobilized to support and opposes a policy; the power of each mobilized player; the position and intensity of commitment for each mobilized player.* Applied retrospectively, the *PolicyMaker* method can help to understand how these three factors shaped the feasibility of a particular policy decision, or how a specific strategy worked in certain political circumstances. By examining the strategies that facilitated or blocked the acceptance of past policies, you can build up your own set of strategies for future action.

As a *prescriptive* tool, *PolicyMaker* can be used to help to design a set of political strategies, and assess the likely impacts of those strategies on policy formulation and implementation. The program can help improve the political feasibility of a particular policy, by identifying supporters and opponents, identifying potential supporters, and analyzing the effects of potential strategies. *PolicyMaker* suggests strategies for producing change, helps analysts think systematically about future scenarios produced by specific strategies and to manage the complexity of real world problems.

Analysis steps

PolicyMaker provides practical advice in a logical and formal way on how to manage the political aspects of decision-making and is based on five analytical steps: *the Policy*; *the Players*; *Opportunities and Obstacles*; *Strategies*; and *Impacts*.

The program displays each step in the process as a series of buttons which lead to a window for each step.

Step One (*Policy Content*) helps to define and analyze the content of desired policy or decision. The user has to identify the major goals of the policy, and specify a mechanism that is intended to achieve each goal. Also, to determine whether the goal is already on the agenda and propose an indicator to measure progress towards achieving each goal. This step asks to specify the policy's content with as much accuracy as possible.

Step Two (*Players*) permits to identify the most important players and analyze their positions, power, and interests, and assess the policy's consequences for major players. This assessment resembles a stakeholder analysis. The data are then displayed in a Position Map, using political mapping techniques, to show the positions of players on a continuum from high support through to high opposition. The program presents the data in a Political Feasibility Graph, using an algorithm that calculates a feasibility index for the policy (based on the three variables of power, intensity of position, and number of mobilized groups). The user then can identify the main interests of each player, evaluate linkages among players, and analyze the possible networks and coalitions among the players. *PolicyMaker* can display this information in easy-to-read reports, tables, and diagrams. One major table, the Player Table, allows seeing all players sorted and colour coded on the basis of their positions and power. This table provides the user with an overview of the key players. It can be sorted by several variables, allowing to look for opportunities which may have escaped a less systematic analysis. The Position Map shows how the players are positioned in a colour coded table, with policy supporters on the left, and opponents on the right and with power coded in black, grey, and white.

Step Three (*Opportunities & Obstacles*) permits to assess the opportunities and obstacles that affect the policy feasibility and need to be changed. The user can identify transitions underway in the

organization responsible for implementing the policy, in the general organizational environment and in the context of political environment.

Step Four (*Strategies*) permits to design strategies to improve the policy's feasibility by using expert advice provided in the program based on the principles of artificial intelligence. Then, to evaluate strategies and the probabilities of success, and to create alternative strategy packages as potential action plans. The user can modify the strategies suggested by *PolicyMaker*, to create a customized set of strategic actions for personal use, based on own experience of what works best.

Step Five (*Impacts of Strategies*) is to estimate the impacts of developed strategies on the positions, power, and number of mobilized players – the three factors that affect the policy's feasibility. The user can compare the future and current Position Maps and Feasibility Graphs to show the aggregate impacts of a strategy package on the policy's feasibility, and to compare alternative future scenarios. The program can also be used to monitor the implementation of strategies, and compare observed and anticipated impacts. In addition, the Feasibility Graph displays a quantitative assessment of the relative strength of all supporters versus all opponents, and the potential to mobilize players currently in the non-mobilized category. The assessment is based on the assumption that political feasibility is determined by three main factors: the strength of the position a player takes (low, medium, or high support or opposition), the power of a player (high, medium, or low power), and the number of players who are mobilized to support or oppose a policy. The Feasibility Graph displays either a bar chart or a pie chart and assesses the political feasibility of proposed policy by calculating a value for each player that combines the Position, Power, and Votes, according to an algorithm that the user can customize.

Domains of application and proposed users

The software can be used as both an analytical and advocacy tool, to help individuals and organizations assess the political dimensions of producing changes, especially for situations that involve multiple players. It can be used at the national, institutional and programmatic levels, in both private and public sectors, in health and other fields, in both developed and developing countries. As a

rapid assessment tool for political analysis, *PolicyMaker* can be applied in a variety of ways and settings. Here are five possible approaches for its application:

- *Gathering and organising political data about a particular policy:* This is the most common way to use *PolicyMaker* - as a tool for gathering and organizing information about a proposed policy, especially in complex circumstances with many players. This approach can help you decide what kind of data to collect about a difficult decision, and allows you to sort and display this information efficiently. You can create separate files for the same policy at different points in time, to show how the political conditions have changed. At a minimum, *PolicyMaker* functions as a policy database.
- *Providing instruction for staff analysis:* *PolicyMaker* can be used as a guide for your staff members, as a way to structure their analytic work. Staff members can use the program to correct and enter information about a policy, and the program can be used for briefing senior policymakers about important specific problems or strategies. Another possible approach is for junior staff members to enter basic data, so that senior policy-makers can use the program to carry out more sophisticated analysis.
- *Presentations about policy decision:* *PolicyMaker* can be used in public or small-group settings, to make a presentation about a policy decision or about a set of policy options and their different obstacles and consequences. In this approach, *PolicyMaker* is used to present the results of a completed analysis, for consideration by a group of decision-makers.
- *Strategic planning exercise for groups:* *PolicyMaker* can be used in a group as an instrument for strategic planning and consensus building among key players, using a skilled facilitator to guide the discussion according to the program's five steps. In this approach, the program creates a set of shared analytic concepts that guides the group's understanding and analysis of the policy.
- *Confidential advice for top policymakers:* *PolicyMaker* can also be used as a confidential advisory tool for senior policymakers, who may wish to have an explicit analysis of the supporters and opponents of particular policies or decisions. In this approach, the data, the analysis, and the proposed strategies remain private, and provide an additional analytic input to the decision at hand.

PolicyMaker should be used by anyone who wishes to influence public or private policy decisions that involve multiple groups with diverging interests. Potential users include:

- government policy-makers with substantial control and resources and who wish to improve the political feasibility of a proposed policy;
- non-governmental organizations that have limited influence and resources and seek to promote a specific policy on the official agenda;
- government officials who seek to increase the loyalty of groups to a proposed policy;
- groups with little formal power who wish to increase their voice in the policymaking process,
- technical analysts who wish that their reports could have more impact on policymakers;
- individuals within an organization who seek more influence over restructuring efforts;
- private organizations that seek to manage public issues and multiple organizations in a public or private arena;
- groups or individuals such as academic researchers, independent policy analysts, and journalists who study and report on political issues and events.

PolicyMaker could be used by both the supporters and the opponents of a single policy, and they should arrive at different strategies. One can also use *PolicyMaker* from the perspective of the other side, to gain insight into their likely strategies and actions.

Because of the diverging potential users and the sensitive data contained in an analysis, all documents and computer files related to a *PolicyMaker* analysis should be treated with caution and discretion. A *PolicyMaker* report designed to assist a specific organization may not be appropriate for public dissemination. Indeed, in some cases, public distribution could have embarrassing and counterproductive consequences.

Expected Products

PolicyMaker can create a number of different products, depending on what the user need and what he wants. The main products are the following:

- a. *Rapid identification of problems (problem identification).* *PolicyMaker* can help identify obstacles to the policy, including groups or individuals who oppose the policy, the motivations of the opposition, and policy goals or mechanisms that are not widely accepted.
- b. *Improved communication among organizations (process).* *PolicyMaker* can provide better information about the positions and motivations of other groups and organizations, and better flow of information among groups. One of the most important products of a *PolicyMaker* analysis is the enhanced ability to view a problem from the perspective of other players.
- c. *New strategies and ideas for policy-makers (output).* The *PolicyMaker* method has expert systems that suggest strategies on how to change the positions of opposing groups, how to mobilize potential supporters, how to enhance the power of supporters, and how to change public images associated with particular decisions. This feature can improve the strategic thinking and options considered by policy-makers.
- d. *A repository for information related to a political problem (database).* The *PolicyMaker* system can be used to construct an ongoing record of information related to a political problem or policy. This database can be an important resource for groups involved in negotiations that occur in complex environments, with large degrees of uncertainty, and with the potential for either high costs or high gains.
- e. *Improved political feasibility of policy (outcome).* The ultimate test of *PolicyMaker* is whether the new strategies and ideas generated through the analysis can enhance the political feasibility of a desired policy. The program includes a tracking feature that allows you to monitor implementation and compare observed impacts and expected impacts for a set of strategies.

Advantages

First, the software uses political mapping techniques to analyze the political actors in a policy environment. These techniques assess the power and position of key political actors, and then display the supporters, opponents, and non-mobilized players in a political "map" of the policy. This mapping provides the basis for designing strategies of political management. *PolicyMaker's* computerized version of

political mapping enhances the flexibility of this method for application to diverse policy environments.

Second, the software incorporates techniques of political risk analysis, in order to provide a quantitative assessment of whether a policy is politically feasible. In *PolicyMaker*, political risk analysis methods have been adapted to assess the feasibility of a particular policy, through an algorithm that is calculated in several basic forms and can be modified by the user.

Third, *PolicyMaker* uses methods of organizational analysis and a rule-based decision system, in order to suggest strategies that can enhance a policy's feasibility. The software includes 31 basic political strategies, which can be customized by users, to affect the power, position, and number of mobilized players and thereby change a policy's political feasibility.

The analysis in *PolicyMaker* results in a series of tables and maps or diagrams that systematically organize essential information about desired policy. These tables and maps can be used in strategic planning for policy formulation and implementation. The results can help with:

- *Understanding* by facilitating the analysis of the political circumstances faced by strategy
- *Problem identification* - by providing rapid identification and definition of obstacles;
- *Policymaking process* - by assisting in communication among different organizations;
- *Organize Data* - by providing a data base and easy-to-use screens to store, track, and analyse positions, power, and other aspects of a political question;
- *Implementation strategies* strategies, helping the user to evaluate their consequences, and to track their implementation;
- *Overall enhanced impact of the policy* by proving the chances that a policy will achieve its intended effects.

Limitations and Potential Risks

On the other hand, *PolicyMaker* is based on a series of assumptions about the policy-making process and a series of

judgments about the characteristics of players and impacts of strategies. As with any analytical method, the validity of the *PolicyMaker* analysis is limited by the quality of these assumptions and the judgments of the analyst. The quality of the analyst can affect the reliability of the data, analysis, and interpretation, because this method involves subjective (but systematic) assessments of players, positions, and power, and speculation about the impacts of strategies. Political data often require judgment and interpretation, resulting in risks of bias from the values, interests and power of the analyst and the policy-maker.

A second limitation is the analytical model contained in *PolicyMaker*. The software uses an algorithm to calculate an index of political feasibility, based on a formula that combines quantitative assessments of three factors (the power of players, the positions of players, and the number of mobilized players), as noted earlier. The feasibility algorithm can be modified in various ways to alter the model for assessing political feasibility. But this model (as with all models) is still limited by its assumptions and simplifications about how the world works.

A third limitation is the fluid nature of policy-making. Sometimes, carrying out a *PolicyMaker* analysis can change what is being assessed. Applied political analysis can generate controversy, for example, if some participants see their interests threatened. If the analysis makes explicit the interests and agendas of organizations and individuals, then pressure may be directed against the analyst. On the other hand, the process of carrying out an analysis can put an issue on the political agenda and improve the chances of political feasibility. The role of the analyst, therefore, critically shapes the interaction between political analysis and the policymaking process. To remind of its limitations, *PolicyMaker* contains a warning screen with this content: "Do not confuse your completed analysis with reality". The analysis depends on analyst's judgments about players and their power and positions, on his assessments of the impacts of specific strategies on players, and on the program's assumptions about interactions among strategies and among players.

Recommendations how to Carry Out a *PolicyMaker* Analysis

PolicyMaker provides a series of tables that are logically arranged to describe the processes that influence a policy. One way to carry out a *PolicyMaker* analysis involves the following steps:

1. Write down a clear definition of the policy. This definition of your policy may change as you carry out the analysis and design your strategies, but it is important to start with as clear a statement as possible. Indeed, you may decide to change some elements of your policy in order to improve its feasibility.

2. Find a willing and enthusiastic policy-maker. In some cases, you are the policy-maker (the person who will use the analysis). In other cases, you are performing *PolicyMaker* for a client who is a policy-maker and who may not have time to enter the data but wants to use the results. The client can help you by providing important background information on the policy as well as introductions to major players (if interviews are to be used). The client can also help you define the policy.

3. Carry out a preliminary analysis. Use available documents and knowledgeable individuals to complete a primary *PolicyMaker* analysis. Identify the major players involved in the policy, and suggest individuals to be interviewed. This preliminary analysis should indicate areas for additional data collection.

4. Conduct interviews with major players. If possible, interview major players. *PolicyMaker* provides worksheets for use in interviewing knowledgeable sources. The fields on the worksheets may need to be edited and rephrased for the particular social, political, and cultural context. In some circumstances (for example, when a confidential analysis is being undertaken), you will not conduct interview.

5. Provide feed back to the policy-maker. If you are not the policy-maker, then you need to find an effective way to present the results of *PolicyMaker* to your client. You can print reports for the key tables and maps of *PolicyMaker* for a presentation, or you can use your computer screen to present the analysis and your conclusions. For these presentations, it is helpful to prepare a brief written analysis for the five main steps of *PolicyMaker*; to interpret and summarize the main points. The tables and maps can also be exported in various formats for word processing and spreadsheet programs, for alternative formatting and printing.

These steps for carrying out a PolicyMaker analysis work are related to an application with an individual analyst and a policy-maker client. The steps will need adapting for other types of applications, such as confidential assessments, group discussions, and strategic planning exercises. It's recommended to be used for situations that involve: multiple players with different interests and with different degrees of power; high stakes for the policy under consideration, so that the effort required to conduct an analysis will be worthwhile; complex problems where intuitive assessments are not adequate for producing strategies that are likely to succeed; technocrats who need assistance in understanding the political dimensions of a policy problem and who need assistance in designing political strategies.

Minimum technical requirements

In order to install and use *PolicyMaker*, the following are required:

- IBM-Compatible PC (MS-DOS PC) with 486 or higher microprocessor.
- *Microsoft Windows* XP, 2000, 98, 95, NT, 3.1
- Approximately 8 megabytes hard disk space (5.6 megabytes must be available on the drive where your
- WINDOWS/SYSTEM files are located).
- ∇ 16 Megabytes Random Access Memory (RAM).
- EGA, VGA, or better display.
- ∇• Mouse or other pointing device.

Conclusions

Experiences with the *PolicyMaker* method demonstrate that this is a useful tool for managing the complex politics of health polico reform. The tool combines several forms of applied political analysis with computer techniques of rule-based decision assistance. The resulting method helps sort out the messy reality of policy Making, and assists the design of practical strategies to enhance a policy's political feasibility. *PolicyMaker* allows the user to adapt the software to meet specific preferences or ideas. For example, one can modify the algorithm that the software uses to calculate a quantitative estimate of the feasibility of his policy. The user can create an own questionnaire to help assess the power and position of critical players and can set the numeric values on the scales used to rate their power and position.

After *PolicyMaker* has guided the user through several analytic steps (to identify how players are allied, estimate the policy's most important consequences, and assess opportunities in the overall political environment), the user is ready to formulate strategies to increase his policy's chance of success. *PolicyMaker* helps to design the strategies by providing a series of expert suggestions, which the user can customize. The strategies can be aimed at changing the power of supporters and opponents or shifting their positions to your advantage. They also can be directed at moving those who have yet to choose a position, who were assessed as non-mobilized. *PolicyMaker* helps also to evaluate the strategies and to estimate the probability of success and judge how feasible the policy might be. The experiences demonstrate that *PolicyMaker* can serve different purposes:

- to help policy analysts assess political feasibility in a systematic manner;
- to assist in the design of strategies to improve the political feasibility of a policy;
- to assist in consensus-building efforts among diverse groups by helping policy-makers understand the perspectives of other players;
- to provide a mechanism for team-building as the basis for introducing major policies;
- to evaluate the relative feasibility of different policy options in a complex political environment.

At the same time, *PolicyMaker* is not foolproof. Each step requires careful consideration of potential bias in the data and the analysis. Policy analysts can reduce the risks of bias through ongoing consultation with decision-makers and other players. Another way to lower these risks is to carry out *PolicyMaker* with a team of "insiders" (who are involved in the policy-making process) and "outsiders" (who are new to the policy problem), to combine local interpretation of the context with new ideas and external perspectives.

Finally this method of applied political analysis does not assess whether a policy is ethically sound or technically correct. Computer-Assisted Political Analysis assists policy analysts in the design of policies, but does not tell an analyst what kind of policy is right or fair. *PolicyMaker* is designed to help policy-makers get what they want, which is not necessarily good from an ethical or a technical

perspective. Managing the political dimensions should not substitute for assuring the ethical and technical bases of a policy. *PolicyMaker* assists only in assessing whether the policy is politically feasible, and suggests ways to make the policy more politically acceptable.

Exercises

Students will participate in working groups. They will analyse the social system in which a concrete public health recommendation should be implemented. They will have to decide which of the two tools offered they find most appropriate to use. Based on that decision they have to follow the steps recommended in the chapter. The final outcome is an analysis of the social system and a plan for interventions.

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Additional information about GAMMA[®] can be obtained through <http://www.topsim.com>
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Additional information about *PolicyMaker* can be obtained through the Internet (email: buy@polimap.com) and on the World Wide Web (<http://www.polimap.com/>). The website: <http://www.hsph.harvard.edu/faculty/reich>

Recommended Reading

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Advocacy in Public Health
Module: 3.2	ECTS (suggested): 1
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Keywords	development; social development;
Learning objectives	After completing this module students and public health professionals will be able to: <ul style="list-style-type: none"> • understand the concept of advocacy • understand the use and relevance of advocacy in public health • design an advocacy campaign, after identifying a policy issue
Abstract	Advocacy is a combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems support for a particular health goal or programme. The term has been internationally recognized and adopted as a core element of health promotion. This module presents the concept of advocacy, differentiates between advocacy and other related terms. It presents the definitions of policies and

	<p>health policies and gives a brief overview of the types of policies and the way these influence the health status of the population.</p> <p>Arguing that advocacy represents the art and technique of deliberate and intentional using the common sense and wisdom of experience as well as knowledge resulted from solid and consistent research to influence the perception, knowledge, behaviour and attitudes of policymakers the paper presents the advocacy framework: policy analysis, identify resources and, definition of strategies and creation of an action plan. The paper concludes that for all its importance, advocacy remains the neglected branch of the public health practice. Although nearly every branch of public health emphasises the critical role of advocacy in translating research into practice and policy, public health community pays little attention to advocacy as compared with all other disciplines.</p> <p>However, advocacy remains the one means to bring up front values bond in the issues such as social justice, human rights and democracy.</p>
Teaching methods	Teaching methods: lectures, group work, small group discussions, seminars.
Specific recommendations for teachers	½ lectures; ½ working groups. Students will work in small groups to design an advocacy campaign and the results will be presented to the class. The presentations will be followed by discussions and analysis.
Assessment of students	Assessment: seminar paper, case problem presentations, oral exam, attitude test.

ADVOCACY IN PUBLIC HEALTH

Carmen Ungurean, Irma Eva Csiki

Public health in all its field sets goals and objectives that are in most cases, highly contested by opponents from various areas and levels: ministries, governments, local authorities, interest groups, manufacturers, industry, community groups as well as from within public health field itself. The barriers ahead of the public health issues include philosophies that devalue health and quality of health at the expenses of economic outcomes, bureaucracy in promoting legislation, adverse policies, permissive legislation to promote and market unsafe or unhealthy products, unethical and inequitable policies conducive to social exclusion.

Advocacy is a combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems support for a particular health goal or programme (WHO, 1995) (1).

The term has been internationally recognized and adopted as a core element of health promotion. Ottawa Charter for Health Promotion 1986 recognizes advocacy as one of the three major strategies for health promotion:

- **Advocacy** for health to create the essential conditions for health;
- **Enabling** all people to achieve their full health potential;
- **Mediating** between different interests in society in the pursuit for health.

The importance of advocacy in attaining the health has been restated by WHO in four subsequent health promotion conferences Adelaide, Sundvall, Jakarta, and Mexico.

Causes of ill health stem both from individual decisions at household levels, as well as from decisions made at community level, national legislatures, and international regulations. The attainment of

public health objectives can be achieved only by program strategies addressing the multiple causes of ill health, including policy causes. One of the essential elements of sustainability assurance is fundamental change induced by policy and by changing the policy-making process.

Policy decisions affect and influence virtually all aspects of the society, from restriction areas for smoking to increased accessibility to health care services, but policy making is not always a rational and orderly process, instead is a political process propelled by dynamic negotiations between groups with competing societal priorities, and conflicting ideology (2).

Policy is a plan or a course of action designed to define issues, influence decision making and promote broad community actions beyond those made by individuals. (3) Policy can have two sources, private and public.

Private policies represent a series of actions directed at persuading private sector decision makers: business groups, members of some communities, such as faith, minorities, community health centres, and hospitals. These types of policies can work towards creating a new service delivered in the community, by using the resources in new ways. Examples of private policy are corporate policy concerning maternity leave or working conditions for pregnant women, banning smoking at work place in the absence of a national legislation, or pharmaceutical companies selling nicotine replacement therapy based on economic objectives.

Public policy is a set of rules that people (public) must abide by. They can be documents and enacted through a statute, law, executive order, ordinance, or court order. They depend on partnerships between many stakeholders, governmental, private agencies, employers, industry, professional associations etc. Governments, ministries, political units, city councils, or boards of supervisors establish policies. Examples of public policies include decision of the city council to prohibit alcohol selling at certain public manifestation, or high weight vehicles to run during daytime, minister's order to require comprehensive education for health in schools, parliament decision to ban the tobacco advertising, or

regulating the regime of firearm utilization and possession. Often public policies developed by agencies from outside health system can have profound community health effects such as compulsory wearing of seat belts, regulations concerning food content, urban planning and housing regulations.

Both public and private policies can have significant and long lasting impact on individual, as well as community health.

Public health has never been high on the political agenda, and seldom spontaneously draws attention of the general public. Although crises, such as serious outbreaks of diseases or disasters push certain issues to the top, generally ongoing and effective communication with decision makers and policy makers is needed to ensure that public health issues are on the narrow list of the time and resources limited officials.

Policy-making is a continuous interactive process with a cyclical nature. This facilitates organised thinking about policy even if the actual process is less orderly. Several cyclical models with varying numbers of steps are available. Some of the examples are as follows (4):

Walt presents four stages for the policy process:

- Problem identification and issue recognition
- Policy formulation
- Policy implementation
- Policy evaluation.

The Dutch health policy process also follows a four-step cycle. It starts with evaluation, as there is almost always a relevant existing policy:

- Policy evaluation
- Policy preparation
- Policy development
- Policy implementation.

Public health has to confront various policy issues posed as barriers to attaining the health goals: absence of policy, adverse policy, lack of implementation or enforcement, lack or absence of

evaluation. Any of these situation calls for proper advocacy, as well as public health groups can intervene at any of the stages of the policy cycle.

Advocacy represents the art and technique of deliberate and intentional using the common sense and wisdom of experience as well as knowledge resulted from solid and consistent research to influence the perception, knowledge, behaviour and attitudes of policymakers. Traditionally public health programmes seek to influence choices, attitudes and behaviours in as many as possible individuals in order to achieve the broad objectives of healthier population groups. Long lasting sustainable changes can be attained by rising above the household level, because policy and policy-making behaviours influence greatly influence the livelihoods of all individuals at once.

Under these circumstances advocacy appears as the logical extension of any public health organization work, setting aside some of the old assumptions and taking the holistic approach recognizing that various actors in both, public and private arena significantly contribute to the health status of the whole population. Part of advocacy process is mustering and strengthening support for a specific issue and fostering supportive environments towards specific causes.

Two main goals underpin health advocacy: that of protecting vulnerable or discriminating people, and that of empowering people to protect their rights, by empowering them to express their needs and make their own decisions (5).

The first goal involves advocacy “on behalf” resulting in the representational role of advocacy. The second goal involves advocacy “with”, emphasizing strategic partnerships, capacity building, thus resulting in the facilitational role of advocacy.

Also, both roles of advocacy are essential elements of the strengthening the relationship between individuals and the authorities, holding the latter accountable when they fail to fulfil their responsibilities to others.

Related terms

Public health advocacy is often used to refer to the process of overcoming major structural barriers to public health goals. It is used to influence the choice and actions of those who make laws and regulations and to those who distribute resources and make other decisions that affect the well being of many people. Thus, it involves delivering messages to influence the policy making process. Therefore the concept needs to be differentiated from a number of related concepts.

Communication. Although the two activities complement and reinforce each other there is a clear distinction between them. The distinction lies not only in goals and targeted audience, but also in communication process, channels and materials. Communication targets individuals and groups of individuals, while advocacy is directed at policy makers, decision-makers and other influential leaders.

Health communication encompasses several areas including entertainment - education, health journalism, interpersonal communication, media advocacy, organizational communication, risk communication, social communication and social marketing. It can take many forms from mass and multimedia communications to traditional and culture-specific communication such as story telling, puppet shows and songs. It may take the form of discreet health messages or be incorporated into existing media for communication such as soap operas (6).

For example, a social marketing reproductive health campaign to promote use of birth control methods is a communication strategy to promote change in the individuals, while advocacy would be directed at promoting institutional, legislative and financial framework to efficient reproductive health services.

Raising public awareness. Advocacy does not mean to inform authorities about programmes and activities of own organization, nor to raise public awareness about it. Advocacy could

nevertheless, have the subsequent benefit of increased visibility and credibility both public and within the policy-making circles.

Fund-raising. Advocacy does not seek primarily to increase financial allocation towards own programmes/organization. However, advocacy militates for more funding towards specific national programmes, or to move health budget higher up on a political agenda.

Lobby. Advocacy and lobby are not interchangeable terms. Lobby seeks to influence members of the parliaments or other legislatures, get a law through, or solicit an influential person for support. The extreme form of lobbying is the engagement into a political campaign in support or in opposition to a candidate for a political function. Technically, they have different legal definitions. It usually depends on the legal implications, the amount and type of activities employed and, the source of funding. In many sates there are financial restriction that prohibit organizations such as public health ones, to allocate money into activities of lobbying. Equally, your own organization's statute and legal framework could prevent involvement in political actions. However, lobbying can be a highly effective strategy to affect policy change and can be one of the many forms of advocacy can take (2).

Advocacy seeks to change upstream factors, such as laws, regulations, policies and institutionalized practices, prices and product standards that influence the personal health choices of millions of individuals and the environments in which these are made (6). Advocacy is influential and deliberate, involving intentional actions, therefore needs a careful planning and strategy.

Advocacy framework

Advocacy framework comprises a number of stages. However, advocacy is a dynamic process involving changing actors, ideas, agendas and policies. The stages of the advocacy process must be viewed as fluid because they may occur simultaneously or progressively or the process may stall or reverse itself.

1. Policy analysis

Policy analysis must highlight **what** is the problem; **causes** of the problem; and **people** affected by it. Policy analysis also identifies the way policies are made, the institutions and persons involved and how they relate and the legal and structural framework the policy emerges within and proposes solutions for improving the situation.

1.1 Identify issues

The first step in the process of advocacy planning is the identification of issue at stake. It is important to clearly describe the current state of things and to determine the factors contributing to the actual problem. Describe what is currently done, what are the achievements of the eventual actions taken so far, identify the gaps that need to be addressed, what are the possible obstacles preventing the objectives to be achieved.

Once the theme or the programmatic issues identified, the underlying policy cause needs to be identified.

Policy analysis examines the regulatory framework set and how this set of regulations specific groups. Policy analysis is an essential tool to describe the problem to be addressed. Policy analysis begins with identification of the policy issue: absence of a policy; adverse or inadequate policy, improper enforcement of a policy. The policy issue can be identified through direct field observation, or through experience, but sometimes requires in depths review of the existing legislation. Review of the legislation includes listing and assessing all the published set of regulations, plans and laws, and interviews with the relevant actors involved in the issuance of the policy. Another key element is to identify the key actors who make the decisions about these policies, as well as those who can influence direct decision making process. All these individuals can be classified according to their roles and degrees of influence. Also, it is important to identify the institutions from where these actors come from, their roles and the relations, both formal and informal, between them.

Along with the policy issue and the key actors, gathering a clear, broad picture of the environment in which all these operate complements the policy analysis. It is important to asses the

opportunities, whether the actual legislature is interested in taking action in the problem, whether there is a general awareness about the issue, or whether the political climate is ready for change.

The sources of information for the policy analysis include generally, publications of the government, ministries, donors, corporations and international organizations such as World Bank, UN agencies; newspapers and periodical publications; public speeches and declarations; and interviews with key informants.

The findings of the policy analysis can be in a problem analysis tree summarized (8) comprising the following three steps:

- problem identification
- direct causes
- ▼ behavioural causes

Sound policy analysis, as the underlying cause of a problem lays the solid foundation for an effective advocacy strategy. It also eases the way to identifying options and to suggest solutions with positive impact, bearing an essential role in choosing the focus of the advocacy initiative.

1.2 Identify solutions

Once the policy issue is identified the next step is to identify if this can effectively be (?) addressed through advocacy so that it would yield the desired results. The solutions proposed must be socially and culturally acceptable. When advancing solutions, the likelihood of success needs careful evaluation.

Special attention must be paid to the potential risks. DO NO HARM framework should be used in any advocacy initiative. Policy analysis helps to understand the environment the initiative will take place in, and to assess the assumed risk and the likelihood of making mistakes. Assess the overall impact of your objectives and ensure that practical steps are taken to minimize unintended harms (8).

The proposed solutions must not cause division in the community, must not raise political violence, and must not deepen the ethnic or racial gaps. Basically the solutions proposed through the

advocacy initiative should reinforce connectors in the society and eliminate the dividers.

1.3 Identify gatekeepers

The key actors involved in policy-making process identified must carefully be identified by the level of their information and knowledge on the problem at stake, the degree of their interest and influence. Also, their support or potential opposition to the cause would be an important element to be added to their profile. Always remember that decisions are made by individuals and decision makers are human. The more complete the gatekeepers' profile is the more chances to choose the successful approach.

2. Identify resources

In general a good cause is enough to bring people to work together, while attracting resources to put into the advocacy initiative requires time, effort and skills. A thorough inventory of the existing resources will enable better planning and choose the best activities to match the availability. Also, a comprehensive inventory would attract potential donors.

But before planning for material and financial resources there is need to establish the individual credibility with the policy makers and in the community (8). A brief credibility checklist includes:

- advocates and his colleagues can legitimately speak on behalf of those affected by the issue;
- advocates known and respected by the politicians involved; do the advocates have information and/or expertise relevant to the issue;
- will the target audience be interested in your opinion on the issue;
- advocates perceived as an impartial and non-political influenced.

The budget for an advocacy campaign can be difficult to estimate, especially for a multi-year initiative. More than in any other type of programmes, during the advocacy campaign corrections will occur and costs could rise higher. The activities of the advocacy strategy have different costs, for example a public relations consultant

or study tours for the policy makers can be highly expensive, while meetings, site visits or letters to the editors are relatively low-costs.

An important item on the resources check list is the identification of potential partners and coalitions. The partnership in advocacy has a critical role, as it significantly increases the impact of the initiative. Experience shows that joint efforts, skills and resources are more likely to minimize the risks, draw attention, and result in successful policy change.

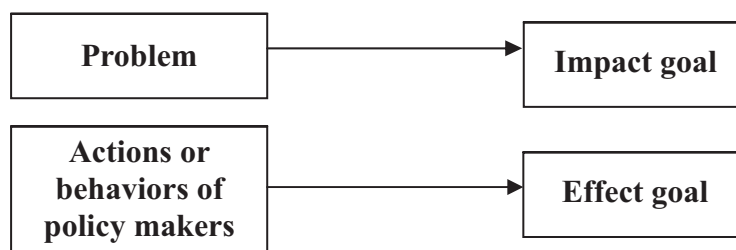
3. Define strategies and create action plan

3.1 Set objective

Similar to any programmes or projects, advocacy initiatives require clear, specific goals and objectives. The goals must be SMART (specific, measurable, achievable, realistic and time-bound). They should clearly state **what** will change, **who** will make that change, by **how** much and **when**. When objectives are poorly vague and poorly articulated they can be differently interpreted by various persons and the focus will be hard to be maintained.

The advocacy objectives must always serve the agreed public health ones, and not be confused as ends themselves. Media advocacy objectives, for instance, may be causing a neglected issue to be discussed, or a much debated issue to be discussed differently (9). The final or impact objectives should refer to the problem addressed and clearly state what the change in people's well being will be. The changes in policy-makers behaviour or systems are only intermediary or effect objectives (8).

Figure 1 **Goals of advocacy initiative**



Source: Sprechmann S., Pelton E. Advocacy Tools and Guidelines Promoting Policy Change

Policy change is not the final goal of the initiative, it is a step that should lead to improvements in people's quality of life (Figure 1).

3.2 Target audience: primary and secondary

The target audience is the person or group of people, who can help the policy change intended to be achieved (7) or the groups of individuals to whom the message is intended to be conveyed (6). There are two types of audience, advocacy is addressing: primary and secondary.

Primary audience - are those individuals with direct authority to make policy changes (Ministers, parliament members, local mayors, etc.):

- manager of a local factory
- a hospital manager
- mayor
- head of an institute
- minister
- parliament member
- prime minister
- president

Identification of the key primary audience requires understanding of how the institution or organization works: who exercises the power and which individuals are linked to them.

Secondary audience - are those people that can influence the decisions of the primary audience. They provide the ways to reach the decision-makers that may not be directly available. It includes: interests groups, stakeholders, journalists, NGOs, different institutions, and groups of the general population. Secondary audience can be even a policy-maker: for example a parliament member willing to advocate a policy position to another. Identification of the target audience begins with the policy analysis and continues throughout the entire initiative.

3.3 Select a role

There are many ways to advocate in. The advocate can take the leading, visible position and directly inform the audience, or he can

work to document the situation for policy-makers, or to support a local organization.

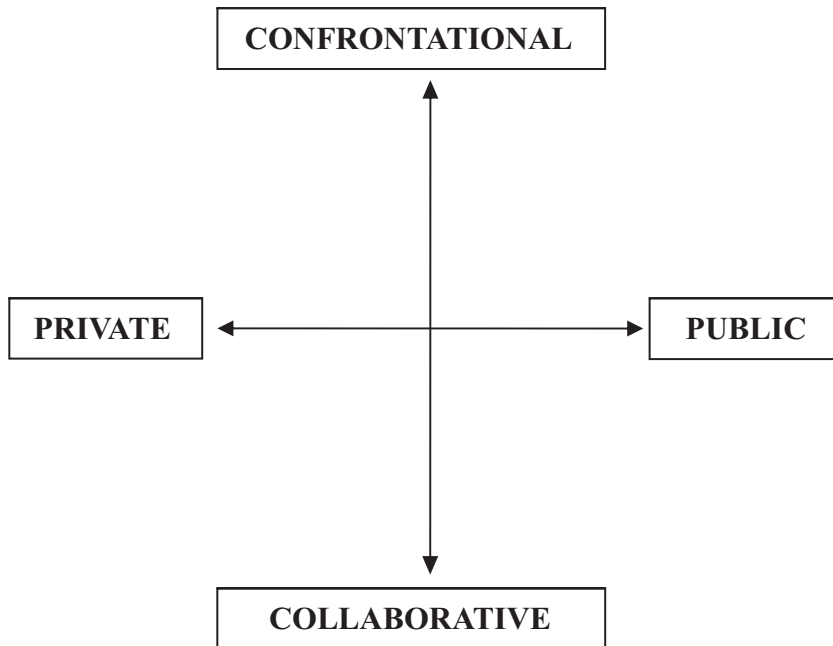
The role depends of the mix factors, like resources, relationships, the experience on the issue, the risk one is prepared to assume, the political norms in the country (8). There are a number of roles an advocate can choose:

- *Expert informant* - provides technical advice and information to primary audience. The role relies much on the credibility, relationship with the policy makers, authority. It can be low-cost and low risk.
- *Honest broker* - participates in the process of policy-making as an expert, impartial and honest mediator between competing interests. This role ensures that the process is transparent, based on data, facts and analysis.
- *Capacity-builder* - provides support to third parties. It may involve rising awareness of the rights and responsibilities, organizing a coalition, providing training.
- *Lobbyist* - fully participates in policy-making process and makes direct approaches to influence policy. This role involves public presentations or meetings with the politicians.

The role influences deeply the required skills and resources needed for the initiative. For example the expert informant relies on technical staff while the role of broker and lobbyist requires negotiating and communication skills.

Advocates often find themselves engaged in public conflicts, and advocacy can take the form of an over politicized activity, posing the risk of creating enemies (7). Many can think that advocacy is confrontational, but it doesn't have to be such. The approaches taken within the above described can be anything between confrontation and collaboration. The higher and up or the further to the right the more risk and more conflictual you can get. Private approaches can include face to face meetings, and public ones include media approach. (Figure 2).

Figure 2 Roles in advocacy



Source: *Advocacy Tools and Guidelines Promoting Policy Change*; Sprechmann S., Pelton E., CARE, January 2001

3.4 Use data and evidences

Document the situation in order to formulate message; good, sound information is the foundation of any successful advocacy. Credible research that documents the severity of the problem, the effectiveness of the proposed solution will be the pillars to sustain the advocacy campaign. Every branch of public health can point the critical role of advocacy in translating the research into policy, practice and changes. Also the issue, if well documented may be welcomed both, by the public and policy-makers, and no interest groups stand to lose by policy or legislative changes, especially if they require little investment, as for example folate to neural tube defect (7). The information must be accurate, and reliable, to maintain the credibility. The documentation of the problem includes:

- severity of the situation and the worsening trends;
- the expenditure due to the problem;
- the toll if nothing is done;

- demonstrate the proposed solution as feasible and effective.

3.5 Formulate and deliver message

The messages to be delivered to the targeted audience have to be clear and compelling. It should explain what are the proposals, why is it worth adopting the proposed solutions and the impacts of the policy proposals (8).

The delivery of the messages has to be effective. For this the advocates must ensure that the message is understood, believed and most important and often overlooked, received.

One message conveyed as one time exercise is not enough, therefore it needs reinforcement. This will allow responding to potential concerns of the audience, or correcting the potential misunderstandings.

There are a number of channels to deliver the message, depending on the resources, skills, the risk willing to assume:

- *Writing a letter* represents a good way to deliver a message, especially when there is no personal relationship with the audience. Advantage of letters is that it creates a record of contacts made and can be sent to multiple audiences. Disadvantage is that anyone can see it and could use against the initiative.
- *Group presentations* require good skills in order to win the audience and to clearly send the right message. Also, requires solid preparation to answer potential questions, reactions and to provide tools if solicited.
- *Use of the media* influences mainly the public opinion, but reaches multiple audiences, as policy-makers also pay close attention to the press. Advantages of the media use are delivery of the message to a large number of people, potential to attract supporters to the cause. It also, may increase the visibility and credibility and facilitate access to policy-makers. Disadvantages are the potential to attract opposition, in accurate coverage of the organization or cause. Working with the media: media is probably the most influential advocacy tool. It plays a key role in mobilization of the public support and setting the political agenda. Media advocacy includes a number of communication channels: press release; call the

journalist to place news and/or feature story; write opinion columns; letters to the editor; press briefings; editorial meetings.

- *Publications.* Advocacy publications must be visual, innovative, organized, focused and concise. They could highlight the human aspect of the issue; simple is more effective than a data overloaded paper; a lengthy publication may be dull and loses attention. Other tips for publications include regular brand, a logo or feature and investing into well-designed papers and extensively distributed.
- *Site visits.* Arranging a site visit for policy makers can be an effective way to advocate. It allows better relationship with the key actors involved in decision making and building a personal relationship.

Effective advocacy requires effective communication skills.

Timing of the advocacy efforts is crucial. Choose a significant date or event tied to the issue you are advocating for. This helps to focus people's attention and increases the chances your message is heard. Also, compiling a calendar of national and international dates and organizes the advocacy activities around them can prove to be useful.

Other elements of essential importance for effective communication are: ability to keep the message clear and focused, ability to respond to concerns immediately, ability to avoid repetition and still be able to reinforce and follow up on the message. Most important are the ability to always be flexible and prepared for trouble. Rarely the advocacy initiatives, regardless of how well planned they are, go as intended, since they depend on so many factors that are out of the advocates control. Effective communication requires that political trends are closely monitored, and that the plan includes appropriate messages to match the new developments. Also, part of the communication strategy is to always being prepared for the press with the right answers, and every member of the team able to talk to them unexpectedly.

When delivering the message, regardless of the channel used, the opponents must be treated with respect and fairness.

The advocacy plan must always include possibilities of discontinuing the activities when the risks are unacceptable, for staff, reputation, programme. Alternative strategies and different approaches must be outlined in advance.

3.6 Build coalitions and partnerships

A coalition is a group of individuals or organizations that work toward a common purpose. In advocacy coalition members are dedicated to shared policy goals (8). Working in coalitions can be crucial when it comes to demonstrate and achieve broad support. A coalition can have far more impact and offers more protection to some members. Also, very important the members of coalitions can complement their activity and decide to choose different profiles in order to minimize the potential overall risks. Challenge arises when members of the coalition have competing interests, have not fully agreed on their common goals or agendas.

3.7 Monitor and evaluate

Monitoring and evaluation are key activities for keeping the advocacy initiative on the right direction, and to identify whether it has achieved the changes aimed at. Also, since advocacy depends on so many external factors it constantly needs reorientations and adjustments. Monitoring and evaluation helps identifying the need for reorienting and redirecting the advocacy initiative in due time.

Monitoring use of resources, carrying out the activities represents activity monitoring; change of knowledge, opinion and/or awareness of target audience represents monitoring results (8). Monitoring of results include mapping of media coverage, change in opinions of both general public and policy makers. Evaluation assesses the extent of achieving the policy goals and ultimately the impact of these changes on the well being of the population. Evaluation of changing actions of policy-makers, changes of policies represents evaluation of the effects and improved quality of life and health of population represents evaluation of impacts.

There are some particularities in advocacy evaluation:

- changes may take a long time to yield measurable results at individual level;

- policy change takes place in an office, far from where the impact is sought, as such it is difficult to link the changes in
- peoples' wellbeing to an advocacy initiative. it is difficult to measure policy implementation, especially if the case of a changed one.

Although the evaluation literature on health promotion activities has increased significantly over the last years, the publications on advocacy evaluation is rather poor. Most of the literature disclosed that advocacy evaluations consisted primarily of descriptions of the what, who and to whom was done, and whether there was a policy change or not.

Prescriptive (advocacy on behalf) campaigns require a different evaluation protocol than empowering ones (advocacy with) (10). The evaluation of the on-behalf campaigns is however more traditional and aims at identifying:

- how much of results, both desired and undesired were achieved in accordance to the initial objectives, and in relation to costs and resources that went into the campaign;
- how is this campaign as compared to other interventions.

Demonstrable health outcomes must remain part of advocacy evidence building process. Rarely resources are available to evaluate beyond intermediate objectives (10).

Conclusions

For all its importance, advocacy remains the neglected branch of the public health practice. Although nearly every branch of public health emphasizes the critical role of advocacy in translating research into practice and policy, public health community pays little attention to advocacy as compared with all other disciplines. Literature on public health advocacy is scarce, training programmes are rarely available and dedicated journals are just a few. Most of the public health professionals are reluctant in engaging in advocacy campaigns, and little resources are directed towards advocacy activities. In fact, advocacy is one of the less likely to be funded activity.

However, advocacy remains the one means to bring up front values bond in the issues such as social justice, human rights and

democracy. The Ottawa Charter defines the advocacy for healthy public policy not only as a technique to alter policies, but also to change the means by which policy is made, particularly through:

- advancing democratic values
- empowering people as participants in the policy
- facilitating the capacities of communities and vulnerable populations to make their needs and interests known
- increasing people's participation in process allocating societal resources and values among its members (10).

Exercises

1. Identify a policy issue and analyse it.
2. Design an advocacy campaign using the framework presented in the module.

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Partnerships in health
Module: 3.3	ECTS (suggested): 0.5
Author(s), degrees, institution(s)	Ozren Totic MD MPH; Public Health Physician Mary Black FRCP(UK) FFPHM(UK) FAFPHM MPH DTM&H DCH DObst; Public Health Physician
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Keywords	Internet, communication, media, advance directives, cost effectiveness, WHO
Learning objectives	After completing this module students and public health professionals should: <ul style="list-style-type: none"> ● be aware of rapidly evolving complexity, scope and nature of partnerships in health and other areas of life and increasing role of non-medical partners; ● recognise that good management skills are necessary for a successful partnership; ● increase knowledge of the range of health partnerships that can occur today; ● understand the role of modern communication technology, internet in particular, in establishment, development and creation of modern partnerships; ● appreciate importance of multidisciplinary nature of public health activity; ● foresee opportunity for public private partnership (PPP) development in their own country

Abstract	Partnerships in health are part of everyday life: from individual encounters between patients and health practitioners to regional and global alliances to fight poverty, AIDS, TB, smoking and land mine production. Development of technology and communication is making possible to utilise our knowledge of multiple determinants of health and develop partnerships that were not possible only few decades ago – we are witness to a revolution in public health partnership structure. The private sector has significant potential to contribute to the public interest and patients in hospitals understand their illnesses much more than before. Successful partnerships need good management skills and focus on the purpose.
Teaching methods	Teaching methods used are interactive lectures with proposed reading beforehand related to the actual issues in relevant society where students live and work. The readings are selected by local lecturers and sent to students in advance of the lectures. The exercise is best done with small group discussion and later presentation back to the larger group.
Specific recommendations for teachers	Students and teachers will require internet connections to research and review materials. Flip charts needed for presentation of learning exercise and group work.
Assessment of students	Assessment will be based on written paper presented on exercise and exercise presentation to group.

PARTNERSHIPS IN HEALTH

Ozren Tomic, Mary E Black

There are many definitions of partnerships. Simple clicking on the Goggle web search engine using “Public health partnerships definition” gives 7 660 000 results! (1). Partnerships are part of every aspect of societal relationships: between individuals, business partners, governments, countries, academia, community.... Partnerships can also take many formal (signed contracts, declarations, agreements, treaties) and informal shapes. Delineating all aspects of partnership relations relevant to health depends on how far one wants to go in describing even everyday interactions between individuals and representatives of organizations.

In this chapter, we will propose a framework for defining partnerships in health and examine current trends in public health partnerships.

What is partnership?

Box 1 gives some definitions of partnership, which offer one possible framework for defining partnerships in general

Box1 Definition of partnership

partnership is the state of being a partner.

1.
 - a) A legal contract entered into by two or more persons in which each agrees to furnish a part of the capital and labour for a business enterprise, and by which each shares a fixed proportion of profits and losses.
 - b) The persons bound by such a contract.
2. A relationship between individuals or groups that is characterized by mutual cooperation and responsibility, as for the achievement of a specified goal. or **partnership** is the state of being associated: affiliation, alliance, association, combination, conjunction, connection, cooperation.

Source: The American Heritage® Dictionary of the English Language (2)

Partnerships in health can be analyzed using this framework.

Partnerships in health care defined by **legal and contractual arrangements** include the formal and extensive agreements between health services providers, clients and those who provide the funds. These include health maintenance organizations, social health insurance funds, health care trusts public private partnerships (PPP) and others. They are increasingly regulated and monitored by governments, professional organizations and community for quality standards, allocative efficiency and effectiveness of health programs they deliver.

As provider/individual patient (client) partnerships become more evenly balanced (see later section), legal and semi legal contracts are developing. Partnerships between individuals and groups characterized by mutual cooperation and responsibility include doctor/patient and insurance plan/client relationships, public health alliances, community groups banding together to jointly address issues such as drug use, violence or to improve water and sanitation .

Partnership evolution and revolution

We have always had partnerships in health. From epidemic control measures in medieval times to the development of the Red Cross and Red Crescent societies as a response to the ravages of war, people have always banded together to address health issues, and there have always been partnerships between healers and patients. What is certain is that the range of scope of health partnership is becoming ever more complex and is subject to rapid evolution and change.

Increasing knowledge and awareness of health as a public good and its environmental, social, economic and political determinants sparked departure from the “old” understanding of public health that was concerned solely with unhealthy settlements, safety of food, air and water, and targeted infections, toxic and traumatic causes of death (3). “New public health” has an emphasis on a multidisciplinary approach, human rights, equity, cost-effectiveness, justice, public-private partnerships and use of information technologies. **Multiple determinants of health** lead to multiple inputs requirements from different public health system stakeholders hence the need to involve them into strategy creation and decision making: business and employers, academia, media, community, governments and health care providers - it is now understood that

peace, water and food are basic prerequisites for health, in that order.

Business and industry, with their increasing global impact on the environment, work practices, science and technology, are adopting strategy of **corporate social responsibility**, including support to sustainable development, respect for human rights of those affected by their activities, protection of consumer interests, facilitation of transfer and diffusion of technologies, and combating corruption and bribery. Still, there are **corporate partnerships against public health** with the most prominent example of tobacco industry practices (4).

“Let us choose to unite the power of markets with the authority of universal ideals. Let us choose to reconcile the creative forces of private entrepreneurship with the needs of the disadvantaged and the requirements of future generations”

Kofi Annan, Secretary General of the United Nations, Davos, January 1999

At the country level, government partnerships with private sector (**public private partnership – PPP**) took different forms and had varied success with United Kingdom leading the way (5). There are many benefits derived from PPPs for taxpayers and governments such as improvement of cost effectiveness through taking advantage of private sector innovation, experience and flexibility; making better use of assets; and improving service delivery by allowing both sectors to do what they do best. Governments’ core business is to serve public and set policy while private sector is at its best at operational level. At the global level PPPs for health have been a defining feature of Gro Brundtland's term as director general of WHO. As with the country level PPPs between governments and business, many lessons have been learnt from global alliances and interactions between WHO and private sector indicating that proper safeguards will go a long way towards inspiring confidence that these initiatives are truly serving public health (6).

Box 2 Public private partnerships involving WHO

European Partnership Project on Tobacco Dependence
Global Alliance for TB Drug Development
Global Alliance to Eliminate Lymphatic Filariasis
Global Alliance to Eliminate Leprosy
Global Alliance for Vaccines and Immunization
Global Elimination of Blinding Trachoma
Global Fire Fighting Partnership
Global Partnerships for Healthy Aging
Global Polio Eradication Initiative
Global School Health Initiative
Multilateral Initiative on Malaria
Medicines for Malaria Venture
Partnership for Parasite Control
Roll Back Malaria
Stop TB
UNAIDS/Industry Drug Access Initiative

Source: *Faltering Steps towards partnerships* (6)

Health care providers and media relationship has also changed from the paternalistic doctor's advice to a consumerist, partnership approach to health care. Media is now one of the most effective public health tools (7).

Why partnerships?

Some partnerships are inevitable, are prescribed by law or are part of the scenery, but new ones tend to emerge and develop when the total value of a partnership is bigger than the simple sum of the individual and organizational values and capacities that constitute the partnership. Relationships, collaborations and alliances can create new solutions to given problems and can create added value.

Partnerships can test the relevance of public health activities and theories. Partnerships take public health from being theoretical and academic exercise into the real world through the scrutiny of competing interests that support a shared health policy goal. The example of PPP (public private partnerships) is instructive where the force of private interest to cut cost and increase profit is complemented with public interest to have cost-effective services. If left on their own, private providers would not necessarily deliver

public priorities while public would not have a choice to commission cost-efficient services that private sector can provide.

Are partnerships always necessary?

If a specific health goal can be achieved using the capacity of one individual, group or organization than making a partnership has another purpose than health. For example while some smokers may not need counselling or advice on the use of nicotine supplements but stop smoking on their own, another might need extensive support and a community might need an integrated public health campaign. Partnerships are not sign of individual weakness – it is just that there are different approaches to solution of a same problem.

Influence of the Internet

Health care and public health services are characterized by asymmetry of information between provider who is selling services or goods (medications) and patient (the buyer/customer). The customer in this case knows much less about the goods and services being sold, including quality, effectiveness and cost which is why such distortions have to be regulated, usually by government and professional organizations that set the quality level, and monitor commissioning and delivery of services.

The information age, electronic communications, the Internet, greater accessibility of information, have contributed to the development of partnerships in all aspects of human endeavour. The information gap between health care providers and patients is narrowing as modern partnerships are being developed between practitioners and their clients. Information about diseases, treatments, quality of services between different doctors, institutions and regions, competing insurance plans and costs is becoming increasingly more accessible and obvious. Modern hospitals are empowering patients to bring Web-enabled patient education to the bedside and providing tools to doctors and nurses to improve quality, effectiveness, efficiency and responsiveness of services they offer (8). In some hospital wards in California (9) more than seven out of ten patients use the internet while in hospital. “Hospitals & Health Networks”, the journal of the American Hospital Association, has named the 100

Most Wired hospitals and health systems annually for seven years. Informed consent is acquiring a new meaning in health care and is changing relationship between health practitioners, patients/citizens and government into one of partnership. On the level of individual care these include **advanced care directives** and living wills in which people set out their wishes for how far resuscitation attempts and life support should go in the event that they become incapacitated through ill health and **birth plans** where pregnant women define their preferred birthing options including the medical and non-medical aspects of their pregnancy, labour and after birth care. Extensive guidelines are now available on line for all of these kinds of partnerships.

In such an atmosphere, privately owned health care services are becoming an increasingly cost effective option and a choice for the allocation of public funds.

Public health is not an exception. Communities are more aware of their potential to change policies that affect their lives and often form partnerships with local institutions, business and international organizations in order to improve conditions of living.

What is important for a partnership?

Partnerships are most effective when they are built around common issues, identified policy goals, shared objectives and interests of partners. For a partnership to work partners need to be formally in a position and technically capable (having capacity) to effect their share of tasks and they have to be willing to adopt the requirements of partnership (be flexible and ready for compromise and also be prepared to surrender some autonomy to shared decision making). All partners have to understand the need to tackle an issue in question together.

No partnership can function successfully without identified human, technical and financial inputs. Management of partnership is of paramount value. Functional partnership requires establishment of clear goals, roles, responsibilities, and decision-making structures. Planning, reporting, monitoring and evaluation are important as different stakeholders have their own dynamic and easily drift towards

their own agendas if not bound within a formal management process. Contract or memorandum of understanding, where appropriate, helps to promote accountability of partners. Communication systems within a partnership should enable effective sharing of information about resource allocation, results, process and outcomes.

It is also important to be clear when the time for partnership is over. It is good to dissolve partnership when enthusiasm is lost, participation decreases and when partnership becomes an end unto itself rather than method of working towards shared objectives (10).

Conclusions

There are few health issues today that do not involve partnerships. The complexity and scope of health partnerships continues to develop and an awareness of this is essential for any public health practitioner. Learning lessons from how partnerships have been formed and what results have been achieved has become much easier due to advances in information technology.

Exercises

Learning objective:

Know how to use electronic resources to strategically analyze health partnerships and apply lessons learned from this analysis to propose practical solutions to a similar health problem in the practitioners' own environment.

Task 1:

Pick one of the following public health topics from the 1990s to date, review the website indicated and locate at least three other websites or other sources of information that can give you the background, development and results of the partnership that was established to address this issue.

Landmines. Over 110 million landmines are spread around the world into an estimated 70 countries within the past 65 years. Landmines kill and injure people and can persist for many years after a conflict has ended. Landmine clearance is costly and dangerous. An alliance of NGOS, national and international organizations successfully lobbied for a global ban on the production and use of

landmines in the 1990's. This resulted in a Nobel peace prize in 1997 for the Global Campaign to ban landmines and Jody Williams, the key activist involved (11).

Tobacco Control. Cigarettes comprise the single greatest preventable cause of death and morbidity in the world. Despite massive and heavily financed opposition from the tobacco industry, The World Health Organization (WHO) led an international coalition to develop the WHO Framework Convention on Tobacco Control (FCTC). This is the first global health treaty negotiated under the auspices of the World Health Organization. The FCTC was developed in response to the globalization of the tobacco epidemic. It commits countries to implement a range of tobacco control measures such as a ban on tobacco advertising, protection of people from second hand smoke, and the regulation of tobacco products. To enter into force, the treaty must be signed and ratified by at least 40 countries. As soon as 40 countries ratify the Convention, it becomes law for those countries and thereafter for other countries that ratify it. By early August 2004, 168 countries had signed the FCTC and 24 had ratified it (4).

Road traffic injuries and deaths. Use of safety belts in cars is proven to reduce deaths and injuries. A series of legal and police measures in the UK coupled with evidence based advertising has led to a measured reduction in deaths. By developing **THINK! brand partnerships**, by 2010 the Department of Transport in the UK aims to have reduced the number of adult road deaths and serious injuries in Britain by 40%. To help achieve this they will use corporate partners, brands who can get THINK! messages on road safety across to their customers (12).

Task 2:

Identify the main partners involved in each example and note their roles and contribution. Note the results of the partnership. Identify three reasons why the partnership was a success. Identify three challenges to the partnership and see how these were addressed by the partners.

Task 3:

For the public health topic you have picked, consider applying this kind of partnership to the same issue in your country. Could it work?

If so how? Who would need to be involved? Prepare a one-page plan detailing the partners who would be involved and say how they would work together.

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Chapter 4

CASE STUDIES

4.1 General Public Health Strategies

PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title:	The Albanian Public Health and Health Promotion Strategy
Module: 4.1.1	ECTS (suggested): 0.25
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Keywords	Health, health promotion, health reform, health strategy, prevention, public health.
Learning objectives	At the end of the module, students should be able to: <ul style="list-style-type: none"> • address the issues of the difficult socio-economic transition in countries of South East Europe; • understand the impact of transition on health status of the populations and on health care services; • understand the main components of the public health strategies formulated and implemented in countries of South East Europe.
Abstract	In the early 1990s, following the fall of communist regime, Albania experienced a severe breakdown of health services. Decentralization and transition to a new market-oriented system resulted in uncontrolled population movement from rural to urban areas. Primary care services suffered most from such a transition. Based on the new challenges associated with the

	<p>difficult transition, the government of Albania has aimed in the past decade to design a comprehensive health sector strategy with encouragement and support of different international organizations, primarily WHO. These attempts were recently materialized with two key documents namely the <i>Public Health and Health Promotion Strategy</i> and the <i>Long-Term Strategy for the Development of the Albanian Health System</i>.</p> <p>The Public Health and Health Promotion Strategy was developed and approved by the Albanian Ministry of Health in 2003. It was designed to respond to Albanian public health challenges and to be in close line with the Long-Term Strategy for the Development of the Albanian Health System. The Public Health and Health Promotion Strategy for Albania is until 2010, with a review and update planned to take place in 2007. A detailed action plan has also been produced and made available to the Albanian Ministry of Health.</p>
Teaching methods	<p>Presentation of the Albanian Public Health and Health Promotion Strategy, after which students should be divided into small groups and asked to review, summarize, and discuss the national public health strategies formulated and implemented in their own countries.</p>
Specific recommendations for teachers	<p>This module should be assigned 0.25 ECTS.</p>
Assessment of Students	<p><i>Individual assignment</i> – take home essay (up to 3000 words, references excluded): Public Health Strategies in students’ own countries – goals and objectives, principles, components, and action plans produced to implement these strategies.</p>

THE ALBANIAN PUBLIC HEALTH AND HEALTH PROMOTION STRATEGY

Enver Roshi, Genc Burazeri, Nertila Tavanxhi

Albania – Country Profile

After the collapse of the communist regime in 1990, a market-oriented economic system has emerged in Albania. Nevertheless, the transition from a hermetic self-reliant system into an open democratic society has been severely undermined at least twice: in 1997 and more recently in 1999 (due to the war in Kosovo). The 1997 turmoil was due to the collapse of savings schemes known as “pyramids”. The “pyramid phenomenon”, to a certain extent experienced by most of the countries in transition, was nevertheless unique in Albania due to the extremely large scale of the population’s involvement. It is estimated that almost 2/3^{rds} of the Albanian population took part in these savings schemes, and that the total sum lost exceeded one billion USD in a country whose total GDP was not more than 2.5 billion USD (1). The social consequences of this collapse were immense and chaos reigned for a prolonged period. Effects on socio-economic status and social mobility were probably profound. The psychosocial environment in Albania is still enveloped by the “pyramid” effect and its sequelae are still shaping to a certain extent the political, economic and social environment.

Population

Based on the census of 1 April 2001 the population of Albania was 3,087,159 people (2); 42% of the population are urban dwellers. The population of municipality of Tirana (the capital city) was estimated to be 343,078 people (2). About 97% of the Albanian population are ethnic Albanians, 1.9% are Greeks, and other groups are represented in small numbers (1). A unified form of the Albanian language has been used since the early 1970s. While Albania is largely a secular state, 70% of the population identify themselves as Muslims, 20% are Orthodox Christian and 10% are Roman Catholic (1). Although religion has not been an important identity element in

Albanian society, with the return of religious freedom many mosques and churches, which were closed in 1967, have now reopened.

Selected Health Indicators

Infant mortality in Albania is one of the highest in Europe, at 12 per 1,000 live births, 2001 (3). In 2001, maternal mortality (per 100,000 live births) was 22 (3). In the same year, incidence of all forms of tuberculosis (per 100,000 population) was 19 (3). In 2000, crude mortality rate (per 100,000) from circulatory diseases was 253 among men and 211 among women (4). Life expectancy at birth in 2000 was 72 years for men and 78 for women (5).

Albanian “Paradox”

Unique among countries of Central and Eastern Europe, Albanian’s health indicators continued to improve up to early 1990s, despite the most restrictive and repressive political regime (6). One possible explanation for this “paradox” is that Albania is, in essence, a Mediterranean country (7). The Mediterranean diet has been suggested as an important factor in keeping rates of coronary heart disease (CHD) low and hence improving overall life expectancy (7). Albania has, what is conventionally believed to be, good nutrition with a traditional diet high in fruit and vegetables. The mean calorie intake per person per day was 2717 in 1999, of which 73% were from vegetable products (almost 46% of the total calorie intake were from cereals) (8). Of the animal sources, two thirds were dairy products. The Albanian mean calorie intake is the lowest of the European countries (5). Mean fat intake of 27% of energy in Albania is low compared with other countries and with current international recommendation (<30%).

