ABSTRACTS OF TECHNICAL SESSIONS

Monday, 8 August, 11:00-12:30

Track 1: New Context

1. Emerging health issues: the widening challenge for population health promotion (Room 1)

A. McMichael, Australian National University, Australia; C. Butler*, Australian National University, Australia

There is a widening spectrum of tasks for health promotion in today's world. Since the Ottawa Charter (1986), substantial political, social, economic and environmental changes have occurred. While many broadly-averaged measures of population health are improving, various other indices of health and its determinants are faltering. There are emerging risks to health from demographic shifts, large-scale environmental changes, the cultural and behavioural changes accompanying national development, and an economic system that emphasises the material over other elements of well-being.

Reinforcement of inter-sectoral health promotion is needed (including engaging with the development, human rights and environmental movements). Not only must health promotion often transcend the health sector, but, increasingly, it must engage beyond national boundaries. The Ottawa Charter argued for "healthy public policy" – yet that was in a world that largely predated HIV/AIDS and a surge of other infections, unyielding widespread poverty and under-nutrition, worldwide declines in freshwater and soil fertility, recognition of climate change as a health threat, and escalating chronic disease burdens in developing countries. The need for that policy-level approach has heightened.

Examples of emerging health risks and trends include:

- Infectious diseases: Many diseases have emerged since the late 1970s, while others have unexpectedly increased. Reasons include persistent poverty, urban crowding, environmental changes (mobilising new microbes), altered sexual relations, intensified food production, increased mobility and trade, and tardy vaccine development.
- Regional life expectancy declines: Life expectancy has unexpectedly declined in various countries. Factors linking these declines suggest that others could follow. Relatedly, the demographic and epidemiological transitions have faltered. In some regions, declining fertility has overshot that needed for optimal age structure, while elsewhere mortality increases have reduced population growth rates despite continuing high fertility.
- Millennium Development Goals, health and sustainability: Several health-related MDGs appear unlikely to be achieved. Most policy-makers do not understand the link between environmental sustainability (MDG #7) and health. Sustainability entails maintenance of Earth's ecological and geophysical systems, and social cohesion, as the basis for health.

These large-scale risks to health present great challenges. Beyond engaging with other sectors, and across levels of society, health promotion must also address population health influences that transcend national boundaries and generations. The *big task* is to promote sustainable environmental and social conditions that bring enduring and equitable health gains.

2. "Back to the future" a perspective on environmental change, environmental health and creating supportive environments for health (Room H)

S. Tamplin*, Global Service Associates, LLC, USA

The Earth's physical environment has undergone considerable change in recent decades. Some of these changes have seemingly occurred outside the control of humankind, while others are directly attributable to human activity. While the causes of these changes are widely debated, finding sustainable solutions to the related public health problems is proving elusive and challenging. Narrow attempts to "quick fix" these problems abound, with the focus often being on providing short-term relief that gives the appearance of solution but fails the long-term test of sustainability.

While theoretical frameworks for addressing the forces that drive environmental change have been developed, the successful application of these frameworks in real-life, real-time settings to solve priority problems has been problematic. While this can be attributed to many factors, two of the most important in

low-income countries, are: 1) the failure of decision makers to implement, in practice, the "integrated" and "inter-sector" approaches suggested by the frameworks, despite much talk about them; and, 2) the reluctance of key stakeholders to take on the inherent issues of governance that are critical to bringing about meaningful and sustainable change.

A framework for responding to the challenges of environmental change would do well to incorporate the collaborative strengths of health promotion and environmental health. For the most part, this grows out of their experience in relation to "healthy settings," where the litany of integrated, inter-sector, participatory approaches to public health problem solving abounds. The grand challenge for the future collaborative work of health promotion and environmental health and their partners is to influence health governance in ways that create and sustain community capital and reduce health inequity.

3. Health in new urban settings (Room A)
N. You*, UN-HABITAT, D. Mehta, UN-HABITAT; S. Galea, New York Academy of Medicine, USA

4. Health of the marginalized groups (Room 3)
A. Mukhopadhyay*, Voluntary Health Association of India; M. Ratima, Auckland University of Technology, New Zealand; C. Tenhaeff, Netherlands Institute for Care and Welfare. Netherlands; M.O Alcantara, Philippine Health Insurance Corporation (PhilHealth), Philippines

Collective action at the global, international and national levels to address the goal of 'Health for All' as enshrined in Alma Ata Declaration has been ineffective in reducing health status inequalities within nation states. Although there has been significant improvement in the health status of the people of the world overall, some groups have benefited disproportionately and the most marginalized peoples (including the economically depressed, indigenous peoples, refugees and women in many societies) have not gained from the global, international and national efforts. As outlined in the Millennium Development Goal, it is critical that strong and focussed attention is given to addressing the health of marginalized groups in the coming decade.

Achieving health gains for the most marginalized sections of society will require inter-sectoral efforts which not only address narrow "health" concerns, but broader development issues which include food security, social and gender equity, and political rights.

This paper looks at the ways in which the health issues of marginalized groups have been addressed within the context of their broader development, and takes into account the changing global environment. Examples are drawn from four case studies:

i) the indigenous people of New Zealand (Maori);
ii) the refugee population in the Netherlands;
iii) people living in poverty in India; and,
iv) health insurance for the marginalized in Philippines.

Lessons learnt at the local level has been translated into the global health promotion context to provide direction for future health promotion initiatives to meet the challenges facing the most marginalized populations and includes a particular focus on the role of health promoters.

5. Gender and health promotion: a multisectoral policy approach (Room G)
P. Östlin*, Karolinska Institutet, Sweden; E. Eckerman, Deakin University, Australia: U.S. Mishra, Center for Development Studies, India; M.C. Omanyondo Ohambe, Institut Superieur des Techniques Medicales, Democratic Republic of Congo; M. Nkawane & E. Wallstam, World Health Organization, Switzerland

Women and men are different as regards their biology, their roles and responsibilities that society assigns to them, and their position in the family and community. These factors have a great influence on causes, consequences and management of diseases and ill-health. This is confirmed by evidence on male-female differences in cause-specific mortality and morbidity and exposure to risk factors. Health promoting interventions and policies aimed at ensuring safe and supportive environments, healthy living conditions and lifestyles, community involvement and participation, access to essential facilities and to social and

health services, need to address these differences between women and men, boys and girls in an equitable manner in order to be effective. The aim of this paper is to (a) demonstrate that health promotion policies that take women's and men's differential biological and social vulnerability to health risks into account are more likely to be successful and effective compared to policies that are not concerned with such differences, and (b) discuss what is required to build a multisectoral policy response to gender inequities in health through health promotion and disease prevention. The requirements discussed in the paper include 1) the establishment of joint commitment for policy within society through setting objectives related to gender equality and equity in health as well as health promotion, 2) an assessment and analysis of gender inequalities affecting health and determinants of health, 3) the actions needed to tackle the main determinants of those inequalities, and 4) documentation and dissemination of effective and gender sensitive policy interventions to promote health. In the discussion of these key policy elements we use illustrative examples of good practices from different countries around the world.

6. Promoting mental health as a neglected issue (Room 4)
S. Sturgeon*, World Federation for Mental Health

Mental health promotion is often overlooked as an integral part of health promotion.
Questions are posed and reasons are discussed for this, and the health sector is challenged to consider these issues. The reciprocal relationship between health and mental health promotion is discussed, and the sector's appreciation of this in practice is questioned. The issue is raised as to whether the sector's lack of motivation for mental health promotion could be influenced by the public's negative attitude to mental disorder. The possibility is also considered that the extent of the burden of mental illness is not fully appreciated, hence the lack of urgency evident in engaging in mental health promotion. An important consideration is whether health promoters are aware of the current development of the evidence base for mental health promotion and examples of evidence based mental health programmes are presented.
The need for mental health promotion to work across disciplines is also discussed, and the willingness of health professionals to work with other stakeholders is questioned. It is suggested that this process of reflection should assist health professionals to identify the factors that are influencing their commitment to mental health promotion.

7. Health promotion capacity mapping - a global overview (Room 2)
M. Mittelmark*, International Union for Health Promotion and Education; a presenter from each of the 6 WHO Regions

This paper reviews approaches to the mapping of resources needed to engage in health promotion at the country level. There is not a single way, or a best way to make a capacity map, since it should speak to the needs of its users as they define their needs. Health promotion capacity mapping is therefore approached in various ways. At the national level, the objective is usually to learn the extent to which essential policies, institutions, programmes and practices are in place, to guide recommendations about what remedial measures are desirable. In Europe, capacity mapping has been undertaken at the national level by the WHO for a decade. A complimentary capacity mapping approach, HP-Source.net, has been undertaken since 2000 by a consortium of European organizations including the EC, WHO, IHUPE, HDA and various European university research centres. The European approach emphasizes the need for multi-methods and the principle of triangulation. In North America, Canadian approaches have included large- and small-scale international collaborations to map capacity for sustainable development. U.S. efforts include state-level mapping of capacity to prevent chronic diseases and reduce risk factor levels. In Australia, two decades of mapping national health promotion capacity began with systems needed by the health sector to design and deliver effective, efficient health promotion, and are now expanded to include community-level capacity and policy review. In Korea and Japan, capacity mapping is newly developing in collaboration with European efforts, illustrating the usefulness of international health promotion networks. Mapping capacity for health promotion is a practical and vital aspect of developing capacity for health promotion. The new context for health promotion contains both old and new challenges, but also new opportunities. A large scale, highly collaborative approach to capacity mapping is possible today due to developments in communication technology and the spread of international networks of health promoters. However, in capacity mapping, local variation will always be important, to fit variation in local contexts.

* Presenting author

Monday, 8 August, 15:45-17:30

Track 2: Health-Friendly Globalization

1. Trade agreements and public health (Room 3)
J. Arunanondchai*, Fiscal Policy Research Institute Foundation, Thailand; C. Fink, World Bank Institute, World Bank Geneva

Promoting quality health services to large population segments is a key ingredient to human and economic development. At its core, healthcare policymaking involves complex trade-offs between promoting equitable and affordable access to a basic set of health services, incentives for efficiencies in the healthcare system, and constraints in central and state-level government budgets. International trade in health services influences these trade-offs. It presents opportunities for cost savings and access to better quality care, but it also raises challenges in promoting equitable and affordable access. Drawing on a research project of the ASEAN Economic Forum, this paper offers a discussion of trade policy in health services for the ASEAN region. It reviews the state of healthcare in the region, existing patterns of trade, and remaining barriers to trade. The paper also identifies policy measures that could further harness the benefits from trade in health services and address potential pitfalls that deeper integration may bring about.

2. Regulation of products harmful to health in an era of globalization (Room F)
N.,N. Kyaing*, Department of Health, Myanmar; S. Casswell*, Massey University, New Zealand

This session examines the way globalization has impacted on threats to public health by facilitating the use of tobacco and alcohol products. It also examines the way globalization enables a public health response to these threats; the use of a global strategy is illustrated with lessons learned from the development of the WHO Framework Convention on Tobacco Control. A case study of participation in the development of the FCTC and its implementation in the country of Myanmar will provide insights to inform the development of a Global Alcohol Strategy in the coming years.

3. Health as foreign policy: harnessing globalization for health (Room A)
D. Fidler*, Indiana University, USA

This technical paper explores the importance for health promotion of the rise of public health as a foreign policy issue. Although health promotion encompassed foreign policy as part of "healthy public policy," mainstream foreign policy neglected public health and health promotion's role in it. Globalization forces health promotion, however, to address directly the relationship between public health and foreign policy. The need for "health as foreign policy" is apparent from the prominence public health now has in all the basic governance functions served by foreign policy. The UN Secretary-General's UN reform proposals demonstrate the importance of foreign policy to health promotion as a core component of public health because the proposals embed public health in each element of the Secretary-General's vision for the UN in the 21st century. The emergence of health as foreign policy presents opportunities and risks for health promotion that can be managed by emphasizing that public health constitutes an integrated public good that benefits all governance tasks served by foreign policy. Any effort to harness globalization for public health will have to make health as foreign policy a centerpiece of its ambitions, and this task is now health promotion's burden and opportunity.

4. Globalization, workplace and health (Room 1)
G. Albracht*, International Labour Organization, Switzerland

Work kills more people than wars. Some 5000 a day, one person dies every 15 seconds from occupational accidents and diseases. Almost 270 million accidents are recorded each year, 350.000 of which are fatal. Manufacturers in high-income countries have increasingly shifted their operation and production to low and middle-income countries where workplace health and safety conditions and standards are comparatively lower. Furthermore, production and many hazardous procedures transfer from North to South causing an important impact on the nature and type of occupational exposures, as well as on the labour force. The current process of globalization especially influences women's health at work.

Globalization requires increasingly creative holistic approaches, taking into account the changes in the world of work and the advent of new risks and opportunities merging the traditional technical and medical with the social, psychological, economical and legal areas. To protect and enhance the health of people in the workplace in the worldwide economy, the paper provides a set of practical strategies to make decent work become reality. Solutions and examples for better governance both at national and global levels to raise social and economic capabilities will be worked out. In a holistic approach, prevention of occupational accidents and diseases, the promotion of the employees health, workplace security and the investment in a preventive culture will allow companies to compete in a globalizing world.

Examples of successful worldwide cooperation on the corporate social responsibility (CSR) as well as best practices and policies of multinational responsibility and OSH will be presented, bringing emphasis on OSH as a cornerstone for CSR and hence the promotion of well-being among employers and their families. In the holistic approach Workplace Health Promotion (WHP) and Occupational Safety and Health (OSH) need to work hand in hand, in order to face the challenges of a globalized world of work. Good practices as well as important linkages of WHP and OSH will be illustrated and additional fields of cooperation will be pointed out.

Furthermore, ways of developing sustainable strategies will be displayed with the aim of improving the working environment and lost working hours as well as increasing the overall OSH standard in the supply chain management. Effective and efficient labour inspection and health inspection services are an essential part of any civilized government and of any successful economy.

A preventive approach for better health and the reduction of accidents and diseases must be linked to labour inspection services. They have a pivotal role in promoting compliance with core labour standards, in giving advice and in providing information on how those standards can be implemented in daily work. Labour inspectors are the controlling authority for OSH and many work- related activities such as preventative measures at the workplace. The effects of globalization will change the role of labour inspectors who should also understand and exercise the role as a facilitator, an advisor and a net-worker. Strengthening labour and health inspection is crucial for ensuring a high standard in the labour protection and health promotion, thus contributing to overall economic stability. In this paper there are several concrete cases of entering and expanding partnerships at international, national and local levels, including social partners, inter-ministerial collaboration (particularly between labour and health ministries) and public/private partnerships, with the example of the English-speaking African countries with the partners WHO, ILO, ARLAC, IALI, ministries and inspection services. From these examples, including projects with multinational companies in Middle America and South Africa, future models for strategic collaboration will be developed and pointed out in a comprehensive approach.

5. Public health emergencies of international concern (Room G)

P.L. Ooi*, Ministry of Health, Singapore; S.Bala Chandran, Ministry of Health, Malaysia; S.K. Chew, Ministry of Health, Singapore

Public health emergencies of international concern are extraordinary events which constitute a public health threat to other countries through international spread of disease and potentially require a coordinated international response. Examples are smallpox, poliomyelitis due to the wild type poliovirus, human influenza caused by a new subtype and SARS. The experience in combating SARS confirmed the need for an effective public health emergency management system to address such emergencies. Public health authorities are expected to detect, assess, notify and report events involving death or disease, and share information widely to enable proper risk assessment. The system must able to build up a comprehensive picture which includes surveillance for zoonotic diseases, environmental health and food safety. Response preparedness includes operations planning and training, and stockpiling of vaccines, chemoprophylaxis and personal protective equipment for field officers, healthcare workers and at-risk populations. In the event of an emergency, the authorities must be able to quickly investigate cases/deaths and refer all contacts for medical screening. Measures to break the chain of transmission include hospital infection control practices, quarantine for those in contact with the victims, sanitation and hygiene, and decontamination of hot zones. Appropriate entry and exit controls for travelers, and facilities for their health assessment and quarantine, have to be applied with feedback to WHO in accordance with International Health Regulations. To rally the community support, simple measures need to be highlighted for everyone to do. Health promotion activities include health screening and temperature

taking, and public education on social responsibility and hygiene. Clear and timely outbreak communications are crucial in maintaining the public trust. As new diseases emerge, we have to rethink the value of available tools for effective disease control.

6. How to strengthen corporate social responsibility and Multinational Corporation commitment to health promotion (Room 4)
R.L. Mallett*, Corporate Affairs, Pfizer Inc.; K. Gustavsen*, MERCK & Co., Inc.; S. Bialous*, Tobacco Policy International, USA,

This session will concentrate on the growing role of multi-national corporations (MNCs) in addressing major public health issues by creating effective public-private partnerships. The session begins with an overview of the role of MNCs in addressing health issues to set the stage for a more specific case study. The case study will focus on the Mectizan Donation Program, which is considered a best practice. Spearheaded by MERCK, the successes and challenges of implementing the program and the effectiveness of MNCs in addressing health issues will be discussed. This session will also provide examples from the tobacco industry to illustrate when public/private partnerships are not in the public's interest.

7. Trade liberalization and the diet and nutritional transition: a public health response (Room H)
G. Rayner*, City University, United Kingdom; C. Hawkes, International Food Policy Research Institute, USA; T. Lang, City University, United Kingdom; W. Bello, University of the Philippines, Philippines

The liberalisation of trade, including of agriculture and food, remains at the forefront of debates about globalisation, not least because it is viewed as a model of progress – economic growth through market liberalisation – that can help address poverty and deliver public health improvement. In debates about trade, insufficient attention has been paid to its implications for health and nutrition, and, in particular, dietary health. Yet the WHO's Global Strategy for Diet, Physical Activity and Health (2004) provided a powerful warning that the future health burden will be increasingly determined by dietary health in the form of diet-related chronic diseases. This article thus examines the "diet and nutrition transition" in the context of liberalising trade and commerce, with the objective of providing to the public health and health promotion community an awareness of the importance of food trade in their efforts to promote healthy diets worldwide. We first describe the evolution of trade agreements, noting those particularly relevant to food trade. We then briefly review the association between trade liberalisation and health and the changing global dietary and disease profile. We then show how trade liberalisation is linked with the diet and nutrition transition through the food supply chain from foreign direct investment and food cultural change, such as supermarketisation and advertising. We propose three discernable scenarios for change, presenting the case for public health professionals and advocates to become centrally engaged national policy making in the food and agriculture arena.

8. Global health promotion (Room 2)
K. Lee*, London School of Hygiene and Tropical Medicine, United Kingdom

The challenges of globalization for the protection and promotion of human health are now recognized as needing urgent research and policy attention. Profound changes to human societies, as a result of intensified trade and investment, population movements, new technologies and environmental changes are requiring the public health community to reassess its efforts. This includes the health promotion field which is focused on "enabling people to increase control over and to improve their health." This paper begins by briefly discussing the new and distinct challenges posed by globalization, and why there is a need for a "global" approach to health promotion. This is followed by an assessment of the extent to which global governance architecture is emerging for health promotion. A distinction between international and global governance architecture is drawn, as well as explanation of what has precipitated this emerging architecture. Particular attention is given to the main institutions involved and whether they have distinct contributions. A discussion of selected examples follows, including the Healthy Cities Initiative, promotion of breastfeeding, Framework Convention on Tobacco Control and more recent Global Strategy on Diet and Nutrition. These will be analyzed in terms of lessons to be drawn for strengthening future global efforts at health promotion. The paper concludes by setting out suggested strategies for building a global approach to health promotion. This will include exploration of how global health

promotion might be mainstreamed within the activities of relevant institutions beyond the health sector (e.g. trade, private corporations, other multilateral organizations), how can we ensure that actions taken at local, national, regional and global level are complementary and synergistic, and what kinds of knowledge are needed to support a global strategy (e.g. social determinants of health).

* Presenting author

Tuesday, 9 August, 11:00-12:30

Track 3: Partners

1. NGO coalition for global health promotion (Room 2)

T. Narayan*, People's Health Movement; M. Wise, International Union for Health Promotion and Education; T. Ghebvehiwet, International Council of Nurses

2. The role of private sector foundations in health promotion (Room G)

D. Langill*, Thrusight Consulting, USA

From 1994 to 2003, philanthropic giving for health promotion in the U.S. nearly tripled, outpacing increases in health giving and philanthropic giving overall. Some issues, such as sexually transmitted diseases, nutrition, and physical activity, experienced dramatic increases in funding, while others, such as mental health and family planning, were comparatively underfunded. Partnerships between foundations and other organizations have the potential to maximize both resources and impact. To ensure success, those seeking foundation partnerships should: involve foundations early in planning processes; invest in relationships with leadership and staff; allow sufficient time for joint planning and decisionmaking; and consider all ways that foundations can contribute to partnerships.

3. The role of independent health practitioners/providers in health promotion (Room H)

B. Nunes*, European Rural and Isolated Practitioners Association; S.Tata, Micronutrient Initiative, Asia (formerly Ministry of Health, India); R. Amaro, University of Lisbon, Portugal; M. Ainin, Health Bureau, Weifang City, Shandong Province, China

From 1994 to 2003, philanthropic giving for health promotion in the U.S. nearly tripled, outpacing increases in health giving and philanthropic giving overall. Some issues, such as sexually transmitted diseases, nutrition, and physical activity, experienced dramatic increases in funding, while others, such as mental health and family planning, were comparatively underfunded. Partnerships between foundations and other organizations have the potential to maximize both resources and impact. To ensure success, those seeking foundation partnerships should: involve foundations early in planning processes; invest in relationships with leadership and staff; allow sufficient time for joint planning and decisionmaking; and consider all ways that foundations can contribute to partnerships.

4. Contribution of health promotion to the achievement of MDGs (Room 4)

E. Petit-Mshana*, Office of the WHO Representative, Tanzania; A. Cassels, World Health Organization, Switzerland; F.J.Mogoma, Ministry of Health, Tanzania

The Millennium Development Goals (MDG) adopted by the United Nations in year 2000 provide an opportunity towards improves global health, through harmonized efforts of the developing and developed world. The MDG process involves critical review of the current innovative practices, prioritized policy reforms, identification of frameworks for implementation and monitoring, as well as evaluation of financial options. Goal number 1-7 are outcomes related, whereas MDG 8 is concerned with process. Out of the eight set MDGs four are directly health related, while the other four have important indirect relationship with health.

This paper shows linkages between health promotion and MDGs. There is brief description of the eight MDGs and adapted in year 2000, highlighting how each goal relates to health. Main issues and challenges are explained under each goal. More attention is given to the health goals and related targets. Health promotion contribution towards MDG achievements and as an important tool for advocating effective global, national and community partnership is demonstrated. There is an emphasis on ways of

tackling future health challenges. Some example of innovative and good practice across regions and countries are given. In addition, relevant equity and cultural issues have been addressed.

In conclusion, the paper shows that health promotion could potentially contribute in accelerating the progress, especially towards achievement of the health related MDGs. Recommendations for the way forward are provided. Specific strategies that could be adapted as part of health promotion initiative are also given, including strategies for disease prevention and management; epidemic prevention and control; information, education and communication; as well as monitoring and evaluation strategies.

5. Integrated health promotion strategies: a contribution to tackling current and future challenges (Room 1)

S. Jackson*, F. Perkins, E. Khandor, L. Cordwell, Centre for Health Promotion University of Toronto; S. Hamann, S. Buasai, K. Chaovavanich, Thai Health Foundation, Thailand

The field of health promotion has a key role to play in addressing the future through the Ottawa Charter strategies. This paper describes what we know about the effectiveness of health promotion strategies and makes suggestions for the emphasis that is required as we move into the 21st century.
The strategies described are taken from four of the five key Health Promotion action areas identified in the Ottawa Charter.
A framework was developed that divides the actions into three levels – the structural, the group, and the individual levels

- Building Healthy Public Policy is mainly at the structural level;
- Strengthening Community Action is mainly at the social/group level;
- Developing Personal Skills is mainly at the individual level; and
- Creating supportive environments is a necessary action at all three levels.

Eight reviews from the last six years were analyzed for effectiveness and cost effectiveness of health promotion strategies. All reviews used established criteria for ascertaining quality of the studies reviewed. In addition, five case studies were reviewed at the international, national, regional, municipal and local levels.

Eight [8] key lessons about the effectiveness of health promotion strategies were:

1. Building healthy public policy is key;
2. Supportive environments need to be created at all levels;
3. More evidence for effectiveness of community actions is required;
4. Personal skills development must be combined with other strategies for effectiveness;
5. Partnerships and cross sectoral action on multiple determinants of health is key;
6. Interventions employing multiple strategies at multiple levels are most effective;
7. Certain actions require greater prominence:
    - Inter-organizational partnerships and inter-sectoral collaboration
    - Participation and engagement of citizens in planning and decision-making
    - Healthy settings
    - Political commitment, funding and infrastructure.
8. Context is relevant.

In conclusion, the four Ottawa Charter strategies are still relevant and effective tools however some need to be strengthened and others given more prominence.

6. Setting-based health promotion (Room A)

R. Afifi-Soweid*, American University of Beirut, Lebanon; K. Nakamura, Medical and Dental University, Japan; M.A. Nyamongo, African Institute for Health and Development, Kenya

Health promotion has been defined as "the process of enabling people to increase control over, and to improve their health (Ottawa Charter, 1986)." The concept of 'enabling' suggests that health promotion has a responsibility to facilitate - or to make easy - health improvement. To do so, the emphasis becomes not only on conducting health promotion in spaces/settings, but ensuring that all settings are 'health promotive.'

The "spaces" or settings that we occupy are numerous. Traditional settings include interpersonal setting; organizational settings; community settings, and national policy spaces. However, new social and physical spaces are emerging and must be considered such as internet cafes, mass media channels, traditional media channels such as storytelling, drama, or music, refugee camps, urban slums, places of religious worship, among others. All these alternative spaces become especially important to reach the disenfranchised within countries.

The concept of health promoting spaces lends itself naturally to partnerships of various types. Partnerships are built with parents in households, teachers in schools, people experiencing a particular condition occupational groups in organizations, key leaders in community settings, and policy makers. Innovative practices involving partnerships in settings have been implemented in a variety of countries and are described for Africa, Asia, and the Eastern Mediterranean region.

Recent scholarship in public health indicates the great importance of social determinants of health in the aetiology of current health threats, including those specified in the MDGs. The health promoting spaces concept is particularly relevant to intervention on such root causes of ill-health.

As we attempt to make health the "easy" choice, we must work in partnership to intervene in the social and physical places we occupy – so that these spaces become dignity-enhancing and thus health ensuring.

7. Information and communication for health promotion: towards a health competent society (Room 3)

S. Farah*, Jordan Health Communication Partnership; Jordan, M. Aguilar, John Hopkins Bloomberg School of Public Health, USA; L. Qarden, Jordan Health Communication Partnership, Jordan; V. Menayang, Indonesian Broadcasting Commission, Indonesia; G. Mengistu, AIDS Resource Centre, Ethiopia

* Presenting author

Tuesday, 9 August, 15:45-17:30

Track 4: Sustainability

1. Whole of government approach to promoting health (Room 1)

J. Salinas*, Ministry of Health, Chile; J.I. Castanedo Rojas, National Center for Health Promotion and Education, Cuba; D. Harrison, Lancaster University, United Kingdom; A.V. Le, Hanoi Medical University, Vietnam

The majority of the upstream "causes of the causes" of ill health, such as poverty and social inequalities, extend beyond the domain of the health sector alone and therefore a "whole government" approach is essential for promoting health. This paper uses four case studies from Cuba, Chile, the United Kingdom and Vietnam to illustrate the following:

Meaning and relevance of the whole government approach:

The whole government approach is both a process and an intermediate outcome. It includes partnerships between the Health Ministry and other ministries for greater policy coherence and the establishment of healthy public policies, as well as a concerted effort from high-level political leaders to unify the entire government behind the common goal of promoting health for all. The four case studies demonstrate the potential and relevance of this approach to promote health across all sectors of government, regardless of the country's stage of economic and social development, or underlying political structure and ideologies. An integrated approach with greater synergy between curative and preventive systems, as well as greater engagement within and outside of government, is likely to be the most effective and least expensive means of promoting health and securing sustainable economic development.

Major barriers:

- Lack of political will and sustainable financing
- Lack of research evidence regarding upstream determinants of health

- Lack of evaluation of health promotion interventions
- Lack of health promotion capacity and infrastructure.

Key elements for success:

- Recognizing new challenges, including upstream determinants of health, ageing populations, environmental degradation, globalization, the rise of chronic non-communicable diseases and mental health problems, emerging and re-emerging infectious diseases, commercialization of health services, lack of health human resources, increasing costs of medical care and growing health inequalities
- Acknowledging roles and responsibilities, by obtaining support from all sectors of society through partnerships and with strong engagement of the entire government, especially from the legislative and economic powers, so that health promotion becomes a priority of society and of the State.
- Strengthening the role of the Health Minister as a focal point in coordinating endeavours and in promoting policy coherence and healthy public policies, with the real inclusion of health promotion as part of government reforms.
- Mapping strategic inter-sectoral 'win-win' strategies for health promotion, for example, through prospective economic impact assessments of the effect on economic efficiency, workforce capacity, GDP per capita, labour force productivity and reduced cost of healthcare services.

2. Knowledge Management as a health promotion model (Room G)

N. Mbananga*, Medical Research Council for South Africa, South Africa; M.A. Lansang, University of the Philippines Manila, Philippines; V. Panich, Knowledge Management Institute, Thailand; M. Hills, University of Victoria, Canada

The paper examines the value that can be added by applying Knowledge Management (KM) frameworks in Health Promotion (HP). HP has been defined as an empowering process and a set of action strategies to increase people's control over their own determinants of health. The paper reviews Evidence Based Medicine (EBM) and Evidence Based Approach (EBA) as a knowledge production and dissemination process for advancing HP. KM is viewed as a complex concept referring to a variety of analytical frameworks and tools aimed at increasing the value and usefulness of knowledge for organizations, communities and individuals. Its emergence as a field of inquiry is linked to the increasing awareness within the organizational sciences that knowledge is a multi-dimensional, multi-stage process that requires strategic action at each stage and in each dimension in order to realize its value. This paper will focus in particular on the knowledge sharing of tacit knowledge, its integration, application, and its relation to Information and Communication Technology (ICT).

Challenges facing KM in HP and in general are highlighted as: *lack of methodology to tap into tacit knowledge, standardizing tacit knowledge, difficulty in integration of implicit and explicit forms of knowledge, the competition between pressing health problems and sourcing ICTs, knowledge sharing transparency and knowledge sharing receptivity and acceptability.*

The paper concludes that KM principles can improve the advancement of HP. A model for achieving this goal is provided.

3. Building the capacity of the Ministry of Health to promote health (Room A)

R. Ching*, Center for Health Protection, Hong Kong SAR, China; C. Rissel, University of Sydney, Australia; C. Vizzotti, Ministry of Health and Environment, Argentina; N. Muragori, Kenya; K.C. Tang, World Health Organization, Switzerland

Capacity building for health promotion may be defined as the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at organization, workforce and community levels, and has different meanings in different contexts. Of all possible stakeholders in health promotion, government ministries or departments of health are vested with the greatest responsibility to ensure that health systems have the capacity to improve population health. Until 'capacity building' can be more clearly defined and accurately measured, it may not be possible to identify areas that require improvement. Ministries of Health are in need of a tool

to measure the countries' health promotion capacity and to pinpoint financial and technical support necessary for effective health promotion. This paper reviews the experiences of capacity building from four countries, Argentina, Australia, Hong Kong and Kenya, and discusses frameworks for building the organizational capacity of health ministries to promote health.

4. Building community capacity to promote health (Room 2)

J. Raeburn*, University of Auckland, New Zealand; M. Akerman, Medical School of ABC Region, Brazil; K. Chuengsatiansup, Ministry of Public Health, Thailand; F. Mejia, Ministry of Health, Honduras; O. Oladepo, College of Medicine, Oyo State, Nigeria

In this paper, community capacity building (CCB) is seen as the current manifestation of a long-standing health promotion (HP) tradition, which views community as a decisive force in achieving personal and collective wellbeing, especially with regard to the empowerment of marginalized and 'poor' communities. All such community approaches involve the building of competencies and social cohesion, and stress organizational elements. The term 'CCB' especially seems to emphasize competencies and organizational acumen, but it needs to be flexibly interpreted. A brief literature review looks at some of the main contributions from the 1990s on, and concludes that CCB is highly effective, although more formal research is needed. Five case studies from the contributing authors show both the range and efficacy of CCB applications. The concluding synthesis and recommendations call for the partnership dimension of community in modern HP to be emphasized, with CCB being seen as an important aspect of involving communities as equal partners with other stakeholders in a globalized health environment.

5. Sustainable financing for health promotion: issues and challenges (Room 4)

V. Tangcharoensathien*, Ministry of Public Health, Thailand; B. Somaini, Swiss Health Promotion Foundation, Switzerland; R. Moodie Victorian Health Promotion Foundation, Australia; J Schremmer, International Social Security Association

A substantial proportion of global burden of diseases can be minimized through proven cost effective prevention and health promotion interventions, such as safer sex practices, control of tobacco and alcohol consumption, and other clinical preventive services for mother and children. In developing countries, government spent less on health, a large portion was paid by households. Resource constraint is the main barrier for government to invest more in health promotion as curative services were given priority especially by households.

Where data is available, in 15 high and middle income countries, 3.82% of Total Health Expenditure was spent on prevention and health promotion, that government had a major role, 73.5% in financing Prevention and Health Promotion, where as Social Health Insurance and donors had minor roles. We estimated that countries categorized as low human development group, spent only 0.6 USD on Prevention and Health Promotion, too little to make a change in preventable burden of diseases. Experiences indicated dedicated tax from tobacco and alcohol for health promotion fund and innovative management of these funds, are sustainable and would make a change.

We recommend (1) governments to give a high priority to finance health promotion, setting up a national target of general government expenditure and Social Security Expenditure for prevention and HP activities and ensure coordination of actions from different financing sources; (2) to ensure prevention and HP services an integral part of the benefit package of Social Health Insurance, and provides legal and fiscal enabling environment that promotes workplace prevention and promotion programs; (3) to establish where possible, through legislation an innovative Health Promotion Fund financed from dedicated taxation of health damaging goods, or dedicated funding from social health insurance contributions; (4) to an active involvement by international development community, to mobilize additional fund supporting prevention and HP activities.

6. Integrating health promotion into health systems (Room 3)

C. Sindall*, Population Health Division, Australia; J. Sriratanabun, Chulalongkorn University, Thailand; D. Matheson, Ministry of Health, New Zealand; R. Loewenson, Zimbabwe

Although the 1986 Ottawa Charter for Health Promotion called for "reorienting health services" as one of five key areas of health promotion action, in comparison with the other action areas, health system reform has received relatively little attention internationally from the health promotion community. There have been some notable exceptions, such as the extensive effort over many years of the Health Promoting Hospitals network. In part, the lack of engagement with health systems development has reflected a commonly held view that health services make only a limited contribution to health outcomes, compared with the more "upstream" determinants of health. This paper argues that, with the many advances in recent years in the effectiveness of curative and preventive care, and the increasing recognition of the role played by affordable access to quality health care in the reduction of health disparities, there is now a strong case for this position to be re-evaluated. The primary focus is on how health system capacity for prevention can be strengthened, using a range of levers for change, such as financing arrangements, service redesign, workforce development, accreditation programs and community involvement. Case examples of successful change strategies from developed and developing countries are provided. The paper also argues that these strategies need to be underpinned by more fundamental measures such as universal insurance coverage, and accompanied by a strong focus on patient-centred care. The paper has two major aims: to provide practical insights on how health promotion can be effectively and equitably integrated into health systems in countries at various stages of development; and to stimulate debate on a global policy agenda on health promotion and health systems.

7. Health impact assessment and the globalization challenges (Room H)

D. Sukkumnoed*, Ministry of Public Health, Thailand; S. Al-Wahaibi, Ministry of Health, Oman.

Globalization can bring several health opportunities, as well as, several health risks to the world population. These opportunities and risks are dynamically intertwined in socio-economic and political processes, leading to the great difficulty in developing healthy policy options. What mostly needed is the capability of our societies in screening, analyzing, protecting and developing the healthy public policies as recommended in the Ottawa charter.

Health impact assessment (HIA) provides a conceptual idea and tool to help our societies in understanding the consequences of our choices and selections on the health of our population and, in reaching the healthier policy options. The practices from several countries show that, as a social learning process, HIA can bring different societal values, types of evidence, and methodological approaches into public discussions and policymaking process through several institutional mechanisms, which, in several cases, turn into constructive policy processes and positive health outcomes.

However, to deal with the globalization challenges, HIA needs further development in terms of the practice, institutionalization, and empowering of social learning process from local to international levels. It is also importance to link HIA with other sustainable development goals and movements to reach greater impacts of re-orienting globalization towards a more healthy human face.

* Presenting author

"Sustainable health promotion"
By
Prof.Dr.Udomsil Srisangnam
9 August 2005 , 2.00-3.15 pm

Distinguished guests, colleagues,
It is my honor to share with you my thought on this very important issue that sits at the heart of health promotion – how to make it sustainable?
As all of us here are advocates of health promotion, you must have pondered this question so many times. Your answer probably varies from one occasion to another. It is also likely to be different for each country.
So this is a very good opportunity to share our thoughts and compare notes. I'll try my best to kick start this discussion.

My speech is divided into 3 parts.
First is a quick review of the progress of health promotion in Thailand that serves as the basis for its future.
Second, I will share with you a very important enabling factor for the sustainability of health promotion in Thailand.
Third, our strategy to make the most of what we have to achieve sustainable health promotion.

Now, let me walk you through the state of health promotion in Thailand with reference to the Ottawa Charter.
All of us are aware that the Ottawa Charter prescribes a comprehensive approach, a very tall order for any country, even a very rich and highly developed one.
It is reasonable to assume that if substantial progress is made on all dimensions of health promotion, there will be enough energy and synergy to make it sustainable.
But the reality is that it is not easy to achieve such comprehensive progress. We may succeed in one area, but fail in another. Can we still hope for a sustainable health promotion then?

Thailand was among frontline countries when health promotion was endorsed as the national health strategy in 1981.After about 20 years the progress is more remarkable in some areas, and lagging in others.

Health Care Skills.
Public interest and skills in health care has considerably increased. The evidence is the proliferation of health magazines, health radio and TV programmes as well as self-help courses – for mainstream as well as alternative health care.

Health Service:
For decades, Thailand has had a good reputation for having good basic health services. Now, the 30 Baht Universal Health Service has expanded access to health service to everyone, especially the poor.
The programme has also been recently rebranded in favor of health promotion. The newly adopted slogan is "30 Baht keeps Thai people away from illness". ThaiHealth and the National Health Security Office are collaborating to integrate health promotion into the Universal Health Service Programme.
In addition, health promotion is also moving into the national society security system, thanks to the partnership between ThaiHealth, the Social Security Office, with support from WHO and the ILO's International Social Security Association.

Healthy Community:.
Today, local communities in urban and rural areas have also become quite active in health promotion.
During the past 3-4 years, the ThaiHealth has received over 6,000 health promotion proposals from communities in 76 provinces of the country. Over 4,000 of them received funding.
The range of activities, age-groups, occupations, social groups that participated in ThaiHealth's Open Grants Programme is really inspiring and impressive.

Healthy Environment and Healthy Public Policy.
These two areas are the most difficult. But we realize that we cannot hope to effectively reduce today's health risks unless substantial progress is made on these fronts.
Why is it so difficult? The difficulty lies in the need to bridge the health and non-health sectors, to make everyone realize that there is a close connection between the people's health and various aspects of the society and public policy-making.
The difficulty also lies in the need to open up the areas that are traditionally perceived as "government's sphere" and turn it to become a "public space".
Nevertheless, we've made some steady progress.
Among the most notable progress is the drafting a new Health Act which is very much inspired by the Ottawa Charter.
What is very special about the Act is that it is drafted in the most participatory manner. The National Health Reform Office, set up specifically for this task, has mobilizing the public to participate in this process. Throughout 5 years, more than five millions people have participated in this process.

Right now, Thailand has at least 2 very important champions for health promotion: the Ministry of Public Health, and the ThaiHealth.

The inception of Thai Health generated impact on the Ministry of Public Health. The Ministry has strengthened health promotion programmes and activities. Examples are the promotion of exercise and food safety.

As for the ThaiHealth, each year it receives approximately 50 million dollars from sin taxes - the 2% surcharge on alcohol and tobacco taxes.
When ThaiHealth was established, there were approximately 15 health promotion organizations or mechanisms in the world. ThaiHealth owes its existence to the inspiration and examples from these pioneers, as well as technical and institutional support from WHO. ThaiHealth has been in operation for only 3-4 years, but it has rapidly expanded the scope of work and networks.
Hence, health promotion in Thailand has a strong financial and institutional foundation.

Is this enough to ensure the sustainability of health promotion in Thailand? We think not. At best, we are not sure.
Some of these elements are in danger of slipping or disintegrating. The Universal Health Service Programme, for example, still has some serious weakness in the implementation.
Another concern is the need for a shared vision and understanding about health promotion especially at the policy level.
These are few of several important challenges to the sustainability of health promotion in Thailand.
So, we do have reasons to be concerned.

But we also have reasons to be optimistic. The most important reason for our optimism is that we can draw upon His Majesty The King's wisdom on "Sufficiency Economy".
This is a wisdom that H.M. The King shared with the Thai people in 1997 - the first year of the most recent economic crisis to help us brave through the difficult period.
But H.M. The King had developed this idea and put it into practice in thousands of his development projects for at least 2 decades before then.

The three principles of Sufficiency Economy are "moderation", "reasonableness", and "immunity".
To most Thais who are Buddhist, these fit right in with the Buddhist way of life.
Moderation, in other words, is the middle path.
Reasonableness requires conscious thinking - prudence - to make sure that each decision or action is suitable for the place, time, and people concerned.
Moderation and reasonableness are likely to lead to *immunity* that protects one's body and mind from overexposure to risk or contamination.

Sufficiency Economy is not only an individual's morality. It is also applicable at household, community, society, and national levels.
It is at the national level that Sufficiency Economy is often misinterpreted. It is often misconstrued as Subsistent Economy.
As a matter of fact, a Sufficiency Economy can be as open and sophisticated as it needs to be. A Sufficiency Economy can engage actively in the world economy, but it is important that it has the immunity, which could be social, economic or cultural, to protect itself from unpredictable and harmful impacts.
It sounds ingeniously simple, but it requires the courage, discipline, and patience to put it into practice.
To date, there are many examples of Sufficiency Economy at different levels, in different sectors. We hope that these examples would multiply and inspire the rest of the country.

It is clear to us that Sufficiency Economy adds the "heart and soul" to the Ottawa Charter.
The 3 principal concepts of Sufficiency Economy provide a definitive reference to the concept of "healthy community", "healthy environment" and "healthy public policy". They also suggest what kind of "health skills" and "health services" would be appropriate for a particular situation/context.
Further, a Sufficiency Economy would be conscious, moderate and prudent with its consumption and production, would not live beyond its means, would not exploit the natural resources today what it should preserve for the next generation. Hence, it would be less exposed to economic, social and health risks.
In this system, the promotion of healthy living and reducing health risks would become internalized and easy to sustain.

This brings us to the third part of my presentation. How to get from here to there?
It is less than a decade that the Thai people started to learn about Sufficiency Economy and health promotion.
There are encouraging signs, but we need to do much more to make sure that the seeds that have been sown would grow and take a firm root.
Here, we have a theory that has been tested many times. It's Prof. Prawese Wasi's famous theory of **"A triangle that moves the mountain".**

This simple theory proposes that, to influence societal changes, there must be 3 key elements: first - the knowledge, second – the social movement, and third – the politics or the political commitment.

If the 3 angles are complete, a small triangle can be a highly powerful tool. It can even move a mountain.
Different cases may require different balances among these 3 elements, but it would be difficult, if not impossible, to influence important changes if the triangle is incomplete.

We have had many experiences that confirm this theory. Today, I'd like to share with you a story about how we put it into practice with the case of alcohol consumption.
Thailand's serious effort to curb alcohol consumption has just started in late 2003, 2 years after the establishment of ThaiHealth. There had been no champion on this issue before then.
Knowledge was the starter. The first shocking revelation was WHO and FAO's warning that Thailand ranked as the 5th largest alcohol consumer per capita in 2000. But situation has got worse as our alcohol consumption tripled during 1989 to 2003 to 58 litres/person/year.
Research also shows that advertisement, especially TV advertisement, is the most powerful factor that stimulates youth's alcohol consumption. 88% of Thai people see or read or hear alcohol advertisement nearly 5 times each day. It is a hugh advertisement business, estimated at $59 million in 2002.

This and related knowledge about the impact of alcohol consumption, for example, alcohol-related road accidents, was the basis of several proposals to the Cabinet that included the establishment of a National Committee on Alcohol Consumption Control, an alcohol advertisement ban during 5 a.m. to 10 p.m.
But these proposals faced policy obstacles; the Cabinet postponed deliberation on these proposals several times. It was not until there was a strong show of support by the civil society that the proposals won the breakthrough.
Now, we have the National Committee on Alcohol Consumption Control as a policy mechanism, the Center for Alcohol Studies as a knowledge institution, and over 200 organizations have joined the nation-wide alcohol control network that continuously carries out public campaigns.

This, and many other cases, convince us that the sustainability of health promotion depends on the ability to develop and advance these 3 elements.
ThaiHealth's scope of work also reflects this approach. It places as much emphasis on creating and disseminating knowledge as supporting social movement.
The political angle, however, still lags a little bit behind. There is therefore a need to realign the understanding, renew the political commitment, and strengthen the political angle.
When triangle is complete, we believe that we will have sustainable health promotion.

To sum up, I believe Thailand's health promotion has a good chance of sustainability.
We have both the body and the soul of health promotion in the Ottawa Charter and the Sufficiency Economy.
We have a range of vehicles, e.g. Ministry of Public Health, the ThaiHealth and a nation-wide network of organizations and community groups to propel the movement forward.
We also have the triangle that moves the mountain as the driving strategy.

I hope we've got the right recipe for success and sustainability. Yours may be different.
It's very important that we share these recipes, success stories as well as lessons learned.
We need to learn from one another, and we need to cheer and support one another.
Success or failure can be contagious in this borderless world.
So, let us work together towards "Health Promotion for All, and All for Health Promotion".

Unedited Working Paper, 14-07-2005

Global health promotion scaling up for 2015 - A brief review of major impacts and developments over the past 20 years and challenges for 2015

WHO Secretariat Background Document for the 6th Global Conference on Health Promotion in Bangkok, Thailand 7-11 August 2005.

Purpose of the paper

The purpose of this background paper is to establish a common frame of reference for the participants of the Bangkok conference in August 2005. It provides a short review of the origins of the health promotion concepts and approaches, presents some major developments in health promotion since the adoption of the Ottawa Charter for Health Promotion and highlights some of the major present day challenges in health and health promotion. It provides orientation for some of the key issues that will be presented and debated in the four tracks of the Bangkok conference and identifies issues that can inform the completion of the Charter to be adopted at the Bangkok conference. It should be noted that the scope of this background paper is neither to be extensive, nor to provide a health promotion handbook. The status of the paper is still a draft. It will capitalize on contributions made during the conference and can potentially also expand on items that cannot be accommodated in the Bangkok Charter. A final version will be compiled after the Bangkok Conference

Process of the paper

- *This draft of the Background Document is based on comments and complementary texts from the BCDG members and the WHO secretariat and was first drafted by a small working team on 13-14 January 2005 in Geneva. It will be distributed to the COC and PC in the first half of January together with a new draft of the Bangkok Charter and will be open for comments until 31 January 2005. At the beginning of February, updated documents will be circulated for discussion at the next Programme Committee Meeting which will be held in Kobe, Japan, on 21-23 February 2005.*
- *Comments made at the meeting in Kobe, further discussions and fora organized by the Conference and the Secretariat and comments delivered on the draft Charter versions have been considered.*
- *The Background Document will be made available to all participants at the Bangkok Conference and serve as a guiding document for the Bangkok Charter and the technical discussions. It is not subject to any organized discussions as part of the programme during the conference, but comments to the Conference Secretariat are welcome.*
- *A final version will be part of the proceedings and compiled after the Bangkok Conference, complementary drawing on the contributions from the key note speeches and technical papers as well as from the discussions they generate.*

Note, both the para's on leadership and sustainable funding (p. 13) should be in consistence with the draft charter.

Introduction – on values, key principles and some historic milestones

Health promotion began to gain acceptance worldwide after the launching of the Ottawa Charter for Health Promotion at the first international health promotion conference held in Ottawa. Canada 1986 and jointly organized by Health and Welfare Canada and the Canadian Public Health Association under the leadership of the World Health Organization. The Charter was based on the Health for All Strategy, the Alma Ata Declaration and inspired by the Canadian Health Minister Marc Lalonde's 'health field concept'. It introduced a focus on health and its determinants into a debate that so far was dominated by a biomedical approach to health.

One aim of the Charter was to engage the industrialized world in applying the Health for All principles of equity, empowerment and intersectorality to its highly developed health care systems and to reiterate the importance of public health action. It proposed a revolutionary shift in perspective that underlined the contribution of other policy sectors in health creation as well as the central role of individuals and communities in contributing to health. In doing so, the Ottawa Charter introduced lessons learnt in the developing world to the developed countries. Health promotion was defined in the Charter as a 'process of enabling people to increase control over, and to improve their health'. This was reinforced by the new approaches advocated by social movements in the 1970ies and 80ies - such as the women's movement and the environmental movement. It also built on new types of health programmes in the developed world that moved beyond a focus on individual risk behaviour towards "making the healthy choice the easier choice" through a wide range of environmental and social interventions. In the developing world health promotion catalyzed a bridge between environmental concerns for access to clean water and sanitation, food supply, safety, reproductive health and health education.

The process of the Ottawa Charter was scientifically facilitated by a document on concept and principles and a significant number of preparatory meetings which contributed to the clarification of the health promotion concept, its values and principles and its approaches. From this intensive debate before and at the conference emerged the five action areas of the Ottawa Charter

- Develop healthy public policy
- Create supportive environments for health
- Strengthen community action
- Develop personal skills
- Reorient health services.

In doing so, it brought together both existing and new ideas in one document, and gave them currency and status by being part of the WHO movement towards health for all. But the Charter went one step further and set forth a new mindset and ethos for health professionals and associates in the wider public health field, defining their role as being to advocate, enable and mediate for health. It proposed a salutogenic view on health which focuses on strengthening peoples' health potential and which is aimed at whole populations over the life-course. It underlined that all people have their individual health potential, even if living with severe disease or disability. It reinforced the direction set by the Health for All Strategy to view the goal of health policy and health programmes as *"providing people with the opportunity to lead a socially and economically productive life."*

Key values and principles

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." This statement in the preamble of the WHO Constitution, - with the inclusion of gender - sets out the point of departure for the key values driving health promotion. Human rights are as fundamental for health promotion as they are for the mission of the health sector as a whole. The shared goals are to improve the health of people, respect their diversity and maintain their dignity. More recently these goals have been expanded to include sustainable development and highlight the need to address the issue of maintaining a sustainable eco-system without which long-term survival and health is seriously threatened and makes the world harder to live in for tomorrow's children and generations to follow.

Health rights are embedded in a humanitarian, social and political context and are subject to changing historical perceptions. Six key links between rights and health have been reinforced by health research:

- The right to health is related to both political and democratic rights, as well to rights against any discrimination.
- Equal life opportunities for women and men are basic pre-requisites in achieving each one's highest health potential.
- Health status is determined by social structures and by the options available to people to participate and influence the society in which they live and work.
- Safe and health-supportive environments including access to safe water, sanitation, decent housing, protection against violence and sufficient nutritious food supply are all means to provide equitable conditions for maintaining and improving health and quality of life for all people.
- Sufficient economic resources and social acceptability, regardless of gender, ethnicity, age, sexual attitude or handicap are all matters of social justice and affecting objective and perceived health.
- Everybody's access to work in favourable work environments pursues valuable material standards both for the individual and the community, improved productivity and meaningfulness and coherence by nurturing social networks.

Member States have, in different ways and in their specific context, further advanced and adopted the humanitarian and social value base for their public health strategies. The notion of empowerment, understood as a strategy for people's active involvement in the development of favourable life circumstances, both in their communities and as individuals in full transparency, is a significant centrepiece of this orientation.

Five key principles have guided health promotion strategies

Health promotion is context driven:
Promoting health requires advanced knowledge about the interface between health and its determinants, social epidemiological skills for analyzing socio-economic, gender and ethnic gaps in health and disease patterns in populations, as well as effective mechanisms to maintain and improve good health for all, taking into account different historical, religious and societal values and practices.

Health promotion integrates the three dimensions of the WHO health definition
Promoting health means addressing the multi-dimensional nature of health. its physical. social. and mental dimensions. For many countries and communities it has also been evident to include a fourth dimension. spiritual health. given their cultural context.

Health promotion underpins the overall responsibility of the state in promoting health
All levels of government have a responsibility and accountability for protecting. maintaining and improving the health of its citizens. and need to include health as a major component in all of its undertakings. i.e. policy development and service delivery. People have a right to equal opportunities to good health and well-being. In countries, or systems, with a weak role of the government and a diminish public sector. voluntary organisations and parts of the private sector are significantly contributing to people's health.

Health promotion champions good health as a public good
Good health is beneficial to the society as a whole. its social and its economic development. In this view health becomes a public good and a key component of modern citizenship. Being aware of health becoming increasingly inter-dependent. there is a need to ensure that health also is viewed as a global public good.

Participation is a core principle in promoting health.
The participation of people and their communities in improving and controlling the conditions for health is a core principle in promoting health. Improved health literacy fostered by modern means of health education will make people better equipped in giving voice and contributing in participatory processes.

20 years of continuous development
The development of health policy and health research in the 20 years since the adoption of the Ottawa Charter has validated and reinforced its key messages and approaches. Health promotion is now understood as a branch of modern public health aimed at actions tackling the major determinants of health and thus contributing to the positive health development of all people. It is applicable for all sectors of society, may they be public, private or voluntary. Policies and programmes dealing with issues as diverse as tobacco, HIV/AIDS or child health recognize the need for integrated action along the lines of the Ottawa Charter action areas - the most recent global action plans in these areas illustrate this clearly. Health is increasingly understood in its socio-economic and socio-ecological dimensions and people's participation in health is increasingly recognized. Health promotion has changed the perception of health. demonstrated the need both for informed top-down and well anchored bottom-up policy making.

Indeed. it is important to realize that the relevance of the Ottawa Charter lies not only in the influence it has had on establishing the field of health promotion as a key public health function and a new professional orientation but in the influence it has exerted on health policy development overall through the change of perspective that it has advocated. There is an increasing awareness that in no country health care systems alone can respond to the rising demand for health expected by its citizens. Health promotion programmes that reached out into other areas - such as healthy cities and health promoting schools - contributed to this as did world wide initiatives to set health goals and targets and to integrate health into development policy. Health promotion mobilizes human resources regardless of professional and administrative borders as well as lay people. and makes health a concern of the society at

large. Initiatives based on health promotion like healthy cities, villages, communities, islands and regions, health promoting schools, workplaces and hospitals, healthy market place, healthy universities, healthy prisons and others have spread the health promotion approach effectively in both developing and developed countries..
Many of the approaches that were considered highly controversial – or not even thought of –at the time the Ottawa Charter was adopted, are now accepted as mainstream such as the salutogenic paradigm shift, empowerment and inter-sectoral approaches to tackle the wider health determinants. Consequently, many policies and programmes with a health promotion approach do neither explicitly refer back to the Ottawa Charter or other international key reference documents, nor even to health promotion as a term.

In turn, health promotion development has been influenced by key changes in society in both developed and developing countries. Significant influences have come to the fore - such as poverty, violence and mental health, new diseases needed a response - such as HIV/AIDS, new social forces - such as globalization, significantly impact health. This implies that health promotion is as much a product of modernization and social change as it is an influence on the societal response to its own health consequences.

In conclusion, health promotion has proved itself to be an efficient and function approach to improve conditions for health on a population level and is now a firmly established branch within public health.

The WHO global health promotion conference series
One mechanism adopted by the World Health Organization to promote health promotion and its strategic approaches, to keep it close to changes in the social and political environment and to make it a truly global undertaking, was to embark on a series of conferences in close cooperation with member states. These global conferences also led to regional, national and even local and community initiatives in health promotion.

- In Adelaide, Australia 1988, the new concept of healthy public policy was clarified and illustrated in the Adelaide recommendations. Examples were given in the fields of tobacco production and food. Human rights and health were highlighted initiated by the indigenous aboriginal community. The gender dimension in health promotion was given specific attention.
- In Sundsvall, Sweden 1991, with the support of all Nordic countries, health promotion gathered for the first time an equal number of participants from the developing and the developed world. The concept of supportive environments conducive to health and the links with sustainable development were established in the Sundsvall statement. Tackling inequalities in health was set as an overall priority and the 'settings approach' was further elaborated and confirmed. The policy and gender dimensions were given specific attention through separate Minister's and Women's statements.
- In Jakarta, Indonesia 1997, an international health promotion conference was for the first time held in a developing country, with a majority of participants from the developing world. Issues related to globalization were discussed for the first time as were the potentials and controversies around public-private partnerships in health promotion. The progress achieved in the field in the ten-year period since the adoption of the Ottawa Charter was documented through the presentation of evidence for the effectiveness of health promotion and the innovative approaches to infra-structures and funding of health promoting institutions and organizations. The Jakarta

Declaration became an important document for engaging developing countries in health promotion.

- In Mexico City, Mexico 2000, high-level political commitment to health promotion was confirmed by the "Ministerial Declaration of Mexico for Health Promotion: A Platform for Action," signed by more than 80 WHO Member States. The Member States committed to strengthening their planning for health promotion activities, positioning it higher on the political agenda and recognizing it as a priority in local, regional, national, and international programmes. This commitment was taken forward into the governing bodies of both WHO and PAHO.

Since the adoption of the Ottawa Charter, health promotion has become a leading and vital component of modern public health and at the beginning of the 21st century it is a major concern of both developing and developed countries. It engages local communities, politicians, decision makers, lay people, popular movements and voluntary organizations, business and numerous other actors. A range of WHO Member States have developed innovative multi-sectoral health policies based on health promotion principles and approaches which address the wider health determinants. All WHO regions have in different ways committed themselves to health promotion by developing their own frameworks, strategies, guidelines, and capacity building. Globally, WHO has frequently enforced health promotion by a number of resolutions adopted by the World Health Assembly:. Most recently in 2004 by the ratification of a Framework Convention on Tobacco Control, and by adopting the resolutions on the Promotion of Healthy Lifestyles (WHA57.16), the Global Strategy on Diet, Physical Activity and Health (WHA57.17). and Public Health Problems caused by harmful alcohol consumption (WHA58.26).

The International Union for Health Promotion and Education (IUHPE) has since the 1950's played a significant role in developing health education, and more explicitly since 1993 also widened to health promotion. IUHPE has its focus on professionals in health education and health promotion and is instrumental in operationalising the health promotion concept, advocacy and wide dissemination of evidence and knowledge. The organization and its members is a driving force in advancing the health promotion agenda.

In conclusion, twenty years after the adoption of the Ottawa Charter its basic values, principles and strategic action proposals remain valid. Indeed, health research provides impressive evidence for the validity of the health promotion approach. However, there is still a need to reflect and assess progress and to examine challenges to promoting health in order to better understand the interplay between the context, differing between most communities and populations, and interventions that work properly and effectively.

Challenges and changing context in the 21st century

Successful health promotion actions are very much context-specific designed, ranging from policies to reducing risk behaviours. Several current and future changes can be seen affecting countries all around the globe, as well as demanding closer global partnership for health and health promotion in particular. The world changes faster and the stage is set for health promotion to bring about better partnerships and effective actions for health promotion at the national as well as global level.

Changing health burden and complex determinants of health

While both developing and developed countries are facing a growing proportion of elderly and a population with more chronic conditions and non-communicable diseases, many developing countries are in addition still faced with infectious diseases, and increasingly injuries and violence as their economies grows. Changing living conditions and lifestyle bring more stress and thus a threat to mental health of those in both developed and developing countries alike. With extensive international travel, no country is safe from potential major communicable diseases outbreaks such as SARS or human influenza or even not-yet-known emerging diseases. Environmental changes are affecting a large number of countries either through far-reaching global climate changes or geographically related natural disasters such as the recent tsunami causing nearly 300 000 deaths by one stroke. Basically all countries are facing multiple, rather than single type of health burden, the underlying causes of which are highly relevant for actions in health promotion. The fact is that there are constant health disasters going on, continuously harvesting millions of preventable deaths in the global village. The ongoing urbanization is predicted to bring 3 billion humans into slums hitting hard against people's health. In turning this reversible situation, children and adolescents are at the heart of concern. In many ways they are facing a much more demanding situation than most previous modern generations. Billions of people are also undernourished and starving, causing millions of premature deaths and avoidable suffering. The story could be continued. In almost all cases children and young people are the prime losers. Much stronger efforts to promote health must be made for and by developing countries.

Inequity and health

In most countries health is improving. In some countries the trend is reverse, e.g. due to war and civil unrest, HIV/AIDS and excessive male alcohol consumption. Widening health gaps is a global concern. Health inequities exist in all societies and social stratification has significant negative health impacts. Throughout the world, inequalities in health are increasing - within and between societies. WHO has appointed the Commission on Social Determinants and Health to take leadership for a process to increase equity in health. There is an unprecedented opportunity to improve health among the poorest and most vulnerable communities of the world. The health of marginalized populations, the role of women in social development and in health and the health of indigenous people in many localities are among some of the challenges that need to be taken into consideration. But also new vulnerabilities, for example the health of migrants and slum dwellers and the health of older people are of concern. It is a key role of health promotion to contribute to a more equal distribution of health, starting by stopping the increasing gaps. Ensuring implementation of public policies and healthy environments that effectively address inequalities, both in absolute and relative terms, can impact people's lives by improved health and well-being and ensure overall quality of life for all. There are overwhelming evidence showing that most of the global burden of disease and health inequalities are caused by wider social determinants. This interdependence is also recognized by the Millennium Development Goals. Without significant gains in poverty reduction, food security, education, women's empowerment and alleviated living conditions in slums, no improved or reduced inequalities in health. Many countries address health inequalities as a prime concern in their health targets and strategies, but so far little progress is reported.

The communication revolution

The development of communication techniques has dramatically changed daily life for most people. Communications for the promotion of health can be powerful and enhance health literacy. If the content is based on solid knowledge and open for a dialogue, it can have a long-term performance: its connection can lead to the delivery of services truly demanded by

the community, provided they reflect people's everyday life conditions. Still there is a substantial information divide, leaving out large populations in developing countries. Access to reliable information about what determines health and appropriate channels to communicate health needs of the communities should be a public good available for all. Modern communication technology is becoming more and more affordable, but it requires skills that must be conquered by the people in order to become a democratic tool for health. Communication technologies have also brought messages from commercial sectors closer to homes even in the most remote rural communities. It is in the realm of health promotion to respond to the indirect and direct marketing of unhealthy products like tobacco, alcohol and unhealthy diet, but also marketing of generally unhealthy lifestyles and the exploitation of mainly girls and women for sexual purposes.

Increasing and expanding democratization in countries around the globe

The last two decades have seen many countries with changes in political system and infrastructure moving towards more and more democratic development and their people wanting to take more active roles in various aspects of policy and socio-economic development. Such changes and concerns create a new context that should properly drive actions in health promotion especially with regards to creating healthy public policies and community empowerment, the two areas that still need to be further developed in many countries and can benefit tremendously from increasing democratization.

Globalization

The dynamics of globalization affects health in many ways: trade, tourism, physical and cultural environment, economic transactions, transports, production of goods and working environment. Like the communication revolution it has both positive and negative effects, and the opinion is split about its advantages and disadvantages. Undoubtly, many people suffer from less poverty due to global economic growth and have substantially improved their standard of living. The impact is unevenly distributed though, and while progress is made in eastern Asia and the Pacific region, less is happening in Sub-Saharan Africa. Globalization offers, among others improved opportunities for access and transfer of knowledge, being one major health determinant. International trade, which was expected and has contributed to better economic conditions, also caused dilemmas in relation to health and health promotion. Marketing efforts of multinational business sector brought health hazardous messages that may be difficult to regulate under "free trade" principles and has created unhealthy working conditions. Present governing mechanisms are not fit for the purpose of managing this situation from a public health perspective. Massive movements of people, migrant workers, business (wo)men and tourists have created multiple new challenges for health promotion. It has created a complex environment within which different types of health threats and health risks can be spread with enormous speed. The potential of globalization in making a significant contribution to health yet remains to be realized. Globalization is a fact of our time, but ways have to be found to harness its disadvantages and make it health friendly.

The threat of war and terrorism

The ultimate threat to good health is the unsafe environment created by war and violence. Conflicts between groups in countries continue with severity and have grown in some regions - and increasingly they affect the civilian population, especially women and children. The refugee population in the world has grown and does not show signs of reducing. The more recent threat of terrorism, both internationally and locally, posed another key barrier to health and health promotion efforts. Health promotion is challenged to be part of efforts of conflict resolution and peace building and all efforts that help to lessen conflicts and confrontations.

The political movement to make health a global public good would be beneficial not only to people, but also to major political and commercial interests by fostering peace, social and economic development. Conflict management and resolution without use of violence, arms or explosives must be understood and accepted as the prime principle in political, as well as citizen's every day lives.

Framework for actions

Following increasing experiences, changing context and new challenges, a framework for future actions in health promotion can be viewed through the following five dimensions:

Healthy public policies

A major strategy for improving the health of the population and reduce inequalities is the development of policies that identify the most health influencing factors in different policy domains. Most public policies conducive to health are of central importance to people's every day lives, ranging from structural conditions, supportive environments and settings to healthy life styles Thus, they must be firmly grounded in the community. Once established, governments at concerned levels have to implement the policies in a sustainable and decisive manner and provide adequate resourcing accordingly. A special responsibility to initiate and orchestrate the muliti-sectoral dimension of such policies rests upon ministries of health. If systematic monitoring and evaluation procedures are linked to policy implementation it increases the possibilities to make a real impact.

Partners and actors for health promotion

The most important strategy for health promotion is to make health promotion an agenda for action by the whole society in both its national and global context. Health promotion is increasingly viewed as actions to be carried out not only by health promotion workers or health personnel, but increasingly by others in adding value to their prime missions. In this changing context, there are at least five groups of major key actors or partners in health promotion that need to be mobilized to work together in addressing the future challenges or determinants of health.

Communities: This is the prime group of actors that may work individually or as groups. Sustained actions for health promotion aiming either at improving individual health or improving on socio-ecological dimension can be realized and sustained only through community involvement and participation.

Policy makers:: Healthy public policies leading to safe and healthy environment as well as other policies dealing with socio-economic development are all relevant to health promotion and thus the roles of policy makers are key to health promotion especially with the ever more complex underlying causes and determinants of health and health burden, integrating health dimension will be crucial as part of the overall economic and development policies, and there is a need to reorient and educate policy makers towards that end. There is a need also for policy makers to create participatory public policy processes (4P's) that will help to reflect the broader societal needs and concerns.

Private commercial sector: With the changing pattern of health burdens and its relation to production and marketing strategies of products affecting health, and with and more and more people working for private companies, the private business sector becomes a key actor in promoting health. This requires commitments, not merely financial, to decrease negative impact created by certain business practices, such as marketing to children, as well

as creating a healthy working environment and not merely through increasing financial contribution to activities in health promotion carried out by others. It is becoming increasingly obvious that products and consumer responsive marketing beneficial to health is a growing and profitable market.

Academic & Research community: Given the more complex interplay and diverse views and needs for active participation of groups in the society, concrete and valid evidences need to be generated to guide actions for health promotion. It is crucial to build up capacities and involve relevant groups of researchers in order to generate useful information and evidences for health promotion within complex interactive settings. Academic institutions have a key role in providing training and developing knowledge-based methods that can be bridged into practice. The scientific community is only gradually recognizing the need for more contextual and dynamic approaches in assessing the role of health in the everyday life of people and its interplay with their environment in all its dimensions in order to be more supportive of developing best practices for health promotion.

Civic groups and NGO's: With increasing democratization and demand for participation, more and more active civic groups and NGO's will be playing active roles in various kinds of social actions influencing health determinants. May it be advocacy for health, delivering services to promote health of people most in need, or being innovative and forerunners in developing health promotion. The extent of their roles and influences will largely depend on the overall political and social environment within countries and the global setting.

Mechanisms and infrastructures for health promotion

Various kinds of mechanism and infrastructure have proved to be useful and crucial for health promotion. Among them are:

Reoriented health systems. Despite the fact that health promotion should be a concern and contributed to by all groups in society, health services units and health personnel remain key catalysts, as well as a key infrastructure from which actions for health promotion should be initiated or coordinated. The need for a more health promoting health care is just as valid as before. Some progress can be identified in this field, but given the potential for promoting health in the health care much remains and should include the whole chain from primary to specialized care. New (HIV/aids) and re-emerging (infectious) diseases (tb, ebola, SARS, aviant flu etc), mental ill-health and chronic conditions (diabetes etc) can be more effectively and affordably managed by health promoting efforts. The health and medical care systems have undergone rapid changes during the past decade, which hits the poor and most vulnerable groups. Privatization and patient fees, formal and out-of-pocket, have restricted the accessibility and hampered a universal coverage. Improving the staff's skills in meeting and empowering patients, improving the psycho-social atmosphere in hospitals and care centres and making the health system a healthy workplace are some major challenges. At the core is cost containment, to which a health promotion approach could contribute more effectively.

Human resources for health promotion: With the increasing emphasis and expanded involvement of various sectors in the society, there may be a need to develop both new competencies and new categories of human resources for health promotion, thus increasing capabilities and employable by various sectors in the society within which actions in health promotion will be deemed necessary.

Mass media: Mass media is a crucial infrastructure and institution in every society that can play a role in promoting health, or the opposite. It is crucial to develop comprehensive

and long-term strategies to provide high quality services to media groups and deploy them in positive actions for health promotion.

Health education: It is convincingly proven that properly designed, targeted and delivered health education enables people to make health choices. It is a responsibility for the State and governments at all levels to provide equal learning opportunities for all people to achieve a basic health literacy.

Key processes for health promotion

Successes in health promotion lie in the ability to mobilize the potential and involvement of various sectors and stakeholders in the society. In the increasingly complex environment with interrelated and interacting stakeholders, effective actions for health promotion can be better achieved through different processes such as the following.

Research and applied knowledge production: Research not only helps to bring about concrete and valid evidences and useful information. It is also a process through which various groups of stakeholders can work together on determinants and become better informed through the working dynamics. A properly planned and managed research process will help to create common grounds and continuity for actions. Research done exclusively through the interest of researchers, or from an academic point of view, may not help to bring about effective and shared knowledge for health promotion. Identifying and involving key stakeholders in the process is thus an important key to success.

Communication: Open and transparent communication is a crucial process in health promotion. Not so much because health promotion is about bringing useful health messages to the people, but more because social mobilization for health promotion need effective communication strategies. In the present era of advanced information and telecommunication technologies, they should be employed to the fullest extent wherever possible to create effective and transparent communication channels that will allow interactive sharing and learning among various groups of stakeholders in the society. Communication should be built and managed in such a way that it becomes a means of getting the messages across as well as a means for effective knowledge management for health promotion.

Networking: Communication should lead to the formation and effective functioning of networks in health promotion. Such networks should be lively, dynamic and growing both in terms of its nodes and membership as well as the learning and sharing capacity among members of the networks. Effective networks should also allow criss-cross interaction rather than mainly interaction within selected groups of members.

Strategies for health promotion

A number of tools should be considered in order to bring about more effective and sustainable actions in health promotion. Experiences exist in various countries making use of the following sets of tools for health promotion addressing different types of health challenges and determinants.

Legislation. Many countries benefited from enacting different types of legislation for protecting and promoting health. Basically, there are four types of such legislation, (1) those setting up restrictions for product, human and environmental safety, (2) those aiming at bring about healthy behaviour by e.g. market regulations, (3) those enacted to establish mechanisms or institutions for health promotion and (4) those dealing with financial and fiscal aspects (such as increasing tobacco or alcohol tax aiming at influencing consumption, and in some countries also used to finance health promotion). Some legislation may at the same time fulfil more than one of those objectives.

Regulatory measures such as legislation, taxation, market regulations and binding agreements forms a foundation for the legitimacy of health promotion, and can be applied on all societal levels. The use of international conventions, like the Framework Convention on Tobacco Control (FCTC) demonstrating an international break-trough and global governance of non-smoking as the general rule, is setting an example to be followed in other health intervention areas. High taxation on tobacco and alcohol, introduction of speed limits for motor vehicles and similar measures are proven very effective in reducing health risks. With regulatory mechanisms as a foundation, additional interventions for health are facilitated and become more efficient.

Health Impact Assessment (HIA) and Strategic Environmental Assessment (SEA): These are instruments that will help to generate information as well as creating awareness about how investments in programmes, projects or implementation of policies either will be beneficial, opposite or neutral to public health. The advantage is that such impact assessments contribute to informed decisions and points at alternative investment and policy options. The use of impact assessments are still very limited, and have been confined mainly only to the technicians or in the context of seeking approval for mega-projects.

Social marketing. Marketing strategies and applied tools are crucial for effective advocacy for health promotion. Health workers or those working to create better awareness or reorient different groups of actors in the society towards the support for health promotion can benefit from such tools and techniques.

Specific challenges for action

The role of the state and governments

The time has already come to act on the present global health situation. At the same time as we can record health improvements in general, the health gaps between regions, countries and within countries are unacceptable since both knowledge and tools exist to make a difference. In this sense there is a global health crisis, since all governments have not taken the appropriate steps for unavoidable mortality and morbidity. Governments at all levels have a unique responsibility in this regard which cannot be replaced.

Participatory public policy processes

It has been demonstrated along the history how crucial participation is for improving health. The example of vaccination provides important lessons to learn. Morden examples are the empowerment of women increasing their control over reproductive health and sexuality. The invention of vaccines and recognition of empowerment are the first parts of the story. The delivery mechanism is the other, and a high coverage can only be achieved if the community is properly and effectively engaged. In terms of health promotion, the crucial aspect is participation in public policy processes in order to ensure positive contribution and recognition of various policies to health. Increasing numbers of more active citizens and more open societies, governments that encourage or establish participatory public policy process will not only lead to better political development, but also ensure concerns on health and quality of life as an integral part of policy directions. Positive synergies can be expected, especially if communities are properly engaged in the process. Engaged participation from the community is the best guarantee for a proper design of health promotion actions, setting feasible and realistic targets, sustainability of achievements and then finally transfer of ownership and self governance.

Partnerships

Health promotion is building on different alliances, sharing common goals, values and approaches. Basically and simplified, partnerships can be categorized into four groups

1. *Between public agencies in multisectoral action,* where e.g. systematic road safety measures have produced substantial positive health outcomes. Most societies, regardless of how developed they may appear to be, are organized in sectors in which specific traditions, paradigms and practices have evolved over time. Opinions may be divided about the feasibility of such 'silo' structures in the interconnected world of the 21st century, but yet it is a fact of life. It is also a fact of life that for most sectors health should be of major concern. Two profound reasons are that fostering health as an asset means both increased efficiency and improved quality of what is delivered. The idea of multi-sectoral action rests on the idea of a win-win situation. Each sector has its specific mission, and almost always good health assists in accomplishing that mission. Only by the respect of self ruling a win-win situation can be established, where health promoters and other actors develop a mutual understanding that the ownership stays with the respective sectors outside the public health system.
Given the today's knowledge and societal organization, there is a need to reorient not only health services, but all public sectors having an impact on key determinants influencing people's health. Key challenges are to transfer ownership, analyze and agree upon what health determinants also are adding values and facilitating the fulfilment of the partner's prime mission.

2. *Between public sector and NGO's,* where there is a tradition that the partnership is centred around specific diseases or risk factors, rather than taking a more comprehensive approach where the social aspects and wider determinants are duly considered. An increasing interest attached to public health is demonstrated from popular movements, departing from a rights and human development perspective, which may pave up new and comprehensive opportunities. Key challenges are to find common denominators for mutual reinforcement of impacting relevant health determinants, both for the NGO's target audience and the broader population.

3. *Between health promotion and the academia.* The need for increased efficiency in health promotion is becoming widely recognized. The knowledge-base for effective health promotion is constantly increasing. Evidence to demonstrate the effectiveness of health promotion must be based on its own concept, principles and values. It cannot simply be copied from other scientific disciplines. By the combination of political sciences, social and behavioural sciences, medicine and epidemiology standards for evaluation the effectiveness of health promotion policies, strategies, interventions and methods are steadily evolving. It is of critical importance to understand the role of different contextual and gender dimensions when transferring successful interventions from one place to another. Solid facts tells that influencing social determinants like a good start in life, education, inclusion in the community and social support, employment opportunities, transports, food and addiction will have major impact on people's health. Increasing evidence is giving support that investing in health pays off by improved social and economic development. Research & development is a key for maintaining and pursuing the legitimacy of health promotion. Key challenges are to increase the amount of intervention research and to develop research standards on merits for health promotion.

4. *Between public sector and private enterprises.* There are numerous examples of how public-private partnerships have been established for healthy products development and

delivery in fields like medicines. safety equipment, devices and food products. Product development often follows when research points out that a health aspect can be managed by a technological innovation. and also can be commercially exploited. Familiar examples are safety belts. iod supplementation, contraceptives, bicycle helmets, safety equipment, less toxic products etc. Product development is also triggered when a demand is created by health and consumer advocacy. More controversial, and by several abandoned, are partnerships with tobacco, alcohol and the gambling industries, although they might, in the short run, add economic resources to health promotion. It is a key challenge to make health a value worth investing in.

The complexity of partnerships and how to make them beneficial to health requires strategic and negotiation skills, where the major challenge is to place health concerns at the forefront.

Leadership and sustainable health promotion infrastructures
Political and administrative leadership is a vital component in implementing health promotion. The skills needed are rather stewardship combining complex goals and infrastructures, than monolithic management approaches. Sustainable delivery mechanisms for health promotion are pre-requisites for a systematic public health work. It contains organizational structures present at all societal levels, with a clear health promotion mandate, responsibilities and services of high professional quality. The capacity building must be ensured to safeguard the access to well qualified professionals, professional networks, infrastructures for health promotion like training, policy analysis, epidemiological surveillance and monitoring, communication, improving health literacy, health impact assessments, health accounts and other planning and management tools, as well as development and research etc

A global approach.
Health promotion needs to become more globally oriented. The links to the determinants expressed in the Millennium Development Goals are evident. Increased attention must be paid to the raising number of older people worldwide, but at the same time to young people who are facing a different world with a rapidly changing labour market and shortages in employment opportunities, strongly affecting their health and well-being. The increasing numbers of youth in developing countries is a challenge by itself. Linked is the fact that those with the highest education tend to emigrate, causing a brain drain. In the longer run it will pose a severe obstacle for development and create new dependencies.

