



# THE FUTURE OF HEALTH – HEALTH OF THE FUTURE

Fourth European Consultation on Future Trends



Also, we recognized that there would be a need in every area of the foresight programme to... recommendations

on the implications of its outputs for skills education and training in the United Kingdom and for sustainable development

# THE FUTURE OF HEALTH – HEALTH OF THE FUTURE

Fourth European Consultation on Future Trends

Keith Barnard (editor)

Preface by John Wyn Owen CB



PUBLISHED ON BEHALF OF THE WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR EUROPE BY THE NUFFIELD TRUST



  
**The Nuffield Trust**  
FOR RESEARCH AND POLICY  
STUDIES IN HEALTH SERVICES

We can break out of the box. We can look ahead. I suggest we look for new

*The Fourth European Consultation on Future Trends, held in London on 13 and 14 December 1999 and hosted by the Nuffield Trust and the WHO Regional Office for Europe, considered the prospects for implementing the HEALTH21 policy framework. It explored the future environment of health in Europe and anticipated future problems and opportunities. A point of departure was provided by the results of a study carried out by the University of Cambridge entitled "Policy futures for UK health". The participants included those involved in the study and other aspects of the Nuffield Trust's programme, those who had participated in the preparation of HEALTH21, and others with international experience and expertise.*

*The importance of evidence and research and the usefulness of scenarios were reaffirmed. Attention was drawn to the limited "life" of futures studies, based as they are on assumptions that are constantly changing. Experience has proved the usefulness of periodically bringing together people from different sectors and different walks of life to discuss futures. Further periodic consultations would be a valuable tool in the continuing process of monitoring, review and revision to ensure that WHO's European policy framework remains relevant for the Region as a whole. The Regional Office should continue its policy dialogues with country partners and others, and its collaboration with the Nuffield Trust in the use of futures in the creation and implementation of health policy.*

*This document has been edited by Keith Barnard.*

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# FOREWORD

The WHO Constitution lays down the objective to promote the highest attainable level of health for all people. Efforts made by and within its Member States are vital tools for WHO to fulfil this objective. The WHO Regional Office for Europe, therefore, highly values the work of the Nuffield Trust both in the United Kingdom, and on the European scale.

The Nuffield Trust pioneers work and provides excellence in many fields of public health in which WHO shares common interests. It promotes independent analysis and informed debate about health policy in the United Kingdom. The Nuffield Trust thereby generates important lessons and reviews options that enable people to enjoy better health, and receive quality and effective health care in the United Kingdom and elsewhere in the WHO European Region. It acts as pathfinder for policies, and acquires experience in their feasibility, affordability and acceptability within a national context. WHO can build on this experience and I, therefore, look forward to our continued collaboration with the Nuffield Trust.

I am particularly grateful to the Nuffield Trust for sharing their work on health futures with us. This volume makes a fundamental contribution to ensuring that health policy translates into practical action to shape the future of health, and the health of the future in the WHO European Region.

Our WHO goal of seeking health for all may be timeless, but the world in which we pursue that goal is changing. We need to be constantly tracking the trends, pressures and innovations that will influence positively, or negatively, our efforts to protect and promote health. Forecasting the repercussions that political, social and technical change will have on health, exerting influence over them, and taking decisions now, to make them as favourable or harmless as possible, are onerous tasks for health decision-makers.

This volume summarises a consultation held by the Nuffield Trust and the WHO Regional Office. It explores the future environment of health in Europe, and anticipates future problems and opportunities. It benefits greatly from the Nuffield Trust's own study "Policy futures for UK health". The Nuffield Trust's achievement is impressive in scanning the future environment of health, in identifying the implications for policy and action, and in distilling the findings succinctly in a form to which decision-makers can respond. It has inspired the WHO Regional Office in its work. I am sure this example will also stimulate colleagues in other countries to undertake their own futures studies to help their policy-makers find sustainable means to improve the health, and quality of life, of the peoples of Europe.

Marc Danzon, M.D.  
*Regional Director*  
*WHO Regional Office for Europe*  
May 2003



# PREFACE

Since its inception, the Nuffield Trust has identified individuals and subjects that would have an impact on health and health care policy in the United Kingdom. The hallmark of the Trust is its tradition of independence. Its main aim has been to provide opportunities for the exchange and discussion of new ideas, new knowledge or simply insights, with the intention of contributing to the medium- and long-term health policy agenda. Our project “Policy futures for UK health” analyses the broad environment for health in the United Kingdom in the year 2015, and the implications of that for current health policy. It indicates areas where the government could take action now to anticipate the likely circumstances in 2015.

This time-frame was chosen carefully, with a view to making a constructive contribution to policy development. It was emphatically not to be a piece of abstract futurology. The period under review extends beyond the usual constraints of the electoral cycle, but is short enough to allow a realistic assessment of future developments. The Nuffield Trust wants to stimulate change in the culture of the health policy-making process and to encourage thinking and analysis based on evidence. It is important that the debate is conducted as widely as possible, not only by politicians but also by others outside the political forum who share the wish to improve health. The policy futures exercise does not focus narrowly on curative interventions but considers more widely the factors that determine health and quality of life, albeit taking care to anchor these to the realities of policy-making and resource constraints. Policy futures provide material to justify considering important elements that could be overlooked in the context of maintaining health and wellbeing and that require cross-departmental working. Also, health increasingly has European and wider international dimensions. Good health is, after all, good economics. Giving health priority and a wider focus beyond health services will bring dividends.

The Nuffield Trust values highly the opportunity of working with the WHO Regional Office for Europe to ensure that the programme of work that it supports is alert to the latest policy thinking and policy analysis.

John Coles, in his book *Making foreign policy*, says, “Policy-making is hard. It needs intellectual rigour, a capacity for innovation, a grasp of political reality, a sense of the future and, quite often, a certain courage”. He advocates planning and futures work, saying, “the purpose is not to predict confidently what will happen in the world – a task for which there is little science – but by concentrating minds on alternative scenarios and possible developments to make today’s decisions sounder and more likely to stand the test of time”. There is much included in this publication to inform those who have health policy and operational responsibilities.

The Nuffield Trust and the WHO Regional Office for Europe hope that this publication contributes to the wider health debate and strengthens both national and international capacity to achieve health gain.

John Wyn Owen, CB  
Secretary, Nuffield Trust  
June 2003



# INTRODUCTION

The Fourth European Consultation on Future Trends, hosted by the Nuffield Trust, was convened to consider prospects for the implementation of the HEALTH21 policy framework adopted by the WHO Regional Committee for Europe in September 1998, to explore the future environment of health in Europe, and to anticipate future problems and opportunities. A point of departure was provided by a study commissioned by the Nuffield Trust and carried out by the Judge Institute at the University of Cambridge entitled “Policy futures for UK health”. This is complemented by the United Kingdom government’s multisectoral Foresight initiative, an explicit use of futures thinking as an input into policy-making across the board.

## Using futures in the policy process

The Third Consultation on Future Trends and the European HFA Strategy<sup>1</sup> provided a direct input into the drafting of the HEALTH21 policy framework. Now the stress is on the place of futures in developing an effective and sustained implementation of HEALTH21.

It is important that policy-makers are enabled not only to respond to present circumstances but to prepare for conceivable future situations (plausible, desirable or potentially catastrophic) that will have consequences for population health and the provision of services.

It is in this spirit that the Nuffield Trust’s futures programme is intended as a contribution to the United Kingdom’s health policy process. The “Policy futures for UK health” project has produced an overview report, *Pathfinder*, that presents a distillation of themes and issues and a policy assessment, i.e. what should inform United Kingdom health policy as we move forward

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1. *Third Consultation on Future Trends and the European HFA Strategy. Report on a meeting, Bratislava, Slovak Republic, 26–27 October 1995.* Copenhagen, WHO Regional Office for Europe, 1996 (document EUR/ICP/EHFA 94 01/MT01).



to 2015 and what are the gaps in health policy now. *Pathfinder* has focused on the following six issues, which provide a synthesis of the health agenda.

*People's expectations and financial sustainability.* Expectations – both about health and about the services provided – are rising, and need to be recognised and managed. This requires looking specifically at the long-term sustainability of the present health service.

*Demography and aging.* In terms of overall population structure, the United Kingdom will have an aging population and a smaller working population. There is a need for an integrated policy for older people, and also a reorientation of policy that takes proper account of the individual experience of older people.

*Information and knowledge management.* An effective strategy would offer many potential benefits in policy-making, training health professionals and communication of public policy. It should have an international focus.

*Scientific advances and new technology.* New knowledge, increasing technical expertise and increasing therapeutic potential all have consequences (e.g. shifts in location of care, greater use of machines and technology) exposing underlying tensions in health policy. Major issues of planning and management, e.g. in changing the location of care, need to be addressed.