Albania may exemplify the link between healthier life-styles and better health, both in comparison to other (more wealthy) countries and also within the country itself, with better indicators in the south than the north (7). Notwithstanding ethnic/religious differences, this pattern (north vs. south) might reflect dietary variation with a typically Mediterranean diet especially in rural areas in the south (high intake of olive oil, fresh fruit and vegetables) versus higher intake of fat of animal origin especially in urban areas in the

north (9-10). Nonetheless, the main oil used in all regions of the country is sunflower seed, consumed far in excess of olive oil, and as such Albania differs sharply from the Mediterranean prototype.

In the past decade “deviation” from the traditional diet is said to have taken place in all regions of the country. Based on food balance data, Albania has comparatively low levels of alcohol consumption (8). However, this is questioned. Tobacco consumption has increased in the last years. Though annual cigarette consumption in Albania is reported to be among the lowest in Europe (5), cigarette smuggling makes it very difficult to validly estimate cigarette consumption in Albania (11).

Concisely, in the past decade changes in life-style (diet, tobacco and alcohol consumption) are believed to have taken place in Albania with an emergent “westernized” life-style, particularly in Tirana (albeit less evident than in other Eastern European capital cities).

Health System

From 1944 to 1990, the health system in Albania was based on Semashko’s approach, a centralized system with free-of-charge governmental provision of services (1). Such a system assured universal coverage virtually to everyone, even to those living in the most remote areas of the country.

In the early 1990s, following the fall of communist regime, there was a severe breakdown of health services countrywide (1). Decentralization and transition to a new market-oriented system resulted in uncontrolled population movement from rural to urban areas. Health system was unable to fit into this demographic transition and meet the needs of the population (1). Primary care services suffered most from such a transition. In addition, government expenditure on health was low (1, 12).

In early 1990s, there was clear evidence of a collapse of public health services, such as primary care facilities, rural health centres, severe shortage in drugs, and lack of vaccination coverage (1, 12). Public health specialists were unable to respond promptly to public health emergencies facing the country. There was an obvious need for a new perspective with regard to primary care service delivery (13).

However, external donors assisted the Albanian government in restructuring the health sector with an estimated US\$120 million during 1992-1996 (1).

Current problems with the Albanian health sector

From our point of view, the main problems involving the health sector in Albania are the following:

- Lack of vision about the concept of health as a "social product".
- Inability to interact and co-ordinate activities in a multi-sectoral fashion as a basic prerequisite for achieving a healthy population. From this standpoint, there is a clear lack of collaboration between the following sectors: health, education, economy, agriculture, transport, veterinary, etc.
- Inability to collaborate and co-ordinate activities and programs between central level institutions and local authorities.
- Misbalanced and preferential policies with regard to allocation of funds in health sector: insufficient investments in the core areas of public health such as Disease Prevention and Health Promotion, as opposed to (relatively) substantial and (often) not cost-effective investments in hospital care.
- In general, minimal and non-transparent investments in all public health activities such as food safety, water and sanitation, waste management, environmental protection, etc.
- Lack of capability to attract health projects funded by international agencies and donors.
- Super-centralization ("*de facto*") of administrative and managerial activities by the Ministry of Health.
- Practically, the role and functions of the specialists of public health are quite neglected by the central health authorities.
- Most of health managers and administrators in both central and local institutions are not trained and do lack the necessary expertise to organize, administer and manage the health sector.
- Lack of a valid and reliable health information system.
- Barriers in communication between health institutions and health professionals on one hand, and the public on the other.

This gap in communication compromises seriously the access to, and satisfaction with health care services.

Consequences derived from the current organizational structure and management of health system in Albania

The consequences derived from the current organizational structure of the Albanian health system are listed below:

Immediate consequences

- Infant mortality and maternal mortality in Albania are among the highest in Europe.
- Road accidents, homicides, suicides, poisoning and other external causes of death (absolutely *avoidable*) are probably the highest in South East Europe.
- Water-borne, air-borne and food-borne infectious diseases are still one of the major causes of morbidity, especially among children 0-5 years.
- Nutritional indexes, especially among children and pregnant women, are probably the poorest in the region (i.e. in South East Europe).

Mid-term consequences

- The high prevalence of smoking, excessive alcohol consumption, drug use, malnutrition, and unsafe sexual practices will inevitably be associated with epidemics of cardiovascular diseases, respiratory diseases, diseases of the digestive tract, diseases of the immune system, as well as sexually transmitted infections.

Long-term consequence

- *Vicious circle*: the unhealthy population obstacles the economic development of Albania and, vice versa, the slow pace of economic progress compromises the health indicators of the Albanian population.

The need for a public health strategy in Albania

Based on the aforementioned problems and their related health consequences, the government of Albania has aimed in the past

decade to design a comprehensive health sector strategy with encouragement and support of different international organizations, primarily WHO. These attempts were recently materialized with two key documents namely the *Public Health and Health Promotion Strategy* and the *Long-Term Strategy for the Development of the Albanian Health System*.

The Public Health and Health Promotion Strategy was approved by the Albanian Ministry of Health in 2003 (14). This strategy was the outcome of a project financed through an agreement between the World Bank and the Albanian Government. It was developed in 2002-2003 by the Albanian Ministry of Health and the Institute of Public Health with the assistance and support of the Health Development Agency of England (14).

The Public Health and Health Promotion Strategy for Albania was informed by the WHO European Regional Strategy for Health for All in the 21st Century (Health 21). It was designed to respond to Albanian public health challenges and to be in close line with the “*Long-Term Strategy for the Development of the Albanian Health System (Draft – Albanian Ministry of Health, May 2004)*” [14].

The Public Health and Health Promotion Strategy for Albania is until 2010, with a review and update planned to take place in 2007. A detailed action plan has also been produced and made available to the Albanian Ministry of Health (14).

Content of the Albanian Public Health and Health Promotion Strategy

The overall goal of the strategy is “*To achieve year-on-year improvements in life expectancy and health experience*” (14). To meet this goal, besides the individual risks, other factors that affect society as a whole must be taken into consideration (e.g. socio-economic conditions). The effect of such factors establishes the state of health of a population, conventionally referred to as the ‘*state of public health*’. Therefore, Public Health is an important ‘indicator’ of a society’s social cohesion and inclusiveness; from this point of view, good Public Health is necessary for sustainable economic and social development.

Given the current situation in Albania, the strategy set realistic goals and objectives. Based on these objectives, a detailed plan of action was prepared which is currently being implemented.

The criteria for prioritization of actions to be undertaken consist of the following (14):

- ***The burden of diseases*** (cardiovascular diseases; cancers; accidents - home, work, traffic; reproductive health / sexual health; respiratory diseases; mental health - social changes, suicides, drug abuse; and diarrhoeal diseases).
- ***Trends of diseases*** (over time, by: sex, age-groups, regions, and population sub-groups);
- ***Preventability*** (of diseases and conditions related to: physical, chemical, biological and socio-economic environment; lifestyle; and health care services).
- ***Plausible actions based on evidence*** (best practices and successful approaches from neighbouring and other countries).

Components of the Albanian Public Health and Health Promotion Strategy

As this strategy intends to improve the health of the whole population in Albania, principles of equity and solidarity in health were considered, and enhancement of a multi-sectoral responsibility, as well as a concrete set of actions were developed. These components are briefly summarized below (14):

- ***Equity and solidarity in health targets:***
 - By the year 2020, the health gap between socio-economic groups in Albania should be reduced by at least a quarter by substantially improving the level of health of disadvantaged groups. The gap in life expectancy between socio-economic groups should be reduced by 25%;
 - Indicators of morbidity and disability should be more equitably distributed across socio-economic groups;
 - People having special needs should be protected from exclusion and given easy access to appropriate services.
- ***Multi-sectoral responsibility for better public health:*** By 2005, all sectors should have accepted and recognized their responsibility for improving PH, and the formulation and implementation of PH policies should engage individuals, groups and organizations in alliances and partnerships for better health throughout the public

and private sectors and civil society. The practical implications to ensuring an effective inter-sectoral collaboration encompass the following:

- Establishment of effective multi-sectoral structures at national and local level for public health practice;
 - Assistance of decision-makers in other sectors regarding investments in health;
 - Establishment of a mechanism for assessment of health impact and use of it to influence policy-making in many sectors;
 - Improvement of information systems to supply baseline data for target setting and progress towards targets' monitoring.
- ***Actions for improving the Public Health System:***
 - Institute of Public Health (IPH) to issue licenses to public health specialists to enable them to practice;
 - IPH to prepare annual national public health reports for the Minister of Health;
 - IPH to enable an effective communication system between district public health Directors and the IPH on all public health issues.
 - The IPH Director to produce an annual report on public health matters;
 - In each district, employment of one Health Promotion Coordinator, thus establishing a strong network of trained health education specialists;
 - Design of local public health strategies - based on the national strategy, but to prioritize to local needs;
 - Establishment of a national training program for the health education and promotion specialists;
 - Establishment of an ongoing post-basic public health training program for doctors and nurses;
 - Each Ministry to work with the Ministry of Health and the IPH regarding its contribution to health, by establishing a health development group.
 - *By the end of 2005:*
 - Common training for public health specialists and more flexible training, including part-time and full-time;
 - Establishment of a School of Public Health;

- Establishment of a national Public Health Forum including NGOs, district departments, other government departments, professional associations and groups. The Forum will advocate, share information and help to coordinate actions;
- Public health specialists to be moved into a higher salary bracket;
- Introduction of a credit system for training courses attended – the more points, the higher the salary;
- Establishment of a comprehensive public health information system within the IPH;
- Feasibility study for establishing screening programs for protecting women's health.
- *By 2006:*
 - Initiation of health education training modules for all nurses and family doctors as part of their basic training;
 - Establishment of a network of community health workers in rural areas;
 - Inclusion of all schools in the network of Health Promoting Schools.
- *By 2008:* Increase the number of trained specialists from 110 partly trained (in 2002) to 130 fully trained professionals.

Conclusions

Sustained economic and social development are crucial for good public health and, vice versa, good public health is essential for sustainable economic and social development. Therefore, the systematic implementation of the action plan pertinent to the Public Health and Health Promotion Strategy will improve on one hand the health of the Albanian population, and facilitate the economic and social progress on the other. The issues of sustainable development and health status of the population are critical for Albania as it seeks accession to the European Union. Nevertheless, improvement of public health parameters in Albania requires co-ordinated and sustained actions based on evidence, scientific principles, and experiences and best practices from other countries. All actions should

be directed at the whole population with the ultimate goal of preventing disease, promoting health, and prolonging life.

Exercises

Students are required to perform a comprehensive review of the national public health strategies formulated and implemented in their own countries. The review should address (at least) the following: goals and objectives of public health strategies, principles, components, and action plans to implement the respective strategies.

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Romanian Public Health Strategy - development process
Module: 4.1.2	ECTS (suggested): 0.2
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Keywords	Health strategy, population health status, health determinants, health system, implementation plan
Learning objectives	At the end of this exercise, students should: <ul style="list-style-type: none"> - be aware of the health context of Romania - be able to retrieve the general components of a public health strategy - be able to compare and conclude about the development process of the public health strategy in Romania
Abstract	This course covers the following topics: <ul style="list-style-type: none"> - The Need for Public Health Strategy <ul style="list-style-type: none"> - General Aspects concerning Romanian Population Health Status - Morbidity - Health Determinants - Aspects concerning Health System - Existing Legislation - Political Will, Driving Forces - Public Health Strategy Development Process - Public Health Strategy Implementation
Teaching methods	Interactive group discussion of each subchapter, revealing the key concepts and main conclusions. Strengths and weaknesses of the strategy will be presented on a flipchart.
Specific recommendations for teachers	This case study takes 3 hours of discussions. Another 4 hours will be destined to review electronic and printed literature in the field. (suggested ECTS: 0,2)
Assessment of Students	A short (max. one page) essay developing the main ideas selected during the discussions.

ROMANIAN PUBLIC HEALTH STRATEGY: DEVELOPMENT PROCESS

Adriana Galan

I. The Need for Public Health Strategy

At present, Romania is undertaking the accession process into the European Union. This fact represents one of the driving forces toward the adoption of the “new public health” concept. This means new challenges for Romania, like: intersectoral co-operation, community involvement, building partnerships and networks, sharing the information and use of state-of-art communication technologies etc.

On the other hand, public health essence is represented by the population. The right for a good health of the Romanian population is guaranteed by the Constitution of Romania. After 1990, the Romanian Governments have been politically committed to the protection of this fundamental human right. Unfortunately, due to the slow course of the economic and social transition, health has never reached a high priority for the Romanian politicians. Sustained economic and social development are reciprocally governing the good public health.

The “new public health” concept, besides the health of population, also includes managerial aspects, like organisation of personnel and facilities for providing all health services (1). Therefore, when starting to design a “Public Health Strategy”, one should carefully look at aspects related to the current situation of the population health status, health system organisation, existing legislation, as well as internal and/or driving forces and political will, in order to plan adequate Public Health interventions. Only after completing this preliminary evaluation, a National Public Health Strategy - term having the general meaning of “*long-term major patterns of activity to describe the means of accomplishing objectives, requiring a substantial commitment of resources*” (2) - can be developed.

I.a. General aspects concerning Romanian population health status

After 1990, poverty and visible decline of living standard had a deep negative impact on the health status of Romanian population, together with obvious inequalities in health.

Population health status evaluation was approached by considering the traditional main fields of investigation: demographic aspects, morbidity and health determinants.

I.a.1 Demographic Aspects. Demographic process in Romania can be generally described by the negative natural growth in the last 11 years. In 2002, this indicator reached the lowest value after 1989 (5.3/1000 inhabitants), of -2.7/1000 inhabitants (3). The main causes for this negative trend were: increase of general mortality rate, marked decrease of birth rate, massive emigration.

Birth rate manifested a steady decline after 1989 (16 new born/1000 inhabitants), reaching a value of 9.7 new born/1000 inhabitants in 2002, while for the same time period the crude mortality rate showed a constant increase from 10.7 deaths/1000 inhabitants in 1989 to 12.4 deaths/1000 inhabitants in 2002 (3).

Maternal mortality is still high, 22.32 maternal deaths/100000 live-born being reported in 2002 (3). Even if the indicator showed a positive evolution after 1990, Romania is still placed in 2002 among the European countries having one of the highest levels for this indicator.

Infant mortality rate has significantly diminished since 1989: from 26.9 infant deaths per 1000 live-born (1989), to 17.3 infant deaths per 1000 live-born (2002) (3). Nevertheless, this indicator has still a higher level than in other European countries.

Life expectancy at birth had a slightly ascending trend in Romania, reaching in 2000 a value of 71.25 years for the general population (3). However, life expectancy at birth in Romania is lower than in Central and East European countries (73.03), and considerably lower than in European Union member states (78.65), according to HFA2003 database.

The main causes of death in 2003, in Romania (3), were cardiovascular system diseases (63%), followed by malignant tumours (16%), digestive diseases (6%), accidents/injuries/poisoning (5%) and respiratory system diseases (5%). Cardiovascular diseases also generated the biggest burden of disease (32% of total DALY in 1998) (4).

I.a.2 Morbidity. Morbidity patterns have sustained important changes in the last decades in Romania, revealing the increase of chronic diseases prevalence and related mortality.

Routine data describing the morbidity generated by non-communicable diseases are underestimating the real dimension of the phenomenon. With a periodicity of 5-6 years, good quality data on the prevalence of non-communicable diseases have been obtained through the Health Status Surveys, performed by the Computing Centre of Health Statistics and Medical Documentation of the Ministry of Health.

Conversely, due to the fact that a functional surveillance system is in place, information related to the morbidity generated by communicable diseases are of better quality. Out of all communicable diseases, public health priorities in Romania are: tuberculosis (the level of TB incidence is placing Romania on the first rank in Europe – 127.54 new cases/100000 inhabitants in 2001), sexually transmitted diseases, HIV/AIDS infection (4679 AIDS cases in 2003) (3), nosocomial infections (although the current data are not revealing the real amplitude of the phenomenon).

I.a.3 Health Determinants. Health status is strongly affected by the synergic action of biological, environmental, lifestyle determinants together with the influence of socio-economic and health care conditions.

- ***Lifestyle factors***

Smoking has increased in Romania after 1990, both in males and females, but especially among youth. A study carried out by the Centre for Health Policies and Services, between April 2003 and February 2004, on a population aged between 14 – 60 years (5), revealed that the smoking prevalence in Romania has a value of

35.1% (46.4% among males and 24.1% among women). The most exposed age group is 25-34 years (39.9%). Smoking inside public spaces has been regulated by law in December 2002.

Concerning the *alcohol consumption*, ESPAD (European School Survey Project on Alcohol and Other Drugs) study from 2003 revealed that 88% of 16 years school-pupils declared lifetime use of an alcoholic beverage. Also, 52% of the 16 years population declared that they became drunk at least once (an increase of 20% compared with the results of ESPAD study from 1999).

Even if *illicit drug consumption* emerged later in Romania than in other countries, the low level of education, poor living conditions and psychosocial weakness have favoured the continuous spread of this phenomenon, affecting especially the youth.

- ***Socio-economic factors***

Social and economic factors had their contribution to the decline of the health status of the Romanian population after 1990.

Poverty was estimated at 27% in 2002, while extreme poverty at 11%, according to World Bank Report from September, 2003 (6). The most affected population groups are: abandoned, severely neglected or abused children; families living under chronic unemployment; large families having many children, etc.

Unemployment rate was 7% in December 2003, in Romania (7). The most affected age group is represented by youth under 25 years of age, with a value of 18.5% in December 2003.

Household expenses structure shows that, even if the Romanian population spent less on food per month in 2002 (35.8% of total household expenditures) than in 2000 (38.5%) (7), the value is still high enough to place the Romanian population very close to the poverty line (when more than 40% of household income is spent on food). Health expenses represent only about 3.6% of total household expenditures.

- ***Environmental factors***

The ambient environment represents a major factor related to the health status. According to the data reported by the Ministry of

Environment and Water Management (8), a slightly improvement of air quality could be noticed in Romania. The report show a decrease of annually emissions of greenhouse effect gases, such as CO₂ and CH₄, together with a slightly decrease of NO₂ emissions (from 362 ktones in 1996 to 332 ktones in 2000) and of SO₂ emissions (from 898 ktones in 1996 to 773 ktones in 2000).

The Ministry of Transport, Constructions and Tourism have reported (9) that the passengers transport has intensified in 2003 compared with 2002, mainly the road transport (from 5.2 mil. passengers-km in 2002 to 9.4 mil. passengers-km in 2003). Unfortunately, the more environmental-friendly transport modes (like: inland waters, air) have diminished.

I.b. Aspects concerning Health System

After 1989, the Romanian health system has experienced some major changes within the health sector reforms. However, the lack of clear strategies and well-defined objectives to be achieved, irrespective of political changes, have delayed the health reform process.

The social health insurance system was adopted only in 1998, introducing new actors in the system and changing the roles of old actors. The Ministry of Health became a body having as main responsibilities: health policies elaboration and coordination, health programmes development and management, health sector regulation, both public and private. The Ministry of Health has 42 decentralized administrative units – district public health authorities – under the authority of the local prefect. Currently, the main financing source of the health system is the National Health Insurance Fund (82.5% of health expenditure in 2003), constituted in principal by contributions paid by employees (6.5% of total income) and employers (7%), and contributions paid by state for unemployed, pensioners, and other deprived population categories.

Another major change introduced by health system reform was a new payment system of the providers. Thus, family doctors are paid through a mix of weighted capitation (75% for 2004) and fee for service (25%) for preventive and health promotion services, plus a fix sum to cover the administrative and personnel expenditures (representing 50% of the total income resulted from per capita and fee

for service). The doctors in ambulatory services are paid on fee for service, while those working in hospitals are still paid by salaries.

Starting with 1st of January 2004, 185 hospitals in Romania are financed by DRG system. The rest of hospitals are paid by global budgets (established on the basis of some indicators stated in the Framework contract).

The Romanian health system is still facing the following major problems:

- under-financing and inefficient use of resources
- low and inequitable access to quality health services
- poor human resources management
- inappropriate health promotion services
- poor information management
- weak intersectoral collaboration

I.c. Existing Legislation

Public Health Law was voted in 1998, modified and updated by further Ministerial Orders. At present, a new version of the Public Health Law is under public debate and is going to be submitted to the Parliament.

This law is establishing the Public Health authorities, responsibilities and functions. The Ministry of Health, together with local public health authorities have the main responsibility of the Public Health sector.

There are many other laws and regulations having an important impact on Public Health, like:

- Law 145/1997 - Social Health Insurance Law
- Ministerial Decision 740/1997 - Organisation of medical and pharmaceutical postgraduate education
- Law 130/1999 - Protection measures for the working population
- Law 146/1999 and 270/2003 - Hospital organisation, functioning and financing
- Ministerial Order 50/2000 - Establishment of co-operation between the Ministry of Health and local public administration for the implementation of Public Health regulations

- Law 649/2001 - List of communicable diseases with mandatory reporting system
- Law 655/2001 - Ambient Environment Protection
- Law 46/2003 - Patient Rights
- Law 275/2003 - Prevention and combat of tobacco products

I.d. Political Will, Driving Forces

Although there is not an official document on the health policy in Romania, the Governing Programme 2000-2004 includes health among its priorities. This Programme proposed as main strategic objective "*A healthy Romania, with a reduced morbidity and lower premature deaths*". Another objective mentioned by the Governmental Programme is "*the improvement of mortality and morbidity indicators in general population, through the national health programmes, through the development of the public health network and by shifting the emphasis out of hospital care*".

Romania started the accession process in EU on February 2002. Even if health was not the subject of a special chapter of negotiation, some health related problems were encountered within different other chapters.

European Commission, in its periodical country progress report from 2003 (10), has emphasised some positive trends concerning public health aspects. For instance, in the field of work safety and occupational health, the general norms for work protection were revised in December 2002, transposing in this way 20 European directives. Chapter 13 of this report, concerning the social policy and use of workforce, is mentioning several aspects related to public health. Even if some progress was achieved in the process of raising population awareness on the danger of tobacco use, the related law is only partially complying with the *acquis communautaire*. There was also mentioned that Romania is participating since 2003 to the Global Fund against HIV/AIDS, TB and malaria. The report is especially mentioning that, for 2003, **there is still missing a coherent health strategy to continue the health system reform process.**

Consequently, the Romanian Government has established a Plan of priorities for the period December 2003 - December 2004 for better preparation of the adherence to EU (11). Among 9 major

established priorities, there were also encountered aspects related to public health, like: controlling the food safety (making operational the Romanian Agency for Food Safety), elaborating integrate policies concerning environmental protection (making operational the National Agency for Environment Protection). The Government has also decided to elaborate and adopt the Public Health Strategy during 2004.

II. Public Health Strategy Development Process

In 2003, the Romanian Ministry of Health obtained a loan from the World Bank (RO – 4568) in order to develop the National Public Health Strategy. Ministry of Health became the co-ordinating body of the strategy development process, appointing the main actors to be involved in this process. So, the main institutions providing expertise and consultancy were:

- Centre for Health Policy and Services - editing co-ordination
- Institute of Public Health Bucharest - scientific support, editing
- University of Medicine Bucharest, Department of Public Health and Management - scientific support
- Institute for Mother and Child Protection - scientific support
- Romanian Mental Health League - scientific support
- USAID, UNICEF, John Snow International - consultancy

The development process of the National Public Health Strategy assumed 3 stages:

1. identification and ranking the priority fields and problems
2. editing stage
3. public debate and adjustment according to the expressed opinions

In the first stage, Ministry of Health organised a consensus meeting where experts from the World Bank, USAID, UNICEF, John Snow International, Institute of Public Health Bucharest, National Institute for Research and Development in Health, Romanian Mental Health League were invited to participate. During this meeting, they identified the main fields/sections of the future strategy and prepared a list of priority health problems. Sections identified by the experts at that moment were:

- Support, general background, implementation mechanisms

- Multisectoral intervention
- Non-communicable diseases
- Communicable diseases
- Mental health
- Preventive services
- Family health
- Public health training and research
- Health services

Anchored rating scale method was further used to rank the health problems from the initial list. In order to do that, a large number of experts from all over the country have filled-in a questionnaire where they assigned a score (between 1 and 10) for each listed problem under each section. Criteria used for ranking were: problem frequency, biological severity, social impact, cost of care, feasibility of intervention, beneficiaries. Finally, a mean was calculated for each problem, providing in the end a hierarchy.

Several expert meetings were further organised in order to refine the initial list of sections and of ranked problems.

During the second stage of the development process, de facto editing process started. For each established section of the strategy, an editorial team was appointed. All the teams were supervised by a nominated co-ordinator. The first draft document considered the official statistics published in the Yearbook of Health Statistics (2002), WHO database "Health for All" and other official information sources. Existing health policy, legislation and sectoral strategies were reviewed. EU and WHO public health policies and strategies were also given due consideration, Romanian Public Health Strategy aiming to comply with international new thinking and trends in the field.

The last stage in strategy development was the public debate. On May 2004, the first strategy draft was posted on the Ministry of Health web site, for 30 days, asking for the comments of experts and/or health institutions interested in the field. At the same time, the draft was also sent to the main public health institutions in the country asking for their opinion in their specific field of competence. Because the Institute of Public Health Bucharest reacted promptly and in a very competent way, the Centre for Health Policy and Services, the editing

co-ordinator, designated some experts from this institute to revise the draft, actually to re-edit the whole document. It was the moment when the final content of the strategy was established together with the editing co-ordinator, some initial sections were again regrouped, but preserving the priorities established by the experts during the first stage. The final draft of the National Public Health Strategy was edited based on all the reactions and comments received from experts and/or institutions, containing the following chapters:

- Chapter 1: **GENERAL BACKGROUND**
 - SECTION I - ASPECTS CONCERNING POPULATION HEALTH STATUS
 - SECTION II - ASPECTS CONCERNING HEALTH SYSTEM
 - SECTION III - THE GOVERNMENT HEALTH POLICY
 - SECTION IV - INTERNATIONAL HEALTH POLICIES
 - SECTION V - GUIDING PRINCIPLES
- Chapter 2: **GOAL AND OBJECTIVES OF THE NATIONAL PUBLIC HEALTH STRATEGY**
- Chapter 3: **KEY AREAS FOR INTERVENTION**
 - NON-COMMUNICABLE DISEASES
 - SURVEILLANCE OF COMMUNICABLE DISEASES
 - MENTAL HEALTH
 - FAMILY HEALTH
 - PREVENTIVE SERVICES
 - HEALTH SYSTEM MANAGEMENT
- Chapter 4: **IMPLEMENTATION, MONITORING, EVALUATION**
- APPENDIX

The goal of the Romanian Public Health Strategy is:
"to establish and to outline mechanisms and guidelines to be followed to the purpose of improving health status of the Romanian population and ensuring a high level of human health protection, by implementing measures for transforming current public health structures in competitive structures to the international new concepts and approaches." (12)

In order to achieve the proposed goal, the general objectives of the strategy are:

- stopping the negative trends and creating conditions for improving population health status
- adopting the EU principles and policies in regards with public health
- continuing the health system reform process in order to improve its performance, as an essential premise for health status improvement (12)

On July 16, 2004, the National Public Health Strategy was adopted through a Ministerial Order (no. 923/2004) and is going to be officially launched by the end of the year.

III. Public Health Strategy Implementation

Being completed under a big time pressure, this chapter of the strategy proposes only an implementation guideline, needing further development and detailed design. There are described several stages of the implementation plan, but no proposals of indicators to support the attainment of the objectives.

The following stages for strategy implementation were planned (12):

1. Adoption of the National Public Health Strategy under a Governmental Decision (already done through the Ministerial Order no. 923/2004)
2. Obtaining the collaboration agreements from the other partners within and out of health system
3. Mass-media campaign for promoting the National Public Health Strategy
4. Setting a Co-ordination and Monitoring Unit for the strategy implementation at the Ministry of Health level
5. Establishing the experts committees responsible with the development and implementation of health programmes
6. Evaluation of the specific needs for reaching each objective of the strategy and identification of available resources

7. Development and implementation of intervention programmes
8. Monitoring
9. Evaluation

Exercises

1. Compare the Romanian Public Health Strategy with other similar strategies developed in Europe or in the region. Discuss similarities and specific differences between them.
2. Reveal the strengths and weaknesses of the Romanian Public Health Strategy. Propose improvements of this strategy.

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Development of Public Health Strategy in the Republic of Serbia
Module: 4.1.3	ECTS (suggested): 0,5
Author(s), degrees, institutions	National Expert Committee on Public Health chaired by prof V. Cucic Adapted for training purposes by Jasmina Grozdanov , MD, MPH, PhD and Svetlana Jankovic , MD Both are working as PH experts within EU-funded Project “Support to the Public Health Development in Serbia”
Address for correspondence	Euro Health Group PO Box 56 11129 Belgrade, Serbia Tel: +381 11 3065413 Fax: +381 11 3065410
Keywords	Public health, strategy, action plan, aim, objective
Learning objectives	By the end of this module the students should be able to: <ul style="list-style-type: none"> ● recognise the differences between: health care system strategy, national health strategy and public health strategy ● get familiar with the process of drafting a public health strategy and action plan ● develop the action plan as a part of a public health strategy ● understand the importance of multisectoral approach in planning, implementation and evaluation related to the action plan
Abstract	The Public Health Strategy in the Republic of Serbia represents a part of the Health policy of Serbia and overall Reform of Health Care System Strategy. The significance of public health is recognized by the top level decision-makers, therefore a strong support has been given to the improvement of concept of health promotion and disease prevention. Public Health Strategy is in conformity with existing

	<p>international documents in this field.</p> <p>Within the Public Health Strategy different problems were identified, and general and specific goals defined, as an answer to existing challenges.</p> <p>The action plan was developed as a part of the strategy. Activities were clearly defined in accordance with identified goals, as well as carriers of those activities, and the deadlines.</p> <p>The strategy, in a draft form, has been delivered to the Ministry of Health, which will organize a public debate with the aim of reaching a national consensus on the new framework of the new public health in Serbia.</p>
Teaching methods	Introductory lecture; group work followed by group reports and overall discussion; exercise
Specific recommendation for teacher	It is recommended that this module is organised within 0,5 ECTS credit. The module should be structured as a combination of supervised and group students work.
Assessment of students	<ul style="list-style-type: none">- Reports presented by each group- An essay on public health strategy in brief

DEVELOPMENT OF PUBLIC HEALTH STRATEGY IN REPUBLIC OF SERBIA

Jasmina Grozdanov, Svetlana Jankovic

Introduction

Public health represents a concept of organized efforts of society to protect, promote, and restore people's health. It is the combination of science, skills, and beliefs that the public health is directed towards the maintenance and improvement of the health of all people through collective or social actions, based upon one of the fundamental human rights – right to health.

The Government of the Republic of Serbia adopted a document named "Health Policy of Serbia" in February 2002 (1), in which the main directions of development and reform processes in the health care system were presented, based on the general social significance of health. One of the high-priority goals defined by this document is protecting and improving the health of people, as well as strengthening the health potential of the nation.

Reaching this goal includes implementation of a huge number of public health activities, which represents recognition of significance of public health. In this sense, a strong support is expressed toward implementation of the following activities: spreading the concept of health promotion, development of partnership for health, stimulation of preventive activities, as well as improvement of health education.

Public health in Serbia today is facing numerous challenges, such as the presence of traditional public theory and practice, insufficiently developed knowledge and skills of professionals in public health and lack of adequate financing mechanisms for the public health. Overcoming the above problems is possible through a strong support of development of new public health concept in general, and health promotion and disease prevention, in particular. The importance of the public health development is highly recognized in the Reform of Health Care System Strategy (2).

As the first step in the process of achieving one of the overall reform goals, the Ministry of Health has established the National Expert Group for Public Health. The main task of the group was development of the Public Health Strategy (PHS). The expert group reached an agreement regarding the key directions in the public health reform through series of consensus conferences in the field of: development of evidence based healthy public policy, reorientation towards cost-effective interventions directed towards health determinants, as well as establishment of national priorities in the field of public health. The early draft of the Public Health Strategy was submitted to the Ministry of Health as the document for the further public debate. Subsequent discussions during 2004 have led to substantial changes from the document presented in this book.

The development of the PHS represented one of the efforts in harmonisation with the existing relevant documents in EU. The PHS is formulated in accordance with the EU Public Health Programme (3), which is accentuating the disease prevention, health promotion, partnership development, as well as participation of the local community in decision-making.

By this Strategy, the existing challenges of public health in Serbia are recognized as epidemiological, population-oriented, environmental and organizational. The identification of the challenges was followed by the setting of the goals and developing of activity plan. Implementation of the activity plan is a precondition for achievement of the formulated goals.

The whole document was based on the concept of the new public health, that is, on its basic principles: development of intersectoral cooperation and multidisciplinary work, participatory approach, direction towards socioeconomic health determinants, and problem-oriented approach in decision making.

Public Health Strategy in the Republic of Serbia

Prepared by the National Expert Group for Public Health,
August 2003

A national strategy of public health represents a part of the overall health care development strategy. It is also part of a global strategy realized through co-operation at international level. Key points of the public health strategy are health promotion and primary prevention.

The functions of public health define the aims and expected results of sustainable health development for the general public, and specific population groups that, with help from the state, actively participate in health promotion, and the preservation of a healthy environment. As well as health status and risk factor monitoring, other functions of public health also relate to enabling people to take care of their health, the mobilization of partnerships and fortification of legal regulations. Special functions of public health are the improvement of quality, effectiveness and availability of health care and finding new approaches to solving health problems in the community.

The public health strategy of the Republic of Serbia was developed in agreement with the new EU action program of public health (2003 – 2008). The program is focused on the local community and its role in public health policy implementation. This program defines three main goals:

- Improvement of information and knowledge in the field of public health;
- Enabling an immediate response to threats to health;
- Establishing the main health determinants with the aim of decreasing the mortality rate.

For the realization of the new public health program, healthy public policy that goes beyond the traditional frame of the health care system has a very important role, with partnership development and active involvement of the non-government sector.

1. THE PUBLIC HEALTH SYSTEM IN THE REPUBLIC OF SERBIA

The government is responsible for the functioning of the public health system in Serbia, on the republic and regional, as well as the municipality level. On the republic level, besides the ministry of health, other ministries are also responsible for public health – those for labour and employment, for social issues, for environment protection, for education and sport, for science and technology and for agriculture and water management.

The public health system comprises networks of different institutions and services. The most important role in the field of public health belongs to the institutes of public health (IPHS), organized on the republic, regional and Belgrade city level. The institutes of public health network are made of twenty-two regional institutes and the institute of public health of Serbia "Dr Milan Jovanović - Batut". These have around three thousand employees, medical and non-medical personnel, whose main goal is not only the professional-methodological coordination of the entire public health area, but also direct participation in health promotion, disease prevention and environment protection.

The institutes work closely with the "Dom zdravlje", the health facility responsible for work on the local/municipal level. The "Dom zdravlje" network comprises one hundred and sixty institutions of this type (excluding Kosovo and Metohija), with around forty thousand employees providing primary health services. About 20 % of services provided in primary health care centres are preventive, mostly individual, in the form of mother and child health care, family planning and immunization. Most of the employees are general practitioners, paediatric physicians, gynaecologists, occupational medicine specialists, dentists and nurses. They all undertake both preventive and curative activity. "Dom zdravlje" are also responsible for the health care of the working population, with around three thousand employees in this sector, whose task is to promote health and protect workers from occupational diseases and risks related to the work place.

Parts of the public health system provide inspection services, from health and sanitation, to communal, market and veterinarian inspections, covering both republic and regional levels. Public health also comprises educational institutions – faculties, medium and high medical schools, elementary schools and pre-school institutions and institutions for social protection. The non-governmental sector consists of societies and associations of various types – for cancer, for diabetes, for hypertension, AIDS, cerebral paralysis and for the elderly.

The area of public health is regulated by a large number of legal regulations and by-laws. Programs of health care are also regulated by law, i.e. national programs approved by the government of the Republic of Serbia. Institutes of public health are financed partly by the Health Insurance Fund, partly by the republic and local budgets, and partly from market-derived income. “Dom zdravlje” are funded by the Republic Health Insurance Fund, and employers also contribute to the health care of workers.

2. PUBLIC HEALTH CHALLENGES FACING THE REPUBLIC OF SERBIA

2.1. Epidemiological profile

Non-communicable diseases

Chronic non - communicable diseases (CND) represent the most significant cause of illness and death in Serbia (e.g. diseases of heart and blood vessels – about 57 % of total mortality, malignant tumours – about 17 %). The prevalence of the most important risk factors (smoking, hypertension, improper nutrition, etc) for CND in Serbia is very high. This situation is partly the result of unfavourable socio-economic conditions and unhealthy life styles. In addition, the system of reporting and registration is inadequate; there are no reliable data in Serbia on which to base valid calculations of the frequency and spread of CND. Programs of primary prevention are still conducted without precisely defined methodology and goals, including efficacy assessment criteria and evaluation. There is no national strategy for CND prevention.

Communicable diseases

Morbidity and mortality from communicable diseases show a decreasing trend: some diseases have been eradicated (poliomyelitis), and some reduced to individual cases, especially vaccine-preventable diseases. Prevention and control of communicable diseases are directly related to the quality of surveillance conducted. In the recent past, certain problems were noted in the system of communicable diseases surveillance (irregular reporting of communicable diseases, problems with conducting programs of compulsory immunizations, problems related to immediate response in epidemic and emergency situations, problems relating to the poor identification of reference laboratories, etc).

Addiction illnesses

These comprise a series of physiological, psychological, socio-economic and other consequences of harmful or socially unacceptable substance abuse. The connection of such abuse with the spread of HIV and hepatitis increases the risks. The most common problems are alcoholism and drug abuse. Although the results of some researches show a high prevalence of alcoholism here, as well as constantly growing drug abuse especially among the younger population, the size of the problem is unknown, and it is not well recognized as such by the public health sector, therefore the response is inadequate and incomplete. These problems are theoretically preventable and there is evidence demonstrating program efficacy.

Injuries, poisoning and effects of other external factors

This heterogeneous group falls within national health priorities because of the consequences, such as premature mortality, invalidity, absenteeism, and the economic burden on the health service. About 11% of inhabitants of Serbia suffer some form of injury each year; one of the most frequent causes being road traffic accidents. Recently, violence (physical, sexual, psychological, neglect and deprivation) has been distinguished as a priority for public health, which is not well recognized in our country. Poisoning by drugs and other chemical substances is increasing generally in modern society, but in our country this problem is not recognized. Violence towards women, children, the elderly, self-directed violence and collective forms of violence are in increasing and demand a public health response.

2.2. Health of specific population groups

Health of women

The female population, fifteen years and over, makes up 42.5% of the total population, including women of reproductive age (15–49), at 24.3% of the total population. The health care of women covers all phases of development: puberty, adolescence, reproductive and post-reproductive. Despite the problems associated with gathering and reliability of data, and with their interpretation, the main issues in the health care of women are stated as follows: complications during pregnancy, delivery and puerperium; incomplete data about the number and trend of intentional abortions; neoplasms (malignant tumours of the reproductive organs – breast, cervix uteri); various endocrine diseases; sexually transmitted diseases are more frequent (because of better diagnosis, evidence and recording) among diseases of the genito-urinary system in women of reproductive age; the total fertility rate is below simple replacement level.

Health care of mothers, children and adolescents

Children and adolescents, at 24.2% of the total population, are a very sensitive population group, sub-divided by physiological and psycho-social characteristics, into the different categories of infants (0-365 days), pre-school children (0-6 years), school children (7-14 years) and those of adolescent age (15-19 years). Serbian population development shows tendencies of a decreasing birth rate and rapidly ageing population. As a result of these, there is obvious depopulation in some regions. Acute communicable vaccinateable diseases have been eradicated (smallpox, poliomyelitis), diphtheria has been eliminated, and tuberculosis, tetanus neonatorum, measles and whooping cough reduced to individual cases. The leading causes of illness and death among infants and small children are now hereditary and congenital conditions and malformations, and among school children and adolescents – addiction illnesses, reproductive health disorders and accidents. The most significant indicators of health status for mothers and children are: increase or maintenance of the high percentage of deliveries conducted with professional help, sustaining of the average value of maternal mortality, continuing decrease in the infant mortality rate, and lowering of the mortality rate among children younger than five years.

Workers' health care

During the last decade of the twentieth century, the health status of workers in Serbia was seriously endangered in their work place as well as by environmental factors. Indicators of the health status of the working population demonstrate this, especially between the ages of twenty-four and fifty-nine.

Health care of elderly persons

The elderly population consists of those aged over sixty-five years. The proportion of the elderly in the total population of central Serbia and Vojvodina is actually high and is expected to double (from 15.7% to 31.3%). Elderly persons among refugees and displaced persons should be added to this number. According to research results, 70% of the elderly have a physician-diagnosed disease or condition which significantly hinders their functioning and independence in every day activities. A large number of diseases and conditions burdening the elderly are preventable. There are no organized responses and programs.

Health care of vulnerable groups

Vulnerability is defined as special susceptibility to a disease or condition, occurring for reasons that may be biological or social. Those social groups recognized as having particular vulnerabilities are: refugees and internally displaced persons; persons with disabilities; persons with chronic, incurable disease; minority populations, especially the Roma population; and homeless persons. A characteristic of all these groups is that there is inadequate information on their health status, as well as on the contextual factors influencing their health.

2.3. Environmental health

The state of the environment leaves much to be desired in Serbia. The most important risks for human health are air pollution by traffic, heating and industry; surface water pollution by lack of waste water treatment; and – to a lesser extent – impure drinking water and unsafe waste disposal. Technological solutions to these problems will require massive investment.

Food safety

Food safety is essential for the population's health and for economic and political reasons. However, food is often not microbiologically or chemically safe in Serbia, as a result of improper production, processing or retailing. Responsibility for food safety is fragmented between various agencies. Food sampling is insufficient, both quantitatively and qualitatively.

Healthy work environment

A healthy work environment refers to the work place and its surroundings plus the conditions protecting and improving the health and capacity for work of employees. Not enough is known about the conditions of working environments in Serbia, but according to available data these do not meet national and international standards.

2.4. Organizational / structural challenges for public health

Partnership for health

Partnership for health is a form of co-operation, a strong coalition that contributes to the improvement of the health of the community. The majority of public health problems are too complicated to be solved by the health service alone. Solutions to public health problems should be looked for where they arise – in the working and living environment. Through partnerships for health, we can influence the development of healthy public policy, bring about changes in human behaviour, and contribute to building the type of community that supports health. Such healthy communities can reduce the risks to health and, through the development of local employment initiatives, ensure the prevention of a range of problems. This form of cooperation has been very strong in our country in the past, but has currently almost disappeared.

Public health workforce

The assessment of the existing public health workforce in Serbia showed the presence of a considerable number of staff. However, most staff lacks sufficient knowledge and skills relating to almost all fields of the new public health. The needs analysis for human resource development pointed out the necessity for the modernization and empowerment of the workforce. From the

perspective of the new public health, a problem area in Serbia is the lack of involvement of different professions and educational levels in public health activities and health promotion.

Public health information and knowledge

There is already a great deal of activity in the area of public health information. This includes various government levels and institutions, using a range of media and data/models, resulting in numerous databases with large quantities of data that are of questionable appropriateness, timeliness and validity. The health information and knowledge system has many different users but the system itself is not adapted to serve their needs. The mechanism for aggregating these large amounts of health data into valuable, decision-oriented knowledge is inadequate. The laws, rules and other regulations of health information handling, around thirty of them, were mostly passed in the '90s with no mechanism for improving the national infrastructure necessary to develop, agree and implement the content and process of a national health information system, i.e. health information which is either national in coverage or has relevance nationally.

Research and development in public health

The strengths and weaknesses of Serbia's public health research capacity have been recognized for a long time. Notwithstanding the excellent achievements of individual researchers and research units there are a number of weaknesses that need to be addressed. The first is the lack of a strategic direction. There has been no clear picture of what public health research and development is achieving or should achieve in Serbia and there has been virtually no systematic consideration of the future development of public health. The second weakness is the fragmentation of the health research effort in Serbia. The third is that Serbia's public health research and development infrastructure and workforce are poorly developed. The fourth is the uncertainty and inadequacy of funding. Overall, Serbia needs not just more "public health" workers but more "population-based" thinking throughout the health sciences and the health services.

Public health legislation/regulation

Today in Serbian legislation there is no specific public health law. There are many laws and by-laws in different fields (health,

environment, social policy, finance, etc) which are relevant to public health activities. We can say that about two hundred different types of official document regulate this field overall.

In the present situation, it seems that there are many contradictions between the laws from different fields which are relevant to public health in Serbia. Also, the existing situation, with the frequently unclear division of responsibilities, produces confusion. This means that in many cases it is unclear who should do what and who should finance what. Responsibility for the realization of public health activities is not well defined between health care levels or between different sectors.

It is obvious that the responsibility for public health rests with several ministries: with the Ministry of Health as the lead ministry, but also with Labour and Employment, Protection of Natural Resources and Environment, Agriculture and Water Management, Justice, Finance, etc. An inter-sectoral approach is a requirement for appropriate public health in any country. This means that ministries should be prepared to co-operate on a structural and ad hoc basis, including joint preparation of legislation.

New coherent public health legislation should be detailed in a revised book of regulations, during 2004. For this purpose it is necessary to revise health related laws (such as penalties for the sales of illegal drugs, traffic safety regulations), which traditionally are not considered as public health laws in Serbia. In addition, it is necessary to assess the success or failure of the current implementation of selected public health laws (e.g. tobacco, alcohol and drug control) and to develop action plans for the better implementation of such laws.

Public health management

The specific problems of public health management in Serbia are related to: the unclear division of roles and responsibilities between different organizational levels of the existing public health system (institutes of public health and public health services at primary health care level, particularly occupational health services); the internal management structure of the IPHs network remaining

oriented towards the roles and tasks of the old public health, based on a biomedical approach; and the lack of inter-sectoral co-operation.

Financing of public health

It appears that public health in Serbia is not underfinanced compared to other health care sectors, but the financing mechanisms suffer from inadequacies. Financial flows are not transparent, finances for preventive and curative care cannot be easily separated, and the proportion of revenues is too high from health insurance and temporary contracts and too low from government budget sources. Resource allocation is still largely based on existing infrastructure, and without priorities, funds are spread too thinly over too many activities.

3. FROM CHALLENGES TO SOLUTIONS

3.1. Rationale and overall aims of the public health strategy.

From the information presented above, we conclude that many health problems need to be addressed by prevention and control measures, among the general population or among specific groups, and often with new methods and a modernized public health infrastructure. This requires a public health strategy covering a medium-term period, 2003-2015.

The overall aims of this strategy are to:

- Promote, protect and improve the health of citizens, leading to an increase in healthy life expectancy.
- Increase equity in health regardless of differences in gender, socio-economic status, or ethnic and religious background.
- Re-orient the public health infrastructure from a medical top-down approach to a more widely spread responsibility for health, fostering health promotion, inter-sectoral co-operation, community involvement and individual responsibility;
- Achieve conformity with international standards in public health.

These overall aims are operationalized below with a number of general and specific objectives. The activities by which the objectives are to be achieved are presented in the implementation plan.

3.2. General and specific objectives of public health reform in Serbia

1. Decrease morbidity and mortality from chronic non-communicable diseases and improve quality of life for the ill, by 2015.
 - *Define a national program for health promotion and prevention of non-communicable diseases.*
 - *Prevent and control the risk factors relating to non-communicable disease.*
 - *Limit the number of population registers to those diseases with the greatest frequency, spread and public health importance.*
2. Eliminate and control specific communicable diseases, prevent and control new communicable diseases and those that threaten with epidemic potential, by 2010.
 - *Bring the existing system of epidemiological surveillance up to date, as the most efficient strategy for communicable disease control.*
 - *Establish an efficient system for early outbreak detection which will be able to support the regular surveillance in early and accelerated detection and time and space aggregation of new cases.*
3. Prevent psychoactive substance abuse and decrease the effects of this abuse, by 2005.
 - *Develop an inter-sectoral program for prevention and reduction of psychoactive substance abuse.*
 - *Develop and implement a community-based program for the prevention and reduction of abuse.*
4. Decrease injuries, poisoning and violence and the morbidity resulting from these, by 2015.
 - *Create registries for monitoring the frequency of injuries, poisoning and violence.*
 - *Educate the population, especially the youth and the elderly, in the prevention of these occurrences.*

5. Preserve and improve the health and health care of vulnerable groups and groups exposed to specific risk factors, by 2010.
 - *Monitor their health needs and utilization of health care.*
 - *Recognize, monitor and record the public health problems of specific population groups (women, children and adolescents, working population, elderly people).*
 - *Realize partnerships and support the efforts of the non-governmental sector in raising the competence of local citizens (e.g. in responsible parental care, avoidance of at-risk behavior, rational family planning, etc).*
 - *Improve the knowledge and skills of the population for preserving their own health and forming support groups.*
6. Provide a healthy living and working environment, during 2004 - 2015.
 - *Apply European Union directives and standards for the quality of water, air, soil and food.*
 - *Improve the working environment by the introduction of safe and healthy technologies, by the reduction of physical, chemical, and biological risk factors, and by multi-sectoral co-operation of all partners responsible for working conditions.*
 - *Improve the social aspects of the working environment by regulating working and resting times, improving human relations and decreasing the number of injuries in the work place.*
7. Adapt the organization and management of the system of public health in Serbia to the roles, tasks, and developmental needs of the new public health, during 2004 - 2010.
 - *Re-organize the system of public health in Serbia, and all sectors relevant to public health, to ensure recognition of their responsibilities in public health development.*
 - *Improve and sustain inter-sectoral coordination to implement the public health strategy by establishing a permanent National Public Health Body.*

- *Strengthen public health infrastructure, particularly the IPHs network, by efficient organization, with clear definition of roles and tasks supporting the new public health and health promotion at national, regional, local and community level.*
 - *Integrate occupational health services in the new public health system and define their tasks and roles in concordance with the new public health.*
 - *Enhance the capacity of local communities to respond to local priorities through collaboration of all community partners (in the fields of education, health and social care, industry, and other relevant fields) and particularly the non-governmental sector.*
8. Improve inter-sectoral co-operation on all levels and develop partnerships between the state, private and civil sectors, starting from 2004.
- *On the national level - identify areas and problems where partnership is necessary and form strategic national bodies for solving those problems.*
 - *On the local level - solve priority problems through partnerships for health, with the full participation of the population to which those problems relate.*
9. Ensure, through the public health reform in Serbia that public health professionals and related professionals in other sectors have appropriate knowledge and skills to protect and promote health, by the year 2010.
- *Provide an adequate number of highly qualified specialists in all areas of public health to realize their duties in the new public health system.*
 - *Establish the School of Public Health with the capacity to provide adequate specialized training, in keeping with EU practice.*
 - *Retrain existing staff in different fields of public health and at different levels of education for their new public health functions.*
 - *Improve the system of basic training, and establish postgraduate education and continuing education in the field of public health.*
 - *Improve multi-professional teamwork in public health.*

10. Develop the information system in health care and improve information and knowledge in this area by developing and implementing a system for the collection, analysis, evaluation and dissemination of health information and knowledge to competent authorities, health professionals and the public, and for undertaking assessments of and providing reports on health status, health-related policies, systems and measures in the health care sector, starting from 2004.
 - *Define health information and knowledge consultative and management framework and a "National Public Health Information Development Plan" for Serbia.*
 - *Develop and implement a health monitoring and surveillance system.*
 - *Develop and implement mechanisms for analysis, advice, reporting, information and consultations on health issues - "Converting Data to Information and Knowledge".*
11. Improve the capacity of public health research and development to contribute to a knowledge-based health service in which decisions about public health policy and action are based on sound information derived from research findings and scientific developments, and reflect the policy context and resources available, starting from 2004.
 - *Develop public health research and development capacity through a process involving the full spectrum of relevant disciplines.*
 - *Strengthen research transfer as responsibility of all relevant ministries and institutions.*
 - *Establish a national agenda for public health research and development.*
12. Develop laws and regulations in public health according to the standards of the European Union, starting from 2004.
 - *Adopt laws and regulations that support the new public health.*
13. Implement a national program for continuous quality improvement in health care, by 2008. In order to achieve this, the following will be started and/or intensified during 2004.

- *Develop a culture of quality of care and education on quality through professional associations of health staff.*
 - *Establish evidence-based guidelines for different fields in health care.*
Prepare health care institutions for accreditation.
 - *Prepare professional associations, educational institutions and management structures for the licensing of professional health staff.*
14. Achieve sustainable financing of public health institutions, by 2008.
- *Provide basic funding for the institutes of public health from national and local governments exclusively, by the beginning of 2008.*
Introduce a new resource allocation formula for the financing of institutes of public health, progressively during 2005-2007.
 - *Define the responsibility of local authorities for public health activities in 2004 and apply this during 2005-2007.*
 - *Realize the financing of occupational health care through contracts with employers; the financing of public health activities in occupational health care from the budget; and the financing of estimation of working ability from the Health Insurance Fund, during 2005-2007.*
 - *Continue to finance the public health activities of the Dom zdravlje staff or future family practices from the Health Insurance Fund.*

4. IMPLEMENTATION ACTION PLAN

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
1	<p>1.1 Health promotion through acceptance of healthy life styles. Re-orientation of the health care system and services to prevention. Promotion of responsibility for health at the community and individual level.</p> <p>1.2 Realization of the national NCD primary prevention program through collaboration of all parts of preventive medicine, some clinical profiles, and other relevant sectors of society, including government institutions. Establishment of criteria for monitoring and evaluation of the national program.</p> <p>1.3. Defining the most important risk factors for NCD in the population and establishing a national system for monitoring these factors.</p> <p>1.4. Limiting the number of national population-based registries and precisely define the methodology for data collection. Establish a data set for each register. Improvement of hospital registries.</p> <p>1.5. Recommendation of adequate and rational screening programs explicitly depending on the epidemiological situation for such diseases.</p>	<ul style="list-style-type: none"> ● IPHs (intersectorial approach). ● MoH. 	<ul style="list-style-type: none"> ● Health care institutions. ● Departments of preventive medicine at the School of Medicine. ● Partners from the civil society. 	By 2015.
2	<p>2.1 Rationalization of the number of compulsorily reported diseases to provide a more efficient reporting system from all health care institutions. Periodic controlling of the reporting system. Preparation of guidelines for definitions.</p> <p>2.2 Providing mechanisms for immediate response in situations with a sudden aggregation of sick people on the same territory and at the same time. Suggesting measures for prevention and control of CD in extraordinary situations.</p> <p>2.3 Adoption of a calendar of immunization according to the current</p>	<ul style="list-style-type: none"> ● IPHs (intersectorial approach). ● MoH. 	<ul style="list-style-type: none"> ● Health care institutions. ● Departments of preventive medicine at the School of Medicine. 	By 2010.

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	<p>epidemiological situation and spread of disease in the population. Provision of a satisfactory scope of compulsory immunization, as well as a centralized vaccine supply. Financing of the Program of compulsory immunization as a priority task. Periodic assessment of collective immunity.</p> <p>2.4 Introduction of standards and norms in the functioning of the laboratory network and definition of referent laboratories for specific analyses, especially expensive ones. Preparation of guidelines for sampling of biological materials and interpretation of the results of analysis.</p> <p>2.5 Provision of good collaboration and coordination between national, regional and local levels in the field of epidemiological surveillance.</p>		<ul style="list-style-type: none"> Partners from the civil society. 	
3	<p>3.1 Judicial-Legal Regulations to sanction turnover, trade and availability, as well as to protect the rights of the diseased and high-risk cases.</p> <p>3.2 Public Health Activities: Health care institutions working in the field. Comprehensive programs based on promotion of health in schools, work places, local communities – along with the full participation of the target group. Harm reduction programs.</p>	<ul style="list-style-type: none"> IPH s and specialized institutions as program initiators and carriers. 	<p>All programs and activities are intersectoral: health care staff, work staff, schools, parents, NGOs.</p>	By 2005.
4	<p>4.1 Adoption of national level preventive programs for traffic injuries, and a violence prevention program.</p> <p>4.2 At local level, after an analysis of local needs, adoption of safety programs for vulnerable groups.</p> <p>4.3 Mass media campaigns.</p>	<ul style="list-style-type: none"> IPHs as initiators and promoters. 	<ul style="list-style-type: none"> Intersectoral co-operation is necessary both at national and local levels. 	Progressively by 2015.
5	<p>5.1. Provision of continuous education and motivation of health professionals to apply prevention practice to women, their partners, future parents and to promote safe motherhood. On the local level, to raise awareness of the population about the importance of the reproductive health of women. To provide</p>	<ul style="list-style-type: none"> PHC, local community, IPHs, Republican centre for 	<ul style="list-style-type: none"> Associations and societies, NGOs. 	From 2004.

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	<p>greater availability of modern contraceptive methods and their better use.</p> <p>5.2. Provision of continuous education of health professionals, with the support of modern methods in counselling work, development of screening methods for early diagnosis. Education and motivation of mothers, fathers and their children about promotion of their health and prevention of disease. Empowering children and adolescents to take care of their own health, prevention of risky behaviours, and protection of their rights and creation of healthy living and work (school) environments.</p> <p>5.3. High risk strategies for the very old people with risk factors; health promotion programs for the reduction of risk factors for cardio- and cerebro-vascular diseases; to cover as large a number of the aged as possible with early detection and specific prevention programs (anti-influenza inoculation); detection and follow-up of new CVD risk factors; enlarged range of rehabilitation. To develop injury prevention programs in local communities; to increase the number of elderly participants in programs for them; a general population campaign in order to change stereotypes on ageing.</p> <p>5.4. Field work – outreach work of health institutions; development of comprehensive prevention programs for major problems in the environment where individual groups live; peer education for group members; education of volunteers.</p>	<p>family planning.</p> <p>IPHs as initiators.</p> <p>IPHs as initiators.</p>	<p>In local community, through partnership: families, PHC, educational institutions, centres for welfare, IPHs, NGO.</p> <p>2004 – 2015.</p> <p>Intersectorial co-operation and partnership at local level is necessary. PHC involvement.</p> <p>2004 – 2015.</p> <p>Interdepartmental, interministerial cooperation at the national level and intersectorial cooperation at the local community level. Partnership for health of these groups in</p>	<p>From 2004.</p> <p>2004 – 2015.</p> <p>2004 – 2015.</p>

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	<p>5.5. Provision of health promotion in work-places, preparing guidelines for professional orientation, education of multidisciplinary teams for professional orientation, development of a national program for prevention of professional diseases and injuries at the work place, development of education programs for enterprise and other employees in giving first aid, as well as their education.</p>	<p>Institute of Occupational Health (OH).</p>	<p>governmental, non-governmental, and private organizations and institutions. Community OH services, Regional OH departments, PHC, employers, unions, MoH, Ministries for Labour and Employment, for Education and Sport.</p>	<p>From 2004.</p>
6	<p>6.1 Setting up a mechanism for regular consultation on environmental health, environmental monitoring and disposal of medical and pharmaceutical waste.</p> <p>6.2 Setting up a mechanism for regular consultation on the issue of food safety.</p> <p>6.3 Operationalization of a new chain of food safety laboratories, including refurbishment, provision of equipment and training of staff.</p>	<p>Ministry for Protection of Natural Resources and Environment and Ministry of Health. Ministry of Agriculture and Water Management. Ministry of Agriculture and Water Management,</p>	<p>During 2004.</p> <p>During 2004.</p> <p>During 2004.</p>	

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Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	<p>6.4 Design of a plan for improvement in the drinking water supply.</p> <p>6.5 Adoption of new Food Safety Law.</p> <p>6.6 Production of a National Environmental Health Action Plan (NEHAP).</p> <p>6.7 Establishment of an autonomous Republican Food Authority.</p> <p>6.8 Upgrading the food safety monitoring and control system to European Union standards, by staff training, improvement of technical infrastructure, and accreditation of food safety laboratories.</p>	<p>Ministry of Health incl. Sanitary Inspection and 9 Institutes of Public Health, European Agency for Reconstruction. Ministry of Health, Ministry for Protection of Natural Resources and Environment, Ministry of Agriculture and Water Management. Ministry of Health, Ministry of Agriculture and Water Management. Ministry for Protection of Natural Resources and</p>		<p>2004 – 2005.</p> <p>2004 – 2005.</p> <p>By 2005.</p> <p>By 2006.</p> <p>2005 – 2010.</p>

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	<p>6.9. To define norms, standards and produce guidelines about work-places and healthy technologies.</p> <p>6.10 To improve co-operation with employers in the state and private sectors. To introduce healthy work-place projects.</p> <p>6.11. Participation in data gathering on working environment polluters, work environment health risk assessment and proposing measures for risk reduction.</p> <p>6.12. Prevention of states of emergencies in the work environment and preparation of plans for immediate response.</p>	<p>Environment, Ministry of Health, World Health Organisation. Ministry of Health, Ministry of Agriculture and Water Management. Ministry of Health, Ministry of Agriculture and Water Management and food safety laboratories. Institute of Occupational Health.</p>	<p>Community OH services, Regional OH departments, PHC, employers, unions, relevant ministries, other participants interested in this field</p>	<p>2004-2007.</p> <p>From 2003. 2004 – 2008.</p> <p>2004 – 2006.</p>
7	<p>7.1. Establish a permanent intersectoral national Public Health Body, supported by the Government of Serbia.</p> <p>7.2. Develop a Strategic Plan for the IPH network and public health services at primary health care level, including occupational health, and with precise indicators for monitoring and evaluation.</p>	<p>Present National Expert Committee on Public Health. National Public Health Body.</p>	<p>7.1 Relevant ministries, faculties, IPHs, other 7.2 Relevant experts for strategic planning</p>	<p>By 2004.</p> <p>2004-2005.</p>

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	<p>7.3. Develop Business Plans for each IPH in the network.</p>	IPHs.	<p>(University school for organizational sciences, international consultants from EAR Project). 7.3. School of Public Health, departments of preventive medicine at School of Medicine, University school for organizational sciences, international consultants.</p>	Every year starting from 2005.
	<p>7.4. Reorganize the public health infrastructure following the strategic and business plans, particularly related to public health laboratory services (including definition of laboratory services of public health interest).</p>	MoH.	7.4. School of Public Health, national Public Health Body, other relevant university schools, MoH, other relevant ministries, local	2005-2010.
	<p>7.5. Provide efficient management of change at national, regional and local level, which will lead to the sustainable development of public health, by specialized public health management training in the national School of Public Health.</p>	School of Public Health.		From 2004.