Ensuring sustainable funding on investment and the contribution of other sectors by reorientation
Adequate and long-term funding linked to defined priorities is a backbone for the delivery of health promotion services and development, just like any other professional activity. There are different models in place. Basically, there are tax-based systems, insurance-based systems or privately funded systems, where people are buying health in the market place. The cash-flow may come trough different, and sometimes complementary, channels. From a percentage of the general taxation system, dedicated taxes from health damaging products like tobacco and alcohol, or returns from state-controlled gambling. In insurance systems a trade off is made between the value of promoting health and thus reducing the risks, compared with other options, calculated on best value for money. In the market place, the individual makes the choices of what best corresponds to personal needs and preferences.
Evidence have repeatedly demonstrated that investments in health are significantly contributing to social and economic development. Thus, health promotion is to be regarded as

the investment it is, and not as a cost or consumption. The Global Fund is one example where the global community has agreed to make such an investment.

Different roles and functions of these mechanisms lead to a varying degree of impact on health promotion. Experiences exist in different countries which could be shared by others. Countries need to explore and develop or utilize some of these mechanisms for upgraded actions in health promotion.

However, it should be kept in mind that the waste majority of resources promoting people's health is made in public, private and voluntary sectors of the community, where major pre-requisites and determinants for a positive health development are placed. Such examples are safety and efficiency investment in road and mass transport systems to minimize road traffic injuries, industrial investment to create employment and at the same time ensure a safe environment, protect the workforce and a productive work environments, as well as promoting healthy life styles, etc.

Continuity and follow-up mechanisms

The series of international health promotion conferences represents the continuity in the development and advocacy for health promotion and should be firmly established by global events on a regular basis. Improved follow-up mechanisms are needed for better penetration of the progress. Experiences from WHO following the Sundsvall conference and from AMRO/PAHO after the Mexico conference provide important learning lessons in capitalizing from the outcomes.

Additional efforts are required for monitoring and evaluation of the progress by standardized mapping processes, like those established for health care systems. Key indicators and monitoring systems on health promotion infrastructures, policies and their impact, major determinants linked to health inequalities, effectiveness of strategies and methods and priorities need to be developed and implemented. The Bangkok Charter for Health Promotion draws from and build on the rich heritage as outlined above. It strongly endorses the Ottawa Charter and works along side it. It draws from the progress made through the sequent conferences and statements while address the challenges and opportunities of a globalized world. It calls for partnership and concerted action across developed and developing countries to seize the special challenges and opportunities of to-days world.

Integrating health promotion into health systems

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1. Introduction

It is a common observation in the health promotion literature that the health sector plays only a limited role in health improvement. The health care sector is often depicted as a costly, downstream, "repair shop" for sick individuals, with very little impact on the real determinants of population health

This paper fully recognises the significance of the wider social determinants of health. But it argues that health systems - seen in totality - are also critically important institutions for progressing health and human development in the 21st Century. The reasons for this include:

- Modern health care services – both preventive and curative – can now be seen to make a substantial contribution to population health status, while differential access to treatment and care contributes to the inequitable distribution of outcomes
- In many cases the greatest health gains can now be achieved through the combined efforts of population wide prevention and effective treatment of individuals, as is illustrated by strategies to reduce the burden of HIV/AIDS and control cardiovascular disease
- How health systems are financed contributes to economic security for individuals and families, and to social cohesion. The out-of-pocket cost of health care is one of the leading causes of poverty in many parts of the world
- Health systems and heath professionals can lead and coordinate change efforts in the wider society to protect health and prevent disease; examples include the role physicians have played in reducing tobacco consumption, and trauma surgeons in advocacy for road safety measures
- As a major employer, the health sector has health and safety responsibilities for a large part of a country's workforce
- Health systems connect with and impact on large numbers of people whether as patients, family members, carers, employees, community members, policy makers, suppliers, scientists, or health professionals
- Health systems consume a considerable proportion of most countries GNP
- Health care and healing are highly valued social institutions in all societies.

Alongside action on the wider determinants of health, building fair, accessible and effective health care systems is one of the major challenges now facing international development. This has been recognised in the new momentum internationally for strengthening health systems, particularly primary health care, in order to achieve the health Millennium Development Goals and other health objectives. But there is an urgent need for health systems to build capacity not only to deliver effective treatment, but to confront and reduce the range of risks[1] faced by different countries (WHO, 2002). It is in this context that the idea of health promotion playing a central and strategic role in health systems should be considered. The opportunity to consider how this agenda can be advanced globally at the 6th Global Conference is therefore timely.

Health promotion and health systems

For the purpose of the paper, health promotion is seen to encompass two main dimensions, which can be summarised as *prevention* and *empowerment*. The prevention dimension encompasses the traditional levels of primary, secondary and tertiary prevention; and empowerment describes the process of enabling people to increase control over their health and their care, and to improve their health potential at any point of the health/illness continuum[2]. While there are many perspectives on health promotion concepts and principles, prevention and empowerment are generally well-understood ideas in a health system context, and provide a tangible starting point for considering how the objective of integrating health promotion into health systems might be operationalised.

Health systems have been defined as the combination of resources, organisation, financing and management that culminate in the delivery of health services to the population (Roemer, 1991). The World Health Report 2000 provided a somewhat broader definition, suggesting that a health system includes "*all the activities whose primary purpose is to promote, restore or maintain health*". Under

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[1] An examination of these risks, their scale, and their consequences in terms of human suffering, inequities and economic cost, is beyond the scope of this paper.

[2] The second dimension derives from the Ottawa Charter definition. See also Pelikan et al (2004); and Kickbusch (2000). In a health care context, empowerment is associated with many of the concepts in the literature on self management and self care; patient-centred care; and community involvement.

this definition, the health system is seen to include all actors, institutions and resources that undertake health actions – where a health action is one where the primary intent is to improve health. Other systems and sectors, such as education or agriculture, while they may impact on health, do not have health as their primary purpose and are therefore excluded from the definition.

Health systems, for the purpose of this paper, are thus seen as comprising more than personal health care services (although these will be a point of emphasis), but not as including other sectors (although these may be a focus of health system advocacy).

Recognising diversity
In considering how health promotion and health systems intersect, it is important that the enormous diversity in context, organisation and capacity of health systems is recognised. The balance between public and private sector services, workforce supply, health insurance arrangements, and regulatory frameworks, for example, have all developed historically within particular social, economic, political contexts. For the poorest countries the imperative in many cases is the development of an effective, functioning health care system. Countries in economic and epidemiological transition, many facing a double disease burden and uneven service and insurance coverage, have different needs and priorities to industrialised countries with "mature" health systems. Strategies or templates for integrating health promotion and health systems must take account of this.

Some common factors can be identified. However they are organised, or whatever stage of development they have reached, all health systems have to perform similar functions – stewardship, financing, developing a workforce and facilities, providing health services (WHO, 2005). How health systems perform these functions and how priorities are set largely determines health system capacity for health promotion[3], and the system response to health risks and inequities overall.
This paper explores what it means to integrate health promotion into health systems, why this is important, and how it can be achieved. The paper proposes a framework for analysing health systems based on their common elements or functions, to assist in identifying opportunities and levers for change. A number of case examples of the use of different levers for change are included. A particular emphasis is given to the use of financing mechanisms to influence the integration of preventive care into health services delivery.

There are now real opportunities for connecting health promotion and health system development on a global basis. The paper is intended to contribute to the technical discussions at the Conference, to help develop a common language to inform engagement with health policy makers, and to provide some stimulus for thinking about what the elements of a global research and policy agenda on health promotion and health systems might contain.

2. Background

Until relatively recently, the connections between health promotion and health systems development have not been strong. Despite the Ottawa Charter call for "reorienting health services" as one of five domains of health promotion action, health systems have received relatively little systematic attention from the international health promotion community. At the same time, health promotion has not been high on national and international health sector reform agendas, which have frequently been dominated by economic and structural concerns.

Nevertheless, a number of important international initiatives have occurred, which provide signposts to how health systems can be organised and structured to incorporate health promotion criteria. These include:

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[3] Operationally, it is suggested that the health promotion capacity of health systems is largely reflected in the following domains of activity:

a. Performing core public health functions
b. Providing leadership for health improvement in the wider society
c. Delivering effective, accessible, patient-centred health services (with a strong focus on prevention across the continuum of care)
d. Fair financing
e. Health facilities serving as models of healthy settings, responsive to communities they serve

- The longstanding experience and achievements of the international Health Promoting Hospitals network, originally initiated by WHO-EURO
- The European Commission project *Health Promotion in Primary Health Care: General Practice and Community Pharmacy* which took a systematic, cross country analysis of health promotion in primary care
- The IUHPE report to the European Commission *The Evidence of Health Promotion Effectiveness* which included health care as one of three major settings
- Work by WHO in the Western Pacific Region involving collaboration between technical units in health promotion and health financing to produce a series of reports and workshops on health promotion financing
- The work of EQUINET, the Regional Network on Equity in Health in Southern Africa, and the Health Systems Trust in South Africa
- The technical report on *Reorienting Health System and Services with Health Promotion Criteria* prepared for the 5th Global Conference on Health Promotion in Mexico by PAHO which proposed a framework designed to support a new strategic engagement between health promotion and the international health sector reform agenda.

Many important lessons can also be learnt from achievements in countries and at the sub national level.

A new environment

In 2005, the international climate is considerably more favourable for dialogue between health systems reform and health promotion, than even a decade ago. This is illustrated by a range of recent reports and initiatives including:

- The 2004 OECD report *Towards High-Performing Health Systems*, suggested that enhanced investment in prevention was one of a number of key opportunities to further improve health, reduce disparities in health and reduce pressures on health care systems
- The 2004 UK Treasury (Wanless) report *Securing Good Health for the Whole Population* focused on prevention and public health, and generated considerable interest internationally, in part due to the report's emphasis on economic analysis
- The establishment of a Knowledge Network on Health Systems by the WHO Commission on the Social Determinants of Health
- Global initiatives such as 3 by 5, the Global Fund, the Millennium Development Goals, the Joint Learning Initiative on Human Resources for Health, the Alliance for Health Policy and Systems Research which provide opportunities to connect health promotion and the needs of lower income countries
- WHO's Global Strategy on Prevention and Control of Non-communicable Disease, and the Global Strategy on Diet, Physical Activity and Health which provide opportunities in both a developed and a developing country context.

Together these and other developments provide the basis for a new meeting ground between health promotion and health systems development.

Nevertheless, there are major challenges. Investment in prevention still faces numerous barriers. Preventive interventions are required to meet high standards of cost effectiveness. In many – but not all -- cases, the benefits of preventive measures accrue over long time frames. Decision makers are faced with a trade-off between meeting demands for care in the present as against the saving of "statistical lives" in the future. The structure of health professional remuneration or health service funding is also often not conducive to preventive activity. Addressing these barriers requires robust economic analysis, understanding of financing mechanisms and credible policy arguments.

Poorer countries face many additional challenges. For example, developing a workforce for prevention is constrained by the continuing migration of health professionals from low and medium income countries to richer countries, accompanied by the results of years of under-investment in human resources. There is a growing recognition that national poverty reduction goals will not be reached if equity of access and pro-poor policies are not given high priority in health system design. (JLI, 2004; WHO, 2003; Kickbusch, 2004).

Connecting Ottawa and Alma Ata

It is important that health promotion engages with these challenges. In the past, the Alma Ata declaration on primary health care was more important in influencing developing world health care policy than health promotion, which was often seen as a luxury for rich nations. However, in many countries, development efforts over time moved away from primary health care, in favour of vertical interventions and a centralised hospital system, with a corresponding failure to support a stable primary health infrastructure with health promotion at its core. Despite the international meetings in Mexico and Jakarta, health promotion has remained on the sidelines as these developments have occurred. The re-ascendancy of primary health care as a focus of health policy (see eg WHO, 2003) provides an opportunity to bring Ottawa to Alma Ata. Informed by more recent understandings of the dynamics of health system development, this could support a coherent global health development approach, with a core focus on equity, community participation, prevention, and intersectoral action.

Many fundamental issues in building equitable and sustainable health systems must therefore be addressed, at the same time as building health promotion capacity. The New Zealand Primary Health reforms described in this paper suggest how these issues have been tackled simultaneously in a developed country context. However, the evolving nature of many health systems in transitional economies also presents opportunities for integrating health promotion into the basic design of financing systems and health care organisation. Thailand's "30-baht scheme" (see case study) provides an example of what is possible.

3. Strategies for integration – taking a systems perspective

Because of the size and complexity of health systems, a focus on changing particular settings or services (such as hospitals) has much appeal. Yet this can overlook the connectedness of many elements of the system and the forces which can drive change, but which can equally work to maintain the status quo. In this section a framework is proposed which provides a way of thinking about health systems and which is intended to inform strategic analysis in considering priorities for integrating health promotion and health systems over the next decade.

In the Technical Paper prepared for the 5th Global Conference on Health Promotion, López-Acuña et al proposed a framework which considered a health system at two levels of operation:

- *Health Systems Development*: the institutional set-up of the health sector and the way in which the functions of the health system (steering role of the health authority, financing, insuring, and provision of services) are organized and performed, and
- *Provision of Health Services*: the design and implementation of health care delivery models, as well as the specific ways in which population-based and personal health care services are organized and managed.

The authors proposed a set of objectives and strategies at each level for reorienting health systems and services with health promotion criteria. These are given at Appendix 1[4].

The two levels are clearly interrelated, but the health systems development level drives much of the design and configuration of the health services level. As described in the World Health Report 2000, the key functions of health systems development are: (i) Stewardship (including policy development and regulation) (ii) Financing (including insurance) (iii) Resource Generation (which includes human resource development) and (iv) Service Delivery.

While oversimplified, the flow of influence can seen to be one in which stewardship and financing arrangements are the key drivers. These largely determine the nature and quantum of the health workforce, the capital infrastructure and the technologies which together form the basis of the delivery of health services.

Stewardship, financing, regulation and resource development are all key macro level levers shaping the capability of a health system. While these set the "rules of the game" and the broad context in which services are delivered, a further set of drivers and influences shape the more locally defined elements of the service delivery system. These levers and influences include accreditation, quality

[4] The objectives and strategies proposed have significantly influenced the thinking in this paper

assurance and standard setting processes; workforce development; payment mechanisms and provider incentives; health service design and management; and community involvement and participation in health service governance, service configuration and priority setting.

In considering these various elements as part of an analytic framework, it also needs to be recognised that how the stewardship and financing functions are carried out and what configuration of services they generate, are in turn dependent on a range of pressures and forces in the wider environment. As Solar et al (2004) point out, the "strength of a health system is deeply embedded in a nation's political economy". How available funding is allocated and distributed is in turn determined by the wider policy framework of the government of the day, community expectations, demography, cost pressures, the power and influence of pressure groups, and the country's health status profile, among other forces and influences.

Finally, all levels of the system are dependent on information to inform decision making. What information is collected, how it is presented, how evidence is used to inform policy, health care delivery and insurance coverage, and who has access to what information, are all contributors to the dynamics of how health systems operate.

All of these elements together shape what a health system looks like, how it performs across the various levels of prevention and care, and the balance of investment across the various structures or sectors which make up the actual delivery system. These sectors are usually broadly categorised as public health, primary health care, acute care and aged care (with further sub categories of ambulatory care, emergency care, specialist care, community care, palliative care, long term care etc). The sectors most often operate as a series of silos, which is reinforced by different financing arrangements, geographic boundaries and professional disciplines. The provision of continuity of care across the various silos in itself has been shown to contribute to improved health outcomes, and is increasingly an objective of health reforms and the movement towards patient-centred care.

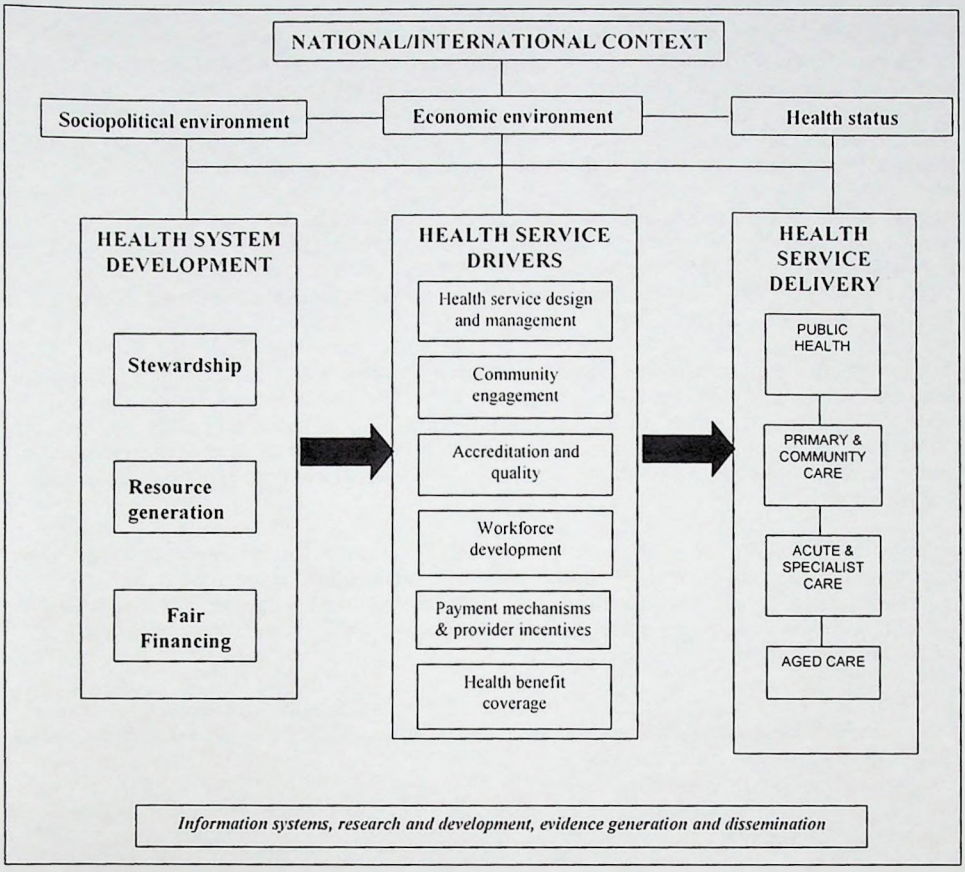
Framework for analysis

Drawing on these various levels of analysis, it is possible to describe a framework (Fig 1 below) which connects the environmental pressures and forces which set the context in which health systems operate; the key macro level functions of the health system; various levers for change; and the sectors where health care services are delivered to the populations they serve. While far from depicting the complex realities of how health systems operate[5], Fig 1 is suggested as a starting point for analysis and identification of the various levels and opportunities for integrating health promotion into health care systems.

In particular Fig 1 is intended to draw attention to the fact that attempts to build health promotion criteria and actions into specific settings or sectors in the absence of system level supports are unlikely to achieve sustainable change in organisational priorities, provider behaviour or in delivery of effective interventions.

[5] Areas not depicted include financial flows, contracting and purchasing arrangements, regulatory structures, pharmaceutical supply chains, private sector medical services, decentralised service models and many others. It should also be recognised that the tidy, linear process suggested by Fig 1 does not reflect the complexity and "messiness" of real world health system functioning and policy making. Health systems are as subject to power, political influence, special pleading, and the interplay of interest groups and policy makers, as any field of public policy. As a recent report on global health leadership notes, politics "is both inseparable from, and preliminary to policy" (OPM, 2003).

Fig 1 Integrating Health Promotion and Health Systems: An Analytic Framework



In the following section, various components of Fig 1 will be considered in more detail and examples provided of how various levers and service configurations are being used to integrate health promotion in health care in different countries and contexts. Many of the examples concern financing as this is an area where health promotion frequently meets the most barriers.

4. Levers of change: case examples

Health System Development

Stewardship
Stewardship is the function of government which includes "setting and enforcing the rules of the game and providing strategic direction for all the different actors involved". (WHO, 2000). Stewardship comprises three essential tasks: formulating health policy, and defining the vision and direction; exerting influence and regulation; collecting and using intelligence.

A sub-function" of the stewardship role with important implications for health promotion is the health sector's responsibility for "intersectoral advocacy" to promote policies and actions in other sectors for the purpose of improving health (Murray and Frenk, 2000).

The case example at Box 1 describes the New Zealand Primary Health Care Strategy which exemplifies many facets of the stewardship role. Health promotion is explicitly built into the responsibilities of primary health services.

Box 1
The New Zealand Primary Health Care Strategy

The Primary Health Care Strategy, released in 2001, set out a new direction for the development of primary health care in New Zealand. The Strategy builds on the population health focus and objectives of the New Zealand Health Strategy and the New Zealand Disability Strategy. The Ministry of Health has overall responsibility for the implementation of the strategy. The 21 District Health Boards established in 2001, are responsible for working with local communities, existing and new organisations to find the best way locally to set up Primary Health Organisations (PHOs).

The Strategy stated that over a five to ten year period, a new vision would be achieved, where:
"People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. Primary health care services will focus on better health for the population, and actively work to reduce health inequalities between different groups" (King 2001, p.vii)

In the four years since the Strategy was published, 77 new Primary Health Organisations (PHOs) have been established and more than 90% of the population have registered or enrolled in one of these. The NZ Ministry has introduced a system of capitation based funding under which PHOs and their general practices are paid according to the number of people enrolled, not the number of times they see patients. Participation by general medical practitioners in the PHOs is voluntary.

The implementation of the Strategy has required a massive transformation in the culture, architecture and financing of primary care services in New Zealand. But evaluation studies show that much has already been achieved. Continuity of care is now available for most of the people who need it. PHOs indicate that they are better able to identify and meet the needs of a known, enrolled, population. For many people, the Strategy has delivered lower fees.

In addition to personal health services, population health and community involvement are defining elements of the PHOs. Specific guidelines for PHO health promotion activities have been developed by the Ministry. PHOs are expected to demonstrate:

- Principles of health promotion practice
- How they will work together with local iwi, hapu, whānau and Māori communities to develop appropriate programmes
- How they will involve Māori and Pacific communities in the planning, development and delivery of health promotion programmes in primary health care settings.
- How they will influence the wider determinants of health and identify ways of strengthening protective factors, reducing risk factors and reducing inequalities in health.
- Partnership with affected communities in decisions about health promotion priorities, design, actions and evaluation.
- Collaboration with existing health promotion providers.
- How they align with local, regional and national strategic goals and priorities.
- How they will ensure the quality of health promotion services.

PHOs are beginning to address population health issues, with innovative programmes related to changing health determinants and identifying populations with low use of services. Improved enrolment data allow better estimation of population health need and facilitate targeting of services on the basis of need.

Sources: King, 2001; Cumming et al, 2005; MoH, 2003; Neuwelt, 2004

Financing
Financing describes the process of collection, pooling and allocation of funds for health service provision – who pays for what.

Box 2 describes Thailand's 30-baht National Health Security Scheme, which demonstrates how equitable financing mechanisms can be connected with service structures and provider incentives to integrate health promotion and preventive care into policy formulation and service delivery.

Box 2
Thailand's 30-baht National Health Security Scheme

Thailand's National Health Security Scheme (the "30-baht scheme") established in 2001, has provided all Thais with access to at least some basic medical services. Under the scheme, which now covers more than 70% of the population, a person pays just 30 baht (around 70 cents US) for a visit to a hospital or a clinic. Since the scheme was established, health promotion has increasingly been integrated into the health system's ideology and principles, and frequently takes precedence over curative care in policy formulation. Curative care still consumes the highest proportion of the health budget, but health promotion is now one of the focal points in the health care system.

The scheme explicitly includes health promotion and disease prevention in its health benefit package and per capita budget allocation. This provision reduces financial barriers for the beneficiaries to access health promotion and disease prevention services. Health care providers are paid either by fee schedule, or on a project-by-project basis, separated from the capitation payment for ambulatory care. This produces additional incentives to initiate and provide promotive and preventive care.

In addition, resources have been invested in redesigning and developing community-based services. A new form of health care delivery and organization—called a primary care unit (PCU)—has been created by integrating services of a community hospital and health centers, and forming an area-based network for providing primary care, including health promotion and disease prevention, as well as patient referral. Moreover, new workforce development programs are in progress, particularly in the areas of family medicine and community nursing. Contracted providers under the scheme are required to provide health promotion services to their registered beneficiaries. (Source: Sriratanaban, J and Thammat-aree, J, 2004)

Generating resources – health workforce development
Regulatory frameworks and educational subsidies, together with the policies of professional bodies, play a major role in determining the numbers of health professionals graduating from universities, as well as in registration, certification, and accreditation of health professions, and the requirements for continuing education. There are therefore a wide range of opportunities for health promotion criteria to be incorporated in this important group of levers.

Health Service Drivers

Health benefit coverage
The inclusion of preventive services in health and social insurance basic benefits packages is an important driver of both consumer and provider behaviour, as it reduces financial barriers for consumers, and ensures providers are reimbursed for delivering preventive care. This can be an important strategy for reducing health inequalities, provided low income consumers are covered by insurance.

Payment mechanisms
As referred to elsewhere, appropriate payment mechanisms can create financial incentives for health care providers to initiate and provide health promotion and disease prevention services. There are a number of ways in which providers can be remunerated with varying impacts on the extent of preventive care services delivered. According to Liu and O'Dougherty (2004), these include:

- Global Budget
- Fee For Service
- Capitation
- Salary

- Preventive Service Account
- Periodic Health Visit Fee
- Performance-Related Pay

An example of how a careful blend of payment mechanisms can help to change practice among providers and patients is shown by the *Australian General Practice Immunisation Incentives Scheme* (Box 3).

Box 3
General Practice Immunisation Incentives Scheme (GPII)

This Scheme was established under the "Immunise Australia" plan by the Australian government in 1998 to promote immunisation for children under seven years old. The scheme provides an "incentive payment" to GPs upon their report to the Australian Childhood Immunisation Register (ACIR) that a vaccination series has occurred (whether or not directly provided by the GP), and a quarterly "outcome payment" to GP practices that achieve a 90 percent immunisation rate for children under seven in their practice. The program also supports immunisation infrastructure at local, state and national levels.

Additional incentives for parents were introduced in 2000 by making certain means-tested government benefits contingent upon compliance with recommended immunisation schedules. The Maternity Immunisation Allowance is payable for children from 18 months of age when all recommended vaccinations have been recorded on the ACIR, and the Child Care Benefit (helping low-income families with childcare costs) is available only when immunisation for children under seven is up-to-date. In both cases, a child may be deemed exempt from immunisation if medically contraindicated, or if the parent has a "conscientious objection".

A series of evaluations of GPII revealed that the average childhood immunisation rate in GP practices increased from 73 percent in August 1998 (when the program began) to 92 percent in November 2003. Practices achieving the target of 90 percent coverage increased from 12 to 78 percent over the same period. While the program was viewed as highly successful in meeting its immediate goals, it is also significant to note the evaluators' finding that the scheme had, more generally, "promoted a population health perspective among GPs encouraging them to think about aggregated data, health promotion and disease prevention". (Case study provided in Steiber, 2005).

Health services design and management
Almost all facets of a health service can play a role in supporting health promotion, from the layout of facilities, to policies on smoking. Modes of service delivery, hours of access, networks with other services, referral arrangements, outreach services and many other dimensions can act as supports or barriers to health promoting actions. Box 4 gives an example of the integration of health promotion in hospital emergency departments, an area most commonly associated with intensive, acute interventions.

Box 4
Health Promoting Emergency Departments Program
This Program operates in the emergency departments (EDs) of seven suburban hospitals in Victoria, Australia. The goal of the program is for EDs to improve the health of individuals and communities by organizational approaches to health promotion. While the immediate need for people presenting to emergency departments is in most cases the need for urgent acute medical treatment, there are many opportunities for health promotion in such areas as: the provision of opportunistic screening and early intervention programs for alcohol abuse, domestic violence and women's cancers; asthma education; health information for parents who are high users of emergency paediatric services; and injury prevention through surveillance and follow up (Bensberg and Kennedy, 2002)

Accreditation and quality
Accreditation is recognised as a process for influencing quality improvement and can be an important driver to integrate prevention and health promotion in health service settings. Accreditation can act both as a learning and regulatory tool. Box 5 describes the particular approach of the Thai hospital accreditation program.

Box 5
Quality improvement as a driver – the Thai hospital accreditation program

Accreditation standards set requirements on how health care is structured, provided, monitored and improved. An accreditation decision about a specific health care organization is made following a periodic on-site evaluation by a team of peer reviewers, typically conducted every two to three years. Normally, accreditation is a voluntary process. Nevertheless, accreditation programs in certain countries are encouraged by law, or set as requirements for providers under national health insurance schemes.

Health care accreditation programs can be important drivers for integration of health promotion in health services. This can be done through incorporation of health promotion criteria in accreditation standards, surveys, hospital consultation visits, and learning networks used to support improvement processes.

In Thailand, a hospital accreditation program has been used as a tool to promote health promotion activities in hospitals, and to encourage certification as "Health Promoting Hospital". The project, which began in 2003, is conducted by the Hospital Quality Improvement and Accreditation Institute (HA-Thailand), with collaboration from the Department of Health, Ministry of Public Health and supported by ThaiHealth. The accreditation program and quality improvement networks of HA-Thailand are used to encourage more health promoting activities by hospitals in a systematic manner, and as a learning forum. To date, more than 30 public and private hospitals have been accredited, and hundreds of others are underway. Furthermore, the hospital accreditation standards have been revised and explicitly stated requirements related to health promotion activities that should be provided to different target groups, including patients and families, staff members and communities. (Prepared by Jiruth Sriratanaban)

Workforce development
Workforce development at the health service level provides important opportunities for integrating health promotion principles and expertise into organisational practices. In-service training and continuing professional development, provide important areas for health promotion-related knowledge and skills development in existing staff, and recruitment policies can help ensure adequate numbers and an appropriate mix of staffing and skills in the organisation. Investment in health services research to identify what drives success in this area could help inform future efforts to build workforce capacity.

Community participation and empowerment
Community engagement is potentially a driver of health service responsiveness, alongside other benefits. The NZ Primary Health Care Strategy provides an example of how community participation ideals can be operationalised (Box 6).

Box 6
Involving communities in New Zealand's Primary Health Organisations

Under the Primary Health Care Strategy, PHOs are expected to involve their communities in their governing processes and to show they are responsive to communities' priorities and needs. This expectation is built into the Ministry's Minimum Requirements for Primary Health Organisations which states:

"The District Health Board (DHB) must be satisfied that community participation in PHO governance is genuine and gives the communities a meaningful voice. In addition, DHBs will require PHOs to show how they respond to their communities."

To support PHOs in their approach to community participation, a Community Participation Toolkit has been developed. A key aim is to effectively engage the enrolled population of the PHO. The Toolkit also provides specific guidance for working with Māori:

- Demonstrating respect for tikanga (Māori practices & cultural identity) in the PHO's processes, such as how meetings are run
- Demonstrating respect for tikanga in clinical care, such as involving whanau in health decision-making
- Offering services in the community and making home visits available
- Employing and supporting Māori staff, including kaiawhina (community health workers)
- Allowing access to te reo
- Keeping the cost of services affordable

How community involvement evolves is a work in progress. The first year evaluation of the implementation of the Strategy reports that the community appeared to be 'well represented at board level in PHOs.' However in some PHOs there was concern about medical dominance and many informants were clear that communication with the community was in its early stages. A community council comprised of representatives on PHO boards was established in early 2005. The Council will advise the Deputy Director General (Clinical Services) on how to ensure communities have a say in the development of PHOs and the further implementation of the Primary Care Strategy.

Source: Neuwelt, 2004; Cumming et al, 2005

5. CONCLUSIONS: WHERE TO FROM HERE?

Future progress on the integration of health promotion and health systems, will require health promotion to focus more directly on the terrain of health policy and financing, and to develop a more strategic analysis of the dynamics of health system development. This is a challenge for health promotion capacity.

However, as the above examples attest, substantial experience in integrating health promotion into health services has been accumulating over many years. Some initiatives are more recent, and evidence of impact and effectiveness is only starting to emerge. Clearly however, there is a rich body of knowledge and practical experience to draw upon. These examples and strategies need to be shared and drawn together to inform future engagement with health system reform. In particular, it is important to share the "behind the scenes" details of how initiatives gained policy traction and funding support, how they are financed, and the management and organisational arrangements that make them happen. These provide insights into the nuts and bolts of change which are rarely captured in the published literature.

Drawing on the framework presented above, the case examples, and the previous Technical Paper prepared for the Mexico Conference, some specific opportunities and strategies for the integration of health promotion and health systems can be identified. Overall, the various levers and strategies collapse into around eight focus areas, a number of which encompass action at the policy and service levels. These are:

- Policy and leadership
- Budget and financing
- Health service design and management
- Accreditation, quality and accountability
- Health workforce development
- Community engagement, partnerships and advocacy
- Health services as health promoting settings
- Research and information systems

These focus areas could be considered by Conference participants as a starting point for discussion on future strategies. Checklists of indicators for each area will be provided at the Technical Discussions. Barriers or enablers for each will be considered in the light of different contexts, and implications for countries at different stages of development. The focus areas or their

subcomponents could then be refined or added to as a result of this analysis. A final listing generated by the Conference might provide the basis for a strategic programme of research and analysis to be established as one of the Conference outcomes.

The Conference provides a major opportunity to formulate how a new global research and policy agenda on health promotion and health systems could be constructed. A programme of work could be developed jointly between, for example, IUHPE, WHO, and the European Observatory on Health Systems and Policies, with close connections to the Health Systems Knowledge Network of the Commission on the Social Determinants of Health, the proposed Health Systems Action Network and the Global Forum for Health Research.

The programme of work could establish a process of engagement with health policy experts and practitioners, financing specialists, comparative health systems researchers, political scientists, health services researchers, legislative experts and others to help inform understanding and analysis of the drivers of change (political, financial, cultural, organisational) in health systems and to formulate new strategies and approaches based on this analysis. The programme would also build on lessons from the health promoting hospitals initiatives, work on health literacy, the evidence of health promotion effectiveness, health promotion financing and other experiences.

The programme could equip health promotion with enhanced analytic tools, arguments, and objectives, to inform a dialogue with international agencies, governments and policy makers. This dialogue could contribute to a range of international processes, including on-going initiatives by WHO, OECD and other international agencies in health system policy development, service delivery, health system performance, health financing and social protection, primary care development and health human resources strategies. In particular consideration could be given to the development of a health promotion Core Technical Framework to feed into the health systems strengthening "road map" developed at the WHO Montreux Challenge meeting (WHO, 2005). The Core Technical Frameworks are intended as "investment guides" for use by international development partners.

These steps would provide a basis to better align health promotion and health system development and help forge a reoriented global health agenda for the 21st Century.

Appendix 1
SUMMARY TABLE
OBJECTIVES AND STRATEGIES FOR REORIENTING HEALTH SYSTEMS AND SERVICES

OBJECTIVES	STRATEGIES
HEALTH SYSTEMS DEVELOPMENT	
1. Define, implement and evaluate Essential Public Health Functions as part of the responsibilities of the steering role of health authorities. 2. Induce financing and resource allocation practices that give priority to the development of public health infrastructure and to the lines of action aimed at reorienting health care delivery with health promotion criteria. 3. Incorporate the contents of reoriented health care delivery models into the basic portfolio of entitlements of social and private insurance schemes.	1. Advocate and facilitate dialogue and consensus between stakeholders in order to expand consensus on need for reorientation and to maximize resources for promotion. 2. Incorporate objectives of reorientation of health systems and services into resource allocation and payment mechanisms, linking payment to health outcomes when possible. 3. Develop public health infrastructure and evaluate the performance of essential public health functions. 4. Include health promotion criteria in regulatory mechanisms, such as certification, licensing and accreditation of facilities, provider networks, health professionals and insurance plans.
PROVISION OF HEALTH SERVICES	
4. Change the composition and balance of the type of health care, and incorporate promotion and prevention as an integral part of the health care delivery model. 5. Incorporate advocacy of health promotion principles in health service management models. 6. Ensure sensitivity to needs and expectations of specific sub-groups in the community, including gender and age differences, as well as religious, ethnic and other cultural determinants. 7. Engage individuals in the process of informed decision making about their own health and that of family members.	5. Improve responsiveness and technological capacity of health care as a necessary prerequisite for establishing social legitimacy of services from the viewpoint of the population. 6. Increase the relative importance of points of entry to the health care system, and establish programs with primary health care providers that assume responsibilities for patients, families and communities and help them navigate their way through the system. 7. Strengthen health promotion component in human resources development programs, both in academic institutions and continuous education of health professionals. 8. Promote consensus among experts on clinical prevention guidelines, eliminating ineffective practices, and train, supervise and evaluate implementation of guidelines. 9. Ensure that organizational conditions facilitate implementation of guidelines, including strategies for modifying provider practices. 10. Improve communication between providers and patients, as well as health services and the communities, in order to increase effectiveness and utility of actions. 11. Create mechanisms that establish formal commitment and co-responsibility between services and individuals and communities, including community feedback mechanisms.

Source: Lopez-Acuña et al (2000) p6

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"Integrated Health Promotion Strategies: A Contribution to Tackling Current and Future Health Challenges"

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Introduction

The world is much more interconnected that it was in 1986 when the Ottawa Charter was created, and the emerging issues of today are more global than those that we faced in the past. For example, demographic shifts on a global scale, environmental changes, new infectious diseases and violent conflict compound the difficulties we face from existing issues such as persistent poverty, mental illness, chronic diseases and health disparities. In order to meet these existing and new challenges, health promotion needs to celebrate its successes, build partnerships, and emphasize the strategies and corresponding actions that will carry us into the 21st century.

The field of health promotion has a key role to play in addressing the future through the Ottawa Charter strategies. Over the last 20 years, these health promotion strategies have been refined and evidence has been accumulating about their effectiveness. This paper describes what we know about the effectiveness of health promotion strategies and makes suggestions for the emphasis that is required as we move into the 21st century.

Health Promotion Strategies and Actions

The strategies described in this paper are taken from four of the five key Health Promotion action areas identified in the Ottawa Charter - building healthy public policy, strengthening community action, developing personal skills and creating supportive environments. Reorienting health services is not addressed here because it is addressed independently by another background paper.

A framework has been developed for the purpose of this paper to organize the many actions that have emerged over the last 20 years in association with the Ottawa Charter strategies. These actions have been divided into three levels – the structural, the group, and the individual levels (See Table 1). As we developed this framework, we suggested that the Ottawa Charter strategies fit naturally into these three levels:

- Building Healthy Public Policy is mainly at the structural level;
- Strengthening Community Action is mainly at the social/group level;
- Developing Personal Skills is mainly at the individual level; and
- Creating supportive environments is a necessary action at all three levels.

This interpretation of creating supportive environments as key at all three levels is consistent with the Sundsvald Statement on Supportive Environments[1]. After almost 20 years of experience however it is clear that this strategy needs greater emphasis and is supported by the evidence presented in this paper and the case studies described.

Table 1: Health Promotion Strategies, Actions and Levels at which they occur

Level	Strategy	Examples of Key Actions Associated with Each Strategy
Structural Level Health Promotion Strategies (Strategies & actions that operate at or require action at the policy or political level in organizations, governments, or multinational organizations)	Building Healthy Public Policy	- interorganizational partnerships or intersectoral action - invest in government and social policies - create legislation and regulations and organizational practices - create standards and benchmarks for success for a country or region as well as develop the funding mechanisms to encourage sub-regions to achieve the standards - advocate, lobby, negotiate, and mediate
	Creating Structural Environments to Support Health	- create healthy settings (e.g. municipalities, schools, workplaces) - build partnerships as a key component of healthy settings approach - address social norms, access to goods and services, sustainable environments - address determinants of health (including physical environment and peace-building) - health communications (e.g. social marketing)
Social Group Level Health Promotion Strategies (Strategies & actions that operate at the community level or require individuals to act collectively)	Strengthening Community Action	- community level interorganizational partnerships and intersectoral action - invest in civil society and social capital - participate in decision-making at all levels - community development and community mobilization actions
	Creating Social Environments to Support Health	- build coalitions and partnerships to engage in political action and social movements - invest in local action with participation of community members - create and revise community, social and neighbourhood norms - communications about the process - increase tolerance for cultural differences and reduce conflict
Personal Behaviour Level Health Promotion Strategies (Strategies & actions that promote behaviour change by focusing on the individual)	Developing Personal Skills	- focus on lifestyle factors and other skills that are important for health (e.g. literacy, life skills, job training) - health education and health communications
	Creating Environments to Support Healthy Personal Decisions	- create policies that create access to information or resources - create policies that limit access to harmful substances (e.g. alcohol or tobacco) - shift societal attitudes or norms

Effectiveness of Health Promotion Interventions, Strategies and Actions

In this section we outline some of the key findings of reviews that have assessed the effectiveness and cost-effectiveness of health promotion interventions. These reviews are aimed at addressing a variety of health issues and social determinants of health that are related to chronic disease, The Millennium Development Goals and emerging health issues. We consulted eight reviews written in the last six years on the effectiveness and cost-effectiveness of health promotion interventions. There is a significantly larger body of published evidence assessing the effectiveness and cost-effectiveness of chronic disease, and particularly non-communicable diseases and their risk factors. We chose this selection of reviews because together they reflected not only health promotion initiatives addressing non-communicable diseases, but also health promotion interventions addressing other areas of chronic disease (i.e. mental health and injury), other health issues (i.e. HIV/AIDS and maternal and child health) and various social determinants of health (i.e. poverty, food security and nutrition)

The following reviews were consulted for this paper:

- A review by Hoffman & Jackson (for World Bank) completed on effective and cost-effective interventions focusing on the prevention of major non-communicable diseases and the reduction of their associated risk factors, including not only "lifestyle" risk factors such as tobacco, physical activity and nutrition, but also health determinants associated with non-communicable diseases such as poverty and food security[2]
- Garrard et al's review (Australia) outlining the findings of reviews of the cost-effectiveness of health promotion interventions targeting cardiovascular disease and diabetes prevention[3]
- A review of mental health promotion strategies by Hosman & Jane Lopis (for IUHPE), which outlines how mental health promotion interventions can be effective not only at addressing mental health, but also at addressing a variety of other health issues and health determinants[4]
- Svanstrom's (IUHPE) review of injury prevention and safety promotion interventions[5]
- A review of food and nutrition programs in Europe (IUHPE) by Schuit et al[6]
- A review by Ross (Canada) of programs and interventions aimed at alleviating poverty and improving the health of people experiencing poverty, including initiatives aimed at improving maternal and child health[7]
- Warren's (IUHPE) review of health promotion interventions targeting disenfranchised youth, which explores the effectiveness of addressing high risk behaviours for contracting HIV/AIDS[8]
- Hills et al (Canada - CCHPR) review of the literature of different community intervention approaches[9]

All reviews used established criteria for ascertaining quality of the studies reviewed. Although several of these reviews aimed to be international in focus, or to focus on specific regions of the world other than North America and Europe, the majority of the reviews outlined above relied solely or heavily on evidence of the effectiveness of health promotion interventions in North America and Europe. Many of the authors of these reviews noted that, although they attempted to find evidence from other parts of the world, little or no evidence, at least in the English literature, was available.

Key Lessons about the Effectiveness of Health Promotion Interventions, Strategies and Actions

The cited reviews of evidence for the effectiveness of health promotion interventions showed that overall interventions using health promotion strategies and actions are effective and cost-effective at preventing and addressing a wide variety of chronic diseases and their associated risk factors, as well as health determinants. One strategy "Strengthening community action", however, showed the need for more evidence in this area.

Seven key lessons can be drawn from the common findings and conclusions of these reviews:

1. Investment in building healthy public policy is a key strategy

Reviews of health promotion interventions addressing several issues and determinants identified the creation of healthy public policy as a key strategy. Key actions include investment in government and social policy, the creation of legislation and regulations, and intersectoral and interorganizational partnerships and collaboration. In some cases, evidence suggested that the creation of healthy public policy was the strategy for which the most evidence of effectiveness exists (e.g., legislation for road safety and social policy for income security and poverty reduction). Reviews of the effectiveness of health promotion interventions addressing poverty and injury prevention illustrate the central role healthy public policy and its actions play in promoting health.

Ross's review of programs aimed at alleviating poverty and improving the health of people experiencing poverty found that little research existed on the effectiveness and cost-effectiveness of programs addressing poverty and health inequities. A major challenge for determining the effectiveness of programs targeting poverty and health inequities is that many interrelated risk factors are involved, which poses difficulties for both the implementation and determining the effectiveness of interventions. Ross was however able to find some evidence regarding the effectiveness of government policies. The extent to which poverty is reduced is directly related to how much is spent. In a study of 12 countries, poverty was reduced by 30% to 80%, depending on government spending levels. The evidence found by Ross clearly shows that creating healthy public policy,

specifically through government development and spending in social policy areas such as income security and employment, is effective in reducing poverty[7].

In Svanstrom's review of injury prevention and safety promotion interventions it was found that in preventing road injuries, educational activities alone were not very effective. Community programs that involved local participation and policy and legislative change have been very effective.
It concludes that health promotion is very effective in preventing injury as well as being cost-effective. Settings-focused Safe Community programs which addressed multiple safety issues, involved multiple sectors and organizations (government and non-government), targeted individual behaviour, social support and environmental factors, and used multiple strategies including policy development and legislation, were extremely effective. Legislation has been shown to be the most efficient way to prevent some injuries, such as making bicycle helmets mandatory[5].

Hoffman and Jackson's review found legislation and enforcement around tobacco use, advertising and sales, to be key parts of successful tobacco programs, and taxation was shown to be most cost-effective for reducing smoking[2].

2. Supportive environments need to be created at all levels

Several reviews point to creating supportive conditions and environments as a strategy that is essential in order to ensure that other strategies are effective (see Table 1). This includes implementing a variety of actions that represent supportive conditions at several levels which is demonstrated by reviews on health promotion programs addressing HIV/AIDS for at-risk youth and maternal and child health.

Warren's review found that successful youth health promotion strategies addressing high risk behaviours must address the social and economic conditions that lead youth to be at high risk. Key to the success of interventions was making behaviour change accessible, including the availability of instrumental supports such as condoms, and psychosocial and emotional supports such as counselling, peer counselling, outreach and life skills training. Effective interventions not only aimed to change behaviour among at-risk youth, but also addressed societal perceptions of youth by targeting a variety of stakeholders, including parents, professionals and community leaders[8].

Hosman & Jane Lopis' review of mental health promotion programs found that mental health promotion interventions have improved maternal and child health and reduced pre-term delivery and low birth weights, as well as reducing teen pregnancy. Central to effective mental health promotion is the creation of positive individual, social and environmental conditions[4]. Ross' review of poverty-related interventions found that several programs focusing on prenatal nutrition were effective at reducing low birth weights. Key activities created supportive environments at a variety of levels – by providing instrumental supports such as food vouchers or supplements, group support, nutritional education, counselling and home visits[7].

3. Effectiveness of Community Action is unclear and requires further evidence.

The eight literature reviews included as part of the Hills et al paper on "Effectiveness of Community Initiatives to Promote Health" agreed that community interventions have had mixed results. Although their impact in terms of behaviour change has ranged from modest to disappointing, they have achieved more success in terms of community and systems change[9].

In Svanstrom's review of injury prevention and safety promotion interventions, it was found that in preventing road injuries, educational activities alone were not very effective, but community programs that involved local participation, and policy and legislative change actions have been very effective[5].

Garrard et al's review of health promotion interventions targeting cardiovascular disease and diabetes prevention identified that while specific large scale programs using multifaceted community based interventions were often effective, they generally failed to produce substantial change at the population level over and above improvements occurring in the general population[3].

Before deciding that community action is not effective as a health promotion strategy, it is necessary to remove other possible explanations, such as a lack of appropriate indicators, evaluation protocols and qualitative systematic review criteria for assessing community interventions. This is an area that requires further investigation and is the target for intensive efforts in Latin America, Canada, Europe, and the Cochrane

Collaboration to name a few. Another area of investigation that shows promise is community network analysis. This work is shifting concepts of community from communities of place (geography) and interest to network-oriented, less concrete bonds that are nonetheless very powerful for driving initiatives of empowerment and capacity building, important foundations to health promotion[10].

4. Personal skills development must be combined with other strategies for effectiveness

Many reviews of health promotion effectiveness showed that developing personal skills (including the actions of health education, health communications and training and skills development) was an ineffective strategy if implemented in isolation from other strategies. This is particularly true when interventions are aimed to address disadvantaged groups and communities of low socio-economic status. Central to the effectiveness of personal skills development is the need to also implement strategies that create structural-level conditions to support health. Specifically, it is essential to address the material needs of disadvantaged groups by increasing access to goods, products and services that can improve quality of life. This is shown by reviews on health promotion interventions addressing non-communicable disease, food security and nutrition, and HIV/AIDS.

Hoffman and Jackson found that people of low socio-economic status are unlikely to participate in lifestyle interventions, and are more likely to participate in initiatives that will lead to a noticeable improvement in people's quality of life in the short-term. For example, interventions aiming to improve indoor air quality in homes, or to increase food access and quality are more likely to be effective with low-income groups. In addition, non-communicable disease interventions using a variety of diverse strategies and actions to address socio-environmental conditions were shown to be more cost-effective than those focusing solely on individual behaviours and lifestyles. For example, taxation was shown to be most cost-effective for reducing smoking, and increased access to better stoves or cleaner fuel was cost-effective to improve indoor air quality[2].

Both Schuit et al's review of food and nutrition programs in Europe[6] and Hoffman & Jackson's review of food security interventions and recommendations[2] found evidence that food security and nutrition interventions that focus on the most disadvantaged groups are most effective, but that it is essential in these interventions that the life realities of people, including the barriers to accessing nutritious food, are considered and addressed. According to both reviews, food interventions are more likely to be effective when they produce tangible short-term benefits, such as increasing access to food (through income generation or food access activities) or better-tasting food[2,6].

Warren's review of health promotion strategies addressing high risk behaviours that put youth at risk for contracting HIV/AIDS and other health issues found that successful interventions address not only the health issues, but also the social and economic conditions that lead youth to be at high risk. Key to the success of interventions was the provision of motivations to change behaviour (including peer education, communications strategies, support and training) and making the products and services needed to achieve the behaviour change accessible (such as providing free access to condoms, counselling and clean needles)[8].

5. Partnership development and cross sectoral action on multiple determinants of health and risk factors is a key to success.

Health promotion interventions that effectively address various health issues and determinants tend to work across a range of sectors (including health, education, social services, employment, agriculture, municipal planning, transportation and development), and effective interventions often address multiple determinants of health and risk factors. Coalitions and partnerships that work across sectors are key to the effectiveness of interventions addressing multiple determinants of health.

Hoffman & Jackson's review of food security interventions and recommendations illustrates the importance of working across multiple sectors. They found that interventions focusing on increasing food security in two Latin American countries were effective and cost-effective at reducing the proportion of malnourished people to below 5%. In addition interventions that work across a range of sectors that focused on increasing food production, increasing access to food (through income generation, agricultural support and food aid programs), increasing the nutritional value of foods, increasing the nutritional quality of diets, and promoting more nutritious diets can improve people's food security. Thus, food security interventions were found to be more effective when they operate across and involve the collaboration of various sectors, including health, education, agriculture and development[2].

Hosman & Jane Lopis, in their review of "mental health promotion" strategies, found that there is significant evidence showing that health promotion interventions are effective in having a positive influence on mental well-being and quality of life. In addition they address a variety of other health determinants and risk factors, and are cost-effective. Effective health promotion interventions aimed at improving mental health have been shown to have a variety of positive impacts on physical health outcomes, risk factors for non-communicable disease and communicable diseases, and health determinants in addition to preventing and managing mental illness. Physical health impacts include improving maternal health and healthy child development, reducing low birth weight and pre-term birth, reducing brain injuries and reducing the contraction of HIV/AIDS. Mental Health risk factors that have been affected by effective health promotion include decreased substance abuse, tobacco use and unsafe sex practices. Health determinants that have been impacted include increased academic achievement and lower school drop-out rates, increased and better employment and less unemployment, and the creation of increased social support and more supportive social attitudes and environments. The authors found that effective mental health promotion interventions operate at the personal and social/group levels, involving multiple activities and addressing multiple life factors, to create positive individual, social and environmental conditions, thereby enabling people to enjoy positive mental health and enhanced quality of life[4].

6. Interventions employing multiple strategies and actions at multiple levels are most effective

Reviews of health promotion interventions working on a wide range of health issues and health determinants conclude that the most effective interventions employ multiple health promotion strategies, operate at multiple levels (often including all of the structural, social group and personal levels), work in partnership across sectors, and include a combination of integrated actions to support each strategy.

Reviews of interventions focused on non-communicable disease provide a strong case for employing multiple strategies and actions at multiple levels. Garrard et al's review of health promotion interventions targeting cardiovascular disease and diabetes prevention asserts that the most effective non-communicable disease prevention and health promotion approaches operate at all levels, involve the collaboration and partnership of organizations in multiple sectors, and use multiple strategies[3]. Similarly, a key finding of Hoffman and Jackson's review was that effective and cost-effective interventions for primary prevention of non-communicable disease used a combination of health promotion strategies at various levels in multiple settings[2].

Specifically, Hoffman and Jackson found that interventions that were shown to be effective at reducing tobacco use, increasing physical activity, preventing cardiovascular disease and increasing food security involved a combination of health promotion strategies occurring at the personal, community and structural levels. For example, comprehensive tobacco programs in several states in the US have led to significant decreases in smoking in the population. These effective combinations of strategies included developing healthy public policy, creating structural and social conditions to support health and developing personal skills. Key health promotion actions that were part of these strategies included policy development, legislation, taxation, increasing access to food, increasing opportunities for physical activity, health education, health communications, lifestyle and skill-building. These comprehensive approaches used multiple strategies at multiple levels, and included actions such as legislation and enforcement around tobacco use and sales, media campaigns, supporting local public health agencies, community-based prevention programs and school-based education for youth[2].

7. Certain actions are central to effectiveness

Key health promotion actions that were identified in several reviews as being central to the effectiveness of interventions include:

- *Intersectoral collaboration and inter-organizational* ***partnerships*** *at all levels*:
  For example, in Svanstrom's review of injury prevention interventions it was found that the most effective programs involved multiple sectors and organizations, including various government departments and non-governmental organizations and groups, as well as local stakeholders[5].

- *Community participation and engagement in planning and decision-making*:
  For example, Warren found that in order for youth health promotion strategies addressing high risk

behaviours to be effective and relevant, interventions need to engage at-risk youth to participate in the development and delivery of interventions, and need to target a variety of stakeholders, including parents, professionals and community leaders[8].

- *Creating healthy settings, particularly focusing on the settings of schools, workplaces and cities, communities/municipalities*:
  For example, Hoffman and Jackson found schools, workplaces and municipalities to be effective settings for many interventions addressing non-communicable diseases and their risk factors, because they provide opportunities to effectively reach large numbers of people with sustained interventions. Schools can reach many children directly at a critical time in their lives, while workplaces can reach adults on a daily basis over a long period of time and have been shown to be cost-effective settings for interventions for both employers and employees. Municipalities offer great potential to effectively address a variety of health issues and determinants based on the municipal governments' responsibility for key areas that affect people's lives, including urban planning, recreation, transportation and aspects of health. The healthy cities and communities movement offers examples and important lessons on how municipalities can address multiple health determinants, risk factors and health issues through a settings approach[2]. A key component of the settings approach is the formation of collaborations, partnerships, and coalitions.

- *Political commitment, funding and infrastructure for social policies*:
  For example, Ross' review finds that creating healthy public policy, specifically through government development and spending in social policy areas such as income security, is effective in reducing poverty[7].

These critical actions are represented as cross-cutting actions in Table 2 – actions that need to occur at the structural, social and personal levels and that need to be implemented in conjunction with all of the major health promotion strategies of the Ottawa Charter.

Table 2: Health Promotion Strategies, Levels and Cross-Cutting Actions

Levels	Structural		Social/Group		Personal Behaviour	
Health Promotion Strategies	Building Healthy Public Policies	Creating Structural Environments to Support Health	Strengthening Community Action	Creating Social Environments to Support Health	Developing Personal Skills	Creating Environments to Support Healthy Personal Decisions
Key Cross-Cutting Actions	Intersectoral Collaboration and Inter-organizational Partnerships					
	Participation and engagement in planning and decision-making					
	Healthy Settings (e.g. Healthy Schools, Healthy Workplaces, Healthy Municipalities)					
	Political commitment, funding and infrastructure for social policies					

8. Contextual relevance is essential

Most reviews used for this paper stressed the importance of ensuring that health promotion interventions are only effective when they are made relevant to the context in which they are being used. This includes awareness of the social, cultural, economic and political context; the capacity and development of infrastructures and systems in key sectors such as health, education and government; and the life realities of particular target populations or communities.Contextual differences are particularly important to consider when attempting to apply findings on health promotion effectiveness in developing countries, as the majority of the reviews discussed above relied solely or heavily on evidence of the effectiveness of health promotion interventions in North America and Europe. Many reviews stressed the importance of ensuring that the goals, strategies and actions of any intervention were relevant and appropriate to the people they aimed to reach and the systems they aimed to work within. Several reviews pointed to the active participation and engagement of community members in planning and decision making as a key health promotion action that could help to ensure that an intervention was appropriate to its context, and therefore effective.

Summary of Key Lessons about the Effectiveness of Health Promotion Strategies

1. Building healthy public policy is a key strategy;
2. Supportive environments need to be created at all levels;
3. The evidence of effectiveness of community actions is unclear and requires further evidence;
4. Personal skills development must be combined with other strategies for effectiveness;
5. Partnership development and cross sectoral action on multiple determinants of health and risk factors is a key to success;
6. Interventions employing multiple strategies and actions at multiple levels are most effective;
7. Certain actions are central to effectiveness:
   - Interorganizational partnerships and intersectoral collaboration
   - Participation and engagement of citizens in planning and decision-making
   - Healthy settings
   - Political commitment, funding and infrastructure.
8. Contextual relevance is essential.

Case Examples of Current Initiatives

To further illustrate the power of integrating several health promotion strategies at the structural, social and personal levels, some case studies were drawn from different parts of the world and focus on different topics or audiences. These particular cases were selected because evaluation information was available or because the process and outcomes were well documented. Key to the success in all case studies was partnership development. They are described very briefly below and each case demonstrates the effectiveness of partnerships at a different level - international, national, regional and local.

International Level Case example: WHO Framework Convention on Tobacco Control
The Framework Convention on Tobacco Control is the WHO's first convention and came into effect on February 27, 2005. As of that date, 168 countries have signed the convention and it has been ratified by the national governments of more than 50 countries. The lengthy 12-year process to develop the FCTC required a partnership between WHO, UN bodies, governments, NGOs and academia. The country negotiating teams were examples of intersectoral collaboration by including members from a wide range of government departments, such as health, tax, finance, economics and trade, development and planning, foreign affairs, treaties and law, commerce, customs and sometimes the tobacco companies. The convention includes a range of policy measures such as legislation requiring health warnings on cigarette packets, creation of smoke-free areas, bans on tobacco advertising and promotion, provision of cessation services, increased tobacco taxes and a crackdown on smuggling. The process of developing the FCTC has had several advantages - governments were encouraged to take action ahead of the finalization of the Convention, health ministries became more politically mature, and awareness was raised among other government ministries[11].

National Level Case example: The Canadian Tobacco Control Strategy
The Canadian tobacco control strategy continues to involve preventing the uptake of smoking, facilitating smoking cessation among smokers and protecting the public from second hand smoke. Key health promotion actions that have been and continue to be part of this comprehensive program include coalitions-building; national policies to ban tobacco advertising on television and sponsorship of sports and arts events; legislation and enforcement around where tobacco can be sold, as well as its use and sales to minors; taxation and increasing the price of tobacco products; media anti-smoking and second-hand smoke campaigns; school-based education for youth; providing free access to cessation information, support and counselling as well as subsidizing nicotine replacement therapies in some areas; and local municipal by-laws banning smoking in public places and workplaces. Such comprehensive tobacco programs have shown to be effective, as have specific aspects of these initiatives such as increasing tobacco prices through taxation[3].

Regional Level Case example: Youth for Health in Ukraine Project
In 1998 the Youth for Health Ukraine-Canada (YFH) project was launched, funded by the Canadian International Development Agency and managed by the Canadian Society for International Health. The initiative aimed to address the large and increasing percentage of youth in Ukraine demonstrating at-risk behaviours by empowering youth, promoting healthier living and behaviours, and emphasizing gender equity and youth involvement. The Ukrainian Institute for Social Research as the lead organization built partnerships with ministries of health, education, and family and youth, another research institute, the Kyiv City Government, and a youth nongovernmental organization. When they adapted their project model in the regions, the Institute worked mainly with different levels of government and youth NGOs. The mutual collaboration of all partners has been key to the success of the project model. The project's activities have included intersectoral partnerships, the development and implementation of an integrated health education curriculum in schools; developing a training program for service providers who can promote youth health; involving youth and practitioners in designing educational materials, resources and programs to promote healthy youth behaviour; and evaluation of the strategies and research on youth behaviour, existing law and policy on youth health, and media influence on youth. The work of the project has led to strong public and political support at the national level for a national health promotion policy, and improvements in the quantity and quality of youth health promotion policies and programs at national, regional and local levels[12].

Municipal Level Case example: Reforming Bogota, Colombia
To improve citizens' health and well-being and reduce rising crime rates, the Mayor of Bogota, Colombia, Dr. Antonus Mockus, in 1995 initiated actions that required the involvement of all government departments and active citizen engagement. To make citizens feel safe, lighting in public places was enhanced, traffic in the centre of the city was reduced, 'safe women only' nights were organized, and police officers were retrained in appropriate law enforcement practices. To reduce traffic, the cost of parking was increased, car free days were encouraged, and a new public transport system was built. Other reforms included modifying hours of operation for bars and entertainment places and improvements to city water and sewerage services. In order to promote a culture of treating one another with respect, artists and street performers were involved, and positive behaviour by citizens was publicly rewarded and promoted (e.g. good taxi drivers were identified by citizens). Intersectoral collaboration under the leadership of the mayor was an important component. As a result of these actions and reforms, Bogota saw a reduction in homicide rates from 80 per 100,000 inhabitants in 1993 to 22 per 100,000 in 2003. Traffic fatalities dropped from an average of 1,300 a year to 600. The cities' water consumption dropped, public transportation usage increased and driver behaviour improved[13].

Local Level Case example: Mobilizing men as volunteers in Southern Africa AIDS Trust
The Southern Africa AIDS Trust began as an initiative of the Canadian Public Health Association and the Canadian International Development Agency. It is now an NGO that aims to increase the HIV competence of communities though supporting community agencies. For example, Word Alive Ministries International is a church-based community organization in Malawi which found that as their home-based care work for people with HIV/AIDS and TB developed, 40% of their home care clients were men but all their HBC volunteers were women and cultural barriers limited the ability of female volunteers to meet the needs of male clients. To address this, they had to use a combination of strategies which included breaking down myths and stigma about care work and HIV/AIDS for men by showing local men in action, involving community leaders to identify potential male volunteers, and providing training, support and supervision to counteract gender stereotypes. Some of the preliminary additional benefits from this mobilization of male volunteers are that it reduces unhelpful gender stereotypes, increases the acceptance of condoms among men, and decreases the stigma associated with volunteer care work for men[14].

In summary:
- The WHO Framework Convention on Tobacco Control focused particularly on intersectoral partnerships and action;
- The Canadian Tobacco Strategy focused particularly on intersectoral action at the policy level;
- The key to success for the Youth for Health in Ukraine project was mutual collaboration of partners at all levels of government and the involvement of youth;
- In Bogota, the focus was on positive community action and political commitment and investment;
- The Southern Africa AIDS Trust focused on community action taking the local cultural context into account.

These case studies are not in-depth analyses but brief illustrations of how multiple intersectoral strategies, especially including partnership building, operating at the individual, community and structural levels are critical for success.

Conclusions and Recommendations

The four health promotion strategies from the Ottawa Charter addressed in this paper have been shown to be effective tools to address many of the issues we faced in the 20th century (e.g. addressing and preventing chronic and communicable diseases, and addressing lifestyle determinants). These same four health promotion strategies are still relevant and important, in addressing the emerging health challenges of the 21st century but need to be strengthened and some other successful key health promotion actions need to be given more prominence.

1. Although "creating supportive environments" is a major strategy in the Ottawa Charter, attention needs to be given to the fact that it is actually three strategies at three different levels (see Table 1 and 2). Its importance receives more emphasis if it is explicitly discussed in conjunction with each of the three other Ottawa Charter strategies, particularly at the structural level.

2. Some of the strategies that are weakly referred to in the Ottawa Charter should be given more prominence given the evidence of their effectiveness. They exist as cross-cutting actions that are required at all levels of health promotion (see Table 2), specifically:

- Interorganizational partnership building and intersectoral collaboration at all levels;
- Participation and engagement of all people in decisions that affect their lives;
- Healthy settings as places where comprehensive strategies that involve multiple actions and partnerships that occur at multiple levels;
- Political commitment, funding, infrastructure for a broad range of social policy and health promotion actions.

In conclusion, the world is much more interconnected at a global level than it was in 1986 when the Ottawa Charter was created, and the emerging issues of today are different than those that we faced in the past. Based on the past success of health promotion strategies in addressing social determinants and health issues, it seems that health promotion strategies have great potential to address the emerging health issues. The Millennium Development Goals with their emphasis on the determinants of health can be seen as an opportunity for action and building new partners in health promotion.

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The role of independent health practitioners in health promotion

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Abstract

Access to prompt, needs driven, comprehensive and quality health services is one of the fundamental and important determinants of health.

Independent health practitioners can contribute both to health care and to health promotion activities in developing and developed countries.

Independent health practitioners can be general medical practitioners, midwives, dentists, nurses and other health workers, faith healers, traditional healers and informal health providers.

But the reality is that a great proportion of people mainly in developing countries, don't have access to prompt and comprehensive primary health care and there is evidence that independent health care providers in some contexts are more frequently used than those of public sector for disease management. In Swaziland 85% of the people use traditional healers and the ratio of traditional healers to patients is approximately 1:100.

Another problem is that most of the encounters between practitioners and clients don't include health promotion advice.

There are several strategies governments are experimenting to engage independent practitioners in promoting health and improving health outcomes like contracting, regulation and standard setting, information dissemination and training. Other strategies like encouraging community workers and traditional healers to cooperate with public services as a mean to improve access and health outcomes has already been experimented with success. Also when talking about independent practitioners like general practitioners and nurses, incentives and training to improve health promotion and prevention during encounters is also necessary.

There are few experiences clearly described, monitored and evaluated and more research is needed on existing experiences to improve the use all the resources available.

Governments should develop appropriate strategies, sensitive to the cultural and socio economic context, to encourage health promotion by independent practitioners and cooperation between public and private sectors.

Introduction

Independent health practitioners can be general medical practitioners / family physicians, midwives, dentists, nurses and other health workers, faith healers, traditional healers, community health workers and other informal health providers.

In several European countries (Germany, Austria, Belgium, Denmark, France, Nederland's, Italy and United Kingdom) and Canada, General Practitioners/Family Physicians are independent providers that contract with the Public Health Service (8).

Independent Health Practitioners and Access to Care

A great proportion of people mainly in low income countries don't have access to prompt and comprehensive primary health care and there is evidence that independent health providers are more frequently used than those of public sectors for disease management.

In Swaziland 85% of people use traditional healers and the ratio of traditional healers to patients is approximately 1:100, whereas that of modern trained doctors and nurses combined to patients is 1:2000 (1)

In Vietnam 60% of all outpatient contacts are provided by the private sector (2).

In Sub – Saharan Africa, faith based organisation have provided care for AIDS in the last twenty years with large staff of outreach workers, home and community health workers (3)

Spending on private health services and medications represent more than one half of all health spending in Latin America (some 3.5% of the region GDP) and until recently public health policies have rarely addressed that challenges or opportunities represented by this segment of health sector (4)

Cross countries analysis suggest that as countries get richer, they spend more in health care, and the government share grows larger. The OCDE countries including Canada, spend 7-8 per cent of GDP while China, Sri Lanka, Indonesia, Philippines and Thailand are spending between 2-5 per cent of GDP.

The governments share in total health spending ranges between 70-90 per cent in OCDE countries and Canada while in several South East countries the percentage ranges from 50-65. (5)

The way money is spend and health system is organised is also important for access to primary comprehensive care and access to preventive and health promotion services, health outcomes and level of population health.

One example is India that spends about 6% of GDP in health care which is a high spending for the region. Nevertheless compared to India a person lives longer by 11 and 12 years in China and Sri Lanka respectively even if these countries have the same per capita incomes in terms of international dollar.(5)

One of the problems is that Indian government spends far less on preventive and health promotion services whereas the proportion is as high as two thirds in China and Sri Lanka. Moreover out of the total curative spending 75% is on secondary and tertiary care in urban areas and very little money is going for rural areas where the majority of population resides. (5)

Another example is United States of America (USA) that in spite of spending more money on health than any other country of the world ranked 15:25 in population health status among industrialized countries . The problem seems to be a weak and poorly organised primary care sector, the gap between the rich and the poor and the well known deficiencies in health insurance that don't cover all the population. Another problem seem to be the overuse of diagnostic and therapeutic interventions, that makes the health care system in USA the third most common cause of death after cancer and heart disease.(6)

So the way the health system is organised and the priorities of health spending (in primary care, secondary or tertiary care) influences the access of people to comprehensive health care meaning health promotion and prevention and also curative care.

In low income countries whereas private provision of health services tends to be larger because public health services are poorly developed governments seldom have clear lines of policy towards private sector (7).

Independent health practitioners and health promotion

Another problem besides the access to primary health care is the fact that most of the encounters between practitioners and clients don't include health promotion advice.

A recent literature review made in Canada, but including international medical literature (9) showed that:

- Few family physicians routinely counsel patients on regular physical activity.

- Physician counselling on physical activity can influence patient behaviour in the short term.

- The most frequently cited barriers to counselling are time constraints , lack of financial incentive, lack of standard protocols, lack of success in counselling role and lack of training.

- Training in physical activity counselling increases the frequency of counselling and physicians confidence in this role. Trained health care

professionals, such as nurses, have taught health promotion effectively, including physical activity counselling.

A Cochrane Systematic Review of effectiveness of "Physicians advice for smoking cessation" revealed that brief advice from doctors versus no advice (or usual care) could lead to a small but significant increase in quitting for six months or more (http://www.cochrane.org/reviews/en/ab000165.html)

A study in Toronto, Canada, that wanted to assess to what extension Family Physicians perform preventive activities recommended by the Canadian Task Force on Preventive Health Care (CTF) for people older than 70 years showed good to fair compliance on screening for smoking, alcohol use, nutrition, exercise, blood pressure measurement and tetanus and influenza immunization, but poor compliance with vision and hearing screening. CTF recommends abandoning traditional annual checkups in favour of age and sex specific opportunistic screening, but this study found that patients who had structured periodic health examinations had much higher levels of screening that patients that where screened opportunistically (10).

Another study about the frequency and adequacy of brief health behaviour advice about exercise, diet and wheat loss during adult primary care visits showed that discussion about those issues occurred in 56% of observed visits and were initiated by the physicians. Advice infrequently included offer of assistance (14-17%) or plans for follow up (3-10%). So the contents of advice rarely included recommended components that could increase health behaviour change (11)

In many developing countries, traditional practitioners are a very important resource to improve access to health promotion and prevention and also to some basic treatments if trained appropriately.

There are several experiences of training traditional healers in different countries, that showed that they are willing to work in primary care and able to establish good working relationships with other modern health staff (12).

The skills taught range from promotion of education in local health problems; promotion of balanced diet and breast feeding; promotion of safe water supplies and basic sanitation; promotion of women and child health and family planning, training in basic delivery techniques, referral for abnormal delivery and distribution of oral contraceptives; promotion of immunization against major infectious diseases referring children to clinics; promotion and control of locally endemic diseases like diarrhoea, tuberculosis, malaria, malnutrition, leprosy, and treating some of these common diseases and provision of essential drugs.

In Nepal the local faith healers plaid a culturally appropriate and cost – effective role in health education and family planning and they were paid modest fees by the people for their services. It was estimate that there were 100 such healers for every health worker, so their inclusion in health promotion

and prevention could improve dramatically access to comprehensive care at low cost and in a culturally sensitive manner (12).

The importance of partnership with independent health practitioners

Promoting effective partnership for health is fundamental not only within the health system but also with other community services like social services, housing and education services, but also with communities, families and patients, tackling social determinants of health to achieve better health outcomes(15) (16).

Involving independent health practitioners in tackling the social determinants of health can include actions like:

-Screening and providing simple information and referral to relevant service units for patients and families with poor social economic profiles.

-Working in deprived areas

-Partnership with local community and welfare services for joint up program in tackling social determinants.

-Identifying, providing treatment, counselling services and proper referral for patients suffering from stress, anxiety and social isolation

-Ensuring safe pregnancy and providing preventive services as well as clinical management for pregnant women, neonates and young children to ensure a good start in life. (17)

Strengthening partnership with communities and improve access to care is happening in AIDS programmes where people with AIDS and other members of the community are trained to provide comprehensive care including treatment to people with AIDS. These health care workers are more effective if they provide not only advice, information, health prevention and promotion but also treatment with anti -retroviral medication (3). The WHO report said that investing in AIDS treatment and prevention through trained community health workers and health professionals also offers the chance to build up health systems in the poorest countries, providing benefits for all in the future.

Some experiences show that, with supervision, HIV/AIDS treatment programmes based on community health workers are able to maintain quality. Supervision is effectively provided by regular meetings, simple forms that facilitate reporting and feedback and willingness of health professionals to engage with communities (13) (14).

A strategy used in China since 1960 when health care resources in villages were very limited was to train villagers to become health care workers. Suitable candidates from villages received one or two months of training and became "barefoot doctors".

The barefoot doctors walked around the village they served carrying with them a box containing simple medications, syringes, stethoscopes and thermometers for providing simple medical services to villages. For illness they were not familiarized with, they would refer them to hospital.

They were very well received by the public since they provided easy access to first contact care and also very important they did not pose a significant burden in financial resources to the government.

In 1980, China had 140 million of barefoot doctors and one or two barefoot doctor in each village (18).

Experience of contracting to engage independent practitioners in health promotion and prevention

Allocating more funds to rural and deprived areas and improving recruitments and retention of health professionals for these most needed areas is essential for equity and access to care.

Contracting with independent providers for health services has been used as a mechanism to increase quality and coverage, lower costs and reduce administrative burden:

Research on contracting for health services in developing countries has, however, shown mixed results. (19).

In India when comparing public services with private services it was found that the quality was better in private for some aspects like cleanliness and lower for others like dietary services (20).

Contracting preventive services in Madagascar and Senegal was successful in providing nutrition services for poor groups, decreasing severe and moderate malnutrition. Community nutrition workers were contracted to provide growth monitoring of children; education sessions to women, referral to health services for children and pregnant women, home visits and food supplementation to malnourished children (21).

The management unit for the implementation of this project that was done by an NGO, cost 13-17% of the total budget and this can be a constraint to the replication of similar projects (19).

In Cambodia contracting was successfully applied to increase access to child health services like immunization, family planning, antenatal care, nutritional support and curative care for diarrhoea, ARI and tuberculosis. Utilization of services such as immunization and antenatal care improved for the population that used contracted services compared to the control group, which used services provided by public services.

A potential constraint to replication of this project is that contracted districts received more resources than the government districts and people working in contracted services had higher salaries than public professionals (22) (23).

In many countries, the lack of capacity to manage and supervise the contracting process is cited as a major obstacle and this task can be done by NGOs, donor organisations, professional associations and other intermediate actors, but that usually also must be paid by the government.

Maintaining the quality of health promotion is also an important task of governments.

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcome and are consistent with current knowledge (24)

Experience of regulation to engage independent health practitioners in health promotion

Regulation and standard setting is used to improve the quality of care provided. Registration and licensing of health professionals and other health workers, legislation against dangerous practices, accreditation of health facilities and staff all have been used to improve quality.

Supporting mechanisms like information dissemination and training, development of clinical protocols and promotion of self regulation, are essential to promote quality and to achieve the defined health priorities.

In China since 1985, the Ministry of Health decided all "barefoot doctors" were required to attend examination. If they reached the standard they would become "village doctor". Since 1995 the Government have adopted a number of initiatives to improve the quality of village doctors work deciding that all village doctors needed to receive two or three years of formal training and attend an examination at the end, so they would received a practising certificate. Also local health authorities asked every year all village doctors to undertake examination. If they failed they were not allowed to practise anymore. From 2000 onward central government encourage the village doctors in higher standard quality to attend a National Examination in medicine and surgery to further enhance their capacities. If they passed they were fully qualified doctors and could also work in cities.

Besides providing curative care, village doctors also deliver immunisation, health education, maternal and child care and other preventive services.

Central government set out standards and mechanisms to regulate and monitor the quality of village doctor work.

Let's take Weifang City of the Shandong Province as an example. The city now has 9510 villages accommodating 648 million people. Within these villages, there were 12000 village doctors serving in 5120 clinics. On average, there are 2-3 village doctors per clinic and 2 village doctors per 1000 villagers. Under conjoint efforts in the past 10 years, the whole city now has 85% of village doctors reaching the standard of medium level. Ninety percent of our village doctors have the "practising certificate for village doctors" accredited by the Central Government. Nearly all village doctors work full time. The village clinic also provides 24 hours clinical services for ensuring that villagers can receive medical care any time.

With the build up of quality assurance and regulatory mechanisms and also providing appropriate training health of villagers in rural China is now better protected (18)

Existing evidence show that information and training should addressed not only providers but also consumers, because consumer expectations influence provider practices.

It is also necessary to find innovative and different ways of disseminate information like one-on-one meetings, case review and discussing with practitioners with negotiating agreements to change practices followed by monitoring and informal training among others, because traditional classroom teaching alone has only limited success.

Various examples in Pakistan, Indonesia, Kenya and India demonstrate that these strategies work (25), (26), and (27) but as private providers are extremely heterogeneous, it is important to identify priority changes and local strategies that work.