*Workforce education and training.* The increasing pressures on health professionals and shifting roles highlight the importance of continuous education and training, and the need to reassess current workforce planning.

*System performance and quality (efficiency, effectiveness, economy and equity).* Questions on the overall performance of the health system point to the value of international comparisons and benchmarking, and the need for developing and improving outcome measures.

The purpose of *Pathfinder* was not to make predictions but to try and discover how policy-making and planning might benefit from a forward perspective. As an “agenda for health”, the findings of the project make clear that innovative, long-term strategic thinking will be needed to deal with the pressing issues.

There are both similarities and differences between the “Policy futures for UK health” project and HEALTH21, and these were noted during the Consultation. More importantly, the project was commended as a model, especially in terms of its comprehensiveness and links with policy-making realities. It was hoped that other countries might follow it as part of their implementation of HEALTH21.

## **Key issues for Europe**

The second part of the Consultation focused on the prospects in the Region for implementing HEALTH21. In the structuring of the meeting a number of issues had been identified as factors that could facilitate or impede the ability of WHO and Member States to implement policies and establish structures and services to improve the health of their peoples.

Analysis of geopolitical and economic developments raises questions as to the ability of the international community to create partnerships and collaborative arrangements that generate mutual benefits – whether countries and European organisations can exercise any influence on

geopolitical developments and the working of the economy at the global level. As the implications of globalisation become clearer, there is concern over the ability of individual countries, subnational levels of government and non-governmental organisations (NGOs) to pursue their economic and social development agendas for the benefit of their electorates and constituencies.

HEALTH21 emphasises that the achievement of its objectives will depend on effective alliances and partnerships in, as well as between, countries. The policy calls for a strategy to mobilise new partners for health: who these partners should be and how health sector actors should go about engaging with them; and what new networks, agendas and relationships should public health agencies at various levels establish and sustain.

There are also questions as to how ordinary people's own resources could be harnessed to improve their own and their communities' health; as to what kinds of relationships will or should evolve between individuals as citizens and as users of services and the political decision-makers and professional providers; and as to whether developments in information technology can close the information gap and the imbalance of resources. What will be the relationship in future between information, evidence and judgement?

Developments in different technologies and in the structures of the economy have serious implications for the future of work and health in Europe: the kinds of workplaces there would be and the nature of the hazards to the health of those working there. There is a range of expected health problems – physical, social and psychological – for which policy responses are needed. As to demographic factors, the shrinking and ageing workforce, for example, will be expected to cover the social costs of caring for the elderly and other dependent groups.

There are the challenges of ensuring meaningful employment opportunities for young workers so that they can lead satisfying lives, and of harnessing the strengths of older workers. Can inter-generational solidarity and equity be sustained in the face of accelerating technological change, with its likely consequences of de-skilling and structural unemployment?

Lastly, what are the prospects for equity in health in a future Europe – for giving people equal opportunity to enjoy good health and lead satisfying lives? If the language of equity is coming back into currency again, then in a WHO perspective this is welcome because such values have always been at the heart of the Organisation's policy-making. It is essential to understand the underlying trends in the macro-environment, in terms both of the impact on the main political forces in society and the distribution of power and of the way they affect people's ability to lead their own lives. It then becomes possible to identify policy options as responses to these trends, and to set up institutional and other arrangements to support a strategy to promote equity across social groups, generations and genders.

## **Implementing HEALTH21**

The final phase of the Consultation first looked at practical experience to bear in mind in implementing HEALTH21. Two thematic issues were then addressed. The first, combining clinical and public health knowledge to support health protection and promotion, reflects a key message of HEALTH21 – the need to “break down the barriers” between the curative services of clinical medicine and the broad field of other health work usually referred to as “public health”.

The second thematic issue – using research and evidence in looking ahead – responds to the recurring theme in HEALTH21 that policies, service development and professional practice should all be built on the strongest possible knowledge foundations. The environment for policy implementation in countries is never static. Continuous monitoring is needed to compare policy in action with the original policy intent, and to assess the implications of any divergence. Foresight and continuous monitoring can be used to detect weak signals portending change in the operating environment. A judgement may then be made on whether there is a need to develop scenarios of possible new futures.

## Conclusions

The emerging sense of the Consultation was that the future environment for health would indeed be complex, volatile and stressful for policy-makers and for those responsible for policy implementation. Some mechanism for continuous scanning of the future is now imperative.

We now have ample evidence of the importance of people from different sectors and different walks of life periodically coming together to discuss futures, such as the consultation in 1998 on food and agriculture<sup>2</sup>. The outcomes of such discussions can be used as an important input to policy-making and planning.

In a WHO perspective, futures consultations continue to be a valuable tool in ensuring that the health for all policy framework, adapted and implemented according to the needs of particular countries and communities, remains valid for the Region as a whole. Consultations help generate the intelligence needed to prepare realistically for possible futures and to craft rational, rapid responses to developments in the Region as they occur.

The Consultation generally endorsed the intention of the Regional Office to continue dialogue with relevant partners. Opportunities for further Nuffield Trust/WHO collaboration in the use of futures for health policy-making and implementation would be explored.

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2. *Food and agriculture aspects of the draft health policy for the European Region. Report on a WHO consultation, Copenhagen, 9–10 March 1998.* Copenhagen, WHO Regional Office for Europe, 1998 (document EUR/ICP/EXCC 01 03 01(A)).

# AN EXPLANATION

The material presented in this volume is set out in two parts, with two purposes. The first purpose is to recapture the spirit of the meeting held in London in December 1999, which had been stimulated by recent significant developments in the macro-environment for health. Most notably there was the Seattle meeting of the World Trade Organisation, and all that the events there seemed to imply when set against other discernable trends.

Seattle made us very conscious of the political and economic implications of globalisation and the impact on countries and communities. We were starkly reminded of the relationship between health and development: the contribution of improved population health to development and the effect of equitable economic development in improving population health.

In the United Kingdom, there were renewed hopes for a real peace in Northern Ireland, reminding participants that peace had long been seen by WHO as a prerequisite for health.

*Part I* is an account of the meeting. It reconstructs the presentations made by the invited experts, who brought the insights of their different professional backgrounds and experience to bear on the issues, and the dialogue between participants that their presentations generated. The presenters were all invited to review the first transcription of the proceedings and, if they so wished, to revise their contributions so that they properly reflected the intended messages.

The second purpose, addressed in *Part II*, is to present the context of the dialogue. Selected papers drawn from those prepared for or used by the meeting, which set out one dimension or other of the context, are reproduced. It will be recognised that – quite consciously – we were dealing with two related contexts.

The first was the international context provided by WHO's health policy and its evolution from the original "health for all" resolution of the World Health Assembly in 1977 to the adoption by the Health Assembly and the Regional Committee for Europe in 1998 of a renewal of the policy to take us forward in a new century.

The European context is conveyed in Part II by an interpretative account by Herbert Zöllner of the preparation of HEALTH21, the policy document adopted in 1998; and by a background paper by Keith Barnard on the experience of using "futures" in WHO health for all policy development. A point of international comparison is offered through a companion paper dealing with developments in the WHO Region of the Americas prepared by Cristina Puentes-Markides, a staff member of the WHO Regional Office for the Americas participating in the Consultation.

The second context is the United Kingdom, a context now made richer and more complex by the devolution of powers in matters of domestic policy, including health, from central government in London to a Scottish Parliament and to Assemblies in Wales and Northern Ireland. Each of these three constituent parts of the United Kingdom now has its own Executive, with Ministers and their departments accountable to the parliamentary body. The United Kingdom government retains responsibility for all countrywide functions and policies not covered by the legislation on devolution, as well as continuing responsibility for domestic policy in England.

The United Kingdom context, and a speculation on trends and the implications for government policy and the need for action, is the concern of the "Policy futures for UK health" project. The executive summary of the project is reproduced here. This multidimensional policy-oriented scan is complemented by an account of developments and prospects in Wales by Morton Warner. This highlights the possibilities of re-thinking current approaches to health policy-making and action by focusing on a particular geographical and political context.

Finally, linking these two contexts together, the Nuffield Trust perception of trends and possibilities in Europe is provided in a paper from Graham Lister. Reflections by Keith Barnard, from a WHO perspective, on the "Policy futures for UK health" project conclude Part II.

# PART I: THE DIALOGUE

## USING FUTURES IN THE POLICY PROCESS

### Background

*John Wyn Owen*

Herbert Zöllner will brief us on the purpose and objectives of the meeting, but first let me say on behalf of the Trustees how delighted we are to be able to work with WHO on health futures.