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
8	8.1. Joint assessment of needs at the national and local levels; exchange of information; developmental strategy; resource planning and mobilization; development of cooperative practice and common work; staff planning for the purpose.	Public health care institutions as initiators and promoters.	governments. Intersectorial cooperation.	From 2004.
9	9.1. Re-examine the existing programs of graduate, postgraduate and continuing education for public health professionals. 9.2. Provide undergraduate education in the public health area within relevant secondary schools and faculties. 9.3. Develop new public health curricula for undergraduate faculty education. 9.4. Develop a strategic plan of the number of postgraduate students according to the tasks and functions of the public health system (services), as well as the necessary skills for performing these functions. 9.5. Improve the system of postgraduate education to provide opportunities for qualification upgrading and change of qualification in the public health area (for professionals in different existing fields – epidemiology, hygiene, social medicine, occupational medicine, and from sectors other than health care – sociology, psychology, economy, law, organizational sciences), within the establishment of the School of Public Health. 9.6. Provide qualified teachers for undergraduate and postgraduate education in the public health area, as well promoting the publishing and availability of qualitative study materials.		Development of a public health workforce in Serbia requires a comprehensive approach by building effective partnerships both within government (between key ministries and public health authorities, and between the national and local levels), and between public (Schools of Medicine, other relevant faculties, Institutes of Public Health in university centres) and the private sector (particularly NGOs) as a key factor for the	9.1 During 2004. 9.2 From 2004. 9.3 During 2004. 9.4 2005-2007. 9.5 Starting from 2004. 9.6 Starting from 2004.

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Objective	Activities	Carriers of activities	In co-operation with	Timeframe
10	<p>10.1 Establish the “National Council for Health Information and Knowledge” (with at least two Bodies in the beginning: “Council for Health Information Standards” and “Council for Management of Health Information Systems and Health Networks”) to work in close collaboration with already established Councils: National Health Council, National Council for Informatics, National Council for Standards and National Council on Data Protection, leading development in the field.</p> <p>10.2 Develop a “National Public Health Information Development Plan” oriented towards: improvement of the scope and coverage of public health information, improvement of the usage and delivery of public health information, and development of the public health information capacity.</p> <p>10.3 Develop and operate a sustainable health monitoring system to establish health indicators for health status, health policies and health determinants, including demography, geography and socioeconomic situations, personal and biological factors, health behaviours and living, working and environmental conditions, methods for the data collection, monitoring and analysis, and creation of the corresponding databases.</p> <p>10.4 Develop and operate an information system for the early warning, detection and surveillance of health threats both for communicable and non-communicable diseases.</p> <p>10.5 Improve the system for the transfer and sharing of information and health data including public access.</p>	<p>10.1 Government of Serbia.</p> <p>10.2 National Council for Health Information and Knowledge.</p> <p>10.3. IPHs and faculties.</p> <p>10.4. IPHs.</p> <p>10.5. Ministries, IPHs, university schools and</p>	<p>success of this activities.</p> <p>10.1 Government and NGO.</p>	<p>10.1 By end of 2003.</p> <p>10.2 By end of 2004.</p> <p>10.3. 2004 - 2008.</p> <p>10.4 2004 - 2007.</p> <p>10.5. Starting from</p>

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	<p>10.6 Develop and use mechanisms for analysis and reporting of information, and provision of advice and consultation with local communities and stakeholders on relevant health issues.</p> <p>10.7 Improve analysis and knowledge of the impact of health policy development and of other national policies and activities.</p> <p>10.8 Review, analyze and support the exchange of information on health technologies, including new information technologies, health interventions, quality and good practice.</p>	<p>scientific institutions.</p> <p>10.6. University schools, scientific institutions, ministries.</p> <p>10.7. University schools, scientific institutions, ministries.</p> <p>10.8. National Council, university ministries.</p>	<p>10.8 international partners, university schools, IPHs.</p>	<p>2004.</p> <p>10.6 2004 - 2010.</p> <p>10.7 Starting from 2004.</p> <p>10.8 Starting from 2004.</p>
11	<p>11.1 Develop high-level expertise in public health research and development (R&D) in the full spectrum of disciplines that contribute to public health knowledge.</p> <p>11.2 Develop inter-disciplinary and institutional linkages that bring a capacity to synthesize bodies of knowledge for implementation and setting the approach for a national public health R&D agenda, together with fostering collaboration among organizations involved in public health R&D, including the government and non government organizations.</p> <p>11.3 Develop and operate organizational infrastructure in the form of the School of Public Health (SPH) to support the</p>	<p>11.1 University schools , scientific institutions.</p> <p>11.2 National Public Health Body and National Council for public health R&D.</p> <p>11.3 MoH and</p>	<p>11.1. International partners.</p> <p>11.2 Governmental and NGOs.</p>	<p>11.1 Starting from 2004.</p> <p>11.2 2003 - 2010.</p> <p>11.3 2004-</p>

Development of Public Health Strategy in the Republic of Serbia

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	<p>development and maintenance of expertise and the multidisciplinary pursuit of knowledge, both for public health R&D in general, and for specific public health topics in particular, and to facilitate efficient processes for ethical review and approval.</p> <p>11.4 Develop and operate research transfer through the synthesis of bodies of knowledge and their dissemination and uptake into practice, management and policy.</p> <p>11.5 Through the national public health R&D agenda strengthen public health interventions that are supported by research that provides empirical information, suggests actions that could be taken, estimates the potential health gains, facilitates the establishment of priorities and provides contextual information that allows decisions to be taken about implementation.</p> <p>11.6 Through the national public health R&D agenda strengthen public health action in clinical practice. At a health system level, public health research has the potential to make a major contribution to questions of allocative efficiency in relation to personal healthcare services through the use of population-based methods in the measurement of outcomes and the evaluation of quality of care. Public health research also underpins the pursuit of equity by providing methods of finding out about variations in the determinants of health, in the effectiveness of interventions, and in the outcomes of interventions.</p> <p>11.7 A significant increase in the financing (by at least 50%) from the state budget (on republic, provincial and local level) for public health research, development, information and public health education.</p> <p>11.8 The support of high-level training in public health research methods, including dissemination and implementation of</p>	<p>School of Medicine in Belgrade University.</p> <p>11.4 Ministries and university schools.</p> <p>11.5 National Public Health Body and National Council for public health R&D.</p> <p>11.6 MoH, university schools, IPHs.</p> <p>11.7 Government of Serbia and relevant ministries.</p> <p>11.8 university</p>	<p>11.6 Health care institutions.</p>	<p>2005.</p> <p>11.4 Starting from 2004.</p> <p>11.5 Starting from 2004.</p> <p>11.6 Starting from 2004.</p> <p>11.7 Starting from 2004.</p> <p>11.8 Starting</p>

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	research. 11.9 Recognition of international opportunities, and the exploitation of these opportunities for the support of public health R&D in Serbia.	schools and ministries. 11.9 ministries, university schools and IPHs.		from 2004. 11.9 Starting from 2003.
12.	12.1. Establish an intersectorial body for co-ordination between the Ministry of Health and other relevant ministries. 12.2. Pass a new Health Care Law with agreed list of public health activities, including the division of responsibilities between various stakeholders and a description of the tasks and organization of the Institutes of Public Health. 12.3. Improve regulations in all fields related to public health, in accordance with EU directives and standards.	□ MoH, relevant ministries.	IPHs, health workers, professional associations.	From 2003. 2004. From 2003.
13	13.1 Establish an interdisciplinary body on the national level for quality of health care, including commission for accreditation. Educational programs and accreditation standards as working results of that body. 13.2 Dissemination of information about quality, establishing teams and organizations for partnership. 13.3 Education of leaders and managers about activities related to quality. 13.4 Organize educational courses for different types of institutions about general facts in the quality field. 13.5. Establish a national program for accreditation.		Professional associations of physicians, nurses and other health care professionals. University Schools of Medicine, Dental medicine and Human Resources faculty,	All activities starting from 2004. National Body established during 2005. Implement -ation of accreditation and

Development of Public Health Strategy in the Republic of Serbia

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	<p>13.6. Define the types of licenses provided by the state and by other professional organizations.</p> <p>13.7. Define the other principles for licensure: requirements, timeframe for different professions, conditions for rejecting / depriving of licenses.</p>		secondary schools.	licensing starting from 2006 as continuous activity.
14.	<p>14.1 Clarify the regulation for the financial responsibility of local authorities for health care in general and public health in particular.</p> <p>14.2. Ministry of Health and local authorities take over financing of the public health activities of the Institutes of Public Health from the Health Insurance Fund.</p> <p>14.3. Local authorities conclude contracts with Institutes of Public Health, and discontinue bidding procedures for public health.</p> <p>14.4. Development of new resource allocation formula for financing of Institutes of Public Health.</p> <p>14.5. Medical facilities for primary and secondary care become responsible for the payment of diagnostic tests in the Institutes</p>	<p>Ministry of Health, Ministry of Local Self-Government.</p> <p>Ministry of Health, Health Insurance Fund, local authorities, Institutes of Public Health.</p> <p>Local authorities, Institutes of Public Health.</p> <p>Ministry of Health, Institute of Public Health of Serbia, Health Insurance Fund.</p> <p>Medical facilities, Health Insurance Fund, Institutes of</p>		<p>Regulation ready by the end of 2004, implementation during 2005-2007.</p> <p>2005 – 2007.</p> <p>Formula tested in 2004, gradually implemented during 2005-2007.</p> <p>From 2005.</p>

Objective	Activities	Carriers of activities	In co-operation with	Timeframe
	<p>of Public Health.</p> <p>14.6. Health Insurance Fund continues to pay for personal preventive services by the dom zdravljia at least at the level of 2003, corrected for inflation.</p> <p>14.7. Establishment of a new way of financing occupational health care.</p>	<p>Public Health. Health Insurance Fund, Dom Zdravljia.</p> <p>Ministry of Labour and Employment, Ministry of Health, Health Insurance Fund, Dom Zdravljia, Association of Employers.</p>		<p>From 2003.</p> <p>Design in 2004, implementation during 2005-2007.</p>

Exercises

1. Name the strategies closely related to Public Health. Find out possible overlaps in defining specific objectives.
2. Make action plan for given specific objectives (activities, main activities holders, partners, and timeframe).
 - Discuss the main characteristics of each objective
 - Explain the role of partners
3. Make the list of key indicators for monitoring and evaluation of selected public health activities.
 - Identify most needed data for listed indicators.

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Recommended readings

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<http://www.who.dk/document/health21/wa540ga199heeng.pdf>
2. Renewing the Health for All Strategy: Guiding principles and essential issues for the elaboration of a policy for equity, solidarity, and health. WHO, Geneva, 1995
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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Reorganisation and refocusing of public health in Slovenia
Module: 4.1.4	ECTS (suggested): 0.3
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Keywords	Public health, reorganization, reform, health indicators, Slovenia
Learning objectives	After completing this module students and public health professionals should (for example): <ul style="list-style-type: none"> • be aware of the specifics of the public health reorganisation in Slovenia; • be able to compare own experience with public health restructuring with that occurring in Slovenia; • increase knowledge about stakeholder interactions; • understand the processes behind the ongoing process of public health reform in Slovenia.
Abstract	Public health started to develop in Slovenia during the period of the "first Yugoslavia" when ideas of Andrija Stampar got fertile grounds in the broader area. Later, the institutional and professional aspects of public health showed a quick development. In the course of transition, the area remained more or less unaffected, but also unchanged.

	<p>Being proud of its advances in the past and of the fact that it was in the forefront of many positive changes both in health promotion as well as in the development of health services delivery, it has somehow become self-sufficient. Circumstances in Slovenia, external to public health, are now not only pushing the system to change, but they actually represent a threat to its future existence in certain branches if no action is to be taken. On the positive side, there have already been several initiatives, which are paving the way for a new, reformed and modernised public health in Slovenia. These include the restructuring of the laboratory services, reformation of all three former independent professional areas (social medicine, epidemiology of communicable diseases and hygiene and environmental health). Dropping some of the old fashioned methods and practices, while adopting new areas of professional development, will be the main tasks in the immediate future.</p>
<p>Teaching methods</p>	<p>Teaching methods could include lectures, small group discussions, and seminars. The teaching of the topic should be composed of a short presentation in a lecture, then specific topics should be discussed in a small group or several groups if the group attending is big enough and finally, a selected number of interested students should make a qualitative comparative analysis between their own systems and the Slovenian experience.</p>
<p>Specific recommendations for teachers</p>	<p>About 25-30% of the total time dedicated to the topic should be performed in a combination of a lecture and small group discussions. The remainder should be done by individual students, the stress to be put on a qualitative comparative analysis.</p>
<p>Assessment of students</p>	<p>Assessment could be based a qualitative comparative study, including own experience in own country with that of Slovenia and making a point by point and an overall comparison of the evolution and the processes involved.</p>

REORGANISATION AND REFOCUSING OF PUBLIC HEALTH IN SLOVENIA

Tit Albreht

Introduction

Public health has a long tradition in Slovenia and its development was shared with the rest of the former Yugoslavia as Andrija Štampar's ideas found fertile ground for their continuous development. The Hygiene Institute (HI) was established in Ljubljana in 1923 and became responsible for two important groups of tasks, one being the classical missions of public health of preventing communicable diseases and ensuring safe and healthy food and drinking water, the other was to set up the scene for the development of integrated and outreach approaches to the health of children, adolescents and women. The HI was the co-ordinator of a gradual development of a network of dispensaries for women, children & school children, venereal diseases and tuberculosis on the one hand and of the primary health care centres (PHCC) on the other. That needs to be specifically noted since PHCCs are sometimes mistaken for the polyclinics under Semashko's model and seen as a result of the socialist era. Instead, they were an authentic outreach solution defined and elaborated by Štampar. In the 1920s and 1930s we saw a steady development of regional hygiene institutes with similar, yet regionally defined, tasks. In 1940, Slovenia had the "central or national" HI and 6 regional HI. The HI became officially the Central Hygiene Institute after WW2 and took up additional tasks which consisted of epidemiology of chronic diseases, laboratory services development, vaccination programme development, updating and execution, health care planning, including manpower planning, etc. It had several changes of titles, the fore last including also social care, which was later dissolved as a service within the institute since social care was transferred under the Ministry of Labour.

Situation after the independence of Slovenia

Independence of Slovenia coincided with the political changes, nowadays synonymous with socio-political transition in the Central and Eastern European countries. That definitely had repercussions on

the entire health care system, including health care delivery and public health. As the reforms of 1990/1991 were mostly driven by political interests and the interests of the medical community, health care delivery was the main focus of attention. The key setting was defined by two legal acts (1, 2), both adopted by the Parliament at the beginning of 1992. Public health was defined in both acts as a special entity comprising the traditional three branches – social medicine, epidemiology of communicable diseases, hygiene and environmental health. There were old and new stakeholders defined by the new legislation of the time, namely the Ministry of Health (MoH), municipalities and the Health Insurance Institute of Slovenia (HIIS). Apart from these, a special role was defined for professional bodies, called chambers, two of them, the Medical and the Pharmacists' Chamber got public authorisation by law to execute some of the tasks that were previously under the MoH.

Public Health remained more or less untouched, all the institutes were redefined and formally established by the State, and therefore, eliminating some uncertainties on how regional PHI would function under municipal authority.

A snapshot of the key indicators

Slovenia's health indicators continued their positive trends throughout the process of transition. Especially life expectancy had a steady growth, though it was at a slightly lower gradient for men than for women. Still, to-date, women in Slovenia have a life expectancy of around 80 years, while men lag behind at about 73 (3). Slovenia dedicates a relatively large share, a total of 8.7-9.1% of GDP for health care, about three quarters of that coming from the compulsory health insurance. The share of that amount spent on public health is negligible, around 1%, adding up all the different fractions and all the individual programmes under the umbrella of public health (4).

Primary health care is delivered through the network of PHCCs (63 with 65 primary care stations) and by single-handed or collective practices of GPs, primary care paediatricians, primary care gynaecologists and dentists. A gate-keeping system is in force, applied in all the mentioned specialties and services. The catchment areas may vary between PHCCs and also between different GPs. Secondary care is organised in geographical regions and mostly hospital care is

organised together with outpatient care. The latter is rarely delivered independently, in such cases those are private providers. The tertiary level is provided by the university hospitals, other clinics and institutes and is organised and co-ordinated at the national level.

Slovenian health care system, in spite of the fragmentation of the administrative structure of the State, remains rather centralised, with local municipalities keeping relatively limited responsibilities. Most of the system's administrative and regulatory functions take place at the State level; the lower levels have mostly executive duties.

Changes in public health

Previously dominant infectious diseases problems continue to require intense and dedicated involvement. On the other hand, the wide spectrum of non-communicable diseases and global health threats, such as harmful environmental changes, is among great challenges of modern public health. Prevention and control of many of these public health challenges require a population-wide and inter-sectoral approach. A renaissance of public health is beginning through new approaches of health promotion, especially in view of Slovenia's troublesome life-style health problems, ranging from alcohol abuse, suicide and other injuries to rising problems of inadequate diet and lack of physical activity.

Developments in the structure of public health system

As mentioned previously, the Health Services Act of 1992 re-established the national institute and the nine regional institutes. In the discussions preceding that final decision, a possible merger of all institutes was suggested among various alternatives. That option would mean that there would be a single national institute with a central unit and nine regional units, all under the same organisational and administrative structure. The final solution was defined as ten independent legal entities, joined by a common nationally co-ordinated and executed programme, financed by the MoH as a special task.

Theoretically, the main source of income should be the so-called national programme for the areas of social medicine, epidemiology of communicable diseases, hygiene and environmental

health. However, that is by far, not the case, as evidenced by Table 1 (see below).

Table 1. Employment and budgetary specifics of the individual PHI in 2001

IPH	No population	The state budget in % of the total revenue	No employees	Annual Revenue (000) in SIT (1 €=240 SIT)
CELJE	298.837	13	101	1.072.542
KOPER	138.971	13	70	642.310
KRANJ	197.217	14	82	723.897
LJUBLJANA	601.726	15	63	746.952
MARIBOR	320.016	7	236	2.251.692
MURSKA SOBOTA	124.031	16	59	529.611
NOVA GORICA	103.204	15	57	490.009
NOVO MESTO	134.977	12	63	561.758
RAVNE NA KOROŠKEM	73.990	28	14	153.929
NIPH	1.992.969	15	211	2.711.426

Source: Annual report of the Association of the Public Providers of Health Care, Ljubljana 2002.

National programme (NP) is a programme of tasks, projects and other outputs, jointly planned and executed by all ten public health entities in Slovenia. It is discussed at the MoH and then submitted for adoption to the Health Council, the main advisory body to the Minister of Health. Upon its approval, the MoH prepares contracts for all and every PHI for the current year. The number of inhabitants in the region is the main criterion for budget allocation; some corrections are used for the two 'extreme' regions, the smallest and the biggest. The NP is defined in rather general terms and its providers are not encouraged to use the resources allocated rationally. The following services are not included in the NP:

- Medical Microbiology Laboratories
- Food Production Control
- Drinking Water Control
- Chemical Laboratories
- Vaccines Supply

How did we come into a situation where no one receives a vital share of their income from the national budget? There are several reasons for such a situation:

1. The State adopted a policy of actively withdrawing from financing of certain programmes, including public health.
2. Once that process started in 1992/1993, PHIs required some sort of compensation, which was eventually granted in the form of a more generous reimbursement system for laboratory services at which PHIs at the time had a definite monopoly.
3. PHIs started actively developing these services, dedicating most of the resources to them.
4. Eventually, the MoH consented to PHIs including various laboratories and other public health related into the PH system rather generously, thus providing for a financial compensation caused by the political initiatives to limit expenditures in the field. Services were paid by the health care insurance and by private enterprises and therefore did not represent a burden on the budget.

Main problems in the organisation of the public health system

Medical microbiology laboratories. These laboratories were essential in the times when PHIs were established and were functioning as hygiene stations. Gradually, the public health aspects declined and the more health care and health services orientation took the key position. Consequently, most of the services of these laboratories are delivered to the general hospitals in Slovenia. The only exception to this is the Institute of Microbiology of the Medical Faculty in Ljubljana which is the main provider of medical and clinical microbiology for the University Medical Centre in Ljubljana. The payment for these tests is fee-for-service and it is only controlled by the capped budgets. As these prices were controlled by the MoH and they were generously defined in the 1990s, some hospitals decided to establish their own laboratories, in some cases completely taking over the services previously provided by the regional PHI. In 2002 the legislation changed, abolishing the monopoly of the PHI's laboratories.

Food safety and production control. Requirements that were part of the accession to the European Union meant that external validation and quality assurance procedures are to be used. This brought a new situation for the public health institutes as they could no longer hold the monopoly in running these services, neither organisationally nor financially. In the past, the public health institutes had the exclusive right to perform these tests but now consultants and suppliers of these services are in competition on an open market. This is true not only for food, but also for the area of drinking water. In the field of sanitary chemistry, the situation is similar, if not worse. None of the laboratories currently can achieve prices that would sustain the service merely by providing them to the regular customers. Laboratories were unable to achieve sharing of work which would enable a certain level of specialisation, leading to reduced costs for certain equipment and maintenance per laboratory.

Main characteristics of the transition period in public health institutes

Public health has definitely managed to achieve important successes in control, limitation and even extinction of certain communicable diseases. Widespread vaccination with introduction of new, compulsory vaccines enabled stability of the system and brought to a drastic reduction in the number of epidemics. HIV/AIDS epidemic was halted also by applying intense measures as proposed by the National Public Health Institute.

Difficult times of the newly independent, young state and the facts surrounding socio-political transition and economic crisis, brought shocks to public health as well. The State was trying to limit its influence in the field by letting the PHIs find different additional or substitution means and source of financing. This led to an exaggerated entrepreneurial and business orientation, at the expense of the pure public health functions in their core meaning.

Why bring changes to the system?

- The public health institutes network is no longer able to respond to the complex contemporary challenges in the field of public health

- The competition weakens the co-operation needed on the common national action and performance programme
- IPHs, as public institutions, are not capable of competition on the free market, which can be seen by the current situation in several PHI.

The basis or the foundation of any such change or reform should be a national public health strategy as outlined by the MoH. One of the essential issues not tackled by the reforms so far, which, however, remains a crucial point for the future developments, is twofold. On the one hand, there needs to be a distinction made between what is understood as true public health's public functions that cannot otherwise be tackled in other settings, and what can be definitely given away to any qualified provider of services (irrespective of whether private, profit or not-for-profit, etc.); on the other hand, there is a need to more clearly differentiate between the national functions to be dealt within the national institute alone, and what is to be a pure regional mission and managed entirely in that setting.

Activities and services that should remain organized within the public health institutional framework:

- Analysing, interpreting and presenting health data
- Identifying the major health problems in Slovenia
- Advising government on public health promotion policies and programmes and designing preventive programmes
- Providing source of information and advice to professionals and the public
- Responding to new threats to public health
- Improving knowledge through continuous training and education
- Health promotion – programmes, implementation and follow-up

Public health laboratories will need to be redefined and their role should become prescriptive and analytical at the national level and much less routinely practical as was the case in the last decade.

We can observe several levels of activity and organisation, like:

1. Strategic activities, which have to be common for the whole country, should be provided at the **national level**
2. At the **regional level**, the implementation of the national public health strategies and activities focused on the regional and local levels should be provided
3. Public health activities concerning individuals should be organised at the **local level**

Options for reorganisation

1. There is a need for a clearer definition and distinction between the national and regional functions and services delivered thereof.
2. Furthermore, there should be a redefinition of public health services, which should lead to the exclusion of those services, which have lost their public health dimension and have become purely health care services and can thus be delivered by different providers (including private and for profit)
3. The essential public health functions should be ensured by the State.
4. Services that are provided freely as market services should be organised as private not-for-profit companies.

The role and the position of the National Institute of Public Health (NIPH)

The NIPH should be organised primarily as a public service, keeping all of those services which are vitally important for the monitoring, prevention, planning and redefining of health, health care and health services. All the other services should gradually be abandoned. It should be natural to see that NIPH would be getting in public funds in order to fulfil the mission it had undertaken. It would definitely bring the institute closer to other similar institutes and institutions in Europe.

Reorganisation of the Regional PHI

Regional PHI should be reorganised in one of the two ways:

1. Those parts that provide services for private payers will have to be organised in a transparent and independent way.

2. On the other hand, those services that fulfil the public health mission and help in developing it, should be organised as public institutions and remain tightly connected with the mayors and other officials.
3. Microbiology is one the areas where services and professionals have to be adequately developed, but it is uncertain whether merging the laboratories with the hospitals would maximise the utility side of the intervention. Regional hospitals have a long-standing obligation to support these laboratories as they are their most important provider.

Conclusions

- In the public health area the state cannot rely only on the entrepreneurial approach, also because most of the present day managers have not been formally educated for their present posts.
- An entrepreneurial approach was helpful considering the survival and prosperity of the IPHs.
- A blurred line between the market oriented activities and public health activities was often harmful for the latter .
- The new organisation should respond to the modern public health challenges and needs.
- Initial **common agreement** that organisational changes of the national public health network are needed .
- A **working group** of experts would be necessary.
- A **pilot project** could be introduced in one of the RIPHs.

Exercises

Task 1: Formulate the main characteristics of the transformation of public health in Slovenia.

Task 2: How would you define the needed reforms in any transition country for the public health system to achieve its goals in view of the general public health challenges faced?

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Recommended readings

1. Health in Transition: Slovenia. European Observatory on Health Care Systems in Transition: 2002.
2. Health in Slovenia 2001. Institute of Public Health of Slovenia: 2002.
3. Health in Slovenia 2002. Institute of Public Health of Slovenia: 2003.
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PUBLIC HEALTH STRATEGIES A Handbook for Teachers, Researchers and Health Professionals	
Title	National Public Health Strategy in Macedonia
Module: 4.1.5	ECTS (suggested): 0.5
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Keywords	Public health strategy, health, determinants, vulnerable groups, access to health care, health insurance, health care reform
Learning objectives	<p>After the completed module students and professionals in public health will understand:</p> <ul style="list-style-type: none"> • Specific social and economic conditions in the overall transition process and especially of health care reform in Macedonia • Population health status, organization and performance of the health system in Macedonia, which emphasize the need for national public health strategy; • The activities undertaken a few years ago for creating a strategy for improvement of health care of the population in Macedonia by the year 2010; • The most recent activities in the health care reform process and for preparing National

	Public Health Strategy in Macedonia.
Abstract	<p>Dramatic period of transition of the weak economy, health status of the population and health system status in Macedonia emphasize difficult conditions and a need for organized and co-ordinated strategic development of the health care system in the country. Macedonian experience and attempts in preparing national public health strategy is somehow specific. The strategic document “Strategy for improvement of health care of the population in Macedonia by the year 2010” was prepared in 2002 by an Expert team coordinated by Macedonian Academy of Sciences and Arts but the document was not officially adopted by the Government or Parliament of Macedonia as a precondition for its organized implementation in practice.</p> <p>The module presents an overview of the public health strategy development process and basic principles followed in creation the Public Health Strategy, as well as the Strategy structure. The reasons for failure to adopt and implement the National Public Health Strategy in Macedonia, as well as recommendations for necessary future activities are also presented.</p>
Teaching methods	Lecture, Focus group discussion, Nominal groups, Case studies
Specific recommendations for teachers	Case Studies – the students are to collect data on priority health problems and health system status related to setting and achievement of the strategic goals.
Assessment of Students	The final mark should be derived from assessment of the theoretical knowledge (oral exam), contribution to the group work and final discussion, and quality of the seminar paper

NATIONAL PUBLIC HEALTH STRATEGY IN MACEDONIA

Doncho Donev, Jovanka Karadzinska-Bislimovska, Mirko Spiroski

Country Overview and Health Status of the Population

Macedonia is located in the Central Balkans, bordering Bulgaria, Greece, Albania, Serbia & Montenegro and Kosovo, covering an area of 25,710 kms. According to the 2002 census, the country's population was 2,022,577. Data on the declared ethnic affiliation from the 2002 census reported that 64.1% of the population identify themselves as Macedonian, 25.17% as Albanian, 3.95% as Turks, 2.66% as Roma, 1.78% as Serbs, 0.84% as Bosniacs, 0.48% as Vlachs and 1.04% others (1). The country seceded peacefully from Yugoslavia after an independence referendum, held in September 1991. The Constitutional name of the country is the Republic of Macedonia, but it was recognized by the United Nations on April 8, 1993 under the provisional name of the Former Yugoslav Republic of Macedonia. The country's title and heritage were the subject of a sharp disagreement with Greece, whose Northern Province is also called Macedonia. This dispute has not yet been fully resolved although a trade embargo was lifted in 1995 and the two neighbours' relations have since improved considerably (2).

At the time of independence, Macedonia was economically one of the least developed of the six republics of the SFR Yugoslavia and in the years immediately following independence, the economy contracted even more. The economy is currently recovering and GDP growth is positive. From an international perspective, poverty in Macedonia is moderate with 20% of the population living below the official poverty line of US \$75 per month or per capita consumption below the international standard of US\$2.15 per day (3). In November 2000 the Government of the Republic of Macedonia produced an Interim Poverty Reduction Strategy reporting an increase in the rates of poverty from 18.1% to 20.7% between 1996 and 1998, with rural poverty rates as high as 25.1% in 1998. It identifies that poverty in

Macedonia is the result of two main factors: 1) a fall in aggregate consumption during the 1990's and 2) a rise in the inequality of its distribution. Amongst others, some of the most important determinants for the weak economic indicators are military conflicts in the region in 1990's and in the country itself in 2001, as well as the low level of technological development.

The population groups identified as being most at risk of poverty are the unemployed, socially imperilled households, pensioners and farmers. Larger households in rural areas, particularly those with members who are unemployed or have low educational levels, are identified as specific risk groups together with the unemployed in urban areas. In 2001, the United Nations Development Programme reported that the unemployment rate in Macedonia was 32.1% of the labour force, placing Macedonia in the rank of countries with an extremely high unemployment rate in Europe (4). Poverty has a serious impact on the health status of the population and accessibility to health services. Certain illnesses associated with poor living conditions remain typical for some vulnerable groups of the population (5, 6).

Key Health Indicators. According to the State Statistical Office, life expectancy at birth for 2001-2003 was 70.80 years for males and 75.74 years for females, an average of 73.21 years. Although life expectancy in Macedonia is lower than in Western Europe, it exceeds the average life expectancy in Central and Eastern European countries and surpasses that in developing countries at similar income levels outside of the region. In 2003 the birth rate in Macedonia was 13.3 per 1,000 population and mortality rate was 8.9 per 1,000 population, resulting in an annual population growth rate of 0.44%. The population is relatively young, with an average age of 35.3 years, but the number of elderly persons is increasing. From 1991 to 2004 the percentage of the population over 65 years of age increased from 7.3 to 10.7%. Although this growth trend is shared with the EU and Central and Eastern European averages, the proportion is considerably lower in comparison.

Macedonia is beginning to see a pattern of morbidity that would be expected of a wealthier, industrial or post-industrial society. This is particularly true for cardiac and cerebrovascular diseases as

well as malignancies, which are by far the leading causes of premature death in both men and women and are associated with risk factors such as smoking, alcohol consumption, a high-fat diet and lack of exercise. Stress and social dislocation associated with the economic transition have undoubtedly exacerbated this situation (5, 6). Access to clean water is satisfactory for more than 90% of the population and as a result of the country's strong agricultural base, under-nutrition is not a significant problem. A recent World Bank survey of adults showed that obesity is on the rise in that 48% of females are overweight, and 19% of women and 15% of men are clinically obese (3).

According to the State Statistical Office, there has been a steady reduction of vaccine preventable infectious diseases; only 50,024 cases were registered in 2003, compared to 74,382 cases in 1997 and 63,585 in 1999. Macedonia is a major European transit route for narcotics and there has been a considerable rise in drug use in the country. In 2003, there were 7000-8000 registered heroin addicts, but the real number is likely to be three times higher (2, 7).

Women and Child Health. Macedonia has experienced a sharp fall in infant mortality rates, from 22.7 per 1000 live births in 1995 to 11.3 per 1000 live births in 2003. It is still high compared with EU average but improvements have occurred especially in the area of perinatal mortality. Also encouraging is the reduction of maternal mortality rates from 21.8 deaths per 100,000 births in 1995 to 14.8 maternal deaths per 100,000 births in 2001. In the last five years a significant number of Macedonian midwives have participated in medical training courses at home and abroad, following the countrywide establishment of UNICEF's 'Baby Friendly Hospitals'. Traditional public health activities working in concert with pre-school health protection programs have maintained vaccination coverage rates above 95%. Macedonia was certified polio free in 2002 by WHO, and no cases of polio have been reported in the last seven years. Also, during the same period, no cases of neo-natal tetanus were reported and there have only been 18 cases of measles and 16 of pertussis in 2003 (7). The health and nutritional status of Macedonia's children are still affected by slow economic development and poor environmental health. In a survey conducted by the Ministry of Health in 1999, 26% of children were found to have iron deficiency

disorders. In order to improve the level and the quality of child nutrition, there is an ongoing campaign to increase the consumption of locally available fruits and vegetables as part of the healthy diet for children and also for the elderly.

The major causes of morbidity and mortality are non-communicable diseases, especially diseases of the circulatory system. There is a lack of prevention and health promotion programs for non-communicable diseases (heart diseases, cancer and trauma as leading causes for death) Tobacco is one of Macedonia's major domestic products and smoking rates are known to be very high. There is a law banning smoking in public places, but there is a significant lack of compliance. Prior to the WHO tobacco-free initiative, there had been no strong anti-smoking campaign and tobacco advertising was intensive. Taxes on cigarettes tend to increase but still are much lower than those in Western Europe, leading to correspondingly higher consumption rates and smoking-related diseases.

Rates of communicable diseases such as tuberculosis (TB) are about 3 times higher than the EU average. The Government has implemented a strong TB control program which is bringing this disease under control. Over the past few years Macedonia has successfully implemented the DOTS strategy, together with Albania and Kosovo within the "Balkan Initiative", halving the number of patients with active tuberculosis between 1997 and 2003, and reducing the average length of hospital stay for TB in both general and special hospitals by more than 20%. The incidence of TB per 100,000 population has been reduced from 40 in 1995 to 34.5 in 2003. HIV/AIDS prevalence rates are lower than the EU average, but this may be the result of misreporting due to weak surveillance systems. According to the national data and UNAIDS, as of 2001, a total of 16 HIV and 43 AIDS cases have been registered in Macedonia. Unfortunately, the low number of officially reported HIV/AIDS cases has influenced the attitude both of citizens and the government towards HIV/AIDS, which is still perceived by some as a minor and non-urgent problem. Antiretroviral therapy for treatment of HIV/AIDS cases is not available, partly due to the size of the market and local drug registration procedures. A Health Sector Commission for HIV/AIDS was established in 1987 when the first HIV positive case was reported. It acted as a predecessor for the Multi-Sectoral

Commission on HIV/AIDS which was created in April 2003. The Commission is responsible for the planning and coordination of HIV/AIDS prevention and intervention, including the development of a national strategy for HIV/AIDS prevention and the collection of revenues to fight HIV/AIDS (including Global Fund Applications), (3, 7, 8).

Health Service Structure and Provision.

The Ministry of Health is responsible for the national health care system, the Health Insurance Fund (HIF) co-ordinates health insurance for the population and the Ministry of Finance sets the budget for the Ministry of Health's vertical programs. The Macedonian Chamber of Physicians is responsible for the licensing of medical doctors. Macedonia has one Republic Institute for Health Protection and 10 regional / inter-municipal institutes for health protection charged with broad scope of public health activities, as well as with collecting health statistics data. The findings of these institutions are collected and published in the annual "Reports on Health Status of the population" and "Health Map" for the country. Quality of health care services (perceived and technical) is not satisfactory. In opinion polls, the public has persistently rated the health care system as "poor" or "very poor." Excess capacity is not a major problem and compared to countries of Central and Eastern Europe, Macedonia has an average number of doctors and nurses (about 6000 physicians and 15000 nurses; 1 doctor per 450 citizens), lower hospital capacity and higher number of dentists. The inpatient admission rate is much lower than the EU average (8.95/100 as compared with 18.2 for the EU), and the average length of stay is slightly higher than the EU average (11.3 days in 2004 versus 10.1 for the EU). However, the occupancy rate in hospitals has steadily worsened and is only 63.8 percent in 2004. Allocative efficiency is a concern and a large proportion of spending (more than 50 percent) goes to secondary and tertiary in-patient care. Low levels of investment in primary care have resulted in a primary care system that provides very poor quality of care. Access to basic services is limited and poor, especially in rural areas. It is no surprise that patients tend to by-pass primary care in favour of treatment at highly specialized health care institutions. The average number of out-patient visits in public health organizations per capita, per year in Macedonia is only around 3.3 in 2004 as compared with the EU average of 8 (2, 9).

Health Sector Financing. Health financing in Macedonia is based on a compulsory system of social health insurance managed by the Health Insurance Fund (HIF). The health insurance coverage rate in Macedonia is over 80% of the population, while the number of private patients is low. The Basic Benefit Package (BBP) of health services is very broad covering almost all medical services with some exceptions, such as aesthetic surgery. The broad coverage of the BBP creates inefficiencies and strains the limited health systems resources. Public expenditures on health have been in the range of 5.5 - 5.6 percent of GDP in the last five years. This is higher than the average spending for lower middle income countries (2.3%). Government spending on health as a percentage of total government spending is also high in comparison to other lower middle income countries. HIF revenue from the general budget in 2002 accounted 5.9% (9). Contributions are collected by the HIF from employees (9.6% of the monthly salary), from the Pension Fund for retired persons (14.69%), from the State Budget for the unemployed and for farmers 9.2% of the cadastre income. Co-payments exist as a source for additional funding and demand management. Although co-payments have achieved the latter, it is estimated that they only contribute 5% of the revenues of health care providers. The annual revenues of the Health Insurance Fund were about \$326 million, corresponding to about \$160 per health-insured person or about 6% of the country's GDP (10). A combination of factors such as shortfalls on the revenue side and poor expenditure management has contributed to persistent cash deficits and the HIF has steadily accumulated debts to suppliers estimated about US\$35 million in 2004 (13 percent of annual expenditures) as well as accumulated debts of the health care institutions estimated at over US\$6.0 million. Private GPs are paid by a capitation rate system. As part of their monthly capitation instalments, primary health-care providers receive incentives for screening and health promotion, while they are capped for drug prescriptions and hospital referrals. Public-sector GPs receive salary-based payments, although a similar capitation system to private practice is in development. Provider payment systems, especially at the hospital level are inadequate and are major cost-drivers in the system. Hospitals are financed on a "fee for service" basis and a "line-item budgeting" system although there are plans to replace the current hospital payment system with a capitation system or global budgeting system. The legal framework

for this new comprehensive budgeting system is in its final stages of development. The benefits package is generous as compared with available HIF revenues and is contributing to the problem of implicit rationing and informal payments (3, 10).

Network of Health Care Institutions. Health care in Macedonia is available from both public and private providers. Primary health care is provided in 6 health care stations, 18 health care centres, 16 medical centres and 9 outpatient clinics. Secondary care comprises: specialist and consultative care, hospital care, specialized hospital care and other specialized forms of health care. Secondary care is provided through 16 general hospitals, 10 institutes for health protection, 7 treatment and rehabilitation centres, two special hospitals for treatment of pulmonary diseases and tuberculosis, two special hospitals for mental disorders, and two other special hospitals. Tertiary health care is provided through 19 clinics and institutes within the Skopje Clinical centre, one clinic specialized in surgery, seven dental clinics, one rehabilitation institute, 15 institutes within the Faculty of Medicine in Skopje, four specialist hospitals and the National Institute for Health Protection (11). The network of hospitals and PHC clinics exhibits fragmentation and duplication. The number of private providers, especially in primary care and dental practices, was steadily growing in the last more than ten years. According to the data provided by the National Institute for Health Protection the total number of private health care facilities in 2004 was 1571, of which 588 were surgeries (87.1% urban), 501 dental clinics (92.2% urban), 405 pharmacies (96% urban), 64 laboratories (93.6% urban) and two urban private hospitals. In 2004 this sector employed a total of 2353 persons, of which 641 physicians, 468 dentists and 430 pharmacists. The process for full privatization of pharmacies and dental services at PHC level is completed. Private providers through doctor's offices mainly operate at primary care level and include services provided by general practitioners, specialist outpatient clinics and private laboratory services. According to the Framework Agreement and the Local Self-Government Law, Primary Health Care, Health Promotion and Education, as well as the Health Inspection activities are to transfer from central to local self-government authority by the year 2004. Hospitals in the country are public, although the process of establishing private hospitals has been initiated. In the medium to long-term, the government aims to

completely privatize the provision of health care services at the primary health care level. Public and private health care providers have contracts with the HIF. The main challenges in health services delivery are weak capacity of health providers to operate in the reformed health care environment where they are expected to operate as managers of health facilities. There is a need to improve efficiency and poor quality of care (11, 12).

Multilateral / Bilateral Assistance. Multilateral agencies and bilateral donors providing support to the health sector in Macedonia include the World Bank, the World Health Organization, the United Nations Children's Fund, the United Nations Development Programme, the UK Department for International Development, the European Commission Humanitarian Aid Office, the Japanese International Cooperation Agency, the United States Agency for International Development, the Canadian International Development Agency, the Swedish International Development Agency, the Danish Agency for Development Assistance etc.

Health Sector Legislation in Macedonia

Health Protection Law. Basic legislative act which regulates the organization, functioning and relationships within the health care system is the Health Protection Law. This Law was adopted in 1991 and supplemented by amendments in 1993, 1995 and 2004. The novelties of the law were a new role of the key subjects of the system, reintroduction of private practice, obligatory and additional obligatory insurance, introduction of voluntary insurance, establishment of the Health Insurance Fund, introduction of medical, dental and pharmaceutical chambers, and reintroduction of health professionals associations (13, 14).

Health Insurance Law. The most recent activities within the reform of the health insurance system were directed to prepare a new Law on Health Insurance, which has been adopted by the Parliament of the Republic of Macedonia on March 30 and enforced on April 7, 2000. The Health Insurance Fund was established as an independent institution outside of the Ministry of Health. The Executive Board of the Health Insurance Fund already adopted many general acts, approved also by the Minister of Health. These acts approach in more detail the most important issues for efficient implementation of the law

in practice: They contribute to the strengthening of mechanisms for collecting regular revenue for the Health Insurance Fund, introduce a methodology for calculating new methods of user participation in health care expenses (co-payments) and regulate the relationship between obligatory and voluntary insurance more precisely. They also define the categories of the insured persons and their rights and obligations, and the scope of activities and responsibilities of the Health Insurance Fund (15).

Beside two basic above mentioned laws there are a number of additional laws regulating some specific fields of activities i.e. Law on Medicines, Law on Infective Diseases Protection, Law on Transplantation, Law on Radiation Protection, Law on Environment Protection etc.

Health Care Reforms in Macedonia from 1991-2001

After its newly gained independence in 1991, the Republic of Macedonia inherited a social model of obligatory health insurance and highly decentralized and locally funded public health care system. The main weak points of the system were a tendency towards further fragmentation and duplication of unsustainable services, excessive staffing that exacerbated the duplication of care, interregional differences and inequities in the amount and quality of care. That system became unsustainable, particularly in actual economic circumstances and economic transition. Up to 1991, there were 35 independent self-management communities of interest for health care on the municipal level and one on the national level. All of them were replaced by a single centralized Health Insurance Fund within the newly created Ministry of Health, with 30 branch-offices of the Health Insurance Fund on the local (municipal) level. Centralization was an attempt aimed, first of all, at stronger control of resource utilization and more equitable distribution during the transition period and economic crisis.

In the period after 1991, both the health insurance system and health care system, were faced with numerous problems, as a result of: (a) the war conditions in former Yugoslavia, (b) the economic and

transportation blockades; (c) drained inflow of funds from health services given to patients coming from other places out of Macedonia; (d) a decrease of funds of the insurance of more than 40% in real terms, due to the great number of unemployed persons, breakdown of state-owned enterprises and reduction of employee income; and (e) different types of tax evasions and other manipulations with obligatory health care payments (9,13).

Total national health expenditure, expressed as a percentage of GDP, decreased from 6,2 in 1990 to 4,8 in 1992, compared with 7.6% of GDP in 1998 and 4,7% in 2002. Per capita health spending decreased from US \$66.8 in 1990 to 39.2 in 1992, compared with US \$97 in 1998 and US \$93,3 in 2002. Thus, at the very beginning of the independence, there emerged an inevitable necessity to undertake urgent measures to prevent further erosion of the health system, provide sustainable volume and quality of the health services, and introduce long-term reforms of the health care system and health insurance system. The Health Protection Law, adopted in 1991, also authorized private health services and pharmacies but did little to streamline the public health system, create incentives for increasing efficiency or define a legal and regulatory environment for private providers. Shortages of medications were mitigated only modestly by humanitarian assistance, which covered the essential needs for medicines and medical materials. Negotiations with the World Health Organization and the World Bank were initiated to acquire loans and technical support for the implementation of the health sector reforms. In 1993, the Ministry of Health undertook activities for a reform process aimed mainly at: (a) allocating the resources on areas with an immediate impact on the health status of the population and maintaining the basic health services operational through provision of adequate drugs and other consumables; (b) undertaking structural reform and reorganizing of the health care system; and (c) facilitating privatization and development of private health services in order to stimulate competition and improve quality of care and health services.

The Ministry of Health asked the World Bank for assistance for further implementation of the reform and Macedonia became a member of the World Bank in December 1993. In early 1995, with the assistance of local and foreign experts and in cooperation with the World Bank, an urgent analysis of the conditions in the health system

was made and a strategy for undertaking sanitation measures was established. Simultaneously, short-term measures and activities for long-term reform of the health sector were determined. The health care system was analyzed in three segments: (a) financing and management; (b) primary health care and health promotion; and (c) supply of drugs and medical materials. The primary objective was to find the most appropriate solutions for redesigning the health care network and functions of the system in order to meet the demands of the citizens for high quality health services (13, 14).

In 1996, comprehensive health care reform was undertaken when the World Bank awarded the Ministry of Health of the Republic of Macedonia a loan of US \$19.4 million. The basic goals of the reform were to achieve universal access to high quality primary health care and establish cost effective finance and delivery systems. The initial reform efforts were supported by a grant from the World Bank. Technical assistance was provided by US-corporation RAND. They joined a team consisting of policy-makers of the Ministry of Health, the Health Insurance Fund and other health professionals in order to initiate reform analysis and create new strategies. The proposed new health care policies were directed to the following specific objectives: (a) identification of the health care priorities in the Republic of Macedonia through assessing the burden of diseases and effectiveness of available treatment; (b) reduction of the overall health expenditures and putting them in balance with revenues; (c) shifting health care utilization patterns away from expensive forms of care; (d) producing a benefit package that is more cost-effective and co-payment structure that improves sectoral efficiency in order to reduce the existing gap between financial resources and given health benefits to the citizens; (e) developing a capitation plan for primary health care providers and concept of family medicine in primary health care, or reorganize the concept of general practitioner's; (f) establishing an integrated and automated health information system as a support for better management in health care system; and (g) proposing an advocacy information strategy that facilitates the reform process. (12, 13, 14)

The most Recent and On-going Health Sector Reforms

In the last five years, activities have been taken to implement the principle of capitation within the primary health care level, for

strengthening the citizen's right to choose the doctor and creating a basic package of health care services, as well as fee for service payment on the secondary and tertiary level according to the official price list. To support these activities, an adjustment of the health information system and management of the health institutions through training of the managers and other employees was introduced. Continuing medical education was developing rapidly after 1998 when a school of continuing medical education was established with a World Bank loan. Beside clinical topics in family medicine (paediatrics, minor surgery, cardiopulmonary resuscitation, preventive health care, antenatal care and general medicine) the three week courses include cost-effective primary care delivery, finance, management, patients' rights and medical ethics, and basic benefits package, payment to providers and the role of the selected physicians.

In spite of a rapid expenditure growth in the last more than ten years and accumulation of significant debts of the public health care institutions and the Health Insurance Fund, the health system does not appear to have significantly improved access to basic health services and remains inefficient and inequitable. Resource distribution is concentrated in secondary and tertiary care, particularly in the capital city of Skopje, while access to basic services in some rural parts of the country is limited and of poor quality. The network of hospitals and PHC clinics exhibits fragmentation and duplication. Available efficiency indicators of the public health care institutions are below EU norms. Health care reforms undertaken in 1990-ties have proved unsustainable, and have in practice largely been abandoned or revised. The development and implementation of policies and plans for reform have been hampered by weak capacity in the state health sector agencies (the Ministry of Health, the HIF and the Republic Institute for Health Protection.), and the lack of data and information systems for surveillance, monitoring, and analysis. The result of this situation is that Macedonia has been slower to undertake health care reform than many EC countries.

Adoption and enforcing the new Health Insurance Law and separation of the Health Insurance Fund from the Ministry of Health were key issues and the most successful implemented reform processes suggested by the international consultants of The World Bank. The HIF is now centralized, hospitals are in practice subject to detailed Ministry

of Health and HIF controls. Technical efficiency has improved as the average length of stay in hospitals has decreased. Public providers are in practice paid on the basis of global budget contracts. PHC reform has increased patient choice through patient enrolment and capitation-based payment to physicians. Primary care contracts have been signed between the HIF and more than 500 private physicians (representing more than 25% of PHC providers). A large number of these private physicians come from the Albanian minority population.

Decentralization is an important policy priority of the government, although so far, the impact on the health sector is limited. The recently-passed decentralization law essentially mandates the representation of local authorities on the boards of public PHC organizations and gives local communities some responsibility for health education. To prevent repeating some mistakes from the previous experience in the country it is necessary that increased competencies on the local level to go hand-in-hand with strong central planning, setting standards and coordination capacities (11).

The second World Bank financed project for continuation of the health care reforms in Macedonia (3) was initiated in 2003 and approved in 2004 with the following specific objectives: 1) to upgrade Ministry of Health and Health Insurance Fund capacity to formulate and effectively implement health policies, health insurance, financial management and contracting of providers; and 2) to develop and implement an efficient scheme for restructuring of hospital services with emphasis on developing day-care services and shifting to primary care. The expected improvement in primary care and increased access to essential health services, especially for the poor and uninsured, would help bring further reductions in infant mortality and improvement in other health status indicators that would help the country meet its Millennium Development Goals.

Need for Public Health Strategy in Macedonia

Macedonia was economically the least developed of all the republics of the former SFR Yugoslavia and its economy contracted even further in the years immediately following independence in 1991. During the 1995-1999 period the country made significant progress in macroeconomic stabilization and structural reforms. This

progress was remarkable considering the country's difficult initial conditions, its external and domestic conflicts, and the external shocks that have hit its economy. Positive trends were interrupted by the Kosovo crisis (in 1999) and the civil conflicts (in 2001) that resulted in a significant decline of industrial production and a severe deterioration of the fiscal balance. From 2002, the recovery of the economy was slower than expected, with investment remaining sluggish. The fiscal deficit rose to 5.7% of GDP due to a significant increase in security-related expenditure and a further rise in government spending due to larger transfers to social funds, higher military spending, new public employee hiring, higher public wages, and exceptional financing of failed pyramid schemes. Although in 2003 the real GDP grew by 3.1% significant challenges remain in achieving macroeconomic stability and advancing toward a market economy and stable political situation that is required to achieve sustained growth and higher living standards for people of Macedonia (3, 13, 14).

Macedonian society is passing through dramatic period of transition. The social protection programs in Macedonia, aiming to alleviate a growing incidence of poverty and persistent high unemployment during transition, are costly, even compared to other transition economies in the region. The expenditures of the Pension and Disability Fund (PDF) alone account for more than 10% of GDP, while, together with the unemployment insurance and social assistance programs (including health expenditures), they represent an equivalent of nearly a third of GDP and comprise over two-thirds of public spending (3, 9).

Macedonian health care sector is experiencing two basic concepts of organization and performance of the health care system: 1) Public ownership and health care delivery, and 2) Private ownership and health care delivery. Some steps forward in health sector transition have been made from 1995-2002, but this sector is still facing serious problems. Frequent changes in the management staff are stemming from the political instability in the country. Low salaries reduce motivation and affect the service quality in health care delivery.

All above mentioned factors emphasize the need for long term strategic approach for future health care reforms and development of health care system in Macedonia.

Public Health Strategy Development Process in Macedonia from the Year 2000

In 2000 an initiative from Macedonian Academy of Sciences and Arts (MASA) was supported by the Ministry of Health for creating Public Health Strategy entitled "**Strategy for Improvement of Health Care of the Population in Macedonia by the Year 2010**" (in further text MASA PH Strategy or Strategy). Multidisciplinary team of 8 experts was created by the decision of the MASA Presidency in mid March 2000. Shortly after that the team was expanded to almost 20 members, including the president and other experts from MASA, the deans of the Faculty of Medicine, Faculty of Dentistry and Faculty of Pharmacy, other experts from the University St. Cyril and Methodius in Skopje, experts from Medical Chamber, Macedonian Medical Society, and health care institutions.

It was supposed that the Ministry of Health, as a representative of the Government of Macedonia, should be responsible for implementation of the Strategy through modification of the financial mechanisms and changes within the public sector of health care delivery. It meant that the Ministry of Health might propose and realize some additions and modifications of the Strategy.

Basic Principles Followed in Creation of the MASA Public Health Strategy

The following basic principles were determined and accepted at the beginning of the process for preparing the MASA PH Strategy in Macedonia (16):

- Health is a fundamental human right as Republic of Macedonia, by the Constitution, is declared as a social state;
- Respect of the human dignity, equity in health and health care accessibility and delivery;
- Solidarity of all relevant factors in the activities for providing healthy life for all citizens, as well as solidarity of providers and consumers of health care;

- Active involvement and participation of citizens through individual, group and community activities for continuous development of health care system in the country, as well as in activities for health education and health promotion;
- Active role of the State / Government in providing universal access to health care, especially PHC, for all citizens with special attention to some vulnerable and marginal groups (children, elderly, persons with special needs, unemployed and poor, homeless and patients with some chronic and devastating diseases);
- Partial privatization of health care system and implementing market mechanisms in health care delivery;
- Integration of preventive and curative medicine;
- Sustainable economic development and environmental protection.

It was assumed that special attention within the strategy for health care reform process should be given to the PHC as essential care which should be accessible to all citizens regardless of their material status. The State should be responsible for continuous implementation of public health activities related to: 1) Quality of air, water and food; 2) Health care of mother and child and family planning; 3) Prevention and control of the diseases typical for this region; 4) Immunization / vaccination; 5) Providing essential drugs; 6) Promotion of healthy life styles in healthy environment; 7) Health economy and health policy; and 8) Control of the quality of health care and its continuous improvement.

MASA Public Health Strategy Structure

Strategy for improvement of health care of the population in Macedonia by the year 2010 (MASA) is structured into seven chapters as follows (16):

I. Analysis of the Current Conditions

1. Population - demographic and social-economic aspects,
2. Health status and indicators of morbidity and mortality of the population,
3. Education of the health manpower,
4. Primary Health Care,
5. Secondary and Tertiary Health Care,
6. Public Health Institutes Network,

7. Dental Care,
8. Pharmaceutical procurement and distribution,
9. Health Legislation,
10. Social-economic analysis of the status of health infrastructure (Public Sector, Health Insurance).

II. Vision for Development of the Health Care System in Macedonia by the Year 2010 in accordance with the needs of the population, scientific discoveries and the most recent developments and achievements in medicine (genetic tests and genetic therapy, transplantation, ethical issues, Public Health and PHC development)

III. Strategy and Directives for Development

(Analysis of the strategic developments of Health Insurance, privatization of PHC and partly of Secondary Health Care, accreditation and continuous education and balanced distribution of physicians at PHC level, health information system at PHC level, Dental care development, pharmaceutical activity and provision of essential drugs, specialist outpatient and hospital care, PH control and improvement of quality of health services, education within health care system, first of all through Faculty of Medicine, School of Public Health, Faculty of Dentistry and Faculty of Pharmacy)

IV. Strategic Priorities

1. Decreasing of child morbidity and mortality,
2. Add years to life, care for elderly and handicapped,
3. Heart diseases (reducing mortality for 40% up to 65 years of age),
4. Cancer (reducing mortality for 15% up to 65 years of age and reducing mortality of lung cancer for 25%),
5. Mental Health, alcoholism, smoking and drug abuse prevention and treatment,
6. Diabetes,
7. Kidney and urinary system diseases,
8. Accidents and Injuries,
9. Oral health,
10. National Environmental Action Plan (NEAP).

V. International Co-operation and Communications

- WHO,
- The World Bank,
- The Stability Pact for South East Europe etc.

VI. Transition of the Functions within the Health Care Sector (Privatization)

VII. Reforms Related to the Environmental Protection and Health Sector

Priorities

1. Primary prevention, health promotion and healthy life styles,
2. Increasing of health security through Health Insurance System,
3. Policy of Governmental subsidies (environment protection, global preventive measures toward infective diseases, mental health and drug abuse, cancer, diabetes, renal failure and other diseases),
4. User's free choice of institution and doctor,
5. Decentralization,
6. Financing of health care and regulation of providers,
7. Changes in the education of health professionals,
8. System of follow-up and control in health care sector by the Ministry of Health, Physicians' Chamber, Health Insurance Fund and State Revision,
9. Responsibility and submitting reports.

Review Process of the MASA Public Health Strategy in Macedonia

Strategy for improvement of health care of the population in Macedonia by the year 2010 was methodologically situated between unsatisfactory reality and desired vision. Even it was delivered from MASA in 2002, the Strategy is still not officially adopted by the Government or Parliament of Macedonia. Even though, some solutions and directives from the Strategy were implemented within the legislation and practice.

During March / November 2004 a broad discussion was developed about the Public Health Strategy in Macedonia within the Health Policy Dialogue Initiative - a project of European Centre for Minority Issues (ECMI), Regional Office in Skopje. Members of the Group for Health Care were a representative sample of influential stakeholders in the health policy area. The primary aim of the working group was to identify problems and make recommendations about the most pressing need in the health care sector - development of a

national health care strategy under the auspices of the Ministry of Health - that will assist decision-makers and experts to formulate, adopt and implement an appropriate comprehensive PH strategy for long-term development of health care in the Republic of Macedonia (17).

Reasons for the failure to implement the MASA Public Health Strategy

The problems that obstructed progress to adopt and implement the MASA PH Strategy can be classified into four categories: (a) the formation and composition of the team of experts; (b) the content of the MASA PH Strategy; (c) not enough attention given to the strategic process for implementation; (d) failure to organize a broad public debate and to present the MASA PH Strategy to relevant stakeholders prior to its publication. (17).

(a) The Formation and Composition of the Team:

There was a lack of transparency in the formation of the expert team. Several questions should be addressed:

- What criteria were used to select members of the expert team?
- How were they selected?
- Was there an effort to ensure representation from different regions in Macedonia?
- What were the specializations of the members of the Expert Team?
- Why were experts with those specializations selected?
- We note that the members of the team were doctors and health professionals, but why no public health or social medicine experts were not involved among the members of the team of doctors and health professionals for drafting the document?

(b) Content of the MASA Public Health Strategy

A second set of problems concerns the content of the MASA Public Health Strategy. In the introduction, three global aims were presented: 1) Health care for all; 2) Increase in the quality of health of the population; and 3) A new consciousness in the health system;

However, no specific objectives are mentioned in connection with these global aims. As a result, there was little attention given to the mechanisms required to achieve these global aims.

The bulk of the MASA PH Strategy is actually a description of the health care system. While this is useful information, there is only a little space devoted to an analysis of the needs of the system, a presentation of a vision and priorities, and mechanisms to achieve those priorities.

There are no references to health system reform in other countries and while some data are presented, often it is not sourced, and no sufficient analysis of the data is provided.

(c) Failure to Develop Strategy for Implementation

The third set of problems is connected to the failure of the MASA PH Strategy to develop clear strategic approach for adoption and implementation of the Strategy. The MASA PH Strategy document provides just a few clues on how to translate the Strategy into action.

Very few health care professionals have ever seen, let alone read and understood, the MASA PH Strategy. In less than three years after the completion of the MASA PH Strategy it is obsolete.

(d) Failure to Engage Important Stakeholders

It was noted that prior to the publication of the MASA PH Strategy there were no public debates or presentations to the key health institutions that would have given MASA the opportunity to gain support for its proposal. It seems that MASA did not seek authorization from the Ministry of Health prior to publication of the Strategy.

It is clear that more thought needs to be given to placing health care reform on the political agenda by persuading political stakeholders that reform of the health care system demands their attention. Beside lack of inside information about MASA's strategy to implement their Public Health Strategy, it seems that their ideas for reform were not soundly accepted by political factors.

In order not to repeat these correctible errors, the following recommendations are proposed:

1. It is important for the composition of a new committee to develop a strategy on health care to be representative of the wider population, i.e. reflect the diversity within Macedonia in terms of ethnicity, regional affiliation, gender balance and broad professional expertise.
2. It is important for the process of selection to the committee to be transparent, and more careful consideration needs to be given to what stakeholders and what expertise is needed in order to craft a strategy that is of high quality and is likely to be implemented.
3. A new strategy needs to include practical and concrete considerations – and needs to provide a time-line that will indicate when steps need to be taken, who needs to be involved, and how their efforts should be coordinated.
4. Ministry of Health should reflect critically about the previous failure, and it will be better positioned to develop a more viable and successful strategy.

