WORLD HEALTH ORGANIZATION
EUROPE

SEVENTH FUTURES FORUM

on unpopular decisions in public health

St Julian's, Malta, 11–12 November 2004

KEYWORDS

DECISION MAKING

POLICY MAKING

PUBLIC HEALTH

CONSUMER SATISFACTION

WORLD HEALTH ORGANIZATION

EUROPE

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by post Publications

WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø, Denmark

ISBN 92 890 1069 X

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Concept and design: Tuuli Sauren, Brussels, Belgium

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CONTENTS

1. INTRODUCTION

"When a decision has been made, its implementation depends on how it is accepted by the general public and the stakeholders involved."

Public health decisions often create strong public resistance from the people who do not expect to benefit from them. Opposition arises because people are afraid that the proposed changes will deprive them of services, rights or freedoms. The most outspoken opponents of a decision are usually those who anticipate suffering individual or collective financial, social or political losses. Thus, decision-makers are frequently confronted with a situation of controversy. On the one hand, their professional judgement tells them that a certain decision is necessary because it will bring health gains; they therefore have to go ahead with it. On the other hand, they understand that this decision may be potentially unpopular and may trigger resistance from various groups in society. Making and launching unpopular decisions is everyday business for top-level policy-makers in public health.

WHO's Seventh Futures Forum of High-level Decision-makers therefore aimed to identify tools for making public health decisions more acceptable and popular. This Futures Forum based its work on presenting practical cases from countries followed by open discussions and an exchange of experience and ideas. The topic of unpopular decisions was selected based on the initially selected topic in the plan of work of the Futures Fora for the period 2003–2005. In addition, the view was expressed during the previous Futures Forum on crisis communication in Iceland in May 2004 that policy-making needs to further address the consumer orientation in decision-making and in health communication.

Launched in 2001, the Futures Fora are a series of meetings for policy-makers. They aim to generate insights into real-life decision-making issues that are often not available from academic sources. They provide an impartial environment for directors-general of health, chief medical officers and senior advisers to debate difficulties in policy-making. During the Fora, the participants share their experience in concrete decision-making issues, describe the solutions employed and draw the lessons. The Fora apply the Chatham House rule to ensure confidentiality. The Chatham House rule aims to guarantee anonymity to those speaking within it. It allows people to speak as individuals, and to express views that may not necessarily reflect those of their organizations, thus encouraging free discussion.

The baseline theme for the Futures Fora in 2003–2005 is tools for decision-making in public health. Several Fora have already been organized under this theme, such as a Forum on evidence-based recommendations as tools for decision-making held in Brussels in June 2003; one on rapid response decision-making tools held in Madrid in December 2003; and another one on crisis communication held in Iceland in May 2004. A report is issued after each Futures Forum. In 2005, a position paper on tools for decision-making in public health will be synthesized and a new framework theme selected.

This report summarizes the discussions at the Seventh Futures Forum held in November 2004 in St Julian's, Malta. Following this introduction, each section outlines one specific problem and the key points from the country case studies and summarizes the debate on that problem. The summary highlights some approaches that all participants agreed would usually work in their country and, separately, some solutions on which there is no consensus that may be useful in one country but not applicable to another.

Section 1 deals with how policy-makers can adjust to the public while remaining firm in pursuing health objectives; **section 2** focuses on the ways of measuring the public demand; **section 3** describes practices and ideas for predicting how the public will accept a decision; **section 4** pulls together the ideas shared by the participants on how to make public health decisions more popular; and **section 5** discusses the issue of popularity in the light of the different roles director-general for health and health ministers play in managing unpopular decisions in public health.

2. How to balance listening to the public and remaining firm in pursuing health objectives

Case study: closing hospital beds

"Not only is closing hospitals unpopular, but opening hospitals is extremely popular."

2.1 The problem

Most countries in western Europe have followed a consistent trend of reducing the number of hospital beds and thus closing hospitals. This is usually part of an overall policy to reduce the proportion of non-essential hospital treatment in total health care, to more strongly emphasize primary care and outpatient care. It may also result from a health ministry's strategic plan to respond to changing health care needs by modifying the specialization of some health care units. Improving efficiency, containing costs and improving the quality of care are some of the other core arguments for closing a hospital. In any case, whether to close a hospital is a decision of major significance for the local labour market and economy. It may also raise concerns among the local population and health workers, who are all accustomed to the existing accessibility of hospital services. Such a decision requires that the health authorities express their commitment to ensuring health improvement. However, this commitment may force politicians to face negative attitudes, non-acceptance and resistance among the population groups that will be affected. The policy dilemma is therefore how decision-makers can best respond to the pressures of the public while resolutely keeping the focus on their long-term health plans. The objective of this session was to share difficulties in closing hospitals and ideas on how to maintain the policy chosen while taking into account public concerns and anxieties.

2.2 Examples from countries

AUSTRIA

"Health care planning is always an adventure."

The decision and its context

Vienna had three small paediatric hospitals, each requiring the same equipment as a large hospital. The challenge was to merge them, with the same functions, staff and beds, into a large centralized one and close the other two. Styria (a region) had two standard state hospitals, each with several specialists in departments but not working together, although the distance between them was 20 km. The decision was to create one centre through an agreement between the federal and the regional government.

Between 1994 and 2003, ten hospitals were closed in Austria and the overall number of beds was reduced by 6000. The two most common practices were either to incorporate the small hospitals into large hospital units or to close them completely. Some of the major reasons for such decisions were assuring the quality of health care,

assuring economic sustainability or the need to change the functions of certain units. The demographic situation played a role – with an increasingly ageing population in certain regions, services had to be brought to the people using them. It was obvious that replacing the previous inpatient facilities with mobile outpatient clinics would accomplish this better. The decision was justified by an increased accessibility of the services for elderly people and by the desire to use resources more optimally.

The resistance – sources and reasons

- Uncertainty: soon after the decision was made, the people who were using the hospital needed some guarantee that the new service would function smoothly.
- Lost employment: resistance came from health care workers, especially nurses, who feared that the change would mean they would lose their job and have to requalify.
- Reluctance of the regional government: in all cases, the hospitals were an economic factor for the region.
- Miscommunication: information reached people too late, when the decision was already taken.
- Socioeconomic and health literacy level of the population: the acceptance of the decision depended on this factor, which, however, turned out to be both an obstacle and an opportunity. Well-informed people resist a decision if they do not clearly see the benefits, but if they are guaranteed that the proposed change is for the better they support it.

The mistakes made when introducing the decision

- The population was not prepared and there was no preliminary discussion. As a result, small citizens' groups were formed to protect the existing structures. Decision-makers were confronted by accusations that deaths would have been avoided if the old structure had been in place.
- There was no preliminary communication to staff. This was especially the case with Vienna: health care workers were informed on the day their hospitals were to close. Thus, for weeks the case was made for a purely political dispute. The debate went beyond talking about health.
- There was no time planning. Even if the previous two mistakes had been avoided, there were still no provisions for the fact that it takes time for the public to accept the decision.
- There was no link to the regional development plan. The decision was not part of this plan, and the population therefore questioned whether it was justified in the context of the overall regional development.
- Planning and financing were not synchronized. When a previously agreed scheme is changed, having financing for the new scheme cannot be expected.