*Herbert Zöllner*

Thank you very much; it is a great pleasure to be here. Health futures is not strange to WHO, this being our fourth European consultation. I think I should start with a word on the genesis of this particular meeting. About a year ago we had a visit to the Regional Office in Copenhagen from John Wyn Owen in his capacity as Secretary to the Nuffield Trust. During this visit we discovered a meeting of minds on the need for futures studies, which we see as an essential input to policy development, and we saw an opportunity for building on existing efforts.

The Nuffield Trust futures team has embarked on a national endeavour to look into the future of the health care system and society as a whole, and to draw conclusions. As the WHO Secretariat, we need to listen to and learn from our Member States and their experts. In turn we can give the work of the Nuffield Trust the international dimension it has been looking for. So we are hoping that in this meeting, with the participation of other international experts who can contribute the European and global perspectives, we can build on what the Nuffield Trust has done so far. This should help both our work in the Regional Office and the work done in other Member States.

As Fritz Schumacher said, the future cannot be foreseen – it can only be explored. Taking stock of the future right now is important for WHO, because it allows us to explore the environment in which our policy and strategies will be implemented. It is the next stage

following the preparation of the renewed health for all policy framework of HEALTH21, when we had to look around and ahead to see what the challenges and the opportunities would be. We looked especially at mega-politics, macroeconomics and social trends to make an assessment of what the policy would need to take into account.

We now have a policy and a framework, which suggests possible strategies. This has been agreed by our Member States, and we now face the challenge of implementing it. In doing so, we come back to a number of the same issues: in what direction society and the economy will move, what the continuing differences between east and west in Europe will be, how the health challenges will be perceived, and so forth. We have put them on the agenda for this meeting as “Key issues for Europe”.

This meeting is part of a continuing or unfolding process in which we both check old insights and understandings and carry forward our scan of the environment. This kind of futures scanning is not something that finishes with one meeting, which is why we have had a sequence of meetings over this past decade. Suppose we had stopped after just one meeting, our first Consultation in Copenhagen in 1990. If, in drafting HEALTH21 in 1998, we had made our assumptions about the future environment based only on what we had perceived in 1990 we would have been quite wrong.

The meeting is nicely patterned. It starts with the place of futures within the policy process. We need to hear from the Nuffield Trust team how they went about this exercise in the United Kingdom and what the main conclusions were. We will then attempt a commentary on the project – a first set of responses and reflections. Then, tomorrow, we will bring in various international dimensions, and in the concluding session we can reflect on what has emerged and the messages we can take from the meeting.

## The work of the Nuffield Trust

*John Wyn Owen*

I am a health service administrator by background. Each decade in which I have worked has had different characteristics. It was *hospital* administration when I joined the service. In the 1970s it became *health services* administration, and in the 1980s health service *management*. I would claim that the 1990s has been the decade of *managing for health*. And looking beyond 31 December, I think we will be moving into the decade of *global* health. That perception is also reflected in the work of the Nuffield Trust. We currently have five main themes, one of which is policy futures. Before I come to that I will give you the other four.

The first theme is the changing role of the state and health policy, globalisation and devolution. Our interest is in trying to raise awareness in the United Kingdom of global issues in health, to ensure that we ourselves play our part as a world resource in health and health care. We have a strong interest in devolution and we have established a standing conference on devolution and health, working collaboratively with the Constitution Unit of University College, London.

The second theme is public health. Unsolicited, we will be offering the United Kingdom government a draft “Health of the people’s bill”, which is our attempt to try and define what a



modern public health act for the United Kingdom would look like. We met in Oxford last year, partly to celebrate the 150th anniversary of the first Public Health Act of 1848 but also to ask ourselves the question: if we were writing instructions for the parliamentary counsel responsible for drafting legislation, what would we want to see in a modern public health act?

The third theme is quality in health care. This has three component parts. First, there are policy matters relating to quality, and for this we are collaborating with the Commonwealth Fund and RAND. Second, we are taking advantage of the investment in measurement made in the United States, particularly by the team at RAND, to say what happens if you try to apply their work to measure health care in the United Kingdom. The third component has been working with colleagues at the Organisation for Economic Co-operation and Development on explaining to ministers of finance and heads of government what they get for their investment in health care.

The fourth theme is humanities and medicine. In March 1998 we had a conference at Windsor. We looked at three components: the humanities in medicine, the humanities in medical education and in community development, and the arts as therapies. We were so taken collectively by what happened at the meeting that we issued the “Declaration of Windsor on the Arts, Health and Well-being”.

In September 1999 we held a second Windsor conference, and the communiqué from that announced the establishment of a national Council for Arts and Humanities in Health and Medicine, with a co-ordinating centre at the University of Durham. David Weatherall was the opening speaker at our meeting. He talked about “the art of the practice of the science of medicine”, and we see that as an important way of indicating how the Nuffield Trust’s traditional role might be interpreted in the present and in the future.

So we come to the fifth theme, which is our main interest today: United Kingdom health policy and the place of futures in that context.

The Trust was set up in 1940 as the Nuffield Provincial Hospitals Trust. Since its inception it has identified individuals and subjects that would impact on health and health care policy in the United Kingdom. If we look back over this period of 60 years, we see some very significant milestone events.

*Screening in medical care* was an influential publication in the 1960s. Archie Cochrane’s *Effectiveness and efficiency*, published by the Trust in 1971, has had a major impact on thinking around the world. Tom McKeown’s *The role of medicine: dream, mirage or nemesis*, published in 1976, has also had a lasting impact, and was even referred to in WHO’s latest annual report. David Weatherall wrote on the new genetics and clinical practice in the early 1980s and, perhaps more controversially, Alain Enthoven responded to the Trustees’ invitation to write a reflective essay on the management on the National Health Service (NHS). We invited him back this last year; he has produced an assessment of what happened to some of his ideas on markets in health care, as well as some recommendations about the future.

One of the hallmarks of the Nuffield Trust is its tradition of independence. Its main aim has been to provide opportunities for the exchange and discussion of ideas, new knowledge and insight. This has had the intention of contributing to the medium- and long-term health and health service policy agenda, thereby enabling the people of the United Kingdom to achieve better levels of health as well as an effective health care service.

Partly in the context of celebrating the 50th anniversary of the NHS in 1998, we funded the NHS Confederation to examine what the next 50 years might entail for the health service. There was a delphi exercise, a public consultation and a number of community-oriented focus groups. And two scenarios were developed: one was called “find my way”, and the other “trust their guidance”.

When people were polled as to which scenario they thought we would have in the future, the overall balance of opinion was that the future would be one of people finding their way rather than trusting professional guidance. But the general conclusion was that it would be an age of uncertainty and anxiety. This mirrored the headline in the *Financial Times* last September, referring to the United Kingdom: “Wealth in 2010 will be marred by a lack of well-being.”

We are not interested in speculation for its own sake, but in analysis with a view to action and in thinking based on evidence. We want to ensure that what is already known contributes to the “cutting edge”, both informing the long-term strategic direction in health policy and improving health care. Adopting the US Institute of Medicine’s maxim, we believe we are a voice of moderation, wisdom and integrity, but above all we are free and beholden to no-one. And we are delighted that we can have this meeting with like-minded people who can help the Trust maintain that tradition.

Over the years I have been personally involved in a number of health policy futures projects. When I was at St Thomas’s Hospital in 1974 the then Professor of General Practice, David Morrell, wrote a speculative paper on health in the London Borough of Lambeth in 1984.

Later, at national level in the Welsh Office, the United Kingdom government’s department responsible for Welsh affairs, we commissioned the Welsh Health Planning Forum project “Health and social care 2010”. This was part of our programme to achieve health gain for the people of Wales. Then in Australia, when I was chairman of the Australian Ministers’ Council, we had a futures project on the Australian health system in 2010.

So it will come as no surprise that, on becoming Secretary of the Nuffield Trust, I argued for policy futures and a medium- to long-term perspective as we developed the Trust’s agenda. I advised the Trustees to establish a Policy Evaluation Advisory Group, supported by the appointment of a Nuffield Trust Fellow at the Judge Institute of Management Studies at the University of Cambridge.

The purpose was to put in place a programme of work to conduct an annual environmental scan and health policy assessment. The particular emphasis was to be on *evaluation* rather than merely monitoring what was happening, and on taking a futures perspective. It is interesting that when the United Kingdom Parliament’s Comptroller and Auditor General commented on our policy futures document, he said, “All I can do is monitor government policy. I cannot actually evaluate government policy”. So our attempt to push the boundaries is an important contribution in the United Kingdom.

The Policy Evaluation Advisory Group meets about three times a year. It has six members in addition to myself, plus a technical support group. It is multidisciplinary. We took people who were at a formative stage in their careers. This means that they were all busy people, but also that they felt that this investment of their time would be rewarded.