Activities of the Ministry of Health Related to Further Strategic Development of Health Care in Macedonia

Ministry of Health recognizes a high priority need to create, adopt and implement an appropriate comprehensive public health strategy in Macedonia. Recently an expert forum on the topic *"Strategy for the Development of Healthcare System in the Republic of Macedonia: Discussing Possible Priorities"* was organized by the Ministry of Health and the Foundation Open Society Institute Macedonia, held on November 19, 2004, in Holiday Inn, Skopje. The forum with relevant healthcare stakeholders aimed at hearing the opinions on how a national healthcare strategy ought to be developed and what would be the possible objectives. The document "National Healthcare Strategy - Macedonian Academy of Science and Art, 2001" was delivered to the participants in advance.

The expert forum developed broad discussion. It was pointed out that the development of a National Strategy will not start from scratch since specific segments in Macedonian healthcare have already developed and are implementing their own strategies in an

organized manner. An official general document however, was still lacking. An official document would imply: document adopted by the Ministry of Health, approved by the Government of the Republic of Macedonia and, finally, verified by the Parliament of the Republic of Macedonia. All relevant stakeholders would need to be involved in the adoption of such a document being the pillars of Macedonian healthcare and operating within the system on daily basis. The PH Strategy prepared by MASA should be the starting point for further development in creating more realistic document, with goals, timetables and strategic priorities in accordance with real capacities, but not a wish list. National strategy should be adopted with national consensus so that no other future minister will be able to change it. Finance is an important element. The strategy should be aimed to achieve certain priorities within the limited available resources, to provide better quality, in terms of human resources management, equipment, funds and additional training of the human resources. The Faculty of Medicine has a key role to play here. The Macedonian Doctors' Society should provide continuous medical education and professional upgrading of doctors and other health personnel. It is essential to facilitate further development of the School of Public Health within the Faculty of Medicine in Skopje for creating qualified and well educated public health professionals. Another significant element is patient's rights stemming from the Amsterdam Declaration on Patient's Rights from 1994 that the Republic of Macedonia already signed.

The Expert forum discussion resulted into following conclusions (18):

- there is a need for strategic document with a clear vision for health care reforms and future development of the health care system,
- the document should be realistic and achievable, accompanied by a financial framework with inter-sectoral approach and timetable of activities,
- the Ministry of Health should be the responsible body for co-ordination of the activities for preparing, adopting and continuous implementing the PH strategy,
- a global framework of priorities and priorities in certain segments should be developed,
- current legal provisions should be taken into consideration,

- individual documents (individual strategies) could be integrated into the national PH strategy,
- attention should be paid to effectiveness and financial coverage of healthcare capacities and resources,
- an analysis of the current health status of the population and the current organization and activities of health care system, with updated data, is required,
- improvement of financial management skills, first of all within the HIF, are required,
- further support from international factors,
- the strategy should not be developed in a hurry, but to take time to draft it carefully,
- consensus is required concerning the issue of whether a health strategy or healthcare strategy is what we want,
- an assessment of opportunities and priorities, as well as standardization and establishing norms is required.

In order to achieve the objectives of cost-containment and improved quality and access, the Government of Macedonia has to focus on strengthening the capacity of the MOH, HIF and health providers, with the objective of improving performance and enhancing transparency and accountability across the various entities. The Government has identified policy reforms and capacity-building of the HIF, MOH and providers as key to achieving its health sector objectives. The overall objective of health policy in Macedonia is to create a system that is aligned to the needs of the population and that can operate efficiently with the resources available. Health promotion, health education and a gate-keeping role for Primary Care are high on the policy agenda. In order to create proper policy for PHC and family medicine development the Ministry of Health organized two round-table discussions in 2005 for sharing of experiences with invited experts from Slovenia.

Priorities identified by the Government in the R. Macedonia for the health sector include: 1) health management training, 2) rationalization of the health sector, 3) establishment of an appropriate IT network to strengthen health information, 4) establishment of mechanisms for the safe storage and distribution of pharmaceuticals together with the adoption of reference price mechanisms for generic

drugs, 5) development of evidence based clinical guidelines, and 6) strengthening of capacity in health policy, planning, management and financing at all levels.

Further legislation is also needed to support competition and free market activities.

Exercises

Specificities of the organization , activities and reforms of the health care system in the Republic of Macedonia

Task 1. Comparing health care reforms between countries

Students should collect data about health care reforms from their respective countries. In addition to that, they have to be compared with Macedonian experiences. An analytical approach about the successes and failures in health care reforms will be considered through group discussion.

Time proposed is 60 minutes.

Task 2. Health Insurance System

Students are asked to collect some specific indicators (HFA Database and other sources) and readings about the Health Care System and the Health Insurance System in their respective countries in order to prepare a seminar paper as practical work about the general directives for further reforms and strategic development of the health system.

This task will be done individually, as a homework.

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Chapter 4

CASE STUDIES

4.2 Health Care Reform Strategies

PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Health and healthcare system in Bulgaria
Module: 4.2.1	ECTS (suggested): 0.25
Author(s), degrees, institution(s)	Lidia Georgieva – MD, MPhil, PhD Associate Professor Faculty of Public Health, Medical University, Sofia, Bulgaria Petko Salchev – PhD Associate Professor Vice Minister, Ministry of Health, Bulgaria
Address for correspondence	Name: Lidia Georgieva Head of Department Preventive medicine Faculty of Public health, Medical University Street: Belo more 8 City: Sofia Country: Bulgaria Tel: +359 888 266 431 Fax: + 359 9570184 E-mail: lidia@omega.bg
Keywords	Health status, health reform, health management, public health
Learning objectives	After completing this module students and public health professionals should: <ul style="list-style-type: none">• Be aware of reform in the health sector in Bulgaria;• Increase knowledge on health status of Bulgarian population;• Understand priorities of reform;• Improve knowledge of health care system in Bulgaria.
Abstract	The development of the health status and the healthcare system in Bulgaria during the past 15 years reflects the radical changes in the political and economical conditions, which are characterized with development of the democratic process and free market and change of the social structure of the population. This paper focuses on trends in the health of

	<p>the Bulgarian population, health policy and reform of the healthcare system</p> <p>The reform in the out-patient (ambulatory) medical care is reviewed. It was based mainly on two laws – the Law for the medical institutions and the Law for the health insurance and also on many dependent ordinances and acts.</p> <p>The reform in the hospital care covers all types of institutions: multifunctional and specialized hospitals for active treatment, for long-term treatment and for rehabilitation. The hospitals are also decentralized as local, municipal, regional and national. The hospitals are financed by the NHIF and from the state budget.</p> <p>Recommendations for improving the ambulatory and hospital care are made. Differing from the radical changes in the areas of hospital and outpatient care, changing the public health is an evolutionary process. The basic principles, stated in the National health strategy and comprising the essence of the healthcare reform are: pluralism of property; democracy in governing; free access availability of medical care; equity and justice; solidarity and shared responsibility for the health of the individual and the population.</p> <p>Governing of the healthcare system, health policy and strategy are described and critically analysed.</p> <p>In conclusion, the basic directions of the reform are given.</p>
<p>Teaching methods</p>	<p>Lectures, exercises, individual work, interactive methods such as small group discussions, seminars.</p>
<p>Specific recommendations for teachers</p>	<p>Work under teacher supervision – 40%, individual students’ work – 60%. Facilities, equipment and training materials: computers, Bulgarian health strategy. Target audience: lecturers and students in medicine, master and</p>

	PhD students in public health
Assessment of students	Assessment could be based on multiple choice questionnaire (MCQ), structured essay, seminar paper, case problem presentations, oral exam, attitude test etc.

HEALTH AND HEALTHCARE SYSTEM IN BULGARIA

Lidia Georgieva, Petko Salchev

Introduction

The development of the health status and the healthcare system in Bulgaria during the past 15 years reflects the radical changes in the political and economical conditions, which are characterized with development of the democratic process and free market and change of the social structure of the population.

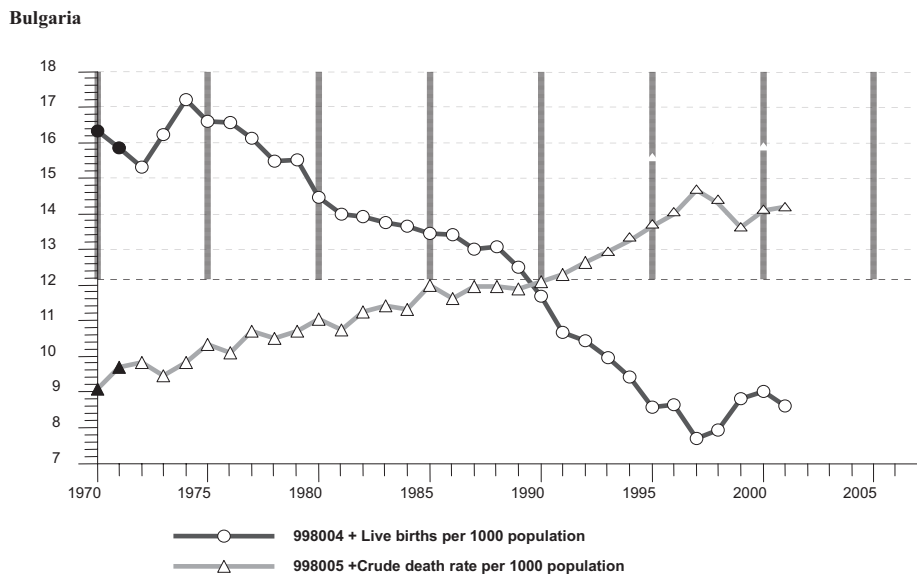
The organizational changes in the healthcare system affected especially the characteristics of medical care (statutory and private health insurance; equal rights of the public and private sector; registration of the medical institutions, etc.). At the same time there was no explicit plan of action for the national health strategy and lack of monitoring and evaluation of the development of the reform.

Trends in the health of the Bulgarian population

A demographic crisis, characterized by a stable process of depopulation, is representative for the last decade in Bulgaria. The number of the population continues to decrease. The aging is expanding mostly among women and in the rural areas. The relative portion of the people above 65 years is 17% for 2002; and for the youth under 15 years is 14.6%. The aging of the population leads to a higher average age of 40.6 years for 2002 (1).

The low birth rate is one of the factors for the diminishing of the population – for 2002 it is 8.5‰. It is lower than in some of the newly adopted countries in the EU (Poland, Slovakia, Hungary – 9.5‰)

Figure 1 BIRTH RATE, MORTALITY RATE BULGARIA 1970 - 2002



**Since 1990 Bulgaria had a negative natural growth demonstrating steady decrease from - 0.4 in 1990 to - 5.8 in 2002).
 The proportion of aged persons (over 65 years of age) is 17% for 2002.**

Source: WHO, HEA 2004 (2)

The low birth rate is influenced by the continuing reduction of the women in fertile age, by the changes in the age structure of this group and also by the low level of fertility of the women.

The tendency of growing of the total mortality rate is still present although in the last few years the level is becoming more stable. The relative mortality rate in active age is smaller for 2002 than before. The mortality in the rural areas is higher than in the urban areas.

The unfavourable demographic situation influences the average length of life. For men it is 68.5 years (for 2000-2003) and for the women it

is – 75.4. This level is with 6.5 years lower than in the countries in the EU and with 1.5 years lower than in the newly joined countries. The expected average life in good health for the men is 60.8 years and for the women is 65.2.

There are 5 main groups of diseases which cause 72 – 75% of the registered incidence cases in the country:

- diseases of the respiratory system – 37.7%;
- diseases of the nervous system and sensory organs – 11.6%;
- cardiovascular diseases – 10.5%;
- traumas and poisoning – 7.5%;
- diseases of the skin and subcutaneous tissues.

Table 1 MORTALITY BY CAUSE, BULGARIA 1985-2002

Causes of death	1985	1990	1995	2000
Infectious diseases	0.6	0.5	0.5	0.7
➔ Cancer	13.7	13.9	14.1	13.3
Metabolic, Immunological, endocr. and eating disorders	1.4	1.7	2.0	1.8
Mental disorders	0.3	0.2	0.3	0.3
Blood diseases	0.1	0.1	0.1	0.1
Neurological diseases	0.5	0.5	0.6	0.7
➔ Circulatory diseases	60.1	61.5	63.3	66.2
Respiratory system diseases	7.7	6.0	4.6	4.1
Gastrointestinal diseases	3.1	3.0	3.2	2.7
Genito-urinary tract diseases	1.8	1.6	1.2	1
Congenital malformations	0.5	0.5	0.3	0.2
➔ Trauma and poisoning	5.3	5.1	4.8	4.2
Unclear conditions	4.3	5.0	4.4	4.4

The commonest certified cause of death in Bulgaria is cardiovascular diseases – 67.9% for 2002, cancers – 14.0% and trauma and poisoning 14%.

Source: National Institute of Health Informatics (3)

Bulgaria is a country with a low level of AIDS/HIV dissemination, but the number of cases is increasing. The most affected group is between 20 – 29 years of age. The main causes for death are the cardiovascular diseases; cancer; traumas and poisoning.

The demographic crisis in our country is a fact. The health of the children, the youth and the women is becoming worse. The number of the disabled and handicapped is increasing. The level of incidence for AIDS/HIV is kept low but there are also prerequisites for its lifting.

The health of the population is an indicator that the general policy for health protection in the last decades is not effective and gives very few positive results. The socio-economic development in the conditions of transition and the influence of the basic determinants of health are undoubtedly among the causes for the existing situation. Some of the negative processes are related to a certain extent with the fails in the healthcare reform and the malfunctioning of the healthcare system.

Health policy and reform of the healthcare system

1. Financing

The total public expenses on healthcare for the year 2000 were 3.7%; for 2001 – 4.0%; for 2002 - 4.5% of the GDP. In the period 2001-2003 the relative financial share of the National Health Insurance Fund (NHIF) from the total expenditure was increasing from 36% in 2001 to 41% in 2002 and to 52% in 2003.

The implemented legal framework and the selected model for health insurance and financing were meant to achieve solidarity and justice in the using of financial resources, equity and free access to the medical services.

Table 2 Expenses for health services per financial institutions for the period 2000 – 2003 (in thousand leva)

	2000	2001	2002	2003
% of the expenses for health services from the GDP	3.7	4.0	4.5	4.8
Including:				
% for hospital medical services of the total expenses	15%	36%	43%	47%
% of the NHIF of the total expenses for health services	13%	36%	41%	46%
Unemployment rate	13.7	16.0	19.5	19.0

Source: Ministry of Health, Report on health of the Nation in the beginning of XXI century. Analyses of the Health Care Reform, 2004 (1)

The difference in the starting point of the reform for the out-patient and hospital care lead to certain disproportions in the financing of the system as a whole, which created tension among the patients as well as among the health professionals.

To overcome some of the problems in the sphere of finances, certain measures should be taken:

- increase the share of resources for healthcare, provided by the GDP;
- optimization of the hospital network by reducing the number of medical institutions and integration and specialization of hospitals;
- creation and initiation of a national strategy for restructuring of the hospital sector;
- implementing uniform method of financing of the hospitals, based on paying for case, than on paying for structures;
- introducing “case-mix” approach and DRGs.

There are some positive features, related to the financing of the public health: 5 national programs were financed for 2001; for 2002 – 12 and for 2003 – 22.

The extended amount of resources and the organizational changes of the financing is a material prerequisite for introducing of the healthcare as a leading national priority. It guarantees the participation of the state in the financing of the activities, connected to health promotion, protection and treatment of the people.

Protection and control of the public health

Differing from the radical changes in the areas of hospital and out-patient care, changing the public health is an evolutionary process:

- changes in the function of the PH institutions
- entire renewal of the legislative basis, harmonized with the EU
- improvement of the internal organization
- intensification of the activities, related to PH
- continual improving of the qualification of the medical specialists
- change in the manner of financing of the system
- constant improvement of the technical and electronic devices
- keep and develop the relations with the hospitals and other medical and non-medical institutions

Out-patient (ambulatory) medical care

On the 01.07.2000 the reform in the ambulatory health care was started. It was based mainly on two laws – the Law for the medical institutions and the Law for the health insurance and also on many dependent ordinances and acts.

The out-of-hospital treatment is organized as following:

- primary general health care – individual (GPs) or group private practices;
- primary specialized health care – individual and group private practices for medical or dentist care, medical centres and clinics, diagnostic-consultation centres.

For the period from the start of the reform till now almost all of the population is included in the statutory health insurance. The

number of the people, registered with their own General Practitioner reaches 97.37% till 31.12.2002.

Basic problems:

- lack of obligatory medical standards and rules for good medical practice in every specialty
- restriction of the secondary visits to the specialist
- method of financing
- not adequate benefits to the insured people
- optimal interaction between primary and specialized out-hospital care
- not enough resources for primary care – mainly for prophylactic measures and prevention.

Recommendations for improving the primary health care:

- accent on the socially vulnerable groups of the population – children, poor, disabled, etc
- better economic and organizational conditions for development of small private individual and group practices
- working on the creation of national program for better economic condition and proper stimulation of the providers of medical services in the small villages
- working on instruments for increasing the personal responsibility of the GPs and making the system more effective
- simplifying the documentation and reduction of the time spent for paper-work
- introducing stimuli and incentives for prophylactic measures and prevention of all the registered persons
- restriction of the payment per capita in favour of the payment per service done
- construction of integrated information system
- introducing chip/smart-cards for patients
- creation of standards and rules for good medical practice as soon as possible
- creation of system for continuing medical education and qualification for the physicians
- free-market oriented reorganization of the primary healthcare sector

Hospital care

The reform in the hospital care covers all types of institutions: multifunctional and specialized hospitals for active treatment, for long-term treatment and for rehabilitation. The hospitals are also decentralized as local, municipal, regional and national. In 2002 the number of hospitals was 251 with 46 929 beds, 13 161 physicians and 29 143 specialists with higher and secondary education. The hospitals are financed by the NHIF and from the state budget.

Basic problems:

- using a “clinical pathways” method for financing from the NHIF – number of disadvantages, concerning mainly the insufficient amount of payment per pathway and its estimation
- insufficient co-ordination between the different sectors of the healthcare system and medical institutions
- need for information system and reliable database
- need for better legal framework

Recommendations for improving the hospital care :

- introducing DRG - system for financing of the hospitals
- structural reforms and better regional and national organization of the hospital care
- creation of integrated information system and proper legislation, related to the requirements of the system and the patients
- communication, co-ordination and integration among the different levels and sectors of the system
- integration of the two financial flows – from the NHIF and from the state budget – in a common framework for estimation of resources
- constant and up-to-date education of the medical staff from all levels of the healthcare system

Governing of the healthcare system

At the head of the healthcare system stays the Ministry of Health. The governing is realized by the Regional healthcare centres (RHC), by the Regional hygiene and epidemiological inspections with the help of the municipal organs of the state.

The basic principles, stated in the National health strategy and comprising the essence of the healthcare reform are: pluralism of property; democracy in governing; free access availability of medical care; equity and justice; solidarity and shared responsibility for the health of the individual and the population.

The activities performed to accomplish the Health strategy are based on the following priorities: stopping the negative trends / tendencies in the system; realization of structural and organizational reforms; development of the economic relations and interactions in the healthcare system and adaptation of the medical staff to the new conditions.

A short-term program (2002 – 2005) – "Healthcare – the right of everybody" with a defined priorities was accepted by the Ministry of Health

- improvement of the preventive measures with a stress on the groups with high risk for the health
- reorganization of the institutions for public health
- increasing quality and effectiveness of out-patient and hospital medical care
- improvement of the methodology of financing of the healthcare system

Considering the health promotion and prevention of diseases as a leading sphere of PH, finds its expression in the 22 working national programs in the following fields: socially-significant diseases; tobacco smoking; drug-addiction; AIDS and sexually transmitted diseases; genetic diseases; infectious and parasitic diseases; antibiotic policy; food and nutrition; environment and health; hospital hygiene and medical standards.

The new health policy realities are demonstrated in a group of laws, which determine the basic characteristics of the healthcare reform: Law for medical institutions (1999); Law for health insurance (1998); Law for the professional organizations of the physicians and dentists (1998); Law for the medicines and pharmacies in the human medicine (1995), Law of health (2004).

These laws regulate the new relations in the healthcare system. They are the basis for the structural and financial reform of the medical services. They put into practice new rules of communication and interaction among the institutions and introduce elements of free market in the system.

Health policy and strategy

The realization of the National health strategy goals, adopted in 2001, was also going on in 2003. The basic principles, which are leading for the strategy, are now put into practice.

- the pluralism of property is already present (private hospitals, medical centres, laboratories, clinics, etc)
- democracy in the process of governing of the health system is insured by the participation of all state, professional and public institutions and organizations
- the free and easy access to medical help is improving step by step
- there is equality for the patients mostly in the out-patient care (primary and specialized) but not in the hospitals
- the solidarity principle for receiving benefits is realized on the basis of the Law for health insurance; problem in the system are the poor and the not insured persons
- sharing responsibility for one's health is not stated as a normative document and there is lack of incentives or financial stimuli for protecting the individual and population health.

The health policy is also realized in some other aspects:

- a new model of the healthcare system is created, where the different medical institutions are registered and working under the Trade law

- the social orientation of the health activities in the preventive sphere and in the medical institutions is introduced
- a number of European organizational traditions and strategic directives are implemented with the help of WHO and other international organizations – national health policy, healthcare reform, national health insurance, contract systems for payment, programs for the children's and women's health, health promotion and prevention and decrease of socially-significant and infectious diseases, etc; there are some restrictions due to the insufficient financial resources of our country
- the marketing mechanisms in the management and distribution of resources are entering progressively the out- and in-patient medical care
- a competitive environment is favoured for the providers of medical services
- better economic effectiveness and medical efficacy is pursued
- better quality of medical care is permanently aimed at

Health priorities

The main priorities of the National health strategy, adopted in 2001, are followed also in the next years.

The first priority is “Ending the negative tendencies in the healthcare system”. A lot of changes were made in different sectors of the health system. A number of improvements were done in the financing framework and principles, in the quality and efficiency management; in the disease management and pharmacy regulation. Serious steps were taken in the areas of health promotion, prevention and prophylactic measures with the cooperation and co-ordination of international and European organizations and funds. Certain positive results were achieved, although there are still fields for development and aspects to be considered – e.g. the creation and proper use of national health information system.

The second priority is “Structural and institutional reforms in the healthcare system”. Almost all of the planned measures were realized. As a basis for them the Law for the medical institutions and the Law for the health insurance were used.

The third priority is “Development of the economic relations and interrelations in the healthcare”. It is considerably worked out. A contract system for the financing is introduced. The process of decentralization of the governance and the autonomy of the medical institutions is a fact. The legal framework for the health insurance and contracting is created and put into practice. The education of specialists in healthcare management, health economics and informatics has started actively.

Another priority is “Adaptation of the health professionals to the new economic conditions and qualification requirements”. A redistribution, re-education and qualification or alternative ways of professional realization is needed for the excessive number of medical specialists. In this direction cooperation is established with nongovernmental and international institutions as the World Bank, USA Agency for International Development (USAIDS), etc. A system for continuing medical education is already introduced.

Legal framework

The new Law for Health adopted in 2004 (4) replaces the Law for the peoples’ health from 1973 (5).

In the period 1995 – 2000, modern health legislation was introduced as a basis for the new health-political and economical realities and in harmony with the European legislation.

- the Law for the medical institutions - 1999 (revised 7 times) (6)
- the Law for the health insurance – 1998 (revised 14 times) (7)
- the Law for the professional organizations of the physicians and dentists – 1998 (8)
- the Law for the medicines and pharmacies in human medicine – 1995 (revised 13 times) (9)

Other important laws: Law for the control over the narcotic substances and pre-drugs – 1999 (10), Law for the blood, blood transfusion and blood donation – 2003 (11) and Law for the transplantation of organs, tissues and cells – 2003 (12).

Another legal regulation concerning the statutory health insurance and the financing of the medical services is the National Framework Contract, signed between the Bulgarian Medical Association on behalf of the providers of health services and NHIF on behalf of the money providers.

Despite the numerous positive changes in the healthcare system, the healthcare reform doesn't fulfil/satisfy completely the expectations of the society. The opportunities for real impact of the state over the health system and the possibility for taking adequate leadership decisions are underestimated and not properly used. The number of changes in the health legislation is very often not coordinated and makes the existing problems even worse.

A holistic, detailed, profound analysis is needed in order to clarify the particular perspective for further development of the system, considering the social influence of the reforms.

Conclusion

The basic directions of the reform are:

- reduction of the incidence rate, early death and disability
- health promotion, promoting healthy lifestyle and reduction of the risk factors
- development of a socially-fair healthcare system
- formation of healthy policy and favourable internal and external environment for medical care

The realization of the entire management of the healthcare system is a basic obligation and responsibility of the government. For the proper development of the healthcare processes, including the health reform, a plan of action is necessary, based on the actual resources and completely aimed at the realization of the priority tasks.

To be more complete and reliable, the evaluation of the key functions of the healthcare system and the achieved results should not be based only on the data, characterizing its internal essence.

To analyze and explain the healthcare system we should consider its interactions with a bigger system, as a part of the socio-

economic system. The right decisions should be searched not only inside the system but also out of it.

Exercises:

Task 1: The students will work in small groups (4-6 students). They will discuss and suggest possible recommendations for improvement of health status of Bulgarian population.

Written recommendations will be presented to the whole group.

Task 2: Students have to make a comparison of the primary health care and hospital care organization and financing in Bulgaria and their countries and present the pluses and minuses of both.

Discussions and recommendations will be made by whole group.

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11. Law for the blood, blood transfusion and blood donation – 2003
12. Law for the transplantation of organs, tissues and cells – 2003.

PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	National health strategy in Croatia 1990-2000
Module: 4.2.2	ECTS (suggested): 0,6
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Keywords	Health care, health policy, health care reform, public health strategy, decentralization,
Learning objectives	After completing this module students and public health professionals should: <ul style="list-style-type: none"> • increase understanding of health care system and reform planning • recognize relevant indicators and tools for health care analysis • recognize stake holders strategy development • be able to identify starting points for national and local health care strategy development • be able to describe to difference between national and local planning and reforming • understand idea of decentralization
Abstract	Croatian health care system has passed couple

	<p>significant changes in the last fifteen years. As the first step after the socialistic era, Government implemented centralization in health care in 1990, aiming to control all segments of the health care system. Main health care reform, started in 1993, promoted decentralization and privatization in health care. Due to big problems with health care funding and resources allocation many attempts were made to balance and support national health care system. On the other side, some local communities and authorities realized that national programs and central planning are not sufficient and fully appropriate for their health needs and resources. Therefore, some counties in Croatia jointed to the special educational and training programs organized by Andrija Stampar School of Public Health. Based on this program they developed their own health plans, particularly in the field of public health. This module present an overview on Croatian health care system and two cases, one with description of national and one of local health care planning.</p>
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Assessment of students	Student should prepare small group case presentation and short seminar paper (based on their individual overview) that will be assessed.

NATIONAL HEALTH STRATEGY IN CROATIA 1990-2000

Aleksandar Dzakula, Selma Sogoric, Ognjen Brborovic,
Luka Voncina

Background for health strategy in Croatia (1990-1993)

In the 1980s, Croatia's health care system was characterized by a high level of autonomy of local authorities and by both health workers' and users' participation in decision-making. This particular system of management was known as self-management (1). The model was designed to allow workers active participation in public services. Decision-making in health care was delegated to the specific "self managing" local health care system, with a strong emphasis on general hospitals.

Political changes that took place in 1990-1991 and the war aggression that followed resulted in extensive material damages particularly in the frontier areas in eastern Slavonija, along the border with Bosnia and Herzegovina and the area around Dubrovnik. By mid-1995, over 16,000 Croatian citizens had been killed in the war and over 30,000 had been made permanent invalids. In 1994 the displaced and refugees accounted for 10.8% of the total population (2). A survey performed in Croatia, in March 1996 (few months after the end of the war) still counted 361,774 displaced persons and refugees (3). This resulted in severe financial crisis where the ratio between adult population who not generate income and those who generate was higher than 1:1.70, what was huge burden for health insurance system and health care financing.

The political system and the war enabled politics to influence major economic decisions. Poorly implemented privatization and dubious political decisions resulted in Croatia's political and economic lagging behind neighbouring countries in the '90s. A drastic fall in GDP, constant growth of unemployment and unbearable public expenditure indicated how severe the recession was.

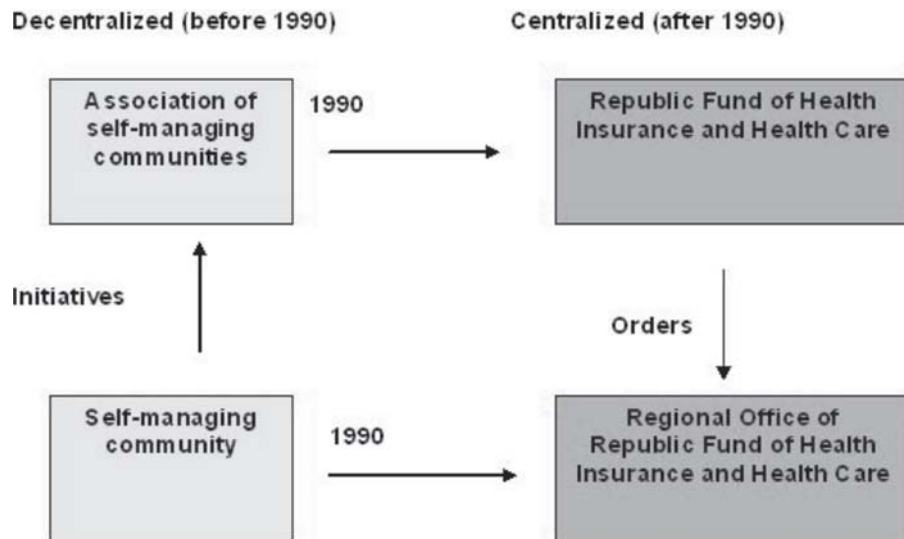
One of the essential changes carried out after the establishment of the first democratic Government was the Amendment of the Health Care and Health Insurance Act (26/07/1990). Two processes were implemented: abolition of self-governed decision-making and centralization of decision-making and financing (4).

The former system of self-management was facing a severe crisis which reflected on the health care in a specific form. In those circumstances it was hard for the system of health organization and financing to meet increasing requirements by citizens and political groups. Another important reason was the striving of the new democratic Government to provide central control over health care and thus strengthen its positions and legitimacy over the newly established Croatian state.

The inherited decentralized health system organized in local communities and based on labour association was bound to change. In 1990 decision-making power was transferred from decentralized authorities of local communities (self-management health communities of interest) to the national level – to the newly founded Croatian Republic Fund of Health Insurance and Health Care (CRFHIHC) (Figure 1). The Fund was based on the structure of the former Association of Self-governing Communities of Interest, which was responsible for control and joint interests of local communities on the national level. Thus, the decision-making level rose from 100,000 inhabitants to 4,500 000. Furthermore, health financing was centralized and placed in the hands of the Republic Fund (4).

In organizational and technical terms, self-governing communities of interest become regional offices of (CRFHIHC), controlled by the parliament that appointed 30 members of Fund Assembly and the director. To sum up, the 1990 amendments abolished self-management and centralized health insurance. These changes remained the cornerstone of the system until the major reform in 1993.

Figure 1 Changes in governing relations



Source: Dzakula A, Oreskovic S, Brborovic O and Voncina L. Decentralization and Healthcare Reform in Croatia 1980-2002 (4)

Strategic guidelines and principles (1993-2000)

Reform - new health system

The deep economic crisis and the war aggression from 1991-1995 presented additional challenges for health care. The 1993 reform continued on the reforms started in 1990 and based itself upon health trends from the '80s. In 1990, new strategic relations were established in the health system and new legislation was needed to define further details and guidelines. The former system, although promoting social equity, had several drawbacks as, for example, it lacked in cost-effectiveness and financial and systematic quality control. Reforms

were therefore aimed at creating a system with balanced market and social values in health care. That was to be achieved through privatisation and changes in public services – centralized decision-making and control and local resource management. Such a system was believed to be elastic and dynamic enough to meet the requirements of the transition period. Direct reforms were brought about by the Health Care Act and the Health Insurance Act in 1993. The Reform was based on the principles of:

- comprehensiveness
- continuity
- availability

Comprehensiveness stands for the right of all citizens of the Republic of Croatia to health care. Continuity refers to uniform health care throughout life span for all age groups. Availability is guaranteed through the network of health providers to ensure the provision of health care to all citizens (5).

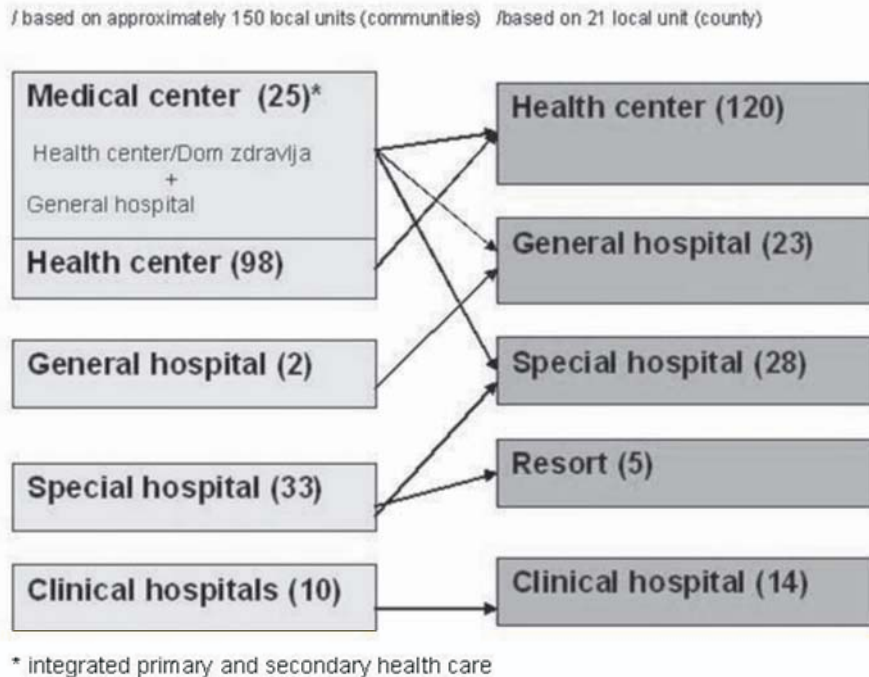
In 1993, primary health care was defined as the foundation of health care. The reformed system was designed with the mission to respond to 90% of all solicitation for health services with special gate-keeper role assigned to family physicians. The new system promoted a more active role of citizens and patients in the health system. Health care was regarded as both a right and responsibility of all individuals. Patients were given the right to informed consent to medical interventions and procedures of treatment and diagnosis (5).

Implementation and outcomes

Organization

The reformed system transferred the inherited system into new organizational schemes with major changes in the hospital system, especially with regards to relations between hospitals and primary health care. (Figure 2)

Figure 2 Organizational changes in the health care 1990 – 2000



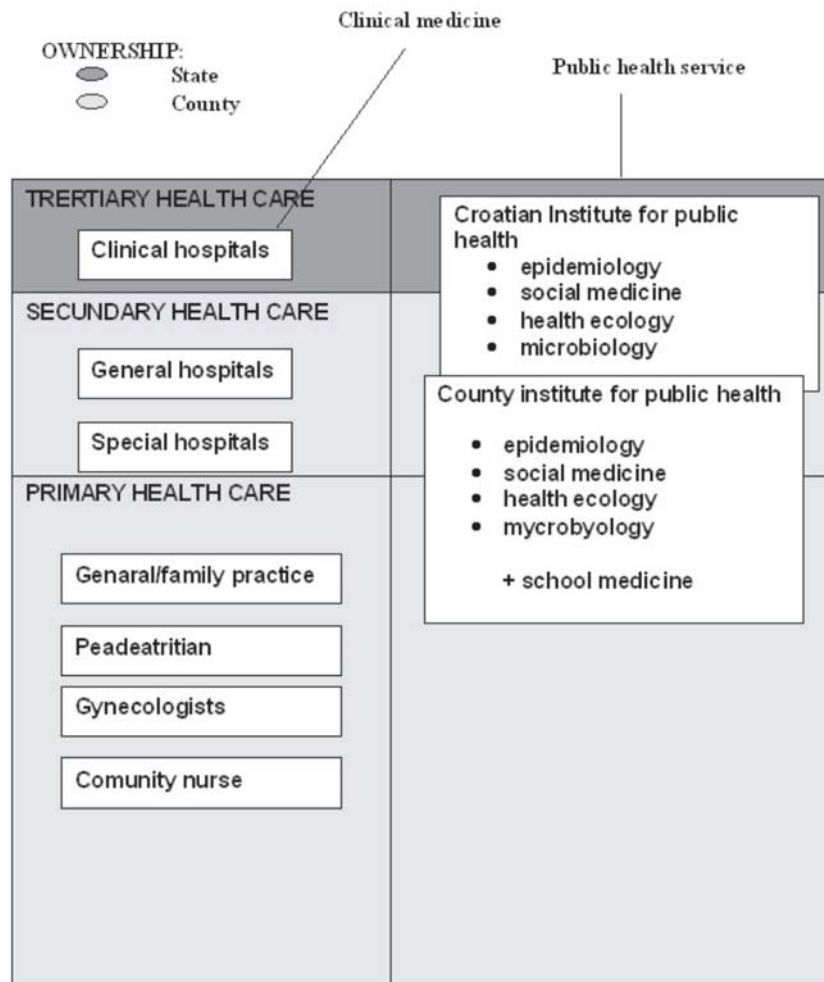
Source: Dzakula A, Oreskovic S, Brborovic O and Voncina L. Decentralization and Healthcare Reform in Croatia 1980-2002 (4)

It was decided that health care will be delivered through primary ambulatory and hospital units, with the general practitioner playing the role of the first-contact doctor. Instead of only family doctors, a model of both general practitioners and other doctors with or without specializations was introduced. Various physicians were given the opportunity to practice in primary health units: general practitioners, paediatricians and gynaecologists. Privatization of these practises in the primary health care was recognized as priority.

Programs addressing the general population included community nursing services and school medicine specialists. Health centres remained the cornerstone providers of primary local health care. General hospitals and specialised ambulatory units continued operating as secondary health care units and finally teaching clinics as the highest forms of health care provision (tertiary health care).

Major changes were carried out in the division between curative, preventive and public health services. (Figure 3) Public health services were separated from health centres where they previously operated as a basis for primary health care (they included curative and public health services). Individual services of epidemiology, social medicine, ecology and microbiological laboratories merged into county Institutes of Public Health and a national institute was founded to coordinate them - the Croatian Institute of Public Health.

Figure 3 Organization and ownership of the health care services



Source: Dzakula A, Oreskovic S, Brborovic O and Voncina L. Decentralization and Healthcare Reform in Croatia 1980-2002 (4)

Ownership

The former system in which ownership was not clearly defined was replaced by a new system with well defined ownership; with the state, counties (local authorities) and private individuals as owners. (Table 1) The state was given ownership of clinics, clinical hospitals and national health institutes (of public health, transfusion medicine, drug control, immune-biological preparations, occupational medicine, radiation protection and toxicology). Primary health care units (health centres, institutes of public health, pharmacies), general and specialized hospitals became the property of decentralized local authorities – counties. Private individuals were allowed to own private practices (one medical team) or to establish private institutions to render all forms of health care services (except for health centres, emergency and transfusion services and institutes of public health).

Table 1 Health care facilities in year 2001

	Public ownership	Private ownership	Total
Health Centres	119	0	119
General hospitals	23	0	23
Teaching hospitals	12	0	12
Clinical hospital centres	2	0	2
Special hospitals	28	2	30
Health resorts	3	2	5
Emergency medical aid institutions	4	0	4
Polyclinics	10	175	185
Home care institutions	1	110	111
Private physician practices	0	2734	2734
Private practice units (laboratories, pharmacies etc)	0	3569	3569
National institutes	6	0	6
County institutes for public health	21	0	21

Source: Dzakula A, Oreskovic S, Brborovic O and Voncina L. Decentralization and Healthcare Reform in Croatia 1980-2002 (4)

Management

The reform was based on a decentralisation principle that left the management of health providers to local authorities, whilst control over them was centralized. Health care units were run by Governing Boards with majority vote of owners and employees, by the Ministry of Health in the case of state-owned units and counties in the case of primary and secondary health care facilities. Participation and control of the state was set through representatives of the Croatian Health Insurance Institute in the Governing Councils. Thus, the state assumed a role in the management and direct control of the health system. Apart from Governing Boards, providers were also given their Professional Councils responsible for monitoring professional work and controlling all health care measures carried out by respective provider.

Health professionals

Special attention was paid to the role of health professionals. They were given a statutory obligation of continuous training. All health professionals are certified through state examination and examination of professional ability after graduation and internship. The Ministry of Health organizes the examinations while professional chambers issue certificates.

Medical doctors, dentists, pharmacists and biochemists have their own professional chambers in charge with controlling and improving each professional activity, licensing after state examinations or continuous professional training. In practice, every six years each physician has to renew the licence.

Health insurance

The 1990 changes replaced the decentralized and locally organized funding system with a system based on a central fund of health insurance - Croatian Republic Fund of Health Insurance and Health Care

The process continued in 1993 when the central state agency for health insurance was founded: the Croatian Health Insurance Institute. The Institute took over the compulsory health insurance system based on reciprocity and solidarity. Apart from compulsory

insurance, it introduced optional voluntary insurance. It was a supplementary insurance, aimed at meeting the costs of services that are not reimbursed by compulsory insurance or providing other privileges. Individuals with annual income over EUR 30,000 were given the possibility of opting out from the compulsory insurance scheme.

Financing

The Croatian Health Insurance Institute was set up as a central financial institution responsible for collecting compulsory insurance contributions and financial means allocated from the state budget. Health providers therefore became directly dependent on contracting with the Croatian Health Insurance Institute. In primary care, medical teams (private or organized as part of health centres) contract services based on the number of patients. Providers that are responsible for carrying out health programs, ambulatory or hospital treatment base contract on standards and price lists according to which they will be reimbursed in a form of fee for service.

Since management and financing were formerly interconnected, the new legislation regulating the activity of the Croatian Health Insurance Institute clearly defined its function as a financial body for collecting and distributing financial resources. This made financial activities economically viable and provided the Government with direct control over the system.

Specific outcomes and experiences

Reform of primary health care

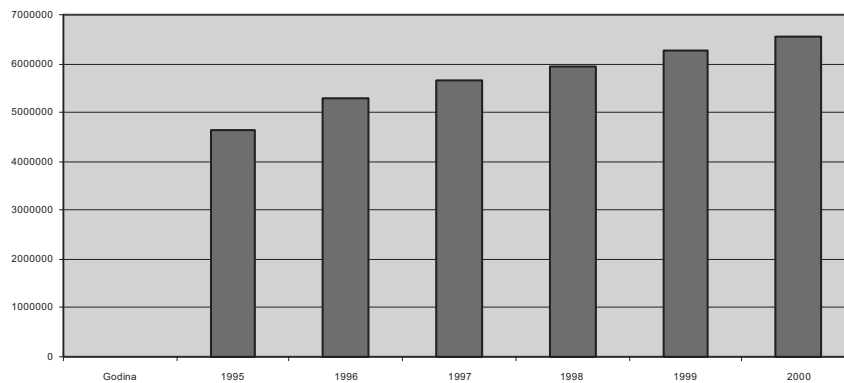
The reformed system was considered adequate enough to meet the needs of the population. Also it was designed in order to provide services to 90% of the demands for health care. The reform program included measures to address the majority of the problems. However, solutions and reforms implemented were not successful.

One of the key ideas the health reform was based on is privatisation, with market relations playing an essential role in improving quality. In order for privatisation to be carried out the existing health centres had to be disintegrated and their public health services organized into separate institutes. Thus, mostly those services

that could be privatised remained in health centres (general practice, dentist, paediatrician, gynaecologist, home care, biochemical laboratories). Instead of selling facilities and equipment to doctors, privatisation was based on the lease model: doctors leased the existing offices under privileged conditions and signed the contract as independent legal entities with the Croatian Health Insurance Institute. Doctors are therefore self-employed and do business independently. Although the onset of the reform was marked by difficulties and distrust, by 2000 over 80% of general practices were privatised by lease model (6).

The doctors were stimulated to compete for larger number of patients through reimbursement by the capitation fee model. At the same time, they not only lost the stimulation to provide comprehensive health care but also narrowed the range of services they provided in order to save financial means. Patients were kept satisfied by referring to secondary health care providers: specialist offices and hospitals (4). (Figure 4)

Figure 4 Number of referral notes to specialist from General Medical Service (1995 - 2000)



Source: Dzakula A, Oreskovic S, Brborovic O and Voncina L. Decentralization and Healthcare Reform in Croatia 1980-2002 (4)

Here are the data to make our point: the number of home visits by general practitioners in 2000 was by 38% lower than in 1990.

During the period of intensive privatisation from 1995 to 2000 the number of referrals to specialists grew by 16%. The most dramatic change might have occurred in preventive and regular examinations: from 1990 to 2000 their number fell by 78%. Furthermore, privatisation resulted in loss of family medicine specializations, which dropped by 90% compared to the period prior to 1990. Thus yet another problem affected the already shaken system. In other words, all the 1990 difficulties referred to are still present. They only have much greater impact.

Such reforms since the period from 1993 to 2000 (and 2002) failed to bring improvements in primary care. Measures introduced to change the situation failed, too. So general limitations were posed on the number of referral notes and prescriptions to be administered by GPs. Physicians whose population included larger number of elderly and chronic patients were forced to reduce quality of their services. Some patients were thus deprived of referral to specialist on no grounds. In order to avoid such cases, physicians were allowed additional referrals upon request. Co-payments had a negative effect on the poorest and given the economic regression, massive unemployment and increase in the number of the retired; these measures were not socially accepted. What started off as administrative measure of restriction resulted in inability of secondary care to render services to all users. Long waiting lists were created, which slowed service rendering and repelled patients.

There are four causes that lead to increased demand for secondary care:

- aging population
- technological advance in medical science
- financing model of GPs
- organizational solutions in primary care.

From 1981 to 2001 the rate of population over 65 years of age increased from 12.2% to 15.7%, meaning that the population of this age group increased by 28.6% (7). Ageing population play an important role in increased demand for health care.

Development of technology, new diagnostic and treatment methods increased possibilities for disease treatment and control,

leading to overall rise in demand for specialist care. Aging population and technological advance are the two factors inseparable from any changes in health system. The key issue remains, however, to what extent can changes in the health system affect those factors.

The health financing system (solely through per capita financing) proved inefficient and failed to encourage GPs to broaden the range of their services. However, the key difficulties are still related to organization of primary care:

- patients overload per GP
- lack of adequate diagnostic support
- lack of co-operation among GPs
- incompetence of primary health physicians due to a lack of specialisation
- big patients demands (4, 8)

The number of patients per GP range from 1000 to 2200, depending partly on population density and partly on local organizational and geographical settings. Some GPs have a daily quota of 60 patients, which is an insurmountable obstacle to quality assurance. Nationally average number of patients per GP does not necessarily indicate large number of patients but uneven patient's distribution remains as impediment to expected quality service.

Health reform ruled out health centres as diagnostic support for GPs. It resulted from general reorganization of health centres and lack of investment in equipment, which in its turn led to patient referral to hospital treatment or direct specialist care. For the patient hospitalisation meant complete diagnostics and specialist examination (with only one referral note).

Privatisation of general practices discouraged co-operation. Consultations with counterparts and "another opinion" sought in the same institution were substituted for referral to specialists.

All activities previously undertaken by GPs, such as work with patients in their communities and homes, were put aside and narrowed to practice in their offices. There was poor co-operation with community nurses which resulted in lack of efficient control of chronic patients and caused their unnecessary presence in doctor's

offices. Such situation was strongly felt in health education and preventive programs.

Preventive programs in community

The community nursing service is organized as a network of health professionals providing care for vulnerable population (infants, elderly, chronic patients). However, their co-operation with the primary health practitioners is not satisfactory. Due to large number of patients and lack of stimulation to work actively with them, primary care practitioners do not carry out adequate preventive and public health programs. Even though it is proven that savings are possible through preventive programs, in real life situations it does not work. The existing model is designed to focus physicians on treatment of some acute diseases, leaving the responsibility for most therapeutic treatments and surgery to specialists. Preventive programs, especially those targeting on chronic diseases are complex and difficult to implement. The results yielded by these programs are slow and they show results over a large period of time. Therefore, if the model is designed to foster immediate goals such as securing sufficient number of patients as cost-effectively as possible, preventive programs are not in focus.

Furthermore, physicians' co-operation with community nurses is far from being satisfactory. Such attitude of primary health practitioners is best illustrated by figures: 38% fall in home visits and 50% drop in preventive program from 1990 to 2000 (4). Lack of co-operation in primary health care is evident both in the cases referred to and generally in population assessment.

Decentralization

The 1993 legislation defined the model that cedes ownership over primary and secondary care (general hospitals) to local authorities and truly enables their management. Local authorities (Counties) are owners and have majority of votes in health care provider Managing Boards. Managing Boards appoint Directors as executive function in management. Thus decision-making remains at the county level of population around 150,000 people.

Difficulties arise with financing. Even though the management system was “decentralized”, the government kept strong control over finances. Overall health insurance and a part of budget allocations are carried out through the Croatian Health Insurance Institute, central state-owned agency. It was a period of economic and financial crisis and health care providers generated their income almost entirely through contracting with the Croatian Health Insurance Institute. In other words, the Croatian Health Insurance Institute had complete control over health care providers. Despite their ownership, local authorities could not do much due to lack of finances other than those provided by the Croatian Health Insurance Institute. Through service-pricing and tight-budgeting the Croatian Health Insurance Institute limited income of health providers. The government earmarked finances for investment and maintenance in order to keep the system going, but these were also available to health care providers through the Croatian Health Insurance Institute. Due to this system organization and state interventions to meet obligations of health care providers, rational management was obstructed, turning hospital management into obsolete and inefficient routine.

Privatisation

Privatisation is commonly considered one of decentralization measures. Such were the expectations when reforms were introduced in primary health care. Private practices were expected to raise the level of their services and improve primary care, but they did not meet the expectations. It resulted from central and uniform control of financing by the Croatian Health Insurance Institute, i.e. through capitation fee which did not stimulate work. Another difficulty arose when privatised practices separated from primary care system, destabilizing integrity of approach in primary care. In the absence of appropriate regulatory mechanisms the model proved inefficient.

Local authorities

The issue of real decentralization was addressed after 2000. As hospital system was tightly connected at the national level attempts are made to co-ordinate standards of overall hospital services. This creates opportunity to cede part of activities and finances from the government to local authorities. It mostly refers to resources for investment and maintenance.

The health care system is decentralized as far as ownership is concerned. However, at the local level it is limited by laws and legislation governing its activities and on the other hand, by financing through the Croatian Health Insurance Institute. Additional limitations are health management skills available to local authorities. For example, development of population programs is not obstructed by state control and financing but by the lack of satisfactory professional and political leadership.

To explain the deficit in management we should look at organisation of county political and civil service of health care. In existing system, local authorities do own health care units, but at the level of management there are only a few people really in charge of health issues. A system is thus created where a group of 5-8 people (politicians and officers or civil servants) are responsible for activities of 500 to 1000 health professionals employed by providers at local level. If programs carried out by non-health professionals are added, local authorities lack the appropriate number of skilled personnel to co-ordinate all programs.

The reason for inability of stronger and far-reaching decentralization lies in disproportion of health management at the local level. Being unable to co-ordinate all activities in their region, local authorities cede management to each individual institution. Rigid legislation and financing prevent the health system from collapsing, but at the same time no space is left for quality management models to develop on the local level. Those would finally enable decentralization of a portion of health activities. Unfortunately, successful decentralization cannot be based on the existing model and human resources. It is hard to imagine a successful system in which the owner does not have sufficient resources and capacity to manage his goods, but must rely on assistance by state services.

Exercises

1. Based upon presented data and recommended readings create a list of:
 - priorities for national health reform
 - stakeholders

- possible partners
 - problems expected during reform processes
2. Analyse and describe the importance of public health professionals for planning process and reform

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Recommended readings:

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
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Module: 4.2.3	ECTS (suggested): 0,6
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Assessment of students	Student should prepare small group case presentation and short seminar paper (based on their individual overview) that will be assessed.

PLANNING FOR HEALTH: DECENTRALIZATION AND EMPOWERMENT 2000-04

Selma Sogoric, Aleksandar Dzakula, Ognjen Brborovic,
Luka Voncina

For Croatia, the transition to new forms of government and economic systems has led to the deterioration of public health services. As a result of a decentralization process of the health sector which started at beginning of 2000, the local County Governments took over public health planning responsibilities. The Public Health System was during 1990-ies mostly centralized. This paper describes the evolution of activities aiming to strengthen the local public health planning capacity at the county level.

The World Health Organization's "Urban Health/Healthy Cities" Program in Europe provided Croatia with an early model for developing new social structures and organizational relationships to improve local public health system (1). The initiative recognized the importance of political will and intersectoral alliances and strove to develop participatory mechanisms. This means that individuals, voluntary associations and city governments could become aware of local public health issues, understand them, and make common decisions on problem solving. Unfortunately, the Healthy Cities experience has remained quite isolated and the value underestimated by the decision makers from the county and national levels. Public health professionals involved in the Healthy Cities project have drawn the conclusion that future commitments at county level would result in more appropriate policy making (2)

Actors in the process

In the summer of 1999, directors of the Motovun Summer School of Health Promotion invited a panel of 25 Croatian public health experts to review existing public health policies and practices at county level. The group used an assessment tool called the "Local Public Health Practice Performance Measures Instrument", which had

been developed by the Public Health Practice Program Office of the U.S. Centres for Disease Control and Prevention (3). Faculties from the Andrija Stampar School of Public Health adjusted the instrument to fit into the Croatian context and translated it into Croatian language.

Methodology and Implementation

The expert panel identified the following aspects as the weak points in existing public health policies and practices at county level:

- priority setting and policy formulation
- strategy formulation and comprehensive planning for solving priority issues
- coalition building among community groups and other stakeholders
- policy evaluation, an issue caused by the lack of clear objectives leading to the impossibility to measure their achievement
- missing analyses of existing health resources.

In 2001, Open Society Institute, New York financially supported and facilitated the ongoing collaboration between Andrija Stampar School of Public Health (University of Zagreb Medical School) and the US Centre for Disease Control and Prevention. Two faculty members from Stampar School attended the CDC's Management for International Public Health course in Atlanta. Returning to Croatia, they developed a unique training program, Healthy Counties, aiming to assist counties to assess population health needs in a participative manner, set up priorities, assure the provision of the right types and quality of services (better tailored to the population health needs). The program includes a multi-disciplinary and intersectoral approach, permanent consultation with community ("bottom-up" approach) and use of qualitative analysis. The curriculum was developed as a combination of well recognized management tools, public health theory and good practice together with the use of SMDP's Healthy Plan-it™ material (explain and put the reference). Program's main goal was to increase the planning capacities at county level and to provide more effective public health services (4).

After two months of consultations with stakeholders like the Ministry of Health, Ministry of Labour and Social Welfare, County Governors, National Institute of Public Health and Andrija Stampar School of Public Health, officials reached consensus about the aims and content of the program. A "learning-by-doing" (explain) training approach was considered to be the best way for public health capacity building and strengthening of collaboration between different stakeholders. All trainees understood from the outset that training inputs were expected to yield measurable outputs within a few months. Each county team was expected to plan and conduct assessments, and elaborate a County Health Profile and a County Health Plan.

Strategy development – professional empowerment

Teams from three counties participated in a cycle of four 4-days workshops lasting a period of four months. Each County team was composed of 9 to 10 representatives: at least three from the political and executive level (County Councils and Departments for Health, Labour and Social Welfare), three from the technical level (County Institute of Public Health departments, Centre for Social Welfare); and three from the community (NGO's, voluntary organizations and media). In order to maximize the participative nature of the workshops, the number of trainees at any training activity was limited to 30. Since mutual learning and exchange of experience was an important part of the process, each cohort was composed of three counties from different parts of Croatia with different degrees of local-governance experience. The Government supported the direct costs of training (training package development, teaching and staff fees) and the counties covered trainees' lodging and travel expenses. A different county hosted each workshop and provided the training venue (5).

Planning and training - description of curriculum

Each cohort from different counties went through the following curriculum:

Workshop 1 – Needs Assessment (4 days intensive training)

County team members reviewed the core public health functions and practices, and became familiar with participatory needs assessment approaches, methods and tools. Each team developed an approach for the health needs assessment of their own county and decided on ways to involve citizens. Considerable attention was devoted to convey management and group management skills, especially time management and team building. Homework assigned to the county teams for completion prior to the next workshop consisted in creating a draft version of a County Health Profile. To accomplish this, the teams had to use one or more methods of participatory needs assessment, identify appropriate sources of information inside and outside the health sector, select relevant county health status indicators, and collect the data needed.

Workshop 2 – Healthy Plan-itTM (4 days intensive training)

Using the educational software "Healthy Plan-it", developed by the CDC's Sustainable Management Development Program, county teams were guided through a health planning process. They were first introduced to different techniques for setting the priorities resulting from community health needs assessment, followed by problem-solving and decision-making techniques. Reaching consensus inside groups that consisted of very diverse professionals and not having met before, was a challenge. Consequently, the trainers introduced a set of different confidence building exercises and consensus reaching techniques that helped to achieve the desired team goals.

On the second day of the workshop, each team selected five county health priority areas and began to develop plans to address them. The teams learned how to identify and analyze problems, find the underlying causes of the identified problems, and identify options for problem solving within complex systems consisting of many different organisations. Prior to the next workshop, the teams had to identify "county health stakeholders" and carry out consultations on selected priorities. Consequently, each county team revised priorities, removed or added new ones and began drafting their County Health Plans.

Workshop 3 – Policy development (4 days intensive training)

This module began with an introduction to the process of building supporting groups. Participants learned interpersonal

communication, collaboration, advocacy and negotiation skills. Collaboration with the media, public relations and social marketing issues were addressed. The assignment consisted of setting up local expert panels in their counties in order to obtain their advice on appropriate policies and interventions to address their priority health issues.

Workshop 4 – Assurance (4 days intensive training)

Skills developed in this module included change management (e.g. building institutional capacity for change, conflict recognition and solving). Another training objective was to familiarize the participants with methods for analysing the wider environment. Presentations provided by representatives of the Ministry of Health, Ministry of Labour and Social Welfare and by the leader of the national health system reform project helped participants to broaden their perspective and view their county projects from a national perspective. Skills for project management (like resource planning, project implementation, quality assurance, monitoring and evaluation) were also part of this training.

Homework for this module was to finalize the County Health Profiles and County Health Plans for public presentation six months later. The assignment required the teams to present the results, as well as the underlying process for achieving them including the previous steps (like participative assessment of health status and needs, selection of priority areas, policies and programs to address priority health needs, implementation plans, monitoring and quality assurance mechanisms, and evaluation plans). Teams had to present their County Health Profiles and Plans at local levels to their own County Councils, and then at national level to other uninvolved counties and ministries.

Results

By the beginning of September 2004, six training cohorts have completed the Healthy Counties program (15 county teams and the city of Zagreb) and produced County Health Profiles and County Health Plans with prioritised health needs and specific recommendations made to address them. In nine counties, the County Councils accepted and approved the strategic health documents and five of them secured funds for project implementation.

Further training focuses on the establishment of a trainee team selected from the Healthy Counties project student's cohorts. The trainees were organised as 'troikas,' meaning groups of 3 people in key positions at county levels: one elected official, one civil servant from the county administration, and one professional from county public health institute. The troikas aimed to establish links between their own county teams and other counties, as well as with trainers from Stampar School. During 2003/2004 troikas met on several occasions and received additional training on the following topics: Evidence based public health - Programs for breast cancer early detection and treatment, Integrated (medical and social) care for the elderly, and Total Quality Management – as a tool for managers in health sector.

Evaluation and follow-up

A tutorial system of guidance and monitoring was introduced after the fourth workshop to preserve the commitment of the team members. County team coordinators met mentors monthly and follow-up workshops on county health policy development were held every three months. Alumni from the first cohort became trainers for the second and third cohorts, providing new trainees with practical advice and guidance from recent graduates of the program. Expert help and support to the counties was provided by the faculty on request throughout the process of development of the County Health Plans.

Conclusions

The shift from a socialist government with centrally planned economies to more representative governments and market-based economies is taking place rapidly throughout the Balkans. The simultaneous process of decentralization and health sector reform had imposed great pressures on local governments to better plan and manage their public responsibilities. Even though local governments are faced with this new challenge, they are also presented with greater freedom in selecting priorities, allocating resources, and satisfying local health needs. These opportunities require increased capacities at the local level to identify and prioritize needs, plan, implement and evaluate interventions.

The Healthy Counties program has built county capacity to assess public health needs in a participatory manner, to plan for health and assure provision of the type and quality of services better tailored to local health needs. The program's benefits in Croatia are extending both below and above the county level. It is providing support for the more localized Healthy Cities project, as well facilitating a paradigm shift in national Ministries' mindset that a centralized "one-size-fits-all" approach is no longer sufficient. The Healthy Counties project has successfully engaged stakeholders from political, executive, and technical arena. It involved a variety of community groups (youth, elderly, unemployed, farmers, islanders, urban families, etc.), local politicians, and institutions in the needs assessment, prioritizing and planning for health cycle. County Health Plans are accepted politically (by County Councils), professionally and publicly. Proposed interventions for health improvements rest on local organizational and human resources and are (at the moment in five Counties) financially supported by the County (Public needs) budgets. With the experience gained through this program Croatian faculty are extending their assistance to neighbouring Balkan nations which are experiencing the same post conflict transitions to different forms of governments and economic systems. The first one to try out and test nationally our training model (since June 2003) was Republic of Macedonia.