The lessons learned

- Go through the whole process of making the decision. At first, ask whether there is a problem, then analyse the problem, focusing on the quality of service in the existing hospital structure, then suggest what can be done in the future; and only after that introduce the creation of another structure.
- Prepare the delivery of the message about the decision step by step. Consider all stakeholders – patients, staff, regional authorities and especially the mass media. No information available is the worst case.

- Ensure the quality of the message. Provide understandable, simple information, as this is essential for people to accept the decision. Prepare to reveal all the evidence, facts and figures you have to make your case to the public.
- Talk about the vision. Be honest about the motives for the proposed change. Each decision is being made to guarantee health care.
- Think of every single word. For instance, talking about hospital restructuring is better than talking about closure.
- Make a commitment. Decision-makers should show that they are not looking for an immediate result only, but they will evaluate the effect of their own decision continually, monitor the results and adjust the structure. It is equally important to demonstrate that politicians commit to finishing implementation during their own mandate.

Planning ahead in Austria

- A federal health structure board is now in place, ensuring planning for the whole system. The board is independent and removed from any political pressure.
- Decisions on structural development will be better synchronized with the overall financial planning of the health system and of the respective region.
- All the latest developments are being used as tools – such as the quality assurance law or the new telematics law that provides opportunities for modern communication.
- The health care workers and the regional governments are included in the planning and the debate.
- There is always a focus on the constitutional guarantee of health care for all, with no exclusion.
- Any further restructuring will be planned, implemented and promoted as part of a broader development effort with benefits far beyond the health sector.

THE NETHERLANDS

"Sudden, abrupt closure is not realistic. Where will all the patients go?"

The decision and its context

Since 1974, legislation has allowed hospitals to close based on planning considerations. Nevertheless, this has very rarely been practised. The first case was many years after the law was adopted, and substantial compensation was offered. The strategy usually applied has been not to close hospitals but to merge hospitals into larger facilities. This was often done by renewing or replacing older hospital buildings with newer ones that have fewer beds. This also arouses resistance, but not as strongly as with clear-cut closures.

In the Netherlands, the reasons for hospital restructuring have usually been excess capacity at the expense of low and deteriorating quality. The national decision-makers found it easiest to deal with the "acute" cases – essential

staff lacking, infections occurring and the hospitals simply not being able to perform their functions. Another type of closure resulted from more general planning decisions, and in these cases, there was usually a long preparation phase.

The resistance – sources and reasons

- Fear that services will be lost: the local population feared that health care and curative services would be less available.
- Lost employment: both the staff and the local authorities saw the decision as a threat for local jobs.
- Fear of electoral consequences: maintaining local hospitals is a favorite topic for regional members of parliament, who would not miss a chance to use it, especially when they are well connected in their electoral region.

The lessons learned

- Think carefully about the core message in advance. Decide which of your arguments to emphasize. Containing costs is not well accepted, especially when it is given as the main reason for the decision (such as telling people that the current arrangement does not use their money properly because having too many beds and hospitals is expensive). Improving quality seemed a much better argument in the Netherlands. Just say clearly that the services provided in small hospitals are not good and not complete, although the staff will counter this argument.
- Offer compensation. This tactic facilitates the introduction of an unpopular decision. Some sort of compensation will draw the attention of the local community to the positive effect of the change: such as, for instance, other (government) employment in the region or improved transport connections (road or rail) to the new location. Such compensation is also useful because it requires an intersectoral approach.
- The resistance to be faced cannot ever be fully predicted before a decision is launched.
- Resistance is most often organized and orchestrated by various population groups who may want to stop the process of giving compensation to the communities. Health care staff or local authorities will surely use their own communication channels to the local public to influence attitudes. The decision-maker cannot counter or prevent this.
- Long, broad public discussions do not necessarily improve understanding. They are extremely time-consuming and give no guarantee that the decision will become more popular.
- Focused discussions, however, have to be carried out with all the groups directly affected. These include the hospital management, the health care personnel, all other employees, the local authority and the local population.
- Good communication cannot prevent resistance but only reduce it and its negative effects.
- The remaining outpatient facilities do not always function in the long term. They may be an intermediate option for compensation but not a good sustainable solution.

A look ahead in the Netherlands

One of the strategies used is to let a hospital wither away. This happens when decision-makers opt for a long public debate about closure, and during this debate many specialists start leaving. There are certain drawbacks, however. The hospital is in danger and it is not good that the hospital keeps deteriorating during lengthy preparations. The availability of services and the quality will surely decline, too. The Netherlands has less planning and more market-determined services. This is a dubious situation for public health decisions. On the one hand, a hospital would usually be closed for financial reasons. On the other hand, hospitals inevitably go bankrupt after a long period of poor quality. Thus, the government is torn by opposing pressures: it may want to withdraw and leave the case to market mechanisms, but if the local community makes demands about quality, then the government cannot do this. Pressed by the public, state health inspectorates will have to intervene more often than in the past. In general, however, closure for quality reasons is a winning approach. The Minister for Health has the mandate and power to enforce closures, but even he has difficulty in totally closing a hospital. The Minister usually needs the state health inspectorates to intervene and speak clearly about the quality problems.

2.3 The solutions

Participants outlined a range of ideas related to how to solve the problem of firmly pursuing health objectives while listening to the public. On some of these ideas, there was a general consensus that they are widely applicable, whereas the debate on others is still open and rich in controversy.

2.3.1 APPROACHES THAT USUALLY WORK

Quality as the flagship for introducing the decision

In some countries represented in the Futures Forum, quality is certainly the factor that shapes the decision on whether to reduce hospital beds or close whole units or hospitals. In other countries, such a decision has also strong financial incentives. In addition, a health facility often closes as part of an overall government reform, such as a strategy to move from a decentralized system to stronger and fewer regional structures or a health system reform.

In each of these cases, placing quality at the centre of the debate is a winning approach. It empowers the decision-makers to come up with a strong, simple and clear message – to say that the proposed change will allow people to consult better physicians and to have better services. Such argumentation will prevent falling into debates in which those who resist the change use purely emotional or political reasoning. Introducing the closure as a quality-related act is the most likely way to attract allies (for example, physicians and other professional staff would be very keen to talk about their own job satisfaction and quality standards, thus agreeing with the policy-makers). Lastly, when improving quality is the core driving force for making the decision, the mass media may be more likely to understand. They are sensitive to new concepts, so they would most likely support a decision based on the need for quality or at least will be less likely to reject such an argument. Talking about quality is also an easier way to get the public to understand why the change is needed.

Planning is essential

The restructuring of a hospital system has to be planned very carefully, with each consequence of the suggested change considered in advance. This will prevent a lack of resources to implement the change, such as an excessive burden on the other components of the health system that will have to compensate for the closed facilities. Planning at the national level is a matter of political legitimacy and mandate to improve public health. Also, having a good mid-term and long-term plan for how to enforce the decision allows a time-frame to be established, such as scheduling the implementation for a certain period, in which it would be easiest to monitor and evaluate how the decision is working in practice.

2.3.2 SOME CONTROVERSIES

How much time?

The debate did not bring the participants to a common agreement on whether taking substantial time for preliminary public debates to warm up public opinion is good or bad. Some national examples clearly show that this pays back as a preventive measure, reducing the potential resistance. On the other hand, implementing a decision slowly is not necessarily good for decision-makers. They may take a long time (including for public discussions) in preparing the decision. However, decision-makers implementing a decision already taken should not be seen as being hesitant but rather go into action.