The group's initial task was to formulate the process for conducting an environmental scan – to develop a methodology. When we considered our first scan we decided that further analysis was needed. Ten technical papers were commissioned, covering a broad range of issues in a futures perspective. And it was reading through these technical papers that enabled us to draft our *Pathfinder* consultation document. This is an assessment of the forward look to 2015. It is asking what the policy should be now to take account of the trends and issues, what should inform United Kingdom health policy, and what the gaps in health policy are at the present time.

As Charlotte Dargie will be presenting later, we have identified six issues that need to be addressed in United Kingdom health policy: people's expectations and financial sustainability; demography and aging; information and knowledge management; scientific advance and new technology; workforce education and training; and performance and quality. In our report we have the four E's – efficiency, equity, economy and effectiveness. But I think there should be a fifth – empowerment – to fit in with the notion of people finding their way. That's a matter for further deliberation.

It was always our intention to produce a prototype health policy futures document in 1999, and this we did by publishing the *Pathfinder* document and the technical papers in September. The next intention is to publish *Health policy futures 2000* and an annual full-scale review thereafter. So, in simple process terms, we are on track and on time. We intend in May 2000 to write what will become an annual three-page letter to the British Prime Minister, based on the analysis developed in the policy futures consultation document.

Performance and quality issues provoke questions of how the health services are doing overall. And that has been the thrust of a number of invitational seminars the Trust has held. I believe that benchmarking the United Kingdom internationally in terms of outcome, health policy interventions and systems performance should be a central part of policy assessment, as well as a driving force for policy development and priorities.

When I was in the Welsh Office, one of the most important insights that we gained was the need to calibrate Wales against Europe. This was not the view of the central departments of government, who believed we should simply benchmark Wales against other parts of the United Kingdom. So it was not politically easy for us. But only when we benchmarked ourselves across Europe could we see where we stood and what needed to be done – and that the United Kingdom was not the gold standard against which we should be judging our performance.

And it is in that context that we have been keen to work with colleagues at OECD on the development of outcomes to present to ministers of finance and to heads of government. It is very important that we take the message about health to the non-health ministers. We should recognise and promote the idea that heads of government are really health ministers in their own right.

To sum up, the six issues that we have distilled from our futures study, and that will be identified in the Prime Minister's letter, will probably require new thinking and priority-setting in health care by governments in the United Kingdom. That is not merely because of the new devolution of responsibility for health to its constituent countries or the impact of globalisation on the United Kingdom. To make a real difference, the agenda will require continuing commitment from many governments in the future.

We would like to think that the *Pathfinder* document represents the first step in new thinking, making as full an assessment as possible of the factors affecting the future of health. When government starts to think about where it wants the United Kingdom to be in health and health care in 2015, we believe our documents will be seen as a way of helping them to determine the policy agenda and to set priorities. They will also ensure that for the people of the United Kingdom, the policies and the priorities are informed by an international perspective.

*Question:* What does the Nuffield Trust expect in particular from this meeting?

*John Wyn Owen*

One of the attractions of holding this meeting with colleagues from WHO and from different parts of the world is being able to take soundings as a further step in ensuring that we are as informed as we can possibly be. We have had a very comprehensive set of responses to our *Pathfinder* document within the United Kingdom but, as we have said, we want the United Kingdom to be benchmarked internationally.

*Charlotte Dargie*

In terms of the project, and preparing the *Pathfinder* document, we had a United Kingdom remit. It will be very valuable for us to see if there are common themes or issues from the wider European and global perspectives. This is our first attempt at a futures study, so we want to tap into whatever experience of futures other people have. Any lessons we can learn for doing further futures work would be very helpful. Any insight coming from the wider perspective that you bring would help us discover what we have got right and what we have got wrong.

*Pam Garside*

Now that we have made a scan of the sectors, we want to go into much more detail in certain areas in the next two years. One area to look at will be benchmarking, including the sources of data and how they can be developed over time. Anything on this front that we can distil out of the discussions in this meeting, to legitimise our work in an international context, would be very valuable.

## **The British government Foresight programme**

*Tim Willis*

Health care is one sectoral panel of the whole Foresight programme undertaken by the British government. Foresight is not new. It was established in 1993 when the government produced its science and technology White Paper *Realising our potential*. Foresight is just one mechanism through which the British government derives policy and actions to accelerate the uptake of new technologies. That is why it is managed by the Office of Science and Technology, which is currently part of the Department of Trade and Industry. Foresight looks across all government departments that are covered by the Trans-departmental Science and Technology Group of the Office of Science and Technology.

We are currently in the second round of Foresight. We are using scenario planning, horizon scanning and other tools to establish a vision of the United Kingdom in the year 2020 in various sectors. This is for the use of industry (especially small- and medium-sized

enterprises), for people in other government departments such as the Department of Health, for the voluntary sector, and for anybody else who wants to use the Foresight process to make themselves more competitive.

There will be many outputs highlighting threats, bottlenecks and opportunities, with recommendations to avoid, accelerate or make the most of them, together with potential needs for skills and education, and implications for sustainable development. We believe that creating a vision of the future together, with people signed up to those visions and making and adopting their own recommendations, will add to the competitive advantage of business. It will enhance the quality of life for the citizens of the United Kingdom.

The output of our programme will be visions for the year 2020, but the purpose is to guide today's decision-makers. We make recommendations on how to be ready for the future now in the United Kingdom. We are preparing reports and scenarios to be ready in November 2000 but, just as important, we want to establish a culture of Foresight thinking in business, in government, in the voluntary sector, in all sectors in the United Kingdom. So for us, the process and the involvement of everybody is as important as the outputs.

This is one important respect in which this round of Foresight differs from the previous exercise. It is very much engaged with the social as well as the technology dimension. We have a huge number of stakeholders and a very wide-ranging list of participants in our panels, task forces and associated activities, as well as the broad government involvement.

We use intermediaries – trade and other associations – to multiply our efforts and as a conduit for our outputs. In the health care sector we are bringing together clinicians, researchers, health managers, trade unions, the voluntary sector and charities to talk and share their visions of the future together.

The previous round was criticised for having academics and the business sector together, picking out the winning technologies. Now, by widening the participation, by bringing in all other sectors and young people as well and formalising the participation of other government departments, we can share the vision together. We can be more inclusive. We also include implementation, dissemination of outputs and recommendations, in the hope that those who are involved now will also be acting on these aspects.

Ten sectors are being taken through the Foresight process. We have a panel for each sector, and we maintain an ongoing dialogue. So when I talk about our health care Foresight, it is being done in an integrated fashion with other panels covering a number of different sectors linked with it in some way. We could cite the future of chemicals, pharmaceuticals, defence, financial services and the funding of health care systems, information technology and its impact on the health care system, retail health care, and others.

When this Foresight round was planned, it was felt that there were three issues that were too important to be taken forward on a sectoral basis. They would have to be taken forward on a thematic basis, because they clearly affected the United Kingdom as a whole. First, there was the demographic trend, also seen elsewhere, of the growing proportion of people aged 55 or over. Second, there is the growing need to have crime prevention take account of new technologies, products and policies. Third, there is the huge effect of manufacturing in the year 2020 in all sectors. This adds three thematic panels to the ten sectoral panels.

Also, we recognised that there would be a need for every area of the Foresight programme to make recommendations on the implications of its outputs for skills education and training in the United Kingdom and for sustainable development.

To put the health care panel in a nutshell we are looking at 2020, at how we are going to get there, at the issues that will drive us to get there (or hinder us) and at making recommendations on action to be taken now. The health care panel is looking at how new technologies will affect the evolution of health care over the next 20 years and the implications they will have for research. It is also looking at the public policy options.

We are identifying significant opportunities and threats in the United Kingdom. We are looking at how we can best exploit emerging technologies now, so that they are taken up and have an impact in 2020; we are not just sitting and waiting for them. We are also attempting to gain a greater understanding of technology needs in the health care sector, so that the United Kingdom can provide for its own health care technology needs.

The health care Foresight panel consists of people from large pharmaceutical companies, from academia, from the Department of Health, from nursing and from other sectors such as venture capital. The panel has defined nine areas of priority importance to be taken forward in a task force approach. The panel is already defining and prioritising issues. Then we are going to look at the year 2020 and the issues that are driving the future, and how they will have an influence – their impact, their significance and the probability of them happening. That will be the actions we need to take forward.

We will test the robustness of those outputs in a consultation exercise next year. We have facilities for that on the Web, so that we can have inputs to the debate from anybody who has access to the Internet. We can gain commitment from the stakeholders, who we hope will take forward our recommendations.

The nine areas we are looking at are grouped under different headings. Under the “People and social” heading comes “National, European and global milieu”, which has just changed to “International influences on health and health care”: activities outside the United Kingdom that may influence the health of the United Kingdom population, or influence health regulations and health policies. We are focused on the United Kingdom, but we are also very aware that there is a huge influence on health and on the British health care system from outside.