Aligning organisational structures and incentives with the objectives and priorities of health policy is a central task for the governments.

Monitoring is needed to assess behavioural change in the right direction, and the effect of different types of contractual relationship with independent providers (7) Experimentation and local adaptation will be necessary, so research and evaluation are important to support good decisions.

Research have shown that inadequate resources are often allocated to monitoring and enforcing regulations, and results of regulatory practices in developing countries are mixed (23).

Strategies for the future

Strengthening participation and partnership with the independent health practitioners are one of the ways to sustain the health promotion efforts, especially for engaging them in tackling the social determinants of health. For instance, independent health practitioners can have the roles in this areas by screening, providing simple information and referral to relevant service units for patients and families with poor social economic profiles; working in deprived

areas and in collaboration with local community and social welfare services for joint up program as well as identifying, providing treatment, counseling services and proper referral for patients suffered from stress, anxiety and social isolation.

In high income countries, reorientation of health priorities from curative to preventive care and health promotion is very important, redirecting resources from wastage and dangerous interventions like over – prescribing, overuse of diagnostic technology and excessive intervention.

Providing incentives to health promotion and prevention services is expected to achieve change in that direction.

Before implementing any strategy it is important to recognize the diverse forms of private provision of health care, number and types of providers and patterns of utilization of their services by the population.

Developing effective ways of communicating with the different groups of private and independent providers is also important.

In order to move towards higher quality of care a better information base on existing provision is required (7).

Setting priorities and defining a benefit package which should be available to all, including those in private schemes, and which should reflect local disease priorities and cost – effectiveness, is fundamental for equity and access to care for all including the most vulnerable. (7)

Strengthening the capacity in primary health care versus specialist care is important and redistributing resources to enable an equitable provision of health care workers among different areas necessary.

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Health Impact Assessment and the Globalization Challenges

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eg pesticide policy, water issue in Thailand

Abstract

Globalization can bring several health opportunities, as well as, several health risks to the world population. These opportunities and risks are dynamically intertwined in socio-economic and political processes, leading to the great difficulty in developing healthy policy options. What mostly needed is the capability of our societies in screening, analyzing, protecting and developing the healthy public policies as recommended in the Ottawa charter.

Health impact assessment (HIA) provides a conceptual idea and tool to help our societies in understanding the consequences of our choices and selections on the health of our population and, in reaching the healthier policy options. The practices from several countries show that, as a social learning process, HIA can bring different societal values, types of evidence, and methodological approaches into public discussions and policymaking process through several institutional mechanisms, which, in several cases, turn into constructive policy processes and positive health outcomes.

However, to deal with the globalization challenges, HIA needs further development in terms of the practice, institutionalization, and empowering of social learning process from local to international levels. It is also importance to link HIA with other sustainable development goals and movements to reach greater impacts of re-orienting globalization towards a more healthy human face.

Since the 1st International Conference for Health Promotion almost twenty years ago, the world health community has asserted the importance of inter-sectoral commitment and action

to improve health determinants of populations in the efforts to ensure the ultimate goal of "Health for All". At the 5th Global Conference for Health Promotion in 2000, however, it was agreed that "high-sounding, general calls to improve social responsibility for health are not sufficient to stimulate action" (Banken, 2003).

In the 1990s, a global process of economic integration and expansion has taken off and rapidly accelerated around the world. Today, globalization is no longer simply an economic phenomenon. It also drives cultural trends, influences national politics, challenges traditional notions of state sovereignty, and reshapes societies (Ludicina, 2005). It is, therefore, not excessive to postulate that globalization affects the determinants of health of the entire world population in many, frequently complex ways. The main question in this section of the paper is how the world health community can deal with the, often dramatic, adverse effects and new opportunities in an ever more complex world that has become harder to govern.

This paper will focus on health impact assessment (HIA) as an important mechanism for the health sector to address the globalization challenges. HIA is closely related to the concept of healthy public policy, which facilitates and enhances societal capacities to influence policy directions towards protecting and promoting the community health status. Clearly, globalization is an irreversible process, but its direction can be reoriented to give it a more human face. This paper reviews and analyzes actual practices of HIA around the world, in order to assess its potential and its limitations, and to design strategies where health promotion is pursued through the formulation of healthy public policy in the context of globalization.

Globalization and Health

In the media headlines, HIV/AIDS, SARS, and avian flu may raise high public concerns over the links between globalization and health. These health phenomena are, however, only the tip of the iceberg. The main health impacts of globalization are not related to the prospect of rapidly emerging microbes, but more to the significant changes of environmental and social health determinants around the world.

On the one hand, facilitating international trade has stimulated economic growth in many countries. For various parts of the developing world globalization has also reduced the sense of isolation. It has brought technological advancement, better infrastructure and educational progress within reach of large numbers of people around the world. Globalization tangibly contributes to raising concerns and awareness on environmental and human-right issues (Stiglitz, 2002).

On the other hand, as a result of the globalization process the determinants of health can deteriorate in several ways. First, it has become more difficult for governments to safeguard people's socio-economic conditions, including unemployment, inflation, commodity price fluctuations, unsafe and unhealthy working conditions and so on. Regulatory frameworks are under pressure from the need for increased competitiveness and dwindling public sector

resources to enforce them. Secondly, the pressure of global economic competition on natural resources can lead to environmental deterioration, natural disasters, exposure to toxic chemical, water and air pollution, vector-borne and other infectious diseases, accidents and injuries and the psycho-social disorders resulting from the dependency on a depleting resource base (Mc Murray and Smith, 2001).

Thirdly, changes in lifestyle and social structures resulting from the globalization process have been shown to lead to a rising incidence of non-communicable diseases, including heart disease, diabetes, cancers and mental disorder. Fourthly, the clash between the new global values and traditional values may cause social tensions in several communities. In several places around the world, these tensions have led to conflicts and violence (Barber, 2004). Lastly, the ability of the health sector to take care of their populations also crucially depends on the macroeconomic policy framework in each country, especially with respect to global liberalization and national welfare policies.

Therefore, globalization brings many health opportunities as well as many health risks to the world population. Normally, these opportunities and risks are dynamically intertwined in socio-economic and political processes, making the formulation of healthy policy options a great challenge. The impacts on health of these opportunities and risks are also interrelated, often through complex mechanisms. This is reflected in the complexity of health promotion and protection options. Importantly, these opportunities and risks are, as a rule, distributed unevenly within and between societies, leading to long-term social tensions and greater inequality.

Healthy Public Policy

In the period when the risk margins of our economies, the fragility of our ecosystems and the fragmentation of our societies are on the increase, the health and livelihood of billions of people are under threat. Therefore, the greatest need at present is for our societies to have the capacity to screen and analyze their development policies and projects, and, to select, develop, incorporate and nurture health safeguards to help protect and promote health.

The concept of healthy public policy, which is highly relevant in the context of health promotion, was introduced in the Ottawa charter for Health Promotion (WHO, 1986). Healthy public policy aims to create a supportive socio-environmental framework to enable people to lead healthy lives. Since our societies are complex and interrelated, healthy public policy must link economic, social, ecological and health issues into integrated development strategies and actions. At the same time, a healthy public policy should assign high priority to underprivileged and vulnerable groups within societies (WHO, 1988).

The core idea of healthy public policy is to put health on the agenda of policy-makers in all sectors and at all levels, so they are aware of the health consequences of their decisions, accept their responsibilities for health and strengthen their links with the health sector on

relevant issues. It is important to identify obstacles to the adoption of healthy public policies in non-health sectors, and design ways to remove them.

In addition to the government responsibilities, the Ottawa charter (WHO, 1986) also stresses that "health promotion is a process of enabling people to have control over, and to improve their health". This means the empowerment of communities – their ownership and control of their own endeavours and destinies - should be at the heart of any healthy public policy strategy.

Healthy public policy is, therefore, one of the key concepts for every society to protect and promote the health of its population, by integrating health dimension, in a more upstream fashion, into processes of policy formulation, adjustment and harmonization and into broader sustainable development goals, and, at the same time, by empowering people to have more control over their health, lives and destinies.

HIA and Health Promotion

A commitment to healthy public policy means that governments, at national and local levels, must measure the health impacts of their policies in a consultative way and communicate their findings to communities and societies. A systematic assessment of the health impact of a rapidly changing environment is equally essential and must be followed by action to ensure positive benefit to health of the public (WHO, 1988).

In line with this idea, Health Impact Assessment (HIA) was initially developed as a main tool to consider health consequences in all policymaking. HIA has been defined by WHO Regional Office for Europe. (1999) as "a combination of procedures, methods, and tools by which a policy, programme, or project may be judged as to its potential effects on health of population, and the distribution of those effects within the population".

The primary output of HIA is "a set of evidence-based recommendations geared to informing decision-making process" (National Institute for Health and Clinical Excellence, 2005). The fundamental goal of HIA goes beyond just providing information, "the aim of HIA is to achieve changes in policies and proposals so that they support better health and reduce health inequalities" (Taylor *et al.*, 2003). In other words, HIA tries not only to predict the impacts of policies, programmes, and projects, but also to influence the political decision-making process on the basis of its findings and processes (Parry and Wright, 2003).

HIA, therefore, has its own specific role, compared to other tools in health promotion. HIA aims to provide a mechanism to achieve the engagement of other sectors in health promotion through the assessment of and recommendations for inter-sectoral actions. In pursuing this goal, HIA needs to address changes in health determinants "upstream" in the planning process, in order to find health opportunities and to avoid health risks in development. Furthermore, since HIA focuses the distribution of health impacts, HIA also helps identify and protect disadvantage and vulnerable groups in the societies. Therefore, HIA can provide more cost-effective options and measures than typical curative health sector interventions. In other

words, HIA can show how healthier policy solutions are also more attractive investment options.

HIA, in this sense, fits in a larger frame of best practice for sustainable development planning, as presented by the World Commission on Dam (WCD, 2000) in the case of dams. HIA, therefore, should be recognized as the bridge for integrating health dimension into development and planning processes, and at the same time, as the window for the health sector to participate more pro-actively and meaningfully in wider public and private spheres of development.

HIA Development in the Recent Years

In the development of HIA in recent years two different approaches can be distinguished. The first approach is project-oriented and evolved from environmental impact assessment (EIA) (Kemm, 2003). This approach, was initially promoted by the WHO in the 1980s to address neglected health considerations in conventional EIA.

The second approach evolved from the concept of "healthy public policy". Although the idea of policy impact assessment on population health is not new, the emphasis on the relation between impact assessment and decision-making is (Kemm, 2003). In 2000, at the 5th Global Conference on Health Promotion, HIA was proposed to be "a device for forcing relevant bodies to take action in favour of healthy public policy" and "a potential catalyst for inter-sectoral action for health" (Banken, 2003).

This approach is based on the socio-environmental model of health, which considers wider determinants of health including individual, social, economic, and institutional factors. This approach has grown popular in industrialized countries, such as Canada, the UK, Sweden, and the Netherlands (Ahmad, 2004). Concurrently, some developing countries, like Thailand, have also played an active role in developing strategic HIA (Phoolcharoen *et al.*, 2003). Recently, it has been applied to raise public awareness and address health inequalities, and has been called equity-focused health impact assessment (Mahoney *et al.*, 2004).

HIA Methodological Development

Although there is no fixed, formally agreed model of applying HIA, there is a developing consensus about core elements or stages of the HIA process. In general, HIA process followed the same steps as those in EIA and Strategic Environmental Assessment (SEA). The HIA method applies a wide variety of tools; for example, literature reviews, epidemiological modeling of risk, mapping, key informant interviews and focus groups to elicit community views and perceptions. As it is such a new approach, it is difficult to determine the most appropriate combination of tools for a specific setting. In practice, the flexibility of applying tools depends very much on what is being studied and the possibility for inter-disciplinary co-operation. This is a strength of HIA. As stressed by Taylor and Quigley (2002), there continues to be a need for further methodological development, to make it both "universally accessible" and appropriate for "any users or groups" of HIA practitioners.

Although the main goal of HIA is to provide evidence-based recommendations, in reality, evidence can also be complex because of the interrelationship between different health determinants and the causal pathways. Moreover, it is difficult to isolate the influences of particular policy interventions on complex and dynamic social systems. Therefore, when predicting health impacts in complex situations, it needs to be understood as "the prediction of tendencies and types of impacts" rather than absolute measures (Taylor and Quigley, 2002).

Underpinning Principles of HIA

From the recent HIA practices in various countries, these following underpinning principles and values of HIA have been reflected and summarized by National Institute for Health and Clinical Excellence (2005) and European Policy Health Impact Assessment (2004) and turned to be guiding principles for new HIA studies;

- **Democracy**: HIA should assert and promote the right of people to participate in the formulation of policies that affect their lives through representatives and direct public involvement.
- **Equity**: HIA should aim to reduce inequality by assessing the differential distribution of health impact across the population.
- **Ethical Use of Evidence**: HIA should identify and use the best available quantitative and qualitative evidence from different disciplines and methodologies.
- **Practicability**: HIA should be designed to be appropriate for time and resource available and the recommendations should also be appropriate for the societal resources and contexts.
- **Collaboration**: HIA should promote the shared ownership with different stakeholders and inter-disciplinary viewpoints in its process and support the integration into public policy processes in different levels.
- **Comprehensiveness**: HIA should emphasize on the wider determinants of health or a broad range of factors from all sectors of society which can affect on health of population.
- **Sustainability**: HIA should assert and emphasize the sustainable development principles and goals as a core element of healthy society.

HIA and Policy-making

Although HIA has a clear aim to influence policy making, the early version of HIA assumed a linear process with a direct link between impact assessment and decision-making process. For example in Australia, Mahoney and Durham (2002) found that the links between policy development and the usefulness of HIA were not explicitly made in many HIA studies. In other words, in these studies, HIA has developed "without real consideration of the political and

administrative frameworks within which it has to operate" (Mathers *et al.*, 2004). Therefore, Kemm (2003) found that many HIAs failed to communicate to the decision-makers or to be policy-relevant, or arrive too late to influence decision-making.

Later versions of HIA tended to emphasize decision-making structures and political processes (Taylor *et al.*, 2003). This requires the HIA process to fit with decision-making rules and procedures (Phoolcharoen *et al.*, 2003 and Bekker *et al.* 2004). Some studies and guidelines also suggest that HIA studies are most likely to inform decision-making, if the decision-makers own the assessment and are closely involved in all stages of HIA (Kemm, 2003). However, this may be difficult to reconcile with the principles of openness and transparency. In numerous cases entrusting HIA to policy-makers could be dangerous, especially in developing countries as presented by Jobin (2003).

The review from UK experiences shows that several HIA studies can successfully influence policy-making such as in formulating mayoral strategies for London (Opinion Leader Research, 2003) or in urban development projects (Taylor *et al.*, 2003). The key to success is apparent in terms of strong political commitment, participatory processes of different stakeholders and finding effective ways in fitting a non-statutory assessment into a statutory planning framework. The importance of an enabling institutional infrastructure has been emphasized in several HIA reviews such as Banken (2003) and Phoolcharoen *et al.*,(2003).

Since policy-making, in reality, is subject to a much fuller range of influences, it can be difficult to establish a cause-and-effect relationship between the HIA process and subsequent policy decisions. Therefore, the success of HIA should not necessarily be evaluated as a one-off event, but more as "a continual effect that brings change in organizational thinking about health and subsequent decision-making" (Mathers et al., 2004). This viewpoint asserts the importance of long-term involvement in the development of healthy public policy (Sukkumnoed, 2003).

HIA Institutionalization

As mentioned by Bartlett (quoted by Banken, 2003), "impact assessment does not influence through some magic inherent to its techniques or procedures. More than methodology and substantive focus, what determines the success of impact assessment is the appropriateness and effectiveness in particular circumstances of its implicit policy strategy". Therefore, the integration of HIA into existing procedures and roles for policy-making, which is usually known as institutionalization, is crucial to create a firm basis for healthy public policy in the longer and broader term .

Institutionalization is, however, very complicated process with many uncertainties. While institutionalization in theory provides an opportunity for health aspects to become a routine part of policy-making, without appropriate design and quality control, HIA can become an inefficient process with merely a symbolic function in a bureaucratic environment, as seen in generic impact assessments in a number of countries (Banken, 2001).

Recently, HIA institutionalizations have taken place in different countries. Canada has developed HIA within the EIA legal framework supported by a comprehensive guideline for EHIA and close technical collaboration between the Ministry of Health and Ministry of Environment (Kwiatkowski and Ooi, 2003). In various parts of UK, political commitment to the health agenda provides a window of opportunity for public health agencies to institutionalize HIA together with the development of technical and practical aspects (National Institute for Health and Clinical Excellence, 2005). The Netherlands has developed an institutional framework to fit HIA in the legislation process and annual budgeting (Netherlands School of Public Health, 2000). Thailand has developed HIA as a part of national health system reform with the strong support from social movements within the country. (Phoolcharoen *et al.*, 2003).

Although the best institutionalization strategy for each country depends on its own political, administrative, and economic contexts, there are always some key aspects to be considered. To improve and maintain HIA effectiveness in a policy system, it is necessary to design and invest in quality control mechanisms, adequate provisions for external accountability and technical support systems for HIA implementation and its development (Banken, 2003).

HIA as a Social Learning Process

Based on the above principles, values and practices, it is clear that HIA has not been developed as yet another technical tool, but rather as a tool for "social learning". By positioning itself as such, HIA can bring different societal values, types of evidence, and potential societal resources into the public debate, which, in various cases, consequently turns into constructive processes and positive health outcomes (Sukkumnoed, 2003).

The opportunities for public involvement in the impact assessment of policy formulation is probably the main advantage of HIA as a health promotion tool. Through their participation people can learn about their attitudes and practices and change them, in relation to various upstream health determinants. This process can also promote the sense of responsibility and self-esteem. At the same time, it can work as conflict resolution mechanism (Nuntaworakarn, 2003) and provide room for marginalized groups to raise societal concerns over health determinants, their health status and their destinies. The participatory process, which enables non-health actors to generate relevant public health knowledge, can also re-orient power relationships with and between professional decision-makers (Parry and Wright 2003 and Banken 2001).

So far, there has been no comprehensive evaluation of HIA in this manner. Perhaps it is too early for such a judgment. However, if the potential for social learning process can be achieved, HIA marks a great step forward for our societies to strengthen our own capacities to protect and promote the health of all members of society in a more risky and complicated world.

HIA and Globalization Challenges

While globalization has been making great leaps, supported by powerful political and economic forces, for over a decade, HIA is just a small step in raising societal concerns and capacities to protect and promote our health. There is no reason for direct comparison between HIA attempts and globalization forces. However, the impacts on human health and risks of globalization will urge our societies and governments to pay more serious attention towards healthy lives and, therefore, healthy public policy.

HIA, therefore, provides a fertile ground for nurturing our societal capacities in developing healthy public policy. Like other impact assessments, its effectiveness in supporting healthy public policy formulation does not depend on some kind of methodological magic, but more on its underpinning values and constructive process of involving health and affected, but previously unheard, stakeholders into public policy debate and decisions.

The future does hold great challenges. Good operational principles are far from adequate. It is important to turn principles into the actual practice, locally and nationally, which, inevitably, will have to face severe limitations in our knowledge and insufficiently uncontrolled political, economic and administrative structures. The appropriateness of its implicit policy strategies, including institutionalization and empowering social learning process, in each societal context will determine the ultimate success of HIA.

Concurrently, to re-orient the globalization process and open it for more health concerns, the other challenge is to move HIA a step forward, towards a meaningful participation in international and global policy. The number of international policies and trade issues, which cause negative health impacts in the developing world, such as dumping of unhealthy food from developed countries to the Pacific islands, the export of radioactive and other hazardous wastes to several developing countries, job losses due to trade diversions from free trade agreements, should be reconsidered through HIA process. This certainly will follow Adelaide recommendations on healthy public policy (the Second International Conference on Health Promotion 1988), which stressed, "the developed countries have an obligation to ensure that their own policies have a positive health impact on developing nations".

Although it is so obvious that HIA attempts alone cannot change powerful globalization track, the strategy is to link HIA with other sustainable goals, forums and movements, including the Millennium Development Goals. This collaborative approach may pave the way for HIA to become an active part of re-orienting globalization towards it having a more healthy human face.

The answers are not clear right now. But then, in a turbulent world, the roadmap for globalization is not clear either. What is clear is the innate and strong aspiration of humankind to pursue "living healthily together". Although, in the past, this aspiration has been blocked by various political and economic powers, it will not disappear. Hopefully, with all these attempts to make this aspiration visible and more powerful, the right answers will come out soon.

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THE ROLE OF PRIVATE FOUNDATIONS IN HEALTH PROMOTION: THE U.S. AS A CASE STUDY

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Abstract: In the decade from 1994 to 2003, philanthropic giving for health promotion in the U.S. nearly tripled, outpacing increases in health giving and philanthropic giving overall. Some issues, such as public health activities related to STDs, nutrition, and physical activity, experienced dramatic increases in funding. Other issues, such as mental health and family planning, did not received as much attention from the philanthropic community. Partnerships between foundations and other public and private organizations have the potential to maximize both resources and impact. To ensure success, those seeking partnerships with private foundations should: involve foundations early in planning processes; invest in relationships with foundation leadership and staff; allow sufficient time for joint planning and decisionmaking; and consider other ways that foundations can contribute to partnerships, in addition to acting as funders.

Since the inception of modern American philanthropy in the early part of the 20th century, private sector foundations have played a critical role in health promotion.[1] Unlike earlier forms of philanthropy, which often provided support and relief to individuals in need, the foundations formed in the first decades of the 20th century saw their task as addressing the root causes of poverty, disease, and other social ills. As such, these foundations included support for health promotion and related activities among their top priorities. For example, The Rockefeller Foundation, formed in 1913, focused much of its early domestic and international funding on health promotion and disease prevention, supporting work on birth control, maternal health, sex education, control of infectious and parasitic diseases, and public health research and education. Similarly, The Cleveland Foundation, the oldest community foundation in the U.S., included an assessment of the role of public schools in promoting a healthy student body in its landmark 1915-1916 survey of social and economic conditions in Cleveland (Ayres 1915).

In the U.S., private sector foundations are categorized by, among other characteristics, the source of their funding, how they use that funding, and their tax status. The National Taxonomy of Exempt Entities, a classification scheme developed by the National Center for Charitable Statistics[2] and used by other national organizations and the U.S. Internal Revenue Service,[3] includes the following categories of private sector foundations (National Center for Charitable Statistics 2005).

- Private grantmaking foundations: Thee foundations are defined as nongovernmental, nonprofit organizations whose funds typically come from a single source. These foundations focus primarily on grantmaking. The foundation's grantmaking program is managed by its own trustees or directors and is aimed at supporting social, educational, religious, or other charitable activities. This category includes private independent foundations, family foundations and corporate foundations.

- Private operating foundations: These foundations differ from private grantmaking foundations in that operating foundations use the bulk of their resources to run their own charitable programs and provide charitable services directly, rather than through grantees.

- Public foundations: These foundations focus primarily on grantmaking, but differ from private grantmaking foundations because they obtain their funding from the general public, rather than from a single source.

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[1] The author accepts the World Health Organization definition of health promotion, as stated in the Health Promotion Glossary: "Health promotion is the process of enabling people to increase control over, and to improve, their health . . . (I)t not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health" (WHO 1998).

[2] The National Center for Charitable Statistics is a national repository of data on the nonprofit sector in the United States.

[3] The U.S. Internal Revenue Service is the federal agency charged with administering the nation's tax system, including granting tax exemptions to qualified nonprofit charitable organizations.

- Community foundations: These foundations get their funds from individual donors, rather than from a single source, and make grants in a specific community or region.

With the exception of community foundations, which typically make grants in a limited geographic area, private sector foundations may operate at the local, state, regional, or national level. While it is difficult to generalize about the types of grants made by different types of foundations, foundations that operate on the local level are often called upon to support direct services, while foundations that function on the national level often play a lead role in supporting large research or demonstration projects.

Recent Trends in Private Foundation Funding for Health Promotion in the U.S.

In the decade from 1994 to 2003, philanthropic giving for health promotion in the U.S. nearly tripled, outpacing increases in health giving and philanthropic giving overall (Figure 1).[4] The types of health promotion activities supported by U.S. foundations are as diverse as the philanthropic community itself. In the U.S., health promotion grantmaking may focus on reducing the risks for chronic diseases such as cardiovascular disease, lung disease, or diabetes. It may focus on prevention of HIV/AIDS and other infectious diseases, or seek to reduce teen pregnancy and premature sexual activity among adolescents. Increasingly, both public and private sector funders in the U.S. are responding to the toll of family and community violence and are using proven health promotion techniques and strategies to prevent violence in America's homes and neighborhoods.

Figure 1. Growth in U.S. Foundation Giving, 1994 - 2003

	1994	2003	% Change
Health Promotion Giving	$258,931,513	$1,033,481,126	299.13%
All Health Giving	$936,834,000	$2,798,070,000	199.67%
All Giving	$6,169,419,136	$14,323,389,414	132.17%

Source: Foundation Center, 2005.
Note: The Foundation Center collects, organizes, and disseminates information on U.S. philanthropy; conducts and facilitates research; and provides education and training on the grant seeking process.
Note: Based on all grants of $10,000 USD or more awarded by a national sample of 1,029 (1994) and 1,010 (2003) larger U.S. foundations.

While funding for health promotion generally has increased more rapidly than health funding or philanthropic giving overall, there are some issues that are receiving relatively more attention from the philanthropic community than others (Figure 2). For example, concerns about the epidemic of overweight and obesity among U.S. children and youth is leading to dramatic increases in funding for projects addressing nutrition and physical activity (community recreation. Nutrition experienced an 11-fold increase in foundation funding, while funding for community recreational facilities increased over 19-fold. There are many factors driving increases in foundation funding for certain health promotion activities. Among the potential forces are the following.

- A sense of urgency regarding the epidemic of overweight and obesity among U.S. children and adults, which is leading to increases in type 2 diabetes, mobility impairments, cardiovascular disease, and other associated conditions. Many private sector foundations, along with public funders, are investing in initiatives to promote physical activity and improve nutrition (Langill and Stepnick 2004).

[4] The author worked with staff of the Foundation Center to select National Taxonomy of Exempt Entities (NTEE) codes that most closely match the WHO definition of health promotion. These codes were used to identify grants from the Foundation Center's database. A full listing of the selected codes can be found in Figure 2. Additional information about the Foundation Center's grants classification system, including definitions of each code, can be found online at http://fdncenter.org/research/grants_class/index.html.

- Concern about the use of tobacco products, alcohol, and illegal drugs by youth. Although progress has been made in reducing substance use, much more remains to be done. Private sector foundations play a major role in prevention and treatment efforts, increasing their funding for smoking, for instance, by over 350 percent from 1994 to 2003.
- Concern about the continuing toll of HIV/AIDS in both the U.S. and overseas, as well as the resurgence of other sexually transmitted diseases in the U.S. Data obtained from the Foundation Center show that funding for public health activities related to sexually transmitted diseases increased a dramatic 11,912 percent in the decade from 1994 to 2003. A recent analysis of funding specifically for HIV/AIDS showed that funding for this global epidemic is also increasing rapidly: funding commitments for HIV/AIDS increased 31 percent in a single year, from $300.4 million in 2002 to $394.5 million in 2003 (Funders Concerned About AIDS 2005). Over three quarters of this funding was committed to global or international HIV/AIDS activities.
- Recognition of violence, including gun violence, as a public health issue. As a result, private sector foundations, along with other funders, are devoting significant resources to crime prevention, violence prevention, and gun control.

Although most health promotion activities have experienced substantial increases in funding, philanthropic giving for some health promotion activities has not kept pace with either health giving or philanthropic giving overall. For example, if foundation funding for public health activities related to sexually transmitted diseases and other communicable diseases is removed from an analysis of public health giving, it becomes clear that other important public health activities such as epidemiology have been underfunded. Mental health is also an underfunded activity, especially given the burden of disease that results from mental disorders in the U.S (Broussseau et al. 2003). Similarly, funding for family planning experienced very slow growth in the decade from 1994 to 2003, rising at a rate lower than that for health giving and overall philanthropic giving.

There are limitations on the data presented in Figure 2. It is not possible to parse out particular types of projects within NTEE code categories. For example, code E71, Public health, sexually transmitted diseases includes grants to "(o)rganizations that provide screening, diagnostic and treatment services for individuals who have contracted gonorrhea, syphilis, genital herpes or other diseases that are spread by sexual contact; or that control the occurrence of sexually transmitted diseases by monitoring the incidence of the disease in the general population, investigating individual outbreaks, and identifying and screening recent contacts of people who are infected to stop the spread of the disease" (Foundation Center, 2005). It is not possible to know what proportion of the grants in this category are targeted to prevention versus treatment, or to individual-level interventions versus population-based interventions. Also, the data presented in this article do not provide insight into the types of foundations making grants in each category. A more sophisticated analysis of Foundation Center data could yield more detailed information on which types of foundations are funding particular activities, further informing efforts to form partnerships with private sector foundations.

Figure 2. Foundation Giving for Health Promotion 1994-2003, by Subject

NTEE Code*	Subject	1994 Amount	2003 Amount	% Change
B5A	Public health school/education	$3,826,631	$4,240,957	10.83%
E42	Family planning	29,009,632	58,859,769	102.90%
E46	Health care, prenatal care	6,496,590	2,701,614	-58.41%
E70	Public health	39,240,426	265,328,135	576.16%
E71	Public health, STDs	720,844	86,589,847	11912.29%
E72	Public health, communicable diseases	23,155,620	139,974,668	504.50%
E73	Public health, occupational health	2,102,887	1,400,418	-33.40%
E74	Public health, epidemiology	5,455,669	1,253,098	-77.03%
E75	Public health, bioterrorism	0	17,016,239	N/A
F20	Substance abuse, services	18,096,746	24,037,384	32.83%
F21	Substance abuse, prevention	6,681,839	9,820,142	46.97%
F22	Substance abuse, treatment	17,528,490	52,159,170	197.57%
F41	Crisis services, suicide	354,885	848,464	139.08%
F50	Mental health, addictions	0	97,500	N/A
F52	Smoking	5,234,717	23,598,696	350.81%
F53	Eating disorders	121,041	379,200	213.28%
F54	Gambling addiction	30,000	42,000	40.00%
I20	Crime/violence prevention	21,020,878	10,798,953	51.37%
I21	Crime/violence prevention, youth	7,528,501	8,462,672	12.41%
I22	Gun control	5,003,429	5,616,200	12.25%
I23	Crime/law enforcement, DWI	266,510	1,129,603	323.85%
I70	Abuse prevention	359,500	3,180,779	784.78%
I71	Domestic violence prevention	3,190,898	4,584,588	43.66%
I72	Child abuse prevention	8,379,136	14,575,451	73.95%
I73	Sexual abuse prevention	1,106,062	1,579,027	42.76%
K40	Nutrition	2,946,343	35,765,867	1113.91%
M43	Safety, poisons	507,000	206,250	-59.32%
N30	Recreation, community facilities	6,567,362	133,374,466	1930.87%
N41	Athletics/sports, school programs	6,711,317	18,790,428	179.98%
N60	Athletics/sports, amateur leagues	1,935,025	7,162,982	270.18%
O20	Youth development, centers & clubs	6,733,462	18,616,687	176.48%
O21	Boys clubs	1,983,001	2,088,200	5.31%
O22	Girls clubs	3,032,078	8,725,378	187.77%
O23	Boys & girls clubs	21,244,619	64,248,743	202.42%
P35	Youth, pregnancy prevention	2,360,375	6,227,551	163.84%
SUBTOTAL		**$258,931,513**	**$1,033,481,126**	299.13%
TOTAL FOR ALL HEALTH GIVING		**$936,834,000**	**$2,798,070,000**	199.67%
TOTAL FOR ALL FIELDS		**$6,169,419,136**	**$14,323,389,414**	132.17%

* NTEE stands for National Taxonomy of Exempt Entities.
Source: The Foundation Center, 2005.
Note: Based on all grants of $10,000 USD or more awarded by a national sample of 1,029 (1994) and 1,010 (2003) larger U.S. foundations. The author worked with staff of the Foundation Center to select codes that most closely match the WHO definition of health promotion. These codes were used to identify grants from the Foundation Center's database.

The Role of U.S. Private Sector Foundations in Health Promotion

This section presents examples of philanthropic support for health promotion in the U.S., including related activities such as workforce development. In the U.S., advocacy groups are encouraging private sector foundations to develop and implement comprehensive strategies for dealing with the prevention of disease and the promotion of health and wellbeing. Such exhortations are falling on open ears: many private sector foundations are moving beyond initiatives aimed at educating individuals to embrace strategies that seek to address environmental and policy barriers to healthy choices. In addition, many private foundations are allocating health promotion funding to historically underserved communities and populations as a way of reducing the racial, ethnic and other health disparities that exist in the U.S. Many of the examples below illustrate these shifts in foundation funding and also show how private sector foundations are partnering with government agencies and nonprofit organizations to address health issues of mutual concern and to achieve common goals.

Supporting Research and Model Development

A traditional role for private foundations is support for research, whether that research is aimed at improving understanding regarding disease transmission, evaluating the effectiveness of current approaches to preventing disease and promoting health, or developing new program models. In one example, The Robert Wood Johnson Foundation, largest U.S. foundation devoted exclusively to improving health and health care, is partnering with the federal government to develop new primary care models for helping patients adopt healthier behaviors. The initiative, *Prescriptions for Health*, is funding 17 groups of medical practices that are working to investigate new ways of promoting physical activity, healthier diets, and reduced alcohol and tobacco use among primary care patients. In addition to co-funding the 17 sites with the foundation, the U.S. Agency for Healthcare Research and Quality and the National Institutes of Health funded a resource center to provide assistance to the sites as they develop and test new strategies.

Conducting Joint Planning

In an ideal world, health promotion efforts are based on solid data and careful planning. To provide the information needed to develop effective solutions to community problems, The Boston Foundation, a community foundation that funds in the city of Boston and surrounding towns, works with the City of Boston and a regional planning authority to administer *The Boston Indicators Project*. The project serves a hub for the collection and dissemination of data about a wide range of community conditions and needs, including health issues. Among the many health and related indicators collected by the project are: the number of cases of lead poisoning, air quality, rates of asthma hospitalization among the city's children, availability of green space, health insurance coverage rates, infant mortality and birth weights, drug- and violence-related deaths, and suicide rates among youth. The data is available to policymakers and the public through a web site and printed reports, and is used to inform planning that addresses community needs.

Promoting Education and Awareness

Increasing people's knowledge and awareness about health risks is seen by many foundations as an integral component of health promotion initiatives. The Annie E. Casey Foundation, a private foundation that funds nationally, made a five year, $5 million commitment to an initiative called *Plain Talk* to help adults develop the skills needed to talk frankly with youth about reducing sexual risk-taking. Through *Plain Talk*, the foundation selected five urban communities and partnered with nonprofit organizations, religious groups, local governments, and community residents (including teens) to assess community needs and resources, identify and nurture community leadership, and implement education and skills building activities.

Preventing Disease and Disability

Funding direct services is central to the mission of many private sector foundations. Several large U.S. foundations have made high-profile, multi-million dollar grants for health promotion activities aimed at individuals and families. Among these is the Bill and Melinda Gates Foundation, which has made major commitments to child vaccination, HIV prevention, and tuberculosis control, among other issues. To accomplish its health objectives, the foundation has formed partnerships with national governments, academic institutions, pharmaceutical companies, and public health and research organization6, as well as international organizations such as the World Health Organization, UNICEF, and the World Bank. While multi-million dollar commitments garner much media attention, state and local foundations with more modest assets are making investments in direct services that are significantly improving health and well-being in communities across the U.S.

Creating Environmental Change

The philanthropic community recognizes that health promotion is possible only when people's environments provide the resources, safety, and support necessary for sustained behavior change. The Claneil Foundation, a private foundation in Pennsylvania, is providing support to the Food Trust, an organization dedicated to combating America's epidemics of obesity, diabetes, and other diet-related conditions by ensuring access to nutritious food. The Trust accomplishes its goals by partnering with farmers, policymakers, hunger advocates, schools, and others to bring fresh produce into schools, advocating for supermarket development in underserved communities, and establishing farmers markets that provide opportunities for farmers to sell their produce directly to consumers that might otherwise be unable to obtain fresh produce.

Changing Public Policies

Changing laws and regulations is a powerful means of promoting health and preventing disease, and many private foundations in the U.S. are involved in advocating for changes in public policies, either directly or through their grantmaking. Washington Dental Service Foundation, a corporate foundation, is both a funder and partner in the *Citizens Watch for Oral Health*, a broad-based coalition of labor, business, medical, public health, education, dental and children's advocacy groups working to build support for policy proposals related to oral health. Since its inception in 2000, *Citizens Watch* has been successful in building support for policies to improve oral health, such as additional funding for children's oral health services and water fluoridation. In another example, The Robert Wood Johnson Foundation partnered with the American Medical Association and state coalitions in a *SmokeLess States* initiative aimed at reducing tobacco use and its attendant harms. The state coalitions funded through the initiative successfully advocated for clean indoor air laws, increases in tobacco taxes, and other tobacco control measures.

Developing the Health Promotion Workforce

Effective health promotion requires a well-trained workforce. *Securing the Future*, an initiative funded by Bristol-Meyers Squibb Company and the Bristol-Meyers Squibb Foundation, *Secure the Future*, is supporting projects aimed at building a diverse and skilled workforce to combat HIV/AIDS in hard-hit African countries. In partnership with the governments of Botswana, Lesotho, Namibia, South Africa, and Swaziland as well as academic institutions, and the Joint United Nations Programme on HIV/AIDS (UNAIDS), the company and the foundation have supported a wide range of workforce development projects. A recent addition to the grantmaking portfolio is a partnership with Baylor College of Medicine to create a pediatric AIDS corps that will send up to 250 doctors to Africa to treat approximately 80,000 children over five years and to train local health care professionals.

Partnerships between foundations and other public and private organizations have the potential to maximize both resources and impact. Yet the development of such partnerships often seems fraught with difficulties.

Grantmakers In Health, an educational and networking organization that works with health foundations and corporate giving programs, has identified common barriers to partnerships between foundations and government agencies, including different risk tolerances, differences in organizational culture, differences in time frames, and stereotyping by and of employees (Tillman and Schwartz 2003). For foundations, the list of barriers may also include the chance that collaborations will be derailed by political changes, concerns on the part of foundations about supplanting public funds, and reluctance to commit funds to problems of such magnitude that a foundation's contribution is unlikely to result in measurable improvements. For government agencies and nonprofit organizations, additional barriers may include a lack of knowledge about the smaller foundations funding in communities of interest and the unwillingness of some foundations to make the kind of long-term commitments that are often needed to ensure success.

In an examination of global health alliances, the Bill and Melinda Gates Foundation identified five factors that contribute to the success of partnerships:

- jointly defining the most important benefits of a proposed collaboration;
- choosing the right organizational structure for the task at hand;
- ensuring that operational minimums such as staffing, technology, money, and facilities are available;
- balancing the need for timely decisions with wide participation; and
- having skilled, credible, and committed leaders and staff (Bill and Melinda Gates Foundation 2002).

While these factors are certainly necessary for successful partnerships, they may not be sufficient for effective partnerships between public entities and private sector foundations. To maximize chances for success, those seeking partnerships with private foundations should:

Start early -- A common error committed by both foundations and potential public and private sector partners is waiting too long to seek a partnership. Government agencies and nonprofit organizations may view private sector foundations as "checkbooks." That is, they approach foundations only when money is required for implementation of a plan or program, rather than viewing foundations as early allies and foundation staff as experts who can contribute to planning processes, program design, and policy development. Similarly, foundations may consider a partnership with a government agency to consist of public sector funding that sustains a foundation project after foundation funding ends.

Understandably, approaches that begin with an appeal for money for a project that is already fully formed are less likely to result in strong partnerships than approaches that seek true collaborations where priority setting, planning, decisionmaking, and funding are considered joint responsibilities. Seeking out partners early in a planning process gives all parties an equal opportunity to contribute their ideas and expertise—and potentially funding as well.

Invest in relationships – The organizational cultures of foundations, like all organizations, reflect the personal characteristics of the people who lead them and the people who work for them. Although partnerships are often discussed as collaborations between organizations, the reality is that partnerships are collaborations between people. Depending on the personal characteristics and histories of the people involved, partnerships may be welcomed with open arms or viewed with suspicion. An early investment in building relationships and trust with the people involved in philanthropy can yield dividends down the line when a partnership is needed to achieve a common goal or address an issue of common concern. Informal consultations, ongoing communication about activities, and invitations to events and meetings are among the ways that public sector officials and staff of nonprofit organizations can build relationships with foundation staff.

Be patient – Building a new partnership takes time, both to build the trust required for all partners to commit their time and resources to it and to engage in joint planning and decisionmaking. Although all health issues are urgent to the people they affect, the time it takes to build partnerships to address them may be worth the wait, if the partnerships result in effective and lasting solutions that address root causes as well as immediate problems.

Consider all the ways that private foundations can contribute to a partnership – As noted above, many in the public and nonprofit sectors view foundations solely as funders. But foundations can play myriad other roles in partnerships: they can convene stakeholders, bring reluctant parties to the discussion table, detail staff to public and private organizations for time-limited projects, host meetings and conferences, and provide technical assistance or hire consultants that help organizations apply for other funding. Another potential, but often overlooked, contribution of foundations is their ability to communicate directly with elected officials and other policymakers. The board members and other leadership of private foundations may have access to people in decisionmaking positions, and may be willing to use these relationships to advocate for resources, statutory or regulatory changes, or other actions required to achieve a particular goal.

Overcoming barriers to partnerships between foundations and other types of organizations requires hard work and patience. It also requires a willingness to surrender some measure of control—over decisionmaking, funds, allocation of credit for successes, and blame for problems or failures. But if approached with an open mind, a willingness to listen to all voices at the table, and a dedication to resolving disagreements forthrightly, partnerships between foundations and other types of organizations can bring the best of all sectors to bear on the critical health problems facing the global community.

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Building community capacity to promote health

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Abstract

In this paper, community capacity building (CCB) is seen as the current manifestation of a long-standing health promotion (HP) tradition, which views community as a decisive force in achieving personal and collective wellbeing, especially with regard to the empowerment of marginalized and 'poor' communities. All such community approaches involve the building of competencies and social cohesion, and stress organizational elements. The term 'CCB' especially seems to emphasize competencies and organizational acumen, but it needs to be flexibly interpreted. A brief literature review looks at some of the main contributions from the 1990s on, and concludes that CCB is highly effective, although more formal research is needed. Five case studies from the contributing authors show both the range and efficacy of CCB applications. The concluding synthesis and recommendations call for the partnership dimension of community in modern HP to be emphasized, with CCB being seen as an important aspect of involving communities as equal partners with other stakeholders in a globalized health environment.

Part 1 Conceptual framework of this paper

This paper deals with the community/people dimension in HP. This is the quintessence of HP, since it embodies the Ottawa Charter concept of people directly having control over their own health and its determinants.

Because of brevity requirements, the style here will be synoptic.

Community capacity building (CCB) is the latest in a long-standing tradition of HP concepts with 'community' as a prefix, where *community* refers to any medium sized grouping of people united by social connections, a common identity and common goals. In particular, community relates to people living in a common locality. Associated concepts are community development (CD)/ organization/ action/ empowerment. The concept of CCB appeared in the 1990s, and seems especially to emphasize the goal of *competency*, with arguably less emphasis on the goal of *social cohesion* than other concepts.

In a wider sense, a CCB approach sits within a paradigm of conceptualizing the issues of health positively, rather than just pathology, risk and deficit. Related terms are *strengths, assets* and *resilience*.

Various concepts are associated strongly with CCB. The most important is *empowerment*, relating to both political and psychological power. Others are *partnership* (implying equal power with other stakeholders), *participation* ('real' vs. token), *self-determination* (agendas set by communities, not outsiders), *community control*, and *social connectedness* (and other terms prefixed by 'social', e.g. *social capital/ cohesion/ belonging/ inclusion/ support/ networks*). Overall, these concepts imply that strong communities are powerful social forces for health and wellbeing.

Equity and *equality* are also central concepts, implying primacy for CCB processes with the most disempowered, an emphasis on dignity, justice and respect for all, and attending to political, economic and other societal structures which result in inequity. *Marginalized, excluded and poor* communities are prioritized. However, CCB principles are also applicable in developed settings. Some CCB examples involve an activist political dimension, others not.

The organizational aspect of CCB is important. Concepts here are *planning models, capacity domains, needs/wishes assessment, asset-mapping, governance, sustainability, evaluation*. The *bottom-up* nature of CCB is central (vs. imposed priorities and organization). The role of outside professionals is one of *facilitation*.

Contextually and philosophically, CCB in HP (CCB-HP) has *ecological* and *public health* perspectives, seeing communities as *human systems nested in wider systems*, influenced by many *internal and external inputs*, and having *outputs* which are *global* and *positive* (e.g. 'overall wellbeing'), rather than just specific disease impacts. This 'holistic' and human-system view readily encompasses dimensions such as *spirituality, qualitative experience, traditional healing, folk wisdom* and *indigenous culture*, often neglected in more reductionist approaches. CCB-HP shares public health's *population* and *social determinants perspective*, its valuing of *social justice* and *healthy policy*, and its emphasis on *research* and *evaluation*.

Finally, *synergy* between communities and other health players is recommended. As Wallerstein (2005) says: 'Multiple case studies have shown that synergy between all elements (anti-poverty strategies, NGO-government collaboration, empowerment and participatory development and active health programs) is probably most effective at improving health and development outcomes'. In this paper, the concept of *community-as-partner* is seen as the key to realizing the full potential of community in global HP.

Part 2: Literature review

Space does not allow for a comprehensive review of CCB-HP and allied literature here. The reader is referred to the much longer paper on CCB written for the 5th Global Health Promotion conference in Mexico (Restrepo, 2000), a major American conference on the topic (Goodman et

al.,1998), a comprehensive Canadian study on CCB measurement (Smith et al., 2003), a technical report written last year for WHO on CCB and community mobilization (Raeburn, 2004) and various books on theory and practice (e.g. Laverack, 2005). Here, we summarize some highlights.

Restrepo's (2000) paper has a Latin American perspective, and emphasizes the political and power dimensions of CCB, placing it in a context of equity, social justice, democracy and respect for human rights. There are many good examples of effective CCB projects in Latin America. It is stressed that CCB is a collective and political activity, and that coercive or manipulative citizen participation has to be avoided. Partnerships with stakeholders are crucial. Social exclusion and poverty are priorities, and socioeconomic development is intrinsic to CCB-HP. Essentially, the starting point for all CCB action is the 'prioritization of problems and needs made by the citizens'.

The Goodman et al. (1998) publication is based on a symposium organized by the US Centers of Disease Control and Prevention on the concept of CC. This they defined as: 'The characteristics of communities that affect their ability to identify, mobilize and address social and public health problems, and (ii) the cultivation and use of transferable knowledge, skills, systems and resources that affect community- and individual-level changes consistent with public health-related goals and objectives'. CCB they see as having both social and organizational aspects. Ten capacity dimensions which can be 'built' in a community are: participation, leadership, skills, resources, social and inter-organizational networks, sense of community, understanding of community history, community power, community values, and critical reflection.

Likewise, Laverack (2005) provides an analytical approach to the components of CCB. He outlines nine domains of CC: stakeholder participation, problem assessment capacities, equitable relationship with outside agents, organisational structures, resource mobilisation, links to other resources and people, stakeholder ability to 'ask why', control over programme management, and local leadership.

There are many definitions of CC, with a major Canadian paper on measuring CC (Smith et al., 2003) outlining five variations, with multiple tools available for assessment.

Australians Arole et al. (2004) give a more social emphasis to CCB, though as a process rather than a goal. They say: 'Improving capacity is about strengthening the ability of a community through increasing social cohesion and building social capital.'

Jackson et al. (2003) did a four-year participatory qualitative project on measurable indicators of CC in four 'problem' Toronto neighbourhoods. They found these 'poor' communities were 'rich' in community resources and activities, especially fairs and celebrations, with residents having a positive view of their communities. They conclude 'Community capacity builds over time...' as successes accumulate and barriers are surmounted.

Finally, in this brief review, a Hong Kong study by Tang et al. (2001) of 3,381 professionals identified three main factors to do with CC: 'participation and commitment', 'community resources', and 'health literacy'. For professionals to assist CCB process in their communities, the key was seen as building workforce capacity.

Regarding research on the effectiveness of CCB, there is little formal academic literature. However, many 'grey literature' studies strongly support its efficacy. A recent example is a publication by the Voluntary Health Association of India (Mukhopadhyay, 2004), which shows dramatic gains in the health and capacity of hundreds of very poor and 'backward' communities from 1993-2003. Another earlier case follows:

> In Lima's El Salvador district, ordinary Peruvians have planted a half-million trees; built 26 schools, 150 day-care centres, and 300 community kitchens; and trained hundreds of door-to-door health workers. Despite the extreme poverty of the district's inhabitants and a population that has shot up to 300,000, illiteracy has fallen to 3 per cent, one of the lowest rates in Latin America – and infant mortality is 40 per cent below the national average. The ingredients of success have been a vast network of women's groups and the neighbourhood association's democratic administrative structure, which extends down to representatives on each block. (Durning, 1989, p 42)

Such examples could be multiplied hundreds of times. Even without RCTs, collectively they provide an impressive picture of a very powerful approach to HP.

Part 3: Case studies

These case studies were contributed by the participating authors, and are listed alphabetically by country of origin.

Africa: Effective participation by the very poor

A core component of CCB is meaningful participation by community people. While this first case is perhaps more treatment than HP, it uses a HP approach, showing the power of such participation, and its ability to benefit large numbers of people in a highly effective way.

Onchocerciasis (River Blindness) is a highly prevalent disease in Africa affecting millions of people. It leads to misery, loss of productivity and social ostracism in affected people in their most productive years of life.

A major challenge for controlling the disease is how to deliver annual ivermectin treatment to all target communities and sustain high treatment coverage over a very long period. Past efforts using health workers to treat most of those affected by the disease in rural communities have led to low therapeutic coverage.

This study uses a participatory approach to develop a community-directed treatment with ivermectin (mectizan), including tools for recording and reporting. The African Programme for Onchocerciasis Control (APOC) has adopted and used this approach since 1995 in 19 African countries.

Evidence from field evaluation confirmed that the strategy is appropriate and cost effective and has led to significant reduction in symptoms, thereby contributing to improvement in the welfare of the poorest people.

Brazil: Partnership and power-sharing

Partnership is a theme of the Bangkok Conference, and is a critical factor for the future of CCB. Here the issue is policy development. While this is not strictly speaking a HP project, its implications for health both directly in terms of funding priorities, and indirectly in terms of citizen empowerment, are obvious.

An innovative experiment in urban governance has been taking place for the past 16 years in the city of Porto Alegre, Southern Brazil. This involves a 'participatory budget' (PB) process. Instituted by the City government in 1989, PB is defined as a process designed to promote sound, transparent management of municipal affairs by involving city residents in decision-making on budget allocations. The PB allows populations of different neighborhoods of the city, within a well-defined process of citizen participation, to debate and set municipal investment priorities. The process is gradually gaining credence as an urban governance model based on cooperation and partnership between local governments and civil society. It provides a model for direct popular participation, and is now being tried in 70 other Brazilian cities and in many other countries) 'It is truly the citizens who set the investment priorities for the municipal budget'. (Cabanes, 2004)

Honduras: El Guante and 11 communities: a social participation experience for health promotion in Honduras, Central America.

This inspiring case illustrates well the power of community-initiated action, and the building of capacity to enhance health in poor and isolated rural communities. The constructive partnership with health authorities is also a feature of this case.

El Guante and 11 other villages surrounding it are poor rural communities typified by their strict agricultural activities, located in Cedros, district of Francisco Morazán, 72 km north of Tegucigalpa the capital of Honduras.

With a total population of 3,559 living in harsh social and economic conditions, these inhabitants cope with geographical dispersion and a high incidence of sanitation and hygiene problems that impact directly on their health.

Two years ago, they gathered under the shade of a tree and discussed their problems. Everyone including children, took part in this discussion, and the entire community initiated the task of establishing their own health clinic.

This impressive community participation was supported by the Ministry of Health, which was willing to help these communities improve the quality of and access to health services. On March 30, 2004, the Ministry and the communities signed an agreement in which a new model of primary health services was to be implemented. The purpose of this model is to offer complete medical attention to the inhabitants of the 12 communities, and also develop a model based on an integrated family-community approach, using health promotion strategies and actions to help achieve changes towards healthy lifestyles.

The project is centered on community participation, which is articulated through community organizations in each of the 12 communities. These community organizations develop educational programs based on improving health and nutritional lifestyles, personal and domestic hygiene, and awareness of the environment. The organizations also develop training courses and make health promotional visits to high risk inhabitants. They have organized an adolescent club which provides information on topics such as reproductive and sexual health, activities promoting a clean environment, and various others.

With the aid of visionary and proactive guidance by local leaders, effective social development program management is being achieved in these communities. Important strategic alliances have also been established with other communities and organizations that help define plans for community improvement.

With this union between government and civil society, the inhabitants of these communities are improving their health and lifestyles. Simultaneously they have managed to establish a frontline healthcare clinic, which provides high quality, efficient and highly humane medical treatment to all the population.

New Zealand: Community houses, empowering resource centres, and partnerships

New Zealand (NZ) is the most 'developed' of the countries cited here, but also the world's 'newest' country in terms of significant human settlement, including Maori, European, Pacific and Asian. There is a strong valuing of community and 'fairness' in NZ, and many examples of CCB projects and partnerships. This case is based on one such project.

In 1973, NZ's first Community House (CH) opened, a collaboration between the University of Auckland and the new, low-income suburban community of Birkdale in Auckland, NZ's biggest city. The aim of this project was 'community wellbeing', and was modeled generally on self-determined CD projects in developing countries. There are now some 300 CHs in NZ, with over 40 in Auckland. In one region of 300,000 people, an associated organization is the Empowering Resource Centre (ERC), which runs on Ottawa Charter principles, is a community/health authority partnership, and provides a wide range of human and practical resources to assist with CCB and self-help groups. While the various projects vary in style and aims, the ideal is a project completely under community control and governance, with maximal participation by all residents. The first project achieved a participation rate of 10,000 of its 14,000 residents, with significant increments in health and wellbeing on multiple measures. This project still survives 30 years later. At the heart of this is a simple community-controlled organizational approach called the PEOPLE System ('Planning and Evaluation of People-Led Endeavors'). Capacity-building is intrinsic to this, with many leadership and other skills being acquired by literally hundreds of people in each community. Over the years, this approach has been tried successfully in many settings, and at the present

moment, is being implemented in Glen Innes (GI), one of the poorest and most ethnically mixed communities in Auckland City, involving a partnership of the community with the university, and with a variety of local and central government agencies. At the time of writing, 40 highly motivated local people are out in the streets of GI doing a random needs/wishes household survey, and the CCB process is already palpable, with many new skills learned, and a sense of control over and engagement in their own destiny.

Thailand: 'The new paradigm of health and community capacity'

The host country for this conference, Thailand is a leader in innovative HP practice in Asia. The recently instituted nationwide exercise programme, which was able to involve 30 million voluntary participants within two years, is one striking example. Equally, the rural community development programme in Khon-kaen province outlined here is a dramatic example of CCB in action.

Ubonrat District is a rural community in Khon-kaen province, 445 kilometers NE of Bangkok. Most farmers there have been in a crisis involving high expenditure, low income, debt, no savings, and environmental degradation, leading to broken families and shattered communities. However, one group of farmers has reassessed the concept of farming for money and riches, and now pursue guaranteed security in life, good physical and mental health, warm families, strong community, good environment, pride, freedom, and living in harmony with nature.

The Sustainable Community Development Foundation (SCDF) has worked for 10 years to bring these successful farmers together into a large network that covers five provinces and 2650 families. As a result of pooling such local wisdom and resources, the Foundation has been able to create a learning curriculum that enables northeast farmers to learn how to be self-sufficient. They also learn how to form strong groups to solve difficult social problems and lead to community well-being. The network has recently created a project based on small-scale, well-planned intensive farming. This aims to enable farmers to focus their own resources onto a small piece of farmland (1 *rai*) to produce self-sufficiency, income for debt relief, a life pension in the form of large timber trees, and most importantly, 'all four dimensions of health and well-being'.

Within this district, Kam-pla-lai Village was the poorest. It is now a self-sufficient and resource-rich community. 40 years ago, Kam-pla-lai was in the middle of a very fertile forest. Following government timber concessions and other state activities, most of the trees were cut down. The villagers then turn to mono-cropping by growing sugarcane, cassava, and jute. Within a few years they were faced with high debts, low income, poor soil and labor migration. They also found themselves in very bad health. For instance there was 25% child malnutrition, 95% liverfluke parasite infestation, depression, insomnia and other anxiety disorders. Socially the community was in complete disorder with widespread gambling, crime (cattle rustling, robbery) and alcoholism.

10 years ago the SCDF and Ubonrat hospital staff chose Kam-pla-lai as one of the pilot villages in an attempt to improve the health and lifestyle of the villagers. By relying on good community leaders, positive participation from villagers, and a highly effective learning process, the situation in Kam-pla-lai has dramatically improved. By facilitating regular meetings, the villagers have gradually learned how to rely on their own resources in order to rebuild their way of life. The Foundation does not directly support specific agricultural activities. Rather it provides the opportunity for villagers to learn on an ongoing basis how to solve the problems of their community. Now Kam-pla-lai is much different. Debts are lower and incomes are higher. Villagers have savings and some welfare benefits. Soil and water resources are much better. Pollution has been reduced through organic farming. Now there is no child malnutrition, no liverfluke infestation, less labor migration, no crime, no gambling, and no drugs. The villagers are much happier and less stressed, and there are many strong groups and community leaders who can operate effectively both inside and outside the government system.

Synthesis

These cases and the preceding discussion show that CCB can either be interpreted quite narrowly, in terms of a list of specific capacity domains to address, or quite broadly, referring generally to communities developing their own resourcefulness and wellbeing on their own terms. Overall, CCB seems to involve three main dimensions: *competencies*, *social cohesion*, and *organization/governance*. Regardless, what has been covered in this paper shows that *community is a highly effective force in enhancing the health of populations.* Internally, CCB processes directly improve people's health and wellbeing. Externally, CCB enables communities, either singly or in coalition, to be effective partners with governments and other stakeholders.

In a globalized environment, discussions of health enhancement may tend to be dominated by large scale policy, regulatory and other such concerns, tending to overshadow the human-scale role of communities. Yet collectively, communities are potentially the most important of all contributors to the effort to improve global health, as well as being the main beneficiaries. It is concluded that optimal HP is where there are balanced and synergistic partnerships between strong communities, supportive governments, and other committed agencies, to enable the health and wellbeing of people in their everyday environments to flourish and grow. This brief report provides evidence that this can happen.

Recommendations

1. That the Bangkok process, and other international health forums, fully value and support the community dimension of HP, which can potentially get overlooked in the face of pressing global concerns.

2. That communities be regarded as full partners with governments and other key players in planning and implementing strategies for healthier nations and a healthier world.

3. That community capacity building of the type outlined here be seen as a critical element in the process of strengthening communities both for their own health and social gain, and also for being viable partners in wider arenas, including input into policy and resource allocation.

4. That attention be given to the logistics of making the community-as-partner concept a reality, especially for those communities who are most marginalized, using successful models already operating around the world.

5. That the competency, social, organizational, community control and other requirements (of the type outlined in this document) for successful capacity building in communities are articulated and broadly agreed on and promulgated, and the necessary resource, training, research and policy environments required to mobilize and support these processes in communities are clarified and acted upon by governments and others in authority.

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Strengthening Partnerships for Health

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Promotion of health and well-being is the concern of governments, people's organizations (POs), NGOs and most of all of local communities. We often talk of health services "delivery". In fact, in our experience, health and well-being cannot be "delivered", especially in a top-down fashion.

Being healthy is ultimately the responsibility of communities and families. But they very much need the support of governments, POs, NGOs, health providers, multilateral and bilateral organizations, and other donors.

The question that vexes us all is how? How can we enable and strengthen local people and their initiatives so that they and their families—and especially the poorest and weakest—can be healthy and well?

From our experience of working closely with women workers, the first step is organizing people into their own membership-based organisations.

Organising and organization

At the Self-Employed Women's Association, SEWA, a union of women workers in the informal economy, we have seen, first-hand, the power of organizing. When very poor people, and especially women, come together because they want fair wages, need financial services or want to work together for healthy communities, they take the first important step towards their own health.

Organising is a process where people are encouraged by local leaders, organisers from a PO like a union or NGOs to unite and join their own organization—it may be a union, cooperative, village-based savings and credit group or any other workers' organization. Local people join by contributing membership fees or shares, creating a common stake, structure and future together. Their most important contribution is their leadership, resulting in their sense of ownership and belonging.

What draws people together initially may differ—it may be any local issue close to their hearts and of their choosing. But the "glue" that holds them all together is always the same—solidarity, and in our case, sisterhood, and all through their own organizations.

At SEWA, over the past three decades we have experimented with several forms of organization for taking up health issues and ultimately for developing our own health services. These have ranged from our union, to health workers and midwives cooperatives, and more recently district-level associations of savings and credit groups. All these workers' organizations have grown and developed to the extent that they can manage one or more health programmes.

Another thing that happens as the poor organize and build their own organizations is that they become visible. And their bargaining power and voice increases, to the extent that they can demand that a non-functional primary health centre be re-opened, better services reach their doorsteps, mobile vans be pressed into service for remote villages in the desert and a full supply of essential drugs be available at the nearest health facility. Their organising can also result in traditional midwives, what we call "dais" in India, asking for an identity card from the government, as they have done in our state of Gujarat, so that referral to hospitals is facilitated.

In our experience, organising has led to workers demanding and obtaining work security. For example, when street vendors organised into their own union, they were able to resist municipal authorities and the police who extracted bribes from them so that they could sell in the marketplace, or even evicted them. They did this by collectivity asserting their right to livelihood in the Supreme Court of India. They obtained a court order which enabled them to sell their wares and pursue their livelihood in peace in the market place.

But the women street vendors continued to spend large amounts of money on their sick children as they lived in squalid conditions, without running water, sewerage and toilets. And they had no child care for their children whey they went out to work. Thus, along with work security, they needed day-care centres, health, insurance, health education – simple do's and don'ts to stay healthy, and basic amenities. Starting with childcare the union began to address their social security needs. Once a day-care centre was set-up in the vendors' neighbourhood, health check-ups of the children, regular weighing and immunization began. And then health education with the mothers was organised – on childhood diseases, women's health and common diseases: T.B., Malaria, acute respiratory infections and diarrhea. Fathers also insisted that we organise "Know Your Body" and other health information sessions for them. And the older siblings of our day-care children – adolescent girls and boys began asking for such health information.

In addition, once their livelihood was secured street vendors began to save every day, and in fact, went ahead and built their own women's cooperative bank. Each street vendor and other workers contributed ten rupees as share capital in 1974, and thus with a total of Rs. 40,000, 4000 women created their own financial institution SEWA Bank. When their savings accumulated, SEWA Bank gave them loans for working capital, thus freeing them from the iron-grip of usurious money-lenders and merchants. These loans also helped women to finance individual toilets, sewerage and water taps in their own homes. It also enabled them to link up with the governments own basic infrastructure programmes. Consequently, women began to spend less on illness, especially on water – borne diseases.

Finally, we have covered the whole family with insurance for sickness. Women pay out premium for themselves and their families, and SEWA Insurance works out a system with insurance companies for coverage, while doing all the claims – processing in-house.

Hence, through work security and step-by-step social security coverage, very poor women and their families' health has been safeguarded. It is this integrated and holistic approach, starting with organising, that will lead local people, like street vendors, towards their goal of healthy families and communities.

Partnerships

Local workers' and people's organizations can mobilize communities for action leading to health, but they cannot achieve their goal of healthy communities or health security single-handedly.

The next important step is building partnerships with organizations—the government, technical training institutes, private providers and others. Local people, and especially women, are not short of commitment or ideas for action. But they need supportive partners who will help them by linking with existing public health services, jointly developing new programmes or approaches, sharing of infrastructure and resources and

by providing capacity-building inputs, including technical training and exposure to how other communities have managed to stay healthy and develop health care.

The partners—be they government or others—for their part, need well-functioning, credible organizations, preferably local, so that they are as close as possible to those most in need of support—the poor and women and children. Organising resulting in membership-based organizations of the poor offers a structure with whom others can join hands.

Partnerships for Health—how they work

Our main partner has always been and continues to be the government, at district, municipal, state and national level. Wherever we have partnered with outside agencies like the WHO or UNFPA, it has always been with or through the government.

We have had many different experiences in partnering for health, but I would like to give two examples—one at the local level and the other at the state level.

I. Tuberculosis Control with the Ahmedabad Municipal Corporation (AMC)

Tuberculosis, TB, is still a major public health issue in India. In the city of Ahmedabad, where our organization, SEWA, is located, we recorded deaths of women workers and their family members. We began our fight against TB by linking with government facilities for free medicines and care, as we found that our members were taking drugs intermittently or not at all, and most often going from one provider to another. They did not know how to go about obtaining services from the nearest public health facility. The state TB director was supportive and encouraged us to meet regularly with the municipal health authorities.

An opportunity came our way when WHO approached us to take on the challenge of developing a TB unit complete with microscopy centre, under the then new DOTS programme. While the municipality with whom we had been working with for years was supportive, as was the state TB director, the central government took a while to mull over the idea, as voluntary organizations had never been delegated this kind of responsibility before in our state. Moreover, we suggested that the actual implementation of the TB control programme be carried out by Lok Swasthya health cooperative, our SEWA-promoted organization of traditional midwives and local women health workers.

Finally, all issues were ironed out and we began two laboratories which tested sputum and put local people on medication—the DOTS method. One of these is located in a working class neighbourhood with high case detection, and another in a large referral hospital which serves the entire state as well as neighbouring ones. The government provided rigorous training and refresher courses for our fresh team of lab technicians and health promoters, most of whom were daughters of SEWA members who readily took up the challenge of ridding their communities of TB. In addition, funds for basic infrastructure with the WHO's support, lab reagents and ongoing technical support through weekly meetings was provided by the municipal authorities. In time, a special structure was created—a district-level TB control society, where all stake-holders were the trustees.

Meanwhile, we not only ran the labs, tested patients, put them on DOTS and maintained all records, but also we went into the neighbourhoods where our members and other poor people lived, provided health education and information through leafletting, videos and street plays, We also encouraged ex-patients to become DOTS workers and health promoters, to support "defaulters" and increase case detection.

It took almost two years for this partnership to gel. There was some frustration on both sides. We wondered, for our part, whether our cure rate would ever go up, given the large number of migrant workers we served, particularly from other states, who periodically disappeared and stopped taking their medicines. But equally, both sides were committed to making things work in the long term. Nobody gave up! And today our higher cure rate and sputum conversion rate speaks for the effectiveness of our partnership, and our joint endeavour has expanded to include 500,000 people in two of the poorest wards of Ahmedabad, our home city.

	2002				2003				2004				2005	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Cure Rate	74	70	79	80	80.2	81.8	81	84.3	78.4	84	82	87.5	83	89
Sputum Conversion Rate	97	84	89	95	95.7	87.2	81	88.6	87.5	88	88	91	92	90
Defaulter Rate	7	15	9	4	8.4	4.5	5	2.8	4.9	5.2	7	4	6	6

Q= Quarter

What was perhaps most encouraging was the trust and faith that developed between the people's organization concerned, our health workers' cooperative, Lok Swasthya, and the municipal corporation. Every year on World TB Day, the municipal corporation organizes a function where the Mayor of our city honours the best health promoters—those who have served and helped to cure the maximum number of TB patients in their area. Families of our members and others gather proudly to see how their mothers, wives and fathers are working to remove the scourge of TB. Every year, several of Lok Swasthya's members-turned-DOTS workers are recipients of the Mayor's awards.

2. Reproductive and Child Health with the state government of Gujarat

Our partnership with the state government of Gujarat dates back to the early nineties, when preparations were underway for the International Conference on Population and Development (ICPD) in Cairo. In those days, there was a large gap between what the community-based groups, people's organizations, women's groups and NGOs were demanding—holistic health care for every household with family planning as part of the integrated package of services—and what the government was promoting at that time—a vertical, target-oriented, family planning programme. This gap was slowly bridged through several meetings and workshops prior to Cairo, and through the good offices of the local UNFPA team. Thus, by the time the Indian contingent left for the ICPD, we were a much more unified group of government and non-government, albeit still with differences. At Cairo, we learned that the opposition to a holistic, integrated approach to health rights and services, led by women, was more formidable than we all had imagined. In partnership with the Indian government and other national governments, the Indian NGO contingent worked hard for the Platform of Action that finally emerged.

The net result of this whole macro-level policy effort was not only a feeling that we had achieved a positive outcome together, but also that we needed to continue the partnership to ensure that the fruits of ICPD, and the new approach to health and population reached the poorest of women and children, and in the remotest of Indian villages. And thus a grass-root level collaboration with the government—first at the centre and then at the state level—was initiated. UNFPA again came forward to encourage this partnership with funding and technical support.

Four years down the road, we are working closely with our state government in Gujarat to ensure that primary health care, and especially reproductive and child health (RCH), reach the poorest of women workers and their families. As in the case of TB control, here also the actual implementation is to be carried out by the local cooperatives and district organizations of women workers.

As the women were organized into local organizations by SEWA, it was relatively easy for the Gujarat government to reach out to large numbers of women, get feedback on the quality of services offered, and whether they reached at all. SEWA members for their part obtained the opportunity to interact directly with doctors and other health personnel, were able to express their health needs and participated actively in joint diagnostic camps and health education sessions. They also obtained much-needed referral care, as they now were more linked-up with providers and their facilities.

Such partnerships for health are not always smooth-sailing. The issues at hand are often complex, like that of prenatal sex determination in our joint programme area. When little girls aren't even allowed to be born, where is the question of safeguarding their health? Both the Gujarat government and SEWA are exercised about this. It will take long years of combined efforts to change a social structure that puts a premium on boys at the cost of little girls.

And then there is the issue of changing mind-sets. Partners always come with their own experiences and ideas. This is an asset but also can act as a "block", if we are set in our ideas and ways of doing things. With time, common ground is reached – at least we all learn to focus on what needs to be done and how to get there.

Doctors and others who were less cooperative initially now readily join hands for health camps, education sessions and referral care. For our part, we have learned that people do change, including ourselves, when ground-level experiences touch and move them. We have also learned to navigate the public health system, collaborate with private providers when other systems are non-functional, and to bring our everyday grassroot level experiences to the policy action table.

Partnership with State Government of Gujarat
Jan-Dec'2004

RCH Camps (159 camps)	Women: 6850	Children: 5486	Total: 12336
Health Education (370 groups for health education)	Women: 3291	Adolescents:4718	Men: 2543
Referral (522 persons referred)	Women: 471	Children: 51	

In the latter process, government and agencies like the WHO and UNFPA have been strong partners. We still don't always agree, but there is enough common ground to move forward.

These are just two examples of partnerships for health. Over the years, we have developed many more – for HIV / AIDs control, during epidemics like a recent malaria epidemic, for RCH in urban slums, low cost drugs, training of midwives and health insurance.

A detailed analysis of lessons learned from these partnerships for health is not given here. But what we have learned all these years is that if we organise and develop our own people's organisations working actively for health care at the grassroot level, then partnerships develop. We need to work together with others, pooling our strengths but on equal terms. Partnerships for health also help to ensure that millions of rupees and dollars of resources for health actually reach very poor communities. Government and others, in turn, benefit from linking up with a credible, working social infrastructure in villages and slums.

Such partnerships go through phases, and sometimes even difficult periods. But if each partner persists then the journey together most often smoothens out. It needs regular communication, sharing, ironing out of issues, clarification of roles and responsibilities and creating systems with joint ownership.

Perhaps above all, it needs political will and leadership to ensure that policy-makers, health planners and programme managers actually sit across the table with people's organisations and NGOs. In this respect, we have been fortunate in our country. Today there are many opportunities for exchange of ideas and experiences, with voices from the grassroots level more audible in policy fora.

All partners, know that in a nation of our size and diversity, and with upwards of 300 million people living in poverty, the challenges are enormous. Joint action is the only way out. And the promotion of health and well-being can only be achieved, as Gandhiji reminded us, so many years ago, if we decentralize our efforts and put our faith in local people, especially the women of our village and slums. Ultimately, it is they who need to be supported in the quest for "Health for All".

National capacity mapping in health promotion

African Regional Report -WHO

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Summary

This survey on Health Promotion capacity mapping in WHO/AFRO Region has covered all the member countries of the region in order to assess the current situation of the latter vis à vis the health promotion in the continent.

Out of 46 member states, 40 answered the questionnaire sent to them by WHO/AFRO regional office. Various answers show that health promotion concept is not integrated in the decision making which leads to prevention and health care services in the countries. Though it is noticed that a progress is being achieved with regard to the fact that people are familiar with the concept in some Anglophone countries.

In a general and non comprehensive way, here are the actions envisaged :

- Increase knowledge and skills in HP for decision maker at MOH level and take it into account the population health planning and management. This capacity building will cover all the aspects of health promotion with practical examples and cases study, which can lead them to action with WHO/AFRO technical support;
- An advocacy should be set up with the ministry of health and many others decision makers involved in H.P (Health Promotion) in order to establish a supportive environment for the process establishment;
- WHO/AFRO should support the process for the establishment of HP educational and research institutes, which is being started by some countries. It should encourage others (mainly the francophone countries) to do the same on individual or regional basis through some institutes like IRSP (Regional Institute for Public Health) in Benin ;
- Encourage states to raise fund themselves for health promotion activities as well as the monitoring and documentation.
-

Some arrangements must be made in the best time limit to facilitate the HP concept establishment and development in the region, mostly when we know how much this concept underlines the value of all potential stakeholders in the resolution process of health issues related to the population.

Abbreviation

HE:	Health Education
IEC :	Information, Education and Communication
IRSP :	Institut Régional de Santé Publique
SM :	Social Mobilisation
WHO :	World Health Organisation
NGO :	Non-Governmental Organisation
HP:	Health Promotion
RCA :	République Centre Africaine
DRC :	Democratic Republic of Congo

INTRODUCTION

In WHO/AFRO region, health promotion role is more and more recognised ; mainly after the adoption of health promotion strategy (AF/RC51/12 Rev.1) by the Ministries of Health. The adoption of this strategy gave rise to a new interest in the region and it led them to examine and reinforce their H P structures and programmes. Despite the interest which HP currently gives rise to in the region; it is not fully used yet to combine various classical approaches. In most cases, health education, community mobilisation, communication for behaviour change, advocacy etc., which are H P components in compliance with the recommendations contained in the regional H P strategy should allow to merge them into one H P comprehensive programme.
This survey purpose is to analyse the H P situation in the member countries of WHO/AFRO region.

1.- Objectives

1.1.- General objective

Assess the effort deployed by African countries not only since Ottawa Conference, but particularly after the adoption of H P by Ministers of Health of the member states.

1.2.- Specific objectives

Analyse H P situation with its components in line with :

- Policies and national action plans formulation
- Core health promotion expertise
- Collaborative mechanisms within government
- Programme delivery;
- Partnership among NGOs, private sector and government
- Professional development;
- Information system,
- Health promotion financing

2.- Methodology

2.1.- Nature of the survey and data collection

it is a qualitative survey on the HP capacity mapping within WHO/AFRO). Data have been collected through a questionnaire worked out by WHO/AFRO and revised in collaboration with partners at the member states level. This questionnaire has been sent to HIPs of 46 WHO/AFRO countries, by e-mail, to be filled out in concertation with the HP focal point or its components at the level of the Ministry of Health of the country concerned.
Once the questionnaire is filled out, it has then been returned to WHO/AFRO regional office by each country that carried out this activity for its analysis.

2.2.- Typing and analysis of data

The typing was done on EPI info and the results on SPSS. The analysis is carried out following a tabulation plan in compliance with the layout of the questionnaire. Then a round up was carried out with a view to showing the situation of the countries that answered vis à vis the questionnaire's main items.
Its allowed to set up two groups (Francophone and Anglophone) with the particularity that Angola, Guinea Bissau and Cape Verde joined the Francophones and Mozambique joined the Anglophones. Thus, the group is made up of 20 francophone countries and 20 Anglophone countries.

3.- Findings

Out of 46 countries of WHO/AFRO region, 40 states (87 %) answered to the questionnaire. The filling out of the questionnaire was not always carried out conveniently. A lot of data were missed here and there. This situation is particularly remarkable in question n°8 which is related to H.P funding. The whole filling out of the questionnaire in relation with question n° 11, only shows that two (2) countries have not answered the question related to the availability of specific HP policy; also two (2) countries did not answer the question related to tobacco control policy, six (6) didn't answer the question related to traffic injury prevention and one (1) did not answer the question related to IEC/SM/HE policy as well as school health.

Table n°1 : Complete filling out with regard to question 1.1

	Non- Complete filling out with regard to Policy				
	HP specifically	**IEC/HE/SM**	**Tobacco control**	**School health**	**Traffic injury prevention**
Countries	Congo and Mauritania	Niger	Centrafrica Republic	Eritrea	Angola, Botswana, Eritrea, Niger, Seychelles and Zimbabwe.

The findings of this survey are presented as follows :

3.1.- Policies and plans pertaining to health promotion.

A total number of 16 countries (42%) say that specific H.P policy is available. However, we notice that 29 (74.4%) countries have declared that IEC/Health Education/Social mobilisation is available. With regard to addiction to tobacco control, 19 countries (47.5%) declared the availability of national policy, 29 countries (72.5%) for school health and 16 (40%) countries for Traffic injury prevention. (rf : table n° 2).

Table n° 2 : Countries surveyed according to the availability or not of a national HP policy and other policies.

Domain	HP specifically		IEC/HE/SM		Tobacco control		School health		Traffic injury prevention	
Situation	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Non Declared Policy	2	5,0	1	2,5	1	2,5	1	2,5	6	15,0
Not available Policy	22	55,0	10	25,0	20	50,0	10	25,0	18	45,0
available Policy	16	40,0	29	72,5	19	47,5	29	72,5	16	40,0
Total	**40**	**100,0**	**40**	**100,0**	**40**	**100,0**	**40**	**100,0**	**40**	**100,0**

The situation of the various policies available is presented as follows :

- Seven (07) countries have a complete and finalised H.P policy against 10 ongoing policy elaboration,
- Eighteen (18) countries have a complete and finalised IEC/MS/HE policy against 06 ongoing policy elaboration ;
- Seven (07) countries have a complete and finalised policy for tobacco control against 10 countries which policy is to be worked out ;
- Seven (07) countries have a complete and finalised policy for school health against 05 countries in a working out process and,
- Six (06) countries for traffic injury prevention against the same number of countries (06) which are still working on their policy.