How much weight should be given to the mass media?

In the end, it is not the mass media that are making an unpopular decision. It is the minister who makes it, with the legitimacy and mandate given to this post. In a way, in democratic societies, the mass media will never be totally fair and loyal partners to the authorities; they will most likely primarily be on the side of the general public. Ministers can not allow all their time to be blocked for fear of journalists, because this would mean giving journalists the right to enforce and legitimize a decision. The balance between working intensively with the mass media while keeping the mandate and goals clearly in focus is delicate; each decision-maker needs to find this balance in each specific case of launching an unpopular decision.

3. How can public demand be measured?

Case study: tobacco control

3.1 The problem

The smoking prevalence is decreasing in western European countries, but tobacco-related deaths have peaked among men and continue to rise among women. The WHO Framework Convention on Tobacco Control has been ratified and entered into force and has encouraged countries worldwide to increase tobacco control. The Convention spells out policies to control harm from smoking. Several European countries have been very active in introducing national strategies for tobacco control, and the WHO Regional Office for Europe has adopted the European Strategy for Tobacco Control and developed a database of all tobacco control policies in the Region.

In western Europe in 2005, the most recent policy developments in tobacco control are related to banning smoking in workplaces. Introducing such a strict measure can provoke resistance. Nevertheless, health policy-makers in many countries are determined to go ahead with the decision to ban smoking in public places. The popularity of this decision is directly linked to its successful implementation, and the session therefore focused on how to measure public expectations when introducing this ban. The objective was to share experiences and ideas on how to analyse and evaluate, in advance and on an ongoing basis, the level of receptivity of the general public and of specific population groups to this decision.

3.2 Examples from countries

BELGIUM

"With such a range of target groups, plan how to deal with them all, in a package."

The decisions and their context

Smoking is the leading cause of preventable death in Belgium. Since 1977, legislators have introduced numerous tobacco control measures. The regulations cover establishing product standards (composition, labelling and advertising of tobacco products), trade standards (vending machines, age limits and excise taxes), usage standards (limiting or prohibiting smoking in public places, workplaces and public transport), prevention (campaigns to prevent people from starting to smoke, cessation programmes and hot-lines). The first steps were taken in the 1980s, when limitations on vending machines and bans on image advertising were introduced. In the 1990s, smoking was banned in hospitals and schools and regulated in spaces where services are rendered (the hospitality sector). In 1997, Belgium banned all forms of direct and indirect advertising and sponsorship, and age limits were established in 2004. Tobacco sponsorship will not be allowed after 2005. See Table 1 for the general opinion trends on these measures.

Measure	Smokers	Non-smokers	Young people	Managers of public places	Hospitality sector	Retail trade sector	Manu-facturers
Composition standards (carbon monoxide, nicotine and tar)	0	0	0	0	0	0	–
Composition standards (ban on sweet ingredients)	0	+	0	0	0	0	–
Large warning messages and pictures	–	+	0	0	0	–	–
Age limit (16 years and older)	0	+	0	0	0	–	–
Ban on sales of chocolate "cigarettes"	–	–	–	0	0	–	–
Advertising ban	0	0	(–)	0	_	–	–
Sponsorship ban	0	0	0	0	–	–	–
Smoke-free public places	–	+	0	+	–	–	–
Smoke-free public transport	–	+	0	0	0	0	–
Smoke-free workplaces	–	+	0	0	–	–	–
Price rises	–	+	–	0	–	–	±

–: negative; +: positive; 0: no opinion.

Table 1. General opinion trends among stakeholders on tobacco control measures in Belgium

The difficulties

- Dispersed responsibility in Belgium, responsibility is delegated at different levels. At the federal level, the Minister for Health is responsible for the tobacco plan; the Minister for Finance controls prices and the Minister for Employment and Labour deals with smoking at workplaces. Prevention is mainly the domain of regional governments. The tobacco plan must be approved by the Council of Ministers, and before that by the Prime Minister. The plan is influenced by the European Union (EU) directive and the WHO guidelines. The tobacco plan was discussed between the regions at one of the regular interministerial conferences. Thus, in a situation of many institutions and conflicting interests, the role of the national health administration is to coordinate all this and to lead.
- Controversy: tobacco control measures draw enormous political and mass-media attention. They have been equally applauded and criticized.

The mistakes made when introducing the decisions

- Wrong manner or wrong timing in communicating the new regulations: this influenced negatively the popularity of the decisions. For instance, when a new regulation was suggested, it was a time when the public still remembered the government failing to ban chocolate cigarettes.

- No long-term, holistic planning: some measures were introduced when there was still no complete national tobacco plan. Thus, a tobacco control decision was accepted with irony because it was launched in the same week when the Ministry of Health announced that people smoking cannabis under certain conditions would not be punished.
- No financial components: when the health authority tried to develop alliances to support the proposed measures, it became obvious that establishing such networks would have been easier if the measures included some financial analysis and planning.
- Evaluation was not an integral part of the tobacco plan.

The lessons learned in Belgium

- Carry out consultation at all levels. Nevertheless, consultation takes time.
- Develop a network of countries in Europe. The argument about what other countries do is important for politicians. Networking with other countries (Ireland, Sweden and the United Kingdom) contributed substantially to convincing the government that it should stay firm and continue with the decision. WHO can help on this.
- Evaluate the new mechanisms and check that they are complied with and then adjusted. For example with restaurants becoming smoke-free, a good mechanism to help restaurants in controlling compliance is essential. This helps inspectors to observe the implementation of the decision. This is essential for popularity: measures that are poorly implemented cause resentment and are questioned, whereas rules that are well enforced become popular sooner or later.
- Different target groups often have conflicting interests. The decision has to reflect this diversity. One way is to raise awareness among each of the targeted groups of the population.

IRELAND

"Your right to smoke does not include a right to harm others. This law is about protecting people at the places where they work and not about freedom of choice."

The decision and its context

On 29 March 2004, smoking became illegal in all enclosed workplaces, including those in the hospitality sector. Since 1978, severe legislative measures against tobacco have been introduced: tobacco advertising was restricted, sponsorship prohibited and smoking in public places limited. Significant work has been done on health promotion and offering nicotine replacement therapy. Strong fiscal measures were also in place – Ireland has the third highest price of cigarettes among countries in the EU. The health authorities wanted to increase that price even more but had difficulties with the Ministry of Finance because tobacco is part of the consumer package. Selling chocolate cigarettes is illegal. Two strategic national papers were developed: on a tobacco-free society (2000) and on the harmful effect of second-hand smoking (2003). The new ban has been broadly

complied with since day one. Today 90% of all hospitality places are smoke-free, and the remaining 10% are in the process of adapting to becoming smoke-free.

The resistance – sources and accusations

- The usual claim was made about the rights of smokers and the freedom of choice.
- The "nanny state" claim: accusations were made that the state had no business intervening in citizens' choices when they use a legal product.
- Ventilation would have been enough. The critics of the ban often brought up this argument, but in Ireland this accusation had a positive effect because decision-makers were ready with the evidence that ventilation is actually not enough and communicated this message frequently.
- The hospitality sector: in Ireland a licence is needed in the hospitality sector, so ignoring the law is not an option. Once it was made clear that the act referred to the whole sector, restaurants accepted, so the pubs were the main problem. The Dublin pubs are business-oriented and the non-Dublin pubs are more family-type. The first were more concerned with enforcement, which made a rational debate with them possible. The second group was very defensive and used public relations methods to undermine the act. From nowhere, an association of the hospitality industry appeared and started to oppose the act. It was found that the tobacco industry sponsored this group.