Then there are the demographic aspects – the health expectations and needs of older people and people’s own emphasis on prevention and self care and on involving the public and patients in health care systems and policy. We are looking at the organisation and delivery of health care systems in the year 2020 and how they may use, exploit and protect the information they generate and hold. In the technology aspect of health care, genomics is going to be a huge issue.

Then there is the issue of innovation, and what is hindering the rapid uptake of new technologies in the United Kingdom. What are the roles of the research providers (such as the pharmaceutical companies and the academics) and various intermediaries in the health care system? What are the research needs of the National Health Service, and what are the regulatory issues? The last two are areas in which there will be a huge acceleration in knowledge and technology: neurosciences and transplantation.



The nine task forces are therefore the following:

- Public and patients
- International influences on health and health care
- Older people (run jointly with the aging population thematic panel)
- Organisation and delivery of health care
- Information
- Delivering the promise of the human genome
- Pharmaceuticals, biotechnology and medical devices
- Neuropsychiatric health
- Transplantation.

Finally, there is our web site, which is able to search directly every British government web site and some others. This is where our outputs will be. But it is also being used as an interactive forum, whereby anybody who has access to the Internet can look at the draft outputs as they are created and comment on them. Thus we are trying to broaden the debate still further.

*Question:* Whom do you see as your stakeholders?

*Tim Willis*

The health care panel envisaged a range of stakeholders. They were identified at the start so that we could involve them in the process itself, and most of the task forces have them on board. They include the health care providers, both the NHS and the private sector, and the suppliers to the health care sector – from small enterprises that create medical devices through to the large pharmaceutical companies. The workforce is represented on our task forces through trade unions and professional associations. We also have the public and patients, patient groups, charities and the voluntary sector.

*Question:* You mentioned that you want to build a broader basis of participation, and you mentioned young people. How do you go about that?

*Tim Willis*

We are using schools panels; the devolved governments and administrations in the United Kingdom have their own schools panels. We are also fortunate to be in the Department of Trade and Industry, as we can work through their regional government offices. We will be going round the regions of the country, consulting on our early outputs. We welcome as many inputs as possible, which is why we are using the Web site and electronic means to widen the debate. I believe that in any futures activity you can never have too many inputs and tests of the robustness of outputs. We are interested in comparing and contrasting our work with that of others. We certainly welcome the Nuffield Trust and other futures activities. It is interesting that we are already drawing parallels with the Nuffield Trust's work in our early outputs.



## Futures in the Department of Health

*Richard Walsh*

We in the Department of Health are taking a very direct interest in this round of the Foresight programme. Last time it seemed to be very much driven by technology, whereas this time there are the implications for health policy and also how NHS services are delivered in the future. Thus we have a different type of engagement from what we had before, and hopefully that will mean that the recommendations are more relevant to what policy-makers think is important.

I think this illustrates a tension between the Foresight programme and our activity in the Department of Health. The Department of Health is unique among government departments in this country, being managerially responsible for the NHS, which employs one million people, and also responsible for the regulation of social services or social care organisations. This means that we have an interest in technological innovation or new products, not merely to ensure that those new products are put on the market or that the company manufacturing them is successful, but as an actual customer for those products.

We have an interest in those products being effective and cost-effective, and that is now coming to the fore with the creation by the government of the National Institute of Clinical Excellence and the Commission for Health Improvement. So while we are signed up to the objectives of the Foresight programme, our particular perspective needs to be taken into account. We shall have to see how that works out as the groups progress and produce their reports.

The Department of Health has carried out a futures programme for a number of years. We were the first British government social policy department to use scenario planning, as it had been developed by Shell. We have used it in different policy settings in a joint collaborative exercise with the pharmaceutical industry and a number of other government departments. We have also used it for workforce planning and capital planning for hospital building. Another methodology used in the Department over the last ten years is simulation, to see how policy developments will evolve in the future.

We now have experience of these techniques, both in terms of running them and of the implications, and there are difficulties in using them. In scenario planning you develop different challenging scenarios as possibilities, in order to explore the implications, but we do not have a political or media environment that understands that purpose.

People take scenarios to be predictions, so a scenario in which the NHS became privatised would create a huge newspaper stir. In the time of the previous government, a simulation exercise suggesting that the NHS internal market established by the government would collapse was not exactly what the Minister at that time wanted to hear! So there are real handling problems in the use of these techniques.

One lesson we have learned is that a high proportion of the gain from using futures in planning is the involvement of people themselves, the involvement of stakeholders. They are very effective in getting shared ownership, getting people's agendas on the table in a non-threatening environment and then getting them to think "what if", in a way that they would not normally do.

So part of my role, as head of strategic planning, is to get that kind of thinking much more commonly accepted in the policy arena. Policy-makers working for government ministers are so often responding to immediate requirements from ministers or political imperatives that they do not think two years ahead, never mind five or ten years ahead. That is what we want to change. These processes are very good at getting people to think in different ways.

My next point is on modernisation. In the past, government departments have tended to operate separately. Current thinking is that we should act in a more coherent way like the recently established Social Exclusion Unit. The way in which we are collaborating on the Foresight programme shows how important that is seen to be.

It is also important that we work with people outside government. That includes participating in meetings like this. I welcomed the opportunity to comment on the Nuffield Trust's work, which we have done. I hope that that this contact will have benefits both for government and for independent trusts and charities. In our perspective we will be less insular and inward-looking, and bodies such as the Nuffield Trust or WHO will gain in the sense that we will involve policy-makers from central government in the development of their programmes, rather than simply presenting policy-makers with the results of a piece of work. That relates to the point I made about ownership too; there will be a greater chance that recommendations will actually be taken forward.

*Ron Zimmern*

I would like to ask about another methodology. In the Nuffield Trust's genetics project we are using both scenario planning and simulation. But there is the potential of soft systems modelling to see whether policy in one arena might interact with other policy arenas that we have been looking at. I wondered what experience you might have had in that as a methodology.

*Richard Walsh*

I know of it and I recognise its importance, particularly when working with large groups of people, where the interactions between all the different areas are so complex. Others in the Department have been working with that process, but I have not used it myself. There is another process that we are looking at called "hyper-game analysis". It was used in Bosnia in conflict resolution. We are thinking about using it in looking at primary care trusts, the new and most local-level bodies providing and commissioning services, and how they will develop in the future.

## **HEALTH21 – a future-oriented policy framework for Europe**

*Herbert Zöllner*

If we go back 25 years or more we find that WHO was then very task-oriented. It followed a "bush doctoring" principle. The doctors went into the bush and did good things. However, unfortunately, as soon as they came back out of the bush, things went back to the original state. WHO really did not have impact in the countries. So something new was needed. Our then new Director-General, Halfdan Mahler, said it was more longer-term thinking, and some sense of context rather than the separate "vertical" technical programmes that we then had.

Mahler had also become very sceptical, cynical even, about interpreting WHO's constitutional concept of health literally and out of context. Such perfect health – not only the absence of disease and infirmity but a complete sense of social, physical and mental wellbeing – was perhaps at the most enjoyed by some people some of the time during their lifespan. In practical terms it was surely a case of the best being the enemy of the good, because if you only promoted the ideal then action would not come forth.

So in reaction to that he facilitated the vision of health for all as WHO's overarching policy, where equity was put in the forefront. And equity is just as important now as it was then. As one clear example, between western Europe and the countries of central and eastern Europe (CCEE) we have a seven-year difference in life expectancy. And then, going further east to the 12 so-called newly independent states (NIS) of the former Soviet Union you have a further seven years' difference in life expectancy between the CCEE and NIS. You can find similar magnitudes of differences within countries. Equity in health is still an important goal.

Under Mahler's leadership health itself became redefined, in the sense that the policy objective was conceived as functional health – that all people should be able to enjoy a level of health, or a health status, that allowed them to participate in normal life. The phrase used in the World Health Assembly "health for all" resolution in 1977 (WHA 30.43) was that of enabling people to lead "a socially and economically productive life".

Informally, another phrase came into use later, that of a "satisfying and fulfilling life". Some people had problems with "economically productive", which they assumed (incorrectly) to mean participating in the labour market, which would never cover everyone. The true meaning was to enable people to participate in normal life. Mahler was very eloquent in interpreting this concept and applying it to every stage of life, not just to the young or physically fit.

We should also remember that in the late 1970s it was a marvellously rousing slogan, not just to say health for all but health for all by the year 2000. It was about a generation away. It looked so far away that it made sense to believe that you had time to really change things; you could rise above the immediate obstacles of life. And that is what the year 2000 meant at the start of the health for all movement.

Now that the year 2000 is upon us, and we are reminded by our detractors how much unfinished business there is, I must make the point quite clear that invoking the year 2000 was in a sense only a tactic. Health for all, both as a concept and as a philosophy, is a continuing policy.