Seven (07) countries (17.5 %) dissociate from others due to the fact that they have policies in each of the domains covered by the questionnaire. They are Algeria, Côte d'Ivoire, the Mauritius, Kenya, Mali, Tanzania and Uganda. In one of these countries (Algeria) all these policies are fully implemented. In the contrary, four (04) have no policy. (cf. table n° 3 and 4)

Table N° 3 : Countries that have HP specifically and other policies

Domain	HP specifically			IEC/HE/SM			Tobacco control			School health			Traffic injury prevention		
Countries	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
ALGERIa	x			x			x			x			x		
COTE D'IVOIRE			x	x			x			x					x
MAURITIUS	x			x			x			x			x		
KENYA			x			x		x			x			x	
MALI		x			x		x				x				x
TANZANIA	x			x			x				x		x		
UGANDA	x			x					x			x	x		
Total	**4**	**1**	**2**	**5**	**1**	**1**	**5**	**1**	**1**	**3**	**3**	**1**	**4**	**1**	**2**

1 - fully implemented, 2 - partially implemented 3, action has just begun

Table n° 4 : Countries which have no national policy.

Domain	HP specifically			IEC/HE/SM			Tobacco control			School health			Traffic injury prevention		
	4	5	6	4	5	6	4	5	6	4	5	6	4	5	6
BURKINA FASO			x	x					x		x				x
MADAGASCAR	x				x		x				x				x
NAMIBIA		x		x			x			x					x
TCHAD	x			x			x			x					x
Total	**2**	**1**	**1**	**3**	**1**		**3**		**1**	**2**	**2**				**4**

4 -being developed, 5 - being considered, 6- not being considered

Out of all respondents, only four countries namely Burkina Faso, Madagascar, Namibia, and Tchad have no national policy (table n°4)
With regard to the availability of HP national action plans and its components implementation, a total number of 21 countries have national specific H.P action plans, 34 countries have for IEC, 21 countries have a national tobacco control plan, 25 countries have for school health and 14 countries have action plans for traffic injury prevention. Seven (07) countries declare the availability of national plans in all domains and two (02) have none. The first are : Algeria, Ghana, the Mauritius, DRC, the Seychelles, Tanzania and Zambia ; the bottom countries are : Cape Verde and Guinea Conakry (table n° 5).
Table 5 : Detailed situation of the countries which have national plan of action/strategies and or programme in all domains mentioned by the survey.

Domain	HP specifically			IEC/HE/SM			Tobacco control			School health			Traffic injury prevention		
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
ALGERIA	x			x			x			x			x		
GHANA	x				x		x				x		x		
MAURITIUS	x			x			x			x			x		
DEMOCRATIC REPUBLIC OF CONGO			x		x			x			x				x
SEYCHELLES		x		x			x			x				x	
TANZANIA	x			x				x		x			x		
ZAMBIA	x				x			x			x			x	
Total	**5**	**1**	**1**	**4**	**3**	**0**	**4**	**3**		**4**	**3**	**0**	**4**	**2**	**1**

1 - fully implemented, 2 - partially implemented 3, action has just begun

Among the 16 countries which have H.P policy, 10 countries have both actions and guides; they are : Botswana, Gambia, Ghana, the Mauritius, Kenya, Lesotho, Mali, the Seychelles, Tanzania and Uganda. Nevertheless, nine (09) countries do not have H.P policy but some guides are available. They are : Eritrea, Gabon, Malawi, Mozambique, Nigeria, C.A.R, DRC, Sierra Leone and Zambia.

3.2.- Core health promotion expertise

A total number of 37 out of 40 countries surveyed (92.5%) have identifiable structures at the MOH among which 30 H.P (81%). The 10 countries which have policies, national action plans and H.P guides also have H.P identifiable structures. Moreover, 16 countries also reported of being endowed with H.P policy, all of them have H.P structures. 14 countries have H.P but don't have a policy in that field. They are : Angola, Cameroon, Côte d'Ivoire, Eritrea, Gabon, Guinea Bissau, Madagascar, Mozambique, Namibia, CAR, DRC, Sierra Leone, Zambia, and Zimbabwe.
With regard to the availability of examples of intervention/HP surveys reports at the local level which were published in the professional papers at central, regional and international levels ; 87.5% of countries surveyed have answered with 15 countries (42.9%) reporting the availability of examples of intervention /survey report against 20 (57.1%) which do not have. Out of 15 countries (46.6%), 07 countries have both policies, plans of action and H.P structures available. They are: Botswana, the Mauritius, Kenya, Lesotho, Mali, Tanzania and Uganda.

A total number of 10 countries (28.6%) report to have national experts recruited to give technical support to other countries on a regular basis.

3.3.- Collaborative mechanisms within government

A proportion of 84% (31 out of 37) countries report on the availability of a systematic coordination of H.P activities within health programmes of the MOH) and 75% (27 out of 36) have evidence of collaboration between the public health section and curative section within MOH for joint HP activities at national/ state/ provincial or lower levels. A total number of 25 countries out of 36 (69.4%) report on having a collaboration between different Ministries within the national state/ government for coordinating joint HP activities at the national and/or lower levels.

3.4.- Programme delivery

A proportion of 69.4% of countries that answered the question report on having one or several national structures/mechanisms for delivery of HP activities. The use of evidence based of health promotion planning, implementation and evaluation is carried out in 21 countries out of 38 (55.3 %) whereas 67.5% of countries surveyed report on a use of combination of intervention strategies in H.P activities.

3.5.- Partnership among NGOs, private sector and government

The collaboration between NGOs/CBOs and national government for joint HP activities exists in 90% of the surveyed, although 72.5% countries report on collaboration between private sector establishment and national government for joint HP activities and (74.4%) in matter of collaboration between private sector establishment and NGOs/CBOs for joint HP activities.

3.6.- Professional development;

Short term for H.P training and development at certificate/diploma level is supported by government in 1 country out of 2. As to the staff long-term training, 47 % of governments bring their support. Less than half (44.7%) countries have a national professional association for health promoters or one that caters for the interests.of health promoters.

3.7.- Information system,

Out of 42.5% of countries surveyed, there is a mechanism for tracking and reporting changes in health related behaviours risks.. As to the mechanism for tracking and reporting on social and environmental risk factors to health, 41 % of countries do have it. There is a national mechanism for tracking and reporting on H.P activities in 42.5% countries.

3.8.- Health promotion financing

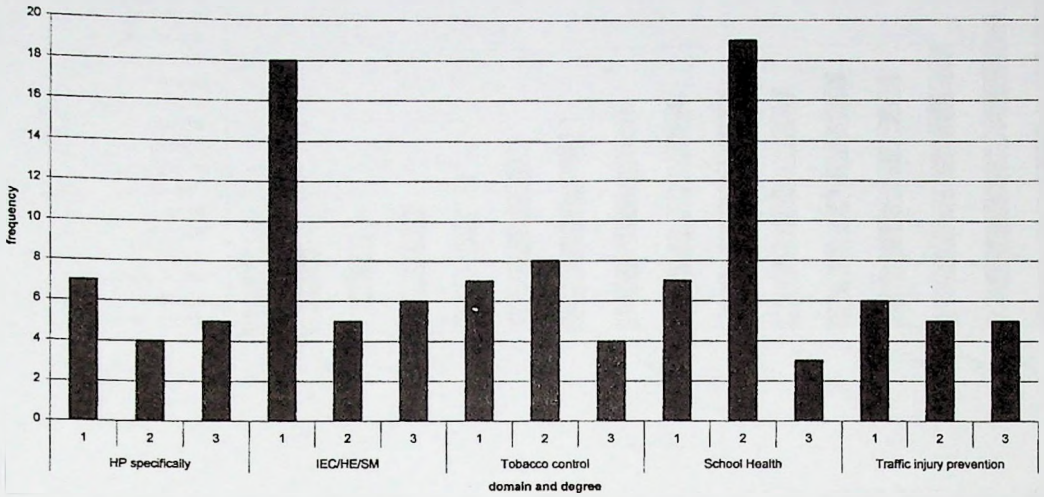
There is a separate budget line designated for HP at the national state level in 52.5% countries. Only three (03) countries, namely : Lesotho, Malawi and Eritrea out of 39 have responded by reporting the availability of arrangements for H.P funding at national/state or provincial government level from specifically designated taxes or levies on tobacco, alcohol, gasoline or other products and services. On the other hand, 11 countries (28%) report on the availability of a separate budget line for designated for H.P provincial, district or lower level. As to the government share, and the non-government partners shares related to H.P. funding, only 13 countries (33.3%) were able to provide some information (nearly usable).

4.- Comments

Generally speaking, we notice a progressive trend of H.P implementation process in the participating countries. In effect, efforts were made since the adoption of the HP regional strategy by the Ministers in 2001 and particularly since HP capacity building process and national multi-sectorial teams for health promotion were set up.

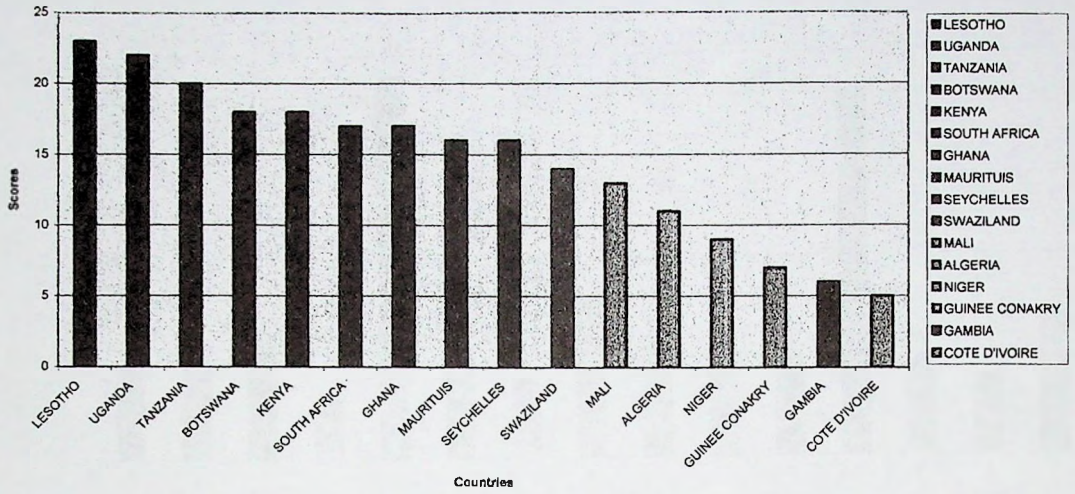
The availability of policies, plan of action/strategies and programmes is effective particularly in matter of traditional approaches like IEC/SM/HE or schoo! health. As to HP Tobacco control and traffic injury prevention,, the countries trend for a take off is much more slow though it is progressing with the time.

Diagram n°1 : Distribution of surveyed countries according to the availability of a national policy in the domains covered by the survey.



The concept of H.P in the region seems to be little understood. Some countries which have specific HP policy continue IEC/MS/EPS policies implementation in a sure isolated manner. This could be due to either a biased comprehension of the questionnaire or bluntly a poor mastering of HP concept. Some countries which do not have a specific policy in matter of HP reported on having some H.P specific plan of actions. They are Eritrea, Mozambique, Nigeria, DRC, Sierra Leone, Zambia and Zimbabwe. This may be related to the non-respect of H.P planning standard process. Nevertheless, the Anglophone countries group is ahead the francophone group. For instance, more than half (11 over 16) countries, which have an H.P policy, are Anglophone. Among them, there are those that better meet the conditions i-e they have most of the items considered, in majority the Anglophone. Following the merit order we have: Lesotho, Uganda, Tanzania, Kenya, Botswana, Ghana, South Africa, the Seychelles, the Mauritius and Swaziland (rf Diagram n°2). Francophone countries which appear in this classification are four in number with Mali on the top.

Diagram 2. Situation of countries which have Health promotion policy

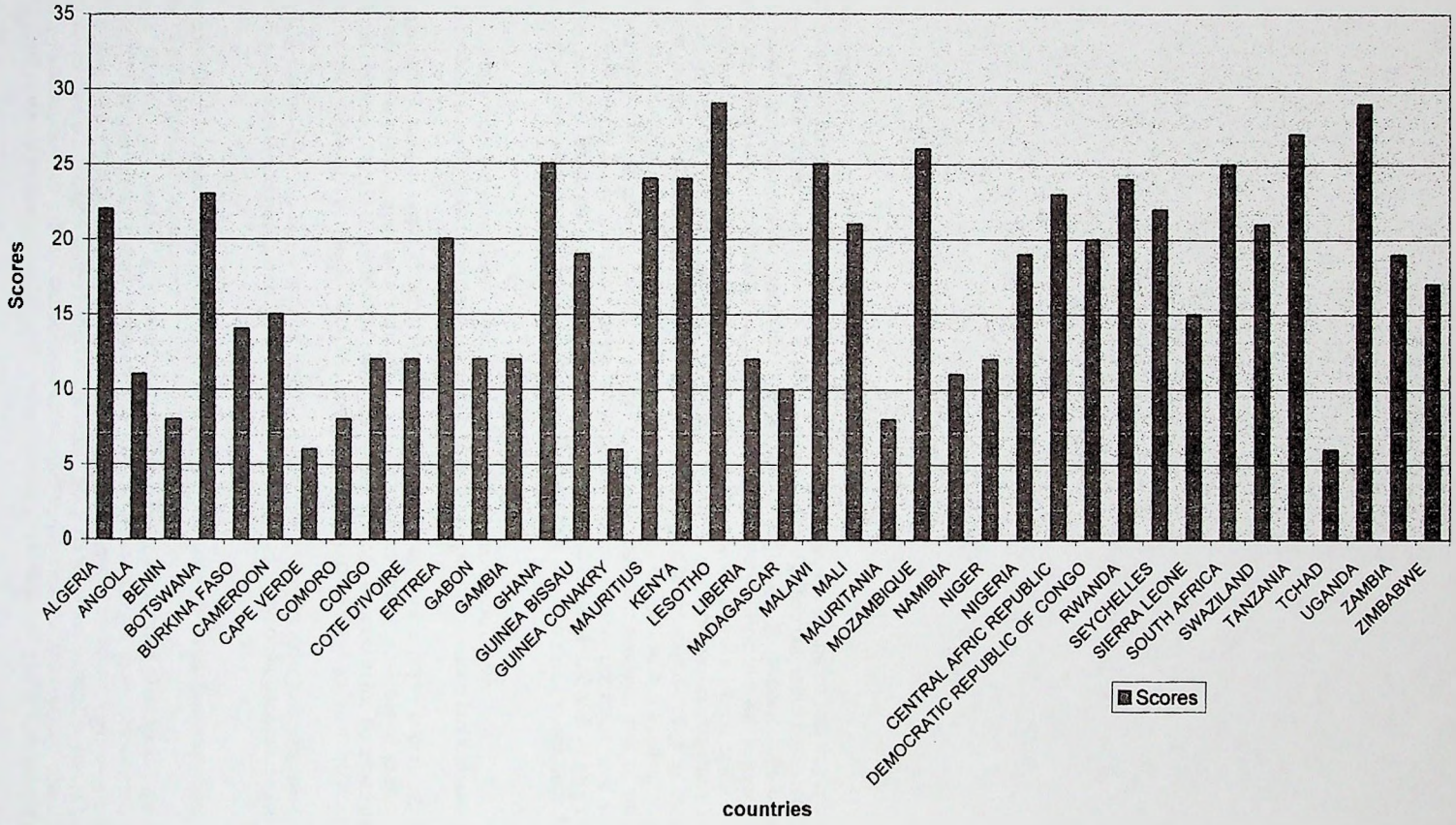


Generally, there is a good collaboration within the government; the execution of the national specific H.P action plans or the traditional approaches seem to be good enough like the partnership between NGO/CBO, the private sector and the government according to the answers collected.

Personal development in matter of H.P is specifically and truly low though 1 country over 2 reports on the support of the short-term training. In addition, the information system is not also a force particularly in francophone countries. These aspects are to be reinforced.

Roughly speaking, the countries as a whole seem to be in dynamism of setting up HP, despite the discrepancies, which can be noticed here and there. In effect, by giving one (1) point to the availability of a sub item, thus we will be able to calculate each country score in relation with each item and also in relation with the whole 8 items gathered. Diagram n°3 shows to us the countries overall situation.

TREND OF COUNTRIES IN HP CAPACITY



5.- Recommendations

- **WHO/AFRO:**

Carry out capacity building of countries and the monitoring/evaluation of H.P interventions. The reinforcement will be based on H.P concept, intervention planning, implementation, monitoring and evaluation. Experiences sharing must be encouraged in order to create emulation among various countries. Back up tools are already available through HP regional strategy as well as the guidelines for H.P activities organisation in African countries. Their dissemination must be effective among member states through national WHO office. Based on the slowness noticed in the establishment of HP in most of the countries, it is necessary to accompany the countries by providing them with focal points in charge of supporting HP interventions.

WHO should also encourage and support the diploma training in HP through institutes which performed well in the sub region like IRSP.

- **Country level:**

Address advocacy to government authorities (the ministries mostly involved in H.P) and other decision makers of all sectors made up of H.P inclusive parties at the level of each member country with a view to establishing a real supportive HP environment.

Further reinforcement of the partnership and negotiation with the private sector, particularly for an endogenous HP funding. Pursue truly the capacity building of the agents, which implement H.P components in the countries through cascade training, and exchange of experience even within the country. For this reason, it is necessary to set up pilot experiences at the community level in order to show HP effectiveness and so, give a better opportunity to the implementation.

Set up a fund raising process through taxes to finance HP. and a partnership between various programmes within the Ministry of Health and also among ministries with a view to improving the intervention results.

Conclusion

Health Promotion in WHO/AFRO region, though it is unbalance here and there, but it performs a very encouraging progress in the last two years in particular. This survey which is based on HP capacity mapping in WHO/AFRO region, allows to notice that the process is geared up but it still remains timid and has not started yet in some countries. An action should be taken to make sure that all states are at the same comprehension level of the health Promotion concept and encourage its implementation in various health programme. The role of the regional office is crucial to be instilled into the countries whose collaboration is indispensable. The dynamism, which facilitates to set up an initiative, the training of the professionals and the establishment of a supportive environment for HP development. A lot of hope is still possible ; it is important that WHO/AFRO, following, the adoption of the regional H.P strategy by the Ministries of Health, the position of HP like an urgent priority in all countries by joining other members of the U N system and international NGOs for its implementation. The 6th global conference on health Promotion will be held with the participation of a number of countries from African region and many other continents; this is a real opportunity to be grasped by AFRO in order to obtain their commitment for the correct and supported implementation of the process.

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Partners for Health: MDG and beyond

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The 6th Global Conference on Health Promotion
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Abstract

The Millennium Development Goals commit the international community to an expanded vision of development-- one that vigorously promotes health and human development as key to sustaining social and economic progress in all countries, and recognizes the importance of creating a global partnership for development.

The goals have been accepted as a common framework for development progress. The first seven goals are mutually reinforcing and are directed at reducing poverty in all its forms. The last goal - global partnership for development - is about the means to achieve the first seven. Achieving the targets set by the MDGs will require more focus on development outcomes. It also will require continuous monitoring of national and global progress towards meeting the MDGs, and more close engagement among partners in helping governments improve human development.

All of the poorest countries will need additional monetary assistance and must collaborate with donors in developing effective frameworks through which additional resources can be delivered and performance can be measured and evaluated. For the poorest countries many of the goals seem far out of reach. Even in better-off countries, there may be regions or groups that lag behind. Countries need to set their own strategies and work, together with the global partners, to ensure that poor people are included in the benefits of development. As proposed by the Monterrey Consensus and the recent G8 summit, debt management and debt relief to countries that are poor and heavily indebted needs to be a top priority in the development agenda in order to accelerate progress towards attainment of the MDGs.

This paper will set the stage for discussion by providing a very brief general overview of what the MDGs are and their importance in relation to global health. It will also review progress in regions so far, highlighting variation among countries, as well as stressing the importance of addressing the equity gap within countries. The paper will present strategies for achieving the MDG agenda, highlighting the importance of policy and institutional reforms that increase absorptive capacity within countries so that they can effectively use additional resources to improve health service delivery. The importance of cross-sectoral actions and the need for good monitoring and surveillance will also be stressed. The importance of effective partnerships will be highlighted and issues of donor harmonization and the need for NGO/Civil Society engagement and public-private partnerships will be addressed. In addition, the relationship between globalization and trade in products potentially harmful to health as well as awareness of different lifestyles, and impacts on health related behavior and NCDs will be discussed. The paper will conclude with a recommendation to

broaden the MDG agenda to include Non-communicable Diseases (NCDs), given that health impacts in some regions may be larger by focusing in this area.

Health Promotion Capacity Mapping:
A Global Overview

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Abstract

This paper reviews approaches to the mapping of resources needed to engage in health promotion at the country level. There is not a single way, or a best way to make a capacity map, since it should speak to the needs of its users as they define their needs. Health promotion capacity mapping is therefore approached in various ways. At the national level, the objective is usually to learn the extent to which essential policies, institutions, programmes and practices are in place, to guide recommendations about what remedial measures are desirable. In Europe, capacity mapping has been undertaken at the national level by the WHO for a decade. A complimentary capacity mapping approach, HP-Source.net, has been undertaken since 2000 by a consortium of European organisations including the EC, WHO, IHUPE, HDA and various European university research centres. The European approach emphasises the need for multi-methods and the principle of triangulation. In North America, Canadian approaches have included large- and small-scale international collaborations to map capacity for sustainable development. U.S. efforts include state-level mapping of capacity to prevent chronic diseases and reduce risk factor levels. In Australia, two decades of mapping national health promotion capacity began with systems needed by the health sector to design and deliver effective, efficient health promotion, and are now expanded to include community-level capacity and policy review. In Korea and Japan, capacity mapping is newly developing in collaboration with European efforts, illustrating the usefulness of international health promotion networks. Mapping capacity for health promotion is a practical and vital aspect of developing capacity for health promotion. The new context for health promotion contains both old and new challenges, but also new opportunities. A large scale, highly collaborative approach to capacity mapping is possible today due to developments in communication technology and the spread of international networks of health promoters. However, in capacity mapping, local variation will always be important, to fit variation in local contexts.

Introduction

This paper reviews approaches to the mapping of resources needed to engage in health promotion at the country level. Capacity mapping approaches are illustrated with examples from across the globe. Also discussed are various uses of capacity maps. The terms 'capacity mapping' and 'health promotion' do not have self-evident meanings. Capacity mapping is perhaps easier to grasp because of the cartography metaphor. Cartography is in its narrowest sense the drawing of images meant to represent the world around us. More broadly, cartography refers to all the activities that lead to finished maps: agreeing the customer's requirements, planning the work, information collection and agreeing unsure or disputed boarders, terms, topography, features and forms. The finished map itself is out of date even before it goes to print, and many map features are disputed by people living in the places that are mapped. A map is a social construction, modelling aspects of environment that are important. Maps are not produced for the cartographers, but for others, whose interests influence greatly what is mapped, and how. Two useful maps of the same coast line may differ greatly, the one intended for navigation having the detail below the waterline, and the other intended for landsmen having the detail above the water line.

So, there is not a single way, or a best way to make a capacity map, since it should speak to the needs of its users as they define their needs. Therefore, the definition of health promotion is of more than academic interest, since the definition will drive much of the decision-making about what a health promotion capacity map should include.

There remains the question of what is meant by national capacity. All ideas are disputable, also the meaning of a nation. Here, the term national refers to sovereign states, but also including regions other than sovereign states that have been delegated the main responsibility for health promotion. Capacity refers to the ability to carry out stated objectives (Goodman, et al., 1998). Having the capacity to perform a task is an essential but not sufficient condition for good performance to take place:

> "The matching of capacity to a desired level of action is the art upon which many enterprises succeed or fail. It is a serious mismatch if one wishes to produce Fords and has the capacity to produce Porsches, and vice-versa. The wide spread interest in measuring capacity arises from the wish to 'tune' capacity to achieve the level of action aspired to. In the development arena, including health promotion, one hardly ever hears about over-capacity. In public services delivery – education for example – there is constant tension between demands for more capacity to achieve better action, and 'good enough' capacity for affordable action." -- Mittelmark, et al, 2005.

Health promotion capacity mapping is approached in various ways, for reasons made obvious above (Ebbesen, et al, 2004). At the national level, the objective is usually to learn the extent to which essential policies, institutions, programmes and practices are in place, to guide recommendations about what remedial measures are desirable (Wise & Signal, 2000; WHO, 2001; National Health and Medical Research Council, 1997).

For at least the past decade, national capacity for health promotion has been the subject of conferences, scholarly dialogue and political debate (French Committee for Health Education, 1995; Wise, 1998; Wise

and Signal, 2000). At the Fifth Global Conference on Health Promotion in Mexico City (June, 2000), national investment for health and the need to build infrastructure for health promotion were dominate themes (Ziglio, et al, 2000a; Moodie, Pisani & Castellarnau, 2000).

Illustrations of capacity mapping around the globe

Europe A capacity mapping model developed by the WHO Regional Office for Europe, and used as part of its Investment for Health initiative (Ziglio, et al., 2000a; 2000b; 2001), has at its heart National Health Promotion Infrastructure Appraisals, since the first such appraisal - in The Republic of Slovenia - which originated from a request for assistance from the President of the Parliament of Slovenia (WHO, undated). Six experts prepared for a site visit by studying a wide range of documents about Slovenian geography, political system and laws, economic situation, demographic, social health and sickness profiles, and structures and institutions. During a site visit in1996, they conducted interviews, participated in semi-structured discussions and a workshop. Based on the information garnered from documents and meetings, the team composed a report with two elements: (1) an assessment of Slovenia's strengths, weaknesses and opportunities for investment in health; and (2) an Investment for Health Strategy for Slovenia, based on the conclusions of the assessment. In the course of the work, the team developed a simple capacity mapping instrument to assess ten elements of health promotion infrastructure, and subsequently applied the instrument during similar processes which were mounted in other European countries.

In Europe, a triangulation approach to capacity mapping has been adopted, using four orchestrated activities, to be reported at the WHO's 6th Global Conference on Health Promotion in Bangkok, Thailand:

(1) Summarisation of existing data on capacity for health promotion, for example from WHO-EURO's Venice Office's 'National Appraisals of Health Promotion Policy, Infrastructures and Capacity' carried out in collaboration with a number of European member states between 1996 and 2004;

(2) Analysis of social and economic trends affecting population health at various levels from country level to Europe as a whole (WHO, 2002);

(3) A WHO Capacity Mapping Initiative, begun in 2005: to synthesise key social and economic trends in 20 countries across four sub-regions of Europe; map the current capacity of health promotion systems, with particular emphasis on responsiveness to the broader determinants of health; and highlight the implications for health promotion policy and infrastructure development WHO, 2005)

(4) Summarisation of present country-level health promotion policy, infrastructure and programmes, from HP-Source.net, a project that: developed a uniform system for collecting information on health promotion policies, infrastructures and practices; creates databases and an access strategy so that information can be accessed at inter-country, country and intra-country levels, by policy makers, international public health organisations and researchers; analyses the databases to support the generation of models for optimum effectiveness and efficiency of health promotion policy, infrastructure and practice; actively imparts this information and knowledge, and actively advocating the adoption of

models of proven effectiveness and efficiency, by means of publications, seminars, conferences and briefings, among other means.

North America In the United States, mapping community capacity to inform community development has for the past 25 years been stimulated by the pioneering work of McKnight and Kretzmann (1990). At a time when American public health was developing advanced methods to assess health needs and develop policy and programmes to meet public health deficits, McKnight and Krtezmann (1990) called for a new perspective – one in which policy and programmes would flow also from an assessment of communities' capacities, skills and assets. This perspective has had great influence in American public health, where the focus of health promotion has been at the individual, small group and community levels.

However, there have also been capacity mapping exercises at the state level, including all 50 states plus eight special districts and territories such as the District of Columbia (ASTDHPPHE, 2001). Using a standard assessment form, each state/territory reported on state-level disease prevention in five arenas: (1) policy and environmental content areas addressed in the prior three years; (2) examples of successful intervention in each content area; (3) critical success factors and barriers regarding policy and environmental change interventions; (4) roles played by local health departments, (5) key contacts. Based on data generated in the period 1996-1999, the mapping results showed clear differences between the content areas addressed by policies compared to those addressed by environmental interventions. Tobacco control was by far the most popular content area for policy development, while nutrition and physical activity were the most popular content areas for environmental change interventions.

In Canada, capacity mapping technology has developed, among other ways, through Canada's strong emphasis on international cooperation for development. Exemplifying this is Canadian collaboration with Nepal and Fiji, to examine various approaches to mapping community capacity for health promotion (Gibbon, Labonte and Laverack, 2002). In this work, community capacity is viewed as both a means and end, emphasising the importance of stakeholder participation, ability to 'ask why' and control over programme management – among other capacity domains such as leadership development and improvement in resource mobilisation (Gibbon, Labonte and Laverack, 2002). Another example of international cooperation for development is Canada's participation in a 19 country analysis of national strategies for sustainable development (Swanson, et al, 2004). Using a country case study methodology, the project mapped three aspects of national capacity: strategy, participation and implementation. For example, each national case strove to answer these and similar questions: Is there a national sustainable development strategy? If so, what are its goals and thematic areas? Is it linked to the national budgeting and planning processes? What roles are played by NGO's? Is there financing for implementation? Is there accountability for performance? Based on analysis of the case studies, the project extracted key learning related to leadership, planning, implementation, monitoring, coordination and participation.

Australia and Asia

Australia's experience in mapping national capacity to engage in health promotion has spanned more than two decades (Better Health Commission 1986; National Health Strategy 1993; National Health and Medical Research Council 1997a; National Health and Medical Research Council 1997b; NSW Health Department 1999). Beginning with an assessment of the capacity (systems for information[1], policy and prioritisation, financial, human, and physical resources, management and design/delivery systems, partnerships) needed by the health sector to design and deliver effective, efficient health promotion, capacity mapping has more recently evolved in three directions (NSW Department of Health 1999):

(1) first has been the continuation of mapping capacity needed to conduct project-based work, but also mapping capacity of the health sector to deliver comprehensive, integrated interventions that influence society as a whole;

(2) second has been mapping the capacity of the health sector and/or agencies in other sectors to sustain either interventions or positive outcomes, or both; and

(3) third has been mapping the generic capacity of communities to identify problems and to design solutions based on the existing strengths of the community (Bush, Dower & Mutch 2002).

There have also been reviews of Australian legislative frameworks for health promotion (Bidmeade 1991) and of public health law (Bidmeade & Reynolds 1997).

The capacity mapping carried out to date has resulted in the clearer definitions of the health promotion capacity required by governments and, to a lesser extent, other organisations. The NSW Health project (1999) developed valid, reliable indicators to help with capacity building, the reviews of legislation included recommendations for the future, and the NHMRC (1997) review was associated with the establishment of a new national, coordinating structure for public health and health promotion, the National Public Health Partnership.

Capacity mapping in Australia has been an effective means of identifying the capacity needed by governments, other agencies, and communities to promote health. It has resulted in more effective national planning and priority setting, and in commitment to the implementation of large-scale, intensive, comprehensive, integrated health promotion interventions.

Australia's experience has demonstrated the importance of mapping capacity to engage in health promotion, and has contributed to the conceptualisation of 'capacity' and to the development of tools to assist in mapping. Australian experience has also highlighted the need to continue to expand the work, but more, to establish minimum benchmarks for governments and civil society to use to assess the extent to which the health of populations and people is protected, promoted and sustained.

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[1] including monitoring & surveillance, research & evaluation

Asia

Korea Korean national capacity mapping for health promotion is an emerging activity, stimulated by the growth of the Korea Health Promotion Fund, a key source of funding for national health promotion programs (Oh, 2001; Nam, 2003). The Ministry of Health and Welfare (MOHW) is responsible for implementation and evaluation of Health Plan 2010, the adoption of which is the foundation for building national capacity in the coming period. The Korea Institute for Health and Social Affairs is in charge of and actively developing programmes on health promotion. However, a critical lack until quite recently has been the absence of capacity to training qualified health educators. In a positive development, the Korean Association of Public Health Administration and the Korean Association of Health Education introduced standards for health education professional training in 1998 (Nam, 2003). In 1999, professional training of health educators emerged at the non-governmental level (Nam, 2002), and capacity is fast accelerating; at the time of this writing it is estimated that around 1,000 health educators work in health centres, health promotion centres and other facilities related to public health.

Capacity mapping in Korea with an emphasis on health promotion policies is now coming to have a higher priority, undoubtedly a product of political commitment. The example of national tobacco control policies illustrates success in government stimulation of health promotion. Today, many public health leaders are interested in strategies for implementing health promotion, and realisation is growing that capacity mapping could certainly help to improve Korean health status and quality of life. Thus, Korea is an example of recently, but quickly emerging interest in capacity mapping, providing the opportunity for fast developments based on lessons learned in places where capacity mapping has a longer history.

Japan Japanese experience in mapping national capacity to engage in public health and health promotion paralleled a remarkable rise of life expectancy after the end of World War II, the increasing prevalence of lifestyle-related disease and the emerging need for nursing care. Responding to these trends, the national government advocated the development of infrastructure for health promotion through two initiatives in 1978 and 1988 and soon thereafter Healthy Japan 21 (Kawahara, 2001). The central government continued to stimulate national capacity for health promotion by passing the Health Promotion Act in 2002. The Ministry of Health, Labour and Welfare is responsible for implementation and evaluation of Healthy Japan 21 (Hasegawa, 2004). Three organizations were established for effective implementation of the initiative at the national level, i.e. Headquarters for Promotion of Healthy Japan 21, the National Council for Promotion of Healthy Japan 21, and the National Liaison Council for Promotion of Healthy Japan 21. Surveys and research on health promotion and the development of relevant databases are conducted by the Japan Health Promotion and Fitness Foundation, the National Institute of Health and Nutrition, and the National Institute of Public Health. National data on public health such as the National Nutrition Survey are regularly collected for the monitoring of public health.

There is no academic institution in Japan which offers a degree in health promotion, however many degree programs in relevant fields such as health sciences and nutrition have lectures on health promotion as a part of their courses. Training courses for instructors of health fitness are also available at universities, colleges, and at the Japan Health Promotion and Fitness Foundation. Also, Japanese Society of Health Education and Promotion introduced professional health education in 1994.

Thus, the cases of Korea and Japan illustrate recent and rapid expansion of interest and activity in the health promotion arena. The kind of international collaboration in health promotion that has arisen in Europe during the past two decades is not yet evident in Asia, but seems on the cusp of emerging. As or more interesting, perhaps, is the very recent development of inter-continental collaboration for health promotion capacity mapping, involving EU countries and Korea and Japan. In collaboration with HP-Source.net, described in an earlier section, capacity mapping has been undertaken in Korea and Japan, using the same general approach that HP-Source.net uses in Europe (Nam, et al, 2004). The experience in Europe, confirmed in Korea and Japan, is that control over and responsibility for health promotion is in many countries situated at a level other than the national. Accordingly, HP-Source.net was adjusted so that mapping may take place at any administrative level, for example at the local prefecture level in Japan. The experience in Korea and Japan also indicates a need to map developments in health promotion policy, infrastructure and key programmes, not merely whether these resources exist of not (Nam, et al, 2004).

Summary

A key outcome of the 5th Global Conference on Health Promotion, held in Mexico City in June 2000, was the call for the development of country-wide plans of action for health promotion. To develop such plans and monitor progress, countries require information on what already exists, is being developed, or does not yet exist in the way of policy, infrastructure and programmes. Having such information for one's own country, and from other countries, helps in priority setting and can speed the development of national plans and action. For example, existing national health promotion policies in other countries can be useful sources of ideas for a country intent on developing such policy.

Thus, mapping capacity for health promotion is a practical and vital aspect of developing capacity for health promotion. The Mexico City conference summarised the context for health promotion capacity building: Because joint and individual responsibility and action are required to improve the public's health, public policies that establish the conditions for health improvement are essential. The links between social and economic determinants of health, socio-economic structural changes, physical environment and individual and collective lifestyles call for an integrated view of health development. Best practices in health promotion need wide dissemination, both with regard to policy-making and programme implementation. Ministries of Health cannot manage the task of health promotion alone; they need to engage other public and private sectors to generate the required policies, infrastructure and key programmes.

These contextual issues have been more or less steady factors for many years, yet in important ways, the global, national and local contexts for health promotion have changed remarkably in the last two decades. Globalisation, a process set in motion many centuries ago, has been accelerated dramatically in the past decade by communication technology that is fast spreading to every corner of the globe. Among the benefits of globalisation has been the linking up of health promoters everywhere, sharing ideas and experience about practical and effective ways to build capacity for health promotion. This has happened, too, in the capacity mapping arena, but there is room for improvement.

The new context for health promotion, which is a major theme of the 6th Global Conference on Health Promotion, Bangkok, Thailand, August 2005, contains both old and new challenges, but also new opportunities. A large scale, highly collaborative approach to capacity mapping is possible today due to developments in communication technology and the spread of international networks of health promoters. In capacity mapping, local variation will always be important, to fit variation in local contexts. However, many elements of health promotion capacity can be implemented in many contexts, with suitable adjustments. An excellent approach to professional education, for example, can be implemented anywhere trained people and data collection resources can be mustered. Capacity mapping provides information about what exists, and where, in the way of health promotion policy, infrastructure and key programmes. The sharing of this information can and should stimulate the dissemination of practices that are suited to the continually evolving context of health promotion.

Some key lessons have emerged from the past decade of experience with national-level capacity mapping. It is impossible to use one single mapping protocol for all health promotion capacity mapping exercises, as capacity has different meanings in different contexts, and is often politically defined. Moreover, the capacity that is required for effective health promotion in a given country may be different from that in other countries because of differing cultural, social, economic and political conditions. For example, regarding information dissemination, a developed media network may be an important aspect of capacity in high income countries but for low income countries, a developed social network is essential and more appropriate. Although there must be a reasonable degree of commonality in what constitutes capacity among countries, there will also be differences arising from addressing different health issues. For example, the facilities, equipment and expertise required for tackling motor vehicle injury vary from those required to eradicate polio. Thus, the mapping of capacity must also take into consideration the priority health concerns of the countries.

While it is not appropriate to pursue one single mapping protocol, for the reasons given above, effort should be made to develop models of best practice and construct typologies of capacity that are suited to various purposes. This can best be done by examining the concept of capacity across different countries through a combination of qualitative and quantitative methods. The triangulation approach being used in Europe seems promising in that regard.

The mapping of capacity as a tool for policy-management is an innovative area that is growing rapidly, but with a number of problems that need addressing:

- First -- what to map? Systems? Money? Manpower? Activities? Plans? Intentions? Hopes and aspirations? This calls to attention the need to define the construct 'health promotion infrastructure' with care, a task for the immediate future, and not addressed at all in this paper.
- Second – what to include... and exclude? The formal public or private investments in health promotion are often not separated from other health budgets. Much of health promotion policy, infrastructure and programmes may be hard to identify as such. This problem is of precisely the same calibre as that facing health promotion in general: broad as well as narrow definitions raise objections and generate controversy.
- Third – who to count? A health promotion workforce is obviously critical, but who is a health promoter? If a country has an established specialist force, which will surely be counted, but if many other health professionals are doing health promoting work, their contributions will be hard to document.
- Fourth – how to map the extent of health promoting work of the hidden workforce? Of individuals themselves, of parents, of teachers, of politicians?
- Fifth – how to compare apples and oranges? Data on capacity cannot be understood without reference to the national context. Users of capacity maps that include the possibility of country comparisons need to be aware that the 'look, feel, smell and taste' of health promotion may be very different even in two geographically adjacent countries. League tables will be difficult or impossible to construct.
- Six – what data to use? Not all data are accessible or dependable. Private institutes consider data as business information and are often reluctant to share it. Public data may be tainted by political considerations.

These and many other problems stand in the way of further development of capacity mapping as a tool for policy-making. Nevertheless, dialogue and consensus-building are feasible, as is collaborative work to create a base of experience with various approaches to capacity mapping. Capacity mappers and map users will not go far wrong if they respect the value, but also the limits of capacity mapping. Map making took a large step forward when Mercator invented his type of projection, yet today many geographic mapping systems are in use, each suited to different purposes. In the arena of health promotion capacity mapping, there seems little point in attempting to develop the 'right' map, but developing the right type of map for the right purpose is a worthy pursuit. A journey without a map – that is wandering.

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COM H-52A.14

GLOBAL HEALTH PROMOTION

Track 2: Health-friendly globalization

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WHAT IS GLOBAL HEALTH PROMOTION?

health promotion
"The process of enabling people to increase control over, and to improve their health" (Ottawa Charter 1986)

globalisation
intensifying flows of people, other life forms, trade and finance, information and communication across geographical boundaries

⇨ need to better manage and shape globalization

⇨ need for effective forms of global governance

DEFINITIONS

governance
agreed rules, norms & institutions by which people organise themselves to achieve common goals

health governance
agreed rules, norms & institutions by which people organise themselves to collectively promote and protect health

global health governance
(a) deal with transborder flows that impact on health;
(b) embrace governmental & nongovernmental actors; and
(c) address determinants of health within & beyond health sector

GLOBAL HEALTH PROMOTION

"the process of enabling people to increase control over, and to improve, their health within an increasingly global context"

25th anniv in 2006. Methods used/shortfalls

INTERNATIONAL CODE ON MARKETING OF BREASTMILK SUBSTITUTES

√	X
•raised public attention to issue •mobilised effective boycott of producers •global coalition of NGOs and governments •support for code by almost all WHO member states	•code relies on voluntary compliance •ongoing reports of code violations •few countries have national legislation •4000 babies die annually from unsafe bottle feeding

IBFAN

Nestlé

HEALTHY CITIES INITIATIVE

•clear and shared vision
•holistic approach to health promotion
•rapid adoption of initiative by cities worldwide
•wide range of stakeholders and partners
•supported by various levels of governance
•International Healthy Cities Foundation and conference

newcastle healthy city project

CityNet Healthy Cities

WHO Collaborating Center in Healthy Cities

HEALTH CITIES INITIATIVE

- focus on cities in high-income countries rather than disadvantaged and vulnerable
- lack of resources in poor countries to achieve real change
- balance between top-down initiative and local participation

FRAMEWORK CONVENTION ON TOBACCO CONTROL

Framework Convention on Tobacco Control

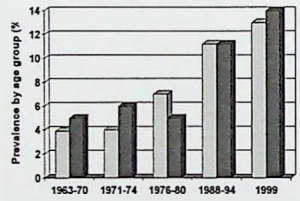
Framework Convention Alliance

- first international health treaty
- strong leadership
- active involvement of governmental and nongovernmental institutions
- success challenge to powerful vested interests

PHILIP MORRIS INTERNATIONAL

BRITISH AMERICAN TOBACCO

GLOBAL STRATEGY ON DIET AND NUTRITION



PERCENTAGE OF OVERWEIGHT CHILDREN AND ADOLESCENTS IN US (CDC 2002)

INDIA

SOUTH AFRICA

CHINA

GLOBAL

Salt Institute

Salt Institute

- "world's foremost source of authoritative information about salt and its more than 14 000 known uses"
- "a non-profit association of salt producers"

→ Dietary Approaches to Stop Hypertension (DASH) recommends reduce salt intake as means of reducing hypertension

Salt Institute (2004):
"There continues a controversy among medical researchers about the appropriate public health response to these facts and whether it's time to reconsider the conventional wisdom that reducing dietary sodium intakes is advisable."

International Life Sciences Institute

- "a global network of scientists devoted to enhancing the scientific basis for public health decision-making"

→ FAO Expert Consultation on Carbohydrates in Human Nutrition (1998) funded in part by WSRO and ILSO

ILSI International Life Sciences Institute

World Sugar Research Organisation
"a worldwide alliance of sugar producers, processors, marketers, users and their associations...dedicated to the development of a better understanding of the role of sugar in health and nutrition based on accredited scientific research"

CHALLENGES FOR BUILDING GLOBAL HEALTH PROMOTION

- What type of governance instruments do we need for health promotion?
- How can we improve implementation of global health promotion initiatives?
- What kind of "partnerships" are appropriate?
- What policies do we need to harness positives, and countering negatives, of globalization?

RECOMMENDATIONS

- To critically reflect on emerging forms of global health promotion
- To agree what we mean by good governance for health promotion
- To support the building of an appropriate and effective architecture for global health promotion

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Global Health Promotion

Dr. Kelley Lee

6th Global Conference on Health Promotion
Bangkok, 7-11 August 2005

1. ger. biographical sketch 2. Rapporteur - Dr Ahmed Afaal from MoH, Maldives

1.0 Introduction

As globalisation increasingly impacts on diverse aspects of our lives, we are beginning to understand how factors that go beyond the national borders of individual countries are influencing the determinants of health and health outcomes. This paper discusses what is mean by "global health promotion" in terms of the process of enabling people to increase control over, and to improve, their health[1] within an increasingly global context. The focus of this paper is the extent to which global governance architecture is emerging for health promotion. After briefly reviewing the concepts of global health governance, it draws lessons from selected examples of global health promotion initiatives. The paper concludes with suggested strategies for building a global approach to health promotion.

2.0 From international to global governance for health promotion

Governance concerns the many ways in which people organise themselves to achieve common goals. Such collective action requires agreed rules, norms and institutions on such matters as membership within the cooperative relationship, distribution of authority, decision making processes, means of communication, and resource mobilisation and allocation. *Health governance* concerns the agreed rules, norms and institutions that collectively promote and protect health.[2]

Importantly, while government can be a central component of governance, governance more broadly embraces the contributions of other social actors, notably civil society organisations (CSOs) and the corporate sector. Moreover, governance embraces a variety of mechanisms, both formal (e.g. law, treaty, code of practice) and informal (e.g. norms, custom).[3] Formal instruments with the strongest regulatory powers can be legally binding and backed by punitive measures (e.g. fines, imprisonment). Informal mechanisms may rely on self-regulation and voluntary compliance, as well as less tangible forms of censure such as public opinion.

Global health governance (GHG) can be distinguished from *international* health governance (IHG) in three ways. First, IHG involves *crossborder* cooperation between governments concerned foremost with the health of their domestic populations. Infectious disease surveillance, monitoring and reporting, regulation of trade in health services, and protection of patented drugs under the Agreement on Trade Related Intellectual Property Rights (TRIPS) are examples of IHG. However, changes being brought about by globalization mean that many health determinants and outcomes are becoming increasingly difficult to confine within a given territorial boundary (i.e. country) and, in some cases, are becoming de-linked from physical space ("deterritorialised").[4] As such, it has been argued that the current IHG architecture alone is inadequate to deal with *transborder* flows that impact on health such as people trafficking, global climate change and internet pharmaceutical sales.[5]

Second, the mechanisms of IHG are, by definition, focused on governments in terms of authority and enforcement. Examples include the International Health Regulations (IHR) and Framework Convention on Tobacco Control (FCTC). In contrast, GHG embraces both governmental and nongovernmental actors, and a wider range of formal and informal governance mechanisms. These include voluntary codes of practice, quality control standards, accreditation methods, and consumer monitoring and reporting. These mechanisms vary widely in their jurisdiction, purpose, scope and associated resources.

Third, while IHG is traditionally focused on the health sector, GHG seeks to address the broad determinants of health, extending its reach to health impacts from non-health sectors notably trade and finance, environment and agriculture. As Collin et al. write,

> In a world where many health risks and opportunities are becoming increasingly globalised, influencing health determinants, status and outcomes cannot be achieved through actions taken at the national level alone. The intensification of transborder flows of people, ideas, goods and services necessitates a reassessment of the rules and institutions that govern health policy and practice.[6]

The three distinct features of GHG described above can be understood through the example of efforts to control dengue fever across multiple countries. An IHG approach would concentrate on a coordinated effort by ministries of health in affected countries to tackle environmental factors (e.g. spraying, reducing potential breeding sites), distribute bed nets, and increase the use of insect repellents. Reporting of data on incidence might be shared among the appropriate public health authorities. In contrast, a GHG approach would consider the role of transborder factors, such as documented and undocumented migration, and migration of the Aedes aegypti mosquito. In addition to government, there might be cooperation among a wide range of relevant stakeholders such as NGOs, private companies, research institutions and local communities. Finally, the impacts on the social and natural environment from changes to agricultural practices (e.g. agribusiness), terms of trade, or conflict and political instability would be taken into account.

To the extent that globalization requires global governance architecture for health, there is a need to rethink traditional approaches to health promotion. There is a need to understand how globalisation, defined as changes that are intensifying crossborder and transborder flows of people and other life forms, trade and finance, and knowledge and ideas, is impacting on the process of enabling people to increase control over, and to improve, their health. For example:

- The promotion of sexual health may require greater attention to changing patterns of population mobility within and across countries in the form of migration, tourism, displaced populations and migrant workers.
- The promotion of healthy diets may require measures to counter the marketing of global brands by transnational corporations.
- The promotion of tobacco control may require measures to tackle the availability of contraband cigarettes, and the targeting of emerging markets in low and middle-income countries by transnational tobacco companies (TTCs).
- The promotion of healthy living environments may require greater attention to the impact of large scale agricultural production on urbanisation and land availability.

In summary, *global health promotion* can be defined as the process of enabling people to increase control over, and to improve, their health within an increasingly global context. The challenge lies in creating effective forms of governance that support such efforts. In principle, there is an emergent architecture for global health promotion as shown in the examples below. By definition, health promotion is broadly conceived to involve a range of social institutions, from governmental bodies to individual families. In practice, however, initiatives to date which seek to tackle global health issues have reflected the uneven nature of existing institutions and how they operate together. In briefly reviewing these examples, particular attention is given to the institutions and mechanisms involved, the effectiveness of these efforts (strengths and weaknesses), and lessons learned for future action.

3.0 Lessons to date: Selected examples of global health promotion

3.1 International Code of Marketing of Breast-milk Substitutes

Adopted in May 1981 by WHO member states, following years of concern about the general decline in breastfeeding in many parts of the world, the International Code of Marketing of Breast-milk Substitutes represented the culmination of a prominent global health promotion campaign by WHO, UNICEF and nongovernmental organisations (NGOs) led by the International Baby Food Action Network (IBFAN). The Code was highly successful at drawing worldwide public attention to the health consequences of the marketing practices of infant formula manufacturers, with NGOs mounting a successful boycott of Nestlé. Despite non-support by the US government, the code was adopted by national health systems around the world and corporations were made acutely aware of the power of consumer action.

Implementation of the code during the past twenty years has experienced mixed success. Despite its high-profile adoption of the code, and efforts in some countries to align national law to its provisions, it remains largely a voluntary code. Widespread violations in many low

and middle income countries have been reported,[7] and there remain few formal means of enforcement beyond public censure. Efforts to raise the issue within the Food and Agriculture Organization (FAO), Codex Alimentarius, World Trade Organization (WTO) and other relevant international forums have sought to embed the code within nutritional guidelines and trading principles. Amid a renewed Nestlé boycott, NGOs also accuse the company of engaging in new marketing tactics to circumvent provisions, including the use of a corporate social responsibility initiative (i.e. ombudsman scheme) to placate public concerns. Meanwhile, NGOs monitoring companies report that 4000 babies continue to die each day from unsafe bottle feeding.[8]

This example suggests that reliance on voluntary codes alone to regulate the behaviour of powerful and well-resourced transnational corporations, without sufficient attention to implementation and enforcement, is likely to be ineffective. While NGOs can effectively campaign to draw public attention to an issue, public pressure can be difficult to sustain in this way in the longer term without the support of more formal governance instruments. This is especially so given the worldwide scale of the issue. A voluntary code can be seen as an initial effort to raise awareness and improve public education. If ongoing monitoring shows non-compliance,[9] stronger governance instruments may be necessary in time.

3.2 Healthy Cities Programme

The idea of "healthy cities" took flight in the mid 1980s following a Canadian conference "Beyond Health Care Conference" focused on community health promotion. The idea was quickly taken up by WHO which launched an initiative in 1988 to protect and promote the health of people living in urban environments. With over half the world's population living in large cities and towns by 2007, and rapid urbanisation continuing apace, the Healthy Cities Programme soon became a worldwide movement.

The Healthy Cities Programme is widely described as a success story. Each phase of the movement has seen a steady increase in the number of supporting cities to over 3000 worldwide in 2003. Regional networks, in turn, have also been formed to support the work of local communities.[10] This is reinforced globally by the International Health Cities Foundation, and an international conference held regularly since 1993. The distinct features of the Healthy Cities movement, in terms of governance, have been its holistic approach to health promotion and its partnerships with a diverse range of actors at multiple policy levels. Building on the principles of Health for All, and the concept of environmental sustainability, the initiative recognises that:

> A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.[11]

Based on this vision, WHO set a common agenda that could be used for promoting local action by individuals, households, communities, NGOs, academic institutions, commercial businesses and governments.

While Healthy Cities has proven effective at mobilising diverse interests around an agreed health goal, Awofeso argues that this success so far "has largely been confined to industrialized countries." It is argued that larger scale health risks such as poverty, urban violence and terrorism, skeletal urban infrastructure in poor countries, and impacts of "capitalist globalization", have as yet been inadequately addressed. Moreover, the evidentiary base, and generalisability as a global movement to local contexts remains unclear. As such, Awofeso concludes that the "Healthy Cities approach is unlikely, in its present form, to remain a truly effective global health promotion tool this decade."[12]

This example suggests that global health promotion can be successfully initiated with a clear and shared vision, and can be effectively built through engagement with relevant stakeholders. Unlike the babymilk code, powerful vested interests were not overtly challenged in this case.

Achieving truly global impact, however, may require careful reflection on its relevance to diverse and underserved populations. A further progression of the movement might then be launched, with adapted evidence-based goals, resources and actions.

3.3 Framework Convention on Tobacco Control

The scale of the emerging tobacco pandemic (predicted 10 million deaths by 2030) led WHO to initiate the Framework Convention on Tobacco Control (FCTC) in 1998. While ostensibly an international treaty between national governments, the increasingly global nature of the tobacco industry, and the consequent shift of the health burden to "emerging markets" in the developing world (70% of expected deaths by 2030) convinced WHO of the need for a global approach to health promotion. As Yach describes, "The rationale for the FCTC was to address the transnational aspects of tobacco control as it strengthens and stimulates national actions. Issues such as illicit trade, controls on cross border marketing and international norms for product regulation..." [13] Similarly, then WHO Director-General Gro Harlem Brundtland stated,

> The Framework Convention process will activate all those areas of governance that have a direct impact on public health. Science and economics will mesh with legislation and litigation. Health ministers will work with their counterparts in finance, trade, labour, agriculture and social affairs ministries to give public health the place it deserves. The challenge for us comes in seeking global and national solutions in tandem for a problem that cuts across national boundaries, cultures, societies and socio-economic strata.[14]

One of the key governance innovations during the negotiation and implementation process has been the contribution of civil society groups. These inputs have been largely organised around the Framework Convention Alliance, a

> heterogeneous alliance of non-governmental organizations from around the world who are working jointly and separately to support the development, signing, and ratification of an effective Framework Convention on Tobacco Control (FCTC) and related protocols. The Alliance includes individual NGOs and organizations working at the local or national levels as well as existing coalitions and alliances working at national, regional, and international levels.

As well as accelerating accreditation of NGOs with "official relations with WHO", the scope of involvement widened to allow access to open working groups. Perhaps more important than the formal terms of participation has been the ability of NGOs to play a number of key supporting roles. These include informing delegates (e.g. seminars, briefings), lobbying, publishing reports on key issues (e.g. smuggling), and even serving on national delegations.[5]

The focus since the FCTC came into effect in February 2005 has been on subsequent implementation within countries. The evidence to date suggests that the treaty, so far signed by 192 countries and ratified by 60, has been an effective catalyst for putting tobacco control much higher than ever before on policy agendas in many countries. The sustained effort to achieve this over the past seven years, culminating in the FCTC, has more recently been followed by a potential decline in interest due to a perception that tobacco control is now "done". With individual protocols to negotiate and the actual implementation of policies in member states, the task is clearly far from complete.

> Unfortunately, governments and international agencies run the risk of becoming complacent. For many, the FCTC is done, tobacco control has an answer and the rest will follow. Nothing could be more dangerous than that premise. In fact, if we are not alert and active, the FCTC could turn into yet another treaty gathering dust in ministries and academic institutions around the world.[13]

The decision by Gro Harlem Brundtland to step down as WHO Director-General in 2003, after a single term, has invariably meant a loss of global leadership on the issue despite reassurances by her successor, J.W. Lee, that tobacco control remains a high priority.

Tobacco control advocates worldwide now face the challenge of keeping the attention of the donor community from shifting to the next "priority" on an already crowded global health agenda.

This example suggests that, like the Healthy Cities Programme, a worldwide health promotion movement requires strong high-level leadership and clearly defined goals. WHO was successful, perhaps even more so than for the babymilk code, in taking on a powerful industry despite strong opposition from vested interests. The role of civil society was critical to the FCTC negotiation process, mobilised into an effective global social movement. Efforts were made to include pharmaceutical companies (manufacturers of nicotine replacement therapy), although involvement by the tobacco industry itself was restricted to submissions to public hearings along with other stakeholders. The industry's production and marketing of tobacco products as harmful products, its rapid and unapologetic spread into "emerging" markets, along with evidence of covert efforts to undermine WHO and the FCTC process, precluded the acceptability of "partnership". How sustainable the FCTC will be, as a pillar of global health governance around which governmental and nongovernmental organisations can rally, will depend on the degree to which this global initiative can now become entrenched in regional, national and local level institutions.

3.4 Global Strategy on Diet and Nutrition

Lessons learned during the FCTC negotiations have begun to be applied to tackle another major contributor to the looming non-communicable disease burden (60% of deaths worldwide) – poor diet and nutrition. Similar to tobacco control, health promoters face powerful vested interests that dominate world food production and consumption. A draft WHO Global Strategy on Diet, Physical Activity and Health, endorsed by the WHA in 2004, was supported by a range of organisations including the International Union Against Cancer (UICC), International Diabetes Federation, and World Heart Federation. However, the US government, reportedly under pressure from the domestic food lobby led by sugar producers, argued against stronger regulation, citing the importance of individual responsibility for lifestyle choices.

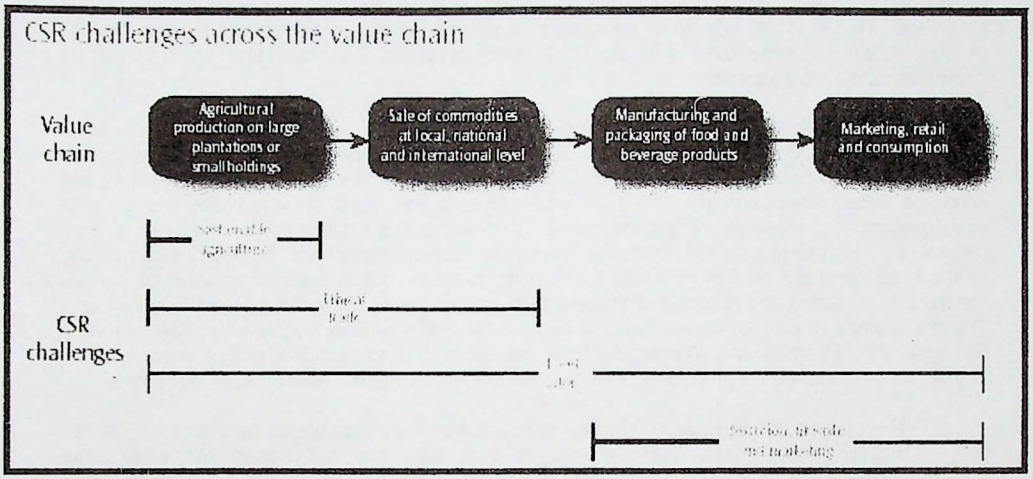
The document eventually adopted in May 2004 was described as "a milder final draft" resulting from "a diplomatic high-wire act to silence its critics and win worldwide support."[15] Defending the need to consider almost 60 new submissions, WHO officials described the need for a "balanced" approach that "takes into account political realities."[15] While parallels were drawn with the FCTC, as Yach stated, "food is not tobacco. The food and beverage industries are a part of the solution."[16] Fuelling the political battle has been a perception of scientific uncertainty. Despite alarming upward trends in obesity and diet-related ill-health, the evidentiary base for underpinning global guidelines on diet and nutrition has remained keenly fought over. The multiplicity of factors contributing to poor diet and nutrition, and the need for a better understanding of what policy interventions are most effective to address them, has made policy discussions fraught with complexity compared to tobacco control. This task has been made more difficult by industry-funded claims that recommended daily intakes of salt, sugar and fat are unnecessary. As Yach et al. advise, "Undertaking research necessary to close the remaining knowledge gaps is therefore important to eliminate any persistent uncertainty, particularly with regard to the health effects of obesity."[17]

The ongoing tussle over a global dietary strategy contrasts with the Move for Health Initiative adopted by the WHA in 2002 to promote increased physical activity. Described as "driven by countries", implementation has sought to involve a wide range of "concerned partners, national and international, in particular other concerned UN Agencies, Sporting Organizations, NGOs, Professional Organizations, relevant local leaders, Development Agencies, the Media, Consumer Groups and Private Sector."[18] The initiative is described as offering core global messages to partner organisations, but allowing flexible implementation at local, national and regional levels.

Importantly, unlike the FCTC and guidelines on diet, this initiative does not face strong vested interests in the same direct way. This has allowed public health organisations to engage a

wider range of partners than available to tobacco control advocates, for example. Indeed, many private companies have begun to support the initiative, possibly as a means of demonstrating corporate social responsibility (Figure 1), but ostensibly to prevent stronger regulation and product liability litigation.[19] Such "partnerships" have not been without criticism. In the UK, with the fastest growing obesity rates in Europe, it was reported that the food industry agreed in 2004 to contribute millions of pounds to the creation of a National Foundation for Sport "if they want to avoid stricter regulation" of food advertising, marketing and labelling.[20] The supermarket chain Sainsbury's has introduced the Active Kids voucher scheme to provide schools with sports equipment. However, Cadbury's Get Active initiative, supported by the British sports minister, has been criticised for requiring schoolchildren to spend over £2000 on chocolate (almost one and a quarter million calories) to earn a set of volleyball posts.[21] The use of sports personalities to promote unhealthy food options has also been criticised.

Figure 1: Corporate social responsibility challenges across the food and beverage industry value chain



Source: Prince of Wales International Business Leaders Forum, *Food for Thought: Corporate social responsibility for food and beverage manufacturers*. London, 2002.

This example suggests that global health promotion on diet and nutrition faces difficult challenges. It must improve the evidentiary base, and build necessary but appropriate partnerships with the food and beverage industry. The public health community should be aware of strategies to undermine such efforts by vested interests, with some parallels to the FCTC process. Nonetheless, there are limitations to applying the interventions used in tobacco control to a global strategy on diet. Most notably, tobacco is inherently harmful to health, while food intake is necessary to life. Excluding the food and drink industry from policy development and implementation would therefore seem inappropriate. Fuller understanding of effective health promotion activities is needed, accompanied by efforts to build a broad global network of supporting institutions, with clearly agreed criteria of acceptable collaboration.

4.0 Strategies for building a global approach to health promotion

This brief overview of global health promotion offers a number of lessons for future action.

First, *a global approach to health promotion should seek to draw on a wide range of governance instruments, from voluntary codes to binding legislation.* Not all of these

instruments will be available at various policy levels. For instance, legally binding regulations at the regional and international level require careful negotiation vis-à-vis principles of state sovereignty. Where agreement to binding measures are not possible, "softer" forms of governance (such as declarations of principles or codes of practice) may need to be relied upon to draw public attention to an issue, lend symbolic value to a health promotion movement, or serve as the basis for public education. In some cases, stronger regulatory measures may unavoidably be needed, with "teeth" to ensure compliance, when dealing with strong vested interests. Moreover, different instruments, or combinations of, will be appropriate for different contexts and at different points in time.

Second, *ensuring the effectiveness of governance instruments for global health promotion requires careful attention to implementation in the medium to long term.* High-profile global initiatives are increasingly numerous, but have stumbled over insufficient attention to ensuring sufficient capacity, political will, resources and leadership to implement from the local level upwards. The "eight capacity wheel"[22] for assessing national capacity for health promotion, supported by the Bangkok conference, suggests stark shortfalls in many countries, as well as at the global level. The existing picture is highly fragmented. If global health promotion initiatives are to prove effective, far greater attention to supporting them through skilled personnel, an authority base and social agreement about the need and approaches for implementation are essential.

Third, *careful reflection on the nature and appropriateness of partnerships for global health promotion is needed.* In principle, "broad based, well networked, vertical and horizontal coalitions"[17] are intuitively attractive. The building of "partnerships" for global health promotion across a broad spectrum of institutions and interests has been an important and popular development.[23] However, the process of formulating such partnerships requires critical reflection. Partnerships can become overly inclusive, hampered by complex working relationships and an insufficient basis for working together. Conversely, partnerships can be too exclusive, failing to recognise the need for a broad social movement or policy advocacy. The abundance of partnerships created to date offer fertile ground for drawing wider lessons. For example, Thomas and Weber describe recent efforts to mobilise global resources for HIV/AIDS as "focused on piecemeal investments based on loans, discounts, or donations."

> The piecemeal approach...is often presented in the language of partnerships. A key problem with these 'partnerships' is that they are not based on substantive conceptions of equality that underpin, for instance, the health for all ideal, and that those in whose interests they are avowedly developed are in general excluded from their negotiation. For serious partnerships to develop, developing countries must be fully involved in deliberations with companies and UN organizations.[24]

In other words, if partnerships are critical to addressing the challenges posed by globalisation to health, there is a need to understanding when such partnerships are appropriate, what the membership should be, how partners should work together, and what governance instruments are needed to regulate them.

Fourth, *there is a need for better understanding of effective policies for harnessing the positive influences of globalisation, and countering the negatives.* This must be based on better knowledge of the interconnections between global (macro) level influences and everyday lives at the individual and community levels. This should include understanding of the ways global forces influence decisions about lifestyle and health. This is well understood, for example, by large transnational corporations employing powerful marketing techniques to build global markets (e.g. branding, sponsorship). Health promotion policies could harness such strategies, and use them to create counter influences.

Fifth, and related to the above points, *there are a number of research areas that require attention to underpin a global approach to health promotion.*

(a) A fuller assessment of what governance instruments have been used, in what contexts, and their degree of effectiveness than can be provided in this brief analysis

is needed. When is it necessary and possible to apply certain instruments? Should instruments used be changed over time and when is this appropriate?

(b) The ingredients for effective implementation of global health promotion initiatives require fuller understanding. What does capacity for global health promotion mean in terms of resources, skills, leadership and political will? How can we build capacity for global health promotion at various levels of health governance?

(c) A critical review of partnerships for global health promotion is needed. What partners are (in)appropriate for which issues? What roles should partners play in such collaborations? How can partnerships improve their transparency and accountability?

(d) A broader review of how well health governance is working to address the challenges of globalization is needed. While there has been some limited analysis of specific governance mechanisms, an overall assessment of the system as a whole (global health governance architecture), and how it can be improved, is needed to take account of significant governance changes since the early 1990s.

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REGERINGSKANSLIET

Ministry of Health and Social
Affairs
Sweden

Presentation by Ms. Ewa Persson-Göransson, State Secretary, Ministry of Health and Social Affairs, SWEDEN

"Public health policy of Sweden – building a strategy based on wider determinants of health"

CHECK AGAINST DELIVERY

6th GLOBAL CONFERENCE ON HEALTH PROMOTION, "POLICY AND PARTNERSHIP FOR ACTION: ADDRESSING THE DETERMINANTS OF HEALTH" BANGKOK, THAILAND, 7-11 AUGUST 2005

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Mr/Mrs. Chairperson.

Thank you very much for the invitation to this conference and for giving me the opportunity to present the Swedish public health policy. My name is Ewa Persson-Göransson and I am State Secretary at the Swedish Ministry of Health and Social Affairs. I am speaking on behalf of the Minister of Public Health, Mr Morgan Johansson, who sends his regrets that he was not able to attend this very important conference since he is currently fully engaged in paternity leave taking care of his newborn child.

Let me share with you some of the lessons learned during the development of public health policy in Sweden. It was adopted in 2003 by our Parliament, the Swedish Riksdag. Our starting point was a very good health status of the population in general, with very low child mortality: less than 4 per 10 000. Swedish women live until the age of 82 on average and men almost until the age of 80. However like in all countries health inequalities are too big. In terms of life expectancy the difference between males living in two municipalities may differ more than 7 years and 5 years for women. This is due to a combination of factors such as income, education and profession, working conditions, marital status, which in turn determines life styles like smoking, alcohol consumption, eating habits and physical inactivity. These differences are of course not acceptable in a welfare society, so there is a lot to do for us before we can truly say that all citizens have equal opportunities to live healthy lives.

1. Building a public health policy is a process – not a one shot game

- **A process takes time**
- **A process involves many stakeholders and partners**
- **A process needs fuel**

The normal procedure when developing a policy is that it should be delivered within a limited time. However, creating a modern public health policy means involving and engaging other parts of society. It requires reflections, re-thinking and numerous discussions to understand the concept and to start establishing a common ground. The government was aware of this and in its instructions to the National Public Health Committee - a committee appointed by the Government with a mission to present a basis including proposals on national objectives for the development of public health - it was clearly stated that it should adopt a process oriented working method involving the public and voluntary sectors at large.

The Committee was given three years to accomplish its mandate, which was done in 2000. In most cases governmental committees are given much shorter time than three years. My point is that if you want to have a process it takes time and there is no shortcut. The advantage is of course that the society has time to prepare. To keep the momentum up during such a long process requires fuel. The fuel in this case was a number of expert reports, pamphlets with controversial opinions around alcohol, modern

diseases due to lack of thrust in the society, tobacco etc, and numerous meetings and consultations around the country.

To my knowledge the chair of the Committee, a former MP, did not turn down any offer when she had the possibility to attend a meeting. I also want to mention that the composition of the Committee was based on four pillars; representatives of the political parties in the Parliament, leading public health scientists, a selection of experts representing the most relevant national state agencies, regional and local authorities, and a number of NGO's including public health professionals. When the Committee had delivered its report, it took the Government almost another two years to process the proposal within the Government Offices, before it was put forward to the Parliament for the final decision, which as I stated earlier was taken in 2003.

2. Why determinants?

- Politicians cannot directly prevent deaths and ill-health, but they can influence the underlying causes – the 'upstream approach'

- Why inequalities?

- A profound political issue based on values and human rights

How come we decided to have a determinant approach when developing the strategy? Given the limited time for this presentation I will give you the short version. Most public health strategies that we knew of at the time were outcome oriented. Objectives and targets were formulated in terms of reducing morbidity and mortality. And, of course, that is what we all want to achieve in the end, but how do we get there?

In a way one can say that we turned direction and started to look up-stream, which means that we started to focus on the underlying causes of ill health instead of only focusing on ill health once it occurs. By tackling the underlying causes, or determinants, ill health is being reduced. While (personal) health rather used to be understood as an individual judgement, public health was now seen as the responsibility of the society at large, where collective actions are required. By approaching determinants, public health also becomes more political.

Especially the politicians in the Committee felt uncomfortable with the fact that they could not directly prevent that people die from cancer or fall ill as a result of heart diseases for example. But we found out that the role of the politicians should be to create societal conditions to promote good health, conditions beyond the immediate control of a single individual. In other words, the role of politicians is to create a society in which people live in a healthier way and make healthier life style choices. As a consequence, politicians can indeed indirectly prevent people from dying from cancer or fall ill as a result of heart diseases!

We were also inspired by what happened in the WHO Europe at the time. The first phase of the European 'Health for all'-policy had come to an end and was to be renewed. A mutual and active exchange of opinions took place, and we were strengthened in our belief that we were on a promising track when HEALTH 21 for Europe was launched. By making health more political in this sense it also became more interesting

and a part of the public debate. For the Swedish government and the majority of the parties in the Parliament it was agreed to put equal opportunities to good health as the overarching aim of public health policy, also as a human right's issue.

3. Swedish policy in brief

Overall objective: "The creation of social conditions to ensure good health, on equal terms, for the entire population".

11 target areas are prioritized and defined as follows:

1. Involvement in and influence on society.
2. Economic and social security
3. Secure and healthy conditions for growing up
4. Better health in working life
5. Healthy, safe environments and products.
6. Health and medical care that more actively promotes good health
7. Effective prevention of the spread of infections
8. Secure and safe sexuality and good reproductive health
9. Increased physical activity
10. Good eating habits and safe foodstuffs
11. Reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in the harmful effects of excessive gambling.

The Swedish Parliament decided upon these objectives during spring 2003. They can be grouped into wider socio-economic determinants, environmental and settings determinants and the promotion of health literacy. The contribution from health promotion is apparent. You can easily trace the action areas of the Ottawa Charter, the idea of a health public policy out- spelled in the Adelaide recommendations, the focus on health supporting environments and the evidence based approach. For each of the 11 target areas there is an expert report behind, summarising their concurrent scientific rationale. The point here is that all the areas should be seen holistically, being interlinked with each other. Promotion of good eating habits are linked to socio-economic conditions and to secure and healthy conditions for growing up to mention one example.

4. Key issues

- Most health determinants mainly fall under the responsibility of other policy areas than health and medical care
- How to convince other Ministries to implement a public health perspective into their respective policy areas
- How to set up an executive structure

The implementation of the objectives involves most of the other Ministries. The determinant approach made it much more understandable for other ministries that they had a crucial stake in health policy. Some ministries became more interested, like Environment, Agriculture and Consumer Affairs, Finance due to alcohol taxation and mainstreaming issues like gender equality. In general we have experienced strong support from other ministries to contribute to improve public health. Often they feel that a benefit for public health from their policy areas will strengthen their argument for resources.

One example could be the minister of education, who understands the benefit of the public health policy for his or her own area of responsibility. How? Well, by taking public health into account in education policy, pupils and students learn faster and are getting better results, which in turn have a positive effect on their health, on their school results and thus on society at large. Another example is the Minister of Agriculture who is actively involved in changing the Common Agricultural Policy of the European Union into a more health friendly policy by for example making fruits and vegetables affordable. In that way, healthy food choices become a reality also for lower income families. The next step of the implementation phase was to establish an executive structure.

5. The Swedish solution

- To identify objectives in existing policy areas and to put them in a public health context – sectoral responsibilities
- Appoint a special Minister of Public health and strengthen inter-ministerial mechanisms within the Government
- Establish a National Steering Group for public health issues in which the most relevant national agencies are represented by their Director-General

The decision to have the determinant approach made it natural to investigate how this was spelled out in already existing policies. Surprisingly, we found that much was already in place, only it was not framed by public health. So instead of inventing new policies we started pointing out and underpinning the health dimension of those policies.

With this comprehensive public health policy the need for a special Minister for Public Health became apparent. In our case this means a senior Minister with a mandate to take initiatives covering all the determinants that are linked to the 11 target areas. Although the Minister does of course not have the formal responsibility of the other policy areas, his or her role is to stimulate cooperation and coordination with the other ministers so that public health is taken into account in all other policy areas.

For the implementation of the policy a National Steering Group for public health was established under the Minister for Public Health. It is inter-sectoral by nature and includes director-generals from almost 20 state agencies who are commissioned by the government to implement those parts of the public health policy that fall under their specific sectoral responsibilities.

6. The Swedish National Institute of Public Health (SNIPH) = the coordinating agency

- co-ordinated reorganisation in pair with the development of the national public health policy

The Swedish Institute of Public Health has an important task in co-ordinating and forcing the pace of the implementation of the national public health policy. In order to have an infrastructure in place for implementation of the policy, a reorganisation of the Institute was co-ordinated with the work of the Public Health Commission. The Institute was given three major tasks:

1. To monitor and evaluate the public health policy and facilitate its implementation
2. To be a national centre of knowledge for effective and knowledge based interventions for health promotion and disease prevention
3. To supervise specific preventive legislation in the fields of alcohol and tobacco.

The role of the Institute has proven to be of key importance so far. It has been very instrumental in supporting the other state agencies in placing health on their agendas, by developing a systematic approach to tackle and monitor the determinants. It has also delivered proposals for necessary infrastructures that need to be developed and put in place to further implement actions and interventions along the main lines of the public health policy.

7. Implementation

- Governmental directives to all concerned state agencies to take action and report on objectives under their sectoral responsibility

- Core function of SNIPH to support and facilitate implementation for sectoral agencies and to publish a Public Health Policy Report

The Government has systematically given guidelines to all state agencies concerned to take actions and to report on objectives under their sectoral responsibility. It is a core function of the Public Health Institute to support and facilitate implementation for all concerned sectoral agencies, regional and local authorities. In general, the response has been more positive than expected, at least so far. Active participation in seminars, meetings and conferences are indications thereof, just like focused activities and interventions to promote health by improving physical exercise in the schools, NGO's taking action on healthy ageing, improving gender equality in work-places by adding health arguments and so forth.

It has been a main concern to put extra efforts into the monitoring and evaluation of the public health policy. The simple reason behind that is: what is monitored is more likely to be implemented.

A core function of the Institute is to publish a Public Health Policy Report focusing on indicators for health determinants and on suggested priorities and measures. This report shall be seen as complementary to the already existing Public Health Report in which trends in morbidity, mortality and risk exposure are presented. I will briefly outline the rationale behind the new Public Health Policy Report.

8. The Public Health Policy Report: in general

- The first to be published in October 2005 and thereafter every four years
- Based on 38 principal indicators for determinants under each target area
- Will guide the Government for further developing public health policy
- Will be subject to a debate in the Parliament

The first Public Health Policy Report will be published this fall and handed over to the Minister for Public Health on October 5 this year. The report will be based on 38 principal indicators that have been decided upon by the National Institute of Public Health in agreement with concerned sectoral state agencies, regional and local authorities. The indicators are linked to the determinants in each of the target areas and to how public health could be improved by efficient actions and interventions at different societal levels.

The report will also contain proposals from the Institute and other stakeholders about how to update and improve the public health policy. Then it will be up to the Government in office to make its political decisions.

The Government will then make a comprehensive report on public health to the Parliament for a political debate and include the Government's plan for actions in the field of public health. The rationale is to maintain public health on the political agenda. It is envisaged that a new report will be produced every fourth year, following the electoral periods.