Tactics and strategy to ensure success: the Irish way

- Political consensus: all parties reached a consensus that action was required. The Minister for Health got passionately involved in the cause and made tobacco the top item on his agenda. Thus, the only blame the decision-makers actually got was that they were not implementing quickly enough.
- The proposed reform was justified with strong evidence about the harms and risks of second-hand smoking.
- Public awareness: the two national reports had prepared the evidence that second-hand smoking kills.
- Clever, unbeatable entry point: workplaces and public places were clearly distinguished. For the first, the ban meant protecting workers; for the second, it would have meant changing lifestyle and habits.
- A consistent message: health authorities kept repeating that a pub is a workplace until smokers had difficulty in saying that they did not care about the small bunch of people who work there. Decision-makers did not allow distraction when talking to the public; they kept repeating that the new law was about workplaces and not about a person's right to smoke. They countered and rejected the "nanny state" argument, showing that many groups of people actually expect the state to take action to protect them and would sue the state on the basis that they have not been properly informed.
- A 14-month running-in period was envisaged to allow solid preparation.
- Advice on jurisdiction was ensured in advance, from the United States, and dedicated legal officers were available all the time.
- Publicity campaigning: there was huge mass-media interest, with features, whole pages and discussion programmes. A separate mass-media campaign focused on the support for people who want to quit.

- Preparations were made to confront business, with plans for how to do this, so they did not get too strong.
- An enforcement mechanism was available right from the start.
- Mobilized opposition: there was a strong alliance of nongovernmental organizations, prominent in organizing actions, with which the health authorities linked up in advance. They mobilized considerable mass-media work and covered quite a wide variety of backgrounds in the public consensus-building.
- Public opinion surveys were not conducted before the decision was launched. It was a purely political judgement that the health authority must act on smoking in workplaces. Surveys were carried out only after the launch and revealed that most of the population approved.

The lessons learned in Ireland

- Look at where you are at the start and gather all the scientific evidence.
- Do not allow the sector to dominate the debate and change the focus; keep up with the core message.
- Be ready for all sorts of legal challenges.
- Public relations advice is very useful.
- Quote the EU directives as much as possible.
- Consider exemptions: private dwellings or places that can be considered as such (where paid service is provided); or psychiatric hospitals. Do not be too purist.
- Preparation pays back: most of the work was done in advance.
- Doing it on a national scale is the winning approach. An eventual choice to do it locally may bring huge problems.

MALTA

"If you know the sector is not ready for a new law, compromise rather than have everyone violate the new act. Such a compromise, however, is possible only if the decision is popular with the general public."

The decision and its context

The act on smoking in public places came into force in October 2004 for premises larger than 60 m^2 and is being enforced as of April 2005 for smaller premises. Smoking in public places is allowed only in areas that are clearly identified and separated, and nonsmoking rooms are also clearly marked.

The national Tobacco Smoking Control Act is from 1986. Mass-media advertising is prohibited, health warnings are in place, tobacco sales are under control, sweets cigarettes are illegal and the legislation on labelling tobacco products introduced in 2004 is very restrictive.

Malta has a relatively low share of the population who smoke regularly: 25.7% of the total population, 30.3% among men and 21.3% among women.

Public opinion

The health authorities were certain that the public would be generally positive towards the new act. Several opinion polls were carried out starting in 1999, with the last one in October 2004 (Box 1). Various types of surveys were conducted, and most revealed great and increasing public support for having public places smoke-free. This gave a strong argument to the health authorities to proceed with the new act.

BOX 1.
PUBLIC OPINION SURVEYS IN MALTA

- In 1999, a telephone opinion poll indicated 76% support for smoke-free public places.
- In April 2004, a telephone opinion poll indicated 83% for smoke-free public places, although 54% opposed a ban in discothèques.
- In March–May 2004, newspaper surveys indicated 78–82% support for smoke-free public places.
- In October 2004, a telephone opinion poll indicated 70% support for the currently launched regulations.

The resistance

Resistance came from the hospitality industry. They did not react until only one month before the enforcement date, when they started to complain that the new act would mean they will lose business and have to close.

The tactics to ensure acceptance

Backed with clear evidence that the general public supported the decision, health authorities felt strong and agreed to make a compromise: to give the hospitality sector a chance. They knew that the sector was not ready – analysis showed that if no step-by-step approach was taken in implementation, the whole sector would have started to violate the new act. Hospitality places were given time to install ventilation systems. The decision to provide for a transition period then turned out to be rather unpopular – stimulating some negative public reaction about slow implementation of this popular law. Today, enforcement is being checked regularly.

The lessons learned in Malta

- If you decide to consult, consult everybody. In Malta, a committee was established that involved practically all stakeholders.
- Public opinion surveys should be conducted regularly to monitor the acceptance and popularity of the decision.

NORWAY

"Our choice was to link to the global message about tobacco-related deaths. The developed world has an ethical responsibility in tobacco control."

The decision and its context

In 2004, a new act was adopted that banned smoking in all bars and restaurants. No exceptions or exemptions are allowed. No smoking rooms and specially designated areas are permitted. The Norwegian Tobacco Act from 1975 was one of the first total bans on advertising in Europe. Since 1988, certain workplaces have been smoke-free. In an environment of public attention increasingly focused on health in general, there is also an increased public acceptance of tight control measures. The state has been steadily increasing the funding, and more targeted and strategic efforts have been made. Nongovernmental organizations and the public health services work together.

The smoking prevalence has declined considerably in recent years, even from 2002 to 2003: from 29% to 26% among adults and from 28% to 23% among 16- to 24-year-olds *(Fig. 1)*.