Overall we have reason to be encouraged by the growth of the health for all movement in Europe. But I must say we had a struggle because at first not all of our Member States were fully with us. I remember delegates of the German Democratic Republic arguing confidently – or so it seemed to me – that they already had health for all: it was in their Constitution. Another country, although it was one of the less developed in the Region, asked impatiently why one should wait for the year 2000. Yet others (actually among the most developed) thought they should be realistic and argued that the year 2000 would not be feasible but they would possibly achieve it by 2020 or, if they hit problems, 2030.

Some countries were almost overtly negative, perhaps in response to the medical lobby, which looked on health for all with great suspicion, seeing it as an attack on medical practice.

So we had quite different mindsets that we had to deal with. But in due course the health for all idea was taken seriously in the Regional Committee, and a European health for all strategy was agreed in 1980. This was elaborated in 1984 into a set of health for all targets to be achieved by the year 2000.

Some of these targets, although serious in intent, were essentially statements of political aspiration. But most were focused on reducing particular health problems, creating the conditions for health improvements, and getting essential machinery in place to pursue the health targets. In 1991 we reviewed and revised them, but kept the same time horizon of 2000. In 1998 we produced our present version, HEALTH21 – health for all for the 21st century.

Preparing the policy documents to present to our Member States involved setting up meetings that served the purpose of sensing the future, although it was not until 1990 that we held a meeting that we labelled “futures”. Our experience since then is summarised in our paper *The use of futures in European health for all policy development*, which has been prepared for this meeting.

Our motive was in our recognition that health futures have to be explored, and that we needed a process of creating policy jointly with the stakeholders, which we would do by taking stock and looking forward and around. We sensed that futures could be a natural entry point for us to say to our Member States – in effect if not in actual words – let’s explore how to develop health policies, how to think about the future.

We also decided that we had to explore not so much the technical issues inside the health sector but rather the likely future environment for the health sector. That meant geopolitics, the macro-economy, ecology, broader technological developments, and social, demographic and epidemiological trends that might impact on health and health care. We later picked up on a number of issues in health care itself: first services for the elderly and then the restructuring issues of so-called health care reform, as well as the re-emergence of public health as a policy focus and the role of health systems research.

At one point we presented a draft with our assessment of some of the macro trends and their implications. Our Member States said that we were much too pessimistic and told us to revise the text. This we did, and we came out with some diplomatic mishmash. Later we submitted the new text to them. Of course, they said we should have written it more realistically! That seems to echo what we heard from Richard Walsh about the difficulties he has experienced in his own ministry.

As a United Nations organisation we have always been very clear that health for all and particular health policies have to do not just with technological developments but also with values. We were quite firm that the values could not change. We might modify if necessary some of the operating principles we adopted in giving effect to or applying the values, but not change the original values. That means, for example, that if good health is a value – something that is valued – we should place an emphasis on health outcome. Things done for health should show benefits in terms of health.

In 1998 we went further and said this should not only apply to those actions in society that explicitly or expressly have a health purpose; all action should also be looked into to see if it had implications in terms of health, that is health as a consequence.

We have been quite clear about the ethical foundations of health development and of the role of WHO itself in speaking out, with a moral but politically neutral voice, on what we saw as happening or not happening. We have pressed the international community on the need to reduce health inequities, those indefensible differences between and within countries, and to strengthen international solidarity. Morally, it is a scandal that there is this seven-year gap in life expectancy between western and eastern Europe and between the east and the far east of the Region.

Then it has to be made clear that the health sector (and WHO itself) cannot go it alone. Health ministers definitely cannot, so therefore the need at every level is for partnership, just as previous speakers have already stressed in speaking about United Kingdom developments.

Now, fortunately, our Member States are of the same mind. The adoption of HEALTH21 by the Regional Committee is evidence that the covenant, so to speak, has been renewed. There have also been very strongly worded resolutions at the World Health Assembly, and in our Regional Committee, in which Member States pledged what they would do. Member States have said quite clearly not only what they would do, but also what they expected from the Secretariat.

I have already mentioned the place of targets in developing the European health for all policy. The Regional Director, Jo Asvall, argued strongly that setting targets and monitoring progress were essential for policy development and implementation. However, these are also two areas where we have been criticised most by Member States. Some have asked us politely, but in effect, “Why don’t you just present your paper and then leave us in peace?” Others say, “Rather than trying to push specific targets on us, just set up an information system. And besides, how do you define those targets – what evidence do you have to support them?”

In fact, we have made sure that for each one of the targets there is at least one country that has already achieved it; and we consider that what has actually happened has a strong chance of happening again. We have also made it quite clear that the targets will not happen automatically, but only if a deliberate effort is made.

We have also changed our tactics, because in 1984 and again in 1991 the targets themselves were the organising principle. So as you worked through the document you went from one target to the next target to the next target, until you reached target 38. The underlying strategic coherence, which was certainly there, was not all that clear to someone reading the text.

This time we have put the strategies up front and then presented the targets as some of the sensitive indicators of what should happen in order to make progress towards health for all. We also have an information system in place, which at least makes it possible to question what progress is being made in the different areas of health for all.

What is really needed is a new ethos of health. You all know the finance ministry ethos. It is the dominant ethos in virtually all countries; it has even infected the east of our Region. The finance minister says “budget deficit” and everybody jumps. The ethos of social and health deficits you do not hear. You do not see any news reports that the social deficit has increased because of a reported increase in the number of single mothers, or an increase in the number of registered unemployed.

So far it is only the finance minister who can promote or create an ethos. If we want to see health much higher on the development agenda we need to argue less that health is a goal in itself, and more strongly that it contributes to overall social and economic development.

This means we need a health sector that first gets its own house in order (it will never be credible if it is itself seen to be an enemy of change) and then becomes much more proactive in terms of what goes on outside the health sector. It has to sharpen its “foreign relations mission” to mobilise other sectors. It has to go out into the settings of daily living and reach out to the other sectors that are producing and marketing their products and services, because that is where health is created or undermined.

When we talk about the settings of daily living and the role of other sectors, we start to think about action on the determinants of health. We have given this much more emphasis in HEALTH21 than before. The non-communicable disease burden and problems of smoking, nutrition and so forth are matters of serious concern. But there is something behind these, which, if not addressed, would leave one with no effect at all. This is why we need to emphasise the determinants of health, and that means a shift from the health sector alone to coalitions.

Let me link that point to the way we have conceptualised primary health care. Primary health care in a local community has three types of client. One is the people: individuals and their families in their homes, the so-called microsocial units. They are leading their own lives and from time to time they are users of health and other services. We also meet them in various community settings, where people normally meet, work, play and learn. These community settings are the second type of client of primary health care, which we need to understand as encompassing much more than the normal *health care* sector. We are talking about promoting and protecting health in those settings.

Then you have the third type of client: the community as a whole. And here we need to think about the local mechanism of “stewardship” or “governance” – how the community’s affairs are ordered to pursue objectives of health improvement. We are talking about having some form of public health organisational infrastructure in place. It means that those in positions of responsibility are reaching out towards people. It is the mobilisation of people, who are creating their own capacity for making healthy choices and for speaking out about their health.

It is sometimes argued that to call this comprehensive community development process primary health care is a misnomer. Perhaps so, but more importantly WHO recognised the need for such a process, and primary health care entered the WHO vocabulary at the start of the health for all movement and it stayed. But if you were to ask me where the health sector starts, where the boundary is, I think the most appropriate response would be “who cares?”.

Stewardship in primary health care means innovation, especially in implementation. That implies John Wyn Owen’s five Es, but also participation, transparency and accountability. We think, for example, that business owes it to its shareholders, its workers and the general public to say what it really does for health.

Part of the innovation has to be research and development on implementation. We need to capture the learning that comes from the shop floor. We also think that we need some early



warning systems: socio-economic determinants should be treated just like epidemics. It is always the same factors that come up, and it should be possible to create some kind of sensing system to provide early warning.

My last point is that building up a foresight capacity is very important. Looking ahead is not just about quantitative forecasts; it is about never stopping learning and pooling insights. It is also about sustaining our values; that will be just as important as we try to draw in all segments of society. It will be very helpful to learn in due course how the organisers of the Foresight programme were able to learn from the diverse inputs they got from the Web site.

It is quite a challenge to take on board and make a coherent whole out of very different ideas to create a common agenda. But it is a challenge we should be ready to respond to. I think the essence of it is rather well captured in a quotation with which I will close. It comes from the Austrian artist Hundertwasser who put it like this, “If one dreams alone, it is only a dream. When many dream together it is the beginning of a new reality.”