Exercises

1. Based upon presented data and recommended readings create a list of:
 - responsibilities, duties or managing networks that should be decentralized
 - stakeholders on the local level
 - possible partners
2. Analyse and describe local community participation

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Case study: Strategy on Mandatory Health Insurance Development in Republic of Moldova
Module: 4.2.4	ECTS (suggested): 0,2
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Keywords	Population health status, Health financing strategy, Mandatory Health Insurance implementation plan
Learning objectives	At the end of this exercise, students should: <ul style="list-style-type: none"> - be able to evaluate the need for a health reform strategy - be able to describe the development process of the mandatory health insurance strategy - be able to design an implementation plan
Abstract	This course covers the following topics: <ul style="list-style-type: none"> - The Need for Health Strategy <ul style="list-style-type: none"> - General Aspects concerning Moldova Population Health Status (Morbidity, Health Determinants) - Aspects concerning Health System (delivery of services, financing, stewardship, resource generation) - Health System Strategy Development Process - Mandatory Health Insurance Implementation
Teaching methods	Interactive group discussion of each subchapter, revealing the key concepts and main conclusions. Strengths and weaknesses of the strategy will be written on a flipchart.
Specific recommendations for teachers	This case study takes 3 hours of discussions. Another 4 hours will be destined to review electronic and printed literature in the field. (suggested ECTS: 0,2)
Assessment of Students	A short (max. one page) essay developing the main ideas selected during the discussions.

STRATEGY ON HEALTH INSURANCE DEVELOPMENT IN REPUBLIC OF MOLDOVA

Valeriu Sava

I. The Need for Health Strategy

The Republic of Moldova became independent in 1991 after the collapse of the Soviet Union. Until independence, the Moldovan economy was highly integrated into the USSR economy through the mechanism of the inter-republican division of labour and economic ties with the other union republics. The break-up of the USSR's economic zone led to the collapse of the established system of economic ties, to emerging of obstacles to the movement of goods, and restrictions on access to the emerging markets of the newly independent states. The process of state building and self-determination was going in a context of social and economic crisis, and radical transformation of the economic system. Dramatic reductions in public spending brought on by the 1998 fiscal crisis combined with growing demands for health services by an increasingly ageing and unhealthy population are creating urgent pressure for system wide reforms.

Because of its geographical and geo-economic and geo-political location, Moldova has specific features which have amplified its vulnerability to poverty. These include regional economic crises, natural disasters particularly of drought, political and social instability, and territorial separation, combined with fear for the future arising from experience of its recent history. As a result of an internal armed conflict in 1992, the country has been divided in two entities, with the emergence of the self-proclaimed "Transnistrian Republic" on the left bank of the Nistru River, situated on the East part of Moldova. This partition within Moldova complicates the collation and interpretation of statistics. The demographic data, the description of the health-care system as well as the economic performance data are relate only to the area controlled by the Moldovan Government (1).

I a. General Aspects concerning Moldovan Population Health Status

After 1991, poverty and visible decline of living standards had a deep negative impact on the health status of Moldova population, together with obvious inequalities in health.

Ia.1. Demographic Aspects. Moldova's population in 2003 was estimated at 3.61 million¹, of which 47.9% are male and 52.1% female. About 41.4% are town-dwellers, including 662,200 residents in Chisinau, the capital of Moldova.

There has been a substantial decline in the birth rate over the last 14 years (from 16.5 live births per 1,000 in 1991 to 10.1 in 2003) (2). The 1995 economic crisis pushed Moldova on the verge of a public health crisis and since 1998 the country has experienced a negative population growth rate.

Infant mortality rate has significantly diminished from 19.8 infant deaths per 1000 live-born in 1991 to 14.4 infant deaths per 1,000 live-born in 2003. Nevertheless, this indicator has still a higher level than in other European countries. Maternal mortality is still high, 21.9 maternal deaths/100,000 live-born being reported in 2003. The standardized overall death rate is among the highest in the Region. The main causes of death in Moldova are diseases involving the circulatory system (including stroke), gastrointestinal tract infections, 'external' conditions (including accidents), malignancies and diseases of the respiratory system.

Life expectancy at birth is one of the lowest in Europe. For women it is 71.6 years (2003) and is well below the NIS average (2).

Ia.2. Morbidity. There are important epidemiological and clinical management links between the main causes of morbidity and mortality in Moldova. Many of the chronic cardio- and cerebrovascular diseases such as hypertension, are responsible for both high rates of morbidity and mortality. Moldova is the third worst of all European and CIS countries in terms of incidence of breast and colon cancer, with the exception of Armenia and Lithuania (3).

¹ The population of the east region (self-proclaim Transnistrian Republic) is not included.

Many regions of the country, and pockets of the population, continue to have a high burden of disease from infectious and parasitic diseases that are characteristics of developing countries. The breakdown of the public health system has weakened the ability to respond to these problems and the lack of drugs has exacerbated the situation. A large and growing share of the population faces the epidemiological profile of a developed country with a high proportion of morbidity due to chronic conditions such as cardiovascular disease, cancers and accidents, but at the same time there are emerging threats of TB and HIV/AIDS.

Tuberculosis is one of the major public health problems. The TB epidemic has seen constant growth over the last decade. This is due to worsening economic and social conditions that increase susceptibility to disease and reduce access to care. Other contributors were improper identification and treatment of TB patients as well as a shortage of effective anti-TB drugs. According to official data, TB incidence increased by 53 percent during the 1990s and this trend has accelerated even more in the last couple of years. While in 2003 the reported number of new cases was 111.2 per 100,000, the experts estimate that the real incidence is at least 2 times higher, given the high proportion of destructive forms and mortality from TB.

The first domestic case of HIV infection was diagnosed in 1992. The infection penetrated rapidly in the intravenous drug users' groups (IDUs), who contributed to the highest HIV incidence in 1998. At the same time, the HIV/AIDS epidemic is escalating after a period of very low prevalence. As with other members of the CIS, HIV/AIDS was maintained at a very low level (prevalence less than 0.001 percent) during the first ten years of the epidemic (1987-1996). However, from the mid-1990's, there has been a surge in HIV infections. HIV/AIDS prevalence has since increased by more than 25 times to reach 0.2 percent among adults of the 15-49 age group. As of 1 January 2004, 1,695 HIV-positive persons were registered and 70 people have died of AIDS. The epidemic of sexually transmitted disease peaked in 1996, when the number of new syphilis cases reached 200 per 100,000 (a twenty-fold increase compared to late-80's levels), with a decrease during the following years, down to 80.7 in 2003.(2)

Ia.3. Health Determinants. Health status is strongly affected by the synergic action of biological, environmental, lifestyle determinants together with the influence of socio-economic and health care conditions. Poverty, alcohol and tobacco are the key determinants in the health of most Moldovans. Morbidity and mortality from these factors account for a sizeable burden on society and on the economy.

Moldova is one of the poorest countries in Europe and approximately 55% of the population live on income below the poverty line of US\$ 2.15 per day (in PPP terms) (1). The most affected population groups are: abandoned, severely neglected or abused children; families living under chronic unemployment; large families having many children, etc. The average salary was equivalent to US\$ 40.3 in 2001, not covering half of the estimated minimum consumption basket. Income inequality is high, as are the disparities between Chisinau, the capital of Moldova, and the rest of the country. The rural population comprises over two-thirds of the poor. A very serious strain on Moldovan society is imposed by labour emigration: it is estimated that 600,000 to 800,000 persons of working age work permanently abroad, supporting their families back home. The UNDP Human Development Report ranks Moldova 108-th of 173 countries listed by the Human Development Index (4).

Among environmental risks, air pollution and industrial waste are not of major concern, but important issues are the quality of drinking water (especially in rural areas) and the problem of organic waste in villages.

I b. Aspects concerning Health System²

The WHO defined the following main functions of the Health System: *Delivering services, Financing, Resource Generation and Stewardship*, which aimed to improve the health status of population, to reduce financial risk and improve the responsiveness to the population's expectations (5).

b.1. Delivery of Services. As with other post-Soviet countries, at independence, Moldova inherited a centralised health system based on the Semashko model. The model was characterised by an extensive infrastructure with a curative focus and a large number of health

² The situation before January 2004

professionals.

The delivery system consists of three distinct tiers: primary, secondary, and tertiary care. PHC underwent significant reform since 1997 and is now based on general practitioners, called family doctors, who work individually in small settlements and in Family Doctor Centres, situated in bigger communities and in towns. Nurses are part of Family Doctor teams; specialist out-patient consultations are performed starting at the district level.

Secondary in-patient care is provided by general hospitals. In response to a profound fiscal crisis in 1998, the health care system went through dramatic consolidation in the next years with cuts in the number of hospital beds, activity levels and personnel. The Moldovan health care system is predominantly a public system: central government or local executives are the owners of facilities and employers of health care staff. Privatization of pharmacies was allowed in 1993 and aimed at overcoming the critical shortage of drugs. Most of pharmacies are private and concentrated in towns, whereas a number of rural settlements do not have access to a pharmacy. Dentistry is almost totally private, too. Private out-patient clinics provide diagnostic and non-essential treatment services such as physiotherapy and cosmetic medicine. There are no private hospitals; however, in some public facilities patients can purchase additional services offered by private firms, such as improved hotel conditions.

There are also a number of out- and in-patient facilities belonging to other ministries and departments (“parallel services”); the most sizeable are those of the Ministry of Transport, Ministry of Internal Affairs and the State Chancellery (6).

The health care delivery network has dramatically changed especially after 1998. The fiscal crisis that has plagued the sector since has forced local authorities and the Ministry of Health to reduce the number of health care facilities and to close unnecessary infrastructure at the remaining hospitals. Between 1996 and 2000, 195 hospitals were closed reducing the number of hospitals to 65, and the number of primary care facilities was reduced from 979 to 800. The total number of hospital beds has decreased more than two times since 1991; however, the restructuring has not followed a clear set of priorities and was mostly the result of closing rural hospitals and of “physical

elimination” of beds in others and did not address the issue of hospital infrastructure as such.

Ib. 2. Health sector financing. The health sector was financed mainly through general taxation. Revenues from national level general taxes are used to finance the Ministry of Health. The amount of funds to be allocated centrally to the Ministry of Health was determined annually according to the “Annual State budget of the Republic of Moldova”, approved by the Parliament each fiscal year (6). The Ministry of Health used its budget to pay for national vertical programmes, such as immunization, mental health, tuberculosis and HIV control, to fund republican hospitals and other central institutions, including teaching and research institutions and centres managed by the Ministry of Health. The expenditure for these programmes and institutions accounted for 90% of the Ministry of Health funds. The remaining 10% of the budget was used to finance the parallel health services managed by the Ministry of Interior (including the penitentiary system), Ministry of Defence, and the Railways. A parliamentary Committee on Health and Welfare monitors the activities of the Ministry of Health.

Local health care institutions and providers were financed mainly from local budgets, made up through general taxation, collected at district level. Regions also received budget transfers from the Ministry of Finance to supplement local budgets for health and each year the local governments (district or municipal) agreed with Ministry of Finance the level of funds to be allocated to the district.

As usual, up to 85% of local health budget went to hospitals and only after 1998, when Ministry of Health issued a special decree, the allocation ratio between primary and hospital care became approximately 30%:70% (1). Services of parallel systems were funded from the budgets of their owners.

In the ten year period since 1993, in real terms, the budgetary spending on health care has declined 62 percent as a consequence of reduced economic activity and decline in the GDP. The Moldovan public sector health expenditure was around 3% of GDP during the last three years before January, 2004 and was equivalent to only US \$12 per capita in 2001 (1). The situation worsened because only 65 percent of public funds were actually available to purchase health care

services; thirty-five percent had to be used for clearing up arrears incurred in the past.

The decline in public funds for health care services has resulted in informal payments increasing and the introduction of a formal set of user fees and private financing. Formal user charges were introduced to create transparency with payments to providers (in an attempt to reduce informal payment made to providers) and also to raise additional source of funds for the health sector to partially offset the diminished funding from the public sector. It should be noted that out-of-pocket payments at the point of delivery became very significant and represented one of the biggest issues in the Moldovan health system after 1999, when user payment were introduced and apply to certain services and pharmaceuticals not covered under the Minimum Package guaranteed by the Government.

There were services for which patients pay officially in the hospitals according to the regulation in force (for example, certain amount per bed-day, laboratory tests, X-ray films and so on). These payments accounted for 19% of total health spending in 2002 (2). However, the biggest share of out-of-pocket health expenditure was incurred by patients in private pharmacies, since they have to buy all of their ambulatory drug treatments and most of medications during the hospital stay. These expenditures were difficult to trace and as usual they were not included in the aggregated figures of health spending. According to household surveys and informal estimates, private out-of-pocket spending was estimated to double total health care spending by contributing another US\$10 per capita.

At the same time, the available resources were used irrationally and inefficiently. The public sector has not been able to translate the savings from restructuring into improvements in access, quality and efficiency because of weak priority setting and poor financial management. Hospitals continued to consume the most of the system's resources but a big share (40-50%) of them was spent on utilities and not on patient care. Many hospitals operated at half or less of their operational capacity. There was an acute shortage of drugs at in-patient facilities; most hospitals possessed only few very basic centrally-purchased drugs and small quantities of donated medicines.

Health professionals were paid by salaries that vary depending

only on years of experience and didn't include the performance-based mechanisms. The average monthly wage of a doctor was equivalent to US \$35, and that of a nurse to US \$20 (3).

Ib.3. Resource generation. As a result of low payment and lack of incentives, the health care professionals often left the profession that created a huge inequity in the distribution of human resources with an excess in certain disciplines and in urban areas and relative absence in many rural communities. Over the past few years nearly 40 percent of personnel have left the system or have been dismissed. It was estimated that, in 2002, around 15% of rural areas were not covered by doctors.

Ib.4. Stewardship. The Ministry of Health was the main player in the system and retains overall responsibility for the health care system; its functions included policy development and quality control, together with the direct running of republican level institutions.

The Ministry of Health was also responsible for coordinating national vertical programmes such as immunization, mental health, tuberculosis and HIV control.

Responsibility for planning, financing and managing local primary health care, secondary care services provided at district and regional hospitals, and emergency services were delegated to the regional health authorities.

Public health services maintain a vertical structure and are accountable directly to Ministry of Health through the National Centre for Preventive Medicine. The latter has a network of territorial branches throughout the country, dealing with the immunisation chain, surveillance of infectious diseases and anti-epidemic response, environmental monitoring and health education activities.

A decline in resources, changes in public administration, and fiscal decentralization, have provoked a redistribution of responsibilities within the hierarchy of the system and weakened the chain of command. By devolving responsibility to local authorities without introducing mechanisms to improve accountability, reforms in public administration have weakened the role of the Ministry of Health and made it unclear how policy making, priority setting and

accountability are to be implemented in the system. A long time this situation was exacerbated by the lack of definition and vision of how the system should separate the functions of financing, purchasing, management and provision among central, regional and local providers. As the input-based planning system disintegrated, the role of government has not evolved to use incentives and accountability as the new tools of public administration.

In such conditions the overall health system's performance was perceived to be inadequate to meet the population's needs. The dual epidemiological profile, with the presence of diseases typical for developing countries (infectious and parasitic diseases) as well as a high rate of diseases typical for developed countries (cancer, accidents and cardiovascular diseases) posed a serious challenge in resource constrained environment.

One of the major problems was an unequal access to health care services caused by the financial crisis and deterioration of health services infrastructure. A household survey carried out by UNICEF in 1997 showed that the direct payments at the point of delivery represented a significant burden to the population and 33% of those surveyed could not access health services because of lack of funds (7). Evidence indicated that the increase in household out-of-pocket spending has had a larger negative impact on poor and low income households, consuming a larger portion of their household income and causing them to forgo needed care.

II. Health System Strategy Development Process

The financial constraints and the declining health status of Moldova population have made reforming of the health system indispensable. That required fundamental changes in the role of government as steward, in the way the system is financed, and in the organization and delivery of services.

The Government recognized that the main goal of health care reform in Moldova was the increase of the population access to the basic health services, and development of the financial protection mechanisms for citizen facing health problems. The first priority for the Government was the change of health system financing, considered as most important factor that promotes equity and

improves performance to any health reform program, and implementation of Mandatory Health Insurance (MHI) has been decided as key catalyst element for this change.

Introduction of the Mandatory Health Insurance scheme is aimed not only to generate more resources, but equally important, to transform economic relationships within the health system by shifting resources to more cost-effective and accessible primary health care and reducing excessive and costly infrastructure. Moldova is attempting to use the MHI as an instrument to improve efficiency and quality of health services rather than a means to raise all health system financing, realizing that in the transition years, health financing needs to be mixed and from several sources. A desired influence of MHI on quality improvement is expected to be achieving by introducing appropriate incentives and new reimbursement mechanisms based on output and outcomes to alter the behaviour of health care providers and consumers. Also, is expected the improvement of providers financial management and autonomy by contracting and sharing of the responsibility between payer organizations and providers and between Region administrations and those institutions.

II a. Key peculiarities of the Mandatory Health Insurance model. According to the MHI legislation the new system has the following main features:

- The health insurance contributions are set on a payroll tax of 2% of monthly salary payable by the employee and 2% by the employer.
- The state pays from the national budget per capita contributions (flat rate contributions) for inactive populations including students attending vocational training, full-time university students, children under the 18 age, and children in primary and secondary education, pensioners and disabled persons, and officially registered unemployed persons.
- The persons who are self-employed have to purchase an insurance policy themselves. The cost of the policy is equivalent to the average per capita cost of health care benefit package guaranteed by the MHI to the all insured persons and is established annually by the Government.
- The benefits for the insured were stipulated in Basic (Single) Program for Mandatory Health Insurance revised and approved annually via Government Resolution, which

includes: (i) emergency pre-hospital medical assistance; (ii) primary medical assistance; (iii) specialized ambulatory medical assistance; (iv) stationary medical assistance, and; (v) other services related to medical assistance.

- The National Health Insurance Company is the most important payer administering about 85% of all public health funds. It contracts with health care institutions to provide services within the defined benefit package. Family doctors are paid on a capitation basis plus performance bonuses, while hospitals are paid according to a ‘per-case’ rate with a ceiling on the volume of care.
- Ministry of Health directly finances preventive medicine services, strategic investments and centralised drug purchases, several components of “socially imperative” interventions, teaching institutions and administrative costs of health authorities.
- A change in the status of health care organisations, from budget-dependent agencies to autonomous public organisations, is envisaged. Institutions and providers are required to pass an accreditation process provided by independent National Accreditation Council for Health Care that was established in 2002.

II b. Historical background of MHI development. The original Health Insurance Law was approved in 1998, establishing the basic legal framework to operate health insurance as an autonomous, non-profit company (8). From 1998 onwards each government continued to highlight health insurance as a policy goal but little action was taken. The process was revived in 2002 when the National Health Insurance Company (NHIC) was founded and started working with Ministry of Health in developing the basic legislative and regulatory framework for the new financing mechanism (9). Government resolutions enabled the creation of 11 territorial branches of the National Health Insurance Company and defined the principles of the contract between the MHI and health providers on the basis of volume of activities included in Common Programme of Mandatory Health Insurance and prices set by the Ministry of Health.

The Government started the health insurance system in July 2003 with a pilot in one district and approved the 2003 budget with additional allocations for health insurance. During the pilot the MHI

contributions were established as 2% payroll tax for employers and the employees in the rayon. The MHI flat rate contributions for pensioners, children, students, officially registered unemployed were established equal to 12.8 USD for half years and the total amount of public funding of the rayon hospital after the merging of all health care institutions joined into one legal entity. At start of the pilot there was a deficit of approximately 40% in the number of family physicians in the rayon. With the introduction of the MHI this deficit was partly corrected by employing physicians in residency training. During the first three months of the pilot, the workload of PHC increased by 35 000 additional visits to the PHC physicians; the proportion of visits for rural citizens increased from 42% in year 2002 to 73% in year 2003. In the same period, the number of ambulance visits decreased substantially in comparison with the same three-month period in 2002.

In December, 2003, the Government passed a regulation defining services to be covered by the Mandatory Health Insurance and available only for the insured population. In addition, 21 national programmes, available to all Moldovan citizens regardless of insurance status, were identified.

II c. Mandatory Health Insurance Implementation. The national roll-out began in January 2004 with appropriate modifications to the Law on Mandatory Health Insurance (10). Changes in the Law also makes possible for individuals or legal entities to establish “medical institutions” to contract with the Health Insurance Company or its territorial branches.

There occurred promising positive changes in health care system during the first year of MHI implementation. According to Summary Mission Report made in December 2004 by the experts of WHO Regional Office for Europe (11), the main outcomes for the *health care system* are:

- the transformation of the old system of health care financing into the new one without any temporal disturbances for medical facilities functioning
- the increase of public funding of health care by 20% in real terms in 2004
- the increase of stability of public funding of health care

- the achievement of real balance between state guarantees of free health care and their public funding

The main outcomes for the *medical facilities* are:

- the increase of incomes
- the achievement of stability of public funding
- the acceleration of transfers of funds from budgets to facilities - The old way of funding medical facilities through the State Treasure was substituted by payments from the National Health Insurance Company through commercial bank accounts. It shortened the payment procedure from 2-3 week to one-two days.
- the increase of autonomy of facilities in spending their funds
- the creation of real incentives to the increase of efficiency of their activity – This is proved by the fact that the expenses of medical facilities for heating, electricity, water-supply decreased by 12.5% in nominal terms for 9 months of 2004.

The main outcomes for the *medical professionals* are:

- the increase of salary by 1.5 times for 9 months of 2004
- the creation of possibility to receive salary in accordance with real volume and quality of their work

The most important results of the reform have been noticed at the population level. There are evidences, that accessibility to free health care services really increased and the magnitude of informal payments decreased. MHI has improved the access of pensioners and disabled persons, children and pregnant unemployed persons to hospital services. The number of visits to the family doctors increased with 25% in comparison with 2003. Also, the access to emergency ambulance services has increased with 42% in rural areas.

During 2004, in Moldova the number of new-borns increased with 1,801 persons in comparison with 2003. There was registered a slight decrease of general mortality: during 2004 died 1,411 less persons than in 2003.

Infant mortality rate has significantly diminished from 18.3 infant deaths per 1000 live-born in 2000 to 12.2 infant deaths per 1,000 live-born in 2004 that is comparable with average European indicator (12).

Exercises

Students are assigned to compare the reform strategy in Moldova with similar ones in their own countries and discuss the strengths and weaknesses of both.

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Health Care Reforms in Romania
Module: 4.2.5	ECTS (suggested): 0,6
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Keywords	Health care, health policy, health care reform, health policy implementation, primary health care, social health insurance
Learning objectives	After completing this module students and public health professionals should be able to: <ul style="list-style-type: none"> • analyse the policy making process • identify factors influencing the policy implementation • understand the importance of strategic planning in implementation of health policies • make comparative analysis of different health care reforms
Abstract	The case study presents the general aspects of health reforms in Romania, stressing the importance of policy making related to major structural changes of the health system. In analysing the health care reforms, particular

	<p>attention is paid to the initial policies after December 1989, the changes introduced at primary health care level and the implementation of the social health insurance system.</p> <p>The analysis of the initial policies after December 1989 shows how prepared was the system for introducing radical changes. The study of the primary health care reform is a good example of introducing reforms step by step. It stresses the importance of “learning by doing” approach. The introduction of the social health insurance is an example of implementing change “over the night”. At the end there are discussed the general factors that influenced the pace of health care reform in Romania.</p>
Teaching methods	<p>Presentation of the case studies structured in three main parts: initial policies after December 1989, the changes introduced at primary health care level and the implementation of the social health insurance system.</p> <p>Structured discussions with case studies, group exercises.</p>
Specific recommendations for teachers	<p>The module may be structured as follows (0.6 ECTS credit): supervised time - lecture 3 hours; seminar 6 hours; structured group exercises 9 hours (unsupervised time 6 hours + assignment presentation and discussions 3 hours).</p>
Assessment of students	<p>An individual written essay on the main factors influencing policy making and policy implementation.</p> <p>Reports presented by each group.</p>

HEALTH CARE REFORMS IN ROMANIA

Cristian Vladescu, Silvia Gabriela Scintee

1. The driving forces of the main health care reforms in Romania

The Romanian health system has suffered two major structural changes in the last five decades. The first main change was brought by the communist regime in the 1950s, introducing the so-called Shemasko model which had very few connections with the tradition or with the real situation in Romania on that time. If health indicators in Romania were comparable with the rest of Europe in the 1960s, they declined in relative and absolute terms in the years leading up to and following the fall of the Ceausescu regime in late 1989 (1).

The second main change has been initiated after 1989, being considered as a reverse process of passing to a model also with foreign roots, but closer to that existing in Romania prior to the Second World War. In some aspects, both situations are comparable. They occurred along with the whole Romanian society transformation and in the context of general tendency of health reforms and social movements.

But which is the way a country should structure its health system? Who should be the people to decide which is the best health policy for a given system? These questions are being asked around the world. In some countries, the rapidly increasing costs in the health sector and the difficulties connected with accessibility to health care are the forces that drive system reform. In the other parts of the world, the former communist countries have the tendency to adopt measures for promoting free market economy in the health sector as a reaction to the decades of centralism and authoritarianism from the communist period. In many developing countries health sector reform emerges from the measures of macro-economical adjustment, which are adopted by the governments, by their own will or under the influence of the international financial bodies.

In spite of the general tendency of reforming the health care sector, finding the optimal structure of the health system has proven to

be a very difficult task. Most countries define three major objectives for their health system (2):

- universal and fair access to a reasonable package of health services
- control of costs of health services, and
- efficient delivery and allocation of resources

In spite of the relative general agreement on the above mentioned objectives, it is very difficult for most of the countries to establish their relative weight and prioritize them. This aspect can be discussed only after the social-economic objectives and priorities of a country were established, so that the health system can function properly. Another important factor for the development of health systems is the ideological factor, most of the debates on this topic taking place between the supporters of the free initiative as a functioning base for the health system and the supporters of the governmental planning for this. Another major obstacle in the way of finding the answer to the question concerning the best health system for the country is represented by the relative lack of information concerning the functioning and performance of different health systems (1). Romania makes no exception from the dilemmas and general tendencies arisen in the health policies field.

In analysing the health care reforms, particular attention will be paid to:

- the initial policies and grounds for change after December, 1989
- primary health care reform
- social health insurance system

2. Initial policies and grounds for change after December 1989

Health reform in Romania was a political option. Policy change has occurred as a result of a series of influencing factors:

- the government has embraced the general concept of a free market economy,
- the rapidly escalating costs of health care caused by advances in medical technology, the ageing of population and the rapid inflation in medical prices,
- the poor performance in terms of health indicators and quality of care

- activities and policies of the international organisations, NGOs and donor agencies.

Following the political changes of December, 1989, the overall approach of the new government was to make preparations for the process of change but not to dismantle the existing system until a new health policy had been adopted. Between 1990 and 1992 the health care crisis grew steadily worse, and the dialogue between the unions of health professionals and the national and sub-national administration became increasingly more difficult. Faced with severe and complex problems, the main difficulty for health authorities did not consist in identifying the needs, but especially in establishing their hierarchy (2). In 1991, the World Bank has taken the role to assist the Government in establishing the priorities and the domains of investments, taking into account our economical background, through a loan of 150 million US\$ approved by Romanian Government to support a Health Rehabilitation Program.

Under the Health Rehabilitation Program, Romanian specialists, with the support of foreign experts, produced in 1992-1993 "A Healthy Romania" Report. The Report proposed the framework of a strategy for the reform of health services (3). The more or less explicit major aims of the strategy were the following:

- reduction of the state monopoly, and of its ownership role, that enabled it, at the same time, to finance and acquire, to provide and to manage health services
- to introduce social health insurance and improve the financing of the system
- to decentralize the system, increasing the political and strategic roles of the Ministry of Health
- to ensure management autonomy for the hospital, and the development of independent medical practice
- to develop primary medical care and free choice of a family doctor
- to develop a mechanism for accreditation, and of mechanisms for quality assurance
- to adjust personnel policies in accordance with national needs and European exigencies

Although based on recommendations from the World Bank, the elaboration of the strategy, and the decision-making, lacked transparency, and was unclear with regard to methodology (2). In the policy making process have participated mainly the central health authorities. Representatives of the medical corps (professional unions, professional associations) have participated only when the implementation ways of the decisions already made by the Ministry of Health were discussed, and the users were not consulted at all. This approach had negative consequences for the policy implementation process. In fact, the very World Bank's Operations Evaluation Department rated the whole project outcome as "moderately satisfactory" on a six -point scale (highly unsatisfactory, unsatisfactory, moderately unsatisfactory, moderately satisfactory, satisfactory, and highly satisfactory). This illustrates the challenges to face when supporting sector reform in a country with relatively weak institutions and an unstable macroeconomic environment (1).

A second big project under the Health Rehabilitation Program developed different decentralization plans to be implemented in four districts. The project was carried out from 1992 to 1994 by four different teams involving Romanian and external consultants. The teams were from UK (Nuffield and King's Fund), Denmark and Sweden, each of them working with a different district. The initial idea was to implement those different options and to compare them and to see which of them was most appropriate. These decentralization plans were never implemented but instead, between 1994 - 1996 pilot health reforms were implemented in Romania in 8 districts, building on some of the recommendations of technical assistance carried out in 1992-1994.

Besides these projects considered as preparatory for further reforms, in the following years (1995-1997) there have been made some developments in what concern the legislative framework.

Legislation was passed in 1995 to establish the College of Physicians. Elections have been held for this body, but they have been confirmed by the government only after the 1996 election and the College of Physicians started to function from 1997. The Social Health Insurance bill was approved by the Senate in 1994 and by the Chamber of Deputies in mid 1997, and its implementation started in

1999, but the numerous amendments changed significantly the initial philosophy of the law (2).

3. Primary health care reform

During the communist era, the Romanian primary health care system was not functioning properly being starved of resources that were directed mainly toward expensive secondary and tertiary inpatient hospital care. Even organized in a countrywide network of about 6000 dispensaries, primary care was relatively neglected. Most outpatient care was provided by specialists in outpatient polyclinics, or in rural health centres. After hours, patients relied on national ambulance services to provide primary care (such that over 90 percent of ambulance visits were for primary care in Romania). General practice doctors were relatively few, received only basic medical training, and had little professional prestige (2).

Primary health care reform began on a pilot basis in eight districts (out of 41) in 1994 (see Box. 1) with a new way of financing, a shift in responsibility from hospitals to the district health directorate (DHD) and the introduction of contracts between DHDs and general practitioners (as individuals or groups). The reforms assigned general practitioners a gate-keeping role and introduced competitive elements through patient choice and new forms of payment. The wage system for general practitioners was replaced with a mix of weighted capitation and fee-for-service payments (4).

The stated objectives of the changes introduced at primary care level were:

- enhancing the role of primary health care and ensuring the split between primary and secondary services regarding organisations and financing
- universal population coverage with a basic package of services
- improving access to primary health care services
- individual choice and participation
- improving quality of care and introducing competition
- consumer satisfaction related to primary health care services
- changing the status of GPs'
- increasing autonomy at local level

Box 1 Romania Pilot Decentralization Program

The reforms described in the case were a response designed in support of one of the key objectives set for health sector reform in Romania in the early 90's, i.e. shifting towards independent providers both in primary and secondary care and developing new payment mechanisms for these providers. This approach was intended to address some of the perceived problems of the Romanian health sector: inefficiency resulting from the imbalance between hospital services and primary care in favour of the former, inequity due to limitations of access to basic services, resulting from inadequate staffing (especially in rural areas) and funding for primary care, lack of choice for patients in primary care. Income of staff was low (also compared to average income in the economy, ratio was much lower than in OECD countries) and was fixed according with professional seniority and years of service - no link existed between income and the volume or quality of services provided. Primary care facilities were part of the same organization with the local hospital and polyclinic, thus sharing one budget allocation, with decisions made by hospital managers, always hospital based clinicians. In an environment of overall scarcity (Romania's public spending on health services has fluctuated narrowly around 3% of GDP from 1990 to 1997) and given the distribution of power in favour of hospitals, allocations for consumables, drugs and equipment were even more limited for primary care centres than for other levels of care.

In the last quarter of 1994, based on a Government Decision (no.370/1994), the 8 pilot districts of Romania's 40 districts (covering 4 million people) introduced changes in the provision and payment of general practitioners' services. The plan for piloting was received enthusiastically by district staff, and generally welcomed by doctors, but had only lukewarm support initially from Ministry of Health. It is notable that the pilots took place at all.

The government had previously resisted piloting, particularly experimentation with private sector approaches to service delivery, and the pilots were only able to proceed in 1994 once Government and Parliament passed specific legislation authorizing them. The system switched from the fixed allocation of patients to GPs according to residence to the free choice of the GP by the population. Payment moved from fixed salary (set according to professional rank and seniority) to a combination of age adjusted capitation (about 60% of total), fee-for-service items (related mainly to prevention, mother and child care, early detection and follow up of major chronic diseases) and bonuses related to difficult condition of practice, and professional rank (about 40% of total). Contracts of GPs were held by District Health Authorities. District health authorities established contracts with doctors, ending their status as hospital employees. Terms of

service introduced new requirements for 24 hours availability for emergencies. The contracts specified primary care services to be covered (which continued to be free), and patients were allowed to choose their family doctor. Family doctors were expected to enrol between 1500 and 2500 patients each.

An evaluation of preliminary pilot experience was carried out in 1995 (5). This was too early for an effective evaluation but provided some preliminary findings. After two years, 86 percent of the population was covered by family doctors, with eight percent higher coverage in urban areas. Few patients changed doctors, but surveys indicated that family doctors had become more client oriented. The output of family doctors increased, providing 21 percent more consultations and 40 percent more home visits, and 87 percent provided emergency coverage that night or weekends. Doctors' incomes increase by 15 percent on average, and there was some evidence of declines in informal payments (although these were already relatively low for primary care). However, differences in access between rural and urban areas persist as the limited financial incentives included in the scheme were not sufficient to attract more physicians in rural areas. There was no effect on hospital admissions, however, and no evidence regarding the impact on key coverage indicators (such as vaccination rates) or health outcomes.

The reforms therefore strengthen the GP as the gateway to the referral system in addition to the introduction of a competitive element through patient choice and new forms of payment. However, purchasing authorities with insufficient capacity and experience, operating in a weak regulatory environment, have been facing serious difficulties in monitoring the payment scheme (especially the fee-for-service component), both in terms of number and of quality of services reported (billed) by providers.

The pilots continued until 1997, when they were discontinued by the new government. While the pilots would have benefited from further evaluation, national and district staff involved in the pilots played key roles in developing subsequent reform regulations, and a number of adjustments were made as a result of pilot experience. These included greater specificity in the contracts regarding doctors' responsibility for primary care, adding a "practice allowance" to the capitation payments for doctors to help cover capital and recurrent expenditure, doubling capitation payments for family doctors practicing in remote or low-income areas, and permitting doctors to charge for vaccinations to children not on their "lists."

Source: Vladescu, C., Radulescu, S., Cace, S., (2)

The experiment in the eight pilot districts has provided many valuable lessons about the reform implementation process:

- GPs have generally welcomed the new method of remuneration, which allowed greater differentiation in pay according to workload; GPs' incomes have generally risen under the experiment (52% of GPs earned more money under the new system than before) but in the same time the workload has increased (with 21% more consultations, 40% more house calls and 64% of GPs offering 24-hour coverage); however, doctors did not feel that the social status of their profession has risen substantially since reforms began (53% thought their social and professional status was unchanged) (6); changes in employment and payment system of GPs should be accompanied or preceded by intensive training for family doctors, to allow them to adapt to their new roles, and to increase credibility for reforms among patients and the medical profession (2);
- purchasing authorities operating in a weak regulatory environment, with insufficient capacity and experience, have faced serious difficulties in monitoring both the number and the quality of services reported (billed) by providers (7); the proposed reforms created the potential for improved primary care, but the success of reforms depends not only on establishing appropriate incentives in the payment system, but also on developing adequate capacity within the purchasing authority (DHA) for regulation and monitoring of general practitioners; therefore changes in payment and delivery system should be accompanied by adequate training for the staff of health authorities, both from national and, especially, from local level (2);
- the changes have not significantly reduced the use of hospital services or redistributed providers to improve access in rural areas; the system needed to establish more credibility before it could encourage patients to change their behaviour and doctors to move to underserved areas (7); while the used PHC approach to primary care had the potential to succeed in urban areas, nearly half of the Romanian populace lived in rural areas, where many of the stated aims of the project could not be achieved due to “objective” reasons: lack of adequate coverage with medical personnel and therefore lack of choice/competition between providers, difficulties in accessing health facilities, inadequate basic medical facilities, etc.(2);
- some of the mentioned problems could be overcome by using new approaches which can maximize the existing scarce resources; for

instance encouraging group practice (where possible) holds promise for addressing a number of issues, including pooled use of equipment and administrative assistance, and improved coverage for after-hours care (2).

4. Social health insurance system

Discussed for the first time in the Romanian Parliament in 1994, voted and promulgated in the summer of 1997, the Law on Social Health Insurance came into force only in 1998. The main expectations from introducing health insurance were: to increase resources available to health (through the compulsory health premiums), to increase transparency and to serve as a catalyst for further system reforms, including improving system efficiency. This reform generated at the beginning country-wide support, but for different reasons: ministries of finance, for example, hoped for increased efficiency and cost control, while doctors expected higher salaries (2).

The implementation of the new system was done “over the night”, without any preparation. During the so called “transitional year” 1998, the Ministry of Finance, the Ministry of Health and district health authorities carried out the functions of insurance bodies (the transition period was extended until the end of March 1999 by Ordinance No. 125/98). During this period, the district health insurance function of payment of providers was performed by the district health directorates, the Ministry of Health acted as the National Health Insurance Fund and the structures under the authority of the Ministry of Finance carried out the function of revenue collection. Insurance funds (National and district) were set up as independent bodies on the 1 January 1999 and took over the actual administration of funds in April 1999. (4).

The Law on Social Health Insurance stipulates a variety of methods of payment of providers, such as capitation (pay per insured person) and fee-for-service – for primary health care; fee-for-service – for specialized out-patient care; global budget for hospitals – calculated to various rates (hospitalized patient, day of hospitalization, health service, and other formulae to be negotiated). The lack of political stability and lack of managerial capacity produced a situation

where the National Health Insurance Fund did not produce any new forms of reimbursement for the main providers of medical services (ambulatory clinics and, especially, hospitals) which functioned in practice, according to previous administrative patterns. In spite of the contracts being signed with insurance houses, almost all the mechanisms for resource allocations at the outpatient and hospital level remained unchanged.

According to the Health Insurance Law, employers and employees each paid a 5% payroll tax and pensioners contributed 4% of their pensions. These contributions did not affect net income by much, because they were deducted after pensions and benefits increased by 4%. The 10% contribution rate of 1998 was increased to 14% since 1999 (7% from employers and 7% from employees). The self-employed, farmers, pensioners, and the unemployed paid a 7% contribution to fund health insurance (4).

All the funds were collected locally by the 42 district health insurance funds (one each for the 41 districts plus one for Bucharest). The money was administrated by the district health insurance funds and by a National Health Insurance Fund. In addition to the 42 DHIFs, there have been created two countrywide funds: one of the Ministry of Transportation and one of the ministries and institutions related to national security (Ministry of Interior, Ministry of Defence, Ministry of Justice, Intelligence Agencies). In order to improve equity across districts in resource allocation, up to 25% of funds had to be set aside for redistribution among districts which was carried out by the National Health Insurance Fund. In addition, 20% of all funds in 1998, and 5% thereafter, have to be set aside as reserves. No more than 5% of funding could be spent on administrative costs.

In November 2002 an Emergency Ordinance of the Government (no.150) has replaced the Health Insurance Law. The main modifications brought by the new Ordinance consisted in: introducing National Health Insurance Fund under the coordination of the Ministry of Health, collection of contribution in a special account opened by the National Health Insurance Fund, the decreasing of contribution rate to 13.5% (7% from employers and 6.5% from employees) and the increase of the percentage used for paying health

services and drugs to 95%, by decreasing the reserve fund to 1% and reducing the limit for the administrative costs to 3%.

The Health Insurance Law grants the insured people's rights to health services, medicines and health implements, as stipulated by the so-called "frame-contract" which includes: the list of health services to be provided by health units, the services quality and efficiency parameters, the method of payment, the hospital length of stay, criteria and medication. Insured are allowed to choose health services providers and the family physicians play a gatekeeper role. The frame-contract is the basis of the contract to be concluded between the District Health Insurance Funds and the health organizations: hospital and their out-patient units, diagnosis and treatment centres, health centres, family doctors' practices, etc.

The legal amendments made since the introduction of the health insurance have brought significant changes to the Social Health Insurance Law as compared to the first text. However, it seems that further legal amendments are necessary, since the reformed Romanian healthcare system has not yet fulfilled the expectations created in 1997. There is also debatable the extent to which the social health insurance principles are applied in Romania.

Health insurance did succeed in increasing the revenues available to the sector, public expenditure as share of GDP increased from 2.8% in 1997 to 3.6% in 2004 and it is estimated at 5% in 2005. Still the amount of spending on health, both as a percentage of GDP and also as net figures, places Romania at the lower end of the spending distribution among countries with a similar per capita GDP, as well as among most other countries in the CEE region.

In practice, the system has operated as a hybrid between social insurance and a publicly managed system, where revenues are collected as health insurance contributions, while the government still exercises a considerable amount of discretion in allocating funds, through the interference of the Ministry of Finance in defining expenditure ceilings. By now, each year the health insurance budget was set with a considerable surplus; for instance in 2001 expenditures were set at 91 percent of revenues and in 2002 at 95 percent of

revenues (2). There are many voices asking where is going the rest of the money collected for health.

The solidarity principle has also been altered by amendments to the initial Health Insurance Law. Starting from January 2003, pensioners do not pay an insurance contribution (which, between 1998 and 2002, was automatically deducted from the pension fund). This happens while 22 millions people are entitled to benefits and only around 5 millions are paying social health insurance contributions.

Among the responsibilities assumed by the government that came into power in 2004 there are: to ensure and guarantee the compliance with the social health insurance principles (solidarity, universal coverage and autonomy), to encourage the development of a private health insurance system and to stimulate the privatization of the infrastructure of medical institutions, to encourage competition between the providers of medical services and the insurance funds, to continue the decentralization process, to assure an adequate financing to the health system, to diminish inequities and corruption within the medical system.

One of the big achievements of the current government was to turn again the National Health Insurance Fund into an autonomous institution taking it out from the coordination of the Ministry of Health.

As main lessons learned from Romanian experience there are:

- the implementation of the health insurance system has been a very difficult process as it has not been prepared properly
- the political instability, lack of managerial capacity and general economic level were the main factors influencing social health insurance system implementation
- decision making not based on evidence can make things even worse
- until health gain a place on the government's priority list, any effort of reforming health system will be subject of failure

5. Policy debates and pace of the reform

Romania needed to radically reform its health sector as all other countries in Central Eastern Europe. Everybody agrees that reform in

transition economies is a slow and contentious process, but comparing with some other Central and Eastern European Countries, the pace of reform in Romania has been even slower.

The main reasons for the slow pace of reform are related to policy making process.

Major changes in an area that concerns every member of a society, i.e. health care, cannot be achieved unless major politicians are involved, appropriate information is disseminated and citizen support is secured (both from providers and recipients of health care). While in other countries the changes in the health policies led to extensive analyses and debates by Institutes and professional analysts, with wide media coverage, in Romania the debates involved only peripheral issues and the discussions were usually triggered more by “spectacular” episodes related to the day-to-day aspects of the systems (non-)operation and less by the causes and possibilities to solve such deficiencies (2).

Implementing social health insurance was a political option not based on any feasibility study. Many decisions related to the financial implications of the provisions of the Health Social Insurance Law were not based on detailed financial studies. Many of the questions that were essential for any analyst were asked too late or not at all, as for example:

- Which would be the consequences of the new financial undertakings?
- What type of redistribution mechanisms – by age, gender, income, etc. will be the basis for the new financial mechanism?
- Which are the consequences of introducing insurance premiums for employees, employers and other categories of personnel?
- What is the role that can be played by additional private insurance? Which services can be provided privately? How much (and which parts) of the health system will be public and how much private?
- How, if this is desired, can unofficial payments be reduced?
- Who will develop the individual contracts for the provision of services in the insurance system and how?

- Which will be the basis for capital investments and advanced medical technologies to gain maximum benefits for public health from limited public resources?

The health policy objectives were never followed by concurrent effort of all stakeholders and finding of complementary solution. For example, introduction of health insurance system and the change of the payment methods alone were insufficient to significantly rationalize or improve the efficiency of the hospital sector. If comparing with what was done for primary health care, we might say that the hospital sector was neglected. The Hospitals Law is still under debate and the National Commission for Hospital Accreditation is not functioning yet.

For all the reform decisions in the health sector, the Romanian authorities used a top-to-bottom approach. For such an approach to be successful it has a series of prerequisites:

1. The circumstances that are external to the body implementing a certain policy should not impose constraints that would invalidate the desired process.
2. The necessary resources and sufficient time should be available for the program.
3. There should exist not only the general resources required, but also each stage of the implementation process should have the resources available in the desired mix.
4. The political option that is desired to be implemented is supported on a solid theoretical fundament, with explicit relations with respect to the causality of the phenomena.
5. There should be only one body responsible for the implementation of the policy, and it should not rely on other bodies for the success of the action or, if other bodies are involved, reliance should be minimal.
6. There should be full understanding and agreement on the goals to be achieved; these aspects should be maintained throughout the entire period of the implementation process
7. It should be possible to clearly define, in detail and sequentially the tasks assigned to each involved party, throughout the implementation process.
8. There should be flawless communication and coordination between the different elements involved in the programme.

9. The persons with authority can demand and obtain perfect deference.

Following this succession of requirements, we realize that few of these were present in Romania's case. Thus, although it is almost a truism that reform requires increased resources to be successful, in Romania the available funds were diminished during the very periods when it was desired to introduce major structural changes in the health system. International experience has also shown that such changes, with an impact at the level of the entire population, must be supported on solid theoretical and conceptual fundamentals and gain wide approval with respect to the goals that must be reached, and the clearly defined involvement of the participants. Although various documents were developed, i.e. Reform Strategy in the Health Sector or the White Book of the Reform, and were uncontested by the main actors in the health sector, because of the lack of substantial debates over these documents their impact were rather low. Furthermore, the frequent staff changes in the management of the central and local health authorities caused the very fundamental political options to be continuously questioned, according to the ideology and values of the Minister of Health in such a way that key reform legislation such as Health Insurance Law are after successive amendments very far from the initial intention of the Parliament which passed them.

Exercises

Task 1. Health policy implementation

Students should collect data about health care reforms from their respective countries and make an analysis on:

- how policy was developed
- how policy was implemented

They have to look on the factors that determined the successes and failures in health care reforms.

Task 2. Health Insurance System

Students are asked to learn about the introduction of the health insurance system in different Central and East European countries and to perform a comparative analysis on the implementation process.

They should be asked to answer questions like:

- how was taken the decision of introducing the health insurance system
- how was done the projection of the system
- what preparations were done before introducing the new system
- how was implemented the system
- what are the results of introducing health insurance system

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Chapter 4
CASE STUDIES
4.3 Specific Strategies

PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Development of the Strategy in public health education – challenges and lessons learned from Macedonia
Module: 4.3.1	ECTS (suggested 0.25):
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Keywords	Strategy, public health, education, public health training curriculum
Learning objectives	At the end of this Module students will understand the key elements of the Strategy in public health education, challenges faced, lessons learned and future directions in the development process of the School of Public Health in Republic of Macedonia.
Abstract	The main strategic goal in contemporary public health education in Macedonia is to develop a new public health teaching program. The Medical Faculty Council approved the establishment of a new School of Public Health in May 2003, and the development of a MPH program, provided by the new formed

	<p>Centre of Public Health within the Medical Faculty Skopje. The MPH program has been developed in accordance with the domestic legislative framework on higher education and has met the required international criteria such as organizational structure, a stated mission with supporting goals and measurable objectives, a curriculum plan, institutional commitment to the development of the school or the program and policies and plans for recruitment and selection of faculty and students. Building a “self image” and a “public image” of the Centre of Public Health, promoting professionalism and ethics, providing training for experts in the field of public health, continuing development of the MPH core curriculum and improving public health approach in the process of education will guarantee future development of the Strategy in public health education. In the transition period, it is crucial for Macedonia to provide modern education for public health practice.</p>
Teaching methods	<p>Teaching methods will include introduction lecture, interactive small group discussions and SWOT analysis of the development of the Strategy in public health education in Macedonia, which will be followed by group reports and overall discussion. .</p>
Specific recommendations for teachers	<p>This Module will be organised within 0.25ECTS credits. Students should be informed about the ASPHER PEER (Public Health Education European Review) criteria for public health training programs. .</p>
Assessment of students	<p>Practical work: SWOT analysis of the public health education system in student countries (papers and discussion).</p>

DEVELOPMENT OF STRATEGY IN PUBLIC HEALTH EDUCATION-CHALLENGES AND LESSONS LEARNED FROM MACEDONIA

Jovanka Karadzinska-Bislimovska, Fimka Tozija

Key elements of the Strategy in public health education

Major potential contributions of the Strategy in public health education consist in helping to create a new health culture, training the professionals to bring to routine practice the elements of health promotion and diseases prevention, with re-assessment of the health system.

The School of Public Health is the primary educator of public health professionals, developing skills and competences to assess the health status of the population, to identify the public health problems and to implement appropriate evidence based interventions. Trained and well educated public health professionals are necessary and valuable resources for providing the best public health practices at all levels. Master of Public Health (MPH) program was developed as a form of education in School of Public Health (SPH) as a key element of the Strategy in public health education (1).

Public health needs

The health of the population in Macedonia is determined by the many factors as well as the adequate public health actions to be taken to improve, preserve health and to solve main public health problems. Macedonia is facing the following public health problems: burden of high rates of mortality and morbidity from preventable diseases, insufficient data collection and information on important health and vital parameters, insufficiency in modern public health education and training, poor utilization of health facilities, absence of cost-benefit, cost-effectiveness and cost-utility analysis. At the same time uncontrolled use of expensive diagnostic and therapeutic procedures, high rates of poverty and unemployment and lack of

properly qualified experts in public health have additional influence on the public health situation in the country.

The mentioned problems can be managed by implementing a comprehensive public health strategy with emphasize on capacity building for professional education in public health. Development of a strategy in public health education is crucial for Macedonia, as a country in transition, for providing a modern education for modern public health practice.

Goals and objectives

The main strategic goal in contemporary public health education in Macedonia is to develop a new public health teaching program - MPH program - as a basis of the School of Public Health. This will ensure the academic development of modern public health ideas and a proper level of training in health sciences during the period of transition and reforms.

To achieve this goal, the following objectives have been set:

- To prepare target-oriented public health practitioners, researchers, policy analysts, managers and decision-makers
- To provide continuing education for current and aspiring public health practitioners, researchers, policy analysts and managers
- To promote public health research and health policy analysis
- To advocate and promote health related issues in public policy

Basic principles

The basic principles that will guide the implementation of the Strategy in public health education are:

- Problem-oriented skills training to identify targets and problem-solving management
- Multidisciplinary approach
- Post-graduate training in multi-faculty settings
- Link education, research and service in public health

Challenges and how they have been faced

The public health challenges became the reality in Macedonia. The Medical Faculty Council approved the establishment of a School of Public Health in May 2003, through the development of a MPH program, in the frame of the new formed Centre of Public Health within the Medical Faculty Skopje. The MPH program has been developed in the direction of ASPHER internationally recognized standards and Macedonian legislation on high education, guided by the Consulting team from Braun School of Public Health, Hebrew-Hadassah University, Jerusalem.

The new public health teaching program has the following elements, according to the international criteria: a stated mission with supporting goals and measurable objectives, external environment, internal environment - an organizational structure, a teaching program, teaching staff, students, teaching/learning facilities, research and institutional quality management system.

Mission

The mission of the Centre of Public Health, as a basis for the development of the School of Public Health, includes three elements: teaching, research and service. Providing trained professionals is a key service to the nation. Research at the faculty and student level is vital to the academic standards of the School of Public Health and its international recognition. The service element must primarily focus on the health problems of the country and provision of education and research related to the policy needs of the country.

A stated mission should support strategic aims:

- to prepare a critical mass of public health professionals who are competent in the public health core content and methodological approaches to public health problem-solving.
- to facilitate teaching, research, providing public health services and analysis/formulation of national health policy.

External environment and institutional commitment to the development of the Program or the School

In response to the need for a modern level of public health education to prepare present and future leaders and analysts in the many fields of the public health, the Medical Faculty of the University “St Cyril and Methodius” has initiated steps to develop a School of Public Health. This initiative has been supported by the Ministry of Health and the Ministry of Education and Science and has resulted in a Government decision to establish the School of Public Health in Republic of Macedonia. During the period 2001-2003, this initiative has been supported by Open Society Institute (signed Memorandum of understanding on development of SPH, OSI Strategy for public health) and the Medical Faculty’s decision to prepare the basis for a Centre for Public Health, as the core for a School of Public Health, within the Medical Faculty. This process included revision of the Statute of the Medical Faculty, establishment of the Public Health Board and the Steering Committee for the development of the SPH, Medical Faculty Skopje.

Internal environment - organizational structure

The organizational structure of the new public health teaching program is based on existing human resources and infrastructure integrated as a Consortium of preventive departments - Cathedras: Epidemiology and Biostatistics, Social Medicine, Hygiene, Occupational Health in the Centre of Public Health - Medical Faculty (Statute of Medical Faculty, Skopje, July, 2003). MPH program has merged into a unified course of modern public health comprising the academic offerings of separate institutions and teaching programs in Epidemiology and Biostatistics, Social Medicine, Hygiene and Occupational Health (2).

Teaching program - Curriculum plan and educational approaches

As a new challenge, the Centre of Public Health has been established to provide for the first time post-graduate training of a multi-disciplinary group of professionals from medical, economics, law, education, sanitary engineering, administration, sociology, anthropology and many other disciplines within the Medical Faculty.

This challenge has been faced by developing a sound core curriculum, as an educational base along with optional courses and independent work on master's thesis.

The Curriculum of Macedonian MPH program includes the principal elements of the Core curriculum for post-graduate public health education (3):

- Basic tools of social analysis: history of public health, demography, medical sociology and anthropology, biostatistics, population sampling and survey methods, political sciences of health systems, principles of program evaluation and health economics
- Health and disease in populations: vital statistics, major human diseases and zoonoses, epidemiology of diseases and risk factors, methods of clinical diagnosis and prevention, infectious and chronic diseases, nutrition, environment, special disease and risk groups, global ecology of disease and risk factors
- Promotion of health and prevention of disease, including program and project development in: communicable disease control (including, STD/AIDS control), chronic diseases and their prevention, environmental and occupational health, family health (including maternal, child, adolescent, adult and elderly health needs), mental health, nutritional and dental health, health education and promotion; rehabilitation, refugee, migrant and prisoner health, military medicine, alternative medicine and disaster planning
- Health care systems and their management: organization and operation of national, regional and local health care systems, voluntary and national health insurance and social security, health services and workforce development, health facilities and their management; food, drug and cosmetics economics and regulation; health planning and policy development; principles of management and application to health programs; budgeting, cost control and financial management; health records and information systems, monitoring and evaluation; health systems research, health legislation and ethics, technology assessment, accreditation and quality promotion in health care, information systems for monitoring and for management; global health systems

MPH program curriculum, developed by the Steering Committee for the development of the School of Public Health, Medical Faculty, Skopje, covers the main areas of public health: Public health science theory and practices, Biostatistics, Epidemiology, Environmental health, Occupational health, Health service administration, management, health economics and Social and behavioural sciences.

The main objective was to develop the MPH program into a School of Public Health, meeting international criteria as set out by the European Association of Schools of Public Health (ASPHER) for European Master Programmes, with introduction of a credit transfer system in public health education.

MPH Study program

The curriculum is designed to meet the needs of students as well as the needs of the market for public health and public health practices. This MPH program is based on a multi-disciplinary approach, taking into consideration different backgrounds and career interests of students, applying the principles of qualitative and quantitative methodology. The study program has been developed with modular type of courses as a part time teaching program in 4 semesters within 2-year period. Modular approach in the MPH program has been attractive for the persons currently employed in the field, as well as for the new graduates, and was successfully applied.

The Macedonian MPH program included basic and elective courses, integrating workshops, research forum and master paper/thesis.

The basic modules are:

- *Module 1* – Introduction to Public Health (Introduction to the New Public Health, Public health organization and practice, Computers and Internet skills as tools in Public health)
- *Module 2* – Quantitative Methods (Principles of epidemiology and research methods, Biostatistics)
- *Module 3* – Health Economics and Management (Health economics, Health management)

- *Module 4* – Population Health Needs (Family and special health needs, Nutrition in public health)
- *Module 5* – Qualitative Methods (Social and behavioural sciences in health, Health promotion and disease prevention)
- *Module 6* – Environment and Health (Environmental health, Occupational health)
- *Module 7* – Disease Control Methods (Control of communicable diseases, Control of non-communicable diseases)

Suggested topics for elective courses include: advanced topics in epidemiology and statistics, environmental and occupational health, health determinants, health policy and management, and health economics.

The research forum as a special course should facilitate the development of student ability for critical appraisal of research proposals/issues in public health and should assist the students in the step-by-step preparation of their proposals through group discussions and instructors guidance. This would provide a cumulative learning experience in which students could bring their actual problems to a peer group setting, with a multi-disciplinary faculty. It would have a problem-solving orientation.

Combined teaching methods included lectures, group discussions, self-instruction of the students through readings and searching relevant data from Internet as well as problem-solving exercises. Independent work, critical thinking, interactive approach are encouraged and supported as integral part of teaching.

There is a continuous assessment of knowledge for students who attend the postgraduate studies. The final evaluation is conducted at the end of the lectures of every course by the responsible teacher or a commission composed from at least two members, in which the results from the periodical assessment of the knowledge are taken as a base.

After passing all the exams, students are required to conduct their Masters paper/thesis. This is taken from the Statutes (Regulations) for organizing post-graduate studies at University “St.

Cyril and Methodius”, Skopje, published in University voice number 7, 25 September 2001.

Teaching staff

The MPH program within the Medical Faculty is realized with teachers from the preventive departments – social medicine, epidemiology and biostatistics, environmental health, occupational health, microbiology and others – from the Medical Faculty, appointed for specific units from the core courses or the optional ones, or from other faculties within University “St. Cyril and Methodius” such as Economics, Law, Philosophical Faculty. The teaching staff is dedicated and committed to the modern public health education, with multi-disciplinary knowledge and skills, competent and able to fully support program’s mission and goals.

International visiting professors from other public health schools have been involved in teaching, to support the implementation of the new MPH training program.

Students

According to the ASPHER criteria (4), the Public Health teaching program or School of Public Health should have student recruitment and admission policies designed to select qualified individuals for a career in public health, should monitor the progression through the program, should follow up the graduates and actively involve the students in decision-making process. As a result of the efforts made by the Steering Committee for the School of Public Health development, the Centre of Public Health was established and a MPH program was developed applying the ASPHER criterion. University “St. Cyril and Methodius” has approved the new MPH program in 2003 academic year, advertising this program together with other Master programs.

Recruitment criteria for the acceptance of the students in the MPH program include an undergraduate degree from a minimum four-year university education, from a recognized university (graduate grade point average of not less than 8.0 on a 5.0 to 10.0 scale is required for admission to the program) and a high level of spoken and

written English, as well as computer literacy. Acceptable degrees include medicine, dentistry, nursing, law, economics, social sciences, business administration.

Target group for this program includes persons currently employed in health management, public health field or professional staff positions, as well as preparing new graduates for careers in this field. The first generation of MPH students started in 2003 with 42 applied participants, while the second generation of 25 participants enrolled in 2004 academic year. The structure of applied participants was heterogeneous, with both experienced people in public health as well as new graduates looking for a career in public health. The undergraduate structure of the participants was also multi-disciplinary, with both medical and non-medical graduated participants. This MPH program gives an opportunity to a wider range of backgrounds, in this way making possible the provision of training which meets the needs of practice.

Teaching/learning facilities and support services

The whole capacities from the Medical Faculty, Skopje, both human and infrastructure, have been used for the realization of the Master program in Public Health. Physical infrastructure – the teaching and learning capacities provided by the completion of the two teaching rooms, a computer room with internet accesses, administrative office and library with scientific books and journals is a very important resource for the process of the public health program development.

Lessons learned and future directions

Continuing signs of progress during 2002-2004 in activities related to the process of realization of the MPH program in Macedonia include strong and continuous support from: the University and Medical Faculty as well as the Ministry of Health, OSI/FOSIM and continual assistance and support from the Braun School of Public Health, Jerusalem, Israel.

Macedonia has well developed medical education in the basic sciences and clinical fields. Public health education has been provided at

the under-graduate and post-graduate specialized levels, but in keeping up with trends across Europe, a post-graduate training capacity in New Public health has been developed. The Centre of Public Health established in the Medical Faculty has outside professional assistance in order to move ahead in terms of capacity building in its efforts for the development of the School of Public Health, after launching its MPH training program in 2003.

The main assets for the successful Strategy in public health education as well as for the School of Public Health development are the knowledge and skills of the teaching staff which have been improved by: training of trainers by international visiting faculties, study visits to well-established schools of public health and participation in international meetings.

Strong motivation and interest of the teaching staff from the five relevant preventive departments of the Medical Faculty were crucial for the development and implementation of the MPH Program in the newly formed Centre of Public Health. One of the lessons learned is the increasing feeling of belonging and contribution in sharing tasks and activities of the teaching staff.

The Core Curriculum for the MPH Program was accepted by the Medical Faculty in May 2003 after being revised several times by the teaching staff for meeting the international criteria. After the first year of the MPH program, the Steering Committee for development of SPH, as an Internal body for quality assessment, together with all teaching staff, evaluated the whole process of education through self-evaluation during this period. The quality of teaching in the MPH program has been assessed by formal student evaluation during the courses and the quality of the MPH program will be assessed at the end of the whole program. It is the opportunity to measure how the teaching program is meeting the needs and perceived needs of students. Strong motivation, interest and satisfaction of the students with the MPH program expressed through the evaluation process and their active participation and input have contributed in continuous improvement of the teaching (5).