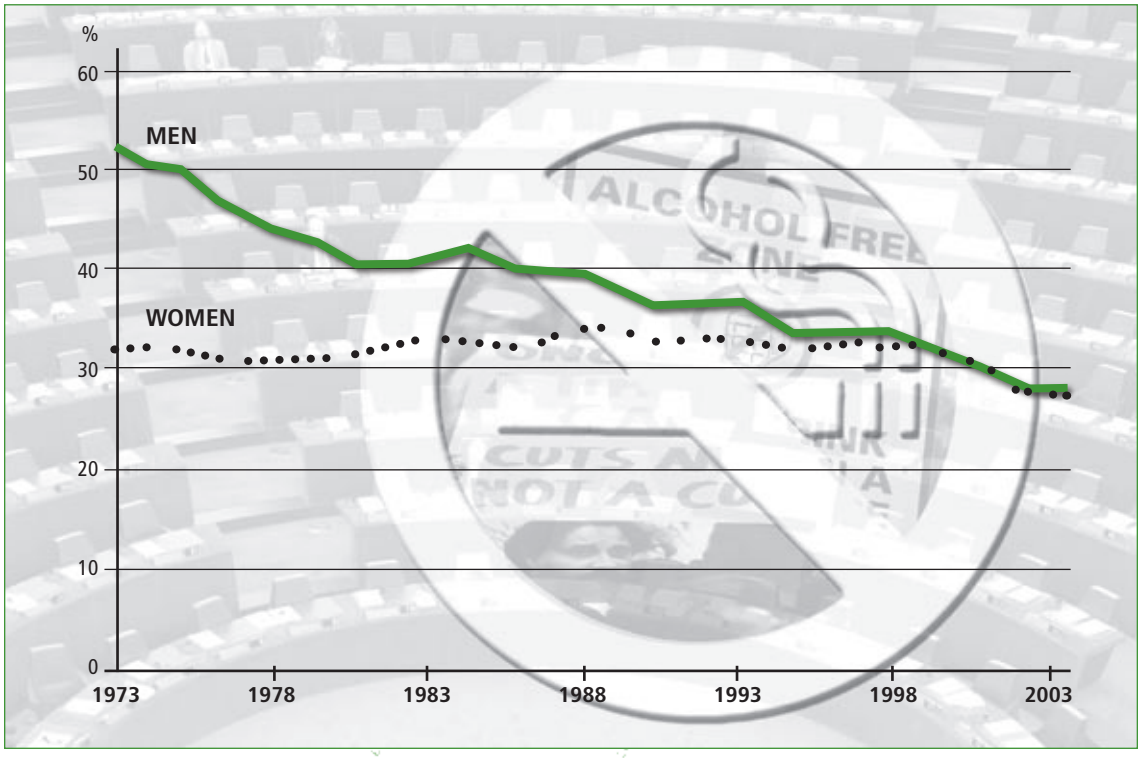

Fig. 1. Smoking prevalence among adults in Norway by sex, 1973–2003

The strategy to ensure success in Norway

- Massive mass-media campaigns: were launched not only on the specific new act, but also in general about the health hazards of smoking and about the dirty business of the tobacco sector.
- Not an isolated effort: the act was enforced as part of an overall effort of the state to protect citizens. Some of the parallel actions that created the setting for the new decision to be well accepted were: strong legislative and taxation policies, smoking cessation programmes, special programmes in the education sector to reach young people and continual dissemination of well-targeted information.
- Use all possible and all the best sources of evidence: scientific magazines, research, WHO data and the WHO Framework Convention on Tobacco Control.

3.3 The solutions

Participants outlined a range of ideas on how to solve the problem of measuring public demand when launching a potentially unpopular decision. On some of these ideas, there was a general consensus that they are widely applicable, whereas the debate on others is still open and rich in controversy.

3.3.1 APPROACHES THAT USUALLY WORK

Introducing a potentially unpopular decision requires strong political will and commitment to enforce it. However, carrying out this commitment to full implementation depends considerably on public acceptance. Thus, measuring public opinion is generally seen as a powerful tool for decision-makers seeking change. An important dimension of this is to base national decisions on international networks and thus on the knowledge and experience of other countries. In tobacco control, countries felt that WHO plays a central role; the WHO Framework Convention on Tobacco Control is one of the best international instruments as a reference for national actions and shaping public opinion in countries. WHO also influences public opinion by providing evidence, which boosts the popularity of the proposed measures.

3.3.2 SOME CONTROVERSIES

On what scale?

In some countries with a very decentralized administrative structure, policy-makers may hesitate to introduce the bans on a national scale or on a regional and local scale. There are examples when very committed regional governments would implement much stricter measures than those chosen by the national government; nevertheless, there are drawbacks in a decision to leave a core, nationwide public health issue to the choice of regional authorities.

How courageous is a minister expected to be?

The chief medical officers participating generally felt that political figures such as health ministers are often confronted with opposition to their decision and that such opposition is not always and necessarily negative. Going ahead with a decision, even when it is not well accepted, can turn out to be a very popular choice for a

politician. In the long term, a politician may be very popular when the public knows and sees that he or she is firm and courageous, as was the case in Ireland. It is a winning position for a minister to go into battle with a sector whose products are proven to harm health. If the evidence for such harm is clear, this will boost the popularity of a minister who decides to go ahead and fulfil the mandate to protect public health. However, a minister must concretely choose how and to what extent to act firmly. Feeling the pulse of public opinion may help but may sometimes mislead a politician, blurring the vision – he or she may decide to choose a compromise to respond to public demand, but from a public health perspective this compromise may be too great.

4. How to predict how the public will accept a decision

Case study: alcohol policies

"Decisions that result in people receiving financial benefits, services or information are usually popular. Decisions that make people give or pay are usually unpopular."

4.1 The problem

The WHO European Region is the region with the highest per capita alcohol intake worldwide. The Nordic countries have traditionally had restrictive alcohol policies since the 1950s, but recently southern Europe has become more strict, especially in controlling the advertising of alcohol products. Restrictive policies have been broadly challenged. In northern Europe, there have been long debates about how to deal with the latest developments, such as aggressive marketing targeting children and young adults. The alcohol industry seems to have learned from the tobacco industry experience and has developed, innovatively and proactively, their own harm reduction strategies to undermine the work of public health and use its tools. In some European countries the alcohol control policies have been dominated by direct restrictions, without sustainable links to pricing, licensing or other policy instruments. Introducing such restrictions is intrinsically unpopular with the population.

In this session, participants presented specific measures to reduce harm from alcohol consumption and shared how public opinion could be predicted and how the results were used in adopting the measures. A special focus was given to the means governments may employ to increase the acceptability of measures to reduce alcohol harm among the population.

4.2 Examples from countries

FINLAND

"This case differs from tobacco. For alcohol, the evidence on harm and risks is more complex."

The decision and its context

Alcohol policy measures were introduced in 2004. Import for personal use was allowed. The tax on alcohol, especially spirits, was lowered, to prevent a large-scale illegal market and imports. The alcohol policy in Finland has been quite restrictive for years. Recently, there has been a process of stepwise liberalization. Nevertheless, the national policy traditionally has two main instruments – high prices and a state monopoly. Economic and

financial incentives were given priority above health targets. Import for personal consumption used to be totally banned.

The new regulation reflects the status of the country as a EU member. Due to the common EU regulations, import for personal use from EU countries had to be allowed as of 1 January 2004, and in March 2004 the alcohol tax was lowered. This poses a great challenge, because several neighbouring countries, such as Estonia, Germany, Latvia and Lithuania, have lower alcohol prices. Alcohol consumption increased 22% immediately after lowering of price, but the increase later levelled to 10% compared to the same month one year earlier.

The difficulty of predicting

There is a discrepancy between the results of the public opinion surveys *(Fig. 2)* and the data about the actual behaviour of consumers. Health authorities in Finland find a significant imbalance between the declared acceptance of restrictive policies and the figures about the increased consumption. Polls show that support for restrictions is increasing; however, the drinking pattern contradicts this.