#### *Sandra Dawson*

I was very taken with Herbert Zöllner’s notion of the social welfare deficit that nobody comments on, whereas the financial deficit always attracts attention. It made me think about the media, because the broadsheet newspapers in the United Kingdom report day after day on some aspect or other of the social welfare deficit. I think the real point is that it is a subject for media comment on its existence but very little follow through, if any, about what might be done about it.

#### *Herbert Zöllner*

Part of the problem with the social deficits is that we do not have a good indicator. It has all fallen apart into many different ones. With the financial deficit there is one indicator that is always cited. But there has been an important step forward in environment and health. The European ministers of health and of the environment, at the London Conference in June 1999, agreed that health was the primary indicator, together with sustainable development. This is particularly appropriate at local level. And at local level, in terms of what can be done to reduce the social welfare deficit, we get very good experiences reported to us from the Healthy Cities Network.

#### *John Wyn Owen*

My understanding is that one of the aspirations of the United States government project “Healthy people 2010” is to have the daily health indicator changes next to the stock exchange results on CNN.

#### *Cristina Puentes-Markedes*

I am not aware of a stock exchange health index. Preparing for “Healthy people 2010”<sup>3</sup> was a five-year process that included the participation of several governmental and non-governmental agencies. There were discussions about putting forth a sort of “report card” on the country’s health. However, this sparked controversies since it is painful to show that the richest country in the world is number 16 in infant mortality, for example, or that inequalities do exist within states, counties and cities. However, one of these agencies, the Institute of

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3. <http://www.health.gov/healthypeople/>



Medicine, produced a document available online entitled *Leading health indicators*, as an effort to define a set of indicators that would give a quick snapshot of the country's health, and that would include a smaller number of indicators that people could more easily remember. The group developed three sets of indicators, each from a different paradigm (health determinants and health outcomes, life course determinants, prevention) that include about ten indicators each. At present, there are discussions as to the choice of indicators, and it is thought that ten meaningful indicators will be more useful than one hundred.

#### *Ilona Kickbusch*

A methodology for a social health index has recently been published. It takes ten practical indicators and combines them into one index. This is a social health index, not health indicators. The argument made is that a society that calls itself civilised and wants to be developed should have reporting on at least three levels; one is economic, as understood in terms of GNP, the second is environmental accountability and impact, and the third is social accounting. In the 20th century we developed the economic accounting, we have gone reasonably far in environmental accounting, and the challenge for the 21st century is social accounting.

#### *Morton Warner*

Herbert Zöllner made the argument that other sectors need to be mobilised by the health sector. I have a comment on the United Kingdom experience. My Institute carried out an evaluation of the *Health of the nation* health promotion strategy. One thing that came through very clearly was that prior to 1992, when the lead was given to health authorities, local government had been extremely active in pursuing the health for all type of objectives. Many local government departments saw themselves as having a role in creating the conditions that could determine good health and support people. When the government then said that it was up to health authorities to take the lead, the local government people felt quite displaced and they dropped away.

It seems to be the case in many parts of Europe that it is local government departments that have given major support to dealing with the social determinants and have tried to counter the causes of inequities.

#### *Ilona Kickbusch*

I think that's a very pertinent argument that we need to take up. The health people have to go out of their health box and argue jointly that health is a dimension of well-being, and not that health is separate or more important than well-being. Otherwise you will never find the allies in society that you need to actually push this agenda forward.

## **The Nuffield Trust "Policy futures for UK health" project**

#### *Charlotte Dargie*

The project has been examining the future environment for health in the United Kingdom. When we started it was decided that the end product would be a futures analysis to examine United Kingdom health policy and policy-making. Our overall aim was to see how planning and policy-making in health in the United Kingdom might benefit from a forward look. We are now at the stage of moving beyond our first assessment and thinking about the policy implications of that work.

We selected a time horizon of 2015. There were two factors that helped us decide. The first was that we were interested in something that was longer than the electoral cycle and the second was that we needed something that was manageable and containable in terms of the time horizon. The year 2015 seemed to fit with other futures projects that had been carried out, adopting a 10–15-year forward look.

As for how the project has been carried out, the Nuffield Trust set up an advisory group. The people in the group cover a range of specialties within health. They have been involved throughout the project and helped us determine what topics to look at and the approach to take. The research capacity for the project is the research team. I am coordinating the project at the Judge Institute, working with Sandra Dawson and Pam Garside and linking the project to the wider work that the Nuffield Trust is doing.

The way we worked for this first round was to conduct an environmental scan. We approached different specialists to write technical papers covering a range of topics, and asking them to think about trends and issues for the future. As John Wyn Owen mentioned earlier, we picked ten categories for this environmental scan: the global context, physical environment, demography, science and technology, economy and finance, social trends, organisational management, work force issues, ethics and public expectations. We asked the authors to follow a common format in their papers.

The next step was to pull all that information together in an overview report, which we call *Pathfinder*, to make the link *between* future trends and issues identified by the environmental scan and doing something about policy on the basis of that information. We describe it as a policy assessment with a forward look to 2015, asking the question, “what should be done about United Kingdom health policy and what are the gaps in health policy now?” We had quite a task in pulling together all the material in the technical papers into an overview report, to put the issues in as broad a perspective as possible.

We wanted to get across the idea that there were “stocks and flows” in health. We were trying to describe what was happening in a category and what might be the policy recommendations. We decided to split the themes and issues covered in the report into three categories: determinants, interventions and outcomes. We then took another step to get from trends and issues to policy recommendations, distilling down from the range of issues covered in the *Pathfinder* report to fashion our key messages for government around six themes.

The first theme is people’s expectations and financial sustainability. Expectations of health continue to rise among the population. At the most basic level, people expect to feel safe and secure and the health service contributes to that. People have expectations about how long they are going to live and also the quality of their lives. They have expectations about the type of service they receive when they interact individually with health services, which might include whether and when they are treated and by whom, what alternatives to treatment are offered, how successful the treatment is and how they will recover their health, and whether they have to contribute financially in any way. People have expectations about those who deliver health services to them, which include the ability to communicate with them on a personal basis.

For health policy, people’s expectations need to be recognised and managed. This involves deciding what people expect from health services and how progress towards achieving those

goals is tested. It also means adapting a health system in order for the health workforce to be able to deal with a sophisticated public. Managing public expectations means thinking about the long-term financial sustainability of the health service in its current form in the United Kingdom – providing universal access and funded from general taxation.

The second theme is demography and ageing. The United Kingdom population is becoming older and this trend, in conjunction with a smaller working population to provide taxes to support health services, will affect the dynamics of health services in the medium- and long-term future. We felt that a positive policy agenda would involve dealing with financial considerations, considering rights and expectations of older people, and developing integrated policies in planning for the health and welfare of older people.

It would also include the evidence base for policy, which involves both more research in the disease profile associated with ageing, and developing broader quality of life indicators for older people on which assessment can take place. Finally, there should be a reorientation of policy towards the individual experience of older people. There should be an understanding of the wider factors affecting people's lives and the part to be played by relationships with family and friends, their social networks and environment and their ability to participate in society.

The third theme is information and knowledge management. Information technology is raising people's expectations. Health professionals, along with those in the other sectors, are now trained in information technology. New technology offers many potential benefits, which need to be assessed along with their costs. Patients are able to compare health services with those available outside the United Kingdom, to undertake research into conditions and treatments using the Internet, and to assess how health services make use of information technology when compared with other sectors such as banking and leisure.

The issues of information technology and information and knowledge management raises wider questions about the focus and formulation of health policy for the future. For example, how the new information technology could be used in an integrated way across the health sector, or for sharing policy learning internationally at a European level, or ensuring proper regulation and developing training for health professionals. And could it be used for the effective communication of public policy and of risk?

The fourth theme is scientific advance and new technology. Scientific advances are increasing technical expertise and therapeutic potential. New discoveries are providing new knowledge about preventive strategies and changing what health services do and how they do it (for example, a shift from secondary to tertiary care, from primary care to preventive strategies, and from people to technology).

These developments have consequences for health policy that need to be managed. They also illustrate some of the underlying tensions that exist in health policy. For example, there are those between the new knowledge we can apply in facilitating preventive strategies in society and the right of the individual to refuse treatment; between increasing therapeutic potential and increasing pressure on the health workforce, and between increasingly complex scientific processes in manufacturing and treatment and demands for assurances on safety issues.

A particular impact of scientific advancement generating new knowledge concerns the location of care. On the one hand larger, fewer and more concentrated centres of specialist expertise are

developing, and on the other there is a shift towards treatment outside hospital, including self-diagnosis and home care.

Professional roles are also shifting, and attention needs to be directed towards an assessment of these roles and the associated education and training. We found that the health workforce is under increasing pressure to adapt to new knowledge, new treatments and new ways of working. So the fifth theme is workforce education and training. This needs to be continuous throughout the health professional's career in order to keep up with evidence and new knowledge in the field.