Intensive international co-operation has been built with Braun School of Public Health, Jerusalem; Faculty of Public Health, Kaunas,

Lithuania; Centre for Disease Control, Atlanta, USA, Andrija Stampar School of Public Health, Zagreb, Croatia; Public Health Collaboration in South Eastern Europe Network within the framework of Stability Pact.

Initial financing for the Strategy in public health education has been provided by Open Society Institute. The MPH activities were financially covered by OSI, Medical Faculty, Skopje, and the tuition fee of the postgraduate studies in public health paid by the candidates themselves and by their employer.

Future directions and expected outcomes

The Strategy in public health education will be further developed in the direction of improvement of the quality of public health post-graduate education through viable and sustainable MPH in Macedonia. Future activities will be focused on:

- support the development of human resources needed to establish the School of Public Health and to strengthen their educational capacity and academic autonomy
- continuous improvement of the teaching quality by: introducing Macedonian lecturers to methods of teaching in ASPHER schools, adoption of pedagogic principles in the applied MPH studies, exchanging knowledge, experiences and information in this field.
- preparation of a critical mass of public health teachers who are competent to develop the content of the modules
- capacity building of the future graduate students to become good leaders, advisors, managers, policy analysts and professional specialists and to contribute to the improvement of the community health
- creation and promotion of the market for public health graduates and more advocacy, formal requirement of the Ministry of Health for career advancement and their involvement in addressing public health priorities
- building partnerships and networking with other Schools of Public Health

Building a “self image” and a “public image” of the Centre of Public Health, promotion of professionalism and ethics by providing

training for experts in the field of public health, process of continuous development of the MPH core curriculum and improved public health approach in the process of education, will guarantee future development of the Strategy in public health education in Macedonia.

Acknowledgments

The Centre of Public Health, Medical Faculty, University “St. Cyril and Methodius”, Skopje, Macedonia, especially thank Prof. Theodore Tulchinsky, as a leader of the Consulting team at the Braun School of Public Health, The Hadassah-Hebrew University, Jerusalem, Israel whose continuous support and suggestions made a crucial contribution to the process of preparation and development of the MPH Program as a basis of development of the School of Public Health in the country.

Exercises

Task 1: After introduction lecture and reading the case study, the students are split in small groups (5 students) in order to make SWOT analysis of Macedonian model of the Development of the Strategy in public health education.

Task 2: Students are asked to make SWOT analysis of the public health education in their own country as an individual paper work.

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Harm reduction: the Republic of Moldova case study
Module: 4.3.2	ECTS (suggested): 1
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Keywords	Acquired immunodeficiency syndrome; antiretroviral therapy, highly active; harm reduction; HIV; methadone; needle-exchange programs; prevention and control; substance abuse, intravenous; transmission.
Learning objectives	After completing this module students and public health professionals should (for example): <ul style="list-style-type: none"> • aware of the challenges posed by the changing patterns of the HIV/AIDS epidemic all over the world, and even more so in developing countries; • recognise the main HIV/AIDS issues in terms of surveillance (including sentinel surveillance), diagnosis, primary and secondary prevention (harm reduction), treatment and care; • increase knowledge about the complexity of shapes that harm reduction programs could take; • understand how to approach the epidemic in resource-limited settings with predominantly IDUs accounting for the largest share of all HIV/AIDS cases reported in a country; • differentiate between various HR interventions

	<p>and the benefits the country could rip by implementing one or another set of HR measures;</p> <ul style="list-style-type: none"> • be able to identify the next steps in fighting HIV/AIDS pursuant to the achievements and/or failures reported to date; and • constantly improve and update the knowledge and skills in the changing HR environment, and swiftly adapt to the changing patterns of the epidemic.
Abstract	<p>The main goal of this paper is to make the reader aware of the escalating HIV/AIDS epidemic that is getting rampant all over the world, and to make them knowledgeable about the basic and cost-effective ways to curb the infection.</p> <p>The case study starts off with a general overview of HIV/AIDS in Moldova, and the consecutive steps towards curtailing the spread of the contagion. A special emphasis is put on preventative measures, with a focus on secondary prevention (harm reduction programs), delegated almost entirely to the civil society, with support from both government and international agencies. It outlines the achievements as well as the failures and challenges yet to be addressed in controlling HIV/AIDS. It specifies specific activities targeting vulnerable groups at high risk for getting HIV/AIDS (IDU, CSW, migrant population, Roma, truck drivers, youth, MSM etc.)</p> <p>The bottom line of this paper is that fighting HIV/AIDS requires a complex and public health approach – treatment and care should be coupled with good prevention and surveillance. It is always more effective, efficient and cheaper to prevent something from happening than to deal with consequences of such a chronic disease as HIV/AIDS is.</p>
Teaching methods	<p>Teaching methods could include a guest speaker from either a community based organization (CBO), non-governmental organization (NGO) or any government agency to teach a formal lecture on the tenets of HR in general, and generate Q&A discussions and debates after that; they could finish the class with a hands-on exercise by splitting the</p>

	<p>classroom into two parts – adepts of opioid maintenance therapy (OMT – methadone or buprenorphine) (with pros for it) and those opposing it (cons) – this could finally result in an informal presentation to all the students, each team delegating a reporter, all that being followed by discussions and a Q&A session. The homework could then be to write a brief summary of what-to-dos in terms of HR in Moldova and where do they see Moldova in terms of HIV/AIDS epidemic (and harm reduction) in five years from now.</p>
<p>Specific recommendations for teachers</p>	<p>Lecture itself (guest speaker) with Q&A, if any – 20%; Work under teacher supervision (OMT group exercise, drafting a plan, wrap-up presentation) – 40%; Students’ individual work – (student paper: HIV/AIDS and HR – next steps) – 40%.</p> <p>Facilities – could attend a needle-exchange site, could invite an active or former IDU attending such a program; Equipment and training materials – PowerPoint projector; plus this book and recommended readings.</p> <p>A short 5-minute pre-lecture survey of the audience’s knowledge about HIV/AIDS in general, and harm reduction in particular, would be instrumental to assess the knowledge gained as conferred against a post-lecture 5-minute survey (could be the same).</p>
<p>Assessment of students</p>	<p>Assessment will be based on the group work and presentations made (30% of the degree), active participation and Q&A (10%), multiple choice questionnaire (MCQ) or open-ended questions (30%), and homework paper (30%).</p>

HARM REDUCTION: THE REPUBLIC OF MOLDOVA CASE STUDY

Silviu Gh. Ciobanu

Background

Following the break-up of the former Soviet Union, the incidence of sexually transmitted infections soared up. Throughout 1988-1996 the incidence of syphilis increased from 7.0 to 200.1 per 100,000 inhabitants in the Republic of Moldova, which further has gradually decreased, yet still was high at 80.7 per 100,000 in 2003 (1). High figures could be attributed to escalating budget deficits, loosening morals, poor knowledge about sexually transmitted infections (STIs) and prevention measures, relatively low access to even the simplest of preventative measures, unsafe sex practices, under-estimation of personal risks to contract sexually transmitted infections, and to commercial sex workers. The high level of sexual transmission, in particular of syphilis, Chlamydia, trichomoniasis and the low level of diagnostics of these conditions conditioned a high spread level of HIV/AIDS by heterosexual route of transmission more recently.

HIV/AIDS in the RM

The Republic of Moldova has started systematically doing epidemiologic surveillance on HIV/AIDS back in 1987. Since then 2,169 people have been diagnosed with HIV, including 154 reported cases of AIDS by the end of 2004 (51 people were diagnosed with AIDS in 2004 alone and 15 have died) and the cumulative AIDS death toll rose to little over 80 people (1). However, there were 5,500 people living with HIV/AIDS in the country at the end of 2003 according to WHO/UNAIDS, and 7,400 people living with HIV/AIDS in 2004 according to the National AIDS Centre. The average HIV/AIDS prevalence rate in Moldova accounted for 33.79 per 100,000 at the end of 2001, to then reach 38.47 per 100,000 in 2004, with the second largest city in the country – Balti – recording the highest prevalence of 430.72 vs. 68.68 only in the capital city of Chisinau (2). The AIDS epidemic is rather young in Moldova – up to 81.2% of the HIV-

positive are 20-40 years old. Some of the most important phenomena amongst many factoring into the outbreak of the HIV/AIDS epidemic in Moldova were the high prevalence of STIs, high rates of migration and human trafficking, and injecting drug use.

The HIV infection has been spreading mainly in injecting drug users (IDUs) over years, although recently there was a decline in the HIV prevalence among IDUs, who accounted for little over 80% of all HIV/AIDS cases in 2000, but plummeted down since then to reach little over 40% in 2004. The Ministry of Interior estimated around 50,000 IDUs in the Republic of Moldova in 2004, in which the sharing of needles is believed to be widespread as a mutual sign of trust. Quite a few HIV-infected IDUs are convicts. According to the Ministry of Justice, the prevalence of HIV/AIDS in prisons was 3,600 per 100,000 in 2004. Of all HIV cases reported in 2004, 42.41% were linked to IDU, 55.36% - heterosexual intercourse, and 2.23% were attributed to mother-to-child transmission. The share of HIV-infected among IDUs notably decreased from almost one-in-three infected in 2001 down to only 19% today, subsiding to the heterosexual route of transmission recently. Hence, there was an increase in sexual transmission of HIV (20% in 2001, 28% in 2002, 43.8% in 2003 and 55.36% in 2004), alongside a higher risk of HIV transmission in young women of reproductive age and of vertical transmission; therefore, gender inequalities almost but balanced off to reach parity in recent years – women with HIV accounted for 24.3% in 2000, 31.15% in 2002, and 45.37 in 2004) (3). There have been 38 pregnant women diagnosed with HIV in Moldova in 2004. The share of men having sex with men and commercial sex workers is still relatively low, at 1.4% and 4.69% respectively (1).

The HIV/AIDS epidemic is believed to have been passing through four stages in the Republic of Moldova (4). Stage one dating back to late-1980s until the end of 1995 was relatively quiet, interrupted by occasional outbreaks in small foreign communities, migrants or travellers. There were no specific public efforts other than the mass screening of people and tightening up border controls in an attempt to keep the contagion out.

The epidemic entered a second stage (concentrated phase) between 1996 and 1999, when a series of rapid outbreaks have been

reported in IDUs brought forward for testing. There was a sharp raise from 7 HIV cases reported in 1995 up to 408 (about 9 per 100,000 population) in 1997, 80% of those being young IDUs, and about 18% believed to have been infected by sexual transmission. Moreover, notified syphilis reached its peak then, implying that needle sharing by IDUs was not the only issue factoring in and that sexual transmission could also soon explode. The upsurge in STIs and HIV/AIDS was accompanied by a decline in the economy and government resources earmarked for health, resulting in scarcity of HIV test kits for long periods. Many believe that the official HIV incidence of 157 reported in 1999 or 175 in 2000 (down from 413 people living with HIV/AIDS in 1998) were unreliable or incomplete. The dire economic plight made many migrate in search of a job mainly to Russia that was experiencing the fastest growing epidemic of STIs and HIV, coupled with a fast growing illicit drug trade. The rising crime brought about commercial sex work and illegal human trafficking as well.

The advent of the third HIV stage in the RM was driven by the resurgence of funding for the HIV test kits, and by resumption of some sentinel surveillance and broad screening and testing programmes. The overall crude incidence of reported HIV is relatively stable at about 200 to 250 HIV/AIDS cases reported each year, still mostly concentrated in exposed populations. However, the heterosexual transmission is taking over IDU, as outlined before. These changes may be suggesting that Moldova could be at the beginning of a more generalised epidemic.

As of 2003 year-end, the country has been entering a new stage, once specific antiretroviral therapy was made available to all people living with HIV/AIDS who qualified for it at no cost to the end-user. As of July 2005 there have been around 179 people on ART, including 26 in the prisons system. Of the 4 children diagnosed with HIV in 2004 (none reported to be born to HIV-infected mothers in 2004), two were receiving antiretroviral treatment. On top of that, another 73 pregnant women were on preventive treatment during the last trimester of pregnancy and during birth, while their newborn also being on preventative therapy in birth.

The AIDS and tuberculosis (TB) Program is one of the key pieces of the Government's poverty reduction strategy in the health

sector (5), as it will prevent further groups from falling into poverty due to disabling diseases. Local and international counterparts alike have a strong commitment for the HIV/AIDS program in the country. The World Bank contributed USD 5.5M (including harm reduction activities worth USD 1.1M) and the Global Fund to fight AIDS, TB and Malaria (GFATM) already disbursed USD 3M in phase one (2002-2004) and committed another USD 3.9M to phase two (including USD 720,000 for harm reduction for 2003-2005), while the Government of Moldova is chipping in with another USD 0.23M. Following the wrapping up of a National AIDS Program for 2001-2005, a new National AIDS Program for 2006-2010 is being developed, targeting apart from exposed groups, the mainstream population too. Article 2 under the NAP 2001-2005 set out measures aiming at preventing the spread of HIV/AIDS in IDUs by: (i) fighting the illicit drug trading; (ii) ensuring the access of people in general and of drug users in particular to information about the harm inflicted by drugs and the impact of HIV/AIDS on health and HIV/AIDS preventive measures; (iii) implementing programs based on the HR strategy in IDUs.

HIV/AIDS Achievements

Currently, 100% of pregnant women are tested for HIV/AIDS in trimesters one and two of pregnancy. Moldova is among the first countries in the Commonwealth of Independent States (CIS) to provide antiretroviral therapy (ART) to people living with HIV/AIDS. The therapy is available, efficient and free of charge to all who qualify. Little over 110 AIDS patients (93% adults and 7% children) currently take ART. The total number of 15–49 years-old people with AIDS requiring ART is estimated at 120 at the end of 2004 (WHO/UNAIDS, 2004). The lab facility of the ART-providing site is fully equipped now. People living with HIV/AIDS could benefit from both inpatient and outpatient services (Department for HIV/AIDS – 35 beds). There were 11 diagnostics departments and laboratory facilities for AIDS, hepatitis and other viral infections overall in the country in 2004. These are capable of screening all pregnant women, groups at risk, donated blood and ensure the HIV/AIDS diagnostics. Little under one quarter a million of tests have been purchased for epidemiologic surveillance in 2004, and the number of people undergoing testing more than doubled in a couple of years (101,221 in 2002, up to 216,762 in 2004). As a result the number of new HIV cases increased

from 210 cases in 2001 to 224 in 2004, making the incidence soar up from 4.4 per 100,000 in 2002 to 6.2 per 100,000 in 2004) (1).

A draft of National Clinical Protocols on HIV/AIDS therapy and care has been completed and is currently refined to include local staff and foreign expert comments and recommendations. Moreover, the breakaway region of Transnistria's Ministry of Health has joined the UN Theme Group on HIV/AIDS to make Transnistria part of the new national AIDS program. The civil society is also playing an important role in developing the NAP 2006-2010, including a non-governmental organization of people living with HIV/AIDS.

The AIDS Centre has been providing the people living with HIV/AIDS and their relatives, health workers and other stakeholders with counselling services. Service recipients are told about HIV prevention, palliative care, STI, and harm reduction services (needle exchange, condom use), behaviour change, family planning, prevention and treatment of TB and other opportunistic infections, ART etc. A comprehensive public awareness campaign on HIV/AIDS has been launched, including health worker training seminars, development and dissemination of information pamphlets and booklets, conducting knowledge assessment surveys, broadcasting radio and TV shows, putting out articles in media, and carrying out national conferences on STIs and HIV/AIDS.

HIV/AIDS Challenges

Despite the progress accomplished to date in attempting to curtail the spread of HIV/AIDS, there is a number of outstanding issues: (i) Drug trading and injecting drug use, alongside commercial sex work, continue to be widely spread phenomena, as young IDU have risky sexual behaviour, putting them at high and immediate risk of infection; (ii) Still, there is low awareness among policy-makers about the impact of HIV/AIDS/STIs on the society and economy, coupled with low awareness in lay populace; (iii) Stigma, discrimination and misconceptions about HIV/AIDS only hitting "undesirable" populations are still pervasive; (iv) Little information is available about HIV/AIDS-related matters (IDU profile, ART needs), with more accurate data missing and official data being underreported; (v) Poor government outreach (outreach services are mostly provided

by the civil society); (vi) Underdeveloped HIV/AIDS/STIs prevention, treatment and support infrastructure; (vii) New interventions are required to deal with the shifting of the contagion from a concentric epidemic in exposed communities to heterosexual transmission; (viii) Breach of confidentiality for the people living with HIV/AIDS; (ix) Scarce palliative care for the people living with HIV/AIDS (no oral morphine or hospice services); (x) No active monitoring and evaluation systems for ART (first- and second-line drugs, resistance, drop-outs); (xi) Vertical structure of health services, leading to poor cooperation between various health services (TB, ART, methadone substitution therapy etc.); (xii) Low quality pre-test and post-test voluntary counselling for the HIV-positive, if any; (xiii) Uneven geographic location of harm reduction sites (low coverage in the South and the breakaway region of Transnistria); (xiv) ART available in one health site only (Chisinau), while a significant proportion of IDUs live in Balti and Tiraspol; (xv) Low penetration of HIV/AIDS/STI prevention measures (condom use); (xvi) Rigid legal framework.

Harm Reduction Concept

According to the United Kingdom Harm Reduction Alliance (UKHRA), harm reduction (HR) defines policies, programs, services and actions that work to reduce the health, social, and economic harms to individuals, communities, and society that are associated with the use of drugs (Newcombe 1992). According to Single & Rohl, the term HR originally referred to only the policies and programs attempting to reduce the risk of harm among people who continued to use drugs, and did not provide for abstinent-orientated programs (e.g. abstinence-orientated detoxification programs). HR doesn't aim at ceasing or even reducing the use of drugs but rather at lessening the harm associated with the use of drug. Nevertheless, some HR measures involve using drugs in safer ways or in lower dosages, such as needle exchange and the use of non-injecting routes of administration.

The following principles of HR are adapted from the Canadian Centre on Substance Abuse (CCSA 1996), and Lenton and Single 1998: HR (i) is pragmatic in that it accepts that the use of drugs is a common and enduring feature of human experience (HR acknowledges that containment and reduction of drug-related harms is

a more feasible option than efforts to eliminate drug use entirely); (ii) is prioritising goals, with the immediate focus on engaging individuals, targeting groups, and communities to address their most compelling needs through the provision of accessible and user friendly services; (iii) has humanist values in that the drug user's decision to use drugs is accepted as fact, and no moral judgment is made either to condemn or to support use of drugs, thus respecting the dignity and rights of the drug user; (iv) focuses on risks and harms in that by providing responses that reduce risk, harms can be reduced or avoided. HR recognises that people's ability to change behaviours is influenced by the norms held in common by drug users, the attitudes and views of the wider community. HR interventions may therefore target individuals, communities and the wider society; (v) does not focus on abstinence in that HR supports those who seek to reduce their drug use, it neither excludes nor presumes a treatment goal of abstinence; (vi) seeks to maximise the range of intervention options that are available.

HR could be attained through any of the following: (i) providing active drug users and non-users with up-to-date information about drugs, their effects and risks associated with their use; (ii) development of skills and abilities on how to use drugs, once started, in a less risky way, correct self-administration of dose, and avoid exacerbating the harm caused by the misuse of drugs; (iii) updating people on recent amendments to laws and regulations, and on sites they could get support and services from; (iv) encouragement of less riskier behaviours; (v) preventive measure to control the contraction of blood-borne viral infections, including HIV/AIDS; (vi) reducing violence and aggressiveness; (vii) avoiding overdose; (viii) management of health matters; (ix) improving one's emotional life; and (x) boosting up one's social connections. An important thing to keep in mind when working with the lay population is to promote a more tolerant attitude towards drug users, and treat them with dignity and as normal human beings, staying neutral regarding legalization or decriminalisation of drug use.

Basically, HR programs target the following objectives: (i) increasing the level of knowledge about the risks of contracting HIV and viral hepatitis among IDUs; (ii) reducing the use of multiple-use injectable devices; (iii) providing accessible information (from

reliable sources) about the risks that the drug use is posing and about less risky health behaviours (rendering emergency assistance in case of overdose, vein care etc.); (iv) identifying changes in high risk behaviours (sexual or drug-use related); and (v) providing psychological support (ability to listen to drug users without rebuking them) (6).

Barriers to implementing HR policies are: (i) effects of zero-tolerance drug laws and abstinence based philosophies (public opinion, politicians, police and broader criminal justice system, abstinence-based training of many medical and health care professionals); (ii) discrimination against drug users and people who are otherwise marginalized (Rick Lines, Canadian HIV/AIDS Legal Network). Besides, there are certain false assumptions about HR on the public side: (i) HR encourages illegal drug use; and (ii) zero-tolerance, abstinence-based, approaches to drug use are successful. There are false assumptions about HR on the health professional side, too: (i) HR is only about HIV or hepatitis C virus prevention; (ii) HR is only applicable to injection drug use; (iii) HR is only applicable to illegal drug use; (iv) HR cannot be practiced by people living with HIV infection or HCV infection; (v) HR is intended as a “stepping-stone” to abstinence; and (vi) HR is intended a bridge to drug treatment. Hence, HR is posing certain challenges to ourselves: (i) HR asks us to adopt a political understanding of the effects of drug use and social marginalization; (ii) HR asks us to defend the human rights of drug users; (iii) HR asks us to question our own assumptions – and often our own training – about drug use; (iv) HR demands that we challenge our own prejudices about people who use drugs.

Among the most effective HR interventions is the syringe/needle exchange. It implies that the provision of sterile syringes to IDUs will decrease needle sharing and thereby decrease the risk of HIV/hepatitis C transmission. Syringe distribution neither increases the number of injection drug users, nor it lowers the age of first injection, nor does it increase the number of used syringes discarded in the community.

Methadone substitution and maintenance is about using a synthetic opiate used by people dependent on heroin or morphine, which is the long-acting drug Methadone that could be taken orally.

Opioid maintenance programs are credited with being safe, decreasing dependency on illegal drugs, reducing criminal behaviour, and developing more trustful relations with IDU's physicians. Methadone substantially reduces the risk of HIV/AIDS/hepatitis C transmission and mortality from overdose. Yet, it has the downside of not being effective for all drug users and is addictive causing withdrawal. Buprenorphine, another opiate, could also be administered orally, it lasts longer than Methadone, is effective at lower doses, has milder withdrawal, and is at least as effective as methadone, yet it is not widely used, partly because the high cost.

The next intervention is the provision of safe injecting sites / consumption rooms. This allows drug users to inject in a safe, hygienic, and controlled environment. Safe injecting sites can improve individual and public health by preventing fatal overdoses, preventing the spread HIV/HCV, and acting as a referral point for other health services. According to Dolan (2004), this intervention is reducing the public nuisance, it improves access/uptake of health and other services, it reduces the risk of overdose, and it is associated with a reduced risk of HIV/hepatitis C transmission.

Target Groups

Injecting drug users (IDU)

The number of recorded IDUs has increased from 4 in 1980 to 765 in 1991. Officially, there were 7,564 IDUs reported in 2002, but the Ministry of Interior estimated that the real figure should be around 50,000. They spread HIV not only by sharing needles, but they also could be introducing the contagion into the broader population by means of unprotected sex.

A behavioural survey (3) recently conducted in IDUs revealed that most of respondents were young people from the 20 – 35 age group. Many are unemployed, despite half of them attempting to find a job and one in three having no income at all. Most of respondents interviewed have been using drugs for 5-6 years on average. Few of them have ever attempted any anti-IDU treatment and only one fifth of them considered they needed such a treatment.

A small number of respondents stated that they shared needles

during the last shot or during the last month; most of them (81-97%) said they didn't share needles with someone else throughout the last month. However, many were sharing needles indirectly, as for instance, 60% reported filling their syringes from a common jar, some 24% used front or back-loading (drawing in the drug directly from another syringe), 24% used pre-loaded syringes (and therefore couldn't be certain about whether those have been used before). Yet, they all corroborated the high availability of syringes, except for the convicts. Many IDUs were sexually active, each IDU having sex with 1.5 – 3.99 partners per year on average, except for commercial sex workers, who admitted having sex with 10.83 different partners per week on average. Most of them have been using condoms regularly, less so when having sex with permanent non-commercial partners.

There was an attempt to gear IDUs towards safer sexual behaviour in order to limit the spread of infection from the so-called "bridge" populations to the general public. More specifically, these activities provided for behavioural studies on IDUs, sentinel surveillance on HIV, information, education and communication activities targeting IDUs, peer education, condoms, bleach, needles and syringes provided to IDUs, facilitating access to services like early diagnosis and effective treatment of STIs based on a syndrome-driven approach, facilitating voluntary and confidential HIV counselling and testing, psychological support to IDUs, providing opioid maintenance therapy, if eligible. It also included a strong training element for specialists and the development of standard protocols and educational materials for the primary and secondary prevention of drug misuse. Without strong social and personal skills, improved self-esteem and long term psychological support, the detoxified drug user will easily relapse to taking drugs again.

Commercial sex workers (CSW)

According to official statistics, there are approximately 5,200 CSW in the country, but this figure is likely to be underestimated. The increase of unemployment and poverty in Moldova pushes many women into commercial sex within and outside Moldova. Women from the RM are working in the commercial sex industry in Italy, Greece, Albania, Turkey, France, FYR, Romania and Russia. Migration is now a growing phenomenon with an estimated 1 million Moldovan citizens working overseas. There has been an increase in the number of abandoned children, many of who live on the streets

and are at high risk of sexual exploitation and drug addiction. Nearly half of all CSW interviewed in the behaviour assessment survey said they were having another job somewhere else besides providing sex services and most of them were financially supporting 2-3 other people in their families.

Furthermore, there is an alarming number of persons who are being trafficked. Moldova occupies the highest position in Central and Eastern Europe of women and children who are trafficked. As in all other countries in the world, clients of sex workers are reluctant to use condoms and are willing to pay more to have sex without a condom, or get violent.

A vocational training subprogram for CSW was started up within one HR project, aiming at providing CSW with an opportunity for social and professional reintegration. Currently, there are five girls enrolled in the vocational training course, including hair styling and accounting. Their background is kept confidential and these girls have regular jobs alongside many other young girls.

Other exposed groups

There is little information on the risk behaviour of men having sex with men (MSM). One of the main reasons is that homosexual intercourse is still illegal in the RM. Fortunately not many men having sex with men have been infected with HIV (1.4% of all cases reported in 2004).

It is estimated that the overall number of convicts in Moldova accounted for 10,900 in 2002. According to the National Research Centre for Preventive Medicine (NRCPM), of all HIV cases registered in prisons throughout the country in 2004, 2% were reported in males, and 11.8% - in females (HIV/AIDS Surveillance Moldova 2004 Report).

The HR in prisons include condom distribution, syringe exchange (e.g., all prisons in Spain, Switzerland, Germany, and some prisons in the RM, while Luxembourg and Portugal are discussing implementation), substitution programs (heroin prescription available in one German prison since 1995, Methadone available in all EU countries, except Greece, Sweden and 2 Länder in Germany, bleach /

disinfectants (available in 12 EU countries and some Canadian prisons). There are some barriers to it, though: (i) zero-tolerance or abstinence-based approaches oftentimes more entrenched; (ii) admission of failure; (iii) discrimination against convicts; (iv) tort laws and punishment; and (v) staff safety concerns.

Finally there have been several prevention and educational activities among the military, people living on the borders, police and staff in prisons. Projects to expand the subjects to lifestyle behaviour and to expand VCT services to the military are about to be developed.

HR in the Republic of Moldova

As a means of secondary prevention of HIV/AIDS in vulnerable groups, the goals of HR in Moldova are (6): (i) to reduce the adverse effect of the social, economic and health harms owing to IDU; and (ii) to prevent the spread of HIV/AIDS/STI among vulnerable groups. HR goals rest on two key objectives: (i) to strengthen civil society involvement in implementing the HIV/AIDS Control Project; and (ii) to reduce the burden of HIV/AIDS in the RM. In this vein, the HR program is targeting the following vulnerable groups in Moldova: IDUs and prison inmates, commercial sex workers, men having sex with men, people living with HIV/AIDS, people living on the border and the military, migrants and truck drivers, and teens and youth.

The HR program got started as a pilot project in one district (district of Soroca) in 1997, that was subsequently scaled up to include one by one other districts and municipalities (Falesti, Orhei, Balti, Chisinau etc.) An NGO Facilitator Agreement was signed on May 8th, 2003, between the Soros Foundation – Moldova (SFM) on the one hand, and the Health Investment Fund (HIF) Project Coordinating Unit (PCU) under the purview of the Ministry of Health on the other hand. According to this agreement the Soros Foundation Moldova is supporting a network of NGOs and public services (Government organizations) to prevent the spread of HIV/AIDS among vulnerable groups at risk for HIV/AIDS. There are 32 HR projects operating in the

RM today. The financial commitment consisted of grants from SIDA/Sweden, World Bank (WB) International Development Association (IDA), GFATM, and Open Society Institute (OSI)-SFM, AIDS Foundation East-West (AFEW) – syringes and condoms, tallying up to some USD 13M for HIV/AIDS for 2003-2007, including USD 1.1M for HR from the WB/GFATM alone.

The increase in funding earmarked for HR made it possible to expand the vulnerable groups included in the projects and scale up the HR projects in the RM. The Soros Foundation Moldova supports HR activities through grant-giving and operational activities. Periodically, the Soros Foundation Moldova calls for project proposals from NGOs and less often from GO on HR-related actions, making allowance for the scope of services to be provided, geography, vulnerable groups covered, number of service recipients, capacity to implement a given project proposal. Secondly, it is also operating various HR activities for project staff members, program staff and other relevant stakeholders. Hence, the Soros Foundation Moldova is doing the management of activities carried out by NGOs implementing HR projects within the framework of the AIDS Control Project. It is also managing procurement of goods in a centralized way by selecting the best offer following a competitive bidding. It provides basic training and is supporting the running costs associated with conferences, trainings, seminars, and round tables in HIV/AIDS/STI in general and HR in particular.

There are tight connections between the national AIDS program and the civil society in: HR (32 projects, including projects in prisons, serving 5,000 service recipients), HIV/AIDS/STI prevention among sex minorities, commercial sex work, training of trainers and training of volunteers in the development of skills and peer education (teenagers, youth, military, special force, people living on the border), social and psychological support, hotline counselling, media training in the HIV/AIDS service area.

More specifically, the provision of goods included centralized procurement of syringes, condoms, disinfecting kits, disposable razors etc., that have been further distributed to project sites on an as-needed basis following written requests from project directors. The Soros Foundation Moldova is also accountable for putting out and copying

information materials and education pamphlets aiming at reducing risky behaviours in vulnerable groups or keeping the general public informed at all times. The transparency of the process is kept by posting all the relevant information on the Soros Foundation Moldova official web site, and by updating it on a regular basis. Besides, information is disseminated on local TV channels and radio stations. There are more outreach activities (free distribution of condoms and lubricants, provision of info materials on HIV/AIDS/STI prevention, and peer education) in gay cruising areas and gay discos.

The first ever methadone substitution therapy (MST) project was started in the last quarter of 2004, after 60L of liquid Methadone was legally imported by SanFarmPrim in Moldova in September of 2004. Moldova was the first one from the CIS countries to introduce MST, an achievement currently matched by Kyrgyzstan only. The MST is provided in the only Methadone treatment entry point available in the country, the National Centre for Drug Addiction. This substitution therapy is provided both in inpatient and outpatient settings. Currently, there are nine people taking Methadone on a daily basis, none with HIV/AIDS though. First, those enrolled in the MST have to comply with an in-patient detoxification therapy at the National Centre for Drug Addiction (NCDA) before taking Methadone. Not all the people wanting to join the MST could do it, subject to medical indications and contraindications, and the condition of being under the supervision of a drug addiction specialists for at least a couple of years. Many think that these terms and conditions should be made less restrictive and more inclusive, so that many more IDUs could join the MST. All those undergoing this therapy are doing well in terms of health, except for one death case, although not linked to the intake of Methadone. Of the 60L of Methadone imported, little over one gallon of drug was delivered to the National Center for Drug Addiction, and just half a gallon was used up to date. There is another contract signed with the Department of Prisons under the Ministry of Justice to provide MST in a female prison (Rusuca), but the program is just about to get started. There are still certain issues with police force and the MAI Drug Control Department, as they periodically run checks on the NCDA and other relevant facilities. It took five years to import Methadone to Moldova. Further efforts are bent to legalize this drug in the country, considering the high consumption of opiates and poppy-based opiate derivatives, although many oppose it. All the 19 prisons in the country

have condoms supplies and disinfecting kits; however, needle exchange is available only in three “pilot” prisons. The World Health Organization is strongly encouraging the use of opioid maintenance therapy in the treatment of IDUs, after methadone and buprenorphine have been added to the complementary list of the WHO Model List of Essential Medicines (July 2005).

More directly, SFM is contributing to the HR program by: (i) capacity building (training courses, technical assistance etc.); (ii) regular monitoring of actions and checking on the financial accuracy of projects by undertaking field visits and running financial report audits and checking the projects’ reports of activities; (iii) contracting firms to carry out behavioural studies and sentinel surveillance studies, and assessing the latter ones; (iv) collaborating with central authority (Ministry of Health, district health authorities) and local public authorities in ensuring the on-site support for its running projects and make them commit to HR actions; (v) keep close ties with media, including an HR web site, advocating for HR, meeting up with journalists, putting out a monthly pamphlet “Saninfo”, and organizing a contest for the best HR article published in the media); (vi) Non-governmental organizations support and needle exchange programs (including peer-to-peer education); and (vii) procurement of goods (syringes and condoms, each project procured disinfectant sets, bleach, a range of different antiseptics and local antibiotics and cotton/bandage to further distribute to their clients).

The success or failure of the HR program in the Republic of Moldova is judged based upon a set of indicators – outcome indicators (drop in the incidence of HIV in vulnerable groups, 25% reduction in HIV incidence in IDUs, 25% reduction in the incidence of syphilis, 90% reduction in mother-to-child transmission rate), and process indicators (60% of IDUs covered, 60% of commercial sex workers covered with services etc.) During the project implementation, the Soros Foundation Moldova program staff is paying visits to some of the project sites, but not fewer than twice a year for each. Well-established “old” projects are supervising the newly accepted “freshmen” projects by providing them with technical assistance whenever the case.

Almost 90% of all subpopulations subject to surveys, except

for the convicts from one interview site, said they have previously participated in HR projects before. Some of respondents used these services without knowing those were called HR services. In all respondent groups, needle exchange and condom distribution programs were cited as the most widely used and heard of, followed by information pamphlets, distribution of disinfecting kits and antiseptics and voluntary testing and counselling, whereas all types of consultations were the least used of all. Approximately 30% of all prison inmates stated that they have participated in HR programs before being sent to jail and all of them used voluntary and confidential testing and counselling, needle exchange, condoms and psychological counselling.

Moldova's HR Priority Directions

There are several quasi-important dimensions to the HR program in the Republic of Moldova. The HR gears changed towards priority areas that are more important in strengthening the joint efforts of all partners in the wake of a changing HIV/AIDS epidemiologic pattern in the country (7).

Public policy and advocacy

The HR policy and advocacy component is critical to HR, especially considering the HIV/AIDS public awareness campaign that is being carried out by AFEW, aiming at targeting the lay population, first of all. Besides targeting the mainstream population, hard work was done with service providers in terms of communication campaigns and cooperation, thus already having involved dermatovenereologists and drug-addiction specialists, alongside primary care physicians and nurses, communicable disease experts etc., in working and better understanding vulnerable groups at risk for contracting HIV/AIDS, the main bulk of which still are IDUs.

Another advantage relevant for many projects started in the past is a strong commitment for media outreach and close ties and cooperation with press in covering HIV/AIDS related issues. The work with journalists and for journalists has been carried on, as the lay people and professionals alike are becoming more aware about what the HIV/AIDS infection is all about and how to fight it. Unfortunately, the community still has little involvement in HIV/AIDS prevention,

care and treatment actions. Media should continue to elaborate on health issues, work of health facilities, health workers etc., and bring up both advantages and disadvantages, as viewed by the lay people and professionals, to the attention of all the stakeholders, not just decision-makers. NGOs are putting out newsletters and health pamphlets with relevant information on a regular basis, going beyond the scope of just making people aware, but also trying to make them more sensitive and get involved in service provision, or at least be more receptive to the needs and efforts in this service area. As many people don't have wide access to printed media, there should be some TV shows and radio broadcasts, as well, on the National TV channel, and the National Radio Station.

Special emphasis is put on the best practices and skills in other countries, where HR have already proven their usefulness and cost-efficiency, by adopting the best knowledge and experience, as well as keeping in mind the lessons learned by our neighbours and other countries in fighting HIV/AIDS, and adjust them to Moldova's changing environment and patterns of infection. Outstanding is the need to streamline the communication between different donors, partners and other stakeholders in attempting to work out global solutions for global issues in HIV primary and secondary prevention, care and treatment. Information pamphlets are printed in two languages currently in use in the RM with enough circulation to cover the present needs. National protocols of care and treatment are being reviewed and adjusted so that they comply with international standards.

Another important issue is the need to tune up the legislation so that it allows for better management of some drugs currently not in use in the country, yet critical for the work of many health facilities, such as Methadone for substitution therapy, and oral morphine in palliative care for terminal HIV/AIDS service recipients. A standing work group on pharmaceutical is being set up now, to target legislation and look into ways to appropriately adjust the laws, human rights being just one of the many issues to work on.

Capacity building and education

Although people working in various HR projects all over the country have benefited from some training courses and seminars in the past, still very few of them have adequate knowledge and skills to operate under scarce funds and underdeveloped legal and policy

frameworks. Most of the projects supported by the Soros Foundation Moldova / Open Society Institute are the first and the only HR services in the communities they operate in, besides short tenure and little prior organizational experience. Moreover, representatives of vulnerable groups should be included in the decision making process by arranging for the NGO representing them or acting on their behalf attend the round tables organized on various HIV/AIDS and policy issues, so that their voice could be listened to.

The Soros Foundation Moldova is carrying on a series of technical assistance and training workshops for the project staff to help them better meet the needs of service recipients, and increase their organizational capacity. Topics brought up range widely: organizational development, overdose prevention, outreach and secondary needle exchange, research, evaluation, and data collection, targeting the needs of minorities and HIV/AIDS customers, and community empowerment. On top of that, the Soros Foundation Moldova is also carrying out local study tours, and makes its roster of local and foreign technical assistance advisors available to the relevant organizations that could be of interest to project managers and their staff.

Networks and coalition building

There have been scattered efforts to get all the stakeholders working in HIV/AIDS get together under a single umbrella organization, or a network of organizations. Despite the communication and information sharing is getting better, still there should be more efforts to develop a single network for all the stakeholders, including, but not limited to, the people living with HIV/AIDS, vulnerable groups and their families, professional community, mainstream population and media, i.e. all who could advocate for the rights of the people living with HIV/AIDS and their families, shape HIV/AIDS policies etc. This would be a perfect tool for disseminating the data and information from the behaviour study accomplished with the Soros Foundation financial support, and advocate for embedding it into NGOs' own strategies.

The Soros Foundation Moldova is about to launch a call for project proposals for organizations that would have the capacity and resources to carry it out with its financial support. This could also be a

joint project between several organizations, such as, for instance, the NGO of people living with HIV/AIDS “Credinta” (Faith), and/or the NGO “Youth for the Right to Live” in Balti. There should be special considerations given to the candidates who have already proven effective in dealing with issues that the people living with HIV/AIDS face day after day, and assist them in implementing the given network.

Direct service support

Despite somewhat shifting the priorities into a slightly different direction, the SFM plans on carrying on the TA and financial support provided to the civil society working with vulnerable groups and mainstream population in terms of HR. There are 32 HR projects currently going on countrywide, run by 17 organizations all over the country (end 2004). HR services will further be targeting vulnerable groups (IDUs, commercial sex workers, men having sex with men etc.) by providing them with needle exchange services, retraining opportunities, public awareness campaigns, condom distribution, MST and other, tailored to the needs of these groups and to the needs of the general public.

Nevertheless, there is a gap in organizing HR services in certain regions of Moldova, such as the South of the country (district of Cahul, ATUG) and to the East of the Nistru River (the breakaway region of Transnistria). Along scaling up the existing services where they have already proven efficacy and progress in reaching out for vulnerable groups, one should look for new organizations out there, or provide existing projects with incentives to scale up their services in regions without HR coverage, so they could reach for the people living in ATUG and Transnistria.

Nest steps

A number of priorities have been identified for the years to follow: (i) lower burden of HIV/AIDS in vulnerable groups; (ii) strengthening and consolidating HIV/AIDS, HR and people living with HIV/AIDS networks; (iii) safer behaviour practices in vulnerable communities; (iv) scale up the coverage of vulnerable groups with HIV/AIDS/STI control services; and (v) national health policies tailored to the needs of vulnerable groups and their compliance with international standards.

More specifically, HR programs should aim at: (i) targeted education activities need to continue to emphasize safe injecting practices and also keep the public alert about the indirect use of injecting drugs, as the respondents showed good knowledge about directly sharing syringes, and poor knowledge about the indirect sharing of needles; (ii) identify specific risk situations which facilitate the indirect sharing of injecting drugs, linked to certain drug use traditions pervasive in drug users; (iii) targeting unsafe sex practices – despite a relatively high use of condoms when engaging in sexual intercourse, condoms are less often used while having sex with permanent partners; (iv) further increase the level of knowledge about HIV/AIDS and prevention measures, safe sex practices, harm reduction etc., by involving drug users and getting their feedback as to the effectiveness and appropriateness of measures suggested; (v) for commercial sex workers projects, ensure a steady condom supply that otherwise were not used because of high cost and the use of other contraceptives, by also alerting them that condoms are not just contraceptives, but also a preventive measure to control STI and HIV; (vi) given that commercial sex workers have non-commercial IDU sex partners, there should be ways to reach for the sex partners of CSW; (vii) change the behaviour patterns in convicts, addressing safe sex practices, stigma and other; and (viii) behavioural assessment surveys should be conducted on a regular basis. Moreover, MST eligibility criteria should be made more-inclusive by reviewing the selection criteria currently employed by the NDAC, and by attempting to legalize Methadone in Moldova; (x) seek the support of policy makers at higher levels in an attempt to institutionalise the HR strategy in the long run; (xi) prisons should get more involved in needle exchange programs and secure an appropriate bulk of methadone substitution therapy service recipients; (xii) There is a need to plan for a suitable system for contaminated needle disposal.

On a larger scale, the National AIDS Program suggests that: (i) exposed groups should be covered with testing for HIV1 and HIV2 markers, especially IDU, TB patients, people with risky sex behaviour, transfusion blood recipients, people having sex with people living with HIV/AIDS, foreign citizens; (ii) there should be more accurate and reliable data on HIV/AIDS cases, risk factors and routes of transmission in HIV cases brought from abroad in performing

epidemiologic surveillance; (iii) look into the possibility to combine ART services with MST and other treatment and care services relevant for people living with HIV/AIDS. Also, seek to make the ART available to people living with HIV/AIDS in prisons, and develop the ART program alongside MST in there; (iv) change the behavioural patterns of IDUs in an attempt to make them comply more with ART and care regimens; and (v) adjust the national mandatory health insurance scheme to include IDUs and other exposed communities who usually lack insurance and can't afford having one.

On the HIV/AIDS treatment and care side, the WHO mission agreed with local and international stakeholders: (i) to have ART needs and targets more accurately estimated for Moldova, as there is no clear picture on the IDU profile, little information about people living with HIV/AIDS etc.; (ii) review and work out confidentiality issues in reporting HIV positive cases within the health system to avoid dissemination of personal information; (iii) to make the selection criteria for MST more inclusive and make people living with HIV/AIDS part of this program, as currently reportedly there are only a couple of HIV infected on methadone, but their HIV status is yet to be confirmed; (iv) to include WHO recommendations into the national protocols on HIV/AIDS treatment and care; (v) make ART geographically available in other regions beyond the only site that is providing ART today (Chisinau), including areas with most of IDU cases (Balti, Tiraspol etc.); (vi) to pre-test a WHO HIV care/ART card and reporting forms, and develop a standard for monitoring these cases; (vii) to initiate a media campaign that is being developed by AFEW in order to scale up access to ART; (viii) develop social care and palliative care to increase life-long treatment and adherence to therapy. Pre-test and post-test voluntary counselling services should be revised and more widely used by relevant specialists; (ix) advocating for policy change (failure of zero-tolerance/criminalisation, evidence-based, cost-effective, promotion of legal, ethical, human rights, collaboration between drug users and health professionals, between organizations, and between countries).

Exercise

Split randomly the class into two parts (left and right, or front and rear), and assign the first team (advocating for the implementation of an opioid maintenance therapy program – OMT – nationwide) to brainstorm the pros for it, while the second team (opposing the implementation of the OMT program nationwide) to think of cons. Give them around 20 minutes to brainstorm pros and cons, and put them down on paper (flip chart) as bullet points. Make each team assign a representative to be their speaker and let them present to the other team their main ideas. After each team made their presentations (one team – on ‘pros’, and the other one – on ‘cons’), start the Q&A session to initiate the debates.

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PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT A Handbook for Teachers, Researchers, Health Professionals and Decision Makers	
Title	Development of a Tobacco Control Strategy as a specific contribution to Public Health
Module: 4.3.3	ECTS (suggested) 1.0
Author(s), degrees, institutions	Dr Eleanor Hill (B.SocSci, M.Ed, PhD) The author is an independent health development consultant based in the UK.
Address for correspondence	7 Cleavley St, Eccles, Manchester, M30 8EB, UK (email: e.j.hill@which.net)
Keywords	Tobacco control, public health, legislation, multi-sectoral, action plan.
Learning objectives	By the end of this module the student should be able to: <ul style="list-style-type: none">• justify the importance of tobacco control in relation to public health;• explain the nature of the WHO Framework Convention on Tobacco Control;• understand the process of drafting a national tobacco control strategy and action plan;• identify the key stakeholders to be included in any debate about tobacco control;• suggest an appropriate structure to ensure successful implementation of a national tobacco control strategy.
Abstract	The control of the negative impact of tobacco consumption is a vital part of public health in the majority of countries. Tobacco consumption is a major cause of morbidity and mortality as it is associated with cardiovascular, respiratory and malignant diseases. Control of tobacco is a priority of the World Health Organisation. The Framework Convention on Tobacco Control is the first document of its kind: achieving international recognition and action in relation to a specific public health issue. The development of national tobacco control strategies can be strengthened by utilising the Framework Convention as a template. However, it is important to pay attention to country-specific aspects of control,

	<p>such as, existing legislation, advertising practice and economic implications in developing a practical strategy that will be possible to implement.</p> <p>Obtaining a broad political consensus is also a vital aspect of tobacco control in order that all stakeholders may be included in the debate and means selected to reduce the negative results of control measures on certain groups.</p> <p>Developing the national strategy must be linked to the production of an Action Plan. This details the steps that should be taken to strengthen tobacco control giving responsible bodies and deadlines for their achievement. A multi-sectoral involvement is essential to success.</p>
Teaching methods	<p>These may include lectures, structured discussions with case studies, group work and individual project work.</p>
Specific recommendations for teacher	<p>Copies of the WHO Framework Convention on Tobacco Control should be made available to students during the module. It will also be helpful to present national statistics on tobacco-related illnesses to support discussion. The module may be structured as follows (1.0 ECTS credit): supervised time - lecture 2 hours; seminar 6 hours; structured exercises 6 hours: unsupervised time - group project 8 hours; individual reading and assignment preparation 8 hours.</p>
Assessment of students	<p>An individual written assignment justifying the relevance of tobacco control to public health within the country, identifying the key supports and barriers to progress and describing the key stakeholders in relation to tobacco control issues.</p> <p>A group project in the form of an outline for a draft national tobacco control strategy based upon the WHO FCTC and including priorities for action in the first five years of implementation.</p>

DEVELOPMENT OF A TOBACCO CONTROL STRATEGY AS A SPECIFIC CONTRIBUTION TO PUBLIC HEALTH

Eleanor Hill

Tobacco control is a priority for public health professionals in many countries. The burden of disease relating directly or indirectly to the consumption of tobacco products is considerable. The health impact of smoking is now well documented internationally. The specific contribution of smoking to mortality from a number of different causes in Serbia was assessed through the Burden of Disease Study undertaken in 2003 (1). Tobacco is cited as the risk factor associated with the greatest health problems and is responsible for 13.7% of the total years of life lost (YLL) in Serbia (18% for males; 7.9% for females). Most of the tobacco burden is due to lung cancer, ischaemic heart disease, stroke and chronic obstructive pulmonary disease. The study also indicated that the burden is greatest in lower ages and declines with an increase in age.

As control measures in specific countries are strengthened, the tobacco industry has responded by moving production or altering the populations it perceives as its primary target groups. For example, more vigorous advertising of tobacco has occurred in developing countries following the restrictions imposed in Europe, North America and Australasia. This strategy enables the tobacco industry to maintain a high level of demand for its products. It has also resulted in an increased burden of tobacco related disease in these countries.

However, mechanisms for successful control of tobacco consumption have been greatly strengthened by the WHO Framework Convention on Tobacco Control (2) which came into force in 2005 following ratification by the required number of countries. This provides an international framework for achieving tobacco control that can be adapted for use by individual countries. Cooperation and collaboration on many control issues have been increased as a result.

The Framework Convention identifies the key areas on which a national strategy should focus to achieve satisfactory impact on levels of tobacco consumption. These include reducing demand for tobacco products, reducing availability of tobacco products, restricting sale and advertising relating to tobacco products, and restricting those areas in which tobacco consumption is legally permitted.

By adapting the WHO Framework, individual countries can more easily create a national strategy that is tailored to their specific context while also meeting these key requirements for successful tobacco control.

This has been achieved in Serbia. A working group was formed by the National Committee for Smoking Prevention, established by the Ministry of Health. The working group included staff from the “Support to the Public Health Development in Serbia” project (SPHDS), funded by the EU and managed by the European Agency for Reconstruction through its contractor Euro Health Group. This small group met several times over a period of five months to adapt the Framework Convention to the Serbian context. The final draft of a national strategy document was then approved by the full National Committee for Smoking Prevention (NCSP) before being submitted to the Ministry of Health. After due consideration and any further amendments, the document will be presented to parliament for approval. An English language draft is presented here for teaching purposes: it is not an official document.

Members of the working group who undertook this work were, from the NCSP, Dr Natasa Lazarevic Petrovic; Dr Srmena Krstev and Dr Snezana Ukropina; and from the SPHDS project, Dr Eleanor Hill; Dr Andjelka Dzeletovic and Dr Sanja Matovic Miljanovic.

**TOBACCO CONTROL ^a STRATEGY FOR THE REPUBLIC
OF SERBIA
(English Language Draft October 2004)**

1. Introduction

1.1 Context for Tobacco Control in Serbia

On 28 June 2004 the Government of Serbia took a significant step in relation to the control of tobacco in Serbia by signing the World Health Organisation Framework Convention on Tobacco Control (FCTC) (2). By becoming a signatory to the FCTC, the government clearly indicated that this is a priority for action, giving fresh impetus to the development of a national Tobacco Control Strategy.

This document is based on the WHO Framework Convention for Tobacco Control, the European Strategy for Tobacco Control (3), the Ministry of Health, Republic of Serbia document Better Health for All in the Third Millennium – Health Policy section (4) and the Poverty Reduction Strategy Paper (5) in Serbia.

The mandate of the National Commission for Smoking Prevention, officially established in March 2003 by the Ministry of Health^a, is to prepare a National Programme for smoking prevention and to implement and co-ordinate all activities related to smoking prevention and cessation. Membership of the Commission is drawn from the Ministry of Health, staff working in primary health care and hospital facilities, members of the public health profession and the pharmaceutical industry, and relevant non-government organisations.

The cooperation of all these individuals and of other relevant institutions and organisations was instrumental in the production of this Tobacco Control Strategy that will provide a sound framework for all other activities relating to tobacco issues.

^a In accordance with Decision Number 500-01-136/2003-02 of the Ministry of Health, Republic of Serbia.

1.2 Smoking prevalence

The existence of a global tobacco epidemic is now accepted as a fact by health professionals around the world. Smoking prevalence in Serbia is among the highest in Europe, with 48% of men and 33.6% of women active smokers (6). Rates of smoking among youths are also high: 40% of teenagers have already smoked a cigarette by the age of 15 years (7), while 27% of girls and 26.5% of boys state that they are daily smokers. Exposure of young people to environmental tobacco smoke is a serious problem, as indicated in the recent Global Youth Tobacco Survey (8).

Although medical staff should play a key role in smoking prevention and cessation, the frequency of smoking among health workers is high. According to a study carried out in 2001, 37% of doctors and more than one-half (52%) of nurses at the Clinical Center of Serbia smoke (9).

According to one of few international comparisons in which data for Serbia and Montenegro are presented, the prevalence of smoking in the Republic of Serbia is similar to other countries in transition where smoking is culturally accepted and very widespread (see Table 1) (10).

Table 1 Smoking Prevalence in European Countries in the period 1988-2003

COUNTRY	Adults (%)		Youth (%)	
	Male	Female	Male	Female
Serbia and Montenegro	48.0	33.6	12.5	16.3
Bulgaria	43.8	23.0	28.7	26.4
Greece	46.8	29.0	13.5	14.1
Russian Federation	63.7	9.2	17.6	26.2
Turkey	62.2	24.3	17.6	11.2
Albania	60.0	18.0	No data available	No data available
United Kingdom	28.0	26.0	20.3	27.4
Finland	27.0	20.0	28.3	32.2
Germany	40.3	32.2	32.2	33.7

Source: WHO. European Country Profiles on Tobacco Control. 2003.

This table is based on WHO European Country Profiles on Tobacco Control 2003 (10). Data for Serbia and Montenegro are from

2000. For other countries the data are from different periods.

1.3 Harmonisation with European Union

Action in relation to tobacco control is an important aspect of the harmonisation of Serbia with the countries of the European Union, which has the eventual goal of membership. The Tobacco Control Strategy identifies the key steps to be taken in moving towards this goal.

1.4 Previous Action on Tobacco Control

The Ministry of Health and the National Commission for Smoking Prevention have already undertaken a number of actions in relation to reducing the supply of and demand for tobacco products.

- Anti-smoking campaigns for National No Tobacco Day, World No Tobacco Day and Quit & Win during 2002, 2003 and 2004;
- Two national conferences for staff from health institutions involved in tobacco control during 2003;
- Support for and development of a national network of counselling services for smoking cessation;
- Implementation of the Global Youth Tobacco Survey during 2003;
- Strengthening implementation of existing anti-smoking and tobacco control legislation;
- Contribution to changes in legislation relating to tobacco control;
- A workshop on promoting smoking cessation funded by the Canadian Public Health Association in 2004;
- Organisation of the inter-ministerial conference on the WHO FCTC in June 2004;
- A national road-show tobacco debate in July 2004 visiting five cities around the country and involving health, education and media personnel as well as members of the public;
- Support to the smoking cessation and nicotine harm reduction aspects of the Kraljevo Pilot Project.

2. Concept and Rationale of the Serbian Tobacco Control Strategy

2.1 Current Status

Within the European Strategy for Tobacco Control (ESTC) a number of indicators are identified that may be used to assess the current status of a country or region in respect of tobacco control policies. Table 2 below shows the current status of these indicators in Serbia.

Table 2 ESTC Indicators and Current Status in Serbia

Indicator	Status in Serbia
Legislation for smoke free public/working space	Legislation exists but implementation is weak or non-existent
Availability of nicotine replacement therapy without prescription	Available without prescription
Established intersectoral coordinating committee	Does not exist
Existence of a national action plan	Draft produced by National Smoking Prevention Commission in 2004
Partial/total bans on direct/indirect advertising of tobacco products	Total ban exists but implementation is weak or non-existent
Sustainable and gender-based public information campaigns	Public information campaigns undertaken on annual basis funded by Ministry of Health and/or international donors; no specific gender element
Earmarking of taxation from tobacco products	None
Restricting access to tobacco products for under 18s	Legislation exists, implementation weak or non-existent
Reimbursing of costs of treatment of tobacco dependency	Provision of support for smoking cessation is limited. Counselling is free, NRT & Bupropion available but cost is not reimbursable.
Publication of comprehensive national reports on tobacco control	No
Health warnings on tobacco products	A specific warning must be displayed, but the size is not legally defined, does not meet EU norms

Regulation of tar, nicotine and carbon monoxide levels in tobacco products	Limits exist in law but allow higher levels than EU norms
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Source: Adapted from WHO. European Strategy for Tobacco Control. Copenhagen: WHO Regional Office for Europe; 2002.

Although it is not related to the criteria used to assess current status within the ESTC, it is important to note that the government of Serbia has taken one important step towards effective control of the tobacco industry with the establishment of the Tobacco Agency in 2003 (11). The Tobacco Agency has responsibility to control the agricultural production and sales distribution aspects of the tobacco industry in Serbia.

There is a substantial body of legislation in existence that relates to issues of tobacco control. At least seven laws and three Books of Regulations either deal primarily with, or contain articles of relevance to, tobacco control. The key legislative documents are:

- Law on Ban of Smoking in Public Places; Official Gazette RS No 16/1995
- Law on Sanitary Regularity of Food and Objects of General Use; Official Gazette SFRY No 53/91, Official Gazette FRY No. 24/94, 28/96, 37/02
- Law on the Foundations of the Tax System; Official Gazette FRY, No 30/96, 29/97, 59/98, 44/99
- Law on Changes and Amendments of the Law on the Foundations of the Tax System; Official Gazette FRY, No 53/99
- Law on Excise Tax; Official Gazette RS, No 22/01, 73/01, 80/02, 43/03, 72/03
- Law on Tobacco; Official Gazette RS, No 17/03
- Book of Regulations on conditions for Sanitary Regularity of the Objects for General Use which are ready for Sale; Official Gazette SFRY, No 26/83
- Book of Regulations on Ways of Posting the Ban on the Sale of Cigarettes and other Tobacco Products to Underage Persons and on Harmfulness of Smoking; Official Gazette RS No. 60/03
- Book of Regulations on Contents and Ways of Posting Labels on Means of Transportation for Tobacco Transport; Official

Gazette RS No. 60/03

Table 3 shows the smoking prevalence rates found in a number of different research studies undertaken around the country (6, 7, 12).

Table 3 Prevalence of smoking in Serbia

POPULATION	Year	% of smokers
Adults, older than 19 (without Kosovo)	2000	40.4%
School children in the 5th and 7th grade of primary school, and 1st grade of high school in Belgrade	1999	23.3%
Students in the primary* and high** schools	1996	* 7.5%
		** 37.5%

Sources: Grujic V. *Zdravstveno stanje, zdravstvene potrebe i korišćenje zdravstvene zaštite odraslog stanovništva u Republici Srbiji*. Glasnik Instituta za zaštitu zdravlja Srbije; Vol.1-2:23-147; 2003; Bjegovic V et al. *Health Behavior of School Children*. Institute of Social Medicine, Belgrad: 1999; Janovski N et al. *Study in children smokers in Serbia*. *Eur Respir J*. 9 (suppl. 23). 1996.

Data from the recent Global Youth Tobacco Survey in Serbia (GYTS) (13) is shown in Table 4 below and, with respect to the trends in tobacco use, this survey indicates that young people are taking up smoking at a high rate.

The GYTS also collected information on other aspects of tobacco control. These data clearly show the normalisation of smoking within Serbian culture, for example, the high proportion of young people living in a home with smokers, and the proportion of pro-smoking messages seen in the media. One more positive statistic is the proportion of young smokers who want to stop smoking and/or have tried to do so.

Table 4 Selected Results of the Global Youth Tobacco Survey of Serbia

<p>Prevalence 54.7% of students have ever smoked cigarettes (Boys = 54.4%, Girls = 55.2%) 16.3% currently smoke cigarettes (Boys = 15.5%, Girls = 16.8%) 19.1% of never smokers is likely to initiate smoking next year (Boys = 16.6%, Girls = 22.0%)</p>
<p>Access and Availability - Current Smokers 69.8% buy cigarettes in a store 92.4% who bought cigarettes in a store were NOT refused purchase because of their age</p>

<p>Environmental Tobacco Smoke 97.4% live in homes where others smoke in their presence 91.3% are among others who smoke in places outside their home</p>
<p>Cessation - Current Smokers 54.4% want to stop smoking 77.8% tried to stop smoking during the past year 66.6% have ever received help to stop smoking</p>
<p>Media and Advertising 84.1% saw anti-smoking media messages vs. 89.8% saw pro media messages on TV 52.1% saw anti messages vs. 70.7% that saw pro messages on billboards 59.4% saw anti smoking ads vs. 80.4% that saw pro-cigarette ads in newspapers or magazines 29.9% have an object with a cigarette brand logo 23.5% were offered free cigarettes by a tobacco company representative</p>

Source: CDC et al. Global Youth Tobacco Survey (GYTS) - Fact Sheet for Serbia. Serbia: MoH; 2003.

The health impact of smoking is now well documented internationally. Smoking is one of the leading individual risk factors for the development of the most common chronic non-communicable diseases (cardio-vascular, respiratory and a number of malignant diseases), for effects on infant, child and young people's development and health, as well as for injuries, deaths and environmental pollution (see Table 5).

Table 5 Comparison of Standardized Death Rates for leading causes of death in Serbia and Montenegro and Europe for age 0-64 per 100,000 population (14)

Cause of Death	Serbia and Montenegro	Europe	EU average
Ischaemic heart disease	44.6	62.3	22.2
Cerebrovascular diseases	39.2	30.9	8.5
Malignant neoplasms	95.8	88.5	76.9

Source: WHO/Europe. European Health For All Data Base. 2004.