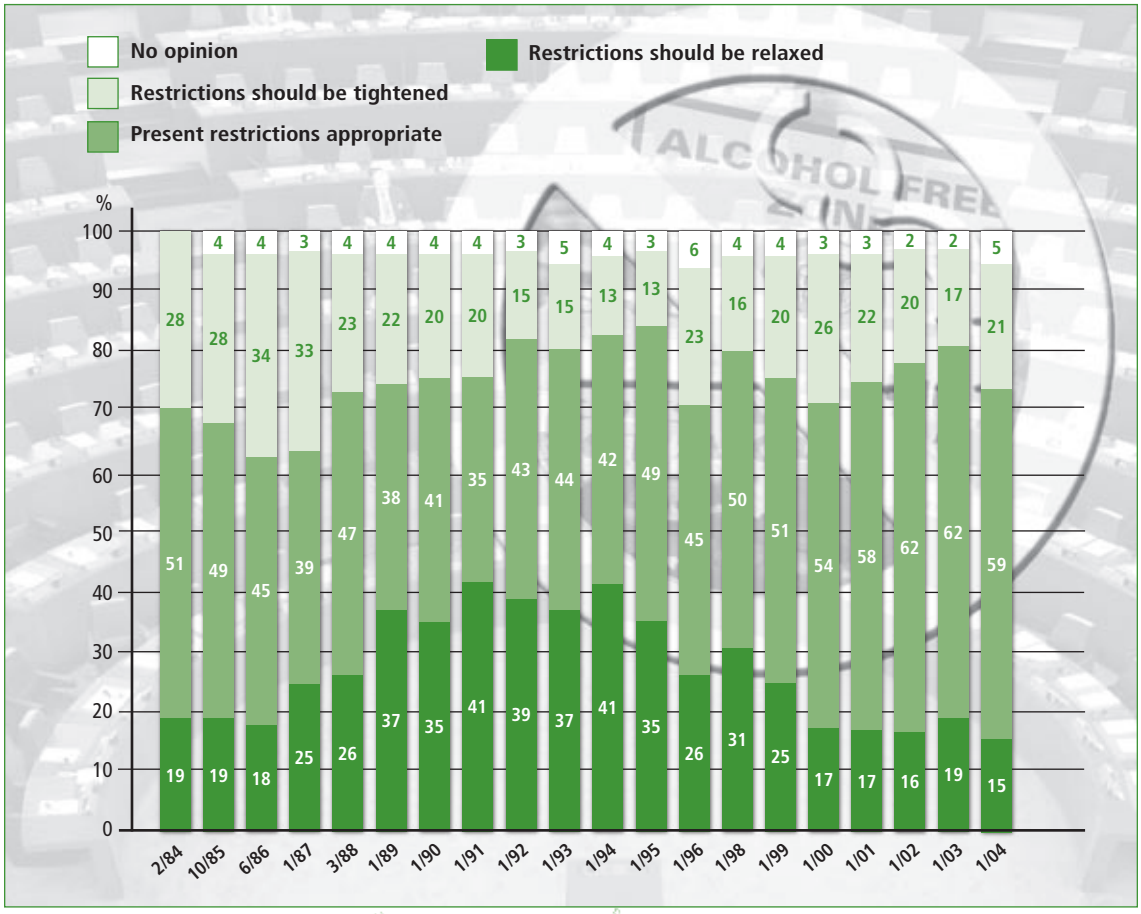

Fig. 2. Public opinion on alcohol policy restrictions in Finland, 1984–2004

A mistake

The approach has been to give priority to the economic and financial incentives and targets. Thus, health targets were left in the background.

The lessons learned in Finland

- Restrictive measures have a sort of hidden unpopularity. In polls, people declare they favour restrictions but drink more, in reality taking advantage of liberalization. There is no consensus on whether lowering prices leads to increased consumption. According to the European Commission, making such a connection is not fair and the correlation is not at all clear. However, national data and statistics show the opposite – such a link exists, and consumption did rise as a result of the liberalization. Contradictory conclusions may therefore be made for the same reasons in trying to predict acceptability.
- Campaigning is not necessarily effective. The experience in Finland shows that authorities cannot predict whether a certain decision will be generally accepted if they measure the effect of one separate campaign only.
- Involving young people is always a winning approach. Through existing school programmes, young people themselves analysed the results of surveys and got involved in the debate about the state alcohol policies. Thus, participation of a core target group is a desirable tactic in striving for (and thus predicting) the acceptance of a given policy.
- Involving health workers has unexplored potential to boost acceptance of restrictive policies. In Finland, the Department for Family and Social Affairs is responsible for state alcohol policy, not the Health Department. Thus, it is natural to expect that the restrictive measures would be more acceptable if health professionals are involved in promotion, especially those working in primary health care.

An observation: a decision may be acceptable, but this is not necessarily always in the interest of public health. In Finland, the alcohol business is very prosperous and is the driving force of liberalization. It strongly influences the national mass media, which also voice their support for liberalizing the alcohol market.

NORWAY

"At one stage of the campaign we had reached a point where the mass media compared the minister with a member of the Taliban. However, he was not alone: both the government and the parliament made a political commitment to reduce alcohol-related harm."

The decision and its context

Alcohol policies in Norway include high alcohol taxes, a state retail monopoly, an age limit of 18 years for purchasing alcohol, strict limits for blood alcohol concentration among motor vehicle operators, limitations on opening hours and the number of outlets, and a ban on alcohol advertising. Norway has the lowest percentage

of adults who drink of any country in Europe. However, consumption has been rising dramatically, especially among young people – it has more than doubled among young girls.

Many restrictive policies are already in place, but most of these restrictions have been challenged.

The resistance – sources and reasons

- Strong lobbying by the industry: the industry strongly challenges alcohol legislation as being ineffective in reducing harm.
- Certain pressures from the EU: courts have been introduced as a tool to decide which policies to implement, whereas in Norway health authorities would like to mainly consider the social dimension.
- Prices have decreased by 40% relative to income over a period of 30 years.
- Increasingly negative attitudes: the issue of individual freedoms is brought more and more often into the debate, and there is less tolerance towards government intervention. Cross-border shopping negatively affects people's attitude towards taxation.
- The mass media are not always supportive – when there was a price war in beer outlets, the mass media called the state organs "the beer police" because they were trying to control prices.

The tactics to make the policies more popular – choosing a core message and firmly adhering to it throughout all campaigns

The main choice was to focus on the harm dimension. Preliminary analysis showed that the alcohol-related harm to health had been underestimated and not sufficiently discussed by the public. The ministry linked all policies to harm, bringing the best evidence about both health and social consequences. This was an unexpected entry point – discussing alcohol harm by focusing on areas that are not usually associated with alcohol. For instance, public attention was drawn to how the pattern of drinking influences the types of injuries and violence. A special focus was the harm caused to third parties. The message was that increased consumption will increase the harm.

- Alcohol is not an ordinary commodity and therefore requires a package of measures.
- Public opinion needs to be monitored continually.
- All kinds of mass media should be used, including a web site.

The lessons learned in Norway

- Success can be predicted by sticking solely to the public health perspective – that the policies aim to reduce alcohol-related harm.
- Aim to increase knowledge rather than to change behaviour.
- Campaigns are very useful for increasing knowledge about effective policies. However, campaigning cannot substitute for policy.
- A public health alcohol policy cannot be implemented without the support of the population.

4.3 The solutions

Participants outlined a range of ideas on how to forecast whether a decision will be well accepted by the public. On some of these ideas, there was a general consensus that they are widely applicable, whereas the debate on others is still open and rich in controversy.

4.3.1 APPROACHES THAT USUALLY WORK

One possibly successful approach is to talk about the problem in a way that has not been explored before, in the light of another problem that is not always clearly associated with the one addressed by the decision. For instance, in several countries the focus was on road accidents and injuries due to drunk driving. From this angle, health authorities challenged advertising, sales or other "weak" points in their national alcohol control. Another such "entry point" is domestic violence as a result of drinking. Harmful effects on children and especially the harm caused by pregnant mothers' drinking is also a strong selling point. Another one that would be especially effective in reducing consumption among young people is an attack on binge drinking in weekends. Such an approach is likely to lead to positive effects on the public.