9. What will the Public Health Policy Report contain?

- Analysis on whether the policy is implemented and has contributed to achieving the public health objective
- Analysis on both undertaken and planned actions and interventions
- Focus on socio-economic and gender inequalities
- Cover all societal levels as far as possible (national/regional/local)

Technically the Public Health Policy Report will provide an analysis on to what degree the policy is implemented and to what extent the objectives are fulfilled. This will be based on how effective policies linked to the 11 target areas have been implemented and whether different actions and interventions have had a positive impact. The outcome will be presented according to socio-economic and gender inequalities, children and adolescents, older people, disabled, immigrants and homo- and bisexuals. As far as possible the data will be presented for the local level and will be aggregated for all societal levels.

10. Some reflections

- It takes time from action to result
- Public health policy ought to have strong support from the Parliament

When starting to prepare a public health policy it is necessary to have a long time perspective from action to result. A lot of effective measures will not bear fruit during the first years. So we will depend on a solid political base to be able to hold on to an action plan for a long period before the figures show that the plan leads to improvement in health.

In Sweden we have put confidence in research on health determinants. This gives us an opportunity to highlight improvements in a stepwise procedure toward a better public health. To give you a very recent example, we considered it a large step forward when we introduced a new anti-smoke law effective as of the 1st of June this year. The law makes it prohibited to smoke in restaurants, cafes and bars in Sweden. We do not have to wait and see the improvements in health from this decision because we already know that tobacco is an important health determinant and providing means for reducing tobacco consumption is an effective measure.

But we need to know more about evidence based public health measures. A lot of health determinants are not as obvious as tobacco. And it is not always easy to pick

out the most cost effective measures to tackle a health determinant. Better knowledge will improve a more efficient use of resources. Although we must admit that there are already a lot of important knowledge that we have not taken full advantage of so far.

In our experience it is and should be rather difficult to negotiate with the Minister of Finance on resources. Not only for actions in the field of public heath. According to my view it should not be easy to get our taxpayers' money for any reason so I can accept that we need to struggle for money for public health. We are usually able to present solid arguments on the fact that measures to improve public health will pay back through improved economic growth, less expenditures for sick leave and pension schemes and other social costs, beside the more non-countable values of a good health for the people. But we do not expect the gain from the measures the same year or even the year after that we bear the cost. Actually we can seldom make projections on exact when the pay back time will come. This makes it very important that there is a solid political base for actions in the field of public health. And also regarding further research to find evidence for effective measures.

Let me conclude by making some general remarks. We are all facing a more inter-connected and globalized world. For many reasons this is beneficial to health, but not in all cases and far from for all, and it is not taken consciously. Therefore health must be recognized as the key driving force for economic and social development, and thus be considered duly in global trade, in the internationalized labour market, in human reproduction, in sustainable investments and so forth.

This is also one major reason why there is an urgent need for a Global Health Promotion Charter to strengthen the position of health in human development. As I mentioned earlier, in developing our own policy in Sweden, we were inspired by the outcomes from earlier international health promotion conferences. I sincerely hope that our example can provide some guidance and good practice in outlining the new Bangkok Charter that we will adopt on Thursday and that this Charter will serve as an up to date global health promotion document, capturing both the major changes in disease global disease burden, the demographic transition with ageing populations as well as innovative and efficient policies, strategies and methods to promote and protect health. It is my wish that tackling the whole range of health determinants and partnerships are put at the forefront of the Charter and that it will become a useful tool for countries wishing to adopt the determinant approach to enhance public health.

Finally I want to stress my conviction that the WHO has a very important role to play in promoting development and cooperation to improve the knowledge on health promotion. At the same time we - representatives of Member States - must improve our efforts and upgrade our commitments in this field, in order to actively strengthen our work in the governing bodies so that health promotion becomes a key strategy in tackling major public health challenges and is clearly visible in the budget as well as in the organizational structure. In this regard, health promotion should definitely get the attention that it deserves in the upcoming General Work Program of the WHO, covering the period 2006-2015.

Sustainable financing for Prevention and Health Promotion: issues and challenges

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The 6th Global Conference on Health Promotion
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Abstract

A substantial proportion of global burden of diseases can be minimized through proven cost effective prevention and health promotion interventions, such as safer sex practices, control of tobacco and alcohol consumption, and other clinical preventive services for mother and children. In developing countries, government spent less on health, a large portion was paid by households. Resource constraint is the main barrier for government to invest more in health promotion as curative services were given priority especially by households.

Where data is available, in 15 high and middle income countries, 3.82% of Total Health Expenditure was spent on prevention and health promotion, that government had a major role, 73.5% in financing Prevention and Health Promotion, where as Social Health Insurance and donors had minor roles. We estimated that countries categorized as low human development group, spent only 0.6 USD on Prevention and Health Promotion, too little to make a change in preventable burden of diseases. Experiences indicated dedicated tax from tobacco and alcohol for health promotion fund and innovative management of these funds, are sustainable and would make a change.

We recommend (1) governments to give a high priority to finance health promotion, setting up a national target of general government expenditure and Social Security Expenditure for prevention and HP activities and ensure coordination of actions from different financing sources; (2) to ensure prevention and HP services an integral part of the benefit package of Social Health Insurance, and provides legal and fiscal enabling environment that promotes workplace prevention and promotion programs; (3) to establish where possible, through legislation an innovative Health Promotion Fund financed from dedicated taxation of health damaging goods, or dedicated funding from social health insurance contributions; (4) to an active involvement by international development community, to mobilize additional fund supporting prevention and HP activities.

1. BACKGROUND

There is a wide gap of health expenditure per capita between rich and poor nations (WDI 2002), Low income nations spent merely 21$US, far below the level of incremental cost for scaling up of 24$US per capita for sub-Saharan Africa countries (Macro-economic Commission 2000).

Unhealthy diet, physical inactivity, tobacco consumption and the harmful use of alcohol are key risk factors for non-communicable diseases (WHO 2002) and can largely addressed by cost effective prevention and health promotion (HP).

In view of low spending in health and resources constraint in most developing countries, this paper argues the need to invest more in prevention and HP, reviews financing of healthcare in general and financing prevention and HP in particular, discusses the innovative financing mechanism for HP and recommends a sustainable financing of HP.

2. WHY INVEST IN PREVENTION AND HEALTH PROMOTION

In table 1, at least 30% of global BOD took place in high mortality developing countries, in sub-Saharan Africa and South East Asia where top ten risk factors result in 50% of BOD. In low mortality developing countries, e.g. China and most countries in Central and South America, the top five risk factors cause one-fifth of the total BOD. These countries faced double burden, tobacco and high blood pressure, while having to combat under-nutrition and communicable diseases. In developed countries, 47% of BOD is attributable to five risk factors: tobacco, alcohol, blood pressure, cholesterol and obesity.

<Table 1 here>

Major risk factors attributable to global BOD could be addressed by low cost community based public health intervention, prevention and HP and other clinical interventions. Interventions widely acknowledged as effective are given in **Box 1** (Jan Bennett, 2003). Fiscal policy and legislative frameworks are major determinants of successful HP programs described in Box 1.

<Box 1 here>

Figure 1 shows that investment in prevention and HP such as tobacco, safe workplace and weight control is worthwhile. If 5% of premiums were invested in prevention and HP, significant savings on healthcare costs will offset spending on prevention.

<Figure 1 here>

Of the 14 most highly rated preventive interventions, Coffield et al (2001) identified a group of eight interventions which are delivered to less than 50% of the target population in the United States. Nutbeam et al (1998) argues that comprehensive and sustained approaches to population health appear to work best. A range of actions is required, for example, education, community development, and legislation at the population level, complemented by targeted approaches for high-risk groups.

Not only evidence on cost effectiveness (Murray et al 2003), prevention and HP are considered as public goods, having positive externalities, deserves to be financed out of public sources, where demand is inadequate and that preferentially benefit the poor (Musgrove 1999).

3. FINANCING HEALTHCARE

This section gives a clear picture of financing healthcare globally. A great variation in health expenditure was observed, ranged from 3.9% in SEAR to 6.8% of GDP in EUR in 2001 (Table 2). General Government Health Expenditure (GGHE) played a small role in poorer region such as SEAR, 48.8% of Total Health Expenditure (THE). In developed countries such as EUR, Private

Health Expenditure played the smaller role, 30.4% while this was 51.2% in SEAR. The Governments in developing countries played a lesser role in financing health.

<Table 2 here>

External resources, a very significant role in AFR, consisted of 21.9% of THE. Reviews indicate that Social Health Insurance (SHI) is least developed in AFR, only 1.8% of GGHE while in EUR, it is the highest share, 43.5% of the GGHE. SHI though small proportion, has potential to mobilize resources for HP in poorer countries due to its mandatory contribution by employers and employees and financial sustainability.

A large gap of per capita THE, was observed across regions, see Table 3. In 2001, countries in AFR and SEAR spent 43.1 and 48.9 USD per capita on health, while EUR spent 933.8 USD per capita. Countries in AFR reported a five consecutive years of reduction in THE per capita, whereas AMR demonstrated a steady increase.

<Table 3 here>

It should be noted that 30 out of 46 countries in AFR spent less than 20 USD per capita per year on health in 2001, leave alone HP and prevention. On the global perspectives, 45 out of 192 WHO member countries spent less than 20 USD per capita per year on health. These countries have least capacity to spend on health, prevention and HP.

4. FINANCING PREVENTION AND HEALTH PROMOTION

The previous section sets the scene on financing healthcare in general, this section deals with financing prevention and HP in specific in particular.

From 15 countries where NHA are available, there is a wide variation of expenditure on prevention and HP per capita USD (table 4), ranges from 4USD in Turkey to 161USD in Canada, with a mean of 57 USD (median 25). Of these, the government had a lion share (31USD), whereas SHI plays a minor role of 8USD. However, there is a great scope of SHI to invest in prevention and HP. Households play a negligible role in financing prevention and HP services.

<Table 4 here>

From these countries where data on financing prevention and HP is available, **3.82% of THE** (range 1.43% to 8.43%) was spent on prevention and HP services, of which 73.5% financed by General Government Revenue, 12% by SHI, 0.1% by Private Insurance, 2.3% by OOP and 12.1% by donors. Table 5 summarizes these parameters.

<Table 5 here>

From these key parameters, we estimate prevention and HP expenditures based on THE per capita USD in 2001 (UNDP 2004), see Table 6. HP expenditure was estimated for each country, and group average (low, medium and high human development) was produced by authors.

In Low human development group (HDI<0.5), countries spent 0.6USD on prevention and HP (range 0.2-1.2) while the high human development group spent 56USD (range 21-124). A large gap of prevention and HP expenditure among groups of country was observed. In high human development group, SHI spent 6.7 USD on prevention and HP, whereas the medium human development groups, SHI has literally no role in financing HP, 0.5USD.

Annex 1 provides health THE and HP expenditure per capita and group by level of human development.

<Table 6 here>

Interpretation should be made with care. We assume 3.82% of THE, are spent on prevention and HP and apply this figure to all 177 countries. This is slightly high estimate, as 15 countries were high and middle income countries, whereby spending on HP is high.

5. INNOVATIVES IN FINANCING PREVENTION AND HEALTH PROMOTION

A limited experience on dedicated tax and levies in financing HP emerged. Earmarked tax from tobacco, alcohol, petrol and unhealthy products such as high calories high fat foods can be collected and directly transferred to support HP and prevention. Without earmarking, additional tax from these products would be channeled to the general treasury. Legislation and strong political will are required to introduce such innovations. Jamaica (Barrett et al 2004) National Health Fund generates resources from three tobacco tax, payroll tax and government budget. Table 7 provides such country experiences.

<Table 7 here>

In such a gloomy situation, there is still hope, provided a strong political leadership. In developed countries where SHI was well developed, there is a high potential to increase additional efforts so that prevention and HP are integral part of the benefit package, as well as active health promotion programs in the workplaces and risk reduction program especially from work injuries.

6. CONCLUSION AND RECOMMENDATIONS FOR BANGKOK CHARTER

Conclusions

Major findings emerged that on average 3.82% of THE in middle and high income countries were spent on prevention and promotion and that government is a major source of financing. There is a potential for SHI and donor resources to invest more in prevention and HP. A large gap on spending in HP was observed among countries. Where the low human development group needs more resources due to its BOD, these countries have least capacity, not only to pay for curative services, let alone prevention and HP.

Recommendations

1. The governments to give a high priority to finance health promotion, setting up a national target of general government expenditure and Social Security Expenditure for prevention and HP activities and ensure coordination of actions from different financing sources;
2. Where social health insurance is functions, the government to ensure prevention and HP services an integral part of the benefit package, and provides legal and fiscal enabling environment that promotes workplace prevention and promotion programs;

3. To establish where possible, through legislation an innovative Health Promotion Fund financed from dedicated taxation of health damaging goods, or dedicated funding from social health insurance contributions; and a strong institutional base for the management of health promotion, especially the primary prevention of risk factors.

4. An active involvement by international development community, to mobilize additional fund supporting prevention and HP activities.

5. A monitoring tool is required, to encourage the development of NHA and to ensure the existing account, dis-aggregate expenditure on prevention and health promotion.

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Table 1 Top ten risk factors, percentage causes of DALY loss in three groups of country

Rank	Developing high mortality	%	Developing low mortality	%	Developed	%
1	Underweight	14.9	Alcohol	6.2	Tobacco	12.2
2	Unsafe sex	10.2	Blood pressure	5.0	Blood pressure	10.9
3	Unsafe water sanitation hygiene	5.5	Tobacco	4.0	Alcohol	9.2
4	Indoor smoke from solid fuels	3.6	Underweight	3.1	Cholesterol	7.6
5	Zinc deficiency	3.2	Overweight	2.7	Overweight	7.4
6	Iron deficiency	3.1	Cholesterol	2.1	Low fruit, vegetable intake	3.9
7	Vitamin A deficiency	3.0	Low fruit, vegetable intake	1.9	Physical activities	3.3
8	Blood Pressure	2.5	Indoor smoke from solid fuels	1.9	Illicit drugs	1.8
9	Tobacco	2.0	Iron deficiency	1.8	Unsafe sex	0.8
10	Cholesterol	1.9	Unsafe water sanitation hygiene	1.8	Iron deficiency	0.7
	Top ten risk factors	49.9		30.5		57.8

Source: WHO 2002

Table 2 Selected National Health Account (NHA) indicators, countries by WHO regions, 2001

WHO region	Total Health Expenditure (THE), %GDP	General Government Health Expenditure (GGHE), %THE	Private Health Expenditure (PvtHE) %THE	GGHE %General Government Expenditure (GGE)	External Resources %THE	Social Security Health Expenditure (Soc Sec HE) %GGHE	Out of Pocket Spending (OOPS) %PvtHE	Prepaid Plans %PvtHE
AFR	4.6	55.5	44.5	9.5	21.9	1.8	82.8	7.2
AMR	6.7	56.7	43.3	13.2	3.6	26.3	80.0	16.6
EMR	4.9	52.4	47.6	9.3	3.2	10.7	80.3	7.4
EUR	6.8	69.6	30.4	12.4	1.4	43.5	85.6	8.9
SEAR	3.9	48.8	51.2	6.7	7.3	4.0	95.8	2.1
WPR	6.3	65.5	34.5	10.1	12.7	11.8	83.8	4.1

Source: WHO 2004.
Note: AFR refers to African Region, AMR American Region, EMR Eastern Mediterranean, EUR European Region, SEAR Southeast Asia Region, WPR Western Pacific Region

Table 3 THE, US$ per capita, 1997-2001 and annual nominal changes, by WHO regions

	1997	1998	1999	2000	2001	1997-98	1998-99	1999-2000	2000-01
AFR	46.5	45.4	43.7	43.1	43.1	-2%	-4%	-1%	0%
AMR	381.2	391.6	400.6	423.5	438.0	2.7%	2.3%	5.7%	3.4%
EMR	243.3	245.2	244.9	247.8	246.6	0.8%	-0.1%	1.2%	-0.5%
EUR	920.3	965.3	975.3	909.4	933.8	4.9%	1.0%	-6.8%	2.7%
SEAR	37.5	37.4	43.7	46.9	48.9	-0.3%	16.8%	7.3%	4.3%
WPR	373.7	341.2	368.9	370.1	353.3	-8.7%	8.1%	0.3%	-4.5%

Source: WHO2004

Table 4 Estimate of prevention and HP expenditure, 15 selected countries, 2002

Country	THE as % GDP	THE per capita, USD	GGHE per capita USD	PHP per capita USD	PHP per capita USD financed by GGE excl. SHI	PHP per capita USD financed by SHI	PHP, % of THE
Australia	9.5	1,995	1,354	103	103	0	5.2%
Canada	9.6	2,222	1,553	161	157	4	7.2%
Denmark	8.8	2,835	2,350	67	66	0	2.4%
Germany	10.9	2,631	2,065	123	22	60	4.7%
Hungary	7.8	496	348	25	8	5	5.1%
Japan	7.9	2,476	2,023	77	9	29	3.1%
Korea	5.0	577	305	8	6	2	1.5%
Mexico	6.1	379	170	11	11	0	2.9%
Netherlands	8.8	2,298	1,507	120	0	0	5.2%
Poland	6.1	303	219	11	10	0	3.8%
Portugal	9.3	1,092	770	19	0	0	1.7%
Spain	7.6	1,192	850	17	17	0	1.4%
Switzerland	11.2	4,219	2,443	97	39	25	2.3%
Thailand	4.4	90	63	8	8	0	8.4%
Turkey	6.5	172	113	4	4	0	2.4%
Average		1,532	1,076	57	31	8	3.8%
Median		1,192	850	25	10	0	3.1%

Note: PHP refers to Prevention and Health Promotion services

Sources:

1. WHO 2005
2. UNDP 2004
3. http://www.oecd.org/document/49/0,2340,en_2649_34631_32411121_1_1_1_1,00.html
4. Thai Working Group on NHA (2004).

Table 7 country experience on dedicated tax for HP

Country/state	Organization	Legal framework	Source funding	Annual revenue, m USD	Population covered, million
Australia, Southern Australia	Dept of Human Service, Office for Recreation, Sports and arts	Tobacco Products Regulation Act 1997 www.dhs.sa.gov.au	State budget, initial from tobacco	2	2
Australia, Victoria	VicHealth www.vichealth.vic.gov.au	Tobacco Control Act 1987	State budget, initial from tobacco	16.2	4.6
Estonia	Health Promotion Commission www.kuka.ee	Tobacco Tax Act 1994, Alcohol Tax 2000, Health Insurance Tax 2002	3.5% tobacco tax, 3.5% from alcohol and Health Insurance Fund	Na	1.4
Iceland	Tobacco Control Committee in the Ministry of Health	Act 15.1 Act 101/1995	Tobacco tax 0.9%	Na	0.28
Republic of Korea	National Health Promotion Fund	National Health Promotion Act 1995 www.nhic.or.kr	Tobacco tax, 3% for HP, 97% to health insurance fund	8 for HP	4.24
Switzerland	Health Promotion Switzerland	Article 19 of the Health Insurance Act 1996, requires insurers and cantons to provide health promotion activities	Insurance premium contribution and local government tax	1.9 USD per capita insured person, 12 m USD 2003	Whole country
Thailand	Thai Health Fund www.thaihealth.or.th	Health Promotion Act 2001	2% from tobacco and 2% from alcohol per annum	50	64
USA, Arizona	Department of Health Services	Tobacco Tax and Healthcare Act 36-772	23 cents for each dollar of tobacco tax	Na	Na

Table 5 Key parameters generated for estimation of global expenditure on HP.

Prevention and HP, % of THE	3.82
Of which, % was financed by	
- General Government Revenue	73.5
- Social Health Insurance	12.0
- Private Insurance	0.1
- Out of pocket	2.3
- Donor sources	12.1
Total %	100

Table 6 Estimate of HP expenditure, by three group of countries, 2001

Level of human Development*	No of countries	THE per capita, PPP$	HP per capita, USD (range)	HP per capita by GGE, USD	HP per capita by SHI, USD
High	55	1,499	56.1 (21-123.8)	41.2	6.7
Medium	86	105	3.9 (1.5-8.7)	2.9	0.5
Low	36	15	0.6 (0.2–1.2)	0.4	0.1
Global	177	537	20 (8-44)	15	2

Sources: UNDP Human Development Report 2004
Note * defined by HDI>0.8 as high human development, <0.5 is low human development, and between 0.5 to 0.8, medium human development

BOX 1

Each USD 1 spent on diabetes outpatient education saves USD 2-3 in hospitalization costs.

Cervical cancer screening among low-income elderly women is estimated to save 3.7 years of life and USD 5,907 for every 100 Pap tests performed.

For every USD 1 spent on preconception care programs for women with pre-existing diabetes, USD 1.86 can be saved by preventing birth defects.

Participants in the arthritis self-help course experienced an 18% reduction in pain at a per-person saving of USD 267 in health care system costs over a four-year period.

Teng *et al* .[1995] have assessed 500 life-saving interventions and their cost-effectiveness. Many population health interventions were found to be highly cost-effective (*e.g.* seat belts laws and use, reduced lead in petrol, pre-natal care, breast and cervical cancer screening, immunization).

A study by the US Public Health Service in 1994 estimated that population–based strategies in six areas– heart disease, stroke, fatal and non-fatal occupational injuries, motor vehicle related injuries, low birth weight and gunshot wounds – would reduce medical spending by USD 69 billion by 2000, or 11% of medical spending on those conditions.

Source: Jan Bennett (2003) and Teng, et al. 1995

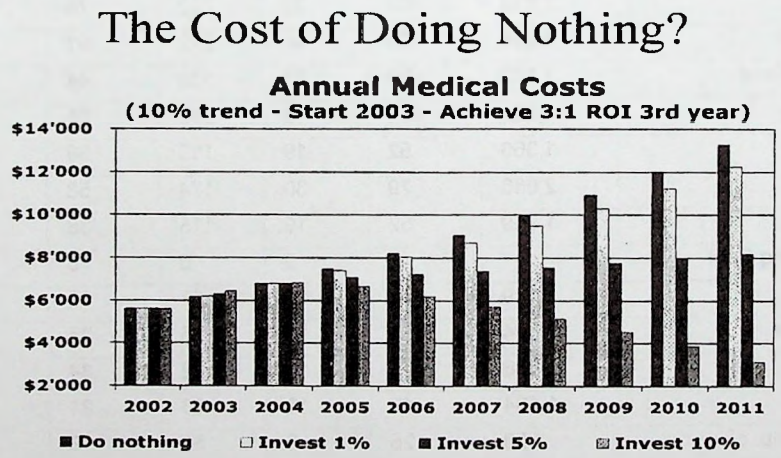

Figure 1 Cost savings from investment in HP, 3 scenarios

Annex 1 Per capita Total Health Expenditure and Prevention and Health Promotion Expenditure, 2001 rank by level of Human Development

HDI rank	Country	THE/cap USD	HP/cap USD	HP/cap USD Min.	HP/cap USD Max.	HP/cap GGE, USD	HP/cap SHI USD
1	Norway	3,941	151	56	332	111	18
2	Sweden	2,728	104	39	230	77	13
3	Australia	2,333	89	33	197	65	11
4	Canada	2,585	99	37	218	73	12
5	Netherlands	2,652	101	38	224	74	12
6	Belgium	2,455	94	35	207	69	11
7	Iceland	3,154	120	45	266	89	14
8	United States	5,095	195	73	430	143	23
9	Japan	2,638	101	38	222	74	12
10	Ireland	2,000	76	29	169	56	9
11	Switzerland	4,530	173	65	382	127	21
12	United Kingdom	2,146	82	31	181	60	10
13	Finland	2,047	78	29	173	57	9
14	Austria	2,295	88	33	193	64	11
15	Luxembourg	2,668	102	38	225	75	12
16	France	2,634	101	38	222	74	12
17	Denmark	3,225	123	46	272	91	15
18	New Zealand	1,582	60	23	133	44	7
19	Germany	3,039	116	43	256	85	14
20	Spain	1,360	52	19	115	38	6
21	Italy	2,066	79	30	174	58	9
22	Israel	1,359	52	19	115	38	6
23	Hong Kong SAR		0	0	0	0	0
24	Greece	1,149	44	16	97	32	5
25	Singapore	904	35	13	76	25	4
26	Portugal	1,206	46	17	102	34	6
27	Slovenia	1,104	42	16	93	31	5
28	Korea, Rep. of	650	25	9	55	18	3
29	Barbados	579	22	8	49	16	3
30	Cyprus	741	28	11	62	21	3
31	Malta	532	20	8	45	15	2
32	Czech Republic	561	21	8	47	16	3
34	Argentina	337	13	5	28	9	2
35	Seychelles	400	15	6	34	11	2
36	Estonia	299	11	4	25	8	1
37	Poland	303	12	4	26	9	1
38	Hungary	484	18	7	41	14	2

HDI rank	Country	THE/cap USD	HP/cap USD	HP/cap USD Min.	HP/cap USD Max.	HP/cap GGE, USD	HP/cap SHI USD
40	Bahrain	456	17	7	38	13	2
41	Lithuania	218	8	3	18	6	1
42	Slovakia	307	12	4	26	9	1
43	Chile	370	14	5	31	10	2
44	Kuwait	564	22	8	48	16	3
45	Costa Rica	275	11	4	23	8	1
46	Uruguay	423	16	6	36	12	2
48	Croatia	410	16	6	35	12	2
50	Latvia	235	9	3	20	7	1
51	Bahamas	1,128	43	16	95	32	5
53	Mexico	384	15	5	32	11	2
54	Trinidad and Tobago	298	11	4	25	8	1
55	Antigua and Barbuda	593	23	8	50	17	3
	HIGH DEVELOPMENT	**1,499**	**56**	**21**	**124**	**41**	**7**
56	Bulgaria	105	4	2	9	3	0
57	Russian Federation	161	6	2	14	5	1
59	Malaysia	167	6	2	14	5	1
60	Macedonia, TFYR	120	5	2	10	3	1
61	Panama	297	11	4	25	8	1
62	Belarus	143	5	2	12	4	1
63	Tonga	57	2	1	5	2	0
64	Mauritius	126	5	2	11	4	1
65	Albania	62	2	1	5	2	0
66	Bosnia Herzegovina	74	3	1	6	2	0
68	Venezuela	269	10	4	23	8	1
69	Romania	164	6	2	14	5	1
70	Ukraine	35	1	1	3	1	0
72	Brazil	221	8	3	19	6	1
73	Colombia	104	4	1	9	3	0
74	Oman	204	8	3	17	6	1
76	Thailand	80	3	1	7	2	0
77	Saudi Arabia	440	17	6	37	12	2
78	Kazakhstan	66	3	1	6	2	0
79	Jamaica	202	8	3	17	6	1
80	Lebanon	623	24	9	53	17	3
81	Fiji	104	4	1	9	3	0
82	Armenia	72	3	1	6	2	0
83	Philippines	40	2	1	3	1	0
85	Peru	102	4	1	9	3	0

HDI rank	Country	THE/cap USD	HP/cap USD	HP/cap USD Min.	HP/cap USD Max.	HP/cap GGE, USD	HP/cap SHI USD
86	Turkmenistan	48	2	1	4	1	0
88	Turkey	144	5	2	12	4	1
89	Paraguay	80	3	1	7	2	0
90	Jordan	190	7	3	16	5	1
91	Azerbaijan	12	0	0	1	0	0
92	Tunisia	167	6	2	14	5	1
93	Grenada	239	9	3	20	7	1
94	China	52	2	1	4	1	0
95	Dominica	217	8	3	18	6	1
96	Sri Lanka	31	1	0	3	1	0
97	Georgia	38	1	1	3	1	0
98	Dominican Republic	109	4	2	9	3	0
99	Belize	168	6	2	14	5	1
100	Ecuador	105	4	1	9	3	0
101	Iran, Islamic Rep. of	129	5	2	11	4	1
103	El Salvador	177	7	3	15	5	1
104	Guyana	52	2	1	4	1	0
105	Cape Verde	52	2	1	4	1	0
106	Syrian Arab Republic	143	5	2	12	4	1
107	Uzbekistan	23	1	0	2	1	0
108	Algeria	62	2	1	5	2	0
110	Kyrgyzstan	23	1	0	2	1	0
111	Indonesia	25	1	0	2	1	0
112	Viet Nam	27	1	0	2	1	0
113	Moldova, Rep. of	41	2	1	3	1	0
114	Bolivia	46	2	1	4	1	0
115	Honduras	58	2	1	5	2	0
116	Tajikistan	10	0	0	1	0	0
117	Mongolia	36	1	1	3	1	0
118	Nicaragua	38	1	1	3	1	0
119	South Africa	216	8	3	18	6	1
120	Egypt	49	2	1	4	1	0
121	Guatemala	102	4	1	9	3	0
122	Gabon	139	5	2	12	4	1
124	Solomon Islands	42	2	1	4	1	0
125	Morocco	74	3	1	6	2	0
126	Namibia	116	4	2	10	3	1
127	India	16	1	0	1	0	0
128	Botswana	185	7	3	16	5	1

HDI rank	Country	THE/cap USD	HP/cap USD	HP/cap USD Min.	HP/cap USD Max.	HP/cap GGE, USD	HP/cap SHI USD
129	Vanuatu	51	2	1	4	1	0
130	Cambodia	27	1	0	2	1	0
131	Ghana	10	0	0	1	0	0
133	Papua New Guinea	36	1	1	3	1	0
134	Bhutan		0	0	0	0	0
135	Lao PDR	11	0	0	1	0	0
136	Comoros	8	0	0	1	0	0
137	Swaziland	56	2	1	5	2	0
138	Bangladesh	13	0	0	1	0	0
139	Sudan	11	0	0	1	0	0
140	Nepal	11	0	0	1	0	0
	MEDIUM DEVELOPMENT	**105**	**4**	**1**	**9**	**3**	**0**
142	Pakistan	24	1	0	2	1	0
143	Togo	10	0	0	1	0	0
145	Lesotho	23	1	0	2	1	0
146	Uganda	10	0	0	1	0	0
148	Kenya	50	2	1	4	1	0
149	Yemen	48	2	1	4	1	0
150	Madagascar	7	0	0	1	0	0
151	Nigeria	13	0	0	1	0	0
153	Haiti	13	0	0	1	0	0
154	Djibouti	41	2	1	3	1	0
155	Gambia	12	0	0	1	0	0
156	Eritrea	6	0	0	1	0	0
157	Senegal	25	1	0	2	1	0
159	Rwanda	7	0	0	1	0	0
160	Guinea	13	1	0	1	0	0
161	Benin	18	1	0	2	1	0
162	Tanzania, U. Rep. of	13	0	0	1	0	0
164	Zambia	26	1	0	2	1	0
165	Malawi	11	0	0	1	0	0
167	Chad	3	0	0	0	0	0
168	Congo, DR	2	0	0	0	0	0
169	Central African Rep.	16	1	0	1	0	0
170	Ethiopia	2	0	0	0	0	0
171	Mozambique	10	0	0	1	0	0
172	Guinea-Bissau	9	0	0	1	0	0
173	Burundi	3	0	0	0	0	0

HDI rank	Country	THE/cap USD	HP/cap USD	HP/cap USD Min.	HP/cap USD Max.	HP/cap GGE, USD	HP/cap SHI USD
174	Mali	11	0	0	1	0	0
175	Burkina Faso	8	0	0	1	0	0
176	Niger		0	0	0	0	0
177	Sierra Leone	7	0	0	1	0	0
	LOW HUMAN DEVELOPMENT	**15**	**1**	**0**	**1**	**0**	**0**
	GLOBAL	**537**	**20**	**8**	**44**	**15**	**2**

KNOWLEDGE MANAGEMENT AS A HEALTH PROMOTION MODEL

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ABSTRACT

The paper examines the value that can be added by applying Knowledge Management (KM) frameworks in Health Promotion (HP). HP has been defined as an empowering process and a set of action strategies to increase people's control over their own determinants of health. The paper reviews Evidence Based Medicine (EBM) and Evidence Based Approach (EBA) as a knowledge production and dissemination process for advancing HP. KM is viewed as a complex concept referring to a variety of analytical frameworks and tools aimed at increasing the value and usefulness of knowledge for organizations, communities and individuals. Its emergence as a field of inquiry is linked to the increasing awareness within the organizational sciences that knowledge is a multi-dimensional, multi-stage process that requires strategic action at each stage and in each dimension in order to realize its value. This paper will focus in particular on the knowledge sharing of tacit knowledge, its integration, application, and its relation to Information and Communication Technology (ICT).

Challenges facing KM in HP and in general are highlighted as: *lack of methodology to tap into tacit knowledge, standardizing tacit knowledge, difficulty in integration of implicit and explicit forms of knowledge, the competition between pressing health problems and sourcing ICTs, knowledge sharing transparency and knowledge sharing receptivity and acceptability.*

The paper concludes that KM principles can improve the advancement of HP. A model for achieving this goal is provided.

Introduction

This paper critically assesses how knowledge management (KM) principles can be used as a model for health promotion (HP). Knowledge management is emerging as an important vehicle in Evidence-Informed (EIHP) or Evidence-Based Health Promotion (EBHP). While evidence-based medicine (EBM) is largely based on external and explicit knowledge, EIHP understands knowledge to be more complex. By its very title, EIHP seeks to be 'informed' by external knowledge whilst also considering a range of other factors including context. The application of KM principles as a framework for HP is examined through local studies and projects. In this paper, technical and non-technical aspects of KM have been applied as conversions of a standard KM framework. These conversions of KM principles are used in the development of a KM model for HP. The social construction of reality theory is applied as a framework for better understanding of knowledge, knowledge sharing and KM.

Health Promotion

Health promotion (HP) is a complex concept, covering a wide range of models and strategies with different meanings and perspectives to various people. According to the World Health Organization (WHO), HP is 'the process of enabling people to increase control over the determinants of health, thereby improving their health' (WHO, 1986, Ottawa Charter). It relates to promoting healthier lifestyles and improving living conditions by empowering individuals and groups to take action in the wider community. It targets the full range of potentially modifiable determinants of health, not only those related to health behaviours, but also socioeconomic influences in health (WHO, 1997, HP Glossary). The concept has evolved from being health professional centered to being population centered, with 'health promotion' done mostly by the people themselves (consumers of HP) and health personnel acting as facilitators.

Given the complexity of HP actions within changing health, socioeconomic, political and scientific contexts, knowledge management (KM) is a potentially powerful strategy to address the dynamic interactions at play and to organise HP knowledge to improve health. To what extent can KM principles enhance sharing and participation by policy makers, practitioners and consumers? In an attempt to answer this question the paper is exploring KM principles with the aim to develop a suitable KM model for HP. Such an exploratory approach by no means negates existing models of HP, but aims to provide an alternative model to strengthening HP.

Evidenced-based health promotion

The key role of evidence in decision-making for HP has been increasingly recognised over the past decade. In the light of limited resources for HP interventions and the demand for

accountability to stakeholders, taking into account the best evidence for effectiveness and quality to justify a proposed package of interventions has become necessary for policy-making (Shediac-Rizkallah MC, Bone LR, 1998). Moving from the more established practice of EBM, EBHP has been defined as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individuals, communities, and populations. The practice of EBHP means integrating local expertise with the best available external evidence yielded by systematic research' (Rada et al 1999).

Just as EBM advocates have pushed for the integration of other necessary elements like clinical expertise and the patient's own values and circumstances in the application of the best evidence available, the more complex challenges of people's participation and the political environment must also be systematically approached and managed to bring about effective HP. There are ongoing attempts to improve systematic reviews of evidence in public health and HP research (Campbell Collaboration, accessed 2005) (Hills, O'Neill, Carroll & MacDonald, 2004; Hills, Carroll & O'Neill, 2004; Hills & Carroll, 2004).

Knowledge management and the evidence-based approach

Knowledge management is a new field in organizational management evolving from the mid-1980s and receiving significant attention in the 1990s (Metaxiots, et, al. 2005). Although KM does not have a standard definition yet, some authors have attempted defining the field. De Jarnett (1996) defines KM as 'the creation of knowledge that is interpreted, disseminated, retained, refined and used'. According to Davenport and Prusak (1998), KM is concerned with the exploitation and development of the knowledge assets of an organisation in order to further the objectives of the organisation. The knowledge to be managed includes both explicit and tacit knowledge. These, and other definitions in the literature, share a common factor: the management of knowledge to achieve something.

Multiple factors influence KM including: culture, leadership, technology, organisational adjustments, managerial influence, resource influence and environmental influences (Holsapple and Joshi 2002). It is crucial that KM models/approaches consider the context within which they operate. This paper seeks to identify KM issues relevant to individual, organisational and community contexts

KM can improve processes at local or practice level, i.e., the process of integrating knowledge and information, thereby enhancing easy access, retrieval, project management, and information flows. KM provides a framework for culture change – changing the way things have been done and adopting a new way of doing the same things.

At the health system management level, KM deals with the management of knowledge to enhance strategic leadership, policy making, designs, implementation, performance measurement, accountability and governance. At this level KM has to be applied in organising knowledge to support HP. In doing this, all HP-related knowledge and information (explicit knowledge and tacit knowledge) are collected collated, captured, analysed, synthesised, integrated, communicated and packaged into a resource to support and inform HP activities. It is through these processes that knowledge becomes user-specific.

KM at public health level leverages tangible assets from intangible knowledge and information (HP television drama, pamphlets, booklets, posters and games = knowledge products). These assets are used to strengthen HP and improve quality of life. While the paper suggests HP television drama as a tool or an asset for HP, caution should be taken because it takes place within a popular culture of entertainment. In some instances the entertainment component competes with the knowledge that is transferred (Mbananga and Becker,2002). It is at the user or consumer level where information and knowledge is further synthesised, integrated and applied to community environments. There exists a feedback - loop gap with current HP approaches particularly at this level (consumer community) and it is where KM can play a significant role.

KM requires several conditions to ensure its effectiveness. These requirements are: *an enabling environment such as culture, willingness to learn and change, communication, involvement and relevant catalysts*. These conditions are not available all the time for HP, hence KM principles may be used to create the needed environment. This can be achieved through communities of practice, interest, users and consumers. With the above issues and concerns, the paper briefly draws on the social construction of reality theory to better understand what knowledge is and why knowledge sharing is important at any level of action.

The social construction of reality theory as a framework

The social construction of reality theory (SCR) (Berger and Luckman, 1967) indicates that knowledge is only what people know as reality in their everyday life and the social context in which it arises. This perspective suggests that, to make any knowledge understandable and usable, its construction must first establish the relationship between people's socio-cultural environment and how they think about issues related to their health and environment (the epistemology of knowledge vs the ontology of knowledge).

Berger and Luckmann (1967) argue that 'common sense' or everyday knowledge, rather than ideas, should be the central focus when analysing and developing knowledge. It is in this light that HP development and planning must first determine the 'common sense' understanding of

health, illness, management and the social structures concerned. This should be done in a knowledge-sharing environment.

Applying knowledge management strategies for health promotion

Figure 1 proposes a KM model for health promotion. It illustrates the complexity of HP, and the many inputs, processes and outputs that KM strategies need to address as an integrated system. This model provides prerequisites and possible outputs of KM and may not necessarily apply in all environments .

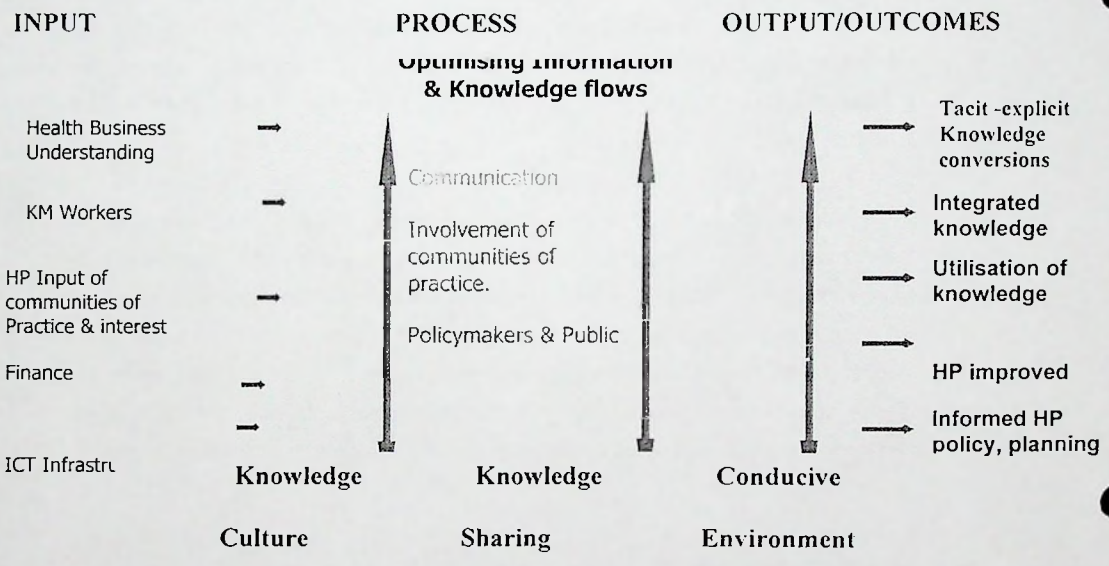

Figure 1: KM Model for Health Promotion

The most important KM elements and strategies are: *strategy and policy, resources, infrastructure, human capital, conducive environment, culture, optimising information flows in communities, promoting learning communities through community centred information technology, knowledge sharing,* and *communities of practice and interest.* Rather than define all concepts, the paper focuses on key principles that have been applied in the case studies presented below.

Utilisation of management health information in policy and decision-making

This study in South Africa was conducted to assess to what extent the management information is used by managers and policy makers in that setting (Mbananga and Sekokotla, 2002). The managers interviewed were at the provincial level, as opposed to the national level. While this study investigated health information, and not knowledge *per se*, it gives some insights into issues related to knowledge use in decision making, policy making, planning and implementation.

Managers at this level said the hierarchical nature of decision-making within the health system stripped lower managers of the authority and power to make decisions. External forces and disruptions caused problems in executing plans and decisions that have already been made. The managers also indicted that policy is made by politicians, not managers.

This suggests that explicit evidence cannot be the only source to inform the decision-making (let alone the policy-making) that is taking place at political level (Tang, et.al, 2003) This study has shown that decisions at provincial and interdepartmental levels are taken through a process of communication and collaboration. These decisions are complex and high-level. The managers' response highlights the importance of communities of practice and a culture of knowledge sharing in decision making.

Another study on the development of medical terms in indigenous languages of South Africa (Mbananga et.al, 2004) has also provided information that may be useful for KM in HP. The study used knowledge-sharing as a method of developing the medical terms. The study used focus groups of community members, health professionals and traditional healers as communities of practice and interest. The focus groups discussed the terms in their own languages, drawing from their indigenous knowledge of both human and animal diseases, gained from their environment, knowledge and experience of diseases. This activity was not a one-way process of learning, but rather a two-way process or double-loop learning. The use of community radio stations to verify the terms introduced the angle of *communities of interest.* The audience members of the community radio station were not practicing in health, but were interested in health matters, including medical terms. This study indicates that HP policy-making process should identify communities of practice and interest and involve them in all the steps up to implementation.

ICT projects (Optimising information flow through ICTs)

To enable or empower populations and/or communities, a number of tools are used to transfer knowledge, including radio, billboards, pamphlets, posters and, more recently ICT. The use of ICT has shown some value to enable and empower the general communities, managers and policy makers. Governments in some countries, including South Africa, have

implemented ICTs in offices and multi-purpose centres (ICTMPCs) for communities. These ICTMPCs are optimising information flows. ICT in general should be seen as promoting communities of practice and interest. ICT maximises information flows and thereby increases knowledge-sharing among a wide area of communities.

The formal and informal sharing processes among communities lead to knowledge generation that can be used for actions. The process of sharing knowledge and learning follow different approaches, for instance, the HIV/AIDS pandemic has led to the development of social groups as knowledge-sharing networks. These groups could be 'real' (a group of people with physical contact) or virtual (those that exist on ICT networks). These groups have mushroomed for HIV/AIDS knowledge-sharing and other health and non-health issues. Networks such as those developed by Advance Africa and partners(http://www.advanceafrica.org/compendium), DELIVER Project at John Snow International (JSI), the Routine Health Information Network (RHINO), The group of women living on the Thai –Burma border, Likhaan Inc., a feminist health NGO in Manila, are examples of knowledge-sharing groups (MAQ PAPER, 2005)

While the examples cited in this paper show evidence of how KM strategies can be used in HP, they are not without challenges.

Challenges facing KM in Knowledge Creation

Tapping into tacit knowledge

Tacit knowledge is stored in people's heads. Getting this information into the open is difficult, due to the lack of specific and rigorous methodology to tap the information. Explicit knowledge, such as research reports and peer-reviewed papers, is developed using certain systematic rules. Currently, qualitative methods are used to tap tacit knowledge (for example, Delphi methods, focus group discussions, in-depth interviews, 'think aloud' methods). Qualitative methods generate a lot of information, which needs extensive synthesis to extract quality knowledge. Therefore, the challenge is the development of methodologies to tap tacit knowledge.

Standardising and integrating explicit and tacit knowledge

Tacit knowledge is often subjective, sometimes varies substantially, and does not lend itself easily to coding, modeling and standardisation so that it can be regarded as valid and reliable. As indicated previously, tacit knowledge is context-specific and generalisation is not

completely possible. This was evident in the study on development of medical terms cited previously.

Moreoever, even when this knowledge has been developed, it needs to be integrated with other forms of knowledge, such as rule-based knowledge. The challenge is standardising, measuring quality and integrating explicit and tacit forms of knowledge, because such integration demands careful synthesis to avoid corrupting the available knowledge systems. There are few, if any, systems that can integrate this information, particularly the knowledge related to policy making and decision making in the health environment. This results in a lack of tacit - explicit conversions of knowledge.

Knowledge-sharing transparency

Knowledge is 'power' and to some people, sharing it may mean losing this embedded power. The process of knowledge-sharing cannot be regarded as fully transparent or open. Knowledge has value, especially the 'know-how'. Sharing this kind of knowledge does not only strip people of power, but also of their value at work which may result into the loss of jobs. At a higher level, issues such as knowledge quality, privacy, intellectual property rights and confidentiality can influence the needed openness in knowledge-sharing.

Technology strategy for KM

Technology, as the enabler to process and manage knowledge (be it tacit or otherwise), needs a good strategy. The strategy should cover areas such as cost, planning, business management and timely execution. Deployment of technology and human resources is very costly and, in some instances, not affordable. Even the available technology considers a 'push' model rather than a 'pull' model. The available intranets and extranets ,do not deliver on their own, but need to be adopted and adapted appropriately to the purpose, environment and users. This task requires highly qualified people with different skills; educating and training them take years. For some policy makers, technology is last on their list of priorities, especially in developing countries where diseases and poverty are pressing priorities. To balance between pressing needs and technology as an enabler is a big challenge.

Knowledge-sharing receptivity and acceptability

As shown in figure I in the paper, a conducive environment for knowledge-sharing is vital. Shared information should be conducted in a way that it will be assimilated and be assimilable. This brings in, the issue of channel capacity to absorb and disseminate this knowledge from communities of practice, interest and partners which is often lacking. This is a very important factor for the right decisions to be made at the right time.

Conclusion

HP is a complex concept. It is a cocktail of actions, activities, decisions and policies, which involves not only the health ministry, but other ministries as well. The quality of any cocktail is not dependent solely on the different kinds of fruits it contains. Measuring HP cannot be isolated from other factors that influence it. The focus of assessing or evaluating HP should be on the quality of life, rather than the actions pertaining to health contribution only. Health contribution can be measured in terms of policy, protocols in practice, resources allocated for HP and the number of communities served – that is wide coverage of HP activities. KM takes place within a certain context and the shared tacit knowledge is context-specific. KM principles and strategies will need to be applied at different levels of HP: policy-making, practice and public health. Technology, as an enabler of KM, needs to be implemented at all these levels, as suggested by the example of the ICT project. ICT is important in encouraging knowledge flows but inter-operability is crucial for horizontal and vertical access to knowledge.

The paper has several limitations, most notably in comparing and discussing other HP models and providing more illustrations of how KM strategies have been effectively applied for health promotion, especially in developing countries. Nevertheless, it is compelling to suggest that applying KM principles and strategies in HP will yield better results in the transfer and use of relevant knowledge to improve health. The SCR theory indicates that useful knowledge is knowledge that makes sense to actors in the context of their everyday use in their local environments. Localising information and knowledge can be achieved through knowledge-sharing and learning through a process of optimising information and knowledge flows among all those involved.

Acknowledgements

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Building the Capacity of Ministries of Health (MOH) to Promote Health

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Abstract

Capacity building for health promotion may be defined as the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at organization, workforce and community levels, and has different meanings in different contexts. Of all possible stakeholders in health promotion, government ministries or departments of health are vested with the greatest responsibility to ensure that health systems have the capacity to improve population health. Until 'capacity building' can be more clearly defined and accurately measured, it may not be possible to identify areas that require improvement. Ministries of Health are in need of a tool to measure the countries' health promotion capacity and to pinpoint financial and technical support necessary for effective health promotion. This paper reviews the experiences of capacity building from four countries, Argentina, Australia, Hong Kong and Kenya, and discusses frameworks for building the organizational capacity of health ministries to promote health.

Capacity building: why is it important?

'Capacity building' is a term that is receiving increasing attention in health promotion circles. Health ministries in some countries are now setting explicit organizational objectives to increase their capacity to promote health. However, the term "capacity" has different meanings in different contexts, ranging from an individual practitioner's ability or power to promote health, to organizational processes and mechanisms that facilitate its employees to promote health, to the level of participation among people in the wider community as well as community infrastructure. Moreover, the capacity that is required for effective health promotion in one country may be different from that in another country because of differing social, economic and/or political conditions.

'Capacity' carries with it many positive connotations, and therefore to build this up and enhance it is desirable. This 'building' work might include activities as diverse as canvassing the opportunities for a programme, lobbying for program support, developing skills, supporting policy development, negotiating with management, guiding the establishment of partnerships or contributing to organizational planning or assisting with evaluation. An important assumption of increases in capacity to promote health is that this will result in prolonged and multiple health gains over and above the results of short-term projects.

Of all possible stakeholders in health promotion, government ministries or departments of health are vested with the greatest responsibility to ensure that health systems have the capacity to improve population health. Therefore, it is important to address capacity building for health promotion within the context of ministries of health. This paper reviews the experiences of capacity building from four countries, Argentina, Australia, Hong Kong and Kenya, and discusses frameworks for building the organizational capacity of health ministries to promote health.

Capacity building models

The concept of institutional capacity has grown out of the idea of processes such as structures, systems, policies, procedures and practices of an organization that reflect its purpose, role, values and objectives and which are managed effectively. As long ago as 1976, Weisbord proposed a six-factor model (comprising purposes, structure, relationships, rewards, leadership and helpful mechanisms) to detect trouble within an organization [1]. The Community Development Resource Association advocates the adoption of a capacity building theory at the

[1] Weisbord Organizational Assessment Questionnaire. In : Jones JE, Pfeiffer J. Annual Handbook for Group Facilitators. California University Association, San Diego, 1976.

organizational level to systematically develop a conceptual framework and foster an attitude for change, institute an organizational structure, acquire skills and material resources for capacity building[2]. These changes increase an organization's readiness to grow. Goodman argues that, within any organization, a programme must go through the adoption and implementation stages. Moreover, organizational values must be modified before the programme can be 'embedded' in the host organization to become durable[3].

Whereas these authors looked at structures within an organization to build capacity, Australia's National Health and Medical Research Council[4] looked beyond the health ministry and recommended the establishment of a national public health partnership of lead agencies at commonwealth and state levels to steer, facilitate and monitor public health actions. In more concrete terms, NSW Health Department[5] stresses five key action areas to build the capacity of health systems to promote health: organizational change, workforce development, resource allocation, partnerships and leadership. It considers the key elements of capacity building are: (1) to build infrastructure to deliver health promotion programmes, (2) to build partnerships and organizational environments so that programmes and health gains are sustained, (3) to build problem-solving capacity. An elaborate checklist[6] comprising indicators for informing and monitoring capacity building practice of stakeholders within the health promotion community was developed.

Separately, Tang and colleagues[7] used confirmatory factor analysis to describe institutional capacity for health promotion under eight dimensions: structure, helpful mechanisms, attitudes toward change, relationships, purpose, expertise, rewards and leadership. Dimensions of workforce and community capacity were also described.

A revised draft glossary of health promotion terms defines capacity building as the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organisations, and the development of cohesiveness and partnerships for health in

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communities (Dr Ben Smith, personal communication, July 7, 2005). The draft glossary explains the rationale for the definition. The competency of individual health promoters is a necessary but not sufficient condition for achieving effective health promotion. The support from the organisations they work within and work with is equally crucial to the effective implementation of health promotion strategies. At the organisational level this may include training of staff, providing resources, designing policies and procedures to institutionalise health promotion and developing structures for health promotion planning and evaluation. The scope of organisational capacity building encompasses the range of infrastructure for health promotion that may be necessary to implement specific programs or to identify and respond to new health needs as they arise. At the community level, capacity building may include raising awareness about health risks, strategies to foster community identity and cohesion, education to increase health literacy, enabling the procurement of external resources and developing structures for community participation and decision-making. Community capacity building includes the ability of community members to take action to address their needs as well as the social and political support that is needed for successful implementation of programs.

Based on previous work, it is considered useful for policymaking at a national level to develop a tool that can measure a country's basic health promotion capacity, to pinpoint financial and technical support necessary for effective health promotion. The tool should cover key areas such as policies, surveillance systems, research and evaluation capability, workforce effectiveness and programme delivery mechanisms. It should be valid and consistent, as well as simple to use and communicate. Moreover, it should be 'health issue free' and applicable to any public health context. Along this direction, the WHO Department of Chronic Diseases and Health Promotion embarks upon a mapping exercise[8] to develop a simple measure to determine the level of health promotion capacity among Member Sates. The framework is made up of interplay of "inside government" as opposed to "outside government" dimension, as well as a "policy" as opposed to "partnership" focus. This approach stresses the need for and responsibility of health ministries to consider developmental needs of the organization and beyond to build health promotion capacity.

Case examples

A number of health ministries with varying degrees of capacity to promote health have been invited to contribute to this paper by documenting their experience in health promotion capacity building. These countries are Argentina, Australia, Hong Kong SAR and Kenya.

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Case Study in Capacity Building for Health Promotion: Argentina

(prepared by Dr Carlos Vizzotti)

In 2001, Argentina suffered a serious structural crisis of the health care system. This crisis led the National Executive Branch to declare a "national health emergency", and identified an urgent need for change. The policy reform that resulted included the design of a 'reoriented' new health care model, the construction of health care networks and recognition of the primary health care strategy as the backbone of the healthcare system. A Federal Health Plan was developed (2004-2007) in which health protection and health promotion are major components.

Changes were made based on the eight dimensions of the "Health Promotion Wheel for National Health Promotion Capacity" which is described in a technical paper for the 6th Global Conference on Health promotion for enhancing the institutional capacity in health promotion. The changes were:

Policies and plans

A Federal Health Plan was established after consultation with 23 provincial health ministers, which also redefined the vision for the health sector and put emphases on primary health care policy, equity, social justice and environmental policy.

Central Expertise

The fact that local health promotion studies were infrequently published in national, regional or international magazines or journals was acknowledged.

Governmental Cooperation Mechanisms

Various committees comprising members from different government and non-government sectors were formed to underpin the need for intersectoral collaboration and multidisciplinary participation.

Services (implementation of programs)

Multiple national mechanisms in local, regional and national levels were put in place for the implementation of health promotion activities.

Health Promotion Financing

Funds allocated for health promotion within the Ministry have increased in the last three years to ensure the effective coverage of primary care as well as the equitable access to care and treatment.

Information Systems

New information systems were established to collect, collate, analyze and disseminate information of public health significance. These included the National System of Health Statistics and Information, the Situation Room, the Health Analysis and Monitoring Unit, the Tracer Events Verifying System, and the Strategic Health Information Unit. Furthermore, the National Survey on Risk Factors is being developed to examine behavioural risk factors.

Professional Development

Training programs for primary health care professionals have been developed. The Ministry also provided financial support for research and postgraduate scholarships in public health. Postgraduate courses in Social and Community Health aiming to equip primary heath care professionals to implement various health promotion programs have been developed in 17 Universities across the country.

Relationship between the government, the private sector and the NGOs

The Ministry also worked with different sectors of the community including NGOs, private sector as well as universities to strengthen collaboration and capacity building.

For the first time, there was a consensus among key players for the building of healthy public policies and a vision for the health system. Health information was also recognized for its importance as a tool to facilitate the process of change. In 2003 the Department of Environment and Sustainable Development was incorporated. The Ministry of Health was then renamed in 2004 as the Ministry of Health and Environment. This integration could support joint and harmonious efforts from both parties in the development and implementation of healthy public policies.

Case Study in Capacity Building for Health Promotion: New South Wales, Australia

(Prepared by A/Prof Chris Rissel*)

The establishment of universal health care for all Australians in the mid 1970s (then called Medibank) also saw the development of a holistic primary health care system. Multidisciplinary community health centres included health education as a core component of services to the community and for the first time employed designated Health Education Officers.

The role of the Health Education Officer included needs assessment, educational program

planning and implementation, and evaluation, and required diverse skills in order to meet the range of health needs of the community. This workforce was, arguably, not well resourced or supported, and functioned largely without a professional framework or discipline. Planning tools and resources were accessed from the US or UK where possible, but practitioners drew on whatever professional training they had, including, teaching, nursing, psychology, community development, journalism, to name a few.

Through the early 1980s Health Education Officers in New South Wales (NSW), the most populous state in Australia, met together informally to share stories and learn from each other. These meetings were generally small and grouped according to the large health regions of the time. A survey of NSW Health Education Officers conducted in 1984 was one of the first such surveys to map the profile and skills of the existing health education workforce. This work informed the development of future professional development and the influential text book 'Evaluating health promotion – a health worker's guide'.[9] Later surveys building on this early work have progressed health promotion workforce competency standards nationally[10] and in NSW.[11,12]

The mid 1980s saw some significant policy and infrastructure change in NSW that increased the capacity of health promotion to improve health. The major policy direction came from the continued shift away from a focus on the individual in health education practice, and also the Ottawa Charter, which broadened the scope for health promotion to address social determinants of health.

The infrastructure change in NSW was the realignment of health services into Area Health Services. Area Health Services were defined geographic regions with a statutory requirement to protect and promote the health of its population. Significantly, the existing Health Education Officers were included in the Areas administration and formed the nucleus of what was to become Area-based health promotion services. Each Area was required to have a designated manager of health promotion. To strengthen the health promotion teams in each Area, the NSW Department of Health funded specialist positions in Research and Evaluation, and then also Communications (Social Marketing). These strategic functions of Management, Research and Evaluation, and Social Marketing were, and remain, critically important for strengthening the evidence base for health promotion, communicating messages effectively as well as marketing

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[12] NSW Department of Health. Competency based standards for health promotion in NSW. NSW Department of Health: Sydney, 1994.

the value of health promotion efforts.

The Health for All by 2000 WHO initiative say the NSW Health Department start to develop about targets for health improvement, and began to focus health promotion efforts on major determinants of poor health. These were later to be consolidated into targets in heart disease, cancer, injury and mental health as part of the Better Health Outcomes of the mid 1990s.

In the early 1990s there was a change in the orientation of health promotion leadership in the NSW Department of Health. Increased emphasis on policy development, strategic planning and organisational change allowed for more championing of the role of health promotion with the NSW Health Department, and also indirectly, the Area Health Services. Funding provided to the Area Health Services (AHSs) from the NSW Health Department was done so on the basis that it was matched by the AHSs, providing a somewhat stable funding base for health promotion programs. Continuity is a key aspect of achieving greater impact by implementing programs over a medium to longer term.

The development support of professional networks was a key strategic element of building infrastructure for health promotion. Regular structured meetings of health promotion managers provided an important mechanism for ongoing professional development, discussion of common issues, and opportunities to collaborate. Similar networks of professionals have developed for research and evaluation staff, and designated health promotion staff working in the areas of physical activity, nutrition, tobacco control and injury prevention.

(Thanks to Prof Bill Bellew for helpful comments on this case study)*

Case Study in Capacity Building for Health Promotion and Health Protection: Hong Kong Special Administrative Region, China

(Prepared by Dr Regina Ching)

The Department of Health (DH) is the HKSAR Government's health adviser and agency responsible for implementing health care policies and statutory functions. The Department operates on a budget approximately one-tenth that of the public hospital system. In 1999-2000, health education units within the Department accounted for less than 3% of the Department's full year spending. Health promotion was neither strategically positioned within the Department nor the health care sector.

In 1999, DH commissioned a health promotion and education review by the then UK Health Education Authority (HEA) aiming to improve responsiveness and accountability of its health promotion functions. The review noted the Department's proficiency in information and resource development, but pointed out the lack of strategic direction in the Department's health promotion agenda. Research and evaluation were lacking, as was staff training, skill mix and development planning in health promotion. 'Traditional' processes of health education were used.

The DH also has responsibility for communicable disease control, including surveillance, outbreak investigation, immunization and enforcement of public health legislation. The SARS outbreak in 2003 highlighted the need to build a system better able to withstand the challenges of infectious diseases. Areas needing improvement were division of responsibility and lines of authority, communication and coordination among players, specialist training, funding and surge capacity.

The DH was determined to strengthen its capacity for health promotion and communicable disease control. The Department identified three major strategies: hardware improvements, software enhancements and staff development.

On both occasions in 2000 and 2003, organizational changes were the most significant capacity building actions. In three years' time, its designated health promotion unit (Central Health Education Unit) expanded from 47 staff consisting mainly of doctors and nurses to a 64-membered multi-disciplinary team. Its structure was revamped. Increased emphasis was put on research and evaluation. IT enhancements enabled efficient and effective work. The Unit budget increased from HK$31Mn in 1999 to HK$37Mn in 2004, a 20% increase. Post-SARS, the DH was reorganised into three main divisions, among which was the Centre for Health Protection (CHP) with designated health protection functions. Manpower, resources and functions were better aligned and overseen by senior staff.

Staff recognized the need to update work practices. They were encouraged to think creatively and pilot new ways of working, including collaboration with those who used to be considered competitors. New networks and partnerships were formed. Greater emphasis was put on community engagement and risk communication.

The DH commissioned a 10 month part-time training program for 40 health promotion staff. Three years later, participants felt they could apply the knowledge and skills at work[13]. In communicable disease control, workforce capacity was increased through staff recruitment, training, building stronger international and regional ties, and promotion of good governance.

[13] Survey on the Health Promotion Workforce Capacity Building Project 2001-2002, Department of Health, Hong Kong SAR, China

Although no scientific measure was used to quantify success of DH's capacity building process, there is increased public recognition of DH's health promotion work and CHP's health protection achievements. Staff morale and job satisfaction are heightened. The DH has moved closer to its goal of implementing professional, evidence-based and effective health promotion strategies in collaboration with the community.

HKSAR's positive experience in building organizational capacity for health promotion and health protection hinged on strong leadership and the Government's political will. Clear policies and high level political commitment provided resources and intersectoral support for actions initiated by the health sector.

Case Study in Capacity Building for Health: Kenya
(Prepared by Dr. Nicholas Muraguri)

The Division of Health Promotion is a prevention-oriented unit, within the Ministry of Health, Kenya. It was previously called the Division of Health Education. The name change followed the adoption of the WHO/AFRO Health Promotion strategy by member states during the 50th session of the Afro-regional committee meeting in 2003.

The new shift from health education to health promotion has created demand for a professional skill mix including media relations, policy analysis, advocacy, research, networking and partnership, mediation, and lobbying. In order to meet its new expanded mandate, the Division of Health Promotion has developed a strategy that encompasses capacity building, infrastructure development at central and district levels as well as policy change.

Current Situation of Institutional Capacity In Health Promotion

Currently all the staff working in the Division of Health Promotion have a medical background such as nursing, occupational therapy, medical assistants, or environment/public health officers. Despite the value of multi-disciplinary teams that involve professionals from a variety of disciplines, employment opportunities are closed to non-medical staff.

There is only one medical school offering a Diploma in Health Education. In addition, three universities have started Masters level courses in Public Health with an option of sub-specializing in health promotion. However, the curriculum content of the Health Promotion

courses offered by the three universities differs significantly.

Key Challenges In Capacity Building

The curriculum of the Diploma courses at the Kenya medical training college is focused on health education and has not been reviewed to reflect current health promotion discourse. This is largely due to insufficient institutional leadership to initiate change.

The little funding available for capacity building at postgraduate level has been invested in clinical courses instead of public health training. Some of the human resource development policy makers have limited insight into health promotion, which is largely a new concept in Kenya.

The majority of staff trained at postgraduate level in health promotion leave the public service to work for better paying jobs in the private sector, such as United Nation Agencies and non-Government organizations.

Because almost all the current staff were trained at the Kenya Medical Training College (offering a diploma course in health education), there needs to be an update and re-orientation of the staff in modern health promotion discourse. However, training opportunities for short courses are not available in Kenya, and no money is budgeted to specifically support training in health promotion

At the moment, the system for continuing professional development or continuing medical education is not well established within the public health system. This limits opportunities for improving staff skills in health promotion. Where pharmaceutical industries provide funding for professional development, clinical staff are more likely than health promotion staff to benefit.

Health promotion discourse is new in Kenya, which traditionally does not provide postgraduate training in health promotion. As a result, the teaching institutions lack trained and competent staff to support postgraduate training.

Despite these challenges, Kenya is making efforts to ensure that the required human resources capacity to develop and implement comprehensive health promotion programs is available. With support from WHO/AFRO, existing curriculums will be reviewed with an aim of developing a core curriculum in health promotion at diploma and graduate levels.

Discussion

What can be learned from these case studies is that an important pre-condition for capacity building to occur is a discourse about health promotion, its principles, practice, and benefits. This understanding of health promotion by key decision makers is essential, as it is closely related to 'political will'. Without political will to improve the capacity of health promotion to improve health, then it is very difficult for systemic changes within the health system or other government organizations to occur. Not uncommonly, a crisis of some kind is needed to prompt reflection on what changes and improvements in the health system are needed, such as in Argentina and Hong Kong. At this point of crisis or identified need for change, if there is a clear discourse of the value and importance of health promotion then there is likely to be much better allocation of resources for health promotion.

Political will is insufficient if all that results is policy statements. The building of health promotion capacity requires adequate resource allocation. In all countries where capacity has increased, there has been significant resource investment in staff training, equipment and infrastructure, and organizational mechanisms that facilitate intersectoral planning and implementation. Policy documents help guide the health system, and these need to be evaluated routinely to demonstrate improvements that have been achieved. Argentina is a good example of the policy to build capacity for health promotion being evaluated, using the WHO Health Promotion Wheel (see Figure 1).

The WHO Health Promotion Wheel is a useful framework for understanding capacity building, incorporating a 2 x 2 matrix, with policy and partnership on one axis and within and outside government on the other. As already discussed, a core of expertise in health promotion is required to direct initiatives that lead to increased capacity building. Policies and plans are a reflection of political will, which need to be operationalised through collaborative mechanisms within Government, with non-Government organizations and the private sector, and program delivery. Capacity cannot be improved without health promotion financing, and investment in professional development and information systems.

On the other hand, it may not be appropriate to pursue one single mapping protocol and assume that one model fits all. This is because capacity may have different meanings to different people in different contexts, and the capacity that is required and built may vary depending on actual health needs, socioeconomic and political circumstances. Moreover, system coherence (e.g. weighting of each dimension), measurement considerations (e.g. subjective or objective) and usefulness of the Health Promotion Wheel as a pointer for action need to be further studied.

Capacity building has in the past[6] been described as the 'invisible work' or the 'behind the scene' effort that increases the likelihood for effective health promotion programs to be sustained. This may no longer be the situation in many countries, where there has been an explicit and substantial investment in health promotion capacity. In some countries where health promotion is reasonably well advanced, many of the elements of capacity building have become part of accepted best practice health promotion.

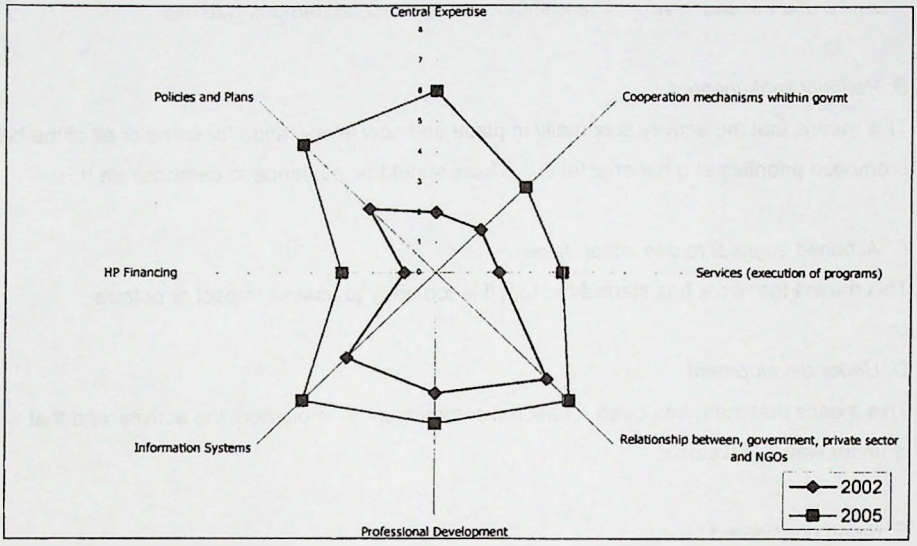
Conclusion

Given the complexity of the construct 'capacity building' there may not be one single model or mapping protocol that is applicable in all circumstances. Differing stages of development or socio-political contexts may require different approaches. However, if we are to improve our ability to increase capacity for health promotion, having models of best practice is useful for comparative purposes, and may lead to a typology of capacity.

In this paper, the term capacity is confined to organizational capacity and the components, indicators or action areas set out are those eight spokes of the capacity wheel. Of course, there may be other components, indicators or action areas identifiable from the case studies and the discussion during the technical session at the 6th Global Conference. Greater amounts of work are required through a combination of qualitative and quantitative methods across countries and contexts to examine the theoretical construct of the concept of capacity. We hope that this paper can also help the international health promotion community acquire a more up-to-date understanding of the concept of capacity building, including the indicators that can be used for measurement purposes and action areas that need to be dealt with.

[6] Hawe P, King L, Noort M, Jordens C, Lloyd B. Indicators to Help with Capacity Building in Health Promotion. NSW Health Department, 2000.

Figure 1. The Health Promotion Wheel: Ministry of Health and Environment of Argentina—Institutional Capacity (2002 – 2005)



Source: Elaborated by the Ministry based on "The Health Promotion Wheel for National Health Promotion Capacity", Technical Paper for 6th Global Conference on Health Promotion.

Notes

Inside Government

This relates to activities which are mostly under direct line management control of government.

Outside Government

This relates to activities which are mostly outside of direct line management of government but can be assisted and supported by government.

Policy Focus

This relates to activities which are more oriented towards policy development to support health promotion interventions and capacity building.

Partnership Focus

This relates to activities which are more oriented towards partnership development to support health promotion interventions and capacity building.

Scale

A: Fully implemented

This means that the activity is totally in place and working well for all the health promotion priorities at a national level. There should be evidence to demonstrate this.

B: Partially implemented

This means that the activity is partially in place and now in operation for some or all of the health promotion priorities at a national level. There should be evidence to demonstrate this.

C: Actioned suggest to use action taken

This means that work has started but that it is too early to assess impact or outputs.

D: Under development

This means that there has been a national commitment to implement the activity, and that work is under way to develop it.

E: Being considered

This means that the activity is being considered for implementation but no firm commitment has yet been given at a national level.

F: No action currently taken

This means that the activity has either not been considered or has been rejected for implementation at this time.

The Whole of Government Approach to Promoting Health

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The 6th Global Conference on Health Promotion

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ABSTRACT

The majority of the upstream "causes of the causes" of ill health, such as poverty and social inequalities, extend beyond the domain of the health sector alone and therefore a "whole government" approach is essential for promoting health. This paper uses four case studies from Cuba, Chile, the United Kingdom and Vietnam to illustrate the following:

Meaning and relevance: The whole government approach is both a process and an intermediate outcome. It includes partnerships between the Health Ministry and other ministries for greater policy coherence and the establishment of healthy public policies, as well as a concerted effort from high-level political leaders to unify the entire government behind the common goal of promoting health for all. The four case studies demonstrate the potential and relevance of this approach to promote health across all sectors of government, regardless of the country's stage of economic and social development, or underlying political structure and ideologies. An integrated approach with greater synergy between curative and preventive systems, as well as greater engagement within and outside of government, is likely to be the most effective and least expensive means of promoting health and securing sustainable economic development.

Major barriers: lack of political will and sustainable financing, lack of research evidence regarding upstream determinants of health, lack of evaluation of health promotion interventions, and lack of health promotion capacity and infrastructure.

Key elements for success: Recognizing new challenges, acknowledging roles and responsibilities, strengthening the role of the Health Minister, and mapping strategic inter-sectoral 'win-win' strategies for health promotion.

INTRODUCTION

The attainment of greater equity in the distribution of health among countries and within each country is the great challenge that current societies face. It is necessary to go beyond focussing on expensive curative-oriented health care systems and interventions that only target the choices individuals make in reducing health risks, when the major differences in health status are caused by social differences and the upstream social determinants or "causes of the causes" of ill health. Individuals who live within supportive environments with fewer social inequalities, higher socio-economic status and stronger social networks are more likely to live longer, healthier lives, and are also empowered to make healthy individual choices which have been structured to be the easiest, least expensive and most accessible options. Therefore governments, the corporate world and civil society must work together on these social determinants to enable the achievement of health for all.

Governments should take the lead in being more active and forceful in correcting the inequities in health, by ensuring not only the equitable access to quality health services and public health programs, but also by encouraging the participation of other sectors in promoting health through the development of healthy public policies that act effectively on the cultural, environmental, social, and economic determinants of the health. Ministries of Health need to be empowered within governments to facilitate and participate in the construction of healthy public policies that take into account the needs of the citizens, as well as the contextual realities and institutional capacities of countries, without compromising the importance of health. For this to become a reality, the continued support of the whole government is required, regardless of changes in political power and orientations that occur over time. In particular, it is also necessary to obtain support and to strengthen the strategic role of other Ministries, especially the ones that have a greater influence on health, such as the Ministries of Economy, Education, Agriculture, Labour, Environment, Transportation, Culture and Sports.

This paper provides a brief description of how the whole government approach has been used in the form of various strategies and governmental programs to promote health in Cuba, Chile, UK and Viet Nam. These countries have diverse political contexts, socio-economic realities and health situations. The authors share their experiences with us, and illustrate the difficulties and strengths of the whole government approach.

CUBA

POLITICAL WILL IN PROMOTING QUALITY OF LIFE FOR THE COUNTRY'S PRINCIPAL TREASURE, ITS HUMAN CAPITAL

"A better world is possible, this is assured by someone who has lived dreaming and more than once has had the rare privilege of seeing dreams become realities, dreams that had never even been dreamt"

President Fidel Castro Ruz

For the Cuban people, the triumph of their insurrection on the1st of January 1959 meant conquering the right to construct a new political and social system capable of resolving problems together with the people in an organized way. In particular, efforts were directed at preserving the country's greatest treasure, its human capital, using a preventive approach that focussed on giving "more years to life and more life to years".

Legislation and Public Policy

From its creation in 1961, the Ministry of Public Health contributed to the development and enhancement of the following principles:

- Health should be a right of all citizens and the responsibility of the State
- There should be a unified and comprehensive system to satisfy the health needs of the entire population
- There should be a strong focus on prevention and health promotion
- Health services should be accessible to the entire population
- Health services should be planned and developed with the active participation of the organized community.

Article 50 of the Constitution of the Republic of Cuba states that "All people have the right to care and protection in health." The state guarantees that right. In the year 2000, the National Assembly of Popular Power, approved Law 91 of the Peoples' Councils, where it is written:

"The participation of the people is an essential principle of our socialist democracy that is shown in the action of the deputies and delegates in the assemblies of Popular Power, the masses, organizations, social institutions, entities and other members of the society, all of who intervene actively and in a coordinated manner in the decisions that have to do with life in the community, the territory and the country".

Achievements in Health

The Cuban health system is universal, free and comprehensive, both in urban and rural areas, and accessible to all citizens without taking into account race, creed, political connection, or place of residence. For more than four decades, the Cuban health system has contributed to great achievements in improving health for the Cuban people. . The infant mortality rate descended from 60 per 1000 live births in 1959 to 5.8 per 1000 live births in 2004, while life expectancy at birth grew from 60 to 77 years in the same period. By the end of 2004, other achievements included: the reduction of maternal mortality to 5.5 per thousand and a decrease in the rate of low birth weight deliveries to 5.5 per thousand.

Previously, vaccine-preventable communicable diseases dominated the health profile. Currently chronic non-communicable diseases and accidents prevail. Poliomyelitis was eradicated in 1962, Malaria in 1967,

and Diphtheria in 1989. In 2004, 14.3% of the Cuban population was over 60 years of age; life expectancy after this age is 21.1 years. 651,872 seniors participate in the "circles of grandfathers", and more than 80,513 seniors that live alone receive specialized community care.

Institutional support within the Ministry of Public Health for the Construction of Healthy Public Policies

Within the Ministry of Public Health the Centres for Health Promotion and Health Education were created. Currently, in addition to the National Centre for Health Promotion and Education, there are 14 provincial centres and 169 municipalities whose principal function is to advise and to coordinate the educational component of health programs, according to the needs and characteristics of each territory. It is important to point out the participation of the people in all public health activities and the inter-sectoral nature of these activities that take concrete action towards solving health problems. Training thousands of activists, including students and pioneers of grassroots organizations, has made an important contribution to the great culture in health that the Cubans possess. This is further supported by the creative participation of the mass media, including radio, television and the written press. The model of Primary Health Care led by family doctor and nurse teams also facilitates the educational efforts aimed towards individuals, families, groups and communities. Every 5 years, the National Institute of Hygiene Epidemiology and Microbiology carries out a National Survey of Risk Factors that monitors popular knowledge, attitudes and practices with regards to health.

Health Councils are inter-sectoral commissions that have been set up in conjunction with the "Local Organs of the Popular Power". In this way, the health councils are better able to facilitate and coordinate the actions required to address priority health problems, such as the management of addictions and the prevention of HIV/AIDS.