The specific contribution of smoking to mortality from a number of different causes in Serbia was assessed through the Burden of Disease Study (1) undertaken in 2003. These are shown in Table 6 below. Tobacco is cited as the risk factor associated with the greatest health problems and is responsible for 13.7% of the total years of life lost (YLL) in Serbia (18% for males; 7.9% for females). Most of the tobacco burden is due to lung cancer, ischaemic heart disease, stroke and chronic obstructive pulmonary disease (Table 6). The study also

indicated that the burden is greatest in lower ages and declines with an increase in age.

A decrease in smoking prevalence would, therefore, be one of the most important measures in public health that should be implemented to improve the health of the 7.5 million people in Serbia.

Table 6 The mortality burden attributable to tobacco use by disease for Serbia and Belgrade in 2000

Disease	Serbia		Belgrade	
	Attributable Deaths	Attributable YLL*	Attributable Deaths	Attributable YLL*
Oral Cavity Cancer	363	4,276	67	861
Lung Cancer	4,101	47,781	1,031	12,228
Oesophageal Cancer	173	1,851	35	402
Pancreatic Cancer	158	1,708	30	280
Bladder Cancer	61	1,149	30	257
Cervical Cancer	45	725	10	157
Ishaemic Heart Disease	2,082	24,127	384	4,482
Stroke	1,816	19,891	364	3,983
COPD **	1,390	9,676	167	1,194
Total	10,187 (9,8%)	111,196 (13,7%)	2,118 (10,7%)	23,843 (14,8%)

*YLL – Years of life lost ** Chronic Obstructive Pulmonary Disease

Source: Atanaskovic-Markovic Z et al. *The Burden of Disease and Injury in Serbia. Serbia: MoH; 2003.*

2.2 Challenges

Smoking prevalence remains at an alarmingly high level in Serbia. The impact upon the health of the population in the coming decades will be devastating, resulting in premature death for many, reduced quality of life for many more, and incurring substantial social and economic costs to Serbian society. As yet, there is only the beginnings of a political consensus to address the problem.

It will take time to alter the perceptions of the population regarding smoking, as this behaviour is very much embedded in Serbian culture. Provision of education and information to the public

about the negative consequences of smoking is an important prerequisite for progress in other aspects of tobacco control. This is necessary to achieve public understanding, acceptance of and support for stronger tobacco control measures.

The tobacco industry plays a significant part in the Serbian economy at both national and local levels. It is in a strong position to defend itself. The weaknesses in the implementation of existing laws allow the industry to promote tobacco products to a broad range of population groups and through a variety of media. The strength of the industry also makes it harder for politicians to seek alterations in price and taxation regimes for tobacco products. Action to ensure full implementation of existing anti-tobacco legislation is therefore a priority in achieving adequate regulation of the industry. Although an multi-sectoral Tobacco Agency has been established, it is only responsible for agricultural production and trade aspects of the industry and has no role in issues relating to control of tobacco consumption.

2.3 Approaches to Tobacco Control Policy in the SE European Region

With respect to the classification set out in the ESTC document Serbia may be said to be moving from a weak approach to a transitional approach in its efforts to address tobacco control. In this respect it is similar to its regional neighbours.

2.4 Guiding Principles and Concept

This Serbian Tobacco Control Strategy (TCS) draws on European and international experience over the last decade, building upon the lessons learnt during their efforts to address issues of tobacco control.

The *guiding principles* of the Strategy are as follows:

- That it is the right of every citizen to be informed about the health consequences of smoking and exposure to tobacco smoke;
- That it is the right of every citizen to live and work in a smoke free environment;
- That it is the right of every smoker to obtain advice and support concerning smoking cessation through the health care

system;

- That it is the responsibility of the government to protect the health of all its citizens and therefore to take whatever legislative, economic and administrative measures are necessary to reduce levels of tobacco use and exposure to tobacco smoke;
- That political commitment to tobacco control is essential and is best achieved through comprehensive multisectoral action to bring about the denormalisation of smoking behaviour;
- That it is the responsibility of the government to allocate sufficient funds to tobacco control activities to ensure continual reduction in levels of smoking and exposure to tobacco smoke throughout the population.

It is intended that the TCS will be regularly reviewed and strategically adapted as the situation in Serbia changes with time as the impact of tobacco control measures is felt. To this end, the Strategy includes provision for a system of monitoring and evaluation.

2.5 Goal and objectives

The overall *goal* of this Strategy is to provide a framework for the implementation of tobacco control measures to ensure the future health and wellbeing of the citizens of Serbia and protect them from the harmful effects of smoking and exposure to tobacco smoke. Numerical targets are set for three aspects:

- To reduce smoking prevalence in minors by 1% and in the general population by 0.5% annually (from the date of strategy adoption);
- To increase rates of cessation among the smoking population by 1% annually (from the date of strategy adoption);
- To increase the number of smoke-free workplaces by 5% annually (from the date of strategy adoption).

The immediate *objectives* of the Strategy are as follows:

1. To prevent the future initiation of smoking behaviour, especially among young people;
2. To reduce levels of tobacco use across all population groups by encouraging and supporting smokers to stop and providing cessation services;
3. To protect the health of the population by reducing exposure to

- environmental tobacco smoke;
4. To educate the public concerning the harmful health effects of smoking and exposure to tobacco smoke;
 5. To ensure adequate regulation of the tobacco industry with regard to the production, advertising and sale of tobacco products.

3. Strategic Framework

This strategic framework identifies the areas in which action must be taken to strengthen tobacco control. The specific actions in relation to each item, with responsible bodies and deadlines for achievement are detailed in the accompanying Action Plan for 2005 to 2010.

3.1 Measures to Reduce Demand for Tobacco Products

3.1.1 Price and tax measures

The government will initiate taxation and price policies for tobacco products that will contribute to the health objectives aimed at reducing tobacco consumption. This may be done by:

- Achieving and maintaining a high price and taxation level for tobacco products;
- Increasing taxation levels on tobacco products at above inflation rates in order to progressively reduce their affordability;
- Prohibition/restriction of tax- and duty-free sales of tobacco products;
- Sustained allocation of government funds to tobacco control programmes, including income from tobacco taxation;
- Harmonisation of taxation and prices across all tobacco products to reduce the likelihood of substitution of one product by another.

3.1.2 Non-price measures

In recognition of the importance of comprehensive non-price measures in reducing tobacco consumption, the government will adopt and implement effective legislative, executive, administrative or other measures to achieve the actions set out in paragraphs 3.1.3 to 3.1.9 below.

3.1.3 Protection from exposure to tobacco smoke

The government accepts that exposure to environmental tobacco smoke is proven to be harmful to health and results in death, disease and disability. Protection from ETS could be achieved through:

- Strengthening and implementation of legislation to make all public spaces smoke-free, including public transport and workplaces;
- Introducing a complete ban on smoking, indoors or outdoors, in educational institutions for those under 18 years of age, and a ban on indoor smoking in all other educational institutions;
- Introducing a complete ban on smoking, indoors and outdoors, in all health care delivery facilities;
- Introducing a complete ban on smoking, indoors and outdoors, and at all public events;
- Introducing a complete ban or severe restrictions on smoking in restaurants, bars and cafes, to protect owners, employees and clients from the serious health risks;
- Include 'environmental tobacco smoke' as a carcinogen in the classified list in order to facilitate attainment of the above protective bans.

The government will adopt and/or implement legislation to protect people from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and other public places as appropriate.

3.1.4 Regulation of the contents of tobacco products

The government will ensure the satisfactory performance of the tobacco industry in respect of the testing, measuring and regulation of the content of tobacco products, as specified in relevant legislation, and will strengthen or revise existing legislation as necessary.

The government will revise and update relevant legislation in accordance with internationally agreed standards, at regular intervals.

3.1.5 Regulation of tobacco product disclosures

The government will require the tobacco industry to disclose

information on, at least, the levels of tar, nicotine and carbon monoxide in the emissions of tobacco products.

The government will ensure public disclosure of information on the full range of toxic constituents of tobacco products and their emissions.

3.1.6 Packaging and labelling of tobacco products

The government will adopt and implement legislation to ensure that tobacco product packaging and labelling do not promote a product by means that are false, misleading, deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions. In particular this may restrict or prohibit the use of terms such as 'low tar', 'light', 'ultra light' and 'mild'.

The government will adopt and implement legislation concerning the inclusion of a health warning on the outside packaging of all tobacco products and on each retail unit of products. This health warning will describe the harmful effects of tobacco use, as well as other appropriate messages. All such messages will conform to the following standards:

- Be approved by the Ministry of Health;
- Appear in rotation;
- Be large, clear, visible and legible;
- Cover no less than 30% and preferably 50% or more of the principal display areas;
- Be in the Serbian language;
- May include pictures or pictograms.

The government will adopt and implement standards and regulations concerning the inclusion of information on the relevant constituents and emissions of tobacco products on the external packaging of each product and each retail unit of a product. This information will be in the Serbian language.

3.1.7 Education, communication, training and public awareness

The government will take action to ensure that the public is fully informed on issues relating to tobacco control, using whatever means of communication are deemed appropriate and effective. This public awareness raising will include provision of comprehensive,

accessible and effective programmes concerning at least the following:

- The health risks and addictive characteristics of tobacco consumption and exposure to tobacco smoke;
- The benefits of smoking cessation and a tobacco-free lifestyle (as specified in paragraph 3.1.9);
- A wide range of relevant information on the activities of the tobacco industry;
- Training on tobacco control issues for health professionals, inspectors, community workers, social workers, media professionals, educators, decision makers, administrators and other concerned persons;
- Inclusion of public and private agencies and non-governmental organisations, unrelated to the tobacco industry, in the development and implementation of intersectoral programmes for tobacco control;
- The adverse health, economic and environmental consequences of tobacco production and consumption.

3.1.8 Tobacco advertising, promotion and sponsorship

The government recognises that a comprehensive ban on advertising of tobacco products will have a significant impact on levels of tobacco use. The government will work towards the implementation of the existing comprehensive ban on advertising, including:

- Direct and indirect advertising, promotion and sponsorship on radio, television, print media and other media, such as the internet;
- Sponsorship of all public events (festivals, sports competitions, school events, fairs, concerts, etc), activities and/or participants therein;
- All forms of advertising that promote tobacco products by means that are false, misleading or deceptive or likely to create an erroneous impression about its characteristics, health effects, hazards or emissions;
- The use of direct incentives to encourage purchase of a product by the public.

The government will adopt and implement legislation to ensure that the penalties for infringement of the advertising

regulations are such that these have a serious deterrent effect. The government also undertakes to cooperate in the development of all means necessary for the elimination of cross-border advertising of tobacco products.

3.1.9 Demand reduction measures concerning tobacco dependence and cessation

The government will develop and disseminate appropriate, comprehensive and integrated guidelines for the provision of effective measures to promote cessation of tobacco use and adequate treatment of tobacco dependence.

In particular, the government will undertake the following actions:

- Design and implementation of programmes for cessation of tobacco use in educational institutions, health care facilities, workplaces and sporting environments, taking into account 'best practices' in smoking cessation;
- Provision of training in smoking cessation techniques for health professionals, education professionals, social and community workers;
- Provision of diagnosis, treatment and counselling for tobacco dependency by staff working in the health service, and other staff as appropriate;
- Strengthen and expand the existing network of centres for provision of the above services within health care facilities;
- Facilitation of affordable access to treatment for tobacco dependence, including pharmaceutical products.

3.2 Measures to Reduce Supply of Tobacco Products

3.2.1 Illicit trade in tobacco products

The government recognises that the elimination of all forms of illicit trade, namely smuggling, illicit manufacture and counterfeiting, in tobacco products is an essential component of tobacco control. (These issues fall within the responsibilities of the Tobacco Agency.)

The government will adopt and implement legislation to ensure tobacco products are marked in such a way as to identify their origin and facilitate tracking of the movements of tobacco products

within and into/out of the country.

The government will ensure, through appropriate regulation, that tobacco products meant for sale on the domestic market only, are clearly labelled in Serbian and can be easily identified as such.

The government will work towards the elimination of illicit trade in tobacco products by:

- Collection of data concerning cross-border trade in tobacco products, including illicit trade, and international exchange of information with tax, customs and other authorities;
- Strengthening of legislation against and specific penalties for illicit trade in tobacco products;
- Environmentally sound destruction or disposal of confiscated tobacco products;
- Close monitoring of tobacco products held in or moving through the country under suspension of taxes or duties, including completion of documentary records;
- Adoption and implementation of legislation to enable the confiscation of proceeds derived from illicit trade in tobacco products;
- Introduction of a licensing system to regulate the production and distribution of tobacco products.

The government will cooperate fully with other regional governments and international bodies in endeavours to eliminate illicit trade in tobacco products.

3.2.2 Sales to and by minors

The government agrees that it is vital to prevent the sale of tobacco products to minors (those under 18 years of age). To this end, the government will:

- Require that tobacco sellers display clearly and prominently within their premises a notice to the effect that sale of tobacco products to minors is illegal, and that they request proof of age from the potential buyer, if in doubt;
- Ban the sale of tobacco products in a directly accessible fashion, such as on store shelves, via vending machines, etc;
- Prohibit the manufacture and sale of sweets, snacks, toys or

other items that appeal to minors in the form of tobacco products;

The government will prohibit the distribution of free tobacco products to members of the public and especially to minors.

The government will regulate the sale of tobacco products to ensure that the size of retail units does not increase their affordability for minors.

The government will implement and revise legislation to ensure compliance with the obligations outlined in the above paragraphs, including provision for penalties with a serious deterrent effect if such legislation is infringed.

The government will also implement and revise legislation to prohibit the sale of tobacco products by minors.

3.2.3 Provision of support for economically viable alternative activities

The government recognises that the people currently employed within the tobacco industry will be negatively affected by the reduction in tobacco use. The government will promote economically viable alternatives for tobacco workers, growers and those employed within other parts of the tobacco industry, such as retail sales.

As a mechanism to encourage movement into alternative economic options the government will gradually reduce any subsidies presently provided to the tobacco industry, transferring these to the alternative activities.

3.3 Monitoring, Evaluating and Reporting on Tobacco Use and Tobacco Control Policies

3.3.1 Funding for regular monitoring, evaluating and reporting on the extent of tobacco use and exposure to tobacco smoke

The government recognises that provision of accurate and timely information is an important component in tobacco control.

The government will allocate specific responsibility for the

tasks of monitoring, evaluating and reporting on tobacco use and exposure to tobacco smoke in the general population to an appropriate health institution, and provide sufficient funds for this data to be collected nationally, at least every three years.

3.3.2 Dissemination of information to public leaders, the media and health professionals

The government will ensure that information concerning tobacco control, tobacco use and exposure to tobacco smoke, along with any other relevant information, is regularly made available to public leaders, the media and health professionals in a form that is accessible and useful to them.

3.3.3 Publication of regular reports on national tobacco control policy, smoking prevalence and related harm

The government will allocate specific responsibility for the task of reporting regularly on the implementation of the national tobacco control policy, smoking prevalence and related harm in the general population to an appropriate health institution.

The government will require that these reports include an analysis of obstacles to progress and recommendations for priority actions to overcome these.

3.3.4 Publication of retail sales figures

The government will ensure that figures detailing the level of trade in tobacco products such as retail sales are published by the relevant authority, such as the Customs and Excise Department, at least every three years.

4. Tools and Mechanisms for Action

4.1 Facilitating Nationwide Political Commitment

The government will take action to place tobacco control as an issue high on the political agenda. It will disseminate information concerning the health, economic and social impact of tobacco use to all relevant ministries, in particular emphasising the costs to the national economy from death, disease and disability.

The Tobacco Agency has been established to regulate the

agricultural production and sales distribution aspects of the tobacco industry. However, it is necessary to establish a separate body with specific responsibility for control of the negative health impact of tobacco consumption. This task requires different expertise and involves additional sectors of society. The new body will cooperate with the Tobacco Agency as appropriate. The roles and responsibilities of the two bodies will be complimentary providing a comprehensive framework for proper control of both the production and consumption aspects of the tobacco industry.

While the government recognises that the Ministry of Health will play the leading role in addressing tobacco-related issues, it will ensure that a broad coalition across all government sectors and ministries is created to take action forward in a comprehensive manner. In particular, the Ministries of Finance; Agriculture, Forestry & Water; Justice; Trade, Tourism & Services; Labour, Employment & Social Policies; Education & Sport; and Science & Environment, and Customs and Excise officials will be integral to all discussions and decisions.

To achieve this the government will officially appoint a national Intersectoral Coordinating Body (ICB) with responsibility to coordinate, supervise and monitor implementation of this Strategy and Action Plan. Members of the ICB should include Deputy Ministers or equally senior personnel from the ministries listed above. The Minister of Health will be President of the ICB.

The ICB will establish a Tobacco Control Centre (TCC) to ensure implementation of the Strategy and Action Plan. The TCC members will be professional and medical/health staff from government institutions and relevant non-governmental organisations (NGOs).

The ICB will be funded through the general government budget as a central cost. A detailed explanation of their role, responsibilities, membership and relationships to existing bodies is provided in Appendix A.

4.2 Building National Capacity

The government will avail itself of all international advice and

support for the development of tobacco control expertise within Serbia, especially any provided through the mechanism of becoming signatory to the WHO FCTC.

The government will introduce training programmes in tobacco control for policy makers and health staff, adhering, as far as possible to internationally standardised provisions for such training.

The government will encourage the active involvement of the non-governmental sector and civil society in general in tobacco control activities, and will support their attempts to obtain funding through a variety of international channels.

The government will promote participation in international tobacco control campaigns, such as Quit & Win and World No Tobacco Day, through the development and dissemination of materials, facilitation of national and local competitions, promotion of media events, and by giving national recognition to local actions.

The government will work towards the establishment of a national tobacco control centre.

4.3 Strengthening Coordination

The government will encourage creation of a broad national coalition for tobacco control, under the leadership of the Ministry of Health and involving all relevant stakeholders. This coalition will bring together expertise, advocacy and funding for tobacco control.

The government will use all possible avenues to highlight the priority of public health concerns in multisectoral action for tobacco control.

The government will endeavour to learn from the experience of the international community and to ensure the application of best practice in all aspects of tobacco control.

4.4 Financing of Tobacco Control Programmes

The government will identify and secure sustainable sources of funding for tobacco control programmes. In doing this it may consider a range of possible sources, such as, funding from the general

government budget; funding through the budget of the Ministry of Health and other relevant Ministries; funding through the Health Insurance Fund; funding directly from taxation revenues from the production and sale of tobacco products; funding from international donor agencies. However, the government will not accept funding from the tobacco industry for implementation of tobacco control activities.

Whatever the source of funding selected by the government, the identified funds will be spent only on agreed and specified activities related to tobacco control.

The government will endeavour to achieve an increase in the available budget on an annual basis, as it is anticipated that the costs of tobacco control activities will be significant.

5. Action Plan 2005 to 2010

Achieving all the objectives set out in the strategic framework will take considerable time. It is therefore important to prioritise and to select certain issues for more urgent action. However, although these priorities are stated here, additional activities will also continue, for example, initiated by non-governmental organisations or international donors. Support will be given to such activities but they will not receive priority attention in the same way as the activities presented in this Action Plan.

This Action Plan deals with priorities to be achieved within this initial period. The priorities for immediate action have been selected on the basis of their overall importance to successful tobacco control, as well as the need to ensure a successful start to the programme that will increase motivation for further action.

In particular priority has been given to the following areas:
In relation to the overall *goal* of the Tobacco Control Strategy:

To provide a framework for the implementation of tobacco control measures to ensure the future health and wellbeing of the citizens of Serbia and protect them from the harmful effects of smoking and exposure to tobacco smoke

- A. Establishment of a national level coordination body with responsibility for supervising the implementation of tobacco control measures;
- B. Ratification of the FCTC;
- C. Regular collection of data on tobacco use, the health impact of smoking in the population, utilisation of smoking cessation services and quit rates among smokers;
- D. Strengthen coordination and partnership with medical and other NGOs to achieve a broad coalition for action on tobacco control.

In relation to each of the immediate *objectives*:

Objective 1 - To prevent the future initiation of smoking behaviour, especially among young people

1.1 Close collaboration between health and education professionals in implementing the programme of anti-smoking education within schools;

1.2 Coordinate action with those responsible for implementation of the National Plan of Action for Children of Serbia;

1.3 Prevention of sales of tobacco products to minors;

Objective 2 - To reduce levels of tobacco use across all population groups by encouraging and supporting smokers to stop and providing cessation services

2.1 Strengthening and expansion of the network of accessible smoking cessation services as part of the health service, including provision of training for staff;

Objective 3 - To protect the health of the population by reducing exposure to environmental tobacco smoke

3.1 Creation of smoke-free spaces in workplaces (especially public administration, health and education facilities) and on public transport;

Objective 4 - To educate the public concerning the harmful health effects of smoking and exposure to tobacco smoke

4.1 Public education and awareness raising concerning the harm resulting from tobacco consumption and exposure to tobacco smoke;

4.2 Improve training of health and medical professionals by revising the undergraduate and postgraduate curricula to include issues of tobacco control;

Objective 5 - To ensure adequate regulation of the tobacco industry with regard to the production, advertising and sale of tobacco products

- 5.1 Implementation of existing legislation relating to tobacco control and revision where necessary, especially in relation to penalty levels;
- 5.2 Introduction of stronger, more effective health warnings on all tobacco products.

It is expected that a further action plan will be developed towards the end of this initial period, based on the progress made, to develop the tobacco control programme further. The detailed Action Plan is presented in Appendix B.

Exercises

1. Compare the WHO Framework Convention on Tobacco Control and the Draft Serbian National Tobacco Control Strategy.
 - Discuss the key differences between the two documents.
2. Gather together and review the current national legislation relevant to tobacco control issues (production, distribution, sales, advertising, use).
 - Discuss how this may affect efforts to implement a national tobacco control strategy.
 - Identify the key revisions/actions necessary to achieve the standards indicated in the WHO FCTC.
3. List the key stakeholders in relation to tobacco production, distribution, sales and control within your country.
 - Identify those who are likely to oppose increased control measures and suggest mechanisms to counteract such opposition.
4. Using the WHO FCTC and the Draft Serbian National Tobacco Control Strategy as a guide, prepare an outline for a draft national tobacco control strategy for your country, indicating the following in detail:
 - key steps in demand reduction, supply reduction and advertising/sales legislation;

- an organisational structure that will support successful implementation;
- key priorities for action in the first five years of implementation.

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Recommended Readings

1. WHO Framework Convention on Tobacco Control available through website www.who.int/tobacco/framework/en
2. Global Youth Tobacco Survey information available through website www.who.int/tobacco/surveillance/gyts/en
3. Model Legislation for Tobacco Control: A Policy Development & Legislative Manual, IUHPE, available through website www.iuhpe.nyu.edu/
4. The journal “Tobacco Control” which can be accessed at low cost through the WHO sponsored HINARI scheme in specified countries.

APPENDIX A

Intersectoral Coordinating Body for Tobacco Control in Serbia

The Intersectoral Coordinating Body (ICB) for Tobacco Control in Serbia will be established by the government of the Republic of Serbia in accordance with the Serbian Strategy for Tobacco Control.

Terms of Reference

Role:

To coordinate, supervise and monitor the implementation of the Serbian Tobacco Control Strategy.

Responsibilities:

- To establish a Tobacco Control Centre that will act as the reference point and technical coordinator for national tobacco control activities in Serbia in cooperation with the Tobacco Agency;
- To ensure that tobacco control issues have high political priority within the government of Serbia;
- To ensure all relevant ministries consider issues of tobacco control when setting policy agendas.

Membership:

President:

Minister of Health

Members:

Senior personnel from the Ministries of Finance; Agriculture, Forestry & Water; Justice; Trade, Tourism & Services; Labour, Employment & Social Policies; Education & Sport; Science & Environment, as well as a representative from the Tobacco Agency and Customs and Excise officials.

Tobacco Control Centre

The Tobacco Control Centre of the Republic of Serbia (TCC-S) will be established by the ICB. It will be the key reference point in the country for all matters associated with the negative health impact of

tobacco consumption, as well as tobacco control issues in general. The TCC-S will cooperate with the Tobacco Agency as appropriate.

Terms of Reference

Role:

The TCC-S will have two functions:

1. To ensure full implementation of the Serbian Tobacco Control Strategy and Action Plan; and
2. To collect information relating to tobacco consumption control issues and the health impact of tobacco consumption on the local, national, regional and international levels and to disseminate this to relevant stakeholders within Serbia.

For each function, the TCC-S will form a separate Unit. These will be known as the Implementation Unit (1) and the Resource Unit (2).

Responsibilities – (1) Implementation Unit:

- To monitor and evaluate implementation of the Serbian Tobacco Control Strategy and Action Plan;
- To promote and technically coordinate tobacco consumption control activities and mobilisation of resources for control of the negative health impact of tobacco consumption;
- To provide technical assistance to the Ministry of Health, other institutions and agencies in matters relating to tobacco consumption control;
- To facilitate collaboration with international experts and academic and reference centres within and outside Serbia.

Responsibilities – (2) Resource Unit:

- To collect relevant documentation and information on tobacco consumption control issues and the negative impact of tobacco consumption on the local, regional, national and international levels into a central resource;
- To disseminate relevant information concerning tobacco consumption control issues and the negative health impact of tobacco consumption to stakeholders in Serbia;
- To respond to requests for information on tobacco consumption control issues and the negative health impact of

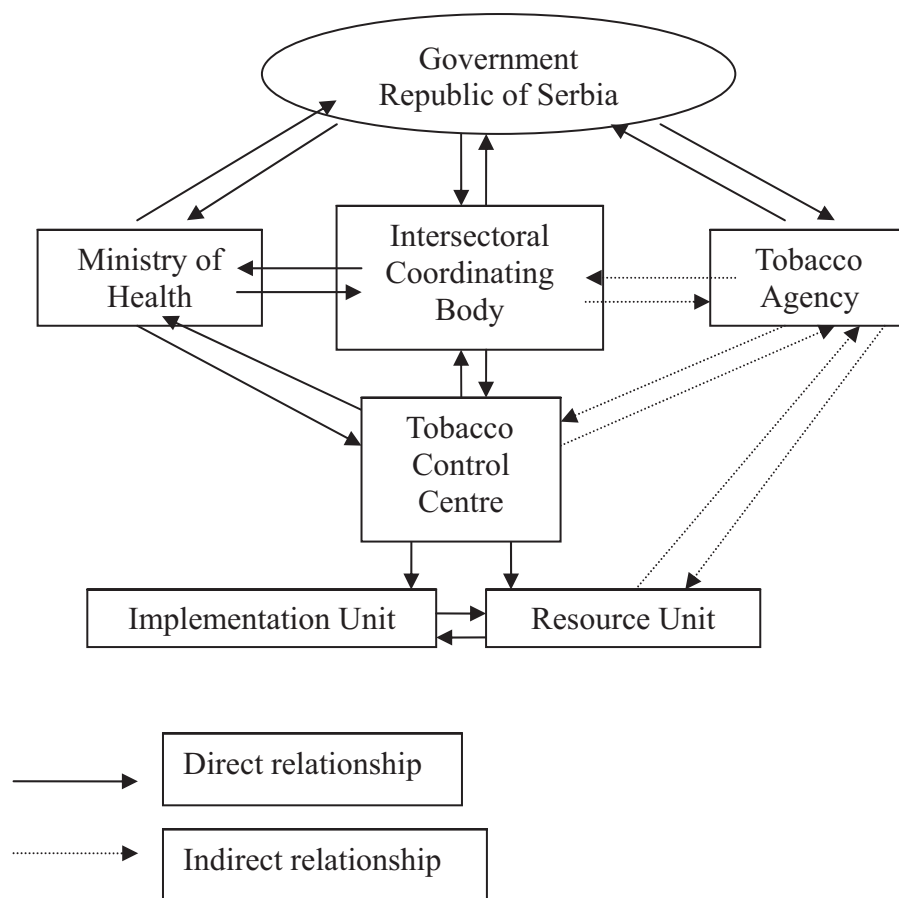
- tobacco consumption by government, non-government and other agencies, as well as members of the public;
- To cooperate with the Tobacco Agency in providing information on other aspects of tobacco control, such as the agricultural production and sales distribution aspects of the tobacco industry.

Membership:

Membership of both Units of the TCC-S will be drawn from the following groups:

- Ministry of Health staff;
- Professional staff of the national and regional Institutes of Public Health;
- Staff of relevant non-government organisations and professional associations;
- Medical staff from relevant clinical specialities;
- Staff of educational institutions;
- Staff of relevant legislative and enforcement agencies.

Relationship of the ICB to Other Government Bodies



APPENDIX B
ACTION PLAN
2005 to 2010

Strategic Goal/ Objective	Sub-Objective	Detail of Activity	Responsible Party <i>/ Implementing Bodies</i>	Source of financing	Deadline	Indicators of Achievement
To provide a framework for the implementation of tobacco control measures to ensure the future health and wellbeing of the citizens of Serbia and protect them from the harmful effects of smoking and exposure to tobacco smoke	A. Establishment of a national level coordination body with responsibility for supervising the implementation of tobacco control measures	A.1 Agree membership, roles and responsibilities and the legal constitution of the Intersectoral Coordinating Body (ICB) & Tobacco Control Centre (TCC)	Government	GGB	May-05	Minutes of government meeting
		A.2 Legally establish ICB	Government	GGB	Jun-05	ICB legally established; documentary evidence (eg in Official gazette)
		A.3 Allocation of specific budget for ICB and TCC	Government	GGB	Sep-05	Government decision regarding budget

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		A.4 Establish the TCC	ICB (this means ICB through the TCC Implementation & Resource Units)	GGB	Dec-05	Minutes of ICB meetings; documentary evidence
As above	B. Ratification of the FCTC	B.1 Hold workshops/meetings every 6 months with politicians to work towards consensus and ratification	ICB, MoH / SPH, SPHA	GGB, Donors	Ongoing	Records of workshops and documentary evidence of movement towards ratification; Ratification of FCTC
As above	C. Regular collection of data on tobacco use, the health impact of smoking in the population, utilisation of smoking cessation services and quit rates among smokers	C.1 Agree data to be collected (at least 10 standard WHO items in the general population, plus the GYTS on a regular basis) C.2 Ensure collection of data C.3 Publish results on a regular basis	ICB, MoH / IPH <i>Batut</i>	MoH	Apr-06	Minutes of ICB meetings; list of data
			ICB, MoH / SPH, IPH <i>Batut, IPH network</i>	MoH	Sep-06	Forms and regulations revised to allocate responsibility for data collection
			ICB / SPH	MoH	Every 3 years	Published reports

			C.4 Cooperate with media to ensure public understanding of the data	ICB / <i>media</i>	MoH	Ongoing	Media articles & programmes; opinion polls
As above	D. Strengthen coordination and partnership with medical and other NGOs to achieve a broad coalition for action on tobacco control	D.1 Identify all NGOs working in the field of tobacco control D.2 Through a series of meetings and workshops create a national coalition for tobacco control	ICB / <i>SPHA, SMS, NGOs</i>	GGB	Ongoing	Report; list of NGOs	Records of meetings & workshops; documentary evidence of formation of national coalition; reports of collaborative action
		D.3 Coordinate activities with the WHO-led initiative in building partnerships with NGOs	ICB, WHO / <i>SPHA, SMS, NGOs</i>	GGB, WHO	Ongoing	Documentary evidence; records of meetings and collaborative action	
1. To prevent the future initiation of smoking behaviour, especially among young	1.1 Close collaboration between health and education professionals in implementing the programme	1.1.1 Establish cooperative working relationships at national, regional and local levels through joint meetings & planning of	ICB, MoH, MoES / <i>Schools, IPH network, SPHA, SMS, NGOs</i>	GGB, local authorities	Feb-06	Records of meetings; joint programme plans and reports on implementation at each level	

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people of anti-smoking education within schools	programmes					
		1.1.2 Agree content for anti-smoking education in primary and secondary schools	ICB, MoH, MoES / NGOs	MoES	Feb-06	Curriculum document for anti-smoking education developed (as part of general health education curriculum)
		1.1.3 Deliver anti-smoking sessions on regular basis (once per term)	MoH, MoES / Schools, IPH network, PHCs, NGOs	MoH, MoES, NGOs, Donors	Ongoing	Records of sessions; attendance registers of students
		1.1.4 Publish reports on anti-smoking education and its impact	ICB / SPH, IPH Batut, IPH Network	GGB	Every 3 years	Published reports

As above	1.2 Coordinate action with those responsible for implementation of the National Plan of Action for Children of Serbia	1.2.1 Through a series of meetings and workshops ensure coordinated implementation	ICB, Serbian Council of Children's Rights / <i>relevant ministries</i>	GGB	Ongoing	Records of meetings; joint programme plans and reports on implementation
As above	1.3 Prevention of sales of tobacco products to minors	1.3.1 Hold training workshops with inspectors to increase understanding and enforcement of legislation	ICB, MoH, MoLESP / IOH, SPH, IPH Batut, IPH Network	GGB, Donors	Jun-07	Records of workshops; documentary evidence of implementation of legislation from inspectors reports
		1.3.2 Design and implement a mass-media education campaign for retailers to inform them of legislation, responsibilities and penalties for infringement	ICB, MoH, MoT / IPH Batut, IPH Network, media	GGB, Donors	Jun-07	Reports; materials; media programmes about campaign

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			1.3.3 Design and implement a mass-media education campaign for parents to reduce use of children as messengers to buy cigarettes	ICB, MoH, MoES / <i>IPH Batut, IPH Network, media</i>	GGB, Donors	Jun-07	Reports; materials; media programmes about campaign
			1.3.4 Implement legislation in several cases with extensive media coverage	ICB / <i>inspectors, media</i>	GGB	Dec-08	Media reports & programmes; documentary evidence of judgements reached
2. To reduce levels of tobacco use across all population groups by encouraging and supporting smokers to stop and providing cessation services	2.1 Strengthening and expansion of network of accessible smoking cessation services as part of the health service, including provision of training for staff		2.1.1 Assess current level of service provision	ICB, MoH / <i>SPH, IPH Batut, CCS-ILDTB</i>	MoH	Mar-07	Report of assessment
			2.1.2 Agree minimum level of services to be provided	ICB, MoH / <i>IPH Batut, CCS-ILDTB, relevant experts</i>	MoH	Apr-07	Minutes of meetings; document detailing minimum service level
			2.1.3 Provide training and equipment for staff	ICB, MoH / <i>SPH, IPH Batut, CCS-ILDTB, relevant experts</i>	MoH, Donors	Sep-07	Reports of training workshops; evidence of procurement; delivery of equipment
			2.1.4 Every PHC to offer the minimum level of service	ICB, MoH / <i>PHCs</i>	MoH	2010	Reports of PHCs; supervisory reports from IPH network;

						ICB visit reports		
				2.1.5 Monitor and evaluate the quality and effectiveness of services	ICB, MoH / <i>SPH, IPH Network</i>	MoH	Every 3 years	Reports of monitoring visits; evaluation reports
			2.1.6 Publish reports on the impact of services on smoking levels	2.1.6 Publish reports on the impact of services on smoking levels	ICB / <i>SPH, IPH Network</i>	MoH, Donors	Every 3 years	Published reports
			3.1.1 Undertake specified research to assess levels of general population exposure to tar and nicotine in selected public administration, health and educational facilities and on public transport	3.1.1 Undertake specified research to assess levels of general population exposure to tar and nicotine in selected public administration, health and educational facilities and on public transport	ICB, MoH, MoSE / <i>SPH, IOH, IPH Batut, IPH Belgrade</i>	MoH, Donors	May-06	Report on completed research
			3.1.2 Discuss research findings in a workshop with politicians to mobilise support for action	3.1.2 Discuss research findings in a workshop with politicians to mobilise support for action	ICB, MoH / <i>SPH, IOH, IPH Batut, IPH Belgrade</i>	MoH	Sep-06	Reports of workshop; documentary evidence of (support for) action by politicians
3. To protect the health of the population by reducing exposure to environmental tobacco smoke	3.1 Creation of smoke-free spaces in workplaces (especially public administration, health and education facilities) and on public transport							

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			4.1.4 National campaign to explain the links between tobacco smoking and disease, disability, death and poverty including media, group and individual discussion sessions	ICB, MoH / <i>IPH Batut, IPH network, NGOs, municipalities</i>	MoH, Donors	Dec-06	Reports; materials; media programmes about campaign
			4.1.5 Expand training for health and education professionals, working in government and non-government sectors, on design and implementation of tobacco related education for the public.	MoH, MoES / <i>SPH, IPH Batut, NGOs</i>	MoH, MoES, Donors	Dec-08	Reports of training events; attendance register of participants; documentary evidence of new educational activities for the public
As above	4.2 Improve training of health and medical professionals by revising the	4.2.1 Revise medical training curricula		MoH, MoES / <i>universities, SPH</i>	MoH, MoES	Jun-08	Documentary evidence of revised curricula; reports from implementation of revised training

5. To ensure adequate regulation of the tobacco industry with regard to the production, advertising and sale of tobacco products	5.1 Implementation of existing legislation relating to tobacco control and revision where necessary, especially in relation to	4.2.2 Revise training curricula to include issues of tobacco control	4.2.3 Implement a programme of continuing professional education on tobacco control issues	4.2.2 Revise training curricula for other health professionals	MoH, MoES / <i>universities, secondary medical schools, nursing colleges</i>	MoH, MoES	Sep-09	Documentary evidence of revised curricula; reports from implementation of revised training
	5.1.1 Pass legislation to reduce levels of nicotine, tar and CO in locally produced tobacco products to EU standards	5.1.2 Monitor levels of nicotine, tar and CO in tobacco products by regular testing	MoH, MoES / <i>medical schools, SPH, SPHA, SMS, other associations</i>	Ongoing	MoH, MoES	MoH, MoES	Dec-09	Reports from training courses
	5.1.2 Monitor levels of nicotine, tar and CO in tobacco products by regular testing		ICB, MoH / <i>relevant ministries</i>	Dec-09	GGB	GGB	Dec-09	Legislation passed
			TA / <i>Inspection authority, laboratories</i>	Dec-09	Tobacco industry	Tobacco industry	Dec-09	Reports from inspectors

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penalty levels	5.1.3 Hold workshops with politicians to mobilise support for implementation of legislation regarding advertising of tobacco products and sponsorship by tobacco industry	ICB, MoH / <i>universities, SPH, SPHA, SMS, other medical associations</i>	GGB, Donors	Dec-07	Reports of workshops; documentary evidence of (support for) implementation of legislation
	5.1.4 Hold workshops with media personnel to mobilise support for implementation of legislation regarding advertising of tobacco products and sponsorship by tobacco industry	ICB, MoH / <i>universities, SPH, SPHA, SMS, other medical associations</i>	GGB, Donors	Dec-07	Reports of workshops; documentary evidence of (support for) implementation of legislation
	5.1.5 Take at least one widely publicised legal action to enforce the legislation on advertising of tobacco products	ICB / <i>relevant ministries</i>	GGB	Dec-10	Media reports & programmes; documentary evidence of judgements reached
	5.1.6 Regular revision of penalties for infringement of tobacco legislation	ICB / <i>relevant ministries</i>	GGB	Ongoing	Revisions made to legislation

As above	5.2 Introduction of stronger, more effective health warnings on all tobacco products	5.2.1 Pass legislation for compulsory disclosure of levels of nicotine, tar and CO in tobacco products to be displayed on item packaging in line with EU standards	ICB / <i>relevant ministries</i>	GGB	Dec-06	Legislation passed
		5.2.2 Pass legislation for new compulsory health warnings for tobacco products to be displayed on item packaging in line with EU standards	ICB / <i>relevant ministries</i>	GGB	Dec-06	Legislation passed

APPENDIX C

List of abbreviations used in the Tobacco Control Strategy for the Republic of Serbia

CCS-ILD TB	= Clinical Centre of Serbia, Institute of Lung Diseases and Tuberculosis
CO	= carbon monoxide
COPD	= Chronic obstructive pulmonary disease
ESTC	= European Strategy for Tobacco Control
ETS	= Environmental tobacco smoke
EU	= European Union
FCTC	= Framework Convention on Tobacco Control
GGB	= General government budget
GYTS	= Global Youth Tobacco Survey
ICB	= Intersectoral Coordinating Body
IOH	= Institute of Occupational Health
IPH	= Institute of Public Health
MoES	= Ministry of Education & Sport
MoH	= Ministry of Health
MoLESP	= Ministry of Labour, Employment & Social Policies
MoSE	= Ministry of Science & Environment
MoT	= Ministry of Trade, Tourism & Services
NGO	= Non governmental organisation
NRT	= Nicotine replacement therapy
SDR	= Standardised Death Rate
SMS	= Serbian Medical Society
SPH Belgrade	= Centre "School of Public Health", University of Belgrade
SPHA	= Serbian Public Health Association
TA	= Tobacco Agency
TCC	= Tobacco Control Centre
TCS	= Tobacco Control Strategy
WHO	= World Health Organisation
YLL	= Years of Life Lost

**FRAMEWORK
FOR A
COMMON REGIONAL
PUBLIC HEALTH STRATEGY
OF SOUTH EASTERN
EUROPE**

PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT	
A Handbook for Teachers, Researchers and Health Professionals	
Title	Framework for a common regional public health strategy of south eastern Europe
Module: 5	ECTS (suggested): 0.75
Authors, degrees, institutions	On behalf of the Public Health Collaboration in South Eastern Europe (PH-SEE)
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Keywords	Public health strategies; regional approach to public health; strategy development; SWOT analysis; participatory methods
Learning objectives	<p>At the end of this module the students should:</p> <ul style="list-style-type: none"> ▪ be more familiar with public health strategy aspects relevant at regional level ▪ be able to use different participatory and consensus building methods ▪ be ready to expand the repertoire of decision-making processes for future professional use.
Abstract	A draft framework for a regional public health strategy in SEE and its development process are documented in this chapter. Following a SWOT analysis of the current public health context in the region, the framework has been jointly developed by public health professionals of the SEE countries. It reflects the priorities to be addressed at regional level. A regional strategy intends to provide orientation for countries and to support the

	harmonisation of public health policies in SEE. The development of this framework is considered a first step in drafting a regional public health strategy. Further discussion with and involvement of key stakeholder groups will be the way forward to an agreed and adopted regional approach to public health.
Teaching methods	<ul style="list-style-type: none">▪ lecture (interactive presentation of key concepts)▪ different participatory and consensus building methods are explained in a concrete case study and can also be experienced in exercises.▪ individual and group work▪ reading
Specific recommendations for teachers	This module could ideally be combined with the modules on methods regarding situation analysis and priority setting as preparation. If this is not feasible, a brief introductory lecture on the methods used in this module should be included in the seminar planning.
Assessment of students	Group reports, individual reports, presentation

FRAMEWORK FOR A COMMON REGIONAL PUBLIC HEALTH STRATEGY OF SOUTH EASTERN EUROPE

On behalf of the Public Health Collaboration in South Eastren Europe (PH-SEE)

1. Background and Rationale

Is there a need for a regional public health policy framework in South Eastern Europe (SEE)? The question could be answered with view to the fact that a decade of profound political changes, collapse of economies and political unrest in the region has led to a deterioration of the populations' health status (1). There is increasing worldwide recognition that health issues do not stop at national borders and a rising awareness that uncontrolled globalisation is widening the gaps between rich and poor.

There are already regional policies on public health in Europe. Within the European Union a common public health framework has been developed since the Maastricht Treaty in 1993, providing the first legal competence basis. While in the beginning the emphasis was on co-ordination of health programmes among Member States, the following development process led to a global action plan, the new Public Health Programme of the EU, 2003-2008 (2). The WHO Health 21 policy framework intends to provide comprehensive guidance for national policy development in the wider European region that is characterised by extraordinary socio-cultural diversity and great contrasts between rich and poor countries (3).

So, why not just take what already is developed and ready, such as the EU Public Health Programme, or the WHO Health 21 strategy?

It is evident with regard to the diversity of the countries that an out-of-the-shelf solution would not be appropriate. The specific situation in the SEE region has to be taken into account for the development of relevant and realistic public health goals. Furthermore, ownership of a policy framework is important for its implementation and application.

This in turn requires the involvement of the major stakeholders, such as the countries' public health experts and politicians and the public, in the development process.

Specific arguments for the development of a public health strategy in the SEE region are the benefits of harmonisation of the various public health approaches and the orientation of these countries towards the European Union (EU). Despite their socio-economic and cultural diversity most of the countries in the SEE region face similar challenges, such as the transition from the centralised socialist system to open democratic political systems with market-oriented economies. Some countries in the region have to cope with the consequences of the war in the 90's and with ongoing conflicts, which especially affect the health of the populations. Poverty is a concern in all countries in SEE despite some countries having achieved socio-economic development to a higher standard of living. Thus, gaps in quality of life and equal access to basic health care are observed throughout the region and within countries. Addressing inequalities in health and ensuring access to health care to the most vulnerable groups is a way to regional socio-economic stability.

The scarce resources committed to the health sector ask for efficient use of these resources. Joining forces by co-operation and co-ordination across borders has the potential to contribute to a more efficient use of the available resources, for instance in avoiding overlaps and duplication of health programmes.

A regional public health framework will underscore the critical role of public health for the socio-economic development and thus help to put it higher on the political agenda. Although the health of populations is an important factor in economic development (3, 4), the potential and contribution of new public health approaches remains underestimated and neglected.

A regional policy provides orientation for countries and sets a framework for the harmonisation of health policies in SEE. The orientation towards common goals helps in comparing achievements of the countries. A regional policy does not implement by itself; it will only be vital and sustainable on the basis of ongoing commitment of the countries.

Finally, an implicit potential benefit may be the contribution to social stability and peace in the region: the integrative impact of an ongoing co-operation process on commonly defined health goals should not be underestimated.

This chapter presents a suggestion for a SEE regional public health strategy framework. The development process is described for providing a practical example of methodological application as well as transparency of the emergence of this strategy framework. Section three summarises the results of the SWOT analysis process, while section four describes the framework for a regional public health strategy. Section five reflects on the way forward.

2. Development process and methods

The suggested framework for a regional SEE public health strategy was developed during a public health expert seminar in August 2004, Belgrade¹, organised in the frame of the Public Health Collaboration in South Eastern Europe Programme (PH-SEE)². The seminar served as a forum for the development process of the regional strategy framework, involving 36 public health professionals from seven SEE countries³. An additional number of experts from other European countries attended the seminar and assisted in the process.⁴

The seminar built on previous work in the region and followed a participatory bottom-up approach:

- Step one: Presentation and discussion of the current national public health strategies.
- Step two: Situation analysis of public health in the SEE region with regard to a regional strategy framework, using the SWOT methodology.

¹ Expert Summer Retreat: National Public Health Strategies in South Eastern Europe and the EU Health Policy; Belgrade, Serbia, August 23-28, 2004

² Stability Pact for South Eastern Europe: Public health Collaboration in South Eastern Europe (PH-SEE) – Programmes for Training and Research; www.snz.hr/ph-see

³ The countries represented were : Albania; Bulgaria; Croatia; Macedonia; Romania; Serbia and Montenegro; and Slovenia (Annex 3: Participant list)

⁴ This included 5 experts from Denmark; Germany; Switzerland; and United Kingdom (Annex 3: participant list)

- Step three: Developing the framework for a regional public health strategy in setting priorities and formulating goals, using the nominal group technique.
- Step four: Processing the goals into operational action plans, group work; presentation and discussion in plenary.

The methods for the development of the framework have been selected prior to the seminar, by considering their advantages and disadvantages. A more rigorous scientific oriented approach to developing a regional framework for public health, by using information on health indicators, determinants of population health trends, and country priority health goals, would have required the analysis of the current public strategies of SEE countries. However, the preparation phase of the seminar revealed that, at that point of time, only a minority of the countries had officially adopted a national public health strategy. The systematic development of such strategies was only very recent and their adoption was – as to be seen later - constrained by rapid political changes in the respective countries. Another constraint was set by the factor time: to develop a regional public health framework within a five-day seminar implies certain limits and it was obvious that within this timeframe only a first step could be accomplished in providing a draft for a regional public health framework.

One of the objectives of the seminar was to provide support for the development of a common regional strategy. One of the principles was to apply a participatory and consensus building approach. The meeting of forty public health professionals from different countries in the region offered a unique opportunity for providing a model on how to apply participatory consensus building methods in health policy formulation. The participants, experienced public health practitioners in the field, do not have an official political mandate, but they all face the realities in their daily work as well as the implications of public health policies developed and adopted at political levels. Involving these experts in developing a regional framework aimed to include the great technical potential, profound knowledge and experience available in the countries in the analysis and priority setting process.

In considering these constraints and opportunities, the combination of the SWOT analysis method and the nominal group

technique was selected for the framework development. Both methods have the advantage of being easy to use and they are recognised in supporting decision making and problem solving processes. Being primarily intuitive and judgmental rather than mechanistic and measurable (5), they nevertheless follow rigorously disciplined regulations. Both methods use heuristic reasoning for advancing analysis and decision making.

The strategic goals formulated as outcome of the exercise show that a more structural and processed approach is felt to be appropriate for the regional level, keeping in mind that in general the WHO Health 21 targets and the EU public health programme are informing the health policy development in the countries.

The two major methodologies used in this process are described below:

SWOT Analysis

SWOT is an analytical tool originally developed for strategic planning in business and marketing. The name is an acronym indicating the four major aspects to be looked at when analysing the position of an enterprise in its environment:

Strengths and weaknesses identify the internal environment of the project and refer to the present situation while **opportunities and threats** represent the external environment and point to the future. According to Vankova et al (5) the primary objective of SWOT is to assess the project's strategic position with regard to its changing external environment, in order to put the organization in the position to respond to the environment. SWOT is a specific tool for the planning process and has to be based on a sound knowledge of the present situation and trends. The outputs of a SWOT analysis are structured information and a set of strategic options.

The analysis process is carried out in four rounds (5):

First the external environment should be examined by identifying opportunities and threats (round 1), before the internal environment will be looked at by identifying strengths and weaknesses (round 2). In analysing the external environment, two categories are distinguished: the societal environment, characterized

by political, economic and socio-cultural factors; and the task environment, describing the specific context of the project.

The next round will map the interactions between the external and internal environment (round 3) and visualize them in a matrix. The identification of relationships between the four components may become a complex process when many factors have been listed in the first two rounds, for which the concept of a two-by-two matrix provides a good framework. The combinations of relationships become the basis for strategic choices.

In round 4 the strategic choices are identified, based on the interactions mapped in the previous round.

The inner cells of the two-by-two matrix represent four strategic options (5):

- The strengths - opportunities (SO) cell outlines the “maxi-maxi” strategy option, or the “comparative advantage” of the project. The internal strengths of the project may be maximised to make the most of external opportunities.
- The weaknesses – opportunities (WO) cell describes the “mini-maxi” or “investment-divestment” option. The strategy may be appropriate in situations where a promising opportunity is perceived but the project is not in a strong position to take advantage of the opportunity. This is an ambiguous situation, which leaves three possibilities to respond to the situation: either invest in the weak aspects of the project to transform them into strengths; or divest the weaknesses and let the opportunity pass; or maintain the status quo.
- The strengths - threats cell (ST) indicates the “maxi-mini” option, which is a strategy for mobilization: if the project is strong, it may choose to manage the external threats. In this strategy the question is how to mobilize its strengths to face certain threats imposed by the external environment or even to transfer them into opportunities in the long-term.
- The weaknesses - threats cell (WT) presents the “mini-mini” strategy, essentially a “damage control” option. This strategy is less attractive but may be appropriate where a vulnerable project faces a catastrophic situation and just tries to survive by minimizing the damage of external threats.

Identifying and deciding on the strategic choices is the critical component in the planning process, as it will define the general approach to be taken, and set the frame for the formulation of goals.

Figure 1 shows the model of a SWOT matrix with its strategy classification:

Figure 1 A Basic SWOT Matrix and Strategy Classification

Internal Factors /	List of STRENGTHS S1 S2 S3	List of WEAKNESSES W1 W2 W3
External Factors	Interaction: SO ----- Strategy option: Maxi-Maxi Comparative Advantage	Interaction: WO ----- Strategy option: mini-Maxi Investment/Divestment
List of THREATS T1 T2 T3	Interaction: ST ----- Strategy option: Maxi-mini Mobilization	Interaction: WT ----- Strategy option: mini-mini Damage Control

Source: adapted from Vankova et al (5)

Nominal group technique

For the identification of priorities and formulation of goals for a regional public health strategy framework, the nominal group method was used. This method is applied in two major phases:

- Naming (nominating): each participant is asked to name one item which is relevant and important for the subject in discussion. In the case of the seminar, the participants were asked to formulate priorities for enhancing public health in the region. As some naming may overlap or duplicate, the group will discuss and adapt the items in question until a cleared list of naming is obtained capturing the participants' agreed opinion. Through this discussion, the final list may have fewer items than participants.

Example: 10 participants name each one item. Two of them are double, so one is deleted. Three items partly overlap or have a similar meaning; they will be merged or reworded until the meaning of the participants is captured. The final list may then consist of 7-8 items.

- Ranking / priority setting: each participant is asked to rank the items on the final list according to priorities with a score between 5 and 1 points; the most important issue is scored with 5 points, the next important with 4 points, etc, down to 1 point. Some items may remain without points. The points given for each item are added. The five items with the most points are finally selected. It may occur that two or more items got the same total of points and a decision has to be taken which one to select or how to rank them. In this case one option would be to analyse the single scoring of the items in determining the median value. These items can then be ranked according the highest scores obtained.

In the context of the PH-SEE seminar, two groups were created, respecting a balanced representation of the countries. Each group produced a list of public health priorities for the SEE region. The results were discussed in plenary and the selected final priorities were formulated as objectives, framing the future regional public health strategy. Subsequently the participants discussed each goal in small groups, creating an action plan by setting operational objectives (= sub goals), specifying those into activities, timeframe, deliverables,

outcomes, indicators, and analysing potential partners, resources and risks. The results were presented and finally discussed in plenary.

3. Situation analysis of public health in the SEE region (SWOT)

For an analysis of the situation in SEE with regard to a regional public health strategy, the SWOT methodology was applied. The first round focussed on the identification of factors supporting or hindering a regional public health strategy development: opportunities and threats of the external environment, and strengths and weaknesses of the internal environment. In the next round the interactions between the factors were mapped in a two-by-two matrix and the following classification of strategy options prepared the decision on a strategic approach.

3.1. Identifying the internal and external environment of public health

This section summarises the information on opportunities, threats, strengths and weaknesses as gathered and analysed by the experts in the seminar working sessions.

Opportunities

Opportunities for the development of public health strategy in SEE can be found at national, regional and international levels.

Significant opportunities are evident at the international level. The climate of opening and co-operation between the countries is supportive to a future regional strategy framework. In the field of public health, the Dubrovnik Pledge of 2001 (6) is one of the most important opportunities as it marks a firm political commitment to regional health development. The Pledge has been recognised by the international community and financial support is provided for the implementation of health projects. The political and technical co-operation has been institutionalised in the “SEE Health Network” as the main political body for providing leadership and sustaining ownership of the countries and implementing concerted action in

defined areas of mutual interest.⁵ The spirit of co-operation and the fast progress of the SEE Health Network have been recommended by the Stability Pact secretariat as a model of good practice for other sectors (1). It can be assumed that the Ministries of Health in SEE, based on their commitment, will be supportive to the development of a regional public health strategy.

There is evidence for a climate favourable to foreign investment in SEE countries in recent years, targeting the socio-economic development. Promising examples concerning the implementation of projects in the health sector are numerous - just to name some foreign funding agencies: European Agency for Reconstruction, PHARE UNICEF, the World Bank, Council of Europe Development Bank.

Further opportunities are the various international initiatives regarding health and poverty as priorities to be addressed. Global agreements and regional declarations provide a frame for action at local level and serve as reference points for the relevance of a regional public health strategy. The United Nations (UN) Millennium Development Goals (MDGs)⁶ (cross-reference with MDG paper) are an important reference point, as their main aim is to reduce poverty; considering the direct link between poverty, education, environment, development and health, all eight MDGs are relevant and related to public health concerns. The European public health policies provide a frame for harmonising SEE approaches and for approximation to European standards. To name here are the WHO Health 21 strategy (3), the Ljubljana Charter on Reforming Health Care 1996 (7), and the new EU public health programme (2, 8, 9). Other relevant international declarations are the WHO Ottawa Charter concerning health promotion and the Verona Initiative advocating for multi-sectoral investment in health (10). These give a boost to the Healthy Cities network in the region and to community participation

⁵ At present, the SEE Health Network consists of 100 members, including representatives of eight SEE beneficiary countries, five donor and neighbour countries and representatives of international organizations, such as WHO Regional Office for Europe and the Council of Europe. The political body of the Ministers of Health of the SEE countries acts as Steering Committee for implementing the Dubrovnik Pledge.

⁶ available from: www.developmentgoals.org

initiatives, as described in the Croatian example (see Croatian public health strategy, chapter 4). A recent policy document, which can be used as reference document, is the WHO Tobacco Framework Convention. Serbia, for example, is using this opportunity by having signed the Convention and subsequently has started promotion initiatives to reduce the tobacco consumption in the country (see Serbian Tobacco Control strategy, chapter 4).

Through the development of information technology (IT) the international body of knowledge in public health is now easier accessible for professionals and politicians in the region. IT helps to disseminate information and improves equal access to new databases, journals and other up-to-date information. The use of this enhances the advancement of new public health in the countries through capacity building and thus contributes to the improvement and development of programmes at local level. The technology furthermore facilitates the co-operation and information exchange among professionals in the countries and with the international public health community, which makes an end to the professional and academic isolation of former years.

There is a trend to increased professional co-operation within and between the SEE countries. This is facilitated and sustained by the establishment of institutionalised structures. One example on political level was already mentioned, the SEE Health Network. Another successful public health network initiated within the Stability Pact is the Project on Public Health Collaboration in South Eastern Europe (PH-SEE), which develops programmes for training and research on a regional level. PH-SEE organises regular meetings aiming for information exchange and co-operation on public health curriculum development, as well as supporting the development of formal schools of public health in the countries for capacity building regarding new public health, beyond the traditional biomedical oriented approach. In several countries, associations of public health have been founded with current or future affiliation to the European Public Health Association (EUPHA). Plans for the creation of a regional SEE association are currently under discussion.

At country level, various political changes in recent years are encouraging for the socio-economic development and provide

opportunities for public health. Further, media are increasingly reporting on public health issues, thus providing information to the public. Growing public awareness of the need for public health combined with an awareness of limitations of the clinical medicine with regard to the broad scope of health topics provide a platform for further recognition of public health as a key to countries' overall development. The recent and ongoing development of national public health strategies⁷ is a good starting point for a regional approach. As the national strategies show, the countries face many common problems and challenges. For addressing them, a regional framework through setting goals of mutual interest, joining forces through co-operation and information exchange is of benefit for advancing public health further in SEE.

Threats

Threats to public health development have been mainly identified in the societal external environment. Instability in the region as a whole and at country level is perceived as a major constraint on the way forward. Among various factors, the political instability is of primary concern. Every electoral mandate brings with itself changes in governmental strategies as well as in the organisational framework of institutions and agencies. In the same time these repeated changes affect legislation and financing mechanisms. There is no sustained continuity of management, legal framework or resources allocation throughout and across different political cycles.

Within a political cycle priorities and approaches are primarily oriented towards short-term goals for strategic reasons serving the political agenda and popularity rather than technical requirements. The sudden changes in the political agendas pose a serious threat to the timeframe of development, adoption and implementation of the public health strategy, causing delays and long gaps between the completion of the strategy preparation and the actual official recognition and adoption at the authority level. Long delays in the adoption and implementation of the strategy may bear the risk to make it untimely and irrelevant. Competing and conflicting interests of the different groups in the coalition pose an additional threat in the

⁷ see further chapters on case studies in this book

political sphere to the thorough development of a long-term public health policy.

Lack of public support is considered as a constraint for a regional public health strategy. This factor could be caused by the failure to deliver the key message to the civil society with the effect that the strategy remains perceived as just a position paper. The public further is exposed to conflicting messages of how the system should develop, on national and international levels. The proposed strategy may not meet the expectations of the general public; it has to be considered that for parts of the populations it may be socially and culturally unacceptable, given the socio-cultural and economic diversity in the region.

The international environment may impose further constraints. The EU, for instance could perceive the regional strategy as unnecessary. Despite the Stability Pact efforts in the follow up of the Dubrovnik Pledge, the SEE countries still feel that the International Community has paid limited attention to the reform of the health system in SEE and health has been excluded as a regional priority in the frame of the EU CARDS Programme (11). Thus, a misunderstanding of the regional needs within the EU and an inappropriate focus within the region could hamper the advancing of the special SEE public health topics. There is an ongoing risk of international goals being inadequately transferred and inappropriately adapted to the region.

The task environment is characterised by the socio-economic instability. Primary concern among the consequences is the high turnover of the professionals. It is further noted that the lack of recognition of public health professionals compared to clinical medical staff, in terms of identity, social status and public image, hinders the evolution of public health within the health system.

Strengths

As supporting factors within the internal environment a number of strengths of the current public health field in SEE were identified.

The countries in the SEE region can build on a respectable tradition and history of public health. Experiences in the past provide a sound basis for the present and future and can serve as good practice models even if adaptations to current trends are necessary. Namely the management of communicable diseases in conjunction with the sanitary control of water supplies have the potential for further development on regional level. These aspects have been taken up in the Health Development Action Programme as the project component “communicable diseases surveillance” (11). The traditional system of family physicians is as relevant to current trends in health care as the focus on maternal and child care.

This is backed up by already existing good legislation and regulations like the laws on surveillance of communicable diseases, occupational health, school children health, immunisation and other. The legislation further ensures close connection between the Ministries of Health, the Health Insurance Funds and the Public Health Institutes, giving for example the possibility to introduce financial incentives for providers of preventive services.

Significant resources are available to create a vital public health in the region, despite the shortage of funds. It can be built on an existing public health infrastructure, comprised of professionals, institutes and inspectorates. There is a core group of public health professionals with international training and connections who provide quality input into projects and institutions. Nearly all countries in Central and Eastern Europe have mature education and training systems (5). In addition to the already existing schools of public health with a long tradition, such as the Andrija Stampar School in Zagreb, new programmes and faculties have been established in recent years (e.g.: Sofia SPH, Varna SPH; Belgrade SPH; Tirana SPH; Bucharest, Chisinau and Skopje MPH programmes). Technical literature is available in the national languages of the countries. A good routine health data collection is maintained in most countries.