Taking the best advantage of existing and newly formulated EU legislation is essential for national alcohol control policies. Nothing in current EU legislation obliges countries to import or advertise products that are clearly proved to bear a health risk. Once a country has clear evidence for such risks, it can limit imports. The new EU Constitutional Treaty has provisions for the first time that tackle the alcohol problem. Sweden and Finland expect the European Commission to counterweight the industrial and commercial advertisement side. An EU alcohol and health strategy will be developed in the next year. The focus will be on harm, because the predictions are that this is the only way to sell it to the public in countries. If national policy-makers refer to these international developments, they can foresee higher acceptability of otherwise unpopular alcohol control decisions.

It is also important for decision-makers in public health to dwell on successful approaches in reducing harm from alcohol and to reduce alcohol consumption in countries. Different perceptions and traditions on alcohol consumption have to be taken into account, for example between the countries in southern and northern Europe. One can build on these differences and identify approaches that usually work. Countries expect WHO to provide strong leadership.

4.3.2 SOME CONTROVERSIES

Should the public health sector work with industry? Views vary, but the general feeling is that public health cannot sustain counteracting several powerful industries (tobacco and, recently, the food industry as the next big rival).

To add to this complexity, drinking is very culturally nuanced. Wine drinking is quite traditional in southern Europe, whereas beer drinking is often thought of as a Nordic habit. Further, the scientific message makes a distinction – with consuming very small quantities of alcohol, benefits can outweigh risks among non-pregnant

adults. In short, the message is not simplistic by far. This makes declaring a war on alcohol a difficult decision, and the potential unpopularity is predictable.

The public health perspective on moderate drinking is therefore not uniform. Unlike the case with tobacco, in alcohol control it is also about how much people drink: the consumption patterns. No uniform answer exists to the question of what moderate drinking is. In this regard, considerable education, information and communication campaigns are needed. However, they cannot do all the work. The alcohol industry is already promoting such messages as “drink smart” and “drink responsibly”. This is why some counties have adopted a tougher approach of introducing severe restrictions, whereas others do not think that such a model will work in their cultural context.

5. How to pre-empt opposition and make decisions more acceptable

Case study: user charges for health care

"What is this? A disease tax? Do you really want to charge the sick?"

5.1 The decision

Many European countries have introduced formal charges for each visit to a physician. Among the participants of the Seventh Futures Forum, Malta is the only country without such a system of co-payment.

The common argument for introducing user charges is that this will discourage the overuse of health care services. The goal is usually cost containment. In most EU countries, such co-payments are a way of co-financing the health care system and diversifying the sources of funding. Health authorities that introduce user charges have an interest in ensuring that the decision does not negatively affect the utilization of services that are essential for people's health and, ultimately, the health status of the population.

5.2 The context

5.2.1 THE GUESSWORK MAY BE MISLEADING

A number of assumptions form the basis for this decision. Many policy-makers take it for granted that:

- people are well informed and will give up only the visits that are not useful for them,
- people can clearly distinguish between necessary and unnecessary care,
- people can make informed decisions about utilizing services,
- health professionals or purchasers will not mind collecting the charges, and
- the financial benefits are greater than the administrative costs for sustaining the system of user charges.

5.2.2 THE REALITY – A MIXED PICTURE

When does it work?

Some countries find user charges very beneficial. This practice has reduced the number of visits to emergency centres (in cases when such units were regularly visited for minor, non-urgent problems) and prevented drug abuse by imposing co-payments for drugs (when such co-payments are regulated according to population group).

What are the negative effects?

The measure is likely to mainly affect people with lower socioeconomic status. Only poor people would decrease the use of services because of increased price; people with higher income do not change their utilization patterns. Hence, the measure inherently affects equity. This is especially true when the charge is a flat rate. This is inequitable for poor people because the rate may comprise a large share of the income of a poor person but a very minor portion of the income of a rich person. People with chronic illnesses are also disadvantaged, as they require health care more frequently than the healthy population. Some national cases confirm this negative impact: when charges for hospital admissions were introduced, only those who were unable to pay were prevented from staying in hospitals, and this affected their health. The same effect applies to preventive care: preventive visits and services are most needed among people who are poorer and more ill; however, preventive services are the first to be given up by these groups when user charges are imposed.

5.2.3 SOME CONTROVERSIES: THE POLICY IMPLICATIONS

Who takes this decision and why?

In most cases, the motive to introduce user charges is purely financial. The finance or economic ministries often take the decision, and the public health sector is not the driving force. This means that the decision will be enforced even if user charges have no clearly proven health benefits.

Is the decision popular for the health sector itself?

When the decision is forced on the health sector, health authorities and health professionals are confronted with the obligation to implement a measure they did not initiate. Explaining to the public why an unpopular decision was taken is difficult for those who have not been involved in taking it.

Where is the money going?

Justifying the burden of new charges or increased charges is complicated because health authorities are not always ready to substantiate this from a public health viewpoint: for example, does the measure finance curative or preventive care? From a public health perspective, health authorities may prefer to promote user charges as a means of strengthening preventive health services: that is, to state that the measure will help make preventive care inexpensive or even free of charge. Presenting the decision with such a vision may actually encourage citizens to use preventive care and may increase the acceptability. Nevertheless, the popularity of such an approach may be questioned: polls often show that the population prefers that the state ensure good curative rather than preventive care.

Is it financially reasonable?

The costs for administering the user charges often turn out to be higher than the inputs to the health system in practice: for example, the costs of collecting the charges and identifying the people who should be exempted from them. In several countries, the actual net gain is quite small due to the high costs of administration. In addition, many health insurers and providers do not accept the system of user charges, as they impose a heavy additional administrative burden.

Will the public trust you?

When one European health minister introduced user charges with the statement "this is only one euro!", the population may remember the process of introducing co-payments for hospital treatment. Those co-payments kept steadily rising over the years, and the public may therefore not be willing to trust a politician when he or she says a user charge is a one-shot measure.

5.3 Solutions and approaches that usually work

5.3.1 DIFFERENTIATE

The decision will be more acceptable if charges are introduced together with mechanism for protecting the most vulnerable population groups – such as poor people and people with chronic illnesses. In some countries, consultations are free of charge for people with very low income, and most countries use an exemption system to ensure that people with chronic diseases can utilize services. This makes the measure socially acceptable and removes the justification for the mass media to attack the introduction of or an increase in user charges based on reducing equity.

5.3.2 INVOLVE HEALTH

The health sector needs to be involved in the whole process – taking the decision, establishing protection mechanisms and explaining the health arguments and the expected health benefits. This may facilitate work on increasing acceptance. Such involvement is needed among the public health sector as a whole to avoid having the finance ministry take the lead in communicating about user charges. Strong involvement among health professionals is advised; they ideally commit themselves to explaining the decision to their patients instead of the common practice of forming alliances with patients opposing the decision.

5.3.3 PREPARE

It pays to take time before launching such a decision. In one case (Slovenia), when the decision was made to introduce co-payment for prescription drugs, the health authorities carried out discussions with all stakeholders – physicians, pharmaceutical companies, patient groups and mass media. Only then was the new measure introduced for adoption in the parliament.