Evidence of the Political Will of the Cuban State in Promoting Health

- The Executive Committee of the Cabinet of Ministers adopted agreement 3790 which led to the establishment of: "The National Commission of Health and Quality of Life", to be presided over by the Ministry of Public Health. The mandate of the Commission is to be in charge of the coordination and control of all activities related to the promotion of a better quality of life for the population as relates to health.

- Recently, on the 7th of February 2005, Resolution 335/04 was published in the Official Gazette of Cuba that regulates the sale of cigarettes, including the prohibition of sale to children less than 16 years. The Resolution emphasizes the warnings that smoking can be harmful to one's health, limits the places where smoking is allowed, and urges agencies, public organizations and the Cuban Institute of Radio and Television to educate children, adolescents and young adults so that they do not start this bad habit. Cuba is a poor, underdeveloped country, that has fought against an economic blockade for more than 45 years. Tobacco is one of its principal exports. This anti-tobacco Respolution is strong evidence that above all the Cuban State defends the health of the people.

- The Government of Cuba through the National Assembly of the Popular Power has supported the strategy of Healthy Municipalities promoted by PAHO/WHO, especially regarding the promotion of healthy schools, through the involvement of children, adolescents, young adults, students and teaching staff in these programs.

- The Cuban strategy in the struggle against HIV/AIDS rests on 4 fundamental pillars: prevention, outpatient care, hospital care and antiretroviral therapy. 100% of patients diagnosed as HIV positive receive prescribed therapy free of charge, and receive medical care in specialized institutions. The education of health promoters for face-to-face counselling and peer education are high-priority action areas.

Although many achievements have been obtained through Health Promotion strategies, there are still important challenges ahead, such as improving the means of evaluating health promotion effectiveness, which will constitute an important sphere of work in the coming years.

CHILE

THE COMMITMENT OF THE CHILEAN GOVERNMENT TO PROMOTING HEALTH

"Let us not forget that the disease of many Chileans is merely an expression of social inequality and poverty. In addition, we point out that the safest way to achieve equity in health. In addition, we point out that the safest way to achieve equity in health is preventing disease, putting within the reach of all, the knowledge and the tools that make it possible to keep the population healthy. Hence, our first commitment is to strengthen public health so as to act comprehensively in health promotion and prevention of disease"

President Ricardo Lagos

The Government of Chile has recognized health as part of the social public policy that aims "to ensure the development of capacities and the access to resources to enable the progressive realization of civil rights for all citizens." In recent decades, Chile has experienced notable achievements in health and important economic growth, although these gains have not been translated into a better quality of life for all. The country is in a post-transition state, with a predominance of unhealthy lifestyles and environments, as well as growing inequities in health and citizen dissatisfaction. There is a predominance of chronic non-communicable diseases including cardio-vascular disease, accidents, mental health problems and cancer. There has been a rise in the prevalence of risk factors, with 55% of the population at high and very high cardiovascular risk, 38% with weight excess, 23% obesity, 89% sedentary lifestyle, 42% tobacco use, and 59% alcohol abuse. Although there are also strong protective factors, with 45% of the population belonging to social organizations and 57% with access to a social support network, there are significant inequalities, with poor and more remote groups having greater risk factors and fewer protective factors. Since 1990, the Governments of the Democratic Consensus have considered that economic growth is necessary but insufficient to achieve health for all. Therefore, the Government is currently undertaking the great challenge to achieve "growth with equality", guided by the principles of equity, solidarity, quality, and participation.

In 1998, to face these growing challenges, the Ministry of Health initiated a strengthening of public health regulations, increased disease surveillance, improved preparedness for public health emergencies and greater citizen participation in promoting health. To achieve these aims, the Ministry of Health created a National Public Health Plan that incorporates the social determinants approach to health and monitors the attainment of public health objectives according to a 10-year cycle. In addition, the Ministry also developed a National Health Promotion Plan that includes longstanding preventive programs including childhood vaccinations, nutrition, and occupational health, as well as more recent public health programs for indigenous peoples, HIV/AIDS prevention and control, and environmental protection. From the legal standpoint, in addition to the Chilean Sanitary Code of 1967 that contains the general regulations relating to public health, and the Political Constitution of 1980 that guarantees that "the State protects the free and egalitarian access to the promotion, protection and recovery of health", there is a new legal framework that resulted from the recent health reforms and was approved in February 2004 (Law N° 19.937: Sanitary Authority) to restructure the health system and strengthen the Health Authority, granting legal rights to health insurance and health care for the entire population.

The contribution of "VIDA CHILE" to creating healthy public policies

The National Health Promotion Plan has an inter-sectoral advisory board called the National Council for Health Promotion VIDA CHILE. This Council is presided over by the Minister of Health, is made up of 28 public and private agencies, and is responsible for developing human resources, initiating communication strategies, encouraging social participation and promoting legislative initiatives for the improvement of regulations. There is also a regional network of Community Councils VIDA CHILE in more than 90% of

municipalities across the country that focus on creating healthy settings and implementing local population interventions. In 2000, VIDA CHILE, established a baseline country health profile using data from the first National Health and Quality of Life Survey. Based on these findings, five priority areas were identified and inter-sectoral goals were developed to be achieved by the year 2010. All five goals are related to "Building a Healthier Country" and are complementary to the Sanitary Objectives of the Health Reform. The five goals target the reduction of obesity, sedentary lifestyle, and smoking, and the increase of psychosocial and environmental protective factors.

In 2004 the National Health Promotion Plan achieved coverage of almost 16% of the population, with a network of 4,500 social organizations as well as partnerships with municipalities, the education sector, the sports and recreational sector, and the Ministry of Labour and Social Security. Almost 25% of educational institutions, and a growing number of health centres and workplaces, have been accredited as health promoting establishments. Various programs and community interventions have also been initiated, such as the promotion of smoke-free environments, physical activity workshops, life skills and healthy lifestyle training in schools and workplaces, campaigns to increase consumption of fruits and vegetables to 5 a day, health promotion within primary care, and "health with people", a program aimed at strengthening community networks and social organizations.

The Ministry of Health has invested four million dollars per year to the National Health Promotion Plan (an amount that represents 1% of the annual health care budget). Funds are allocated to the municipalities, and often there are incentives to further raise money by matching contributions from other institutions and from the community. Process and outcome evaluations of the Plan are complemented by a disease surveillance system and monitoring of accreditation. The Ministry is also gathering economic evidence of benefit and has found that for every dollar invested in health promotion, between 7.5 and 36.6 dollars are saved through disease reduction, depending on the scenario.

In 2002, the Second Chilean Congress of Health Promotion was held with more than two thousand participants from all the regions of the country and from different social sectors and areas of public administration. During this event, national leaders and representatives of civil society signed a public commitment to health promotion called Proceedings of Huechuraba, *"Recognizing the urgency of addressing the determinants of health and in light of the different challenges that every State faces, we reaffirm that it is essential to strengthen the collaboration mechanisms among all sectors and at all levels of society, for health promotion and equity"*. In that same year, Chile was the headquarters of the WHO Forum for Health Promotion in the Americas in conjunction with the Fifth World Conference on Health Promotion in Mexico in 2000. In March 2005, the country hosted the launching of the WHO Commission on Social Determinants of Health, and the President of the Republic, Mr. Ricardo Lagos, became on of the 17 commissioners, with a mandate for the period 2005-2008.

Enabling factors and remaining challenges for the integrated governmental approach

The integrated action of the government in health promotion was made possible by:

- The political will of the highest authorities within government, in a democratic context where citizens are also participating and engaged in moving the agenda forward.
- A limited number of clear and precise goals backed by inter-sectoral commitments and explicitly explained to the population by the President of the Republic.
- Greater involvement of local governments and revitalising alliances and building capacity in academia and within social movements for a renewed solidarity in promoting health.
- The leadership assumed by the Ministry of Health and the necessary legislation (i.e. the Health Authority Law) that led the way for institutionalisation of health promotion through inter-sectoral programs (e.g. VIDA CHILE), developments within the health sector (e.g. creation of the Department of Health Promotion and the Division of Healthy Public Policies) and reorientation of the health care system to prioritise a primary care approach with an emphasis on health promotion and prevention.

In spite of the inter-ministerial coordination reached and the social legitimisation of VIDA CHILE, through its functioning for over more than seven years, with a progressive integration of actors into a social network (health and education services, municipalities, universities, NGOs and social organizations), the effort is still insufficient, in view of the magnitude and complexity of the problems faced. There is growing

awareness that these problems require additional effort to create healthy public policies, a new articulation between State-Market-Civil Society, and re-boosting the process of cultural and social change by taking into consideration issues of gender, culture and poverty. The critical steps that this National Plan for Health Promotion still must take to reach the objectives are:

- Improvement of the regulatory and legislative frameworks for priority issues where there are still normative gaps, particularly in tobacco, nutrition, physical activity, environment, and citizen participation. New and decisive political will be required to prioritise or to speed up the legislation of these matters in parliament.
- Establishment of a stable financing with governmental policies that sustain it, so that the local governments can maintain effective health promotion activities and strive for a greater coverage than that achieved currently.
- Improvement of information and social communication policies and the incorporation of the media and the private sector into the campaigns for healthy lifestyles and supportive environments
- Leadership and advocacy to influence the formulation of healthy public policies in priority areas, and their implementation through the different spheres of government

The great challenge is to succeed in making health promotion a State policy that transcends all sectors and all administrations of national and local government, to act in an inter-sectoral and collaborative way on the social determinants.

UNITED KINGDOM

INTEGRATED PUBLIC HEALTH AND HEALTH INEQUALITIES STRATEGY

Since the election of the new Labour government in 1997, England has witnessed rapid growth in the resources allocated both to the health sector and to public health policies, strategies, programmes and projects. Two recent policy initiatives were: 1) the "Wanless Reviews", relating to balancing health sector and public health priorities and funding, and 2) "Choosing Health – Making Healthier Choices Easier", the White Paper for Public Health in England. England also has a national strategy and targets for addressing inequalities in health, as well as the National Institute for Health and Clinical Excellence (NICE), an independent organisation responsible for providing national guidance on health promotion, disease prevention and treatment, which make major contributions to the effectiveness of cross-government public health and health promotion programmes.

The Wanless Reviews

In 2002, Derek Wanless (a British banker) was asked by the Treasury to assess "the financial and other resources required to ensure that the National Health Service (NHS) can provide a publicly funded, comprehensive, high quality health service on the basis of clinical need and not ability to pay". The review (*Securing Our Future Health: Taking A Long-Term View.* London: HM Treasury, 2002) concluded that the UK must devote a significantly larger share of its national income to health care over the next 20 years to catch up with the most developed countries in the first 10 years, and to keep up for the following 10. Success or failure would depend largely on how effectively the health service uses its resources, including on public health and health promotion. Using sophisticated economic modelling, the Wanless Review looked at three different scenarios: 1) slow uptake, 2) steady progress, and 3) fully engaged. In the "fully engaged" scenario where there are high levels of public engagement, use of resources is more efficient and the health service is responsive, life expectancy goes beyond current forecasts and health status improves dramatically. The fully engaged scenario was the least expensive scenario modelled and delivered better health outcomes. In absolute expenditure terms, the gap in health care costs between the slow uptake and fully engaged scenarios is around £30 billion over 20 years, or half of current NHS expenditure.

Wanless was further asked to review how best to develop public health (*Securing Good Health for the Whole Population: Final Report.* London: HM Treasury, 2004). This second review concludes that whilst the major drivers of public health have been recognised since the 1970s, the last 30 years has at best seen only partial implementation. Health policy has remained biased towards the 'National Sickness

Service', and a medical model of avoiding ill health and disease. As a result the contribution of other sectors and agencies to the wider public health agenda has not been incorporated explicitly into health policy, and has therefore failed to fully engage them. The main barriers to achieving the fully engaged scenario and possible solutions are as follows:

- Policy level barriers: Moving from sickness to health based policies may be achieved by re-aligning incentives based on a clear articulation of priorities and accountabilities for health, within and outside the NHS, that are reflected in performance and inspection regimes.
- Health care delivery barriers: It is necessary to address gaps, duplication of functions, and lack of levers in the delivery chain for improving health. The Department of Health (DoH) needs to shift to providing good health, backed by agencies that provide evidence of what works and how to improve health. Public health should be given equal weight with health care activities in performance regimes, which should align across sectors – for example the DoHs Priorities and Planning Framework with the Comprehensive Performance Assessment for local authorities. Local capacity for public health work must be strengthened, and in particular the potential contribution of the 'wider' public health workforce must be fully recognised. The skills of the 'specialist' public health workforce to engage with this wider public health community must be strengthened.
- Strategy barriers: There needs to be a comprehensive set of objectives on key on key public health issues to reduce inequalities in the risk factors and the burden disease, which can then be translated into evidence based action plans.
- Health evidence barriers: Substantial investment in the public health research sector is required to remedy inadequate national and local information on the population's health and weak evidence on the costs effectiveness of interventions. There should be a national strategy to evaluate policy and practice as a series of natural experiments, to build evidence on cost effective interventions, to ensure the rapid dissemination of successful experiments., and to make evaluation a condition of funding.
- Economic evidence barriers: The relative lack of economic evidence about public health interventions opposed to treatment is a barrier to investment in public health, which requires the adoption of the same methodology for both preventive and clinical interventions.
- Individual behaviour barriers: Health improvement from the 'fully engaged' scenario would require large changes in individual behaviours across the whole population, but there are barriers to people taking 'healthy' decisions. Information is poor, wider social consequences are not well set out, and some engrained social attitudes are not conducive to healthy lifestyles. In particular, persistent socio-economic inequalities, combined with market failures affecting lower socio-economic groups, result in significant inequalities in health outcomes and present a barrier to many people becoming 'fully engaged'

These barriers can be tackled by individuals, but also by public services, government, media, business, society at large, through-families, and the voluntary and community sector. Principles are suggested to balance collective action and individual choice. Theses include:

- Interventions should tackle public health objectives and the causes of any decision making failures as directly as possible
- Interventions should be evidence based but a lack of conclusive evidence should not block action proportionate to serious health risks
- Costs of interventions should be kept to a minimum and be less than expected benefits over the life of a policy. Interventions should be prioritised in relation to best value.
- Distributional effects should be acceptable
- Individual choice must be balanced against adverse impacts on the quality of life in others

Choosing Health: Making Healthier Choices Easier

At the end of 2004 the Department of Health for England (DoH) published a new national public health strategy: *Choosing Health: Making Healthier Choices Easier.* In its Foreword, the Prime Minister stated: "This Government is committed to sustaining an ethos of fairness and equity – good health for everyone in England. We are already taking action throughout society to tackle the causes of illhealth and reduce inequalities." This White Paper establishes priorities and goals to 2012, and contains over 170 deliverable proposals for working in partnership across government with people, their communities, local government, voluntary agencies and business. It explicitly states three core principles of a new public health approach:

- Informed choice: People want to be able to make their own decisions about choices that impact on their health. They want information to help them do so and they want the government to create a supportive environment. However, they also want to be protected from the damaging impact of others' choices, and children who are too young to make informed choices need to be safeguarded
- Personalization: To be effective in tackling health inequalities, support has to be tailored, services personalized and equal access assured.
- Working together: Progress depends on partnerships across communities, with government taking the lead and providing coordination.

The national public health strategy in Choosing Health emphasized that the health of the population is increasingly being seen as an under-utilized economic asset - of growing importance to Economic Development Agencies - and work on this agenda is now part of the whole government strategic approach. The importance of this issue is confirmed by the recent report *The Contribution of Health to the Economy of the European Union* states: "a 10% increase of life expectancy at birth increases economic growth at least by 0.3 to 0.4 percentage points of GDP per year. This translates into a growth differential between an average high-income and least-developed country of 1.6 points of GDP per year." Collaborative inter-sectoral economic research (*Measuring the Economic Contribution of Equalities Communities in the North West*, 2005) revealed that "if the Northwest region delivered equal employment opportunities (participation and pay) for 'equalities communities' the region's economy would perform 25% more effectively. Instead of being 10% below the UK average it would be 10% above it." Equalities communities were defined as all those marked by diversity of age, gender, race, ethnicity, faith, belief, religion, disability, and sexuality.

Tackling Health Inequalities

In addition to a new national public health White Paper, there is a national strategy for tackling health inequalities, since there can be up to a seven years difference in life expectancy between and within English towns and cities, which are not only related to cardiovascular disease and cancer, but may be increasingly related to obesity and alcohol consumption. The Department of Health and Treasury lead cross government planning for all sectors to address this issue. The national strategy (*Tacking Health Inequalities: A Programme for Action*. London: DoH/HM Treasury, 2002) provides an action plan to "narrow the gap in life expectancy and to narrow the gap in infant mortality between the worst firth of local authority districts and the population as a whole by 10%." by 2010.

NICE and the evidence-base for effective public health and clinical interventions

On 1 April 2005 the National Institute for Clinical Excellence (NICE) took on the functions of the Health Development Agency in England to form the National Institute for Health and Clinical Excellence (NICE). NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health in England. Further economic assessment evidence of the impact of ill-health on populations is now emerging from more detailed UK work by NICE on the costs to the economy of undiagnosed and untreated common illnesses. For instance a recent NICE consultation (2005) revealed that "societal costs per year of depression in children and young people totals £149 million in treatment costs. However, the societal costs rises to £14,393 million when 10% of patients who require such care are left untreated, and as a result incur work related absences in adulthood." With economics on this scale, investing in effective evidence based prevention, referral, diagnosis and treatment of depression in children and young people may well provide Economic Development Agencies with a strong 'business case' for collaborative investment in the health of the public. The National Institute for Health and Clinical Excellence in England is currently planning to expand its economic assessments within both public health and clinical guidance documents.

VIET-NAM

THE COMMITMENT OF VIETNAM TOWARD HEALTH PROMOTION THROUGH A COMPREHENSIVE STRATEGY DEVELOPED BY THE HIGHEST LEVEL OF THE POLITICAL SYSTEM

Since 1980, Viet-Nam (VN) has adopted a number of vertical health programs that contain small components of health promotion. These programs have been acting in a limited number of provinces.

Recently with help from WHO some health promotion programs have been launched, namely healthy villages, healthy schools, markets and culture, but still in a limited geographic area. The results have not been evaluated. However, a platform emerges for further development of a national strategic plan for health promotion. It also helps in shaping the minds of people at all levels to develop a comprehensive and holistic approach towards health for VNese people.

Official government declaration

On the 23rd of May 2005, the highest level of government of VN officially passed resolution number 46 on the People's Health Protection, Care and Promotion. This milestone has allowed for further development of the National Strategy for Health Care Protection, Care and Promotion, and includes a number of recommendations focusing on different areas of health care protection and promotion including curative, preventive, pharmaceutical, food hygiene, emergent outbreak, epidemic, and so on. After analysing the current situation of health care throughout the country, the report showed that:

> *"Health protection and care activities in our country have encountered many problems and weaknesses...The awareness and habit for self protection, care and promotion of health have not been shaped among a proportion of the population. Environmental hygiene, sanitation, and food safety have not been put under close control. A number of health policies have proved to be inappropriate without being given prompt amendments and revisions; state investment allocated to health is still low, while distribution and utilization of resources are irrational and inefficient. Effective measures/solutions to mobilize resources from the community and society for health protection and care have not been developed... Some executive committees in the party hierarchy and authorities at different levels have not shown their real concerns in providing leadership and direction in people's health protection, care and promotion. Dependence on state subsidies is still found in many localities."*

This statement has been seen as directly looking at the reality, and this has never been done before for the health sector. This also helps with problem identification for developing a comprehensive plan to address these issues.

Challenges facing the people's health protection, care and promotion

Together with the weaknesses mentioned above, the people's health protection, care and promotion in VN are facing enormous challenges:

- Many social problems are emerging such as environmental pollution, social evils which pose negative impacts on the people's health; income discrepancies among people are posing big challenges for ensuring equality in medical consultation and treatment; the reverse side of the market economy threatens honourable ethical values of the health professionals.
- The population of our country will continue to grow in the coming years, and there are increasing and diversified needs for health care while the health system's capacity to respond to those needs is still limited.
- Health care costs are increasing while our country is still a relatively poor country with a correspondingly low level of investment in health care.
- Globalisation and international economic integration both bring favourable opportunities and place our country at a risk of transmission of dangerous epidemics, as well as facing challenges from drug production and the integration of high-tech applications in health care.

Guiding viewpoints

- Health is the most precious asset of each individual and the society as a whole. To provide health protection, care and promotion to the people is a humanitarian task. Investment placed in this field is a development investment, reflecting the good and fair nature of the current regime.
- Reforming the health system to be in line with the socio-economic development of the country by improving equality, efficiency and quality will create favourable conditions for all people to enjoy health protection, care and promotion.
- Implementation of comprehensive health care can be achieved by combining disease prevention with treatment, rehabilitation with physical exercise for health promotion.

- Socialization of health care activities should be associated with the increasing investment made by the State to provide health care and promotion for poor and vulnerable groups.
- Health protection, care and promotion are the duty of each citizen, family and community, as well as being the responsibility of the executive committees of the party hierarchy, authorities at different levels of government, the Fatherland Front, mass and social organizations, in which the health sector should take the lead in terms of professional and technical work. Encouragement should be given to different economic components to make investment in developing health care and promotion services.

Objectives:
To reduce the morbidity and mortality rates, promote health, increase life expectancy, improve the quality of life quality, develop a synchronous health care system from the Central level to the grassroots level as well as fostering habits of health protection among the people, thus meeting the needs of industrialization and modernization, construction and defence of the Fatherland.

Developing and perfecting the people's health care system
- To continue to develop and perfect the public health system by expanding and effectively carrying out national target programs on health and health promotion. Facilitating campaigns for improved sanitation, disease prevention and increased physical exercise; actively taking control measures for food safety; timely forecasting and taking preventive measures to minimize the negative effects on health due to changes of lifestyle, working environments and conditions related to industrialization and modernization; improving the surveillance, detection and containment of epidemics, especially HIV/AIDS and newly emerging infectious diseases; intensifying prevention of occupational diseases; strengthening and developing school health; attaching special importance to health care for mothers, children, elderly people, and rehabilitation activities.
- To combine military medicine and civil medicine as part of the national target health program to assist in providing health protection, care and promotion, especially for civilians living in remote and border areas and islands, and for taking the initiative in preventing, relieving and overcoming consequences of emergency situations such as epidemics and natural disasters.
- Renovating and perfecting health financial policy in a way that rapidly increases the proportion of public financial sources (including state budget, health insurance), and reduces direct hospital fees paid by patients.
- Strengthening the leadership and direction of executive committees of the party hierarchy and the authorities, especially at grassroots level, to raise awareness and define clearly the roles and responsibilities and to monitor operational activities of executive committees of the party hierarchy and the authorities, the Fatherland Front, mass and social organizations, the community and each citizen in health protection, care and promotion.
- Clear objectives for the people's health protection, care and promotion should be integrated into strategies, policies for socio-economic development of the whole country as well as in each locality. The movement of developing "Cultural and Healthy Village" should be launched to cover every village or hamlet.

Improving efficiency of information-education-communication
To bring about clear changes in the collective consciousness, the whole political system needs to take responsibility for the people's health protection, care and promotion. It is necessary to provide knowledge and skills to each individual, family and community so that initiatives can be taken to prevent disease, to develop a hygienic way of life, to increase physical activity, to minimize the harmful effects caused by unhealthy lifestyles and habits, and to become actively involved in activities for community health protection, care and promotion. It is also important to act at a government level, for instance, by strictly prohibit advertising tobacco, strong alcohol, and stimulants, which are harmful for one's health.

Organising the implementation
Executive committees of the Party hierarchy, the party civil affairs committee, and appointed party committees taken from ministries, branches and other organizations shall be responsible to disseminate this Resolution to managers, party members and the public, and will also be looked to in providing

leadership for developing and implementing an action plan, as part of the implementation process of the Resolution.

The Minister of Health (MOH) has been a key partner of health promotion. Immediately after having this resolution announced, the MOH emphasized that: "in order to catch up with and integrate into the world, we should not be satisfied by the current level of health protection and care, rather the ultimate objective of health promotion should be achieved." The Minister of Health is actually planning to develop a comprehensive health promotion strategic plan.

The concept of health promotion covers multiple aspects: from the government level policies, tactics of the state leaders, investment in infrastructure, and operating the public health care system with high efficiency; to developing one's own healthy lifestyle and maintaining the traditional culture and ways of life which are beneficial to the people's health. Our ultimate goal is "to promote health, increase the life expectancy, improve the quality of the generation, and contribute to raise the quality of life and human resources." Adequate investment is needed in terms of manpower, material power, and operational methods. Seminars, training, exchanges among people who are the educators, managers, researchers and health workers should be held so that the spirit of the report could be more thoroughly absorbed and put into practice.

CONCLUSIONS AND RECOMMENDATIONS

Based on the four case studies, and without intending to make direct comparisons among the countries, some conclusions and general recommendations for the development of a whole government approach are proposed. The four case studies represent diverse situations and yet there are certain common key elements which can be identified as contributing to making the whole government approach strong and sustainable:

To recognize new challenges: ageing populations, environmental degradation, globalisation, the rise of chronic non-communicable diseases and mental health problems, emerging and re-emerging infectious diseases, commercialisation of health services, lack of health human resources, increasing costs of medical care and growing health inequalities.

To acknowledge roles and responsibilities, obtaining support from all sectors of society through partnerships and with strong engagement of the entire government, especially from the legislative and economic powers so that health promotion becomes a priority of the State.

To strengthen the role of the Health Minister as a focal point in coordinating endeavours and in promoting policy coherence and healthy public policies, with the real inclusion of health promotion as part of government reforms.

To map strategic inter-sectoral 'win-win' strategies for health promotion investment through prospective economic impact assessments of the effect on economic efficiency, workforce capacity, GDP per capita, labour force productivity and reduced cost of healthcare services.

In this globalising world, societies place a high value on health and quality of life. Policy-makers across governments and sectors need to respond by working together to create new healthy public policies based on equity and human rights. A common shared agenda with inter-sectoral goals are necessary to promote health and to reduce inequalities. The strategic actions needed to reach these goals require specific and concrete agreements among the different sectors. This should not be a theoretical exercise where there is only support in principle. There should be direct support from different ministries and from the highest authorities (Presidents) to make this a reality in practice. The health and well-being of citizens must be considered as a key part of their responsibilities for which they are held accountable and for which they also have the control to make changes that will promote health for the whole of society.

"The success of economics and of society
cannot be separated from the lives of the members of that society.
We do not value only living well and satisfactorily but
we also appreciate having control over our own lives".

Amartya Sen (1999)

Trade in Health Services in the ASEAN Region

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Abstract

Promoting quality health services to large population segments is a key ingredient to human and economic development. At its core, healthcare policymaking involves complex trade-offs between promoting equitable and affordable access to a basic set of health services, incentives for efficiencies in the healthcare system, and constraints in government budgets. International trade in health services influences these trade-offs. It presents opportunities for cost savings and access to better quality care, but it also raises challenges in promoting equitable and affordable access. Drawing on a research project of the ASEAN Economic Forum, this paper offers a discussion of trade policy in health services for the ASEAN region. It reviews the state of healthcare in the region, existing patterns of trade, and remaining barriers to trade. The paper also identifies policy measures that could further harness the benefits from trade in health services and address potential pitfalls that deeper integration may bring about.

I. Introduction

The performance of a country's health sector is critical for the well-being of its citizens. Promoting quality health services to large population segments is a key ingredient to human development. It is also grounded in basic economic considerations. Caring for sick workers preserves a country's stock of human capital, laying the foundation for sustained economic growth. The provision of health services also has important public good characteristics, in particular when it comes to containing the spread of infectious diseases such as HIV/AIDS, tuberculosis and malaria.

Given the centrality of healthcare to human well-being, policy reform discussions in the health sector tend to be of a sensitive nature—be it in poor or rich countries. The provision of health services is typically not regarded as an economic transaction in the way the purchase of a car or a train ticket would be. Indeed, many countries have inscribed a basic right to healthcare in their constitutions, sometimes mandating the provision of services free of charge. Trade policy discussions in the health sector add another layer of sensitivity. Health services are commonly not viewed as a tradable commodity that can be subject to global market forces. The idea of foreign medical institutions providing essential services to the local population may be perceived as encroaching on national sovereignty.

Notwithstanding these sensitivities, healthcare policy does involve serious economic choices. Today, medical technologies exist that can completely cure many ailments and provide effective treatment against others. Yet bringing diagnostics tools, advice, clinical treatment, drugs and vaccines to patients requires resources that are scarce in every country and that can be employed elsewhere in the economy. Few countries can afford state-of-the-art healthcare for every citizen. Choices about what kind of health services are provided to which segments of the population have to be made—explicitly or implicitly. Generally, these choices will depend on a country's level of economic development. To illustrate, if Malaysia were to spend the same per-capita amount of money on healthcare as Switzerland, Malaysia's health expenditure would be roughly equal to its Gross Domestic Product (GDP), leaving no money for food, housing, clothing, or transportation. For Thailand, Indonesia, and Cambodia, health expenditure would be, respectively, twice, five-times, and thirteen-times the value of national GDP.[1]

No country leaves the provision of health services entirely to market forces. Governments intervene in a number of ways, by directly providing health services, financing healthcare through public insurance mechanisms, and regulating private health services and private health insurance. At its core, healthcare policymaking involves complex trade-offs between promoting equitable and affordable access to a basic set of health services at minimum quality, incentives for efficiencies in the healthcare system, and constraints in central and state-level government budgets. International trade in health services influences these trade-offs. It can present opportunities for cost savings and access to better quality care, but it can also raise challenges in promoting equitable and affordable access.

Against, this background this paper offers a discussion of trade policy in health services for the ASEAN region. It draws on a set of national research studies that were conducted by researchers of the ASEAN Economic Forum. These studies covered 7 of the 10 ASEAN countries: Cambodia, Indonesia, Laos, Malaysia, the Philippines, Thailand, and Vietnam.[2]

As will be shown later in this paper, trade in health services is already an important phenomenon in the ASEAN region. To a large extent, this trade occurs outside the framework of existing trade agreements. At the same time, ASEAN governments have established a framework for progressively liberalizing trade in services and, in particular, have identified healthcare as a priority sector for region-wide integration.

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[1] According to the World Health Organization (2005), Switzerland spent $4,219 per person on health in 2002. Data on ASEAN countries' population and GDP are available from the World Bank's World Development Indicators.

[2] See Chea (2005) for Cambodia, Leebouapao (2004) for Laos; [Indonesia]; Abidin, Alavi, and Kamaruddin (2005) for Malaysia; [Philippines]; Arunanondchai (2005) for Thailand; and Thang (2005) for Vietnam. In view of its economic importance, Singapore is also included in parts of this paper, drawing on information available from the seven country studies as well as publicly available data.

Therefore, a key aim of this paper is to identify policy measures that would harness the benefits from trade in health services and address potential pitfalls that deeper integration may bring about.

The paper is structured as follows. To set the scene, the next section will offer a brief overview of the state of healthcare across the ASEAN region, focusing on the roles of the public and private sectors and the performance of the healthcare system in terms of access and quality. Section III will introduce the concept of international trade in health services and review the patterns of existing trade in the region. Section IV will document remaining barriers to trade in health services. Section V will outline the gains that further trade liberalization could offer and also point to possible pitfalls that expanded trade may hold. Section VI discusses several policy implications and makes several recommendations for policy initiatives that ASEAN countries could pursue. The final section offers concluding remarks.

II. The state of healthcare in the ASEAN region

This section reviews the performance of the healthcare sector across the seven ASEAN studied thus far and problems that remain. We focus on four dimensions of healthcare performance: (i) accessibility of basic healthcare services; (ii) provision of healthcare by the public sector, private sector and NGOs; (iii) sources of healthcare financing; and (iv) quality of healthcare services.

Accessibility of healthcare services

Unsurprisingly, accessibility of healthcare services in the ASEAN region varies significantly with countries' level of economic development. At the same time, income cannot explain everything. Countries' histories and policies also play an important role.

Data from the World Health Organization (WHO) on immunization coverage amongst 1-year olds, antenatal care coverage and the proportion of births attended by skilled health personnel are revealing in terms of access to healthcare in the ASEAN region (Table 1). The health service coverage figures of Malaysia, Singapore and Thailand are comparable to those of the United Kingdom and the US. Interestingly, Vietnam also performs relatively well compared to the rest of the group. It enjoys higher immunization coverage and higher proportion of births attended by skilled health personnel than the Philippines and Indonesia, although not for antenatal care. As expected, Cambodia and Lao PDR lag behind others countries in its health service coverage.

Table 1: Healthcare services coverage

Country	Immunization coverage (%) among 1-year-olds[a]			Antenatal care coverage[b]		Births attended by skilled health personnel[b]	
	Measles 2003	DTP3 2003	HepB3 2003	(%)	year	(%)	Year
Cambodia	65	69	0	44	2000	32	2000
Indonesia	72	70	75	97	2003	66	2003
Lao PDR	42	50	50	44	2001	19	2001
Malaysia	92	96	95	...	...	97	2001
Philippines	80	79	40	94	2003	60	2003
Singapore	88	92	92	...	...	100	1998
Thailand	94	96	95	...	...	99	2002
Vietnam	93	99	78	70	2002	85	2002
United Kingdom[c]	*80*	*91*	*0*	...	...	*99*	*1998*
United States[c]	*93*	*96*	*92*	...	...	*99*	*1997*

Notes:
...Data not available or not applicable

a. World Health Organization, Department of Immunization Vaccines and Biologicals, Vaccine Assessment and Monitoring Team. (http//www.who.int/vaccines-surveillance, accessed on 16 April 2005)
b. The World Health Report 2005: make every mother and child count. Geneva, World Health Organization, 2005. (http://www.who.int/whr/2005/en/index.html)
c. The figures for the UK and USA have been included for purposes of comparison.

A similar picture emerges when comparing the number of hospital beds across the seven ASEAN countries studied (Table 2). The Thais, Malaysians and Singaporeans enjoy the highest number of beds per population. Vietnam also performs relatively well. Despite this, there are signs that the healthcare infrastructure in Vietnam is not being used efficiently. Thang (2005) describes heavy reliance on hospitals for primary treatments and high inpatient admission rates relative to other countries in the region, indicating over-utilization of hospital beds. The number of hospital per population in Cambodia and Indonesia are respectively one-third and one-fourth that of Thailand.

In Thailand, Indonesia, Vietnam, Cambodia and Laos, state-funded primary healthcare centers (HCs) are the main providers of basic healthcare services to the majority of the people.[3] Thailand enjoys the highest number of HCs per population in this group. HCs in Cambodia and Laos are reported to be ill-equipped and ill-staffed due to insufficient funding. Poor access to HCs in Laos is largely due to the termination of the cooperative farming system in the early 1990s which led to the closure of associated health facilities.[4]

Table 2: Number of hospitals, hospital beds, and health centers

	Thailand (2001)	**Malaysia** (2001)	**Singapore** (2001)	**Indonesia** (2001)	**Philippines** (2002)	**Vietnam** (2002)	**Cambodia** (2002)	**Laos** (2002)
Total no. of hospitals	1,409	345 (g)	29	935	1,738	987	1,073	150
No. of beds	135,303 (a)	44,120	11,840	109,948	85,166	250,000 (d)	9,800	6,315 (e)
Beds per 10,000 pop	21.8 (b)	18.8	29.0	5.2	10.8	14.8	7.4	9.2
Total no. of health centers (HCs)	10,037 (f)	...	...	7277 PHC 21587 SPHC (h)	...	10,000 approx.	...	644
HCs per 10,000 pop	1.6	...	...	1.4 incl. SPHC	...	1.2	...	...
Total pop in thousands	61,997	23,467		211,895.4	78,681.2	80,897.8	13,274.8	5,537

[3] The services typically include preventive, ambulatory, inpatient services and referral services.

[4] According to Leebouapao (2004), more than 700 health centers were closed and the health system almost came to a collapse. The Northern region was the worse hit. As of 2004, 29.1 percent of the villages were at least 16 kilometers away from the nearest health center. To improve access to essential drugs to the poor, so-called Drug Revolving Funds (DRF) were established in the mid-1990s. The system is self-funded through revenues received from the sale of drugs to patients (although poor people are exempted from user charges). The performance of the DRFs has been mixed, as the level of poverty in a district typically dictates the viability of DRFs.

(c)

Notes:
...Data not available or not applicable
(a) Health Resources by WHO (1999)
(b) Assuming that the number of hospital beds remains at the 1999 level.
(c) Calculated from "World Population Prospects: The 2004 Revision Population Database".
(d) Approximate figure taken from STAT-USA Market Research Report at http://strategis.ic.gc.ca/epic/internet/inimr-ri.nsf/en/gr108259e.html.
(e) Figure includes 1,241 beds at health centers.
(f) The figure does not include Primary Health Care Units which are made up of trained village volunteers.
(g) Comprising of general hospitals, district hospitals, special medical institutions which are all public and other private hospitals.
(h) PHC and SPHC are Primary Health Centers and Supporting Primary Health Centers respectively.

Looking at countries' stock of medical personnel, the Philippines and Singapore stand out from the rest of the group in terms of the number of physicians and nurses per 10,000 inhabitants (Table 3).[5] Thailand also enjoys a relatively high number of nurses per population, although there are complaints of shortages of skilled (diploma level) nurses. Despite better access to healthcare service, the number of physicians per population in Thailand is lower than Vietnam and Laos. In Vietnam, due to limited number of medical facilities, many medical graduates cannot find work and take on the role of nurses.[6]

Table 3: Number of registered health personnel

	Malaysia (2000) (d)	**Singapore** (2001) (m)	**Thailand** (2000) (c)	**Indonesia** (2003) (e)	**Philippines** (2003)	**Vietnam** (2002)	**Cambodia** (2001) (f)	**Laos** (1996) (m)
Total no. of physicians*	16,468	5747	22,435 (a)	48531 (g)	101,758	45,702	2,055 (h)	2812
Physician per10,000 pop	7.1	14.0	3.6	2.2	12.7	5.6	1.6	5.9
No. of dentists	2,001	1087	6,966	9,177	45,321	NA	NA	196
Dentist per 10,000 pop	0.9	2.6	1.1	0.4	5.7	NA	NA	4.1
No. of pharmacists	2,801	1141	10,354	NA	49,117	6,148	NA	NA
Pharmacist per 10,000 pop	1.2	2.8	1.7	NA	6.1	0.8	NA	NA

[5] One must be careful when interpreting the numbers in Table 3 since the figures available are often exaggerated. Many of the registered health personnel are no longer working or work abroad (see Section III). Moreover, the figures refer to different years. However, given the long training period for physicians, their numbers tend to be relatively stable through time.

[6] In the 1980s, Vietnam had cooperation pacts with countries in Africa, e.g. Mozambique, Angola, Lybia, Algeria, Madagascar etc., whereby surplus medical doctors from Vietnam were sent abroad under the pact.

No. of nurses	39,890	17,398	119,651 (k)	81,190 (j)	354,544 (b)	47,006	11,105 (i)	4931
Nurse per 10,000 pop	19.3	42.4	19.3	3.8	44.2	5.8	8.5	10.3

Notes:
The population estimates for Indonesia, Cambodia, the Philippines and Vietnam are calculated from UN's "World Population Prospects: The 2004 Revision Population Database".
Figures for Lao PDR are not available.
(a) 75% are medical specialists.
(b) A substantial share of registered nurses in the Philippines work abroad (see Section III).
(c) From Thammarangsi (2003a)
(d) From 8th Malaysian Plan (2000) p.489
(e) From Indonesia's Ministry of Health (2001 figures for nurses).
(f) Ministry of Health's employees only
(g) 23% are specialists
(h) Physicians are supplemented by 1,425 medical assistants.
(i) In Cambodia, 44.8% are primary nurses and 55.2 are secondary nurses.
(j) Only 13% of nurses in Cambodia carry the 3-Year Diploma degree, the rest carry high school diplomas.
(k) The figure comprises nurses of various skill levels (from diploma graduates to college graduates).
(l) Global Health Atlas of infectious diseases. World Health Organization. Data updated with recent information from Regional Office websites and publications.
(m) Data from WHO Global Atlas of the Health Workforce.

Finally, there is not only substantial variation in access levels across countries in the ASEAN region, but also within individual countries. In particular, those who live in urban areas enjoy better access to healthcare services—infrastructure as well as personnel—than those in the rural areas. For example, in Cambodia, Indonesia, and Thailand, districts with the best access conditions have 10 times or more the number of physicians per population than districts with the worst access conditions. In Indonesia, 47.44% of all health personnel are located in Java. The ratio of hospital beds per population in Jakarta is 1:621 compared to 1:3,906 in Lampung ([Indonesia study]).

Provision of healthcare

In most ASEAN countries, health services are predominately provided by public hospitals (Table 4). At the same time, the private sector plays an increasingly important role in the region's richer economies. The share of hospitals belonging to the private sector ranges between 30-64.9 percent in Indonesia, Malaysia, the Philippines, Singapore, and Thailand, compared to 0-1.7 percent in Laos and Vietnam. Private hospitals are smaller in size and tend to be located in urban areas, serving middle- to high-income patients as well as foreign patients. Several private hospitals in Thailand, Singapore and Malaysia offer advanced specialist services. They are often better equipped with advanced medical technologies and personnel than public hospitals.[7] In poorer ASEAN economies, the role of the private sector entry has been limited to the operation of clinics and pharmacies.

Table 4: Public versus private sector healthcare provision

	Hospitals		Beds	
	Public (%)	Private (%)	Public (%)	Private (%)

[7] For examples, in Malaysia in 1999, 23 of 27 MRI facilities; 67 out of 86 CT scanners; 67 percent of physicians; 66 percent of surgeons and 80 percent of obstetricians and gynecologists worked in the private sector.

Cambodia (2002)	....	...	78.6	21.4
Indonesia (2001)	56	44.0	63.3	36.7
Laos (2002)	100	0	100.0	0
Malaysia (2001)	35.1	64.9	78.4	21.6
Singapore (2004)	44.8	55.2	74.4	25.6
Philippines (2002)	38.0	62.0	53.3	46.7
Thailand (2001)	69.1	30.9	...	...
Vietnam (2002)	98.3	1.7	...	...

Notes:
... Data not available
Figures taken from the Ministries of Public Health in the countries concerned.

Since private healthcare providers pay higher wages than the public sector, the growth of the private sector has led to a migration of medical doctors, specialists, pharmacists, nurses and other allied health personnel from the public to the private sector in all countries. This has led some countries, e.g. Cambodia and Thailand, to impose public service requirements.[8] The share of health personnel in the private sector typically correlates with the business cycle—expanding during economic upswing as the demand for private healthcare rises and contracting during economic downturns.

Thailand's private medical services market is further segmented into those that participate in public health insurance schemes and those that cater to foreign visitors and expatriates (see Section V). The latter offer the most sophisticated and highest quality medical services.

In Vietnam, Cambodia and Laos, the high proportion of public provision is a legacy of the past political regime. In Vietnam, the deregulation of the healthcare sector in 1986 resulted in only 17 private hospital setups. The 1994 deregulation in Cambodia did not attract many private hospitals either. As mentioned, private participation in both countries has been mainly in the form of drug outlets, pharmacies and clinics. This has led to improved drug supplies and distribution, particularly in Laos where public health facilities are inaccessible in many areas.

In Malaysia, the Government has made a conscious effort to contract out to the private sector certain auxiliary health services, such as cleaning, laboratory tests, drug distribution and others. This was done to bring down medical costs, although there are indications that this form of outsourcing has actually increased costs (Abidin, Alavi, and Kamaruddin, 2005).

Public healthcare is subsidized in all of the ASEAN countries studied, although to varying degrees. In particular, the ability to subsidize is constrained by governments' budgetary resources. The Malaysian government can afford to subsidize most public services (only 5% of the total expense is covered by fees). The Thai Government also subsidizes the public provision through the national tax-funded 'Universal Care' scheme. In the poorer ASEAN countries, user fees were introduced because the government could not afford to fully subsidize the provision of health services.

Healthcare financing

While per capita expenditure on health is closely correlated with income, there is no such systemic variation for the share of health expenditure in GDP and the share of government spending devoted to health (Table 5).

Table 5: Healthcare expenditure in 2002

	Total expenditure on health[a]	General government expenditure on health[a]	Per capita total expenditure on health[a]

[8] In Cambodia, all healthcare professionals are not allowed to work in the private sector unless it is off-working hours.

	(% of gross domestic product)	(% of total government expenditure)	international dollars)
Cambodia	12.0	18.6	192
Lao PDR	2.9	8.7	49
Indonesia	3.2	5.4	110
Malaysia	3.8	6.9	349
Philippines	2.9	4.7	153
Singapore	4.3	5.9	1 105
Thailand	4.4	17.1	321
Vietnam	5.2	6.1	148

Note:
[8]The World Health Report 2005: make every mother and child count. Geneva, World Health Organization, 2005. (http://www.who.int/whr/2005/en/index.html)

As expected, Malaysia, Singapore and Thailand have the highest per capita expenditure on healthcare. However, Cambodia spends as much as 12 percent of GDP on healthcare, far more than other countries in the group. The Thai and Cambodian governments devote over 17 percent of public spending to healthcare—again, far more than other governments in the region.

In Singapore, Laos, Cambodia, Philippines and Indonesia, most of the healthcare expenditure comes from private sources, the majority of which is out-of-pocket (Table 6). In Cambodia and Laos, a substantial share of healthcare funding also comes from foreign donors and NGOs. Only in Malaysia and Thailand is the public sector the most important source of healthcare financing.

Table 6: Sources of healthcare financing (in percent)

	Singapore (2001)	Thailand (2002)	Malaysia (2001)	Vietnam (1998)	Cambodia (2002)	Indonesia	Laos (1999)	Philippines (2003)
Government (including subsidized public insurance where applicable)	33.5	67.5	53.7	19.5	8.8		9.0	37.5
Social Insurance								7.8
Private Sources	66.5	32.5	46.3	80.5	72.9		55.7	54.8
of which are:								
Out-of-Pocket	*97.0*	*84.6*	*92.8*			*70.0*	*60.0*	*78.1*
Private Insurance		*10.0*	*7.2*			*<2.0*		*2.4*
Health Maintenance Organization								*7.3*
NGOs					18.2		35.2	

Sources: Philippines' National Statistical Coordination Board (PSY 2003); WHO World Health Report.

Notwithstanding the overall strong reliance on out-of-pocket financing, public health insurance is playing an increasing role in a number of ASEAN countries. In Thailand, 80.4 percent of the population is covered by the 'Universal Care' scheme, which was introduced in 2001. By 2002, this mechanism reduced private out-of-pocket spending of the uninsured households by 14.2 percent, while increasing government spending on health by 24.4 percent. In Indonesia, 27.6 percent of the population is covered by various public health insurance schemes. Vietnam has compulsory public health insurance for civil

servants, state-owned enterprises and large private companies, covering around 12 percent of the population. In Cambodia, health insurance was introduced in 1991 but the system has not taken off due to its high cost and the lack of trust in public health facilities (Chea, 2005). The Filipino Government has initiated a compulsory National Health Insurance Program (NHIP) in 1995, targeting those in the lower income brackets. By 2002, 54 percent of the population was enrolled.

In all countries, private health insurance plays a minor role in the private health care expenditure. For example, in Thailand, private insurance covers only 2% of those participating in health insurance. The main purchasers of these products are the middle and high income groups.

Quality of healthcare services

Poor quality and weakly regulated private healthcare services is a pressing issue in Cambodia, Laos and Vietnam and has in some circumstances led to adverse health outcomes and a proliferation of informal medical practitioners. Public health facilities in these countries are notoriously plagued with demoralized staff and insufficient medical equipment and drugs. In Vietnam, improper drug use has led to high levels of antibiotic resistance in the population. In Laos, despite the relatively large number of health personnel, training is considered to be inadequate, leading to high rates of misdiagnosis and maltreatment.[9] In Cambodia, many private facilities use obsolete equipment and more than half do not hold a license from the Ministry of Health.[10]

In Malaysia, the Philippines, Singapore and Thailand high quality medical care is, in principle, available. A number of hospitals in these countries offer advanced specialized services, relying on modern equipment and highly qualified medical personnel. However, the best medical care is typically provided by private hospitals and can only be afforded by upper middle income and high income patients. While the richer ASEAN countries have the basic regulatory infrastructure in place, monitoring and quality enforcement is often insufficient, leading to large variations in the quality of healthcare within countries.

To sum up, many of the healthcare indicators presented in this section vary closely with countries' level of economic development. Economic research suggests that causality goes both ways: healthier societies are more productive and richer countries can afford better healthcare. At the same time, differences in health performance are not fully accounted for by income. In particular, comparisons among ASEAN countries suggest that there is an important role for government policy to maximize resources available for healthcare and to ensure that those resources are effectively utilized.

III. Current trade patterns in the ASEAN region

The concept of trade in services goes beyond the traditional concept of trade, whereby physical goods move across borders from one country to another. Since most services require close proximity between the supplier and consumer, trade discussions in services typically adopt a wide definition of what constitutes trade, involving the following four modes of supply:

- *Mode 1: cross-border supply.* This mode of supply is akin to traditional goods trade, whereby suppliers and consumers are located in different countries. An example would be a 'telediagnosis' by a doctor in one country of a patient located in another country.

[9] There is only one medical school in Laos and six nursing schools. There are approximately 100 graduates in medicine, pharmacy and dentistry per year.

[10] It is estimated that there are approx. 896 legal pharmacies and almost 3 times the number of unlicensed ones; 500 legal clinics coexist with approx. 1,700 unlicensed clinics; and 13,000 village drug sellers. In all, approx. 87% of drug stores are unlicensed.

- *Mode 2: consumption abroad.* International trade also takes place when the consumer moves to the country of the supplier. An example would be a patient temporarily traveling to a foreign hospital to undergo surgery.

- *Mode 3: commercial presence.* This mode of supply describes the situation whereby producers, in the form of juridical persons (or companies), move to the country of the consumer. An example would be the establishment of a hospital, in which foreign investors hold a direct equity stake.

- *Mode 4: movement of individual service providers.* As in the case of Mode 3, this mode of supply describes the situation whereby the producer moves to the country of the consumer, but the producer takes the form of a natural person (or individual). An example would be a nurse relocating to a foreign country and working there in a hospital. Mode 4 trade typically captures the movement of service workers that is of a temporary nature and does not involve permanent migration.

Remarkably, current trade patterns of countries in the ASEAN region involve all four modes of supply. This section will offer a brief overview of these patterns by individual modes.

Mode 1: cross-border supply

Technological progress has enabled the remote supply of services that were previously not-tradable across borders. Thus, firms in richer countries have been able to realize significant cost savings by outsourcing certain service activities to poorer countries with lower wages. The one country in the ASEAN region that has been able to benefit from new export opportunities in this area is the Philippines. In particular, the Philippines have started to export medical transcription services to the United States. The Philippine's comparative advantage in medical transcription is explained mainly by its pool of well-qualified English-speaking workers. Transcriptionists are usually medical school college graduates who work part time while preparing for the Philippine's board exams. The majority of the 25 companies exporting these services in 2004 were owned by US investors. Indeed, the Philippine Government offers special incentives for foreign direct investment (FDI) in this sector. While exports are still small in absolute value ($10 million in 2004 by a rough estimate), they hold substantial growth potential. For example, current exports to the United States still account for less than 1 percent of the $13 billion spent on medical transcription in the United States per year.

Mode 2: consumption abroad

Several ASEAN countries have become significant exporters of "health tourism" services. These are chiefly Malaysia, Singapore, and Thailand. Table 7 presents information on export revenues and the number and origin of foreign patients for these countries. Thailand is the largest exporter in the region, followed by Malaysia and Singapore. Interestingly, in the case of Singapore and Malaysia, the majority of foreign patients come from other ASEAN countries (mainly Indonesia), whereas in the case of Thailand only 7 percent of foreign patients are from the ASEAN region. For Thailand, Japanese nationals account for the largest share of foreign patients.

Table 7: Export of health tourism services

	Export revenues	Number of patients	Origin of patients
Malaysia (2003)	RM 150 million ($40 million)	More than 100,000	60 percent from Indonesia, 10 percent from other ASEAN countries
Singapore (2002)	$420 million	210,000	45 percent from Indonesia, 20 percent from Malaysia, 3 percent from other ASEAN countries
Thailand	Around 20 billion baht in 2003 ($482 million)	470,000 (2001) 630,000 (2002)	42 percent from the Far East (mostly Japan), 7 percent from ASEAN countries

Sources: Singapore Tourism Board; Abidin, Alavi, and Kamaruddin (2005); Arunanondchai (2005).

The competitiveness of Malaysian, Singaporean, and Thai hospitals primarily stems from two factors. First, they can offer medical services at significantly lower price compared to developed countries. As illustrated in Table 8, a coronary by-pass graft surgery in the United Kingdom is three times more expensive than in Malaysia. A hospital bed in the United States is almost 25-times more expensive than in Thailand. In view of the labor-intensiveness of hospital services, differences in labor costs are likely to account for much of the observed price differences. Second, hospitals in Malaysia, Singapore and Thailand have established a reputation for high quality services. In Thailand, service quality has been explicitly promoted by an accreditation system administered by a dedicated government agency—the Institute of Hospital Quality Improvement and Accreditation. Foreign patients mainly undergo treatments in the 9 private hospitals having the highest rankings for tertiary care in Thailand. A related aspect is that Malaysian, Singaporean and Thai hospitals can offer specialized services not available in other, especially poorer, ASEAN countries.

Table 8: Price comparisons (US$, 2001)

	Coronary by-pass graft surgery	Single private hospital room, per night
Malaysia	$6,315	$52
Singapore	$10,417	$229
Thailand	$7,894	$55
United Kingdom	$19,700	n/a
United States	$23,938	$1,351

Source: Abidin, Alavi, and Kamaruddin (2005)

For a number of medical treatments, hospitals from Malaysia, Thailand, and Singapore directly compete with each other. The price comparisons in Table 8 suggest strong competition, in particular, between Thailand and Malaysia. At the same time, hospitals in these three countries are differentiated by their medical expertise, the type of patients to which they cater, and certain ancillary services. For example, in order to attract foreign patients, some operators in Malaysia have started to offer integrated healthcare packages, involving not only medical treatment, but also transportation from and to the patient's home country, accommodation for family members and certain entertainment services.

Interest in developing the health tourism industry has also emerged in the Philippines. While health service exports are still in their infancy, the country benefits from a pool of well-qualified and English-speaking medical professionals. The Philippines have also built up expertise for certain specialized medical operations, such as cosmetic and laser eye surgeries. Hoping to build on these advantages, the Government included health tourism in its 2004 Investment Priorities Plan and is in the process of developing a business plan for the industry.

As for the low income ASEAN countries, Vietnam also exports health tourism services, mainly to neighboring Cambodia. The number of foreign patients treated in Vietnam is thought to be small, but no precise statistical information is available. Indeed, most Cambodian patients seeking treatment abroad choose hospitals in Thailand and Singapore. Interestingly, several private hospitals in Cambodia make a business in facilitating treatment in foreign hospitals. Similar services are also provided by independent agents at Cambodia's borders.

Mode 3: commercial presence

Health services in ASEAN countries are predominately provided by domestic medical institutions. Nonetheless, some foreign participation in the private sector healthcare segment can be found in six of

the seven ASEAN countries studied (Laos being the only exception). Foreign service providers typically account for small shares of the healthcare market. For example, in Indonesia foreign hospitals are estimated to account for only one percent of total hospital beds (Timmermans, 2002). In the Philippines, only 2 of 19 Health Maintenance Organizations (HMOs) are foreign-owned. In Thailand, foreign investors hold equity stakes in a number of hospitals, but they do not have a controlling interest, reflecting restrictions on foreign equity ownership (see Section III). Foreign investment is estimated to account for only 3 percent of total investment in private hospitals in Thailand. Some foreign presence also exists in Cambodia and Vietnam, though no information is available on the market shares of foreign hospitals. Across all countries in the region, foreign-owned healthcare facilities cater to the middle and upper income population segments and are mostly found in urban areas.

Little comprehensive information exists on the origin of foreign investors. However, foreign investment appears to originate both from within and from outside the ASEAN region. In Cambodia, most foreign hospitals are of Chinese origin. Among AESAN countries, Singapore and Thailand, in particular, have emerged as outward investors in the healthcare sector. For example, Parkway Group Healthcare, the biggest investment group in the healthcare sector in Singapore, has set up joint ventures with hospitals in India, Indonesia, Malaysia, Sri Lanka, and the United Kingdom. Bumrungrad Hospital in Thailand has entered into management contracts with hospitals in Bangladesh and Myanmar, and has formed a joint venture with a hospital in the Philippines. Bangkok Hospital has established twelve branches in Southeast and South Asia, locating primarily in tourist towns.

Mode 4: movement of individual service providers

The ASEAN region hosts two of the world's largest exporters of healthcare workers. The Philippines and Indonesia send large numbers of nurses and midwifes to countries around the world. This form of trade is driven by a growing supply of well-educated professionals in these two countries and shortages of healthcare workers in richer economies. Demographic pressures and rapidly rising healthcare costs in developed countries is likely to increase the demand for healthcare professionals from lower wage economies in future.

In the case of the Philippines, the number of nurses working abroad is estimated to be around 87,000.[11] The main export destinations are outside the ASEAN region. They include Ireland, Kuwait, Libya, Saudi Arabia, the United Arab Emirates, the United Kingdom, and the United States. Hospitals and specialized recruitment agencies in these countries directly source their nurses from the Philippine's labor market. Over the past few years, there has been a sharp increase in the number of medical schools offering nursing degrees. Several of these schools have adapted their course curricula to the needs of foreign markets. Other attractive characteristics of Filipino nurses include their command of English as well as their reputation for being industrious, warm and capable of adapting to other cultures. Concerns about domestic shortages of nurses in the Philippines have so far not materialized, as there has always been a sufficient supply of newly graduating nurses.

For Indonesia, the main export destinations are other Islamic countries, especially countries in the Middle East (Saudi Arabia, United Arab Emirates) but also Malaysia and Singapore. Language and cultural affinity account for this geographic export pattern. Concerns about exports leading to domestic shortages are more pronounced than in the Philippines, as Indonesia's healthcare system is chronically understaffed.

Within ASEAN, the main host economies for foreign healthcare workers are Malaysia and Singapore and, to a lesser extent, Thailand. Interestingly, Malaysia is both a recipient and a sender of healthcare workers, with Malaysian hospitals hiring mainly Indian and Filipino nurses, and Malaysian nurses working in Singapore and Saudi Arabia. In 2001, there was a net outflow of about 450 nurses, which represented less than 3 percent of total nurses employed. The same holds for medical doctors. Over the past decade, private and public hospitals have hired several hundred doctors and medical specialists, partly to

[11] Unfortunately, no statistics are available on the number of returning nurses.

address a serious domestic shortage of doctors. At the same time, a significant number of Malaysian doctors have moved to higher wage countries—in particular, to Singapore.

Cambodia, Laos and Vietnam have, so far, not become significant exporters of healthcare workers. This reflects language barriers as well as less developed medical educational systems in these three low income countries.

IV. Existing trade barriers

Notwithstanding the fact that trade in health services is already an important phenomenon in the ASEAN region, foreign service providers encounter a variety of barriers in supplying services to countries in the region. This section will offer an overview of these barriers. It will distinguish between three types of barriers: *explicit policy barriers* that directly restrict the supply of services by foreigners; *regulatory barriers* that have a trade-impeding effect; and *economic, cultural and reputational barriers* that work to disadvantage foreign suppliers.

Explicit policy barriers

Explicit policy barriers are of greatest relevance for services supplied through commercial presence (mode 3) and the movement of individual service suppliers (mode 4). Governments generally do not restrict telemedicine or remote medical transcription services supplied cross-border (mode 1). Indeed, since this form of services trade is typically delivered via electronic networks, it may be technically difficult for governments to impose import limitations. Similarly, governments usually do not explicitly prevent domestic residents from seeking medical treatment abroad (mode 2).

As for commercial presence, key explicit policy barriers include foreign equity limitations, economic needs tests, and various performance requirements. Table 9 summarizes these barriers for the seven ASEAN countries in question. Interestingly, policy seems to be more liberal in the poorer countries relative to the richer countries. Cambodia, Indonesia, Laos, and Vietnam allow, in principle, for full foreign ownership in the sector, whereas Malaysia, the Philippines, and Thailand only allow minority foreign ownership. This difference in policy may partly reflect the desire of poorer countries to attract foreign investment as a means to develop the domestic healthcare system.

Table 9: Explicit policy barriers and GATS commitments (Mode 3)

	Explicit policy	GATS commitments
Cambodia	Full foreign ownership allowed; one director must be Cambodian.	No restriction, except at least one director for technical matters must be Cambodian.
Indonesia	Conflicting policies; full foreign ownership allowed according to investment policy; 90 percent foreign equity limitation according to Ministry of Health.	Unbound.
Laos	Full foreign ownership allowed.	Laos is in the process of acceding to the WTO. US-Laos BTA grants full market access and national treatment for health and medical care services.
Malaysia	30 foreign equity limitation (though foreign equity in one hospital exceeds 30 percent); economic needs test; minimum of 100 beds.	30 percent foreign equity limitation; economic needs test; minimum of 100 beds.
Philippines	Foreign equity ownership limited to 40 percent for hospitals; full foreign ownership allowed for health maintenance organizations.	Unbound.
Thailand	Foreign equity ownership limited to 49	Unbound.

Regulatory barriers

The absence of explicit policy barriers is a necessary but not sufficient condition for foreign service providers to access domestic healthcare markets. In many cases, they face domestic regulatory measures that effectively put them at a competitive disadvantage. These regulatory measures differ across modes of supply.

In the case of telemedicine and cross-border medical transcription services (mode 1), countries typically have laws to protect the privacy of patient data. To the extent that data protection standards and enforcement practices are weaker in foreign jurisdictions, regulators may prohibit the sending of patient information to foreign countries and thereby effectively curtail services trade. In the case of the Philippines—the most significant exporter of medical transcription services in the region—privacy concerns have so far not inhibited services exports. Patient information is protected through service contracts between the importing hospitals in the US and the exporting transcription companies in the Philippines (most of which are US-owned). Nonetheless, privacy standards may well become a more important for cross-border services trade, as the technology continues to widen the scope of tradable services and more countries participate in this form of international trade.

One of the most significant barriers to health tourism exports (mode 2) is the lack of portability of health insurance in foreign countries. This may not necessarily constitute a regulatory barrier. Private health insurers may voluntarily restrict coverage for treatments incurred in foreign countries. Even though treatment in foreign hospitals may offer opportunities for cost savings, insurers may be concerned about the quality of treatment in foreign hospitals and higher costs due to the need for follow-up treatments. But insofar as health insurance is provided by government-run schemes, the lack of health insurance portability may be considered as a regulatory barrier. Indeed, Thailand, in its negotiations towards a free trade agreement with Japan, has requested that Japan's public medical insurance system cover the treatment of Japanese patients in Thai hospitals.

In the case of commercial presence (mode 3), foreign-owned hospitals in all ASEAN countries studied need to comply with all relevant domestic regulations, including requirements on location and minimum size, standards for medical equipment, qualification of medical personnel, availability of emergency facilities and other matters. These regulations apply equally to domestic and foreign hospitals and therefore do not constitute a discriminatory barrier to trade. But to the extent that hospital regulations vary among ASEAN countries and foreign hospitals are unfamiliar with regulatory requirements abroad, these measure may place foreign operators at a competitive disadvantage.

Regulatory barriers are of great relevance for the movement of healthcare workers. Domestic regulatory authorities typically require that foreign doctors and nurses have at least the same level of qualification as domestic doctors and nurses. How competencies are assessed differs from country to country. In Thailand, interested foreign doctors have to pass professional examination in Thai language, which effectively shuts out foreigners. Since 1985, only seven foreign doctors were able to pass the examination and obtain a medical license. In the Philippines, qualification requirements are similarly restrictive. Interested foreign medical professionals need to pass the 'state licensure examination' and, additionally, must have permanently resided in the Philippines for at least three years prior to registration. Apparently, no foreign medical professional has so far applied for a permanent permit.[13]

In Malaysia, qualification requirements do not pose an equally severe barrier to the entry of medical professionals. Foreign doctors need to have at least five years of post-specialist experience in a recognized hospital, as determined by the Ministry of Health. Provided they can prove that no domestic doctor can fill an open position, Malaysian hospitals can typically process an application and hire a foreign professional within 12 months. Malaysia's less restrictive regulatory regime may be partly explained by the shortage of medical personnel described above.

[13] In both Thailand and the Philippines, special exceptions to these rules exist for doctors entering the country on a temporary basis as part of humanitarian missions.

Qualification requirements in Cambodia are also less restrictive compared to the Philippines and Thailand. Foreign doctors need to prove possession of a medical degree and have five years of relevant experience. Applications are examined by the Ministry of Health, though it is not known how many applications have submitted and how many have been approved.

Regulatory entry barriers for nurses are typically less severe than for doctors. Still, recognition of nursing degrees can be important for determining the level of seniority and pay of foreign nurses. Filipino nurses moving to other countries sometimes are limited to junior positions or are paid lower wages than local nurses—an issue which the Philippines have raised in bilateral trade negotiations with Japan.

As a final observation, even though regulatory measures may have a trade-impeding effect that does not mean that they do not serve legitimate objectives. Certainly, no country would want to allow entry of any doctor who claims to be one. Yet two questions are important from a trade policy perspective. First, whether regulatory regimes unnecessarily impede trade, that is to what extent the same regulatory objectives could be met by less trade restrictive regulatory measures. And second, how trade can be promoted by pro-active regulatory cooperation between countries in a way that preserves regulatory goals. We will come back to these questions in Section VI.

Economic, cultural and reputational barriers

In addition to government measures, the entry of foreign service providers is constrained by a number of other factors. First, limited entry of foreign service providers in Cambodia, Laos, and Vietnam can largely be explained by their low level of economic development. The size of the private healthcare market in these countries is still too small to attract significant amounts of foreign investment—despite their openness to FDI. In addition, high income patients who can afford high quality medical care have the option of seeking treatment abroad. Similarly, foreign medical professionals have little economic incentive to move to these three ASEAN economies, because of low wages and better opportunities in other countries.

Second, the movement of healthcare workers and health tourism exports are held back by language barriers. Since doctors and nurses need to communicate with patients, knowledge of the host country's language is an essential requirement for the employment of foreign medical professionals. For patients seeking treatment abroad, knowledge of the local language is a less binding constraint, as many hospitals catering to foreigners offer their services in English (or Japanese). But it is still a factor affecting the choice of where to seek treatment. As described above, existing health tourism trade and movements of nurses in the ASEAN region already reflects language and other cultural affinities.

Third, for hospitals to attract foreign patients, especially from more developed countries, they need to build a reputation for high quality medical treatment. This is of particular importance for enticing foreign health insurers to cover treatment costs incurred by visiting patients. As already described, accreditation systems can be helpful in signaling quality to foreign patients and insurers, although many of these systems are confined to national jurisdictions. Marketing campaigns can be an important vehicle to advertise hospital service to foreign patients. However, it usually takes a number of years and substantial investments before a hospital establishes an international reputation.

V. The gains and pitfalls from trade in health services

As pointed out the introduction, trade in health services creates both opportunities and challenges. This section will review the key economic effects from greater openness in healthcare. Since these effects depend on the way in which services are supplied internationally, the discussion will proceed along the four modes of supply introduced in Section III.

Cross border trade and consumption abroad (modes 1 and 2)

The gains from cross border medical transcription services, telemedicine and health tourism are akin to the gains economists traditionally associate with international trade in goods. Differences across countries in endowments with capital, labor, and technology imply that some countries possess a comparative advantage in the supply of certain health services, meaning they can provide them more cheaply than others. Allowing trade in healthcare services can thus generate important efficiency gains for both the importing and the exporting economies. Patients who seek medical treatment abroad and hospitals which outsource medical transcription to foreign service providers can realize significant cost savings. One recent study, for example, estimated that the United States would save $1.4 billion annually if only one in ten patients were to go abroad for a limited set of low-risk treatments (Mattoo and Rathindran, 2005). Countries that export health services realize gains from specialization, allowing them to employ their capital and labor where they are most efficient and generating export revenues for the import of other goods and services.

As already pointed out, the comparative advantage of Malaysia, the Philippines, Singapore and Thailand in certain health services is founded on their endowment with a well-educated, but relatively cheap healthcare workforce, combined with access to modern medical technologies. The latter aspect highlights a second important benefit from trade: greater choice. Patients from poorer ASEAN countries and elsewhere are able to undergo treatment for certain conditions not available in their home countries. In addition, some hospitals in the ASEAN region (especially in Singapore) have developed a reputation for exceilence in certain specialized medical fields, which attracts patients from around the world.

Notwithstanding these efficiency and choice gains, trade also has adverse effects. Any economic activity that experiences rapid growth due to export expansion will become dearer in the domestic economy. In principle, trade theory holds that economies as a whole gain despite rising prices for exported commodities. But even if economies as a whole gain, export expansion in the health sector may have important distributive consequences for domestic patients. In addition, the public good characteristics of healthcare alluded to in the introduction raise the question of whether economies as a whole could even be worse off by rapidly expanding health tourism exports.

Distributive concerns are particularly relevant for Malaysia and Thailand. In Thailand, private hospitals that treat foreign patients do not participate in social health insurance schemes. In addition to foreigners, they also serve middle and upper income Thai patients, who pay out of pocket or are covered by private health insurance. Since they generate more revenue per patient, they can offer higher salaries to medical staff. This has diverted medical personnel away from public hospitals and private hospitals that serve Thai patients only (many of which participate in social health insurance schemes). By one estimate, an extra 100,000 patients seeking medical treatment in Thailand leads to an internal brain drain of between 240-700 medical doctors.[14] This has exacerbated shortages of medical professionals in Thailand, especially in the public sector and in rural areas. A related concern is that tertiary medical education in Thailand is provided by the public sector. Private exporting hospitals hire from the same pool of doctors as public hospitals, yet they do not share the costs of medical education.

Similar concerns exist in Malaysia. The rapid growth of private hospitals in the country has led to a drain of medical professionals away from the public sector, causing serious staff shortages and long waiting times in public hospitals. The inflow of foreign medical professionals has not alleviated domestic shortages in medical personnel (partly because Malaysian doctors and nurses have gone abroad, too). Greater numbers of foreign patients seeking treatment in Malaysia would put further pressures on the domestic healthcare system.

Commercial presence (mode 3)

Foreign investment in hospital and related services can contribute in various ways to the reach and quality of health services. It may relax domestic capital constraints and alleviate supply shortages in the domestic healthcare system. Foreign hospitals may bring advanced medical knowledge and specialized

[14] See Pannarunothai and Suknak (2004).

equipment, offering new treatments to domestic patients. The host country may also benefit from links that foreign healthcare providers may have established with medical schools abroad, which could stimulate research collaborations and the provision of specialized training. Foreign entrants may also transfer valuable organizational skills and managerial know how, gained through experience abroad. Being part of multinational hospital networks offers additional benefits. Bangkok Hospital, for example, cites increased bargaining power vis-à-vis suppliers of medical equipment and improved quality control mechanisms as key advantages of operating a large network of hospitals. The contribution of FDI could be especially important in the poorer ASEAN economies with underdeveloped health systems. This explains why Cambodia, Laos, and Vietnam impose few policy barriers to the establishment of foreign hospitals—though the small size of their healthcare market remains a binding constraint to attracting more FDI.

The more controversial aspect is to what extent foreign investment may exacerbate inequalities in the domestic healthcare system. As described above, foreign hospitals typically cater to middle and upper income patients and almost exclusively locate in urban areas. That also means they can offer the most attractive pay package to medical professionals, leading to the internal brain drain phenomenon discussed above. There is no evidence, however, whether such adverse effects have been important in the ASEAN economies studied. That may partly be because the extent of foreign participation in countries' healthcare sectors has so far been small. In addition, as described in Section II, existing healthcare systems are already tilted towards more affluent patients who are covered by private health insurance or pay for treatment out-of-pocket. Foreign investment may improve the quality and choice for those who can afford private health services. This would, indeed, worsen inequality, but it would not necessarily affect access to the health system by those patients which rely on public provision or public insurance schemes.

In the end, the net contribution of foreign investment to equity and access also depends on the type of foreign entry and accompanying policy choices. If entry takes the form of acquisition and domestic medical personnel is scarce, internal brain drain effects may be more pronounced. By contrast, if foreigners build new hospitals and bring along doctors and other medical staff, their investment may help alleviate pre-existing shortages.

Movement of healthcare workers (mode 4)

The gains from nurses and doctors moving from one country to another are at first similar to the ones outlined for cross border trade and health tourism. The movement of health workers from low wage countries to high wage countries can improve economic efficiency. For receiving countries, the benefit usually takes the form of alleviating shortages of domestic medical personnel—a growing problem in many middle and high income countries. In the case of medical specialists, additional benefits can arise in the form of new treatments becoming available and incoming doctors transferring medical knowledge. For the sending countries, the welfare effects depend crucially on where foreign healthcare workers spend their income. If a significant share of earnings is remitted home—as is the case for Filipino nurses working abroad—the sending country is likely to benefit, too. Otherwise, the sending country will experience a net economic loss.

An important question is how the outflow of healthcare workers affects the supply of medical personnel in the sending countries. As described in the previous section, the outflow of nurses from the Philippines has so far not led to any domestic shortages. By contrast, the net outflow of nurses from Indonesia and Malaysia seems to have exacerbated already existing shortages of nurses in the country.

Another key consideration for the sending country is whether the movement of healthcare workers is of a temporary or permanent nature. In fact, as pointed out in Section III, this is precisely what distinguishes trade in services from migration. If nurses and doctors return to their home countries after a number of years, concerns about domestic supply shortages may be less severe. Returning medical professionals may also bring with them new skills and capital that can be invested in the domestic economy. If, by contrast, labor movement is permanent, there is the risk of substantial human capital losses—so-called brain drain—with damaging effects on social and economic development.

VI. Policy implications

Trade policy in healthcare cannot be considered in isolation from domestic healthcare policy. The latter involves defining the roles or the public and private sectors in providing and financing healthcare. In doing so, governments face difficult choices. We highlight four key domestic policy challenges.

First, few countries can afford state-of-the-art medical services for every citizen. Most high income and some middle income countries can provide universal healthcare covering a limited set of treatments. In low income countries, access to healthcare services will often be unavailable or restricted for certain population segments. At the same time, some richer patients in all countries will always be able to afford high quality medical care, relying on private insurance or out-of-pocket financing. Private financing can alleviate the healthcare burden of the public sector. But the emergence of a two-tier healthcare system can also undermine governments' efforts to provide healthcare to those who cannot afford. On average, richer patients and patients private insurers are willing to insure tend to be healthier. Their dropping out of public insurance schemes may, on balance, diminish the funds available to treat the poor. In addition, high quality providers may draw away scarce medical personnel—especially the most talented doctors—away from hospitals serving poor patients. Few countries have left the provision of health services for those who can afford entirely to market forces. At the other end of the spectrum, no country has entirely thwarted the emergence of a two-tier system. Governments need to decide where to draw the line and what levels of inequality are deemed acceptable.

A second and related challenge is the choice of mechanisms to promote universal—or at least wider—access to health services. This is a priority in most ASEAN countries, where existing healthcare systems are biased towards more affluent patients in urban areas (see Section II). Again, difficult trade-offs exist. Providing basic healthcare services for free promotes access to healthcare by those who truly cannot afford. But free universal healthcare is beyond the means of most state budgets. In addition, free access benefits those middle income patients who can afford to contribute and it may encourage overuse of the public healthcare system (so-called moral hazard problems). Since patients derive a private benefit from medical treatment, a system of user fees would establish better economic incentives. But user fees may precisely cut off from the system those who truly cannot afford. A possible way out is the establishment of health equity funds that subsidize user fees to those truly in need. An example of how such a fund operates in Cambodia is described in Box 1. If properly run, health equity funds can maximize the utilization of limited public resources to the benefit of the poor.

The reach of health services can also be promoted through cross-subsidies. For example, user fees or insurance contributions can be fixed to vary with patients' income. A more implicit form of cross-subsidy is to require doctors to spend a certain time period in public hospitals or remote areas, before they can be hired by the private sector—as is practiced in Cambodia and Thailand. Similarly, private hospitals may be required to reserve a certain share of beds to poor patients. Such requirements can also be extended to foreign hospitals—as is practiced in Indonesia. These forms of service obligations can create economic distortions (and may pose a disincentive to FDI). But they are attractive regulatory tools for resource-strapped governments, as they do not involve any direct budgetary outlays.

Box 1: The operation of a health equity fund in Cambodia

As part of a 'new deal' on improving healthcare in the poor rural district of Sotnikum in Cambodia, a special health equity fund was established in 2000. Several features of this fund seek to overcome traditional problems encountered in improving access to health services by the poor. First, assistance from the fund does not only cover the user fees charged by the district hospital, but also transportation costs and other expenditures that prevent poor people from seeking medical treatment. Second, the management of the fund was subcontracted to a local social welfare NGO. Experience has shown that entrusting such a fund to the hospital itself can be problematic, as hospitals would pay their own user fees and would have little incentive to target those truly in need of assistance. Third, candidates for assistance are not only identified by referral from the hospital, but also through active recruitment by the staff of the managing NGO. Fourth, eligibility for assistance is determined through rigorous interviews, which collect data on applicants' income, assets, and other variables relevant for assessing the degree of impoverishment. The level of financial assistance is determined on a case-by-case basis.

After four years of operation, the health equity fund can be considered a success. On average, 40 percent of the district hospital's inpatients have received some financial assistance. Monitoring has confirmed that beneficiaries were actually poor. A considerable number of patients were from poor households that would not have sought medical care without financial assistance. Another beneficial effect is that poor patients are less likely to seek treatment from informal private practitioners, where the quality of services is generally poor. Finally, a large share of the fund goes to the hospital in the form of user fees. This contributes to the financial base of the hospital and promotes the development of the public hospital system.

Source: Meessen and Ir (2005).

A third important challenge is the development of adequate human resources, in terms of both numbers and skills. Experience has shown that as countries grow richer the demand for health services grows even more rapidly. Often, the supply of new graduates cannot keep up with demand. As described in Section II, shortages of medical personnel exist in one form or another in most of the ASEAN countries considered here. Addressing these shortages requires investments in medical education and sufficient pay incentives for students to enter the medical field. Since there is a long time lag before medical students become practicing doctors, governments need to plan for the long term.

A fourth challenge of greatest priority to the poorer ASEAN countries is the development of regulatory capacity in the health care sector. As described in Section II, regulations in Cambodia, Indonesia, Laos and Vietnam are both underdeveloped and inadequately enforced. Patients in these countries suffer from poor quality medical treatment and sometimes even abusive practices. Strengthening regulatory systems requites dedicated efforts by governments, combined with technical assistance from richer countries and specialized international health agencies.