Professional associations and non-governmental organisations (NGO) reflect the already ongoing co-operation and communication and are a means of empowerment of public health. National public health associations have been founded in Romania, Serbia, Macedonia and Albania, accompanied by some associations of public health

professionals. Other initiatives are: the “Partnership for Public Health” Consortium in Bulgaria and the Forum of Public Health in Albania at national level, and the “Sharing for Action” project, initiated by the Institute of Social Medicine, Medical Faculty, Belgrade, Serbia and Montenegro, the Institute of Public Health Bucharest, Romania and the Department of Public Health, Faculty of Medicine, Tirana, Albania at regional level. International networks such as the PH-SEE prove to be an effective platform for advocacy and fundraising. The productive collaboration is visual in joint publications and projects. The sustainability of such networks and co-operation is ensured by participants’ willingness and commitment to continue and enlarge the collaboration.

A further strength is the recognition of the need for change in the professional community and the public. A raising awareness of the relevance and importance of public health issues can be stated among politicians, the general public, clinicians and non-health sectors, which are indicated in media reports on environment, industry, food production, transportation and education. This will be backed up by the willingness of the public health professionals to improve the general status of public health, which will impact positively on their own professional status as well.

Weaknesses

The list of weaknesses within current public health in SEE countries is long and addresses the areas of legislation, organisation, financing, health information system, human resources, education and training, and ethical issues.

Due to the ongoing health sector reforms, legislation on one hand is undergoing rapid changes; on the other hand it is obstructed by long processes of approval. The unstable political situation often requires new restarts from the beginning and as a consequence results in a lack of persistent vision and policy, which would be independent from a certain political person or party. The slow transition from centralised structure to decentralised systems reflects the inflexibility of former systems. A lack of ownership and a low sense of responsibility may be at the roots of this. Additionally, poor vertical and horizontal communication impedes the advancement of new

structures and initiatives. Community involvement in health development needs to be enhanced as it is currently neglected.

The quality and use of health information is another weakness within the system. Data sets tend to be not interlinked; an overall integrated system does not exist as this is not perceived and recognised as a solid source for decision making. In some countries only few hospital information systems exist but often they are not standardised or do not comply with EU standards. A lack of transparency of the information has been claimed as well as insufficient data confidentiality and security and missing data quality assurance. All in all the efficiency of the health information systems is questioned.

The financing is perceived to be insufficient; this being said, a specification has to be made: while an efficacious financing of the health systems needs to be implemented, it is also the inappropriate allocation of funds and the low effectiveness and efficiency in spending the money that urgently need to be addressed. The lack of control mechanisms enhances the inefficient spending. Furthermore, the financing of the health system, whether through the means of taxes or fees, as well as the expenditures are currently not linked to the health risks. Inappropriate salaries and non-existing incentives are another feature weakening the delivery of public health services.

While inappropriate salaries may be a major cause of lack of motivation on the side of the public health personnel, it is also the lack of professional and social recognition and the missing formal inclusion in decision-making processes that demotivate the professionals. A critical mass of well-trained public health professionals is not yet built. The missing of minimum requirements concerning knowledge and skills for certain public health fields coincides with the improper use of existing knowledge and skills. Some countries are short in programmes for continuous education. Generally, systematic training needs assessment should be developed for a better adaptation of the education to the needs in the field. There is a definite shortage of management skills in public health, resulting in inappropriately educated managers. This is aggravated by the fact that management positions tend to depend on political correctness rather than on qualification.

A crosscutting weakness is observed in the area of ethical issues. Besides the inefficient use of resources and inappropriate job performance, it is the corruption that worries most. As a consequence, inequalities in health care are on the rise and sufficient access to quality health care is not ensured.

3.2. Mapping the interactions

The next step in the analysis process was to look at the relationships between the factors of the external and internal environment of public health development in the SEE region. This provided a better understanding of the reality and prepared the choice of a strategic approach.

We will outline the interactions according to the four cells in the two-by-two matrix.⁸

Interaction of strengths and opportunities

There are clear trends of increasing awareness of the public, among politicians and professionals on the need for new PH approaches, enhanced by the perception of the limitations of clinical medicine in addressing health problems of the society. Media support plays a role in information and awareness rising in this regard.

The region can build on existing resources in terms of infrastructure (IPH, SPH), human resources (public health professionals), primary health care and programmes in health surveillance, health promotion and education as well as on the potentials of NGOs. The positive experiences with the regional networks such as PH-SEE and the SEE Health Network illustrate the benefits in improving collaboration and information exchange in the field of public health. This joining of forces and the proved professional capacities have great potential in attracting international investment in the SEE regional PH development.

The recent developments of national public health strategies are a starting point for the emergence of a regional policy framework.

⁸ see Annex 1; for a model of a SWOT matrix refer to chapter “situation analysis”

The existing legislation together with recent new laws constitutes a promising basis for the implementation of new public health strategies and a more efficient management of the health system. A regional approach is supported by the Dubrovnik Pledge of 2001. Many of the political changes in the countries have the potential to facilitate the harmonisation with EU standards and other international public health policies.

Interaction of weaknesses and opportunities

Weaknesses constraining the development of public health are identified in the fields of organisation of the health systems; financing aspects; human resources management (development, education/training); health information systems; legislation; and ethical issues.

The raising awareness of the need for public health in the region together with the increased international interest for public health development in SEE provides opportunities to address and overcome the prevailing weaknesses. There is a common willingness in the region to be integrated in the EU. The requirements to meet EU standards are supportive to the shift from traditional public health towards new public health. Experiences with existing networks such as PH-SEE and the SEE Health Network demonstrate the potentials to impact on a regional level on the development and harmonisation of public health approaches.

Interaction of strengths and threats

The already existing human resources, legislative instruments, inter-ministerial protocols and agreements can have a beneficial impact and diminish the barriers posed by the political instability from most of the SEE countries.

Although the recognition of the need for public health is observed at all levels, professional and general public, a regional strategy may lack support because it may fail to meet the expectations and become socially and culturally unacceptable.

The regional collaborations, active for several years, have proven to be successful and may serve as role models of how to

overcome the possible competing and conflicting interests that may arise in national and international coalitions and partnerships.

However, the financial constraints cannot be overcome with the existing strengths, as the financial resources are scarce in most of SEE countries further public health development relies on international aid. Though there are many well-established institutions with a long tradition in the region, the equipment and infrastructure are rather obsolete.

Interaction of weaknesses and threats

The organisational framework and political as well as economic instability are perpetuating the lack of resources: underfinancing, improper allocation of the existing funds, the high turn-over of public health professionals and their poor professional and social status cause the numerous drawbacks and setbacks of the public health reform.

Frequent changes in political orientation result in lack of a proper formulation of messages from the health system to other sectors; thus systems from outside health do not get a clear picture of the importance of health issues, and as a consequence these are ignored in overall policy formulation.

Furthermore, EU misunderstanding of the regional needs and the insufficient external funds might also constrain the overall sustainability of the health systems.

3.3. Clarifying the strategic choices

Choosing a strategy is not an easy task (5). Using the two-by-two matrix, four main strategy options for regional public health development can be described. Priority will be given to the most promising and feasible strategy approach.

Damage control strategy

This strategy may be an alternative to liquidation of an organisation, but can only be a temporary measure. In the context of public health in SEE, such a survival strategy is not appropriate

because of the existing internal strengths and external opportunities, which allow for coping with weaknesses and threats.

Mobilisation strategy

The aim is to maximise the strengths in order to control the threats or even to transfer the threats into opportunities. However, this would require extraordinary strengths. In the current situation, the public health system is not yet in that kind of strong and powerful position to control or transfer the threats of the external environment. Therefore the mobilisation strategy appears not to be the best choice for advancing public health in the region.

Investment-divestment strategy

A more promising strategic approach could be to minimise the weaknesses while maximising the opportunities. This would mean to invest to overcome weaknesses in order to make the best of the external opportunities. There are resources and potentials available, which can be used to tackle the weak points in public health. For instance, the ongoing health sector reforms aim to create a more efficient and effective health system, addressing the organisational and financial shortcomings. The investment option points to moving towards the maxi-maxi strategy.

Comparative advantage strategy

The strengths in the current public health field in SEE matched with the external opportunities are in favour for the comparative advantage approach. Public health in itself is a 'moral and economic necessity' (5) for all nations. Building on the current potentials does not mean to walk in the clouds losing reality out of sight: maximising the strengths implies overcoming the weaknesses for a stronger position to take opportunities offered by the external environment.

In this understanding a set of key messages and recommendations have been formulated:

- A priority in the SEE region is the reduction of health inequalities within and between the countries with view to further socio-economic stabilisation of the region and to better use of external opportunities.

- The perceived political changes and the social and economic developments in several countries should be used as a basis for improved community involvement and social participation in the decision making process. Increased participation of communities in health activities will contribute to meeting the expectations of the population and make the public health strategy socially and culturally acceptable. Further, public support facilitates the process of implementation. It could for example be realised through health promotion activities at the community level with the active involvement and participation of all sectors of society.
- Inter-sectoral collaboration (vertical and horizontal) is indispensable for getting public health on the agenda of all sectors and the overall politics. It is further a response to overcome the possible competing and conflicting interests that may arise in national and international coalitions and partnerships.
- The willingness of joining the EU could be the engine for economical and social development. The public health field should take advantage of the requirements to adapt to EU standards and regulations in order to improve legislation, professional regulations and harmonise public health practices.
- The growing interest of the international community in developing public health enhances investments in this field. Joining forces to apply for projects regarding research, capacity building and improving infrastructure could be used to overcome the weak financing of public health in the region. Regional co-operation contributes to improve the capability of attracting external funds for multi-national projects.
- The sustainable development of human resources in public health is highly recommended to ensure a critical mass of public health professionals in the region to support public health aspects in health reform and health policies. This includes the strengthening of personnel management, training, education and research. Capacity building should include

management of health systems and better use of existing resources.

- Further, an improved status of public health professionals would enhance their active involvement in policy development and decision making processes, thus ensuring the integration of public health knowledge and the use of data for evidence based policy making processes. This could be operationalised in strengthening existing public health associations; creating them where they do not exist; and forming a regional umbrella organisation.
- Professional collaboration in forms of networks represents a response to obstacles imposed by the centralised structures still existing in the countries. The international collaboration and co-operation in the SEE region will help that strengths already existing in some countries can be replicated in the others and that successful national projects can be disseminated all over the region.

4. The SEE regional public health strategy framework

The results of the SWOT analysis and the eight recommendations were considered by the PH-SEE seminar participants for the development of a framework public health strategy. A priority setting process was necessary, as a direct translation of the recommendations into goals would not have been appropriate. For this process, the nominal group technique was applied.

Two groups were created, respecting a balanced representation of the countries. Each group produced a list of public health priorities for the SEE region. The results were discussed in plenary and the selected final priorities were formulated as goals, framing the future regional public health strategy. Subsequently, the participants discussed each goal in small groups, creating an action plan by setting operational objectives, specifying them into activities, timeframe, deliverables, outcomes, indicators, and analysing potential partners, resources and risks. The results were presented and finally discussed in plenary.

This section outlines the framework for a regional public health strategy as jointly developed and suggested by the experts within the PH-SEE network.

Guiding principles

The strategy framework subscribes to the basic values as expressed in the World Health Declaration, 1998 (3), reiterating health as a fundamental human right. Improving health is the ultimate aim of social and economic development. The commitment to the ethical values of equity, solidarity and social justice forms the foundation of the work in public health. The gender perspective is integrative part of this framework and should be reflected in all health action. The participation and accountability of individuals, groups, institutions and communities is indispensable for the sustainable development of health.

The SEE regional framework for public health refers to European public health policies, namely the WHO Health 21 policy framework (3) and the EU Public Health Programme (8, 9); it further seeks to link with work already done at a regional level in SEE as follow up to the Dubrovnik Pledge in 2001(1, 6, 11).

A regional strategy framework aims to complement the national public health strategies. In addition to the countries' strategies, it provides a framework for common health challenges in the region. Following the suggestions of the framework, it will contribute to the harmonisation of the public health policies between the countries and to the approximation to European standards according to the capacities of the countries.

Framework

Five priorities represent the overall framework for action to advance public health on a regional level, as illustrated in figure 2. Based on the priorities identified and agreed upon, the PH-SEE experts formulated goals to address the priorities. An initial five-year period has been established, starting from 2005; this aims giving

enough time for discussion and acceptance of the regional framework and for implementation of an action plan.

Figure 2 Suggested strategic goals for regional public health in SEE

Goal 1:	Reducing inequalities in health
Goal 2:	Strengthening social participation
Goal 3:	Strengthening human resources in public health
Goal 4:	Improving regional public health information and knowledge
Goal 5:	Establishing intersectoral co-operation

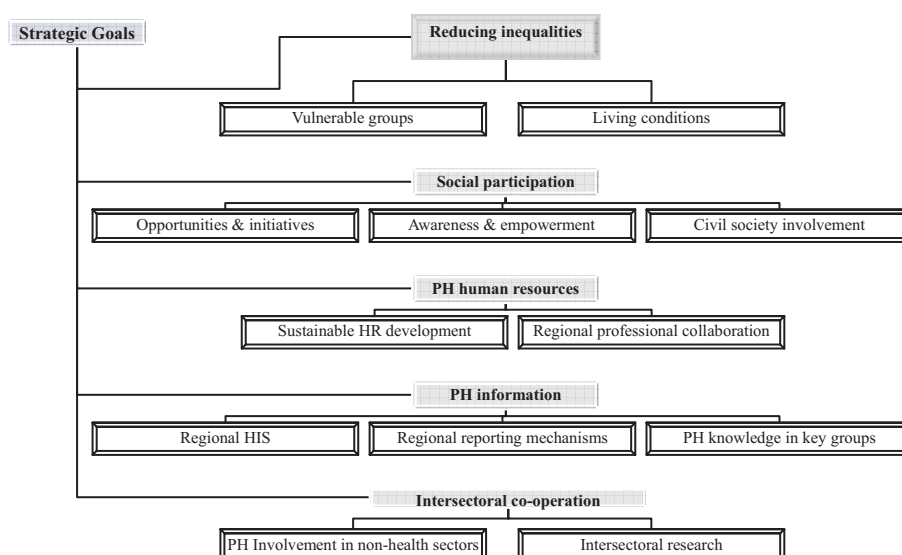
Source: documents from the Expert Summer Retreat - National Public Health Strategies in South Eastern Europe and the EU Health Policy, Belgrade, Serbia, 2004

The sequence of the goals does not imply a ranking order. The goals have been specified into objectives and operationalised according to suggested activities with timeframe estimation, outcomes, deliverables and indicators. Additionally potential partners, resources and risks have been identified.⁹

Figure 3 provides an overview of the framework outlining its five goals and their respective objectives.

⁹ for overview tables, see Annex

Figure 3 Framework for a SEE regional public health strategy



Source: Christiane Wiskow, based on the documents from the Expert Summer Retreat - National Public Health Strategies in South Eastern Europe and the EU Health Policy, Belgrade, Serbia, 2004

The details of the regional public health strategy framework are presented below according to the sequence of the goals.

Goal 1 → Reducing inequalities in health

Reducing inequalities in health intends to close the gaps in health status and in access to quality basic health care within and between the countries in the region. One decade of political changes, economic breakdowns and war have resulted in the deterioration of the overall population health status, affecting the vulnerable groups most. While some countries are more affected by consequences of war and political tumult, other countries recovered from the drastic socio-economic changes better, resulting in better living conditions for their populations. This is reflected in the range of different ratios and indicators such as life expectancy, infant mortality, among others.

Within the countries, the gap between socio-economic population groups is of concern. Those living in poverty, as members of marginalized groups or in insecurity are at the risk of social exclusion and deprivation from resources influencing health, such as education and healthy living conditions. Many national public health strategies explicitly address the health inequalities in their countries and aim for equity, for instance those of Albania, Macedonia, Serbia and Montenegro¹⁰.

Two objectives were formulated to achieve this goal:

- Objective 1.1 Targeting vulnerable groups
Objective 1.2 Ensuring adequate and safe living conditions

Objective 1.1: Targeting vulnerable groups

Reaching those who are most in need implies to focus health development efforts on vulnerable groups. This objective is in line with the Dubrovnik Pledge, which aims to meet the health needs of the vulnerable populations (6). Who are those considered as vulnerable groups? A special challenge for some SEE countries is the ongoing desperate situation of internally displaced persons (IDP) and refugees; those living in conflict areas under the stress of insecurity and violent threats; and those considered as ethnic minority groups, e.g. the Roma communities. Common vulnerable groups further are small children and the elderly; persons with chronic diseases and disabilities, such as HIV positive patients; and those living in poverty.

Activities should include:

- The identification, research and monitoring of indicators of inequalities relevant for each of the vulnerable populations, starting from 2005 and ongoing
- The establishment of a comparative report on inequalities and trends at regional level, every two years
- The design and implementation of intervention programmes, such as educational campaigns and awareness rising among health staff.

¹⁰ Presentations at the Expert Summer Retreat: National Public Health Strategies in South Eastern Europe and the EU Health Policy; Belgrade, Serbia, August 23-28, 2004; unpublished

- The establishment of a regional office for human rights, to be prepared by 2007
- Advocacy for those in need

Objective 1.2: Ensuring adequate and safe living conditions

In order to reduce inequalities in health, safe and adequate living conditions have to be ensured for all populations. This includes the general environment, concerning water and air quality as well as the direct living environment of people in their housing and workplace, sanitation and food. It is well recognised that environmental factors are major determinants of health. In ensuring adequate living conditions for all, a priority is to address ill-health living environments, such as unsafe water, insecure sanitation and insufficient nutrition supply; this will be of benefit for vulnerable groups, suffering most from inadequate conditions for housing and nutrition, such as refugees in particular. The relevance of objective 1.2 is reflected in the fact that food safety and nutrition is a priority within the SEE Health Network initiatives. Projects have been launched with the aim of better policies and practices, including legislation, which are in line with European standards. Among others, the creation of a regional food control network is planned (1).

Activities would include:

- Development and implementation of an environmental control network at regional level, complementing the planned regional food control mechanism; preparations such as an initial mapping of the existing national control systems and their potential links starting from 2005 and the established control system would be functioning by 2010
- The implementation of international recommendations for health security, such as for example the International Health Regulations for the prevention of transboundary spread of infectious diseases (12)
- Specific programmes for health education, e.g. disease prevention; healthy nutrition
- Continuous monitoring and evaluation of the measures taken and their health impact on various vulnerable groups as well as their effects on the general population

Expected outcomes of both objectives are the improvement of health and social status in vulnerable populations; supported by viable recommendations at national and regional level. Deliverables will be publications, such as reports and articles; conferences and inter-ministerial meetings. Indicators to measure the impact of activities are suggested to be selected from general sets of indicator as defined by WHO, EU or OECD (e.g. vaccination rate, infant mortality rate, low birth weight, prevalence of major communicable diseases such as TB and HIV/ AIDS; rate of injuries caused by accidents; burden of disease)

Resources, which could be made available in the countries, are the existing staff in the partner institutions, while additional funds would have to be raised with the government, with potential donor countries and organisations. Besides the lack of funds, potential risks to a regional approach targeting specifically vulnerable groups could be the lack of political will at different levels and a general lack of understanding and readiness to support the activities. With regard to ensuring adequate living conditions, further risks include the political and socio-economic instability, and a non-sustainable development.

Potential partners for the achievement of the entire goal 1 with both objectives are the Ministries of Health; institutions such as the Institutes of Public Health, the Schools of Public Health; non governmental organisations active in the field; the local communities; the representatives of the target groups; public health professionals; and international projects and agencies. Collaboration with the SEE Health Network projects should be established for synergy effects. Especially with respect to objective 1.2 intersectoral co-operation is indispensable, which refers to goal 5 of the strategy framework.

Goal 2 → Strengthening social participation

Public participation in health policy development has been promoted since the Alma Ata Declaration on Primary Health Care (PHC) in 1978 and is integral part of the Global Health for All Strategy. As stated in the guiding principles, the responsibility and accountability of all is a requirement for sustainable health development. Responsibility and support can only be achieved by active involvement of the relevant stakeholders at various levels in

decision-making processes and implementation of strategies. Through dialogue with the users and the communities, the needs of the population for health services can be identified more reliable according to the local context or to special needs of groups of people. Though a number of initiatives are known in individual countries (e.g. Croatia), an overview on what is being done currently in the region is missing. It is suggested that the potentials and possibilities of participation in health initiatives and decision-making processes are not sufficiently known to the general public, the professionals and the politicians. Perceived reservations by the professionals and politicians to enter into partnership-oriented dialogue with the health service users and the communities can be overcome by information exchange and good practice models. The concept of social dialogue is a recognised means for positive contributions to development processes in the health sector (13). Originally developed and used in labour relations and collective bargaining processes only, it is also applicable in a broader context where various stakeholders and partners influence and are affected by public policy decisions, such as the health sector. As in every formal negotiation context, the components and processes of social dialogue require knowledge and skills, which could be trained at regional level for disseminating the knowledge at country and local levels.

Three objectives are set to enhance social participation in health development:

- Objective 2.1 Mapping social participation opportunities and initiatives
- Objective 2.2 Awareness rising and empowerment of the public
- Objective 2.3 Developing mechanisms to involve civil society in decision making processes

Objective 2.1: Mapping social participation opportunities and initiatives

Since social participation in health has not yet been systematically dealt with in the region, starting with a situation analysis appears most appropriate for obtaining an overview on what can be built on and what needs to be developed. This includes an analysis of the current legislation in the countries and the gaps, for

allowing public participation in decision making processes. An overview may also provide information on the readiness and knowledge of the public and the professionals on social participation.

Activities include:

- Situation analysis in the countries on the opportunities for and constraints to social participation in public health development, starting in 2005 with country reports delivered in 2006
- Identification of key players and existing networks, formal and informal, 2005- 2006 and ongoing
- Identification of gaps and suggested measures to address them, with the country reports in 2006
- Regional synthesis analysis, by 2006

Objective 2.2: Awareness rising and empowerment of the public

Participation in policy development requires awareness on the need and possibilities on one hand and knowledge on how to participate and about the subject on the other hand. Thus, awareness rising, where necessary, is the next step based on the situation analysis, while the need for empowerment of the general public and especially the users of the health services, once identified, can be addressed by specific interventions.

Activities include:

- Public awareness campaigns and knowledge dissemination, using mass media; ongoing from 2006
- Education of educators, ongoing from 2005; to arrange for regional courses may be appropriate for efficient use of funds and information exchange between countries.
- Organising specific events, altering with awareness campaigns, from 2006 ongoing; an example could be the dedication of an award for the most active community in health in SEE.
- Co-ordination and co-operation with other similar programmes; intersectoral co-operation recommended, ongoing from 2005

- Holding an international conference on citizenship and participation, planned for 2008

Objective 2.3: Developing mechanisms to involve civil society in decision making processes

On regional level the establishment of formalised mechanisms for social participation would complement the country activities with the aim of harmonisation of subjects, such as patient rights or consumer protection. This could, for instance, take the form of nominating representatives in the various fields for consultation processes.

Activities include:

- Building alliances between various actors in public health in the countries; ongoing from 2007
- Creating a regional chamber of consumers and health service users; this could be located within the future regional public health association; by 2007
- Initiating a special interest group on social participation in health development, as part of the future regional public health association; 2006
- Establishing social dialogue procedures between stakeholders; ongoing from 2006

The expected outcomes of the activities outlined for goal 2 are best framed as changing attitudes of politicians, professionals and the public towards a more partnership oriented dialogue process; joint responsibilities in the health field; specific skills for social participation among the various key actors; more and better professional collaboration; and finally, functioning and recognised mechanisms for social participation in public health development.

Deliverables concerning objective 2.1 would include the country reports and the regional synthesis reports; a data base of networks, associations and alliances; sound recommendations for further action. This would be complemented by press releases, meeting reports and formal statements as well as publications from the conference with regard to objective 2.2. Additionally, formal agreements on the establishment of procedures and regional

associations would be delivered under the third objective. Indicators for monitoring activities and evaluating the impact include the number of country reports delivered, the number of activities executed and the persons involved; materials produced; the number of new networks and alliances created; the level of activity in the chamber of consumers and the activities of the special interest group on social participation; potential changes in legislation.

Potential partners for achieving the goal of improved social participation are key persons in communities, representatives of consumers and the public; community leaders; local health authorities; non-governmental organisations; decision-makers; educational institutions; professionals; as well as the mass media. These partners represent in the same time important resources for achieving the goal; they could be supported by international organisations and agencies, such as WHO, Stability Pact, and ILO. Funds would have to be allocated from existing local budgets and the local health authorities; additional funds would have to be raised from international donors. Insufficient funds are identified as one of the risks. A constraint with greater impact however would be the lack of interest among the actors as well as potential obstruction of decision-makers. Another risk constitutes the potential lack of members of the public being capable, available and committed to social participation in health development.

Goal 3 → Strengthening human resources in public health

There is wide recognition that health human resources are critical for the delivery of quality health services. The trends in public health with the emergence of the so-called new public health are not yet mirrored in the public health workforce in SEE. While there is a well-developed body of knowledge, institutions and professionals concerning the bio-medical aspects of public health and an existing expertise in social medicine, the need for improved multi-professional co-operation remains evident. The interdisciplinary composition of the public health personnel is not yet sufficient with nearly all staff working in public health being medical doctors. Further, as the SWOT analysis showed, the recognition of the discipline of public health within the biomedical environment is not satisfactory and accordingly, the status of the professionals is comparatively low. Strengthening the public health workforce will give public health a stronger platform

within and beyond the health sector. For this, the education of public health specialists needs to be adapted to the new public health approaches and harmonised within the region and with the European standards. In this regard and in the context of mobility, the question of mutual recognition of qualifications has to be addressed and processed. Regional collaboration has proved to be beneficial as shown by the PH-SEE network.

Two objectives specify the way to strengthening the personnel in public health:

- Objective 3.1 Ensuring sustainable development of human resources
- Objective 3.2 Enhancing regional professional collaboration

Objective 3.1: Ensuring sustainable development of human resources

On regional level the development of human resources mainly aims at developing and implementing education complying with common trends and standards in public health education. The harmonisation of the public health education will be of advantage for the professionals in the region, as this would allow for easier communication and co-operation. At the basis of this, a common terminology is recommended to be developed. Additionally the career opportunities for public health specialists would improve and provide more international mobility. Though migration of qualified professionals constitutes a problem for many health systems in transition countries, potential benefits of international mobility are increased knowledge and skills and international contacts, for advancing health personnel development.

Activities include:

- Developing common training curricula for public health on different academic levels; as some initiatives have been already taken, starting in 2005 is realistic with an ongoing negotiation process and the final adoption and establishment of a common curriculum framework expected by 2010.
- Developing practice guidelines informed by international protocols; 2006 ongoing.

- Providing a common glossary and terminology in public health for the region, by 2007.
- Holding a consensus conference in 2007.

Expected outcomes of the activities are a harmonised approach to public health human resources development, ideally expressed in the promotion, adoption and continuity of common curricula and a common terminology in public health. Deliverables are the documentation of the curricula development; the provision of a regional public health glossary and of practice guidelines in electronic and print version; and the organised consensus conference. Indicators for the activities and their impact would be for instance the number of running education programmes per year and the number of students with completion of degrees; the number of institutions recommending and using the practice guidelines; the frequency of requests for materials, and the number of website visitors; the number of participants and the level of media echo concerning the conference.

Objective 3.2: Enhancing regional professional collaboration

Looking beyond the own borders is known to be instructive. The benefits of professional collaboration on regional level are related to the common challenges many health systems in the region face. There is potential for synergy effects of efforts and experiences by continuous information exchange. Lessons learnt in one country may inform the proceeding in other countries. Good practices in one country may inspire initiatives in another country. Joint research and intervention programmes covering several countries in the region help spending scarce resources in efficient manner. For these effects collaboration of the professionals in the countries is necessary and should be supported. An implicit effect of continuous co-operation goes beyond the health sector: the constructive contribution to stability in the region.

Activities to enhance professional collaboration in the region include:

- Developing regional research projects; subjects relevant to several countries could be researched jointly, resulting in the production of comparable data, from 2005 ongoing
- Developing regional intervention programmes where appropriate; this could include specific subjects, such as a quit-smoking promotion campaign or specific target groups, such as health promotion with IDP and refugees; planning starting in 2005, implementation from 2006 onwards.
- Initiating mobility of public health professionals in the region; e.g. through academic exchange programmes, fellowships, regional training courses, or temporary career opportunities with regulated return options.
- Establishing periodical regional conferences or meetings

Expected outcomes of these activities are a rising awareness among the public and decision-makers of the common regional health issues. It is further expected that the scientific recognition could be improved by multi-country research and intervention. Harmonised knowledge, methodologies and teaching skills will contribute positively to public health development, as well as the exchange of experiences and good practice models. Indicators for monitoring the outcomes include the number of implemented regional programmes, the number of participating countries, the number of visiting professionals in other countries for research, education or work purposes, number of publication on regional health issues, and the number of participants in regional conferences.

Potential partners for strengthening human resources in public health (goal 3) are the institutes of public health; the schools of public health and the universities; professional associations and unions; public health associations; and international organisations such as ASPHER and EUPHA; as well as local authorities, NGOs and the media. Resources to achieve the goal are persons from the Ministries of Health and the Ministries of Education; from professional and public health associations; schools of public health; regional consultants, researchers and lecturers; and key persons in the communities. Financial resources would have to be made available by the Ministries concerned, notably the Ministries of Health and Education, as well as by the institutes of public health; additional funding could be applied for at health insurance companies,

international donors and within international projects. Risks to the achievement of the goal were identified in lack of political support; financial instability; a high degree of diversity leading to lack of consensus among professionals; competing interests among countries and stakeholders; and the overproduction of papers.

Goal 4 → Improving regional public health information and knowledge

Every health policy and action needs to be evidence based to ensure quality health care to the people. Decisions have to be informed by sound data and their analysis. While health data are generated in numerous institutions and projects, the access to public health information is not obvious. Thus the knowledge on public health is not disseminated sufficiently to the main stakeholders, the public, the decision-makers and the professionals. Improving information and knowledge for the development of public health is one of three objectives in the EU public health programme, 2003-2008; and health information is one of the priorities in the work plan of 2004 (9). Within the Dubrovnik Pledge, the commitment to “establish regional networks and systems for the collection and exchange of social and health information” is one of the set objectives (6). This underlines the relevance of including the health information aspect in the SEE regional public health strategy framework. A regional information system aims to harmonise the data gathered in the countries, and to improve the dissemination of the knowledge gained from the analysis. Within the SEE Health Network, the SEE Communicable Diseases Surveillance Project (2004-2005) aims to develop a standardised system for reporting, monitoring and evaluation of infectious diseases data, including an internet based database (11). A regional public health information system intends to refer to these existing initiatives and materials, and broaden the scope beyond infectious diseases while focussing on the SEE regional context and its specific public health needs.

Three objectives have been set to pave the way to better regional public health information flows:

Objective 4.1 Establishing a regional public health information system

Objective 4.2 Developing mechanisms for reporting and analysis at regional level

Objective 4.3 Improving the level of public health knowledge among three key groups: the professionals, the decision-makers and the public

Objective 4.1: Establishing a regional public health information system

The definition, collection and exchange of relevant data found the basis for systematic information flows. The regional level requires inter-country consultation to identify what of the existing national information systems is consistent and relevant for the regional level and what is acceptable at the national level. The need for harmonisation with EU standards is evident, and the development of an information system should refer to work already done. This means to integrate indicators defined within health information systems, such as the EU health indicators, the PH-SEE minimum indicator set, or the communicable disease surveillance project.

Activities for establishing a regional public health information system include:

- Defining a regional data set
- Defining compliant indicators according to EU and Eurostat definition and standards
- Design of an information system with a functionality compliant to standards of EU and ISO
- Operating the system
- Creation of a regional Clearing house together with local focal points, by 2007
- Benchmarking

The timeframe for the sequence of activities would start from 2005 ongoing.

Objective 4.2: Developing mechanisms for reporting and analysis at regional level

Parallel to the establishment of an information system, mechanisms for reporting and analysis at regional level need to be

developed in order to make the information available to all concerned in the region. A regional reporting mechanism has the advantage to provide valuable information about developments and trends in health in the countries. Differences and commonalities can be analysed. The inter-country comparison will be made possible which may have a kind of benchmarking effect and lead to more targeted regional intervention.

Activities include:

- Design of standardised reports compliant with EU reporting requirements, by 2006
- Dissemination of information through different channels, by 2007

Objective 4.3: Improving the level of public health knowledge among three key groups, the professionals, the decision-makers and the public

The outcome of the two previous objectives will advance the information dissemination and thus improve the availability of public health information for those concerned and interested. Decision-makers, professionals and the public can take advantage of the information for their local health development purposes. In the same time they get an overview on the position of their direct local environment within the regional context. Improved knowledge and timely information lead to more effective health interventions at all levels.

Activities for improving the public health knowledge include:

- Providing free access to information for professionals, decision-makers and the public, by 2007.
- Developing a regional public health newsletter, from 2007 onwards.
- Developing common regional tools and mechanisms for evaluation of public health knowledge, starting from 2005. This could include the conduct of prospective studies or establishment of a health barometer.
- Promotion, marketing and advocacy for effective use of information

- Evaluation of the regional health information system, from 2006 ongoing

The expected outcome of all objective related activities focuses on a sustainable health information system which produces and disseminates relevant and timely information. The increased knowledge concerning public health issues allow for informed decisions in health and contribute to the general health gain in the region. The specific outcomes will find expression in an agreement on a regional information system and its adoption, such as a data set; continuity of data collection and harmonisation of information available. Providing free access to this information will result in increased efficacy of public health interventions and better-targeted decisions. Deliverables are notably documentation and publications, a regional database, standardised reports and information materials, in print form, on CD or on website. Additionally, a regional clearing house will be established as well as national focal points to structure the co-operation. Indicators for monitoring the activities and evaluate their impact include the number of compliant indicators; the ratio between benchmark and original indicator; number of implemented or ongoing campaigns; number of requested materials and website visitors; number and quality of research studies; number of publications.

Potential partners supporting the achievement of the goal have been identified as national offices and agencies related to health information; the institutes of public health and the universities; the SEE Health Network; relevant EU bodies and other international organisations; in the private sector the information technology industry could be a promising partner, and the pharmaceutical industry; further the media. Financial resources will be acquired through governmental sources and sponsors; technical equipment is partly available, partly has to be upgraded. Regarding human resources there is sufficient expertise in the region among public health professionals, national health information co-ordinators, information technology specialists and designers, educators and communication experts. Perceived risks to the realisation of the objectives are mainly insufficient funding, lack of political support and competing interests of different stakeholders.

Goal 5 → Establishing intersectoral co-operation

“*Is it healthy?*” This simple question may have great potential to “alter the course of human development”, as suggested by WHO (3). There is a wide range of factors determining human health and it has been recognised already in the early 20th century that a majority of health determinants are outside the sphere of influence of the health sector. An integrated approach to address health issues has been claimed for long time by health professionals, and finally found its way into policy formulation. One of the three general objectives set within the current EU public health programme is “to promote health and prevent disease through addressing health determinants across all policies and activities”, which intends to contribute to “ensuring a high level of human health protection in the definition and implementation of all Community policies and activities, through the promotion of an integrated and intersectoral health strategy” (8), as it has been laid out in the Treaty of Amsterdam, Article 152 (2, 8). Nevertheless, the awareness of health impact of action taken in other sectors than health is still limited and neglected when it comes down to practice. Further, the need to look beyond the health sector is also not yet sufficiently internalised by health professionals. All in all, regular and institutionalised mechanisms of intersectoral co-operation have to be developed and established in the region in order to promote the protection of health and ensure sustainable health development.

Two objectives were set towards a practical approach to improved intersectoral co-operation:

- Objective 5.1 Establishing involvement in programmes of non-health sectors
- Objective 5.2 Introducing intersectoral research

Objective 5.1: Establishing involvement in programmes of non-health sectors

It was felt that public health professionals should take the initiative to get involved into regional programmes run within other sectors, which are relevant for public health issues. This aims to gradually get the health perspective integrated and present in the overall policies and action in the region.

Activities include:

- Mapping existing regional programmes, by 2005.
- Identifying programmes relevant for public health participation, 2005 and ongoing. This implies the development of indicators to specify which programme is considered relevant for public health.
- Initiating information exchange with colleagues in these programmes, starting in 2005 and ongoing.
- Active participation in other sectoral and multi-sectoral programmes, established by 2007. Active participation goes beyond information exchange, including the mandate for consultation and negotiation of public health representatives.

The expected outcomes of the activities are established and institutionalised structures of intersectoral co-operation at regional level. In the long run it will lead to normalisation of the involvement of health experts in programmes outside the health sector to ensure optimal health protection across all sectors. Deliverables are a database providing an overview on public health relevant programmes in the region; and implemented processes of information exchange. Indicators to monitor the activities and their impact could be the number of identified programmes which have been assessed as relevant to public health; the number of official invitations of public health representatives to programme meetings within other sectors.

Potential partners for the activities are professionals in other sectors who are responsible for relevant programmes; the respective ministries, NGOs, and WHO liaison officers. Those partners constitute a part of the resources for supporting the objective, together with professionals in the institutes of public health and the Ministries of Health; technical resources are existing databases, information technology, including retrieval systems. Funding should be provided mainly by the Ministries of Health and the institutes of public health. Risks for the achievement of the objective have been identified in potential information overload; instability in the region; unequal status of the countries resulting in barriers in acceptance and regional recognition. A lack of political and professional willingness may pose a serious threat to intersectoral co-operation, expressed and underlined by so-called “silo-thinking”, which consists in prevailing

fragmentation between and within sectors, institutional selfishness and competition.

Objective 5.2: Introducing intersectoral research

A way to generate evidence on the importance of intersectoral co-operation is the introduction of intersectoral research. This implies the interdisciplinary approach to research topics and requires real cross-sectoral thinking. The issue of safe food and nutrition, as addressed in the SEE Health Network projects, may be a very obvious example for health gain based on evidence of research jointly done by agricultural, biological, nutritional, medical and social disciplines. Another possible field would be the city planning where architects, traffic planners, geographers, demographers, environmentalists, and health experts could be contributors to healthy planning of cities.

Activities include the cycle of research projects:

- identifying relevant topics, by 2005
- priority setting, by 2006
- project proposals, by 2006
- project implementation, 2007- 2009
- project evaluation, by 2010

The expected outcome of the research undertaken would be improved cross-sectoral knowledge on public health issues. Deliverables would be project proposals and reports of finalised projects including a regional evaluation report. Indicators for the activities and their results are the number of project proposals; the rate of accepted and finalised projects; and the number of publications.

Partners for intersectoral research are among the schools of public health, the institutes of public health, universities, health insurance funds, the ministries of health and other ministries; and in the private sector partners should be identified within the respective industries. The partners also represent potential resources, in providing their existing staff and equipment, as well as donors for funding. The potential lack of professional and donor interest would pose a risk to the achievement of the objective, resulting also in the lack of funds.

Figure 4 recalls all goals and objectives of the draft framework in summary.

Figure 4 Summary of goals and objectives of the draft SEE regional public health strategy framework

<p>SEE regional public health strategy framework, 2005 – 2010</p> <p>Goals and objectives</p> <p>Goal 1 Reducing inequalities in health</p> <ul style="list-style-type: none">1.1.: Targeting vulnerable groups1.2.: Ensuring adequate and safe living conditions <p>Goal 2 Strengthening social participation</p> <ul style="list-style-type: none">2.1.: Mapping social participation opportunities and initiatives2.2.: Awareness rising and empowerment of the public2.3.: Developing mechanisms to involve civil society in decision-making processes <p>Goal 3 Strengthening human resources in public health</p> <ul style="list-style-type: none">3.1.: Ensuring sustainable development of human resources3.2.: Enhancing regional professional collaboration <p>Goal 4 Improving regional public health information and knowledge</p> <ul style="list-style-type: none">4.1.: Establishing a regional public health information system4.2.: Developing mechanisms for reporting and analysis at regional level4.3.: Improving the level of public health knowledge among three key groups: the professionals, the decision-makers and the public <p>Goal 5 Establishing intersectoral co-operation</p> <ul style="list-style-type: none">5.1.: Establishing involvement in programmes of non-health sectors5.2.: Introducing intersectoral research
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Source: Christiane Wiskow, based on the documents from the Expert Summer Retreat - National Public Health Strategies in South Eastern Europe and the EU Health Policy, Belgrade, Serbia, 2004

Discussion

The framework for regional public health strategy in SEE, as it has been developed in the PH-SEE seminar and documented here, represents a first step aiming towards an agreed regional strategy framework. The purpose of the exercise was to demonstrate the benefits of regional collaboration in using the technical competencies and potentials of public health professionals in the region and to initiate a discussion and development process leading to a regional viewpoint on public health. It is not always obvious and easy to distinguish between country level and regional level needs and requirements. Furthermore, the harmonisation with EU public health standards and policies has to be taken into consideration in health policy development, making the process even more complex. Given the current absence of officially adopted national public health strategies, the diversity of public health situation and health systems throughout the region, as well as the continued diverse discourse in the professional communities and at political level of what is public health, there is still a long way to go to agree on well defined health targets, as suggested by the model of the WHO Health 21 strategy. While this may be perceived as a weak point of the draft framework, its strength is the emphasis on process and structural aspects of public health. This focus allows complementing and orienting the national public health policies and makes it a cross-cutting framework considering local levels as well as national and regional levels.

The methodological approach may be challenged by the scientific community; however in regional development, as well as in strategic planning, the use of heuristic reasoning is well established. This framework has benefited from the profound knowledge and experience of public health professionals in the region. A weak point for the time being is though the absence of voices of other key stakeholders in public health, namely political decision-makers and the public, in the development process. For this reason the present draft framework is considered as a first step on the long road to a regional public health strategy.

5. The way forward

The previous sections described the development process of a public health strategy framework for the SEE region and its outcome. Following a SWOT analysis of the current public health context in the region, based on the thorough knowledge of public health professionals of seven SEE countries, the present draft framework has been jointly developed. It reflects the priority action areas suggested to be addressed at a regional level, which have been selected in a participatory approach among a broad variety of priority subjects mentioned. The production of this framework and its objectives for a practical approach is in itself a result of regional professional cooperation in the field of public health and marks a starting point to be built on. The strategy is meant as a framework for complementing, guiding and inspiring national public health action plans. The integration with existing policies and projects is core to the relevance and feasibility of the framework. A regional approach to public health action aims to create synergy effects and to contribute to stability in subscribing to the overall goal of all health policies: the improvement the populations' health.

Now a regional public health strategy framework has been drafted, how to take it forward? In order to avoid that it remains just one additional policy paper facing the risk of being forgotten in a drawer, another strategy needs to be developed: the promotion of the strategy framework. The ambitious aim is the adoption of the framework at regional level and subsequently its implementation. The way to adoption leads via acceptance. The logical next step therefore is the dissemination of the strategy framework and its discussion. A discussion of its content and purpose is required on a broad platform, including relevant key stakeholders in the countries, as well as regional and international actors involved in public health development in the region. The option of an internet based discussion forum would facilitate the involvement of the public in the discussion process. Comments and suggestions may be reviewed by a core group of key persons for adaptation of the current draft in a consensus seeking process. The next milestone within this process could be the presentation of the regional strategy framework at the next inter-

ministerial conference in the follow-up of the Dubrovnik Pledge, planned for 2005.

Provided that a regional public health strategy framework would be accepted and adopted, further development is needed: the current proposal focuses on priority formulation, outlines objectives and suggests activities for the translation of the goals into practice. In its present form it shares a common weakness of policy proposals: an overall guidance to implementation, monitoring, and evaluation. This would have to be addressed as soon as an overall acceptance of the regional strategy framework can be assumed. It includes the clarification of the roles and responsibilities at regional level concerning the various actions and the regional overview (who does what), and it may imply the institutionalisation for regional public health development beyond the suggested timeline of 2010. The work done within the SEE Health Network provides a basis to build on for political and technical sustainability.

Exercises

Task 1:

After critical reading of the strategy framework and its development, students split up into groups. They discuss, analysing the strengths and weaknesses from their point of view, considering a) the development process; b) the draft framework with its goals and objectives; c) recommendations for improvement. Each group prepares a summary report on strengths, weaknesses and their recommendations, and presents them in plenary.

Task 2:

The students compare the national public health strategy of their own country (or health policy in case no specific public health strategy is existent) with the draft framework for a regional strategy and elaborate on the compatibility of both by highlighting commonalities and differences. This could be done as an individual homework with a brief report on the findings or a presentation in the seminar.

Task 3:

The students experience the cycle of participatory and consensus building methods: A SWOT analysis on the public health situation in

their country (note: it may be appropriate to choose another setting than the national level, such as the province, district, community, or city) is conducted and subsequently a priority setting method applied for producing a list of public health priorities in the chosen setting.

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List of Abbreviations

ASPHER	Association of the Schools of Public Health in the European Region
CE	Council of Europe
EU	European Union
EUPHA	European Public Health Association
ILO	International Labour Organization; International Labour Office
MDGs	United Nations Millennium Development Goals
NGO	Non-governmental organization
PH	Public Health
PH-SEE	Public Health Collaboration in South Eastern Europe– Programmes for Training and Research; a programme within the Stability Pact for South Eastern Europe
SEE	South Eastern Europe
SWOT	Strengths, Weaknesses, Opportunities, Threats
UN	United Nations
WHO	World Health Organisation

(Annexes)

ANNEX 1: SWOT analysis matrix

ANNEX 2: Overview tables on goals and objectives of the regional public health framework

ANNEX 3: List of participants of the PH-SEE seminar, having contributed to the SWOT analysis and the development process of the draft framework for regional public health in SEE.

ANNEX 1 SWOT Analysis Matrix - Mapping interactions

Internal factors	<p>List of STRENGTHS (S)</p> <ul style="list-style-type: none"> • Tradition and history of PH in countries of SEE region • Existing institutions, services, data and education resources • Recognition of need for change • PH-SEE network • Existing legislation and strategies • NGO potential and professional's associations 	<p>List of WEAKNESSES (W)</p> <ul style="list-style-type: none"> • Organisation • Financing • Human resources • Health Information System (HIS) • Legislation • Education, training, research • Management skills • Ethical issues
External factors	<p>List of OPPORTUNITIES (O)</p> <ul style="list-style-type: none"> • Awareness of Need for Public Health • Co-operation, Communication, Transfer • Body of PH Knowledge • IT • International Declarations • Investment in SEE countries • Networks • National PH strategies • Political changes • Economic and social development 	<p style="text-align: center;">WO</p> <p>Weaknesses constraining the development of public health are identified in the fields of organisation of the health systems; financing aspects; human resources management (development, education/training); health information systems; legislation; and ethical issues.</p> <p>The rising awareness of the need for public health in the region together with the increased international interest for public health development in SEE provide opportunities to address and overcome the prevailing weaknesses. There is a common willingness in the region to be integrated in the EU. The requirements to meet EU standards are supportive to the shift from traditional public health towards new public health. Experiences with existing networks such as PH-SEE and the Health Network demonstrate the potentials to impact on a regional level on the development and harmonisation of public health approaches.</p>
	<p style="text-align: center;">SO</p> <p>There are clear trends of increasing awareness of the public, among politicians and professionals on the need for new PH approaches, enhanced by the perception of the limitations of clinical medicine in addressing health problems of the society. Media support plays a role in information and awareness rising in this regard.</p> <p>The region can build on existing resources in terms of infrastructure (IPH, SPH), human resources (public health professionals), primary health care and programmes in health surveillance, health promotion and education as well as on the potentials of NGOs. The positive experiences with the regional networks such as PH-SEE and the Health Network illustrate the benefits in improving collaboration and information exchange in the field of public health. This joining of forces and the proved professional capacities have great potential in attracting international investment in the SEE regional PH development.</p> <p>The recent developments of national public health strategies are a starting point for the emergence of a regional policy framework. The existing legislation together with recent new laws constitute a promising basis for the implementation of new public health strategies and a more efficient management of the health system. A regional approach is supported by the Dubrovnik Pledge of 2001. Many of the political changes in the countries have the potential to facilitate the harmonisation with EU standards and other international public health policies.</p>	

<p>Internal factors</p>	<p>List of STRENGTHS (S)</p> <ul style="list-style-type: none"> • Tradition and history of PH in countries of SEE region • Existing institutions, services, data and education resources • Recognition of need for change • PH-SEE network • Existing legislation and strategies • NGO potential and professional's associations 	<p>List of WEAKNESSES (W)</p> <ul style="list-style-type: none"> • Organisation • Financing • Human resources • Health Information System (HIS) • Legislation • Education, training, research • Management skills • Ethical issues
<p>External factors</p> <p>List of THREATS (T)</p> <ul style="list-style-type: none"> • Political instability • Socio-economic instability • International environment • Societal environment • Competing and conflicting interests • Low status and high turn-over of PH professionals 	<p>ST</p> <p>The already existing human resources, legislative instruments, inter-ministerial protocols and agreements can have a beneficial impact and diminish the barriers posed by the political instability from most of the SEE countries. Although the recognition of the need for public health is observed at all levels, professional and in general public, a regional strategy may lack support because it may fail to meet the expectations and become socially and culturally unacceptable. The regional collaborations, active for several years, have proven to be successful and may serve as role models of how to overcome the possible competing and conflicting interests that may arise in national and international coalitions and partnerships. However, the financial constraints cannot be overcome with the existing strengths; as the financial resources are scarce in most of SEE countries further public health development relies on international aid. Though there are many well-established institutions with a long tradition in the region, the equipment and infrastructure are rather obsolete.</p>	<p>WT</p> <p>The organisational framework and political, as well as economic instability are perpetuating the lack of resources: underfinancing, improper allocation of the existing funds, the high turn-over of public health professionals and their poor professional and social status cause the numerous drawbacks and resets of the public health reform. Frequent changes in political orientation result in lack of a proper formulation of messages from the health system to other sectors; thus systems from outside health do not get a clear picture of the importance of health issues, and as a consequence these are ignored in overall policy formulation. Furthermore, EU misunderstanding of the regional needs and the insufficient external funds might also constrain the overall sustainability of the health systems.</p>

ANNEX 2 Overview tables on goals and objectives of the regional public health framework

Objectives	Activities	Partners	Time frame	Resources	Deliverables	Outcomes	Indicators	Risks
I.1 Targeting vulnerable groups	<ul style="list-style-type: none"> • Identification, research & monitoring of indicators of inequalities relevant for each vulnerable group • Comparative report on inequalities and trends at regional level • Design and implementation of intervention programmes • The establishment of a regional office for human rights • Advocacy 	<ul style="list-style-type: none"> • IPH, SPH, NGO • MOH, IPH, NGO, local community • MOH, Ministry of Education, IPH, Stability Pact, other international agencies • MOH, Stability Pact, other international agencies • PH professionals, representatives of target groups 	- 2005 continuously - every two years, starting 2007 - 2007	Staffing: IPH, NGO, UN Funding: Budget, Loan, Donors	Reports, Articles, Publications, Conferences	<ul style="list-style-type: none"> • Improvement of health and social status in vulnerable populations • Recommendations for national level • Conferences • Inter-ministerial meetings • Recommendations for regional level 	Using indicators defined by WHO, EU, OECD For example: <ul style="list-style-type: none"> • % Vaccination > 90% • infant mortality rate • low birth weight • no. of disability spec. mortality rate • drugs abuse, trafficking • number of HIV, TB burden of disease 	Lack of: <ul style="list-style-type: none"> • political willing • funding • understanding and readiness

Annex 2 : Overview Tables on Goals and Objectives of the Regional Public Health Framework

Objectives	Activities	Partners	Time frame	Resources	Deliverables	Outcomes	Indicators	Risks
Ensuring adequate and safe living conditions	<ul style="list-style-type: none"> implementation of an environmental control network at regional level Implementation of international recommendations for health security Specific programmes for health education, e.g. disease prevention; 	MOH, Govt. <ul style="list-style-type: none"> IPH, local authorities, relevant institutions developing programmes 					defined by WHO, EU, OECD For example: <ul style="list-style-type: none"> Number of communicable disease Number of accident 	Economic situation <ul style="list-style-type: none"> Political instability Non sustainable development
GOAL 2 : Strengthening social participation in public health 2.1. Mapping social participation opportunities and initiatives	<ul style="list-style-type: none"> Situation analysis with country reports delivered in 2006 Identification of gaps and suggested measures to address them, with the country reports in 2006 Identification of key players and existing networks Regional synthesis analysis report 	<ul style="list-style-type: none"> Key persons communities representatives and consumers and public; community leaders; local health authorities; non-governmental organizations; decision-makers; educational institutions; professionals; massmedia. 	2005-2006 2005- 2006 and ongoing by 2006	See partners plus WHO, Stability Pact, ILO Funding: local budgets; local health authorities; donors	<ul style="list-style-type: none"> country reports regional synthesis report database of networks, associations and alliances recommendations 	<ul style="list-style-type: none"> changing attitudes joint responsibilities specific skills better professional collaboration functioning mechanisms for social participation in public health development 	<ul style="list-style-type: none"> number of country reports number of activities & persons involved; materials produced; number of new networks level of activity in the chamber of consumers activities of the special interest groups on social participation changes in legislation 	<ul style="list-style-type: none"> Insufficient funds Lack of interest, obstruction by decision makers Lack of capacity and interest of the public

Objectives	Activities	Partners	Time frame	Resources	Deliverables	Outcomes	Indicators	Risks
2.2. Awareness rising and empowerment of the public	<ul style="list-style-type: none"> Public awareness campaigns, knowledge dissemination Education of educators, Organizing specific events Co-ordination and co-operation with similar programmes; Holding an international conference on citizenship and participation 		from 2006 ongoing from 2005 ongoing; 2006 ongoing; from 2005 ongoing planned for 2008		<ul style="list-style-type: none"> press releases meeting reports formal statements publications conference 			
2.3. Developing mechanisms to involve civil society in decision-making processes	<ul style="list-style-type: none"> Building alliances Creating a regional chamber of consumers and health service users; Initiating a special interest group on social participation in health development, Establishing social dialogue procedures 		from 2007 ongoing by 2007 2006 from 2006 ongoing					

GOAL 3: Strengthening human resources in public health

Annex 2 : Overview Tables on Goals and Objectives of the Regional Public Health Framework

Objectives	Activities	Partners	Time frame	Resources	Deliverables	Outcomes	Indicators	Risks
3.1 Ensuring sustainable development of HR	3.1.1 development of common training curricula and practice guidelines (2006) 3.1.2 provision of the common terminology in PH 3.1.3 consensus conference	3.1.1 IPHs, Schools of PH, Chairs of PH, International Organizations, Professional Associations and Associations of PH EUPHA	3.1.1 Curricula – 2005 Guidelines – 2010 3.1.2 2006 3.1.3 2006	Staffing Professional associations, Consultants from the region, MOHs, MOEd, core groups, schools of PH, IPHs Funding MOHs, Int. Donors, grants Technology ICT,	Documentation Paper and electronic format Conference	Adoption Promotion Continuity	No. of running programmes/year, No. institutions recommending the practice guidelines No. of web visitors No. of requested printed materials No. of participants at conference(s)	lack of political support, over production, high diversity, lack of consensus among professionals financial sustainability
3.2. Enhancing regional professional collaboration	3.2.1 developing regional research 3.2.2 developing regional intervention programmes 3.2.3 starting the mobility of PH professionals in the region 3.2.4 establishing periodical regional conferences or meetings	IPHs, Schools of PH, University, national and international organisations, professional associations, local authorities, NGOs Mass-media	by 2005	Staffing Professional associations, Consultants, researchers and lecturers from the region, MOHs, MOEd, MoScience, core groups, schools of PH, IPHs Funding MOHs, Int. Donors, Health Insurance Companies, grants, international projects	3.2.1 final reports 3.2.2 periodical and final reports 3.2.3 participation in different regional activities 3.2.4 conference	3.2.1 raising community awareness and scientific recognition 3.2.2 raising community and decision-makers awareness, follow-up of selected health indicators 3.2.3 harmonising knowledge, methodologies and teaching skills 3.2.4 exchanging successful results and promoting best practices	3.2.1 no. of published papers 3.2.2 no. of intervention programmes running No. of countries participating 3.2.3 no. of courses No. of visiting professors No. of visiting students 3.2.4 no. of participants No. of conferences	Competing interests among countries and different stakeholders Unsustainability of funding Lack of political support
GAOL 4 Improving regional public health information and knowledge								
4.1. Establishing a regional public health information system	4.1.1 Defining regional data set (mortality... 4.1.2 Defining compliant indicators according to	- Offices at national level related to health information (governmental, NGOs, prof. associations)	2005 2006	-existing minimum indicator data set -Regulation for the Region - Financing (governmental,	-Document -Document	- Adoption -Agreement	- No. of compliant indicators - Ratio between benchmark and original indicators	-different level of standards and communication protocols, and different standard equipment

Public Health Strategies: A Tool for Regional Development

Objectives	Activities	Partners	Time frame	Resources	Deliverables	Outcomes	Indicators	Risks
	Eurostat definition and standards 4.1.3 Design of IS and functionality compliant to standards (EU and ISO) 4.1.4 Operating the system 4.1.5 Creation of a Regional Clearing House together with Local Focal Points 4.1.6 Benchmarking	- IPHs - Universities - EU bodies (WHO, Eurostat) - Other international bodies - Hardware, software and pharmaceutical industry - Mass-media	2006 2007 2007	grams, sponsorships) - Human resources (national coordinators, designers, inform, technolog. staff, PH professionals, educators, communication PR) -Equipment (software & hardware) - Consumables (CDs, papers...) - Study tours and training	-Document + database -Database -Operational Clearing House and national local points -Document	-Continuity -Continuity of data collection -Sustainability -Continuity	- No. of website visitors - No. of achieved or ongoing campaigns - No. of requested printed materials	- Lack of financial support - Lack of political support - Competing interests of different stakeholders
4.2. Developing mechanisms for reporting and analysis at regional level	4.2.1 Design of standardised reports compliant with the EU reporting requirements 4.2.2 Dissemination of information through different channels (printed, CDs, website)		By 2006 2006		-Several report forms	-Approval	- No. and quality of research studies - No. of published research results	
4.3. Improving the level of PH knowledge in 3 Key groups (professionals, decision-makers, public)	4.3.1 Providing free information to professionals, decision-makers and public 4.3.2 Developing a regional newsletter 4.3.3 Developing		By 2007 By 2007		-Printed materials, CDs and website - Access secured	-Continuity - Continuity	- No. of website visitors - No. of requested printed materials	
			By 2006		- Paper and electronic format	- Continuity		

Annex 2 : Overview Tables on Goals and Objectives of the Regional Public Health Framework

Objectives	Activities	Partners	Time frame	Resources	Deliverables	Outcomes	Indicators	Risks
	<p>common regional tools and mechanisms in order to evaluate and improve knowledge in PH field in the region (health barometer, prospective studies)</p> <p>4.3.4 Promotion, marketing and advocacy for effective use of information</p> <p>4.3.5 Evaluation of Regional HIS</p>		<p>By 2005</p> <p>By 2006</p> <p>By 2005</p>		<p>- Scientific tools</p> <p>- Campaigns</p> <p>Periodical and final reports</p>	<p>- increased efficacy of PH interventions</p> <p>- continuity</p> <p>- Further HIS developments</p>		
<p>GOAL 5 : Establishing intersectoral cooperation</p> <p>5.1. Establishing involvement in programmes of non-health sectors</p>	<p>- Mapping of existing regional programmes, Identify relevant programmes for PH participation</p> <p>- Information exchange</p> <p>- Active PH participation in other regional sectoral programmes¹</p>	<p>Professionals in other sectors responsible for relevant actions and programmes, NGOs, Ministries; WHO liaison officers</p>	<p>- Immediate start (2005), and ongoing process</p> <p>- 2005 and ongoing</p> <p>- 2007 and ongoing</p>	<p>Technologies Retrieval system, computers, database</p> <p>Information carriers Coordinators of the programmes / projects; MOH; national institutions of PH; WHO liaison officers</p> <p>Funding MoH</p>	<p>- Overview on relevant programmes (data base)</p> <p>- Implemented processes of information exchange</p>	<p>- established institutionalised structures of IC at regional level</p>	<p>-numbers of identified programs</p> <p>-number of relevant programmes (indicators to be developed)</p> <p>- number of official invitations of PH representatives to programme meetings in other sectors</p>	<p>information overload</p> <p>"silo thinking"²</p> <p>instability in the region</p> <p>unequal status of countries leading to barriers in acceptance, regional recognition</p> <p>lack of political and professional willingness</p>
5.2. Introducing	- identify relevant	SPH; MOH; IPH;	-2005	Technologies	- proposed projects	- regional	- number of project	lack of funds

¹ Information, consultation, negotiation

² prevailing fragmentation, institutional selfishness, competition

Objectives	Activities	Partners	Time frame	Resources	Deliverables	Outcomes	Indicators	Risks
intersectoral research	<ul style="list-style-type: none"> topics - priority setting - project proposals - project implementation - project evaluation 	Insurance funds; other ministries	<ul style="list-style-type: none"> -2006 -2007-2009 -2010 	Existing databases Staffing Staff SPH/IPH Funding MOH Insurance funds donors	<ul style="list-style-type: none"> - accepted project - finished projects 	knowledge on PH issues	<ul style="list-style-type: none"> proposals - number of accepted projects - number of finalized projects - publications 	lack of donors and professional interest

ANNEX 3 List of participants at the PH-SEE seminar

List of participants involved in the development of the draft framework for a regional public health strategy in SEE (alphabetical order) at the Expert Summer Retreat: National Public Health Strategies in South Eastern Europe and the EU Health Policy, Belgrade, Serbia: August 23-28, 2004

Organized within the Stability Pact for South Eastern Europe: Public Health Collaboration in South Eastern Europe (PH-SEE)

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Annex 3 : List of Participants at the PH-SEE Seminar

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