5.3.4 FOCUS ON PROVIDERS

In many cases, the high costs of health services are driven by supply. Charging the users as an isolated measure is therefore unlikely to contain costs significantly unless the providers have incentives to deliver effective care. Targeting the supply side (providers) and the purchasers of health care services is equally important.

6. The respective technical and political roles in handling unpopular public health decisions

"As a chief medical officer, you cannot attack or criticize the minister in public. Neither should he or she do the same to you. The higher you are in a structure, the more loyal you need to be to the others working in the same field."

6.1 The problem

In a democracy, two main actors have the legitimacy and the mandate to take decisions in the field of public health: the politically appointed people – health ministers, and the technical experts or civil servants – director-generals for health and chief medical officers. The popularity of decisions may be influenced by this separation of roles, functions, power, responsibility and accountability.

6.2 Some lessons learned

There is no one-answer-fits-all solution to the problem

Different countries have very different arrangements, with various regulations and separation of responsibilities. Nevertheless, several key principles are in place in all democratic societies.

Everybody works in a political framework

In public health, achieving results is unrealistic if you choose to work outside and beyond the political framework. All actors have to relate to the political level in every decision they make. This does not deny chief medical officers the right to take decisions alone, but each and every decision they make has political impact of which they must be aware. Most chief medical officers and directors-general find it important to achieve political acceptance for the decisions they take. This is especially needed in countries where they have certain executive power and are therefore responsible for implementing the decisions taken by the minister.

There is no such thing as complete independence

Clearly separating the responsibilities of the chief medical officers and of the ministers is very difficult and, in some countries, impossible. The two actors work very closely together. In a well-functioning health system, the technocrat gives strategic advice to the minister and also has a range of executive powers, and the minister regularly asks for technical analysis and advice, basing political decisions on the technical knowledge. In some countries, the law strictly defines the normative roles of the chief medical officer or director-general to ensure that political considerations do not influence technical judgement. Nevertheless, most countries see no clear demarcation between the political and the technical roles.

When in crisis

Countries differ in their chosen lines of mandate, authority, responsibility and accountability in emergency situations, such as the outbreak of an epidemic. Directors-general in some countries may take over the responsibility to communicate with the public and the mass media, to explain the risks, uncertainties and the decisions taken. In such situations, they are sometimes authorized to make independent judgement and act, while keeping the minister informed. In other countries, however, the minister takes the lead and handles the crisis, with all the intrinsic drawbacks of acting without consulting the technicians. In a third case, a country has established an emergency board. Headed by the chief medical officer, this board supports the minister, makes the political discussion shorter and improves the acceptance of the urgent measure.

A third-party mechanism

Parliament: a good balancing mechanism is the possibility of a parliamentary inquiry. In controversial cases, this inquiry would analyse the roles and inputs of the various players.

Mass media: in a few countries, any civil servant has the right to contact the press directly. This applies in different situations – when a chief medical officer has not listened to someone lower in the hierarchy but also when a minister did not take into account the advice of the chief medical officer. In principle, bringing the case to the mass media would be normal in a democratic system, to the extent that the ministers are accountable to the general public, their constituents. However, actors choose to have an open discussion through the press in very few cases. Usually coordination and discussion takes place.

Regional and European authorities also have a role

The existing decentralized, federal structure in some countries and the emergence of health policy-making at the level of the EU further complicate the balance of roles and responsibilities, adding other dimensions (national versus regional and national versus European) to the understanding of roles.

7. Conclusions

How to make public health decisions more acceptable

"The Seventh Futures Forum showed that decision-makers can have difficulty in talking about and tackling unpopular decisions in public health."

Participants agreed that very clear distinctions are required in several areas regarding the popularity of decisions.

Theory versus practice: popularity "happens" when a decision is being implemented in real life. Making decisions more popular is therefore no academic exercise but one that deals with actual endorsement.

Image versus health gains: in terms of their popularity, decisions fall into two categories – those that aim to solve a specific health problem and bring health gains and those intended to boost the personal popularity of specific politicians (populist decisions).

The whole population versus specific groups: the possible negative reaction of the general public may force decision-makers to not introduce a decision that would benefit a specific target group (patients, low-income people or disadvantaged people). Popularity depends on the population groups affected and which ones express their views on the decision.

Unpopular versus acceptable: a popular decision is usually the one that results from broad public demand. An unpopular decision is often the one that does not respond to clearly expressed public expectations but rather is made because the minister and/or the chief medical officer know that this is the right thing to do and will bring health gains and improved quality. Thus, a potentially unpopular decision should not be pushed to be made popular but, rather, to be made understandable and acceptable.

Material versus moral values: the public expects politicians to explain whether material or moral values formed the basis of proposed decisions in public health. The popularity of a decision depends strongly on the answer to this question.

Constant consultation versus direct action: politicians have the legal mandate to take decisions on behalf of and for the benefit of people. Accordingly, they have the right to act without necessarily going back to the public every time they want to make a decision. Popularity is therefore linked to finding a good balance – how often a decision-maker looks for the approval of the public, for what type of decisions and at which phase of introducing the decision.

When an unpopular decision is to be launched, participants agreed that health executives are advised to use apply some of the following approaches.

Talk about health and quality improvement. Health is the core area of expertise and competence, and the explanations of how the decision will improve the quality of health and health services should therefore

come first. Avoiding non-health arguments that are difficult to sell may be useful – for instance, in the case of hospital closures, it is much better to talk about improving quality than about containing costs.

Offer compensation. Explain what people will receive to balance what they will have to give up. Offer some gains in other sectors or in other services; work to make a win-win interpretation of the coming decision by balancing good and bad news.

Be strong on implementation. If health authorities are not ready to implement the decision, they should refrain from introducing it until they are ready.

Be transparent. Who is taking the decision? What are the stakes of those involved and affected? Who are all the stakeholders? Are they involved negatively?

Avoid one-shot decisions. Design and propose the decisions as part of an overall plan or strategy.

Timing is essential. Before making a decision, it is good to take enough time for developing a good plan and preparing. When the plan is ready, the best choice may be to act quickly for implementation.

Involve all groups. Bring into the discussion both the disadvantaged groups and the ones who will benefit from the decision. Diversify the approach.

Do not expect mass-media comfort solely because the decision is the right one from the viewpoint of health gains. The mass media cannot be expected to be always neutral or positive; they may often be brought into the debate by the opponents of the decision. Be prepared to face problems with the press.

Some modesty helps. the acceptability of the decision is higher when decision makers acknowledge in public that there is some uncertainty about the result and they commit openly to monitoring and evaluating these results. This leaves the door open for adjusting the decision depending on what happens in the process of implementation.

Be ready for quick changes. Sometimes the feelings of the public change quickly and what was perceived as opposition can turn into acceptance.

Be ready for crisis and unexpected side effects. Certain groups of populations can be especially impacted by a decision (such as general practitioners with hospital closures, or other sectors of society). Public health decision-makers have to cope with reactions that were not planned.

Stick to good evidence. Public acceptance may be low not based on any objective grounds. Having good facts is a good way to shape the debate and avoid resistance.

Use examples from other countries. Decision-makers may look at what is being done elsewhere and explain why other countries deal with a problem differently. Decision-makers can use such arguments to make decisions more acceptable in their own country.

Involve health professionals.

Be courageous.

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ISBN 92 890 1069 X