The effects of trade policy need to be assessed in the light of the vision governments have in addressing the challenges outlined above. In some areas, trade reforms can be helpful in advancing objectives set by governments. In other areas, trade can make existing problems worse. The effects will also differ across countries, as already illustrated in the previous section. With these considerations in mind, the remainder of this section explores two questions. First, how are domestic policy and trade policy best sequenced? And second, what is the role of international agreements and cooperation within ASEAN?

How are domestic policy and trade policy best sequenced?

In Malaysia and Thailand, the growth of private hospitals has provoked a brain drain of health professional from the public sector towards the private sector. Greater mode 2 exports would channel more healthcare resources in the private sector towards servicing foreign and high income local patients, to the detriment of low and middle income patients. Ideally, this problem needs to be addressed before actively promoting mode 2 exports. There are three ways in which supply shortages could be alleviated:

(i) invest in the education of more health professionals; (ii) stem the brain drain from the public sector and rural areas by appropriate incentives; and (iii) import foreign healthcare professionals.

Increasing the supply of healthcare professionals require resources and time. Currently medical education in all ASEAN countries is heavily subsidized by the government. Given that the private sector is also the beneficiary of medical graduates, it makes sense that they should also share some of the cost. This may be done in-kind through private participation in the training of medical students; or else through tuition refunds. In Thailand, it is compulsory for medical graduates to work in the public sector for three years after graduation from state universities. However, those who opt to move to the private sector in less than three years are made to pay a fine of USD 12,000. However, this fee bears no relationship to the opportunity cost to the public health system. At least the fee should reflect the cost of education and the productivity foregone until a new graduate is ready for work. Given the long training period for physicians, advanced planning is required should a government decide that promoting mode 2 trade is the way forward. For other types of medical personnel, the period of training is shorter and private provision already exists—witness the success of nursing schools in the Philippines.

One of the most worrying repercussions is the indirect impact on medical doctors in rural areas where healthcare resources are already scarce. Several measures have been used by the Thai government over the years in an attempt to improve the distribution of healthcare personnel. These include: hardship allowances; rural recruitment and placement; career development incentives for physicians in rural areas; and relaxing barriers to foreign physicians practicing in the rural areas. In many countries, physicians work in both the public and private sectors. This type of sharing arrangement could be encouraged to avoid permanent drain from the public to the private sector and could be justified by the public sector's investments in medical education.

Similar sequencing issues arise in the case of FDI opening. If there are concerns that the entry of foreign hospitals will cause an internal brain drain—or exacerbate an already existing internal brain drain problem—full market opening may need to be postponed. Investments in the education of more health personnel could resolve such conflicts, but will likely take time. In the meantime, brain drain effects could be attenuated by appropriate incentives and obligations for doctors to practice in low income and rural areas. Alternatively, governments could require foreign entrants to bring in own medical personnel. Having said this, it is worth reemphasizing that internal brain drain effects are not automatically associated with foreign entry—especially in view of the fact that many healthcare systems in the ASEAN region are already skewed towards those who can afford and those who live in cities.

Finally, long term human resource planning is also necessary before countries choose to actively promote the sending of healthcare workers abroad. Better access to foreign employment—negotiated, for example, through trade agreements—increases the opportunity cost of healthcare workers to stay at home. As long as there are sufficient numbers of newly graduating or returning medical professionals ready to serve the domestic market, this does not pose any problem. But given that salaries in most ASEAN countries are significantly below those paid by the United States, the United Kingdom or oil-rich countries in the Middle East, domestic shortages are bound to arise. A case can be made for actively managing the outflow of healthcare workers—in particular, to stop exports when there are domestic shortages. However, this is likely to require the cooperation of trading partners, as it may be difficult for governments to stop workers from moving abroad.

The role of international agreements and cooperation within ASEAN

In principle, trade agreements offer three different benefits to participating members. First, they offer a forum for reciprocal bargaining. Governments that see benefits from own market opening may find it easier to liberalize trade in the context of international agreements. This is because domestic opposition to liberalization may be overcome more easily if a government can show market access gains in other negotiating areas. Second, a commitment under a trade agreement, even if it only locks in status quo policies, can lend credibility to the domestic policy regime. Once committed, it is difficult for governments to reverse market opening policies, providing foreign investors and traders with some assurance of policy stability. Third, trade agreements offer a forum for regulatory cooperation. As pointed out in Section IV,

the removal of explicit trade barriers may be insufficient for foreign service providers to enter the domestic market. Often, trade can only take off if countries' regulatory systems are made compatible.

To what extent have trade agreements delivered on these benefits? In which trade forum—multilateral or regional—are they best realized? And what are areas for regulatory cooperation that could promote deeper integration in the healthcare sector? We will consider these questions in turn.

As for the first question, it seems fair to say that trade agreements have so far played only a very minor role in stimulating trade in health services in the ASEAN region. Where ASEAN governments have opted for liberal trade policies, they have done so unilaterally. In particular, the scope and depth of trade commitments made by ASEAN countries at the WTO and under AFAS have so far been limited (see Section IV). In the WTO, only Cambodia and Malaysia have scheduled a commitment in the health sector. This largely reflects the broader lack of ambition in multilateral services negotiations so far.

One exception to this pattern has been the case of countries that have acceded to the WTO in recent years. Negotiations for accession to the multilateral trade body are inherently asymmetric, as acceding governments have to satisfy the demands of the existing membership without being able to ask for reciprocal trade concessions. This has resulted in aspiring members making commitments that are wider and deeper than the ones of existing WTO members at similar levels of development. Thus, Cambodia has locked in its liberal trade policies in healthcare when it acceded to the WTO in 2003. Vietnam is still in the accession process, but the Government's third offer on services includes a comparable commitment. Laos is at an even earlier stage in the accession process and has not yet made any offer in the service sector. But the Government may well come under pressure to extend the liberal commitment in services (including in healthcare) it made in its bilateral trade agreement with the United States to other WTO members (see Table 9).

At the regional level, the four negotiating rounds under the ASEAN Framework Agreement in Services (ASEAN) have so far not resulted in commitments in the health sector. However, healthcare was identified as one of eleven priority sectors for integration at the 2003 Summit of ASEAN Economic Ministers in Bali.

If ASEAN countries were willing to commit to market opening in healthcare in future trade negotiations, should they do so at the multilateral or regional level?[15] No general answer can be given. The benefit of engaging in the WTO is that trade commitments are made on a non-discriminatory or most-favored nation (MFN) basis. This is economically advantageous, as services providers from around the world will enjoy the same market access conditions, favoring entry of the most efficient suppliers.

At the same time, there are also reasons for negotiating at the regional level. One is that bargaining may be more productive among a smaller set of countries. The WTO now has 148 members at all levels of development and the multilateral trade agenda has much expanded since the early GATT days. Trade negotiations at the multilateral level therefore tend to be complex and time-consuming. Indeed, progress in the current multilateral services negotiations under the Doha Development Agenda (DDA) has been limited, so far.[16]

For countries ready to commit to market opening in services, a bilateral or regional forum may deliver quicker results. In addition, if service providers from within the region are at an infant stage, regional

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[15] For a more detailed discussion of the choice of regional versus multilateral agreements in services, see Mattoo and Fink (2004).

[16] The climate for negotiating trade in health services under the GATS also does not appear to be favorable. Some NGOs have raised concerns that GATS commitments in the health sector would encroach on national sovereignty and promote inequitable health systems. In the current negotiating round, this has led the European Communities to refrain from making market-opening requests in this sector to developing countries. Compared to other service sectors such as financial and express mail delivery services, there also do not appear to be strong private sector lobbies pushing for liberalization.

market opening may, in theory, offer learning externalities that can enable these providers to become more efficient and eventually face global competition. But regional liberalization may also entail economic costs, mainly in the form of second-based service providers entering the domestic market. Notwithstanding these considerations, many bilateral and regional trade agreements have a political imperative, which in recent years has favored the conclusion of bilateral and regional agreements.

There is little controversy that regional agreements have an important role to play in the area of regulatory cooperation. Making regulatory regimes more compatible seems neither feasible nor desirable at the multilateral level. The WTO currently has 148 members, at every level of development and with a wide variety of legal and regulatory systems. While the ten ASEAN countries are not a homogenous group either, there does appear to be scope for increased cooperation in the health sector—as is already happening in many other fields.

The national research studies for the seven ASEAN countries identified a number of specific areas for regulatory cooperation in the healthcare sector that could be pursued at the ASEAN level:

- *Promoting health tourism exports.* Notwithstanding the need for appropriate policy sequencing as outlined above, there are a number of initiatives that could expand trade within the region. First, an ASEAN-wide framework for the portability of health insurance could be developed, which would seek to address the concerns of public and private insurers in covering medical expenses occurred in other ASEAN countries. Second, the development of rules on the privacy and confidentiality of patient information would help assure patients that foreign hospitals treat such information responsibly. It could also encourage the exchange of patient data between hospitals in different countries, when this is necessary for optimizing medical treatment. Third, while there is already an ASEAN initiative to promote visa-free travel among its member countries, there is scope to further minimize visa requirement for traveling patients—for example, for patients seeking treatments requiring a stay longer than the maximum number of days allowed in tourist visas. Fourth, an ASEAN-wide system for the accreditation of high quality hospitals could be developed. This could help hospitals overcome reputational barriers to greater health tourism exports.

- *Managing the movement of healthcare workers.* An ASEAN facility could be created that would monitor shortages and surpluses of medical personnel in different ASEAN countries. This could help policymakers evaluate where the movement of healthcare workers is warranted and where it exacerbates existing shortages. In addition, a special ASEAN visa—not necessarily limited to healthcare workers—could be developed that would be truly temporary in nature. Such a visa could address concerns in host countries that foreign workers will stay permanently and, at the same time, reduce negative brain drain effects in home countries. Where the movement of healthcare workers is considered desirable, it can be actively promoted through the harmonization of professional standards and the conclusion of agreements recognizing foreign qualifications. The short term movement of medical specialists for individual treatments could be promoted by developing a framework for malpractice insurance of out-of-jurisdiction medical personnel.

- *Improving the quality of health services and medical training.* The transfer of medical knowledge could be promoted by encouraging exchanges of hospital staff within the ASEAN region. Skills transfers could also be promoted by region-wide training initiatives and the harmonization of course curricula, especially for new medical technologies. In the long term, cooperation on training could also contribute to increased mobility of medical personnel in the region. Regulators could exchange best practices in developing and enforcing medical service standards, which could be of particular benefit to the poorer ASEAN countries.

Several of the proposed regulatory initiatives would require the direct involvement of the private sector and medical associations. The role of ASEAN governments in these cases would be to provide the forum and set the direction for cooperation among those entities. In addition, in some areas regulatory cooperation may still not be feasible at the regional level. For example, it may not be realistic to craft

region-wide mutual recognition agreements (MRAs) for medical professionals. But developing regional frameworks for regulatory cooperation could help promote feasible cooperation at the bilateral level and ensure such cooperation could in the longer term be extended to other ASEAN members.

As part of ASEAN's effort to advance integration in the so-called priority sectors, the Government of Singapore has developed a Roadmap to advance the region-wide integration of the healthcare sector.[17] This Roadmap was adopted by ASEAN Trade Ministers in November 2004 and incorporates many of the recommendations outlined above. Interestingly, the one area that has received relatively little attention in the Roadmap is the promotion of health tourism exports. In particular, while the streamlining of visa requirements for foreign patients is recognized, no measures are proposed to promote the portability of health insurance.

As a final note, while ASEAN provides a geographic and political foundation for regulatory cooperation, for at least some countries in the region there are likely to be large pay-offs from pursuing such cooperation with countries outside the region. As described in Section III, health services and healthcare workers are exported to the United States, the United Kingdom, Japan, and countries in the Middle East. Indeed, cooperation on certain regulatory aspects has already taken place in the context of bilateral free trade agreements that ASEAN countries have signed in recent years.

VI. Concluding remarks

ASEAN governments have set themselves the goal to progressively liberalize trade in health services in the region. From an economic perspective, opening healthcare markets promises substantial economic gains. Yet it may also intensify existing challenges in promoting equitable access to healthcare. In a way, trade may raise the stakes of domestic policy reforms. It may help focus policymakers' minds and create new opportunities for improving affordable access. But it may also lead to outcomes from which only the better-off will benefit.

Pursuing integration regionally, rather than through unilateral liberalization, holds certain advantages. Every country has something to gain from collective action—whether the prospect of greater exports or the promise of regulatory capacity building. This may help overcome domestic resistance to market opening—for example, from protectionist medical associations. In addition, deeper integration requires pro-active cooperation between governments, which by definition cannot be pursued unilaterally. Still, delivering on the recently adopted ASEAN Roadmap on Healthcare will be no small feat. ASEAN's past experience in promoting deeper integration points to the difficulties posed by differences in regulatory regimes and levels of economic development.

Economic research on the effects of liberalizing trade in health services is still in its infancy. In particular, more studies are needed which empirically assess the impact of trade reforms on key healthcare performance indicators. Such research would improve policymakers' understanding on what works in which circumstances and could thereby contribute to improving the design of trade reforms.

[17] The sectoral initiative in healthcare is not limited to the integration of service markets, but also encompasses the promotion of trade in healthcare goods (for example, medical equipment, pharmaceutical products) as well as cooperation on questions of technical standards, intellectual property protection.

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Regulation of products harmful to health in an era of globalization

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Abstract

This session examines the way globalization has impacted on threats to public health by facilitating the use of tobacco and alcohol products. It also examines the way globalization enables a public health response to these threats; the use of global strategies is illustrated with lessons learned from the WHO Framework Convention on Tobacco Control and its application in the context of Myanmar. These lessons will inform the development of a Global Alcohol Strategy in the coming years.

Globalisation and health

Impacts on health

In the era of globalization, marketing and promotion of harmful products such as tobacco and alcohol have been identified as major transnational determinants of ill-health. The enormous resource of the powerful multinational corporations which are producing and distributing alcohol and tobacco facilitates the use of innovative and sophisticated marketing, sometimes globally themed, sometimes with national emphasis. As Jernigan (Jernigan, 2001) states in relation to alcohol: "What is emerging worldwide is the dominance of a small number of companies, several of which are based in Europe, whose marketed images, created to appeal to young people in the developed countries, increasingly define alcohol and the culture of alcohol use for the world." In a globalised, media-saturated world the commodification of youth culture provides a fertile environment in which the marketing can grow demand for these products, particularly among the young (Hong, 2000, Klein, 2000).

Globalization via trade and economic agreements also have had and have potential to have further impacts on alcohol and tobacco as determinants of ill-health. Globalization restricts the capacity of countries to regulate these products through domestic legislation alone. While aiming to achieve free trade across borders the rules in trade agreements limit governments' regulatory authority over trade and enhance the authority of international financial organizations and trade organizations (Kickbusch cited in Shaffer et al., 2005). The mechanisms which have affected this include GATT (general agreement of Trade and Tariffs), regional free trade agreements and the WTO negotiations on the GATS (General Agreement on Trade and Services). These have meant that national governments have had less ability to control in key policy areas. International trade treaties have already forced changes in many government measures affecting availability and control (Grieshaber-Otto et al., 2000).

The World Health Organisation's Comparative Risk Assessment has determined the contribution made to the global burden of disease of a range of risk factors including alcohol and tobacco. Globally tobacco contributed 4.1% of disability adjusted life years lost in 2000 and alcohol contributed 4% making them respectively fourth and fifth leading cause of the loss of healthy life years (Ezzati et al., 2002). In both developing and developed regions alcohol and tobacco were major causes of disease

burden. However the relative contribution of these products varied in different regions of the world depending on their levels of use and the importance of other risks to health. In developed regions tobacco (12.2%) and alcohol (9.2%) were consistently among the leading causes of loss of healthy life. In high mortality, developing countries tobacco contributed 2% and alcohol 1.6% to loss of healthy life. The role of both alcohol and tobacco is particularly striking in developing countries with low mortality, such as parts of America and Asia Pacific: Alcohol contributed 6.2% to loss of healthy life in these countries, making it the leading cause, and tobacco contributed 4.0% (Ezzati et al., 2002). It is these countries, some with expanding economies and many with yet unsaturated tobacco and alcohol markets, where many of the impacts of globalisation on the production and marketing of these products are yet to be fully experienced.

A global public health response

In response to the globalization of the tobacco epidemic, the 191 Member States of World Health Organization unanimously adopted the WHO Framework Convention on Tobacco Control at the 56th World Health Assembly in May 2003, as a global complement to national actions. THE WHOFCTC is a major global development for addressing the globalization of the tobacco epidemic and an example of emerging global health governance (Dodgson et al., 2002).

In response to similar concerns with regard to the globalisation of alcohol the member states unanimously passed the resolution "Public health problems caused by harmful use of alcohol" at the 58th World Health Assembly in May 2005. The WHO Secretariat has been asked to report back to the World Health Assembly in May 2007 and work on regional strategies is already underway. This signals the beginning of the development of an urgently needed Global Strategy on Alcohol.

This paper describes the involvement of a low income country, Myanmar, in the development of the WHOFCTC and the implications of this at the national level. It then describes some of the health impacts of alcohol and draws on lessons from the Myanmar case study to delineate the key elements of a global public health strategy aiming to reduce harm at the national level and the impact of globalisation on these key determinants of health

Globalization and tobacco in Myanmar – a case study

Tobacco use has long been culturally and socially accepted in most countries of the WHO South-East Asia Region. The Region is also unique in having a diversity of tobacco products being used. Home to one-quarter of the world's population and undergoing significant demographic and socio-economic changes, the Region has become a lucrative market for the tobacco industry. The multinational tobacco companies had intensified their marketing practices in the Region during the last two or three decades through a variety of complex factors with cross-border effects such as advertising, promotion and sponsorship, trade liberalization and foreign direct investment.

Myanmar, like other Member Countries of the Region is a fertile ground for the tobacco habit and a probable scene of tobacco-related morbidity and mortality explosions by the turn of the century. With the opening of the market economy, multinational tobacco companies and a few Indonesian tobacco companies came to invest in the country in the 1990s. New cigarette brands were introduced through vast investments on advertisement; hundreds of cigarette advertising billboards were erected in major cities and gradually expanded to rural areas. The cigarettes were sold at relatively cheaper prices than imported cigarettes and the "foreign" brands with colorful pictures attracted many customers. With the lack of tobacco control legislation, youth had easy access to tobacco products which were sold in loose forms without age limitation. Cigarette consumption increased rapidly among all ages, especially among adolescent males and young adults. The Ministry of Health became seriously concerned about the increasing trends in tobacco use and increased its health education activities on dangers of tobacco.

Myanmar and the global movement for tobacco control

In July 1998, WHO reorganized its tobacco control efforts within a new structure, the Tobacco Free Initiative (TFI) and this movement greatly enhanced the momentum of the anti-tobacco activities in Myanmar. The National Health Committee which is the highest inter-ministerial advisory group of all concerned ministries at the national level issued guidelines for prevention and control of smoking related diseases at its 26th meeting held in September 1998.

The National Programme on Tobacco Control was officially launched in January 2000 with the drafting and approval of the National Policy on Tobacco Control and Plan of action. The National Tobacco Control Committee was formed in March 2002, headed by the Minister for Health and included heads of related departments and chairpersons of several national NGOs as members. The Committee set guidelines for the tobacco control measures to be implemented in the country.

The Ministry of Information prohibited advertisement of tobacco on television and radio and from all electronic media in the year 2000. Tobacco advertising billboards were banned from the vicinity of schools, hospitals, health facilities, sports stadiums and maternity homes in May 2002 and from other places in April 2003. Tobacco advertisement were also been banned from the newspapers, journals and magazines in early 2003. Smoking was prohibited at all hospitals and health departments, at all basic education schools, all sports stadiums and sports fields and at some workplaces.

In May 1999, the World Health Assembly-the governing body of the World Health Organization, adopted a resolution (WHA 52.18) (World Health Assembly, 1999) which paved the way for starting multi-lateral negotiations on the WHO FCTC and possible related protocols. Myanmar along with fellow Member States actively participated in the negotiating process of the WHOFCTC and strongly supported the convention. Myanmar delegates expressed their strong commitment towards comprehensive tobacco control measures and voiced the need for a comprehensive ban on all forms of tobacco advertisement including cross-border advertising. Myanmar proudly hosted the 4th Inter-country Consultation Meeting on Framework Convention on Tobacco Control in August 2002, where the countries of South-East Asia Region issued the "Yangon Declaration" (The Yangon Declaration, 2002).

Myanmar delegates who participated at these negotiations, reported back to the national authorities with strong recommendations to sign and ratify the convention. The theme and provisions of WHOFCTC were put up by the Minister for Health to the 34th meeting of the National Health Committee in April, 2002; the meeting principally agreed the provisions of WHOFCTC and gave the green light for becoming Party to the Convention. Myanmar became a proud signatory to the FCTC on the 23rd of October 2003 and became a Party to the Convention on the 20th of April, 2004; it was the 11th country to become Party to the Convention.

National legislation on tobacco control

Drafting of Tobacco Control Law started in 2002, when Myanmar was actively participating in the negotiating processes of WHOFCTC. The ratification of WHOFCTC increased the momentum of the drafting process and also widened the scope of contents of the legislation as the drafting committee tried to cover the provisions of FCTC as much as possible. An example was prohibition of sale of individual or small packets of cigarettes; this was previously not included in the legislation as it was considered impractical in Myanmar but was later included in the law as one of the FCTC provisions. The legislation has been approved and is in the process of being enacted by the Government of the Union of Myanmar.

Opportunities and challenges

Dedicated personnel at the Ministry of Health and multisectoral collaboration mechanisms among sectors contributed to the achievements in the tobacco control activities of Myanmar. The negotiating processes of WHOFCTC had been successfully used as an advocating tool for tobacco control; becoming a Party to the FCTC further strengthened the dedication and commitment of anti-tobacco advocates.

Reluctance of the decision makers to increase tax and price on tobacco products for fear of increasing the burden on the poor was a major challenge in the drafting process of the legislation. The legislative draft has failed to include any measures on price and tax. More research studies need to be conducted to provide the policy makers with evidence-based information.

The whole process of implementing the tobacco control programme, involvement of multi-sectoral bodies in the national committee, active participation in the FCTC negotiations, signing and ratifying the FCTC, drafting the legislation and having it approved had achieved significant impact on public health measures regarding tobacco in Myanmar.

Framework convention on tobacco

The initiation and adoption of WHOFCTC had an enormous impact on the world-wide anti-tobacco movements. Getting involved in the negotiating process itself moved the tobacco control measures of countries forward; in countries like Myanmar, delegates who had participated in the Intergovernmental Negotiating Bodies reported back to the policy makers with strong recommendations to enhance the momentum of anti-tobacco activities and public awareness campaigns. The whole process of adopting, signing and ratifying the WHO FCTC was a challenging and exciting experience and having the national tobacco control legislation approved was a huge success in the history of public health in Myanmar. In many countries the WHOFCTC has been used as a strong advocating tool to fight against the powerful lobbying of tobacco industries.

Global strategy on alcohol

Lessons can be learned from the Myanmar case study which illustrate the value in the development of a global strategy on alcohol.

The resolution on alcohol harm passed in 2005 was the first WHO resolution solely addressing alcohol since 1982. Unlike both narcotics and tobacco the United Nations system has not identified alcohol as in need of a global response. However, recent data has illustrated clearly the importance of alcohol as a risk factor for ill health. Alcohol is causally related to more than 60 medical conditions (Room et al., 2005). The WHO study on the global burden of disease has illustrated the importance of alcohol in developed and developing regions of the world with the contribution made to loss of healthy life in developing countries with low mortality, where it was the leading cause, of particular concern (Ezzati et al., 2002).

The size of the burden caused by alcohol is likely to be even greater than indicated in these WHO analyses since they take into account primarily health problems related to drinking. The limited evidence available, however, suggests that social problems related to drinking impose as much of a burden (Room et al., 2003). Furthermore, not only the drinker experiences the health and social consequences of alcohol but so do others; the externalities from alcohol use may well exceed those of tobacco.

The impacts of alcohol are also importantly related to development opportunities and poverty. While consumption of commercially produced alcohol may remain the prerogative of the elite in low and medium income countries the transfer of money from the local community to global corporation via a product which does not generally aid development efforts make it a relevant issue for health inequalities.

Expansion of alcohol harm

Developing countries, especially those with expanding economies, have been identified as areas for market expansion. Thailand provides a good example of such a country. Thailand has seen a rise in GDP accompanied by a substantial rise in per capita consumption of commercially produced alcohol over the last four decades.

Commercial alcohol consumption doubled in the eight years from 1992 to 2000 (Thamarangsi, 2005).

Harm from alcohol has also become a topic of concern and measurement in Thailand. Calculations of the costs associated with alcohol related traffic crashes have been estimated at between 2 – 3.5% of GDP (Thamarangsi, 2005). Families with a drinking member have been found to have 3.84 times higher rate of household violence (Thamarangsi, 2005).

While there have been expansions in consumption and harm the implementation of effective public health policies has not kept pace (Thamarangsi, 2005). Taxation policies are in place but do not have an explicit health goal; there is little effective restriction on the availability of alcohol and the minimum purchase age of 18 is not enforced. There is legislation to regulate conduct in licensed premises in Thailand, for example, against selling to intoxication, being drunk in public place and being underage in tavern but this is not enforced. With regard to drinking and driving there is a per se law at 0.05% but once again there is little enforcement of this. Finally controls over alcohol promotion are limited and have been subjected to sabotage by the industry.

This lack of enforcement and, in many cases, lack of legislation and regulation for the most effective policies, is common in high income countries (Babor et al., 2003) and also in countries with low and medium incomes.

Need for the development of an international framework for alcohol control

The situation with regard to alcohol is such that a similar process to that engaged in for the development of the WHOFCTC would be likely to assist the development and implementation of more effective policies at the national level and also to assist urgently required regional and international co-operation. Both the process and the elements of the WHOFCTC are relevant to the needs of a Global Alcohol Strategy. The involvement of member states in regional and global strategy development, as illustrated by Myanmar's involvement in the WHOFTC, will have a positive impact on national development.

Elements of a public health framework/global strategy

Surveillance, research and policy analysis

The Myanmar case study illustrated the impact that monitoring of trends in tobacco consumption and noting increases in young and in males had in motivating action by the Ministry of Health.

There is a similar need for surveillance and analysis of alcohol. WHO is currently undertaking the collation of data at a global level on consumption (World Health Organization, 2005) and the policies jurisdiction have in place (World Health Organization, 2004). With regard to data on consumption, countries have often relied on statistics collected for taxation purposes to make estimates of per capita consumption. In countries with developing alcohol markets it is necessary to estimate

among what proportion of the population the alcohol is shared. Taxed alcohol also excludes illicit supply of commercial alcohol and informal, often traditional, beverages. The need to obtain accurate estimates is likely to increase reliance on population surveys to measure and monitor trends in use and makes the issue of appropriate measurement methods very important. Population surveys also allow for monitoring of specific demographic groups, which is important in the context of increased youth drinking, and for the monitoring of patterns of drinking such as episodic, heavier consumption, which are important for harm and policy development.

To a greater extent than is now the case for tobacco, there is a need to measure harms causally related to alcohol use. Alcohol interacts with the cultural setting in ways which influence much of the harm associated with its use. Measurement of alcohol harm needs to cover the full range of social consequences. Current estimates of economic costs lack adequate data in many areas. In countries in which the globalization process is accelerating socioeconomic transition alcohol plays a important, but largely undocumented, role in changing traditional family and community structures and can also have impacts on spiritual values.

The Myanmar case study also described the importance to the policy development process of the analysis of market developments – it was noted that new brands were introduced at cheaper prices, and were being heavily marketed. Analysis of alcohol issues requires economic literacy given the globalized and privatized context.

Finally, there is a need to evaluate in low and medium income countries the implementation of policies. This includes policies which have been shown to be effective in high income countries and new approaches relevant to the country setting. In a country like Myanmar, with high levels of poverty, the adoption of taxation policies in relation to both alcohol and tobacco in order to achieve a public health goal requires clear evidence of effectiveness.

Advocacy

The Myanmar case study illustrated the way in which the drafting of the national tobacco control legislation took place in parallel with the participation by Ministry of Health personnel in the development of the WHOFCTC and showed that there was synergy between these two parallel developments.

While alcohol has come to greater prominence in a number of jurisdictions and regional and international organizations in recent years (GAPA, Eurocare, European Commission, Secretariat of the Pacific Community, 2004), it is apparent that progress on a Global Alcohol Strategy will enhance developments at the national, regional and international level and there will be similar synergies to those which occurred in relation to the WHOFCTC.

The Myanmar case study illustrated the complementary role of the NGO sector. Globally 200 NGOs were engaged in the successful achievement of the WHOFCTC. They came together in a Framework Convention Alliance which included a range of NGOs working at the national, regional and international levels. The work of the NGO network was crucial. The NGO network in alcohol is less well developed globally than is currently the case for tobacco but there are some clear indications that

this is growing (GAPA). The technological developments which have allowed globalization of the markets for alcohol and tobacco also facilitate the global development of public health networks.

Much of the societal level response to alcohol occurs at the community level in the informal sector (eg. women's organizations, religious organizations) and the involvement of these organizations in advocacy on alcohol issues is important.

An important difference in alcohol advocacy compared with tobacco is the salience of the role of the alcohol industry and its associated organizations. Some sectors of the global alcohol industry are actively engaged in lobbying at national, regional and international levels (eg. distilled spirits re economic agreements). They also fund a large number of 'social aspects organizations' which advocate for industry-friendly policies (McCreanor, 2000, Anderson, 2002). One important issue which will be increasingly clarified during the development of a Global Strategy on Alcohol is the appropriate role of industry sectors in policy development and implementation. While local retailers may have an important role in responsible supply of alcohol the interests of alcohol producers conflict with those of public health and their involvement in a policy development process will tend to frustrate public health objectives in favour of more industry friendly approaches (Babor 2000 cited in Anderson, 2002).

Resourcing

In Myanmar resources were provided for the tobacco control work. First there was the establishment of national level committee and then the funding of a national programme in 2000. Myanmar also hosted the WHO meeting resulting in the Yangon Declaration, a significant step towards the WHOFCTC. Such resourcing will also be required to support the development of a Global Alcohol Strategy.

Important here is the resource required for civil society to develop and sustain networks able to be involved in the process of global health governance. At the national level there is a need to ensure resources for policy implementation; in addition to the needs of the health sector there is resource required for cost effective policies such as the enforcement of effective drink-driving legislation, the minimum purchase age, and hours and places of sale. Much of this requires funded community mobilization as well as adequate funding for the relevant sectors.

Implementation of effective policies

The adoption of effective tobacco control policies at the national level was facilitated by the WHOFCTC. Myanmar established controls on marketing tobacco and some smoke free environments in 2000 – 2003. However, the inclusion of the prohibition of sale of single cigarettes was included in national legislation only after Myanmar became a signatory to the WHOFTC which requires it. Taxation remains an area which is a crucial part of the WHOFCTC but is not included in Myanmar's legislation.

There are effective alcohol policies which have been shown in evaluations in higher income countries to reduce harm (Babor et al., 2003, Chisholm et al., 2004). These are

often less popular than the more individually focused approaches and the support of a Global Strategy, by promoting the evidence base on effective implementation, would assist their uptake. The implementation of effective policies requires a legislative framework, enforcement, and media and the resourcing and development of community capacity to sustain their implementation.

Regional and international collaboration

The involvement of Myanmar's Ministry of Health personnel in the development of the WHOFCTC helped in their role as national level advocates. Similarly the involvement of these advocates assisted the momentum of the WHOFCTC. The development of a Global Alcohol Strategy will also require strong input from a range of supportive member states.

Many of the effective policies relating to both tobacco and alcohol increasingly require regional and international response. Effective public health policy for both alcohol and tobacco requires restriction on availability, marketing and pricing. Alcohol policies have generally until now been the concern of national and local governments. In the globalised world there is a need for regional and international support for national efforts to control the alcohol market.

Public health professionals and organizations have rarely participated in trade negotiations or in resolution of trade disputes. The linkages among global trade, international trade agreements, and public health deserve more attention than they have received to date (Shaffer et al., 2005). There is an urgent need for alcohol and tobacco to be excluded from the general trade and services agreement of the WTO and of regional trade agreements (Room et al., 2003).

Some form of global health governance (Dodgson et al., 2002) will also be required if the myriad of new technological possibilities for brand marketing, including the internet, are to be appropriately controlled.

Conclusion

Globalisation has affected the use of alcohol and tobacco and the consequent experience of harm. This has resulted from the growth in global corporations leading to increased marketing and accessibility of commercially produced, branded alcohol products. The globalization of media and youth culture has also facilitated their spread in many countries of the world. The economic agreements which have reduced the barriers to the distribution of these products have facilitated their penetration into new markets. Future agreements in regard to trade and services as well as new regional economic agreements have the capacity to allow greater access and marketing of these products and threaten the capacity of national governments to control access to these products. This requires a strong public health response with much greater analysis of the public health implications of all economic agreements

The WHOFCTC illustrates a strong public health response to the threats of globalization to the health and welfare of the world's citizens. It requires ongoing support, including resourcing of national and community capacity in lower income

countries to ensure that more countries become signatories and to ensure that the WHOFCTC's clauses are implemented at national levels. A similar global response to the threats to health posed by the spread of alcohol is urgently required and many of the key issues to do with the marketing and promotion of the products are very similar to those of tobacco.

Global health governance requires a combination of regulatory frameworks and informal, normative developments (Dodgson et al., 2002). There is a need for an ongoing response to alcohol and tobacco which incorporates the strength of the regulatory framework agreed to by national governments and the informal monitoring and influence which is an essential part of the role of civil society in governance in this area.

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Health as Foreign Policy: Harnessing Globalization for Health

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Abstract

This technical paper explores the importance for health promotion of the rise of public health as a foreign policy issue. Although health promotion encompassed foreign policy as part of "healthy public policy," mainstream foreign policy neglected public health and health promotion's role in it. Globalization forces health promotion, however, to address directly the relationship between public health and foreign policy. The need for "health as foreign policy" is apparent from the prominence public health now has in all the basic governance functions served by foreign policy. The UN Secretary-General's UN reform proposals demonstrate the importance of foreign policy to health promotion as a core component of public health because the proposals embed public health in each element of the Secretary-General's vision for the UN in the 21st century. The emergence of health as foreign policy presents opportunities and risks for health promotion that can be managed by emphasizing that public health constitutes an integrated public good that benefits all governance tasks served by foreign policy. Any effort to harness globalization for public health will have to make health as foreign policy a centerpiece of its ambitions, and this task is now health promotion's burden and opportunity.

Introduction

1. The 6th Global Conference on Health Promotion seeks to reaffirm the values, principles, and purposes of the health promotion movement that stretches back nearly two decades. Reaffirmation of the tenets of health promotion as a core component of public health today unfolds, however, in an environment radically different from the situation prevailing when the Ottawa Charter was adopted in 1986. This technical paper focuses on one transformation that affects health promotion—public health's rise as a foreign policy issue in international relations.

2. Increasing the visibility of health promotion has previously linked health promotion and foreign policy. These linkages tended, however, to be subsumed in advocacy for the larger goal of "healthy public policy."[1] The last decade witnessed relationships between public health and foreign policy intensify, expand, and become more explicit. These developments reveal that a new context and a new reality for health promotion and foreign policy have emerged.

3. Intersections between foreign policy and public health have become critical in analyzing the management of globalization in ways sensitive to health promotion. Thinking about "health as foreign policy" requires understanding the opportunities and challenges this task creates. In addition, health as foreign policy necessitates initiatives that can make foreign policy a more robust channel for health promotion.

The Health Promotion Movement and Foreign Policy

4. The transformation of the relationship between public health and foreign policy should not obscure the long-standing intersections between health promotion and foreign policy. Past conferences framed health promotion in global terms, stressed the need for health promotion to be advanced by all governmental sectors, and called for healthy public policy at all levels. The health promotion vision encompassed foreign policy as an important governance activity.

5. Foreign policy's relevance for health promotion remained, however, implicit and mostly assumed. None of the documents issued by previous health promotion conferences specifically mention foreign policy. Earlier conferences conflated policy categories to emphasize that health promotion "puts health on the agenda of policy makers in all sectors and at all levels[.]"[2]

6. This message did not, however, penetrate mainstream foreign policy. Experts have noted how the study and practice of foreign policy and international relations historically neglected public health,[3] treating it as a non-political matter best left to technical specialists.[4] A gap existed between foreign policy communities, which relegated public health to the "low politics" of foreign policy, and health promotion advocates, for whom public health was among the most important challenges facing countries in an interdependent world.

Health Promotion and Foreign Policy: The New Context

7. The decision to focus on foreign policy at the Bangkok Conference represents recognition that the relationship between health promotion and foreign policy has been transformed. This recognition echoes the realization by foreign policy makers that public health has risen on their agendas in ways that challenge the traditional neglect of this area. Developments over the past decade precipitated a collision of the worlds of public health and foreign policy that is historically unprecedented.

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[1] Ottawa Charter for Health Promotion, 21 Nov. 1986, WHO/HPR/HEP/95.1.
[2] *Id.*
[3] *See, e.g.*, I. Kickbusch, "Global Health Governance: Some Theoretical Considerations on the New Political Space," in *Health Impacts of Globalization* (K. Lee, ed.) (Palgrave, 2003): 192-203, p. 192.
[4] E. B. Haas, *Beyond the Nation-State: Functionalism and International Organization* (Stanford University Press, 1964), pp. 14-17.

8. A key factor producing this collision is globalization. Earlier health promotion conferences identified international interdependencies as one reason why healthy public policy should be a global objective.[5] Assertions about interdependence did not produce robust foreign policy engagement with public health, especially among the great powers. Globalization has, however, expanded, intensified, and transformed interdependence to the point that public health problems cascade across foreign policy agendas and capture the attention of strong and weak countries. See Box 1.

Box 1.

Examples of Public Health Issues and Developments of Foreign Policy Significance

- Emerging and re-emerging communicable diseases
  - → HIV/AIDS pandemic and associated infections (e.g., tuberculosis)
  - → Outbreak of Severe Acute Respiratory Syndrome (SARS)
  - → Outbreaks of avian influenza (H5N1)
  - → Problems with the fight against malaria
- Proliferation of biological weapons by states and the threat of bioterrorism
  - → Breakdown in the negotiations for a compliance protocol to the Biological and Toxin Weapons Convention
  - → Anthrax attacks in the United States in 2001
  - → Development of policies to improve biosecurity
  - → Fears of rapidly advancing science making perpetration of bioterrorism easier
- Global increase in non-communicable diseases
  - → Concerns related to tobacco consumption leading to the WHO-sponsored negotiation and adoption of the Framework Convention on Tobacco Control
  - → Growing problem of obesity worldwide leading to WHO work on a global strategy on diet and physical activity
- Linkages between international trade and public health
  - → Controversies over the protection of patent rights for makers of pharmaceutical products and access to essential medicines in developing countries
  - → Concerns about further liberalization of trade in health-related services adversely affecting the quality, affordability, and accessibility of health services
- Reassessment of the role public health plays in economic development (e.g., Commission on Macroeconomics and Health)
- Public health and human rights issues
  - → Reinvigoration in international interest in the right to health
  - → Renewed concern about respect for civil and political rights in connection with responses to dangerous outbreaks of communicable diseases (e.g., SARS)
- Major diplomatic initiatives on global public health problems
  - → UN's Millennium Development Goals
  - → Global Fund to Fight AIDS, Tuberculosis, and Malaria
  - → Roll Back Malaria Campaign
  - → Stop TB Partnership
  - → WHO's "3 by 5" Initiative
  - → U.S. President's Emergency Plan for AIDS Relief
  - → Doha Declaration on the TRIPS Agreement and Public Health and related initiatives (e.g., Paragraph 6 Agreement and the WHO Commission on Intellectual Property, Innovation, and Public Health)
  - → Global Health Security Initiative
  - → Negotiation and adoption of the WHO's new International Health Regulations

9. Globalization exposed vulnerabilities of countries to public health threats that were previously non-existent, latent, or ignored. Governments faced mounting public health threats with the realization that globalization constrained policy control over many determinants of health, limiting options to the detriment of population and individual health. Globalization also affected the traditional dichotomy between

[5] *See, e.g.,* Recommendations from the 2nd International Conference on Health Promotion, Adelaide, Australia, April 1988 ("The achievement of global health rests on recognizing and accepting interdependence both within and between countries.").

domestic and foreign affairs, blurring the utility of borders to demarcate where and how policy should be made. Interconnectedness between the local and the global produced centralization of policy making at the national level because only at that level could states address the international and transnational contexts of globalized health issues.

Health as Foreign Policy: The New Reality

10. Globalization's impact on public health appears to underscore the need for healthy public policy at all governance levels given the ways in which globalization challenges every level of policymaking within countries. The reality of public health's emergence in foreign policy has been, however, to make foreign policy more important to public health. Globalization has not altered the political structure of international relations—humanity remains organized into nearly 200 territorial states that interact in a condition of anarchy, defined as the absence of any common, superior authority. The dynamics, and many of the foundational norms, of this anarchical structure privilege sovereignty as a governance principle. Intercourse between sovereign states is the essence of foreign policy—policy that organizes the state's relations with other sovereigns.

11. Historically, public health has predominantly been a domestic policy concern;[6] but developments over the last decade have forced public health experts and diplomats to think of health *as* foreign policy, namely public health as important to states' pursuit of their interests and values in international relations. This transformation is complicated and cannot simply be equated with "healthy public policy." This new reality presents opportunities and risks for health promotion.

Foreign Policy Functions and Public Health

12. One way to understand the new reality of health as foreign policy is to see how public health connects with the basic functions of foreign policy. Although foreign policy is complex, states engage in it to fulfill four basic governance functions. First, through foreign policy, states seek to ensure their security from external threats. Achieving national and international security is, thus, a foreign policy function. Second, a country uses foreign policy to contribute to its economic power and prosperity. States promote their interests in international trade and investment through foreign policy.

13. Third, states use foreign policy to support the development of political and economic order and stability in other countries. Such development supplements a state's interest in its security and economic well-being. As a result, political and economic development forms part of foreign policy. Fourth, states make efforts to promote and protect human dignity through foreign policy, as evidenced by support for human rights and the provision of humanitarian assistance.

14. Identifying foreign policy's governance functions does not imply that any given state integrates these functions well or even considers them equally important. Students of international relations have frequently noted a hierarchy in the foreign policy functions,[7] with security and economic power ranking higher than development or human dignity. Public health's traditional place in the "low politics" of foreign policy can be attributed to this hierarchy because public health was generally categorized as a development or human dignity issue. See Figure 1.

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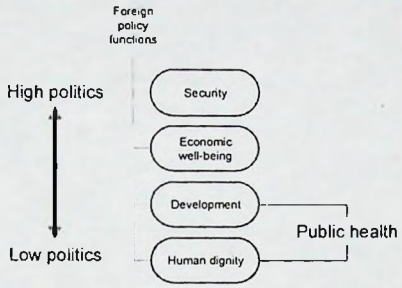
[6] R. Cheek, "Public Health as a Global Security Issue," *Foreign Service Journal* (Dec. 2004): 22-29, p. 23.
[7] *See, e.g.*, Steven Weber, "Institutions and Change," in *New Thinking in International Relations Theory* (M. W. Doyle and G. J. Ikenberry, eds.) (Westview Press, 1997): 229-265, p. 230.

Figure 1.

Traditional Hierarchy of Foreign Policy Governance Functions



15. The health promotion strategy reinforced public health's subordination in mainstream foreign policy. Global conferences on health promotion stressed the health of individuals over the security of states, the right to health over economic interests, and the primacy of global equity and justice over the aggregation of national power.

16. Public health's subordination was entrenched during the 20th century because many states faced military threats to their existence and diplomacy rife with political and ideological hostility about how to organize economic systems, how political and economic development should proceed in developing countries, and what constituted human rights. These problems were acute during the Cold War. Advocacy for healthy public policy based on human rights, equity, and social justice emerged into a foreign policy context inhospitable to health promotion's universalistic ambitions.

17. The emergence of health as foreign policy in the post-Cold War period signals a sea change in public health's relationship with foreign policy's functions. Public health today features prominently in all foreign policy's basic functions. Those concerned with national and international security have realized public health's importance concerning threats from biological weapons proliferation and bioterrorism. Debates concerning the impact of international trade and investment on public health demonstrate public health's importance to the state's pursuit of its economic interests. The traditional trope of "wealth leads to health" that guided economic development's relationship to public health for most of the post-World War II period has been challenged by the "health produces wealth" argument.[8] In addition, rising health care costs in many countries are becoming major macroeconomic factors that can affect a country's global competitiveness and fiscal policy options. Finally, public health's importance to civil and political rights and economic, social, and cultural rights has been a feature of human rights and public health discourse over the last decade. See Table 1.

18. For the first time since health promotion advocacy began, health promotion advances in a context in which the role of public health features prominently in all foreign policy's functions. In terms of foreign policy, public health has a higher profile than ever before.

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[8] *See, e.g.,* Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development* (WHO, 2001).

Table 1.

Foreign Policy Governance Function	**Examples of Importance of Public Health to Each Function**
Security	• Fears about the state proliferation of biological weapons • Concerns about the use of biological weapons by terrorists • Acknowledgment that emerging communicable diseases, such as SARS and avian influenza, can pose direct threats to the security of states, peoples, and individuals • Recognition that the political, economic, and social devastation caused by HIV/AIDS can threaten the security of states, peoples, and individuals • Development by WHO of the concept of "global health security" with respect to communicable disease threats
Economic well-being	• Understanding of the economic damage communicable disease epidemics and pandemics can cause to national economies integrated through globalization • Tensions between states that export products harmful to human health (e.g., tobacco products) and states that import such products and try to mitigate the health effects of the products • Health care costs as increasingly important factors for national economic performance and the dynamics of global economic competition • Controversies over the effect of trade liberalization strategies on national health regulatory powers and capabilities
Development	• Advocacy to put public health at the center of economic development strategies • Centrality of health to the achievement of the UN Millennium Development Goals • Research and analysis that highlights the contributions health makes to macroeconomic and microeconomic development • Linking debt-forgiveness and future international assistance to increased attention on, and investments in, health
Human dignity	• Focus on a human-rights based approach to HIV/AIDS • Human-rights centered arguments in favor of increasing access to essential medicines subject to patent rights under TRIPS • Appointment by the UN of a Special Rapporteur on the Right to Health • Challenge of balancing enjoyment of civil and political rights and addressing dangerous communicable disease outbreaks effectively

United Nations Reform, Foreign Policy, and Health Promotion

19. One can appreciate this transformation by examining the UN Secretary-General's proposals for United Nations reform. UN reform is not new for the foreign policy of UN members; but never before has public health appeared in UN reform proposals as significantly as it did in Kofi Annan's March 2005 report *In Larger Freedom*.[9]

20. Each of the Secretary-General's objectives for UN reform—freedom from fear, freedom from want, and freedom to live in dignity—depends on public health improvements. To achieve freedom from want, the Secretary-General emphasizes fulfillment of the eight UN Millennium Development Goals (MDGs),[10] three of which target specific health problems (child mortality; maternal health; and combat HIV/AIDS, malaria, and other diseases) and four of which seek improvement in key health determinants (poverty

[9] *In Larger Freedom: Towards Development, Security and Human Rights for All*, A/59/2005, 21 Mar. 2005.
[10] *Id.*, ¶¶28-32.

and hunger; universal primary education; gender equality; and environmental sustainability).[11] The eighth MDG (develop a global partnership for development) targets cooperation with pharmaceutical companies to provide access to affordable, essential medicines in developing countries.[12]

21. The Secretary-General also asserts that ensuring access to sexual and reproductive health services, providing safe drinking water and sanitation, controlling pollution and waste disposal, assuring universal access to essential health services, and building national capacities in science, technology, and innovation are national priorities for achieving freedom from want.[13] Strengthening global infectious disease surveillance and increasing research on the special health needs of the poor are global priorities in realizing freedom from want.[14]

22. In terms of freedom from fear, the Secretary-General's new vision of collective security includes addressing threats presented by naturally occurring infectious diseases and biological weapons. These tasks require strengthening national and global public health and potentially involving the UN Security Council in "any overwhelming outbreak of infectious disease that threatens international peace and security."[15]

23. The Secretary-General's conception of freedom to live in dignity also connects to public health. The Secretary-General declared that "[t]he right to choose how they are ruled, and who rules them, must be the birthright of all people, and its universal achievement must be a central objective of an Organization devoted to the cause of larger freedom."[16] Public health feeds this right and attribute of human dignity because "[e]ven if he can vote to choose his rulers, a young man with AIDS who cannot read or write and lives on the brink of starvation is not truly free."[17]

24. The Secretary-General's UN reform proposals constitute a vision in which UN members must elevate public health as a foreign policy priority in order to support security, development, and human dignity. The Secretary-General's UN reform strategy clarifies the importance of states thinking in terms of health as foreign policy. Indeed, this strategy fuses the success of UN reform to the effectiveness of global health promotion.

Opportunities and Risks with Respect to Health as Foreign Policy

25. The prominence the Secretary-General gives public health reveals that health promotion, as a core component of public health, is a strategic necessity for the international community, the fulfillment of which depends on how states organize and implement their foreign policies. Health's rise on foreign policy agendas, and the centrality of public health to UN reform, demonstrates that strengthening foreign policy approaches to public health offers significant contributions to all the governance functions served by foreign policy. These contributions can develop at national, regional, and global levels. Engraining health promotion into foreign policy helps ensure that linkages between health and foreign policy assist states in addressing governance challenges the world faces as globalization accelerates.

26. The number and significance of the links between public health and foreign policy suggest that effective public health has become an independent marker of "good governance" for 21st century humanity and its globalized interactions. Health promotion has long emphasized the need for healthy public policy, and the emergence of public health as an independent marker of good governance opens new opportunities for health promotion as a normative value and a material interest.

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[11] UN Millennium Development Goals, http://www.un.org/millenniumgoals/.
[12] *Id.*
[13] *In Larger Freedom,* ¶¶40-41, 43-44, 46.
[14] *Id.*, ¶¶63-64, 67.
[15] *Id.*, ¶105.
[16] *Id.*, ¶148.
[17] *Id.*, ¶15.

27. Opportunities do not come without risks, and health as foreign policy is no exception (see Box 2). One danger is that states will use public health for ulterior foreign policy motives or purposes that have little to do with health protection and promotion. In other words, health policy becomes another pawn in a power-political game of competition that values public health as a short-term instrument not as a sustainable foundation for good governance nationally and globally. Health policy can, thus, become yet another arena in which states engage in traditional foreign policy conflicts over power, security, and influence.

28. A second danger concerns the possibility that foreign policy interest in specific public health problems, such as the control of infectious diseases and the threat of bioterrorism, subordinates health promotion's emphasis on determinants of health in policymaking. Such subordination would mean that only parts of public health connected to national security and economic power emerge into the "high politics" of foreign policy while health promotion remains neglected.

29. A third danger involves the disequilibrium of power that exists in international relations. This imbalance can create conditions in which more powerful countries pursue foreign policy agendas with respect to public health that do not address the needs of weaker states. Health as foreign policy contains the potential for the mixture of power and epidemiology to create controversies.

30. A fourth danger is gridlock because foreign policy interests of different states concerning public health can produce divergence rather than convergence on appropriate actions. Public health's rise as a foreign policy issue has been accompanied by controversies that have undermined trust and goodwill among states. Even in the realm of public health, producing a harmony of interests among states in their foreign policy pursuits is not easy.

Box 2.

Opportunities and Risks: The New International Health Regulations

The new International Health Regulations (IHR), adopted in May 2005 by the World Health Assembly,[18] provide a case study for the opportunities and risks health as foreign policy presents to health promotion. The new IHR constitute a radically different set of rules from the old IHR and are designed to achieve global health security in the context of the globalization of disease threats. The WHO, its member states, and the UN Secretary-General have embraced the new IHR as a critical instrument in protecting and promoting public health in the 21st century.

The new IHR's negotiation raised, however, risks that health as foreign policy can create. Tensions arose about the new IHR's application to suspected incidents involving biological weapons and the politically sensitive relationship between China and Taiwan. Further, the new IHR concentrate on detecting and responding to public health emergencies of international concern and do not directly address determinants of health that create the conditions conducive for disease emergence and spread. Such determinants are targets of health promotion efforts. Concerns exist, thus, that the attention the new IHR bring to global health security between states might drain resources and interest away from improving determinants of health within countries.

Health Promotion and Foreign Policy

31. Health promotion now faces a context transformed by globalization and public health's emergence as an issue for all the governance functions served by foreign policy. In this environment, health promotion needs to sharpen its focus on foreign policy as an aspect of the larger objective of healthy public policy, which means paying more attention to substantive and institutional aspects of public health as a foreign policy issue.

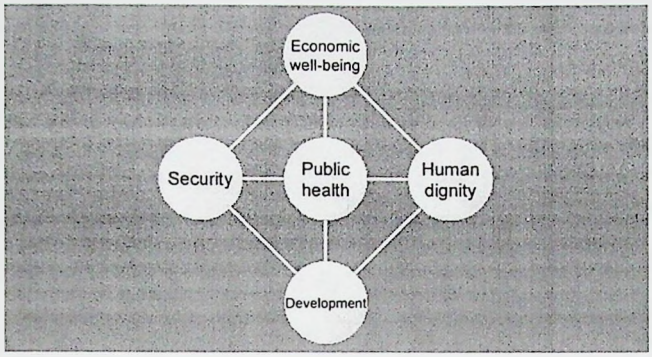
32. Substantively, health promotion's message should be that public health constitutes an *integrated public good* that benefits the state's pursuit of security, economic well-being, development efforts, and

[18] World Health Assembly, Revision of the International Health Regulations, WHA58.3, 23 May 2005.

respect for human dignity. The multiple interests and governance purposes public health supports make it a "best buy" for foreign policy. As such, health as foreign policy allows public health to escape its traditional relegation to the "low politics" of foreign policy. See Figure 2.

Figure 2.

Health as Foreign Policy:
Public Health as an Integrated Public Good



33. Foreign policy pursuit of the integrated public good of public health will necessitate changes to the structure and dynamics of health and foreign policy bureaucracies. Health promotion should focus attention on how governments can better facilitate public health as a foreign policy objective. Pursuing public health as an integrated public good requires health and foreign policy bureaucracies to develop new skills in order to understand the new context in which they operate, promote more effective interagency collaboration, produce policy coherence, and assess progress. Health and foreign ministries could exchange staff more frequently to increase the health competence of foreign ministries and the diplomatic competence of health ministries.

34. Health as foreign policy offers health promotion opportunities to engage non-governmental actors. For example, non-governmental organizations (NGOs), such as universities and schools of public health, could contribute to the pursuit of public health as an integrated public good by deepening understanding of the health-foreign policy dynamic and training prospective public health practitioners to operate in the new environment created by the health as foreign policy transformation. Foreign policy collaboration with NGOs through public-private partnerships may also be a fruitful strategy for health as foreign policy. NGOs may also be valuable in assessing how well countries engage in health as foreign policy.

Conclusion

35. Public health's rise as a foreign policy issue has transformed how health promotion unfolds in the future. This transformation forces health promotion advocates to pay more attention to health as a foreign policy issue rather than subsuming foreign policy in the concept of healthy public policy.

36. Health promotion's challenge is to advance the concept of health as foreign policy defined as the pursuit of public health as an integrated public good across all governance functions served by foreign policy. Advancing this concept of health as foreign policy serves not only each country but also perspectives on how global politics should progressively develop in the 21st century.

37. Although the increased intersections between public health and foreign policy generate risks for health promotion, these risks do not negate the challenge facing health promotion at the Bangkok Conference and beyond. Any effective effort to harness globalization for public health will have to make health as foreign policy a centerpiece of its ambitions. This responsibility is now the health promotion strategy's burden and opportunity.

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GLOBALIZATION, WORKPLACE AND HEALTH

Gerd Albracht

The 6th Global Conference on Health Promotion
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OUTLINE:

1. Introduction

World trade has risen rapidly over the past two decades (Metzler 2004). The production of information, knowledge, and technology increased vastly, so that the global gross domestic product at market exchange rates is now USD 36892.9 billion (IMF 2005), implying the average person produces about USD 5675 annually. Nevertheless, not all are benefiting from this change. Global statistics show that globalization under liberalized markets has mainly benefited the strong industrialized economies and marginalized the weak. The average gross national product per capita, for example, varies by a factor of about 12 between high- and low-income countries, and between 1960 and 1990 the poorest countries' share of world trade fell from 4% to 1%. Further, investment flows have concentrated in only few countries instead of benefiting the broad majority. Poor countries have been marginalized from investments and markets and have not developed the capacity or exposure to engage in investment or trade. Instead, they compete against each other for a small share of the market, which drives down the returns to trade through economic and labour-market concessions. Increasing debt burdens can then consume a mounting share of scarce domestic resources, further reducing the possibility of development. Not surprisingly, income has declined for a quarter of the world's people, many of them in sub-Saharan Africa and even within regions and countries there are widening disparities in wealth and economic opportunity. In southern Africa, for example, globalization has produced mixed employment outcomes and the highest-paid 20% of the population controls 10–20 times the income of the lowest-paid 20% (Loewenson 2001).

It is evident that globalization has contributed to the spread of human rights and the development of equity in employment law; wider employment in nontraditional spheres of employment has brought more people into the workforce. New information technology, and chemical, biotechnological, and pharmaceutical production processes have also widened industry options for low-waste, low-energy, and recycling strategies, which has generated new types of work organization and a shift from "blue-collar" to "white-collar" employment. However, for the large majority of workers in the less-industrialized countries, liberalized trade has been accompanied by transfer of obsolete and hazardous technologies, chemicals, processes and waste, including asbestos and pesticides which are no longer produced or used in many industrialized countries. Globalization has also been associated with an increase in assembly line, low quality jobs, with minimal options for advancement, and a growth of insecure, casual employment in a small-scale informal sector. The International Labour Organisation (ILO 2005) estimates that the number of people unemployed or underemployed in the world today exceeds 800 million, or nearly one third of the labour force. Globalization has also freed capital from many of its historic and nowadays obsolete boundaries. National workplace standards, collective bargaining as well as supervisory state agencies and courts, instruments that became an indicator for development, an institution to secure and humanize working conditions. Hence, the economic benefits and social costs of globalization are not evenly distributed. A logical outcome of these facts is that people in uncompetitive enterprises are adversely affected. A weaker role of the state has led to cuts in government expenditures, which resemble a vital

element for the poor in terms of health systems, education, social safety nets, agricultural extension services and poverty reduction.

Occupational safety and health (OSH) as well as Work health promotion (WHP) are more than newsworthy topics in this context. Due to the ongoing movement of capital to regions and countries with low standards in OSH and WHP, these vital issues for workers' health and safety need strong advocates. Manufacturers in high-income countries have increasingly shifted their operation and production to low and middle-income countries where workplace health and safety conditions and standards are comparatively lower. Furthermore, production and many hazardous procedures are being transfered from North to South causing an important impact on the nature and type of occupational exposures, as well as on the labour force. The current process of globalization especially influences women's health at work.

The effects of globalization are considered to contribute to the high numbers of workplace-related fatalities and accidents every year. The ILO found that a total worldwide amount of about 6000 fatalities is being reported from workplaces every day. This implies that work kills more people than wars. Every 15 seconds a human dies because of an occupational accident or disease. Work-related fatal accidents and diseases add up to 2,2 million cases annually. There have been 270 million occupational accidents and 160 million work-related diseases reported in 2004. Taking into account that the global gross domestic product (GDP) reached about 30.000 billion USD in 2004, the loss due to occupational accidents and diseases adds up to an annual 4% of the global GDP, which underlines the economic importance of OSH and WHP (ILO 2005).

The multidimensional framework according to Landsbergis (2003) and being extended in this paper provides a good understanding of the complex issues related to globalization and its impact on the workplace and brings up comprehensive examples how stakeholders can tackle present and the future challenges in order to provide and ensure decent work for all.

2. Safety and Health as a Basic Human Right: Legal Framework

Recent developments show that the global distribution of capital follows its idiosyncratic characteristic to detect and exploit the most economical environment available to produce goods and services for the global marketplace. Cost of capital is lower in places where workers health is a secondary issue and costly occupational and safety regulations are omitted. Many critics argued that the global distribution of work and capital, according to the logic of the economic goal of efficient production would lead to a global "Race to the Bottom" in labour standards (Sight / Zammit 2004).

These trends led to an international consensus to find global versions of national regulative institutions by establishing universal minimum standards of work, international inspectorates and courts to monitor and enforce them. A pivotal effort in the field has been taken by the introduction of the ILO's Core Labour

Standards, which mark the furthest reaching international agreement in securing Decent Work as a basic human right (see table 1). Standards, risk control, and compensation systems are outcomes of both scientific evidence and workers' struggle. The systems thus vary across countries and institutions such as ILO have played a prominent role in promoting policy convergence. For example, ILO conventions have set norms for safe work and for managing occupational health and safety, including ILO Conventions 155 (tripartite occupational health systems, rights, and responsibilities), 161 (occupational health services), 170 (chemical safety), and 174 (prevention of major industrial accidents). The ILO Tripartite declaration of principles concerning multinational enterprises and social policy requires common standards across all branches of multinational enterprises, and the Code of practice on safety, health and working conditions in the transfer of technology to developing countries requires technology exporting states to inform importing states about hazardous chemicals or technologies (Singh / Zammit 2004).

Table 1: ILO Core Conventions

	Year	Convention	Number of Countries Ratifying
Forced Labour	1930	No. 29	168
Freedom of Association and Protection of the Right to Organize	1948	No. 87	144
Right to Organize and Collective Bargaining	1949	No. 98	154
Equal Remuneration	1951	No. 100	162
Abolition of Forced Labour	1957	No. 105	164
Discrimination Convention (Employment and Occupation)	1958	No. 111	162
Minimum Age	1973	No. 138	140
Worst Forms of Child Labour	1999	No. 182	156

Source: ILOLEX 2005

The core labour standards are those embodied in the various ILO Conventions (see Table 1). Freedom of association and collective bargaining (Nos. 87 and 98), freedom from forced labour and discrimination (Nos. 29, 105, 111) and abolition of child labour (No. 138, subsequently amplified by the Convention Concerning the Elimination of the Worst Forms of Child Labour, Convention No.182), are regarded as the basic principles of the ILO. At the 1998 International Labour Conference, the Member States unanimously adopted the Declaration of Fundamental Principles and Rights at Work, embodying the eight core conventions in Table 1. By doing so, the nations of the world accepted the obligation to implement the core conventions by virtue of their membership of the ILO, whether or not they had ratified the conventions themselves (Singh / Zammit 2000).

Convention 81 (1947; Ratified by 134 Countries) on Labour Inspection was officially declared to be one of the fundamental Conventions of the ILO, which significantly assists in implementing the core labour standards of the Organization. The objective of Convention No. 81 is the establishment of a system of labour inspection responsible for securing the enforcement and bringing to the notice of the competent authority any possible loopholes in existing legal provisions relating to conditions of work and the protection of workers in industrial workplaces, from which mining and transport enterprises may, however, be excluded. Convention No. 129 proposes the establishment of a system of labour inspection for the agricultural industry in general. The Conventions lay down the main rules governing the setting up, organization, means, powers and obligations, functions and competence of the labour inspectorate as an institution responsible for ensuring respect for the protection of workers in the exercise of their duties, and for promoting legislation adapted to the changing needs of the world of work (ILO/SafeWork 2005).

The Conventions and Recommendations forming the legal framework on labour standards are an essential pillar for promoting and ensuring safety and health at the workplace. Nevertheless, globalization requires increasingly creative and holistic approaches, taking into account the changes in the world of work. The prevention of occupational accidents and diseases, the promotion of employees health, workplace security and the investment in a preventative culture will become competitive advantages which will allow companies and countries to compete in a globalized world. As one important element in enforcing compliance with the above mentioned legislative subjects as well as promoting a heath and safety culture at the workplace, labour inspectors play a vital role in making decent work a reality. In a holistic approach Work Health Promotion (WHP) and Occupational Safety and Health (OSH) have to work hand in hand. After taking a closer look at the impacts of globalization on the workplace and worker's health in chapter 3 and 4, best practices of Corporate Social Responsibility (CRS) and ways of developing sustainable strategies will be pointed out in order to protect and enhance the health of workers in the worldwide economy. The pivotal role that labour inspection plays in a preventative approach for better health and the reduction of diseases and accidents at the workplace will be illustrated and practical solutions for better governance will be worked out (Singh / Zammit 2004).

3. Effects of Globalization on the Workplace

Direct effects of globalization on the actual workplace can be illustrated in a three-dimensional model, in which the main variables consist of the external-, meta- and internal sphere. The influential factors for the external sphere can be found in the external working context, the meta-sphere is the organizational context and the internal sphere is resembled by the actual working context itself (Landsbergis 2003).

3.1. External Context

Various factors and changes due to globalization come into play by analyzing the external working context. The legal and political framework, demographic trends as well as technological innovations at all levels contribute to the external framework conditions of the world of work. Trade and regulatory policies and aging societies heavily influence the workplace itself. Shifts in the distribution of high- and low-skilled labour following manufacturing prices, labour costs and skilled workers mainly contribute to an increasing North-South gradient. While working conditions improve in certain industrial countries, examples of slavery and exploitation of labour are being reported from other parts of the world. The role of Labour Inspection in this context is of vital interest, not only for safety and health issues concerning the workplace but also for the enforcement and monitoring of fundamental human rights. Labour inspectors have the ability to freely enter any workplace and therefore act at the inception of the value chain. There they can actively promote labuor standards at the workplace and act as a vector for development by acting as an mediator between employers and workers and by providing technical assistance, advice and expertise. This way labour inspectors can mainstream decent work into all their functions, programmes and activities (ILO/SafeWork 2005).

3.2. Organizational Context

Due to international sharing and spreading of management tools and practices, the organizational globalization is evolving quickly. Restructuring, downsizing, quality and process management initiatives, telecommuting and variable compensation systems have become common practices all over the world. The effects on workers safety and health are ambiguous. Downsizing has been found to have a negative effect on the safety of workers in the US (Richardson/Loomis 1997). Fatal accidents increased in the study after companies downsized their workforce in the construction and manufacturing sector. Also in hospitals, the accidents among nurses rose due to understaffing and stressful working climate. Overtime work and lack of concentration is considered to be one of the main causes for severe accidents at the workplace. In contrast to these figures, recent research has shown that there is a negative correlation between the empowerment of the workforce, good relations between management and workers and the risks of severe accidents. Factors like autonomy, efficacy, delegation of control and low grievance rates were found to be sound indicators for the prevention of occupational accidents and injuries (Landsbergis 2003).

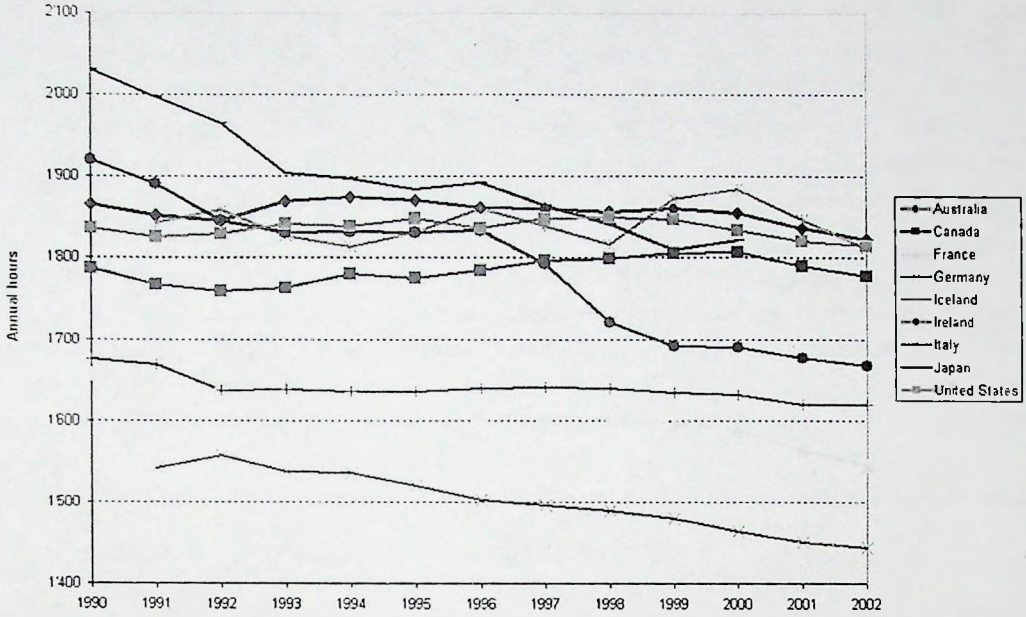
To make the organizational changes clear, the ILO found that working hours per person have been declining in Japan and many parts of Europe during the 80s and 90s, while the trend is being reversed in

the last years. In contrast, there has been a constant increase in working hours in the US, nowadays resembling one of the longest average working hours in the developed world (1820 hours per worker in 2002). A number of surveys conducted between 1977 and 1996 show dramatic increases in "time constraints", i.e. the time pressure and workload demands on workers. The increasing pressure on workers and related stress exposure lead to the evolvement and spreading of occupational diseases and disorders. Clearly a phenomenon, which is not entirely new to the world of work, but which has been shifting form primarily physical to more and more psychosocial illnesses.

Even though today's highly competitive business environment increasingly demands extended working hours and overtime, its important to keep in mind that it is the human resources – the workers – that frequently hold the key to the company's competitive advantage (Messenger 2004).

Graphic 1:

Annual hours worked per person, selected developed economies, 1990-2001



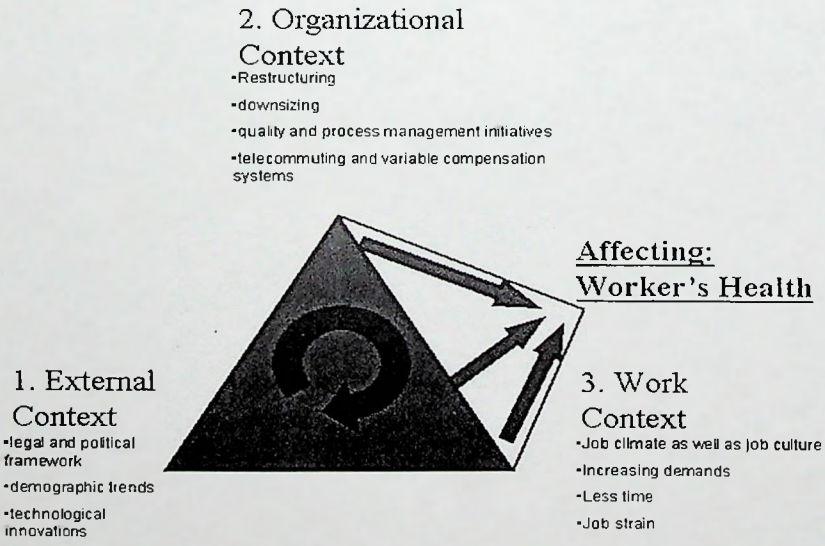
Source: ILO: Key Indicators of the Labour Market 2005

3.3. Work Context

Job climate as well as job culture are considered to undergo massive changes in the context of a globalizing world of work. Social relations at work and worker's role in the organizational context are considered to be important indicators for the well-being and psychological health of the workforce. Increasing demands on workers' quantity and quality of labor and less time to compensate their stress levels in terms of free time is causing job strain. Job strain is defined as the combination of high job demands and low job control. These issues are considered to be an important risk factor for the evolvement of stress related diseases, such as hypertension and the cardiovascular disease.

The following graphic illustrates the influential factors on worker's health in a three-dimensional model. The three different contexts and especially the changes undergoing in these spheres have a dramatic influence on the well-being of the worker in physical as well as psychosocial terms. This illustration clearly focuses on the direct links to the workplace and leaves further external issues such as social and family background apart. These issues would be subject for further research.

Picture 1: **Three-dimensional Model on the Effects of Globalization on Worker's Health**



(Source: Landsbergis, 2003, modified)

4. Effects of Globalization on Forms of Work

It is an acknowledged fact, that workers health and safety is exposed to external-, organizational- and work-related factors, which are certainly undergoing constant changes, not only due to globalization. Although the issues discussed above seem to refer mainly to the industrialized world, they are present all

around the globe. Globalization not only implies changes in the workplace itself, but also brings along entirely new forms of work and contributes to the expansion of existing working models. The transfer of low skilled manufacturing and processing jobs to less developed countries with generally lower standards of work lead to the formation of export processing zones, informal sectors and the need for workers to travel over long distances. Migrant workers, people who are the prototype of the on-demand workforce, have become one of the most prominent features of globalization (ILO/SafeWork 2005).

4.1. Safety and Health in Export Processing Zones

Examples of occupational health under liberalized tax and trade regimes can be seen in export processing zones (EPZs). EPZs have been associated with high levels of machine-related accidents, dusts, noise, poor ventilation, and exposure to toxic chemicals. Job stress levels are also high, adding further risk. It has been reported that accidents, stress, and intense exposure to common hazards arise from unrealistic production quotas, productivity incentives and inadequate controls on overtime. These factors create additional pressure to highly stressful work, resulting in cardiovascular and psychological disorders. With young women, the stress in EPZs can affect reproductive health, leading to miscarriage, problems with pregnancies, and poor fetal health. Some EPZ companies were even reported to offer prizes to women undergoing sterilization, to avoid losing time from maternity leave.

In the dormitory-style hostels of EPZs hygienic conditions have been described to commonly be in poor state. Also sexually transmitted infections including HIV/AIDS, for example, are a prevalent phenomenon. These side effects are usually not classified as occupational, but are certainly work-related.

The ILO recently introduced a handbook for Labour and Factory Inspectors to deal with the issue of HIV/AIDS in their work. In particular, it will help inspectors apply the ILO Code of Practice on HIV/AIDS and the world of work, which was adopted in June 2001. The Code provides guidance for governments, employers and workers, as well as other stakeholders, in formulating and implementing national action plans and workplace policies and programmes to combat HIV/AIDS. To this end the Guidelines aim to make it clear why HIV/AIDS is also a labour issue and a development challenge to discuss the ways it concerns labour/factory inspectors. Further they aim to help inspectors understand and apply the ILO Code of Practice on HIV/AIDS and the world of work to examine the links between HIV/AIDS and the principles and practice of labour inspection, with particular reference to occupational safety and health to develop practical tools for use during inspection and help inspectors integrate HIV/AIDS into their future activities (ILO/SafeWork 2005).

4.2. Safety and Health of Migrant Workers

Production systems across the south have long used migrant workers, but increased trade and financial flows have added new waves of migrants, including informal sector traders. Migrant workers may be found in various industries, notably construction, agriculture and manufacturing (in "sweatshops") but in other

sectors of employment as well. They are often exposed to poorer working conditions and may be further disadvantaged by a limited knowledge of the language in their host country and a lack of understanding of their legal rights. This poses a number of cross-boundary problems when trying to locate migrant workers who were exposed to severe shortcomings in working conditions at former employers. Studies in Botswana and South Africa, for example, signal the potential size of the problem, in the thousands of undetected or unreported cases of occupational lung diseases in former mineworkers in the rural areas of southern Africa.

There are several international Conventions and other instruments on migration and migrant workers. While it is for Governments to ratify such Conventions, labour inspectors have a key role to play in promoting compliance with national standards for migrant workers, monitoring conditions of work and enabling migrant workers to lodge complaints and seek remedy without intimidation. In 2004, the International Labour Conference agreed to a Multilateral Framework for Migrant Workers in a Global Economy. Among other things this promotes the strengthening of labour inspection as a means by which national standards on migrant workers can be effectively applied. Therefore the activities of labour inspectors in the field of migrant work have the potential to fill a crucial gap in the reporting line of national authorities, to identify fundamental drawbacks at their roots and to ensure social justice. Further, labour inspectors can play a vital role not only at the end of the trafficking cycle, when a migrant is already in the position of a victim, but also at the beginning of the trafficking cycle, i.e. the recruitment stage. Monitoring and inspecting can also be extended to recruiters and thus be used during the prevention phase. Recruiters fall under the term agency as defined by the ILO Private Employment Agencies Convention No. 181, 1997 (ILO/SafeWork 2005).

5. Holistic Approaches for OSH and WHP

The effects and consequences of globalization on the workplace face local authorities as well as policy makers with new challenges, which demand further measures than traditional, unilateral approaches, focusing only certain elements of the socio-economic working context. Globalization requires increasingly integrative and holistic approaches, taking into account the changes in the world of work and the advent of new risks and opportunities merging the traditional technical and medical with the social, psychological, economical and legal areas. To protect and enhance the health of people in the workplace in the worldwide economy, practical strategies have to be worked out to make Decent Work become reality. A main pillar of the mutual efforts is based upon the understanding that a preventative culture at the workplace has to be developed in order to promote a sustainable decrease of occupational accidents and diseases.

5.1. Public Private Partnerships

The ILO and the WHO participate in a number of global public–private partnerships (PPP). These collaborative relationships transcend national boundaries and bring together at least two parties, a

corporation (or industry association) and an intergovernmental organization, in order to achieve a goal on the basis of a mutually agreed and explicitly defined division of labour. The proliferation of public-private partnerships is rapidly reconfiguring the international safety and health landscape. There are various factors, which have led to the convergence of public and private actors (Buse / Walt 2000). Generic factors such as globalization and factors specific to the safety and health sector, as well as market failure in product development for special diseases and missing commitments to higher safety standards, are brought forward by researchers. This relatively new trend in global cooperation is demonstrating significant possibilities for tackling problems that formerly seemed intractable, particularly those requiring increased research and development (R&D) on drugs and vaccines for diseases disproportionately affecting the poor or modern safety as well as health regulations where investments have to be made before measurable financial ease is being produced. Partnerships with the private sector have also demonstrated an ability to advance public messages, serving as positive examples to demonstrate that economic benefits can be reached by implementing sustainable practices, which promote a modern and adequate health and safety culture. Industry incentives for the development of safer and healthier products are being generated. Further companies feel the need to follow the advancing competitor in the field of profitable safety and health strategies. Through collaboration, the United Nations (UN) have the opportunity to gain access to resources and expertise so as to further its mission, while the commercial sector may, through an improved corporate image, among other things, attract new investors and establish new markets. Many benefits, therefore, including the immediate health-related ones, favor the continued development of public–private collaboration for safety and health.

5.2. The ILO-GTZ-Volkswagen Project

In 2004 the ILO started a PPP project with the Gesellschaft für technische Zusammenarbeit (GTZ: German technical cooperation agency) and Volkswagen AG, which has agreed upon a Declaration on Social Rights and Industrial Relationships including the affirmation to assure the principles of core labour standards within the company and even beyond, by setting standards for their suppliers. The overall objective of the project was to establish and implement a national SafeWork action programme in 3 countries based on ILO standards, focusing on occupational health and safety and a pilot implementation of a prevention culture at enterprise level in each partner country.

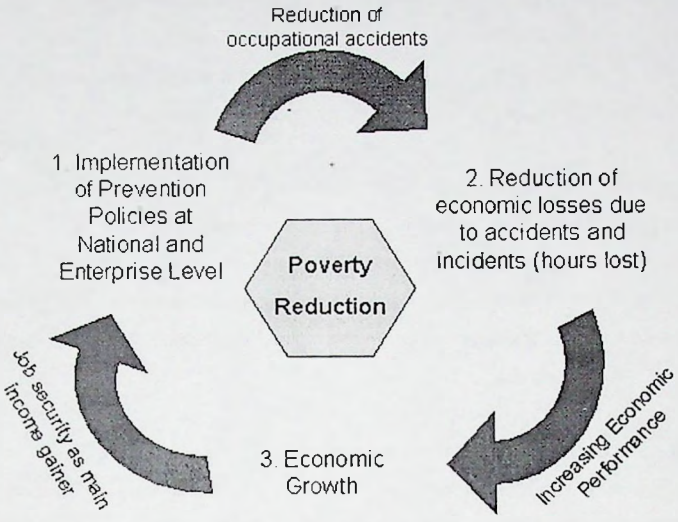
The project strongly emphasizes on the new linkages and the possible knowledge exchange that can be established by including a multi-national company in the project. VW has a strong interest to improve the social performance of their suppliers, as it does not only result in more job-satisfaction for the workers and the suppliers enterprises, better quality of the products or higher economic performance, but it also increases the overall corporate social responsibility (CSR) standards for Volkswagen. The project is drawing on the experience of the BMZ/GTZ with Private-Public partnership arrangements in the field of technical cooperation.

The project is based on the idea to implement social standards of Decent Work through establishing a health and safety culture at both, national and enterprise level to prevent accidents to happen and new poverty to arise ("good health is good business"). In June 2002, VW has defined a Codex for social rights and industrial relations in a Social Charter, the first one in the automobile industry. The Federal German Ministry for Economic Co-operation and Development strongly supports activities, which aim at implementing ILO's Core Labour Standards. The strong common interests of all project partners in the field of social standards have born the idea of a joint OSH and CSR project.

The Global Compact, a UN initiative aiming at poverty alleviation and making globalization more stable through enterprise commitment, is a new approach for sustainable development. Launched in 1999, it is based on three major principles encompassing human rights, labour standards and environmental sustainability. The Global Compact is challenging enterprises to pursue these principles. The project will contribute to implement the global compact programme by providing a sustainable and lasting approach to face the challenges of globalization at the workplace. Through its far-reaching impact, targeting upstream business activities at the supplier level, it sets an example for corporate social responsibility beyond company boarders.

At enterprise level, VW will provide guidance to their suppliers on how to improve the social performance of the company. This will be done through enterprise audits or other forms of assessment. As a follow up action of the audit, the supplier will have to implement the recommendations given and adjust their standards to the relatively high VW OSH standards. The suppliers will have to designate a person responsible for the follow up of the audit recommendations. This person could also become a first contact person for labour inspectors while conducting inspections.

By establishing a health and safety prevention culture, the enormous economic losses due to accidents, incidents, early retirement or sickness benefits can significantly decrease and these unspent budgetary funds can easily be invested to increase the enterprises performances and to create new jobs, allowing the poor to be able to escape the vicious circle of poverty in the long run. Policy makers, labour inspectors, safety and experts, etc all play an important role in the prevention process and initiation of a shift from short-term profits towards long-term investments in safety and health.



Picture 2: The strategic outline for the ILO/GTZ/Volkswagen-project (Source: ILO)

According to the national needs, a national OSH programme could be established or further developed. This implies assistance in drafting national OSH strategies or labour inspection policies. A mini profile on OSH could be introduced to better assess the current situation and find means and ways for improvement. The national OSH programmes aim at promoting a health and safety culture, strengthening the national OSH system and it also implies targeted action on specific subjects (e.g. high-risk sectors, HIV/AIDS; SME's, etc.).

Establishing and implementing a health and safety prevention culture at national level requires the active participation of the labour inspectorates. Labour Inspectors are the only state enforcement agents who actually have access to the enterprises and who can bring the health and safety messages across. It is therefore crucial to increase the labour inspectorates' capacities in terms of organizational structure, frequency and quality of inspections, knowledge on its advisory role, competency, etc. in a sustainable approach. This shall be achieved through a range of proposed activities, such as policy analysis and policy reform, the development of training modules, the training of national labour inspection trainers, the setting up of a competency network and the development of international guidelines on supply chain management.

Based on a training needs analysis, specific modules will be developed for training of labour inspectors. The subjects are to be defined according to the national needs. Training could also be set up for the responsible OSH experts at enterprise level. If training needs of the labour inspectors are in coincidence with the needs of the VW suppliers joint training workshops could be organized.

The project also intends to set up an internet-based system that can provide the basic information on potential accidents and health hazards in certain working environments. This database could be accessed by anyone who needs advise on occupational safety and health, including small and medium sized enterprises. The project will bring on board the Internet technology and experts to set up such a system at national level. It will be adapted to the national content and the system would need maintenance from a dedicated and motivated national expert.

Through this project it has been practically made clear that OSH resembles a cornerstone for corporate social responsibility (CRS) and promotes decent work through various channels. Through the integration of suppliers and associated partners the programme is a far reaching vector to raise social and economic capabilities of the countries and institutions participating. Not only the workplace itself, but also the surrounding spheres, such as the well-being of workers' families and their social and economic perspectives experience sustainable improvement. In the context of globalization, merging traditional technical, social, psychological, economical and legal areas, workers' health increasingly relies on strong partnerships. Commitments by companies to follow a preventative path in order to increase the social and economic capabilities in global competition, play a vital role in promoting and securing safety and health at the workplace. Therefore this example can be seen as a prototype for further PPP-Projects, leading the way to a comprehensive approach, integrating all major stakeholders and ensuring sustainable development.

5.3. Corporate Social Responsibility

In the modern commercial era, companies and their managers are subjected to well publicized pressure to play an increasingly active role in society – so called "Corporate social responsibility". Corporate social responsibility (CSR) has recently been the subject of increased academic attention. While social responsibility has figured in commercial life over the centuries, in the modern era increasing pressure has been placed on corporations to play a more explicit role in the welfare of society.

Over the past decade the concept of sustainable development has expanded to include the simultaneous consideration of economic growth, environmental protection, and social equity in business planning and decision-making. Many multinational enterprises engage in corporate citizenship programs to promote sustainable development. Corporate citizenship programs are often defined narrowly, however, as philanthropy or external relationships with stakeholders to address social problems.

In the 1970s international organizations, such as the International Labour Organization, the Organization for Economic Co-operation and Development and the United Nations already tried to introduce international codes of conduct, which were rejected at that time. Fortunately the interest in such measures has increased again in the course of the 1990s. These days, interest in codes of conduct is primarily the result of actions by consumer groups and other non-governmental organizations, and by managers of transnational corporations themselves. These actors have started to think about social responsibility and self-regulation in a more proactive fashion. Social and financial performances seem to be linked. More recently, governments and international organizations have also become involved again.

A study published by Kolk; van Tulder and Welters in 1999 examines 132 codes of conduct drawn up by four different actors: social interest groups, business support groups, international organizations and firms. The contents of the codes and their capacity to address the regulatory void left by processes of globalization is assessed. Complementary to the literature on codes of business ethics their article's analytical framework centers on specificity and compliance mechanisms. The likelihood of compliance not only depends on the contents of the code, but is also heavily influenced by the interaction of various stakeholders in its formulation and implementation. The content analysis of a large number of codes drawn up by the four different actors, supplemented by two case studies, improves understanding about the dynamics and likely policy implications of codes of conduct. Voluntary transnational company (TNC) codes are showing clear potential in addressing unstable socioeconomic relations provided other actors do not step aside.

5.4. The 3M Business Conduct Manual

Although 3M has business operations in more than 60 countries, the company has only one set of Business Conduct Polices that apply globally. It sets a high standard of conduct for every employee. The Business Conduct Manual helps define everyday ethical and lawful business conduct and is available to employees electronically and in print.

All 3M employees, supervisors, managers and other leaders are responsible for understanding the legal and policy requirements that apply to their jobs and for reporting any suspected violations of the law or 3M's Business Conduct Policies. Training is provided to help employees understand their responsibilities and the resources available to them. Executives and managers also are accountable for creating and promoting, by sound leadership and good example, a workplace environment in which compliance and ethical business conduct are expected and encouraged. A number of policies and management systems are in place to guide the company and its employees in continuous improvement in the areas of environmental protection, social responsibility and economic progress (3M 2005a).

According to the company, the 3M Environmental, Health and Safety Management System is a key element for sustainability. It builds on activities that are already occurring in facilities around the world. Policies and management systems supporting a socially responsible workplace are described in the

"Business Conduct Manual" and "Ethics in Employment" sections of the report. Policies and management systems supporting community involvement are described in the "Stakeholder Interaction" section of the report.

Ethical behavior includes acting in a socially responsible way towards potential, current and former employees. As an ethical and law-abiding company, 3M complies with government regulations around the world concerning human rights, employees and employment laws and expects ethical behavior from employees in accordance with their global Business Conduct Manual. The conduct goes beyond obligation to include policies that help support a challenging, productive and enjoyable work culture (3M 2005b).

As part of the Business Conducts, the company implements security measures and practices crisis preparedness. Further it is auditing against the ILO Core Labor Standards in which the company ensures that its operations adhere to the ILO Core Labor Standards through self-audit checklists and annual ethics audits. Managing Directors responsible for 3M's operations in countries outside of the United States complete self-audit checklists each year to confirm compliance with the standards. In addition, in 2005 3M is expanding its ethics audits to include the labor standards. These audits are conducted annually for each of 3M's country subsidiaries.

Various Initiatives, such as the Corporate Safety and Health Policy, Global Safety and Health Plan, Global Safety and Health Plan Self Assessment and Employee Health and Safety (EHS) Management System work together to help maintain the safety and health of employees and provide a safe and healthy workplace worldwide. The goal is to implement sustainable Health and Safety systems to bring about continuous improvement towards zero incidents. The company invests in safety and health worldwide in a number of ways, including providing EHS resources, safety and health training, personal protective equipment, and capital investments to improve safety and health. The investment in personal protective equipment, including items such as safety eyeglasses and safety shoes, amounted to $4.8 million in the year 2002. Over the past five years, 3M has spent over $172.4 million in capital to improve safety and health (3M 2005c).

The company reports, that it has been their experience that incorporating good ergonomics into the manufacturing and administrative processes is effective in reducing the number and severity of musculoskeletal disorders (MSDs). The ergonomic efforts not only benefit employees, but can precipitate increased productivity and make good business sense. 3M has increasingly focused on identifying and preventing illnesses and injuries related to ergonomic factors. Fifty-eight percent of recordable incidences in the company now are related to ergonomics factors. The top two causes of injury are due to manual material handling and repetitive motion.

In 2001, 3M rolled out an expanded ergonomics program consisting of a management system for hazard awareness, assessment and implementation of ergonomic solutions. As we increase the effectiveness of

3M's ergonomic programs and employees are educated on the signs and symptoms of musculoskeletal disorders, the severity rate of ergonomics injuries has improved significantly.

The company recently introduced a new EHS Scorecard, as an important part of the EHS Management System, which also tracks the safety and health progress at the facility, division/subsidiary and corporate levels. In the EHS Scorecard, health and safety metrics cover all critical performance issues of their operations. For some of these, the company sets targets to drive safety and health improvements. The following table shows 3M's progress on the safety and health front in terms of recordable and lost time incidents and workers' compensation from the early 1999 through 2004. The Global Safety and Health Plan, along with self-assessments, are driving continuous improvements in this area. All are part of the 3M EHS Management system (3M 2005c).

Table 2: **Annual Comparison of Safety and Health Data**

	1999	2000	2001	2002	2003	2004
3M U.S. Recordable Incident Rate	4.54	5.19	5.16	4.27	3.56	3.35
U.S. Bureau of Labor Statistics Recordable Incident Rate for Manufacturing	9.2	9	8.1	7.2	6.8	N/A
3M Worldwide Recordable Incident Rate	2.83	3.11	3.12	2.74	2.35	1.70
3M U.S. Lost Time Incident Rate	0.8	1.06	1.14	1.04	.93	.92
U.S. Bureau of Labor Statistics Lost Time Incident Rate for Manufacturing	2.2	2	1.8	1.7	1.6	N/A
3M Worldwide Lost Time Incident Rate	0.63	0.79	0.82	0.86	0.81	0.57
Worldwide Fatalities	1	1	0	0	0	1

Source: 3M Public Homepage (3M 2005c)

6. Conclusion

Fair rules for international trade, investment, finance and the movement of people, which take into account their differing needs and capabilities, have to be agreed upon. This requires an intensified dialogue process at all levels bringing the key actors together to work out ways of handling major global issues and putting them into practice. Fair globalization also calls for more emphasis at national level, for improved governance, an integrated economic and social agenda and policy coherence among global institutions. After all for every individual worker globalization is a workplace issue. Along those lines, national policy makers should make use of the available resources of Public Private Partnerships, Corporate Social Responsibility Guidelines and labour inspectorates to strengthen the capacities of every individual company, institution and at the bottom line the worker's well being. These measures have been identified as useful tools to promote and secure employees heath, workplace security and the investment in a preventative culture. The paper makes clear, that a preventive approach for better health and the reduction of accidents and diseases at the workplace must be linked to labour inspection services. They have a pivotal role in promoting compliance with core labour standards, in giving advice and in providing information on how those standards can be implemented in daily work. Labour inspectors are the controlling authority for OSH and many work- related activities such as preventative measures. The effects of globalization changed the role of labour inspectors who should also exercise the role as a facilitator, an advisor and a net-worker. Strengthening labour and health inspection is crucial for ensuring a high standard in the labour protection and health promotion, thus contributing to overall economic stability. A number of recently conducted studies and publications point out the positive effects of combining workplace health promotion and occupational safety and health to provide sound and sustainable solutions and interventions for present issues and future challenges in the world of work.

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PUBLIC HEALTH EMERGENCIES OF INTERNATIONAL CONCERN

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Abstract. Public health emergencies of international concern constitute threats to many countries and require coordinated surveillance and response at the national and international levels. Our experience in combating SARS confirmed the need for preparedness to detect, assess and notify events involving death/disease, and to break the chain of transmission through measures such as hospital infection control practices, contact tracing and quarantine, and community health education and promotion. In addition, requirements for inbound and outbound travelers, and facilities for their health assessment and quarantine, must be applied with appropriate feedback to WHO in accordance with the International Health Regulations (2005). With emerging diseases, we have to rethink the value of available tools for effective disease control.

INTRODUCTION

Public health emergencies of international concern are extraordinary events which constitute a public health threat to other countries through spread of disease and potentially require a coordinated international response. The distinguishing features of such events are a potential for mass casualties and a short window period for effective response. Generally, the emergency may involve toxic agents that have immediate results close to the source of release, or microbial agents with exposed people falling ill days to weeks later. Microbial agent involvement tends to be more covert and the resultant outbreak can only be traced by epidemiological investigation. Examples would be the occurrence of smallpox, poliomyelitis due to the wild type poliovirus and human influenza caused by a new subtype. Despite many advances made in disease prevention and control, the threat of a public health emergency today is more ominous than ever in terms of scale and severity.

From time to time, a public health emergency is expected to occur somewhere in the world. The reasons have to do with expanding international trade and travel, exotic new infections, spread of existing diseases to new areas, antimicrobial resistance and bioterrorism. Singapore was not spared when in late February 2003, SARS moved from southern China across several countries and threatened to establish itself endemically in the city state (Leo et al., 2003; Hsu et al., 2003). Drawing from this experience with SARS, we present herein the concepts of preparedness and the capabilities needed to tackle public health emergencies of international concern.

METHODS AND RESULTS

1. SURVEILLANCE PREPAREDNESS

Surveillance is defined as the ongoing systematic collection, analysis and interpretation of health data essential to the planning, implementation and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know (Thacker *et al.*, 1988). Most of the surveillance systems today involve "health events" and are dependent on physician-initiated reports of notifiable infectious diseases or information from laboratories regarding bacterial or viral isolates. The system should, however, be comprehensive to show a bigger "risk" picture which includes animal surveillance for infectious and zoonotic diseases, environmental surveillance for mosquito breeding and rodent infestation, and food safety surveillance for food-borne pathogens. "Risk" surveillance is often carried out outside the health sector and effective early warning requires links to these other sectors. In addition, situational awareness can often be improved by tracking emerging diseases overseas and capturing anecdotal information about sentinel events from specific sites.

With all the components of surveillance in place, the public health authority is expected to detect, assess, notify and report events involving death or disease above expected levels for the particular time and place. When such an event hits, the information should be shared widely, under the auspices of WHO if necessary, in order for scientists to elucidate the causative agent, source of infection and mode of disease transmission, and for the authorities to weigh their risk management strategies. Proper surveillance requires training and support from specialized staff, and laboratory capacity to analyse samples domestically or through collaborating centres, as well as logistical assistance.

In the 2003 SARS pandemic, the success of surveillance systems in detecting the disease were facilitated by ready access to health care among the ill persons and good information exchange. We observed that effective surveillance could be undertaken even before confirmation of the microbial agent. The infection was later found to be caused by a novel coronavirus and transmitted from person-to-person by close contact (caring for, living with, or direct contact with respiratory droplets or body fluids of a suspect or probable case. The virus was established to be primarily spread via droplets, possibly fomites, and in at least one instance, it may have opportunistically aerosolized (Heymann, 2004). A single case was estimated to infect an average of three secondary cases in a population that had not instituted control measures (Lipsitch et al., 2003). Surveillance also picked up the phenomenon of super-spreading events, triggered by cases who were highly efficient in amplifying the virus and spreading it to many people (Li et al., 2004). The reasons were unclear but contributing factors included clinical severity of the disease, presence of co-morbid conditions which masked the tell-tale symptoms of SARS, and failure to isolate the cases early.

In Singapore, a total of 238 SARS cases (including 33 fatalities) developed onset of illness between Feb 25 and May 11, 2003. They comprised seven imported cases, 21 introduced cases (secondary to imported infections), and 210 indigenous cases (secondary to introduced infections). 121 of the cases were directly linked to contact with five cases in super-spreading events. Because existing control practices at that time were inadequate, infection spread rapidly to involve healthcare workers, other patients, visitors and close family contacts.

2. RESPONSE PREPAREDNESS

As the purpose of early detection through surveillance is to institute effective control measures, being ready to respond is crucial. Public health response preparedness encompassed operations planning, training for field officers and healthcare workers, and stockpiling of vaccines, chemoprophylaxis and personal protective equipment for at-risk populations. In the event of an emergency, the public health authority must respond quickly to investigate all cases/deaths and refer all contacts for medical screening and chemoprophylaxis. Measures to break the chain of transmission include stepping up hospital infection control practices, contact tracing and quarantine, environmental sanitation and hygiene, decontamination of hot zones, disposal of contaminated materials, and burial/cremation of deceased persons. These measures are collectively important because slowing the spread of infection at the start of a potential pandemic can buy time for other countries to draw up controls.

Outbreaks are frequently marked by uncertainty, confusion and a sense of urgency. Hence, clear and timely public communication on issues such as monitoring of symptoms, personal preventive measures, and travel precautions are of immense value in maintaining the public trust. Key to the success and management of a public health emergency of international concern is that the authorities must be able to determine the control measures required to prevent disease spread, and disseminate the information and recommendations rapidly to the healthcare institutions and the community at large.

In the 2003 SARS pandemic which was characterized largely by contact transmission in the hospital and household setting, the national level activities to control the situation focused on three areas, viz. hospital infection control, contact tracing and quarantine and community health education and promotion.

Hospital infection control. The healthcare institutions constituted the battleground in the fight to prevent further spread of the disease. Stringent measures were instituted to prevent and contain SARS in the hospitals, national healthcare centres, nursing homes, medical, dental and traditional Chinese medicine clinics. Healthcare workers were required to wear N95 masks, gloves and gowns and practice frequent hand-washing after every patient contact. Goggles were also required in isolation facilities, emergency departments and intensive care units. When performing high risk procedures such as bronchial aspiration and intubation, positive airway pressure respirator hoods were used. All healthcare institutions were also required to monitor their staff closely through twice- or thrice-daily temperature monitoring and strict instructions were given to disallow any staff who had fever or was unwell to work. To prevent cross-infections between hospitals, no inter-hospital transfers of patients were allowed. Doctors and other healthcare workers in the private hospitals were required to register to work in one hospital only. In addition, all visitors had to be registered so that they could be traced quickly.

The Ministry of Health, Singapore, provided directives to all healthcare institutions on hygiene, sanitation and infection control practices and carried out regular audits to ensure compliance. The hospitals also restricted the number of visitors per patient to just one per patient and strictly enforced the visiting hours. This measure was stepped up one notch from April 29-May 31, 2003, when no visitors were allowed in all public sector hospitals with the exception of paediatric and obstetric (delivery) cases, which were allowed just one visitor each day. The measures were deemed to be effective and sufficient when no more healthcare workers contracted SARS after April 13, 2003.

Contact tracing and quarantine. Contact tracing procedures were established for the identification and quarantine of all close contacts of probable/suspect SARS cases and observation cases in whom SARS could not be ruled out. The close contacts involved immediate family members and persons who worked full-time in the household; healthcare workers, patients and visitors exposed in primary health and hospital facilities; and other contacts with more than passing exposure in specific locations. Policies on who constituted close contacts were periodically modified in the light of new findings (Olsen et al., 2003). Home quarantine was deemed the most logistically feasible means of quarantine for the large numbers of contacts. Persons who were quarantined were given instructions to monitor their temperatures twice daily and to call for the dedicated ambulance service if they were unwell. These quarantine measures prevented any potential spread to others in the community from delays in getting to hospital.

In Singapore, the decision to quarantine rested with the Director of Medical Services, assisted by a Quarantine Board which provided advice based on clinical and epidemiological findings. Singaporeans served with the Home Quarantine Order (HQO) could choose to be quarantined at home or at a designated quarantine centre as "temporary home". Travellers to Singapore served with the HQO could choose to leave Singapore within 24 hours so long as they were afebrile, or to remain in Singapore at a designated quarantine centre. Quarantined persons were checked upon daily by telephone to make sure that they did not break quarantine (they had to appear before an electronic picture camera each time they are called) and were well. The measures came across to the public as hard but necessary. Later, the approach was softened by home visits by Health Promotion Board nurses and an HQO monetary allowance.

Community health education and promotion. SARS was a crisis not just of public health but also a crisis of confidence in good governance. Activities of daily living and business had to continue and the role of the government was to work with the public, private and people sectors to guard against infection in the community itself. To rally the community in support of disease prevention and control, simple measures were highlighted for everyone to do. The following health education and promotion activities were undertaken:

- Emphasis was placed on social responsibility and personal hygiene, including the value of hand-washing and respiratory etiquette. If people had fever, they should seek proper medical attention instead of going to work or school. Those that were ill were advised to wear a surgical mask to protect others. Use of N95 masks was considered unnecessary in the absence of community outbreaks.
- Fever checks became the norm and daily temperature taking was instituted in all national schools and public institutions. Private sector workplaces were also encouraged to conduct temperature taking of their employees. In addition, organisers of mass events such as concerts, social gatherings and recreational activities were encouraged to screen participants for fever prior to admission.
- Campaigns to spruce up the environment through good hygiene and sanitation were introduced to guard against fomite transmission in public areas, including on board public transport.

During the outbreak, the Ministry of Health, Singapore, was inundated daily with requests for information on what mitigation measures could be taken by members of the public. The tremendous pressure for coordinated flow of timely information to the public enabled a more organized management system to emerge. Practical advice provided by the Health Promotion Board on mitigation measures gave confidence to the public that the authorities were in control of the situation. A "Singapore OK" programme was introduced, which mobilized the community to play their part in promoting cleanliness and hygiene. In addition, fever centres to screen patients who presented with fever were set up in four government polyclinics located across the island. To ferry symptomatic suspects to Tan Tock Seng Hospital, the Ministry of Health also commissioned a dedicated ambulance service which reinforced public confidence that the public transport system was not compromised and remained safe.

3. INTERNATIONAL HEALTH PREPAREDNESS

Surveillance and response preparedness are equally applicable at the international level. Systems have been set up and tools to gather information include the Global Public Health Intelligence Network and Pro-Med, while the co-ordination of global resources for response is facilitated through WHO's Global Outbreak Alert and Response Network. During emergencies, time is a factor and WHO can play an important role in contacting the affected country to gather epidemiological information. The public health authority needs to work closely with WHO on the border health issues in accordance with provisions of the International Health Regulations (2005). As part of core capacity requirements for designated airports, ports and ground crossings, the authority has to apply appropriate checkpoint exit and entry requirements for outbound and inbound travellers, respectively, and provide facilities for their health assessment, quarantine, isolation or treatment. They should also continue to communicate with WHO with timely, accurate and sufficiently detailed public health information available to it on the notified event, including case definitions, laboratory results, source and type of risk; numbers of cases and deaths, conditions affecting the spread of the disease and the health measures employed; and report the difficulties faced and support needed in responding to the public health emergency.

In the 2003 SARS pandemic, while the main battle against the disease continued in the hospitals, health screening at the border checkpoints formed a line of defense against export and import of infection. To prevent the export of SARS cases, mandatory screening of all outgoing travelers through temperature checks were conducted at airport and the seaports, and all bus travelers at land checkpoints. Temperature checks were also conducted on incoming passengers. For ease of tracing, all visitors were required to complete a Health Declaration Card. The declaration covered symptoms of SARS, contact and travel history as well as personal particulars and address. In case travelers from SARS-affected areas were incubating the disease, they were given a Health Alert Notice explaining the disease and how they could get medical help if symptoms appeared.

In Singapore, all inbound and outbound passengers and crew were subject to health screening using thermal imaging scanners. Persons picked up by the scanners had their temperatures re-checked by nurses and were referred for examination by doctors at the airport if found to be febrile. Suspect cases were sent to Tan Tock Seng Hospital for further assessment and admission for isolation. Outgoing travellers from the air and seaports were also asked to declare symptoms of SARS and contact history with SARS patients. Through the World Health Organization, Singapore informed other countries whenever there were possible contacts of SARS cases who travelled out of the island. Singapore also initiated a multi-lateral agreement within the ten ASEAN countries, China, Japan and Korea on information exchange in relation to travelers. In view of the high volume of people movement to and from Malaysia daily, a special bilateral arrangement was set up between the two governments for contact tracing and operations when persons with fever were detected at the land checkpoints. On May 31, 2003, WHO, satisfied with the effectiveness of the measures taken, took Singapore off the list of countries with local SARS transmission (WHO, 2003).

DISCUSSION

In a public health emergency of international concern, preparedness can be subdivided into surveillance preparedness and response preparedness. This preparedness contributes to both primary and secondary prevention. Primary prevention takes place when a local emergency that is detected early and responded to effectively never becomes an international concern. Secondary prevention takes place when, even if we cannot prevent the public health emergency of international concern, systems of alert and response at both national and international levels mitigate the worst damage measurable in terms of reduced morbidity and mortality and in economic consequences.

We approached the subject of public health emergencies by drawing some key lessons from SARS as a concrete example. The first lesson is the importance of surveillance and response preparedness to reduce opportunities for the agent to spread from potential reservoirs of infection. We found that contact tracing, with or without quarantine, was an important measure in both the assessment and control of an emergency. It should be clear that while quarantine was effective in the control of SARS, it cannot be universally effective in all other emergencies. Response preparedness must include plans for instituting mass chemoprophylaxis, vaccination and other interventions. The second lesson is the critical value of community mobilization through health education and promotion activities. People were keen to do their part but needed to understand the way disease was transmitted, measures for prevention and control, and obligations to observe if quarantined. The third lesson is the need for public health authorities to stay flexible and be prepared to use extraordinary measures and adjust strategies as new challenges emerge (Ooi *et al.*, 2005). We uncovered many legal, operational and financial challenges when mounting new and large scale public health operations. Extrapolating these lessons to a wider public health context, our rapidly changing global infectious diseases situation mandates that we evaluate all available tools and build institutional capacity to effectively manage a public health emergency.

The rise of public health emergencies of international concern has also prompted WHO to revise the International Health Regulations which had stood little changed since 1969. An Inter-Governmental Working Group was convened in 2004-5 to rewrite the document with additional provisions for cooperation between countries, global surveillance and collaborative research, all to facilitate good governance in an emergency. The purpose and scope of the new regulations are to prevent, protect against, control, and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which would avoid unnecessary interference with international traffic and trade. In May 2005, the 58th World Health Assembly endorsed the new International Health Regulations (2005) and called on member states to implement the regulations to the full when they enter into force in 2007. They are binding on every member state that has not rejected or reserved against them.

Because high population density in urban environments can lead to greater transmission potential, new initiatives for disease detection and control are urgently needed to reduce opportunities for spread of infection (Ooi *et al.*, 2003). Outbreaks, unwelcome events as they are, represent natural experiments which afford opportunities for us to derive valuable information. Cooperation at the national and international level and public communications are key elements in outbreak management. The modern-day evolution of infectious diseases is one of microbial agents taking full advantage of economic and environmental activities that allow for them to thrive, prosper and spread among humans. As we take stock of this new reality of emerging disease threats, we have to recognize the need for heightened levels of vigilance, commitment, and resources to safeguard public health.

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Trade liberalisation and the diet and nutrition transition: a public health response

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Abstract

The liberalisation of trade, including of agriculture and food, remains at the forefront of debates about globalisation, not least because it is viewed as a model of progress – economic growth through market liberalisation – that can help address poverty and deliver public health improvement. In debates about trade, insufficient attention has been paid to its implications for health and nutrition, and, in particular, dietary health. Yet the WHO's Global Strategy for Diet, Physical Activity and Health (2004) provided a powerful warning that the future health burden will be increasingly determined by dietary health in the form of diet-related chronic diseases. This article thus examines the "diet and nutrition transition" in the context of liberalising trade and commerce, with the objective of providing to the public health and health promotion community an awareness of the importance of food trade in their efforts to promote healthy diets worldwide. We first describe the evolution of trade agreements, noting those particularly relevant to food trade. We then briefly review the association between trade liberalisation and health and the changing global dietary and disease profile. We then show how trade liberalisation is linked with the diet and nutrition transition through the food supply chain from foreign direct investment and food cultural change, such as supermarketisation and advertising. We propose three discernable scenarios for change, presenting the case for public health professionals and advocates to become centrally engaged national policy making in the food and agriculture arena.

Key words: Globalisation, trade, commerce, economic development, epidemiological transition, diet, nutrition, food governance, public health.

Background

World Trade Policy, Agriculture and Food

The last half-century has witnessed the massive growth in international trade. The volume of global merchandise trade has increased 17-fold, more than three times faster than the growth in world economic output. [1] Agricultural trade has grown around the same rate as world economic output but accounts for less than ten percent of world merchandise exports. The World Food Summit in 1996 made the case that international trade permits food consumption in a country to exceed production and to iron out national and local fluctuations in supply, but it was also noted that trade, through competition, might produce harmful effects, such as the disruption of traditional food production systems or deleterious environmental consequences. [2]

Since 1994, world trade policy has been managed by the World Trade Organisation (WTO), a supranational body dedicated to liberalising (i.e. opening up) commercial interactions between nations. Member States of the WTO negotiate trade deals in a series of "Rounds", addressing international trade issues such as protectionist mechanisms (tariff and non-tariff barriers), subsidies, intellectual property, foreign investment, food safety and other matters once solely the province of nation states or international trade groupings (Box 1). Given this breadth of scope, trade policy should be understood not simply in terms of the movement of goods across borders, but commerce in the broadest sense.

Until 1994, trade policy was subsumed by the loose trade 'club ' of member nations known as the General Agreement on Tariffs and Trade (GATT). The final GATT Round, the Uruguay Round (1987-1994), established the WTO, and for the first time brought agriculture and food into the negotiations, leading to the Agreement on Agriculture (AoA).

As a result of the work in the GATT, the average tariff on non-agricultural goods fell from around 40% in 1947 to 4.7% by the end of the Uruguay Round in 1993. In contrast the average level of protection for agriculture, despite fluctuations, has risen in both percentage and volume terms. Producer support in OECD countries was an estimated $US 279 billion in 2004[3] while total world trade in agriculture in 2003 was $US 674 billion. [4] When it assumed the responsibilities of GATT, agricultural liberalisation was high on the WTO agenda but it made little headway. Such protectionism is thought to in part explain the decline of food exports from developing countries from about 50% of total world exports in the early 1960s to less than 7% by 2000. [5]
Addressing protectionism in agriculture thus remains high on the agenda of the current Doha Round of WTO negotiations, which aims to create "substantial improvements in market access". [6] WTO negotiations on agriculture have, however, proved painfully difficult (the 1999 talks held in Seattle collapsed, as did the Cancun talks in 2003). So while agricultural trade has unquestionably increased since the AoA, numerous barriers still exist and, arguably, far greater agricultural trade liberalisation is yet to come.

Food is also affected by other trade agreements. The WTO Agreement on Technical Barriers to Trade (TBT) applies to food quality standards and labelling (e.g. of nutrients), and the Trade Related Intellectual Property Rights Agreement (TRIPS) to seed patents. The Agreement on the Application of Sanitary and Phytosanitary Measures (SPS) has been notably important in food trade, applying to any trade-related measure taken to protect human health from unsafe food. SPS recognises the standards set by another important trade-related text: the Codex Alimentarius (the joint WHO/FAO international food code). Reflecting the considerable emphasis placed on food safety in trade, SPS notifications to the WTO

1 Food and Agriculture Organisation of the United Nations, World agriculture: towards 2015/2030. An FAO perspective, Rome: Earthscan, 2003

2 Food and Agriculture Organisation of the United Nations, Paper No. 5 Food security and the WTO trade negotiations: key issues raised by the World Food Summit, in Agriculture, trade and food security: issues and options in the WTO negotiations from the perspective of developing countries, Report and papers of an FAO Symposium held at Geneva on 23 - 24 September 1999, Rome, FAO, 2000

3 OECD, Agricultural Policies in OECD Countries: Monitoring and Evaluation, Paris, OECD, June 2005

4 WTO, International trade statistics,Table iv 3 Geneva, WTO 2004

5 Committee On Commodity Problems Sixty-Fifth Session Rome, Italy, 11-13 April 2005 Food Security In The Context Of Economic And Trade Policy Reforms: Insights From Country Experiences. FAO 2002

6 Information on the Doha Development Agenda mandate can be found at http://www.wto.org/english/tratop_e/dda_e/dda_e.htm

increased from 196 in 1995 to 855 in 2003.[7] Nutrition, in contrast, has received negligible attention.

Trade policy is also set through "regional trade agreements", such as NAFTA (the North American Free Trade Agreement between the US and Mexico), MERCOSUR (between Brazil, Argentina, Uruguay and Paraguay), and the EU (the European Union is a free trade zone). Such agreements are becoming critically important in the face of tensions at the WTO, as are what are known as "bilateral agreements", such as the recent US – Australia Free Trade Agreement and the new Central American Free Trade Agreement (CAFTA), a series of bilateral agreements between the US and each of the five Central American countries and the Dominican Republic.

Box 1: Definitions of Trade Terms

Agreement on Agriculture (AoA): The AoA, part of the document founding the World Trade Organisation, provides the rules governing international agricultural trade and, by extension, production. It bans the use of border measures other than tariffs, and it puts tariffs on a schedule of phased reduction.

Foreign Direct Investment (FDI): Foreign direct investment is investment of foreign assets into domestic structures, equipment, and organisations

GATT: General Agreement on Tariffs and Trade, superseded by the WTO

GATS: The WTO's General Agreement on Trade in Services.

Multilateral, regional and bilateral trade agreements: Multilateral trade agreements (MTAs) require that reductions in trade barriers should be applied on the same basis to all WTO members. Under Regional or Bilateral trade agreements (RTAs, BTAs) reductions in trade barriers apply only to parties to the agreement. They must be consistent with the WTO rules governing such agreements, which require that parties to a regional trade agreement must have established free trade on 'substantially all' goods within the regional area within ten years, and that the parties cannot raise their tariffs against countries outside the agreement.

Non-tariff barriers (NTBs): Non-tariff measures which pose barriers to trade, such as quotas, import licensing systems, sanitary regulations, prohibitions, etc.

Quotas: Quantitative restrictions (commonly known as import quotas) are used to control the number of foreign products that can enter the domestic market.

SPS: Agreement on the Application of Sanitary and Phytosanitary Measures (1995). Sanitary and phytosanitary measures are those to protect human, animal and plant life and health, and to help ensure that food is safe for consumption.

Tariffs: Customs duties on merchandise imports.

Technical Barriers to Trade (TBT): Measures that countries use to regulate rnarkets, protect their consumers, and preserve natural resources, but which can also discriminate against imports in favour of domestic products.

Trade liberalisation: The reduction of tariff and non-tariff barriers to trade and other forms of commercial interaction

Subsidy: There are two general types of subsidies: export and domestic. An export subsidy is a benefit conferred on a firm by the government that is contingent on exports. A domestic subsidy is a benefit not directly linked to exports.

WTO: The World Trade Organisation WTO) is "the only global international organisation dealing with the rules of trade between nations. At its heart are the WTO agreements, negotiated and signed by the bulk of the world's trading nations and ratified in their parliaments. The goal is to help producers of goods and services, exporters, and importers conduct their business."

7 Regmi A, Gehlhar, M, Wainio, J., Vollrath, T., Johnston, P. and Kathuria, N. Market Access for High-Value Food. Agricultural Economic Report Number 840. Washington DC: USDA, 2005

Codex Alimentarius: The joint FAO/WHO international food code, managed by the Codex Alimentarius Commission (CAC)

Sources: Based on WTO Glossary (http://www.wto.org/english/thewto_e/glossary_e/glossary_e.htm) and Shaffer[8]

Trade policy and public health

Underlying trade agreements is the postulate that trade liberalisation and economic globalisation – defined here as the trend of economic integration and interdependence of countries - benefits all societies, especially poor ones. The idea is that increased trade lowers prices for consumer goods (notably food, which makes up a relatively larger proportion of the expenditures of poor people), economic openness boosts the incomes of agricultural producers (who comprise large segments of the populations of low-income countries), and the resulting economic growth increases the relative demand for skilled labour, in turn raising the demand for education and public goods. The result is a virtuous cycle of economic growth and social and health improvement. According to Lant and Summers, 40% of differential mortality improvements between countries could be explained by differences in national income growth; if the income of people in developing countries rose 1% as many as 33,000 infant and 53,000 child deaths would be averted annually. [9] Others have suggested that liberalising markets extends life expectancy; [10] even where inequality is increased, positive benefits outweigh the negative ones. [11] In other words, economic growth via trade liberalisation is 'good for health'. [12] [13]

Advocates of trade liberalisation present a powerful economic, indeed, moral case. However their evidence is disputed since predicted outcomes, including poverty reduction, have often not been borne out in reality. Some suggest that *insufficient* liberalisation is to blame, others being more concerned that trade rules inevitably favour the powerful.[14] According to the former chief economist at the World Bank, the new trade rules, the adjudication process on the rules, and the required domestic disciplines, reflect the priorities and needs of developed countries more than developing countries. [15] It has also been alleged that advocates of trade liberalisation confuse mechanisms with outcomes. For example, the Food and Agriculture Organisation (FAO) of the UN, says that market openness should not be viewed as a policy tool to achieve growth but primarily as an economic outcome;[16] consequently globalisation "does not automatically benefit the poor". [17] Removing protective tariff barriers may produce benefits for some groups but may also reduce state expenditure on public goods, such as education or health services, which benefit the poor most. [18] Some have also raised concerns about trade policies, cautioning that health may deteriorate if the new patterns of economic activity are more dangerous, general working conditions deteriorate, or trade facilitates the transfer of disease or unhealthy consumer goods and practices across borders. [19] [20] [21]

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8 Shaffer ER, Waitzkin, H., Brenner, J., Jasso-Aguilar, R. Global trade and public health. American Journal of Public Health (2005) 95,1:23-34

9 Pritchett, Lant, and Lawrence H. Summers (1996), "Wealthier is Healthier." Journal of Human Resources 31 (4): 842-68.

10 Owen, Ann L. and Wu, Stephen, "Is Trade Good for Your Health?" (November 2001). Hamilton College Working Paper No. 01-09. http://ssrn.com/abstract=291055

11 Martin Ravallion 2004. "Pro-poor growth: A primer." World Bank Policy Research Working Paper # 3242, March. Washington, D.C.: World Bank.

12 Dollar D, Kraay A. Growth Is good for the poor. J Econ Growth 2002;7:195-225.

13 Dollar D. Is globalization good for your health? Bull WHO 2001;79:827-833

14 Oxfam. Rigged Rules and Double Standards: Trade, Globalization and the Fight Against Poverty. Oxfam, 2002

15 Stiglitz, Joseph E and Charlon Andrews (2004): "A Development Round of Trade Negotiations?" - Report prepared for the Commonwealth Secretariat by the Initiative Policy Dialogue (IPD) in collaboration with the IPD Task Force on Trade Policy.
http://www0.gsb.columbia.edu/ipd/pub/CompleteCommonwealthReport11_3.pdf

16 Food and Agriculture Organisation of the United Nations , World agriculture: towards 2015/2030: An FAO perspective, Rome: Earthscan, 2003

17 Food and Agriculture Organisation of the United Nations, The State of Food and Agriculture 2000, Rome, 2000

18 Tim Conway, Trade liberalisation and poverty reduction, London: Overseas Development Institute, October 2004

19 Owen, Ann L. and Wu, Stephen, "Is Trade Good for Your Health?" (November 2001). Hamilton College Working Paper No. 01-09. http://ssrn.com/abstract=291055

20 Shaffer ER, Waitzkin, H., Brenner, J., Jasso-Aguilar, R. Global trade and public health. American Journal of Public Health (2005) 95,1:23-34

Amartya Sen has noted that the debate on globalisation has often taken the form of an empirical dispute about whether the poor who participate in trade and exchange are getting richer or poorer. The more fundamental question, he suggests, turns on the distribution of the benefits of globalisation which in turn raises broader issues about the adequacy of national and global institutional arrangements that shape global economic and social relations. [22] A similar point can be made more broadly in terms of global governance for public health and more specifically with regard to food. In terms of the likely impact of trade policy as a driver of dietary change, fundamental questions may need to be asked about how and in what way the nation state and civil society can formulate effective systems of 'food governance' both to minimise the deleterious health consequences of expanding trade and commerce while garnering its advantages. This question is considered in the final section.

To analyse the impact of trade policy on health, the WHO and WTO prepared a joint report on the public health implications of trade in 2002. [23] It noted that trade agreements do take some account of health, permitting national trade-restrictive measures that protect human health – but only those that are the least trade restrictive relative to any other measure. The report concluded "there is common ground between health and trade" (p.137), but in the face of past disputes between health and trade, it also argued for greater health and trade policy 'coherence'. While the report covered matters as diverse as intellectual property rights, food insecurity, infectious disease control and food safety, it failed to include an increasingly important class of health threats: diet-related chronic diseases (DR-CDs).

Diet-related chronic diseases and the nutrition transition

Until recently public health concerns around food largely focused on undernutrition and food safety. These remain important concerns. For example, while undernutrition decreased from 28% of the global population in the 1980s to 17% in 1999-2001, the rate of decline has since reduced. The FAO's recent estimates are that more than 800 million people in the developing countries suffer from chronic undernutrition. However, it has also observed that the picture is now considerably affected by new trends of globalisation, urbanisation, and changing food systems. [24] A fuller picture, therefore, is thus one of an increasing dual burden of malnutrition and disease.

The burden of DR-NDs, such as obesity, diabetes, cardiovascular diseases, cancer, dental diseases and osteoporosis, is rising fast worldwide. [25] According to the WHO, chronic (noncommunicable) diseases account for 60% of the 56 million deaths globally, with unhealthy diets being a major contributor to key risk factors (high blood pressure, high cholesterol, low fruit and vegetable intake, overweight and obesity). [26] Over one billion people worldwide are now overweight or obese. In the US and the EU the resultant health costs are massive [27]; in developing countries, these diseases promise to overwhelm far less well resourced healthcare systems.

This changing disease profile was first predicted by Omran's theory of the Epidemiological Transition. He proposed that as societies economically developed, chronic diseases increasingly substituted for infectious diseases. [28] From this, Popkin and associates have more recently developed a theory of "nutrition transition", incorporating diet, nutrition and lifestyle determinants in the explanation of the emergence of DR-CDs (figure 1). [29] Popkin

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21 Owen, Ann L. and Wu, Stephen, "Is Trade Good for Your Health?" (November 2001). Hamilton College Working Paper No. 01-09. http://ssrn.com/abstract=291055

22 Amartya Sen, "How to Judge Globalism," The American Prospect vol. 13 no. 1, January 1, 2002 - January 14, 2002

23 WHO/WTO, WTO Agreements and Public Health: A Joint Study by the WHO and WTO Secretariat, WTO/WHO, 2002 p.74

24 FAO, The State of Food Insecurity in the World 2004. Monitoring Progress towards the World Food Summit and Millenium Development Goals, Rome, FAO, 2004

25 WHO/FAO, Diet, Nutrition and the Prevention of Chronic Diseases, WHO Technical Report Series 916, Report of a Joint WHO/FAO Expert Consultation, World Health Organisation, Food and Agriculture Organisation of the United Nations, WHO/FAO Geneva, 2003

26 World Health Organization, The 2002 World Health Report. Geneva, WHO, 2002

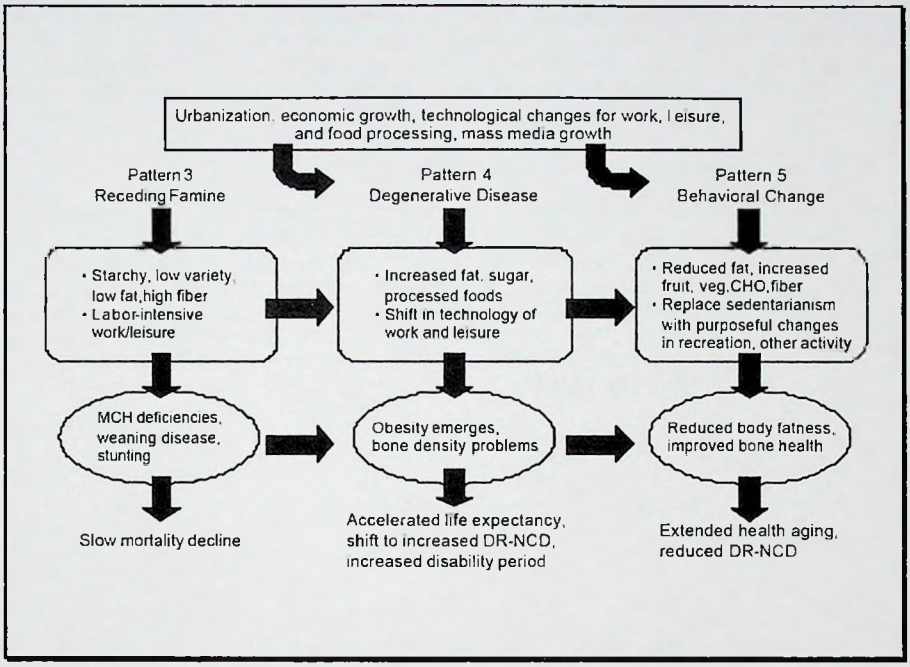
27 Rayner, G and Rayner M, Fat is an economic issue: combatting chronic diseases in Europe. Eurohealth, 2003, 9(1, Spring): p. 17-20

28 Omran, Abdel R (1971). 'The epidemiologic transition: a theory of the epidemiology of population change', Milbank Memorial Fund Quarterly, 49, 4, p. 509-538

29 Popkin, B. M. (1998) 'The nutrition transition and its health implications in lower income countries', Public Health Nutrition, 1 (1): 5-21 Popkin, B. M. (1999) 'Urbanisation, lifestyle changes and the nutrition transition', World Development, 27 (11): 1905-1915.Popkin, B. M. (2002) 'An overview on the nutrition transition and its health implications: the Bellagio meeting', Public Health Nutrition, 5 (1A): 93-103. Popkin BM,

and others show that radical dietary change is occurring worldwide: traditional diets with a more limited range of staples are being substituted by a diet more composed of livestock products (meat, milk and eggs), vegetable oils and sugar. These three food groups together currently provide 28% of total food consumption in the developing countries (in terms of calories), up from 20% in the mid-1960s. Their share is projected to rise to 32% in 2015 and to 35% in 2030. [30]

Figure 1 Popkin's Stages of the nutrition transition



CHO: carbohydrates
MCH: maternal and child health
NR-NCD: nutrition-related non-communicable disease.
Source: Popkin BM, An overview on the nutrition transition and its health implications: the Bellagio meeting, *Public Health Nutrition* 2002, 5(1A), 93-103

The links between trade liberalisation and the diet and nutrition transition

The global disease profile has been changing at the same time as trade has been liberalising. So are the two processes linked? Numerous researchers have suggested so, [31 32 33 34 35 36 37]

Richards MK, Monteiro C. Stunting is associated with overweight in children of four nations that are undergoing the nutrition transition. J Nutr. 1996;126:3009-3016

30 Jelle Bruinsma (ed) World Agriculture: Towards 2015/2030, Rome: FAO/Earthscan, 2003

31 Lang T. Diet, health and globalization: five key questions. Proceedings of the Nutrition Society (1999) 58, 335-343

32 Lang T. The public health impact of globalization of food trade. In: Diet, Nutrition and Chronic Disease: Lessons from Contrasting Worlds. Ed Shetty PS and McPherson K. Chichester, John Wiley &Sons, 1997.

33 Hawkes C. The role of foreign direct investment in the nutrition transition. Public Health Nutrition (2005) 8,4:357-365

34 United Nations System Standing Commission on Nutrition (UN SCN). Fifth Report on the World Nutrition Situation: Nutrition for Improved Development Outcomes. Geneva, UN SCN, 2004

35 Manuel Peña and Jorge Bacallao, Malnutrition and Povery, Annual Review of Nutrition, Vol. 22: 241-253, July 2002

36 Chopra M, Galbraith S, Darnton-Hill I. "A global response to a global problem: the epidemic of overnutrition." Bull World Health Organ 2002;80(12):952-8

37 Evans M, Sincalir, RC, Fusimalohi, C., Liava'a, V. Globalization, diet and health: an example from Tonga. Bulletin of the WHO (2001) 79,9:856-862

[38] and the WHO Technical Report 916 stated that international trade issues "need to be considered in the context of improving diets" (p.140). [39] Trade, in fact, proved one of the most contentious issues during the negotiation of the WHO's Global Strategy on Diet, Physical Activity and Health, suggesting a recognition that addressing dietary changes requires a closer look at trade (contentious because this might threaten certain economic interests).

Yet global trade patterns are immensely complex. Trade policy acts at the macro-level, affecting households and individuals through complex and poorly understood pathways with potential for unpredictable and unintended effects, both positive and negative. There is, moreover, enormous variation in the pace and style of dietary change worldwide. It is thus difficult to trace the precise links between trade liberalisation and dietary patterns. Still, considering the potential importance of trade for dietary health, a critical starting point is to understand how trade liberalisation affects the food supply chain and what this implies for diets.

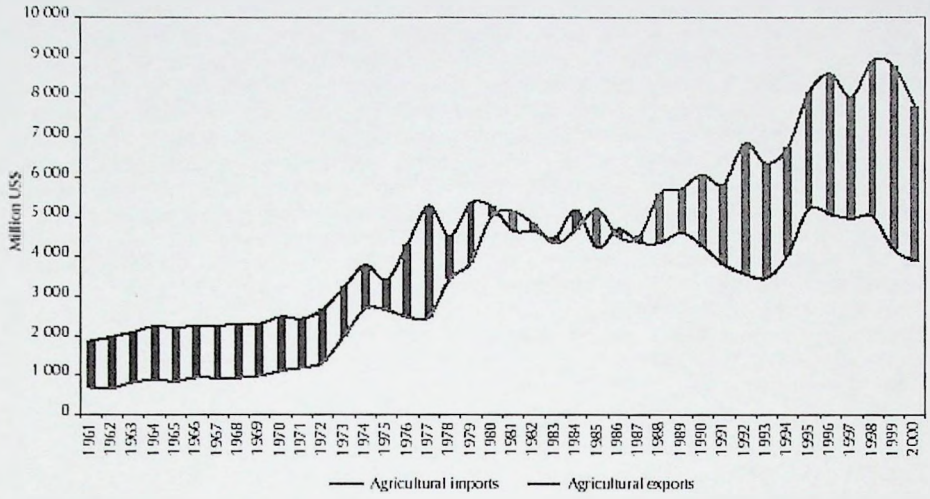
Trade Liberalisation and the Food Supply Chain

Trade liberalisation affects the food supply chain at varying levels of complexity – all of which require public health analysis and debate. The very large subsidies going to agriculture in the richer OECD countries, given rising productivity, has meant that although the world's population doubled between 1960 and 2000 and levels of nutrition improved markedly, the prices of rice, wheat and maize - the world's major food staples - fell by around 60 percent. The other consequence has been that food imports play an increasingly important role in many national diets. In the case of the 49 Least Developed Countries (LDCs) by the end of the 1990s, imports were more than twice as high as exports (See figure 2)

38 FAO. Globalization of Food Systems in developing Countries: Impact on Food Security and Nutrition. Rome, FAO, 2004

39 WHO/FAO, Diet, Nutrition and the Prevention of Chronic Diseases, WHO Technical Report Series 916, Report of a Joint WHO/FAO Expert Consultation, WHO/FAO Geneva, 2003

Figure 2: Agricultural imports and exports of LDCs



Source: Food and Agriculture Organisation of the United Nations , World agriculture: towards 2015/2030: An FAO perspective, Rome: Earthscan, 2003, Section 9.2.1

Independent of the GATT and pre-dating the WTO, the role of food imports in the Pacific Islands States present an historical example of dietary impacts. Pre-1945, each nation was essentially self-sufficient, but during the subsequent era of "development" each country became more reliant on imports, with impact on diets and local production systems. In Fiji, for example, imports of rice, tinned meat and fish, wheat flour, mutton, pork, sweet biscuits and sugary drinks increased rapidly after 1945, a trend associated with increased consumption of bread and meat relative to the traditional *dalo* and fish.[40] In Tonga, meat imports rose from 3389 tonnes in 1989 to 5559 tonnes in 1999, accompanied by a 60% increase in consumption.[41] More recent trade policies have had significant effects on imports, changing the availability of specific foods: in the US, for example, fruit imports play a far greater role in the diet than two decades ago.[42] Globally, the most notable example is vegetable oils. According to the US Department of Agriculture, oilseeds products are the most internationally trade products when total exports are compared with global production.[43] In China, agricultural imports more than doubled between 2002 and 2004 due in part to a more open trade regime. Soy oil, palm oil, and raw soybeans crushed to make vegetable oils (and animal feed), accounted for nearly half of this import growth. [44] Imports of soybeans increased from 1,107 to 20,416 thousand tons between 1996 and 2000, largely from the United States.[45] Higher imports have led directly to greater availability of vegetable oils (i.e. they are not only substituting for domestic production). Participation in the WTO is further predicted to lower

40 Schultz JT. Globalization, urbanization and nutrition transition in a developing island country: the case of Fiji. In Globalization of Food Systems in Developing Countries: Impact on Food Security and Nutrition, pp.195-505. Rome, FAO, 2004.

41 Evans M, Sincalir, RC, Fusimalohi, C., Liava'a, V. Globalization, diet and health: an example from Tonga. Bulletin of the WHO (2001) 79,9:856-862

42 Kantor LS, Malanoski, M. Imports play a growing role in the America diet. FoodReview (September-December 1997) 13-17.

43 Regmi A, Gehlhar, M, Wainio, J., Vollrath, T., Johnston, P. and Kathuria, N. Market Access for High-Value Food. Agricultural Economic Report Number 840. Washington DC: USDA, 2005

44 Gale F. China's Agricultural Imports Boomed During 2003-04. USDA WRS-05-04. Washington DC, USDA, 2005

45 Hsu H-H. Policy changes continue to affect China's oilseeds trade mix. In: Hsu H-H, Gale F, editors.Washington DC: USDA ERS; 2001. p. 30-6

prices and increase demand for vegetable oils.[46] [47] *Given the highly differentiated impact of trade at a country level there is an urgent requirement to undertaken health impact analysis to unravel this complex trade picture.*

A second more complex effect of trade liberalisation is on the internal dynamics of the food supply chain. While local factors remain critical, changes in the food supply chain appear to be taking on an increasingly uniform character worldwide. Market liberalisation has the effect of changing existing means of food production and distribution and substitution in increasingly similar ways. In traditional societies, food supply chains are short and focused on products grown locally and seasonally available. Farmers typically sell their own produce through street markets. As the food supply chain develops in capital intensity and becomes more liberalised, the task of moving food from farm to table becomes more complex and supply chains are vastly lengthened. In the process, localism is displaced, scale increased, and investments increasingly shifted from basic, fresh or seasonal commodities to 'value added' processed foods. [48] These circumstances are driven by new market players, attracted by the more open – and thus easier and more cost-effective – market operating conditions: thus the considerable importance of trade policy. Also important are existing national groups (or co-operatives) reforming to combat the new players, often borrowing their food supply chain technologies. *A public health question is whether or not trade liberalisation discourages local production and what health impact this has.*

At a third level of complexity, trade regulations affect how much investment is made in the food supply chain – and in which part it is made. Liberalisation of finance is part of trade regulations, and encourages foreign direct investment (FDI). FDI has proved particularly important in the spread of highly-processed foods. [49] In fact, whereas growth in cross-border processed food trade has remained minimal since the mid-1990s (in part because of high tariffs), [50] FDI has become increasingly important. In the decade 1988-1997, foreign direct investment in the food industry increased from US$743 million to more than US$2.1 billion in Asia and from US$222 million to US$3.3 billion in Latin America, outstripping by far the level of investments in agriculture.[51] In the case of US food companies these sell five times ($US 150 billion) more through FDI sales than through export sales ($30 billion). FDI has also stimulated the global spread of supermarkets, in turn a major sales driver of nontraditional packaged foods The US has the highest concentration of supermarkets, but growth rates in some regions, such as Latin America and China, have been extremely rapid, as shown in Table 1. [52] [53] The largest shopping malls in the world are now longer in the USA but in China.[54] *The implications of the food supply chain and retail revolution over the last half century has been assumed to deliver public health gain by widening the choice of foods and lowering price. If nothing else the above analysis suggests that these assumptions are questionable and too simple.*

Table 1. Share of Food Sales for Retailers in Selected International Markets, 2002

46 Fuller F, Beghin J, De Cara S, Fabiosa J, Fang C, Matthey H. China's accession to the World Trade Organization: what is at stake for agricultural markets? Review of Agricultural Economics 2003;25(2):399-414.

47 Diao X, Fan S, Zhang X. How China's WTO Accession Affects Rural Economy in the Less-Developed Regions: A Multi-Region, general Equilibrium Analysis. Washington DC: IFPRI; 2002. Report No.: TMD Discussion Paper No. 87.

48 Carol Whitton, Processed Agricultural Exports Led Gains in U.S. Agricultural Exports Between 1976 and 2002, FAU-85-01, USDA/ERS, February 2004

49 Hawkes C. The role of foreign direct investment in the nutrition transition. Public Health Nutrition (2005) 8,4:357-365

50 Regmi A, Gehlhar, M, Wainio, J., Vollrath, T., Johnston, P. and Kathuria, N. Market Access for High-Value Food. Agricultural Economic Report Number 840. Washington DC: USDA, 2005

51 FAO, The State of Food Insecurity in the World 2004: Monitoring Progress towards the World Food Summit and Millenium Development Goals, Rome, FAO, 2004

52 Thomas Reardon, C. Peter Timmer, and Julio A. Berdegue, Supermarket Expansion in Latin America and Asia Implications for Food Marketing Systems, in Anita Regmi and Mark Gehlhar (eds). New Directions in Global Food Markets, Markt/AIB-794 Economic Research Service/USDA, Feburary 2005

53 Euromonitor data sourced in Anita Regmi and Mark Gehlhar (eds). New Directions in Global Food Markets, Markt/AIB-794 Economic Research Service/USDA, Feburary 2005

54 David Barboza, China, New Land of Shoppers, Builds Malls on Gigantic Scale, *New York Times*, 25 May, Section A , Page 1

Table 1—Share of food sales for retailers in selected international markets, 2002

Retail outlets	United States	Western Europe	Latin America	Japan	Indonesia	Africa and Middle East	World
				Percent sales			
Supermarkets/hypermarkets	62.1	55.9	47.7	58.0	29.2	36.5	52.4
Independent food stores	10.0	10.0	33.0	11.3	51.1	27.1	17.8
Convenience stores	7.5	3.8	3.1	18.3	4.8	10.0	7.5
Standard convenience stores	5.7	2.5	1.8	18.2	4.8	9.5	6.4
Petrol/gas/service stations	1.8	1.2	1.3	0.1	0.0	0.5	1.1
Confectionery specialists	0.5	2.0	1.7	0.3	0.1	1.3	1.2
Internet sales	0.2	0.1	0.1	0.4	0.0	0.0	0.2
Chemists/drugstores	0.2	0.3	0.2	0.4	0.2	0.3	0.3
Home delivery	0.4	0.2	0.0	0.0	0.0	0.0	0.1
Discounters	7.4	10.3	0.2	2.2	2.7	6.2	5.7
Other	12.0	17.5	14.0	9.0	11.9	18.6	14.9
Total	100	100	100	100	100	100	100

Source: Euromonitor, 2004

Source: Euromonitor / USDA ERS (2005)

Supermarkets may be the visible end point of the new supply chain, but in terms of products, soft drinks provide a critical illustration of the complex market development process – and are probably the best indicator of likely changes in overall diet, since increasing demand for soft drinks indicates the likelihood of purchasing processed foods.[55] Table 4 shows sales of soft drinks worldwide by country income. These products use cheap constituents, the bulk of which is acquired locally, some of which is imported from the company point of origin. They typically require large investments in production facilities, distribution infrastructure, and marketing. The biggest brands already have global recognition although the products are produced locally, vastly reducing transport costs. FDI sales for US soft drink brands were $US 30 billion in 1999 (in a global market of $US 393 billion) while US soft drink exports only $US 232 million in 2001.

55 Bolling, Chris. "Globalization of the Soft Drink Industry," Agricultural Outlook, No. 297, December 2002, pp. 25-27

Table 2. Retail sales of soft drinks, 2002 and growth 1997-2002

Table 1-4—Retail sales of soft drinks

Market	2002 sales	Share of carbonated drinks	1997-2002 an. avg. growth	
			All soft drinks	Carbonated drinks
	Million liters		*Percent*	
High-income countries:				
France	12,755	17.4	4.4	2.4
Germany	18,920	31.2	2.4	2.9
Japan	16,885	16.3	4.5	1.0
Singapore	448	41.2	4.9	-0.9
United Kingdom	10,031	57.3	3.6	1.9
United States	91,286	66.0	3.1	1.4
High-middle-income countries:				
Brazil	16,630	71.8	5.9	2.5
Chile	1,762	85.2	2.4	1.9
Czech Republic	2,524	33.3	10.7	8.0
Hungary	1,561	44.1	7.0	1.6
Mexico	34,874	46.0	8.6	4.1
South Africa	2,938	80.1	6.8	6.2
South Korea	3,737	33.4	5.7	3.8
Turkey	7,508	32.2	6.7	5.2
Low-middle-income countries:				
Bulgaria	774	52.3	14.3	10.4
China	22,952	27.4	15.9	8.8
Colombia	3,484	76.0	-0.1	3.3
Morocco	961	38.6	3.5	2.8
Philippines	4,998	64.2	12.0	8.4
Romania	1,561	41.8	13.5	9.9
Russia	5,010	47.6	7.9	2.7
Low-income countries:				
India	3,272	60.3	13.9	7.9
Indonesia	9,017	8.9	21.7	7.8
Ukraine	1,378	47.7	7.9	6.0
Vietnam	539	58.4	4.8	-1.8

Source: Euromonitor, 2003.

Source: Euromonitor / USDA ERS (2005) (Note correct attribution above table is Table 2)

Much has been written about the dietary and health impact of increasing consumption of sugary drinks in western countries,[56] [57] [58] like supermarkets, international brands often bring with them powerful notions of modernity, with a particular appeal to young people.

The rise of personal income in urbanised middle income groups is associated with high growth rates of packaged food products, which range from 7 percent in upper middle income countries to 28 percent in lower middle income countries, compared to 2-3 percent in

56 Ludwig DS, Peterson KE, Gortmaker SL. Relation between consumption of sugar-sweetened drinks and childhood obesity: a prospective observational analysis. Lancet. 2001; 357 :505 –508

57 Popkin, B. M. and Nielsen, S. J. (2003) 'The Sweetening of the World's Diet', Obesity Research, 11: 1325-1332;

58 Committee on School Health, American Academy of Pediatrics, Policy Statement: Soft Drinks In Schools, Pediatrics, Vol. 113 No. 1 January 2004, pp. 152-154

developed countries (Table 3).[59] Concerns about diets high in fat, sugar and salt, found increasingly in developed countries, may have no counterpart in many developing countries. Consequently, many manufacturers which experience growing resistance to these product ranges in their home markets look to developing countries for potential rapid growth. Moreover, such investments are likely to be welcomed by developing countries as evidence of modernisation, new foreign investment and employment. Another cross-border factor shaping the impact of trade on public health is the rapid growth of sophisticated marketing and advertising (see table 4).

Table 4: Worldwide growth in advertising – 1990-2003

WORLDWIDE AD GROWTH: 1990-2003

	U.S.A.		OVERSEAS		TOTAL WORLD	
	BILLION US$	% CHANGE	BILLION US $	% CHANGE	BILLION US$	% CHANGE
1990	$130.0	+ 3.9%	$145.9	+ 11.8%	$275.9	+ 7.9%
1991	128.4	- 1.2	153.9	+ 5.5	282.3	+ 2.3
1992	133.8	+ 4.2	165.4	+ 7.5	299.2	+ 6.0
1993	141.0	+ 5.4	163.2	- 1.3	304.2	+ 1.7
1994	153.0	+ 8.6	179.0	+ 9.7	332.0	+ 9.1
1995	165.1	+ 7.9	205.9	+ 15.0	371.0	+ 11.7
1996	178.1	+ 7.9	212.1	+ 3.0	390.2	+ 5.2
1997	191.3	+ 7.4	210.0	- 1.0	401.3	+ 2.8
1998	206.7	+ 8.0	205.2	- 2.3	411.9	+ 2.6
1999	222.3	+ 7.6	213.8	+ 4.2	436.1	+ 5.9
2000	247.5	+ 11.3	226.8	+ 6.1	474.3	+ 8.8
2001	231.3	- 6.5	209.6	- 8.6	440.9	- 7.9
2002	236.9	+ 2.4	213.6	+ 1.9	450.5	+ 2.2
2003*	247.7	+ 4.6	222.1	+ 4.0	469.8	+ 4.3

* In current local currencies

Future scenarios for trade and dietary health

In nineteenth century Europe, nutrition was a powerful driver for both improving population health and industrial development.[60] In the twenty first century, the health and economic consequences of dietary change for developing countries may prove equally important. In conditions of increasing inequality, a proportion of the population are likely to continue to be undernourished while another section are likely to undergo massive changes in their diet, with profound nutritional and health consequences.

What therefore is the future for trade policy and dietary health? In the past trade policy used to be dominated by farm and commodity groups but from the 1980s multinational food firms began to participate in the trade negotiations. Protectionism has been strong, but the balance

59 Euromonitor data sourced in Anita Regmi and Mark Gehlhar (eds). New Directions in Global Food Markets, Markt/AIB-794 Economic Research Service/USDA, Feburary 2005

60 Fogel, Robert William. "New Findings on Secular Trends in Nutrition and Mortality. Some Implications for Population Theory," M. R Rosenzweig and O. Stark, Handbook of population and family economics. Handbooks in Economics, vol. 14. Amsterdam; New York and Oxford: Elsevier Science North-Holland, 1997, pp. 433-81

of power has now shifted. Much more liberalisation of the farming and food sectors is likely, and food-related WTO, regional and bilateral agreements are likely to become more important, along with the influence of non-farm food groups. Past experience of trade policies suggest they result in a growing separation between agriculture, whose commodities are dropping in value, and the food processing and retail industries, which take an increasing share. From this, we discern three possible scenarios for how the relationship between food trade and dietary health could develop:

- *Business as usual*. Further development of global and national markets drawing on globalised technology, supermarketisation and consumer dietary patterns, but retaining a semblance of regional and national variations in dietary composition. This represents what will happen in the absence of a public health or food industry response to concerns about unhealthy diets.
- *Fragmentation*. Development of processed 'niche' food products designed to contribute to healthy diets, heavily packaged and advertised, but which do not fundamentally alter existing farm and food systems, or how food is grown, processed or traded. This represents what will happen if the dominant response to the problem comes from the food industry. Stung by the obesity crisis worldwide, some international food companies are already pursuing this scenario, hoping to highlight their products' health benefits.
- *Health at the centre of trade*. Dietary health and nutrition becomes a key arbiter of future food and farming, including trade. This represents what will happen if there is a strong public health response to dietary concerns, integrated into a health-sector wide approach to centralising health considerations into trade. Driven in part by recognition of immanent drivers of change such as water shortage and climate change, this 'ecological public health' approach to food and farming is beginning to emerge.[61]

We judge the first two as currently most likely in the short-term, but believe that public health analysis will increasingly argue for the third. We now explore this further.

Putting health at the centre of trade: promoting health governance

In an increasingly globalised obesogenic culture, merely encouraging people to adopt healthier lifestyles cannot work without tackling some of the upstream forces, such as commerce and trade. [62] Thus we propose that to move towards the "health at the centre" scenario, dietary health needs to be incorporated into a cogent and consistent public health approach of making health as a whole (e.g. under- and over-nutrition, infectious and chronic diseases) a central consideration of commerce and trade. For this to happen, civil society would need to take a strong advocacy role, and national governments integrate health strategies across departments of state, involving business and civil society. One potential model is that formulated through a consultation by WHO (see figure 3). Lessons could be learned from attempts to inject sustainability / environmental protection into business activity.[63] Measures must also address both the supply and demand side of economic activity, for example by attempting to change the relative prices of healthy and less healthy foods.[64]

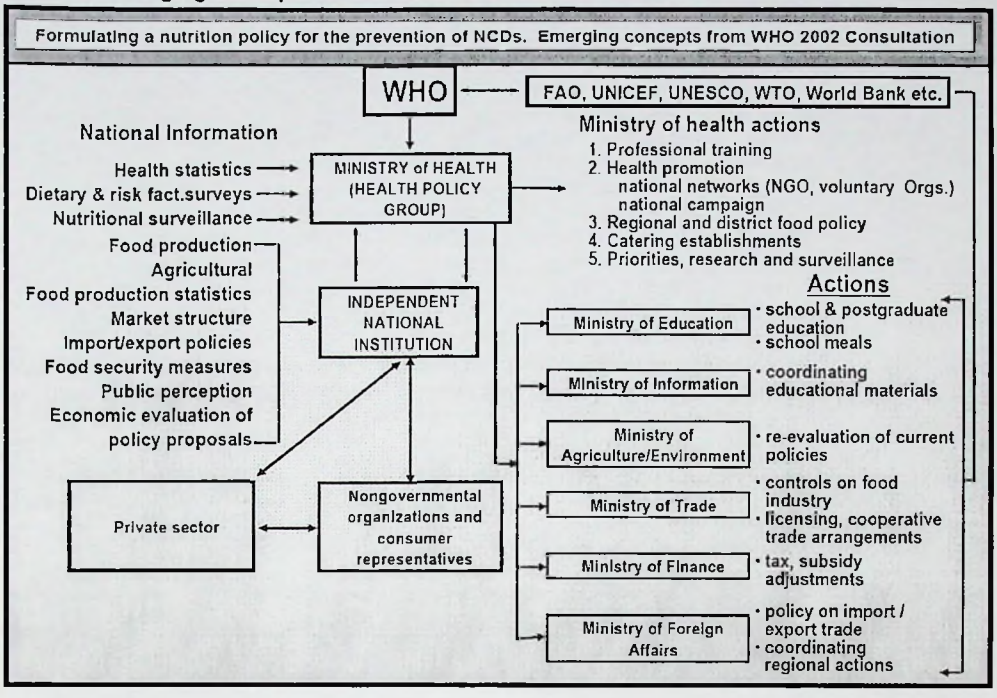
61 Lang T, Heasman M (2004). Food Wars. London: Earthscan

62 Chopra M, Galbraith S, Darnton-Hill I. "A global response to a global problem: the epidemic of overnutrition." Bull World Health Organ 2002;80(12):952-8

63 T Lang, M Heasman (2004). Food Wars. London: Earthscan

64 Lawrence Haddad, Redirecting the Nutrition: What can Food Policy Do? In Food Policy Options Preventing and Controlling Nutrition Related Non- Communicable Diseases November 20-21, 2002, pp 11-15, Washington, World Bank, 2003

Figure 3. Formulating a nutrition policy for the prevention of Non Communicable Diseases: emerging concepts for a WHO 2002 consultation



Source: Personal Communication, Amalia Waxman & Derek Yach

More specifically, we propose a spectrum of action by public health professionals and advocates in international organisations, ministries of health and civil society organisations to address trade-related diet issues, as follows:

- *Strengthen food governance and build capacity to address dietary health.* A central issue is the effectiveness of institutional frameworks for control and monitoring of the food supply chain from a nutritional balance perspective, alongside food safety, which, as shown, is the major focus of international and national food governance. Globally, the Codex Alimentarius Commission is now beginning to discuss how they could implement components of the WHO Global Strategy on Diet, Physical Activity and Health. Nationally, developing capacity to address dietary health is a real challenge, so drawing on existing frameworks – and using complementarity to strengthen them – would be critical. Filling these capacity gaps is a necessary precursor to further action.
- *Audit the impacts of commerce and trade on diets.* While much has already occurred, the liberalisation of food trade is still in its relatively early stages. Auditing emerging trade liberalisation on diets is thus needed. Monitoring of food industry and agribusiness responses to trade agreements – mergers across borders, growth and marketing trends, and internal efforts to move to a healthier product mix – would be one example. This is also of interest to investment banks, with their concerns about the long run sustainability of the food sector. [65]
- *Consider the role of trade agreements and international agreements which affect trade to address dietary health.* There have been calls for trade agreements to be made more sensitive to health issues,[66] but realistically there are limits on what can be done within international trade agreements: trade institutions view their agenda as

65 J.P. Morgan, (2003) Obesity. The Big Issue, JP Morgan European Equity Research, 16 April

66 Ron Labonte (1998) 'Healthy public policy and the World Trade Organisation: a proposal for an international health presence in future world trade/investment talks'. Health Promotion International, 13, 3, 245-256

liberalising trade under the assumption it will generate health benefits, and WTO agreements already have a "pro-health" clause. But dietary health remains excluded as food is considered only is so far as it is unsafe – not its nutritional quality. More thinking is needed about how this gap can best be addressed. The Framework Convention on Tobacco Control provides some lessons of developing a non-trade treaty which nevertheless sets a pro-health standard in any trade dispute (The FCTC does not specifically refer to trade, but uses language indicating that health should be the prime consideration). The Treaty also contained potentially commerce-restrictive consumer-oriented strategies, including taxes, labelling, advertising, product liability and financing. Food is not tobacco, but concerns warrant a similar approach, such as on food marketing to children, product labelling, or tax discrimination between healthier and less healthy foods. There is a powerful case for consumer protection strategies to protect or activate the most vulnerable. On marketing, these might range from bans on advertising to decisions that schools or public institutions should be commerce-free areas.[67] Such regulations have trade implications, so public health professionals must play a role in educating trade policy professionals about their potential health benefits in order that health can be taken into account in any potential adjudication process. Of note, however, the WHO Strategy includes the phrase: "reaffirming that nothing in this strategy shall be construed as justification for adoption of trade-restrictive measures or trade-distorting practices".[68]

- *Develop national supply side measures to build new markets for healthy foods.* In developing countries, traditional food markets are denoted by short supply chains and high levels of contact between primary producers and consumers. Further commercialisation is associated with the replacement of local markets by regional and then national markets and patterns of ownership, often instigated by national and local government.[69] [70] A way to maintain local patterns of ownership is the encouragement of cooperatives linking suppliers, retailers and consumers. Building markets for healthy foods could be a focus for such cooperatives, while also benefiting local economies.
- *Financing public health capacity.* The foregoing proposals have little hope of success without adequate resourcing. In many countries the public health infrastructure – professions, resources, facilities, influence and power – is already weak. One potential means for resourcing capacity – including new social marketing efforts – may be through industrial levies or special or hypothecated taxation, as has occurred in the case of the former linked to developed countries tobacco legal settlements, or potentially through marketing taxes or taxes on energy-dense foods.

Conclusion

The paper has pointed to the considerable complexity in the impact of commerce and trade in food on public health. The solutions required to avert the negative consequences of the diet and nutrition transition will neither be simple nor applied without considerable difficulty. At the very least Departments of Commerce and Trade ought to have better public health input into their deliberations and policy making and - vice versa - Departments of Health and the public health movement need to become more sophisticated in their analysis of the health impact of commerce and trade and in determining the potential entry points to achieve public health gain.

67 Hawkes C (2004). Marketing Food to Children: the Global Regulatory Environment. Geneva: World Health Organisation

68 Fifty-seventh World Health Assembly, Geneva, 17-22 May 2004, WHA57.17 Global strategy on diet, physical activity and health {OECD, 2005 #1}

69 Reardon T, Swinnen JFM. Agrifood Sector Liberalization and the Rise of Supermarkets in Former State-Controlled Economies: Comparison with other developing countries. Development Policy Review 2004; 22: 515-523

70 Hu D, Reardon T, Rozelle S, Timmer P, Wang H. The Emergence of Supermarkets with Chinese Characteristics. Challenges and Opportunities for China 's Agricultural Development. Development Policy Review 2004; 22: 557-586

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