The health workforce might learn from other sectors in terms of greater flexibility in choice of career patterns, improved incentives and motivation, and greater levels of protection. A longer-term perspective should be taken in workforce planning and alternatives to the current workforce planning system should be considered.

The sixth theme is system performance and quality. This provokes the question, how well does the health system perform overall? It was felt that the present mechanisms were incomplete for assessing United Kingdom performance, particularly in terms of international comparison. For the longer term, policy will benefit from using international outcome measures to benchmark the United Kingdom. There needs to be more work on the development of outcome measures, which can be used to evaluate health policy. Policy and performance measures currently being developed in the United Kingdom that are focused on monitoring, evaluation and review should be extended to the performance of the system overall in addition to specific services within it.

What does this all mean in terms of where are we now in the project? The project now presents an agenda for health, and that is what we set out to establish. We certainly do not think that we have answers to the questions that we have raised, but the aim at this stage is to raise those questions and to promote the idea of new, innovative and long-term strategic thinking in order to determine the future of health.

In terms of other work that was going on, we could not see whether anyone else was taking the broad perspective of trying to pull together the trends and issues in the various sectors of health to provide an overall picture of where health is now, where we might be going, and therefore what we should do.

And, finally, who is the agenda for? So far, we think it is the policy-makers, the staff, the patients, the consumers of health services and the public. We have tried to address the consumer by putting the papers out to consultation, a process that has just come to an end. And now we are embarking on a second process, where we think about what people have reflected back to us in terms of the recommendations and how we pull it all together in a summary of issues for government.

#### *Cristina Puentes-Markides*

What we are seeing now in the United States, and also in Canada, is some recognition that the way the health services system is structured really can affect health by jeopardising access or utilisation. We really need to take another look at the way we are structuring systems.

#### *Laura Balbo*

Charlotte Dargie talked about a “sophisticated public” with rising expectations. Not only do

people want to get better, they want a good relationship. And in the report there is reference to an informed and demanding patient. The right to refuse treatment was mentioned, but there could even be discussion of the right to choose the moment of one's death. This is the kind of public we already have, and certainly the one we are going to have. It is not just changes in the health care delivery system but the fact that people are informed, demanding, sophisticated. I was very pleased to see that this was one of the issues that had been identified.

*Charlotte Dargie*

This issue came out more strongly as we went on with the project. We started in terms of thinking what might be the technical or environmental drivers in terms of health. When it came to considering what technical papers we should commission, public expectations came up, and then in the discussions that followed it became a much stronger issue.

It has been brought to our attention since that there is often a simplifying assumption made that there is just one set of public or people's expectations. Rather than assuming a demanding public, we should be thinking more about different groups of people. In that case, we need to explore the mechanisms that can be used to respond to their different expectations. More work is needed on that.

*Cristina Puentes-Markides*

We have been told that one of the purposes of the project was to raise issues for policy-makers. Then we were introduced to the sophisticated consumer. What happens to the "unsophisticated public"? How could this project be used to raise issues among all kinds of publics?

*Charlotte Dargie*

Our initial remit was to identify messages for government and we have developed an agenda that is directed towards ministers. The projects undertaken by government itself, for example Foresight, have the capacity to engage with the public in a much more wide-ranging way than we would be able to. But if we can push for issues to be put on the government agenda and for policy discussions at that level, and if policy were then changed as a result, then we would say that we have had an impact.

One of the questions that we have asked ourselves is how we would measure the project's success. Would or should it be how we got issues on to the government agenda, or the number of people who now know about the project, or the number of local groups we have helped to consider the impact of the issues on them?

We do know the number of visits to the Nuffield Trust's web site and the number of people who are accessing the reports. We are also aware of the interest among local health services; they would like to use the work or run scenario exercises or consultation exercises in their local areas. Certainly in that way the project would reach a wider public than we could ourselves.

*Pam Garside*

I personally got quite frustrated when we received the paper we had commissioned on public expectations. It responded to what we asked for, but it led us to think that we needed a much more sophisticated look at the issue: what is the public, how do they engage as individuals, sophisticated or non-sophisticated? We have started something that we want to look at further. Hence, we deliberately called one of the six themes "sustainable financing and people's expectations".

*Tim Willis*

Reaching the public is one of the Foresight objectives. We use patient groups, charities and the women's voluntary sector, among others. When we became aware of new types of initiative in primary health care – say a new use of information technology to strengthen links with the population in a deprived area – we involved the innovators in the work of Foresight. But it really is difficult to identify the public. How is it done in the United States?

*Cristina Puentes-Markides*

It is difficult because, consciously or not, our cultural, professional, gender and socioeconomic biases determine how we look at the world. In preparing the United States' health promotion and disease prevention policy for 2010, the consultation meetings engaged a variety of people, professional associations, associations of patients, some business advisory groups and the faith communities.

Nevertheless, however you look at it, the problem in the developing world is similar. Social policies in Latin America do not always reach the people who are truly disadvantaged. Including people and reaching them through social policies and programmes may need different ways of thinking and approaching health issues.

*Graham Lister*

As chairman of a United Kingdom patient-based organisation, I would like to stress that we should not take this sort of social capital for granted. It requires investment and support. In the Netherlands, one in five people are members of a patient-based association. This is partly due to a history of civic engagement, but one of the reasons is that the government has invested in an infrastructure, the Netherlands Patient/Consumer Association, which supports patient organisations and patient advocacy and provides information and ways of looking at the world from the patient's perspective.

*Ann Taket*

The presentation concentrated most on health services and the health service system. What has been coming through about what the response could, should be or is in the other sectors that impinge on health?

*Charlotte Dargie*

That is quite difficult. It partly relates to the design of the project, which was a secondary analysis looking at the trends and issues that could be discerned from the published literature and other reports. When it came to thinking as a group, we felt at the beginning of the project that we were taking a broad perspective. But looking at actual interventions, we were drawn more into what the health services can do. The difficulty is thinking in terms of policy recommendations. We first have to determine who has responsibility for health policy and where responsibility should lie. We thought about it, and we have not really answered it. We are still at the stage of asking questions.

*Sandra Dawson*

We need to be very focused and to draw attention to the things that are most important. I think we have to be clear how ministers would know in one or five years' time whether the recommendations that we had suggested had made a difference. We need to know not only how we should judge the success of the project, but also how the recommendations that we bring forward could be benchmarked on hard data.



*Question:* What view did you come to on health inequalities and social exclusion?

*Charlotte Dargie*

After we had received all the technical papers we held a workshop in which we tried to identify issues that cut across all the topics we had covered; if one issue stood out, it was health inequalities. The information in the public domain about widening inequalities in health has recently become an issue in the United Kingdom.

There is the difficulty of measurement and benchmarking. I noted the point made by Ilona Kickbusch on the argument of having social rather than just health indicators. We have looked at the work that the Joseph Rowntree Foundation is doing in terms of indicators and playing a monitoring role. We do not have the capacity to undertake the Rowntree type of monitoring project, but I see it as an overall aim of the project that there should be a monitoring capacity and time for issues like that.

*Sandra Dawson*

Although social exclusion was high on the government agenda, we found very little optimism that anything could be done to improve the situation in terms of social exclusion or health inequalities.

Rather than reducing inequalities, changes in information technology and the immediacy of information available could well exacerbate inequalities, precisely because of the way that information is used and the people who have it available for use.

*Morton Warner*

If you start by accepting that you cannot give people health, it may be possible to think of the task as: first, to set the conditions that are conducive to better health and allow people to benefit; and second, to protect them from things that could cause them ill health. Access to health services is not going to have anything other than a marginal effect on people's health and health inequities. Unless we tackle the bigger social exclusion agenda, we will not deal with the conditions that would be conducive to better health.

*Ilona Kickbusch*

I think that there needs to be a significant shift in thinking about health futures. If you take the work of Evans and Stoddart, they are saying very consciously that over-investment in medical care can actually draw resources from the creation of health. There is a new type of economics that we need to address in terms of the types of values that Herbert Zöllner identified earlier.

The project papers may be looking at the health care sector in the widest sense, but they are framing it as social expenditure rather than social investment. We continue to think about health as sickness and the deficit model of health. Even the very well meaning prevention/health promotion people tend to look at the other sectors and ask what they are contributing to creating health rather than looking at their own responsibility in creating a good society. They should also ask themselves whether their own sector produces health at a good price.

Sen and others argue we need to frame our thinking in terms of supportive or support-led policies. Some of you may be familiar with a recent editorial by the great epidemiologist Lester Breslow. He says, "We are on the verge of a third public health revolution. The first was



fighting infectious disease, which was more the health protection agenda, the second fighting noncommunicable disease, which is the prevention agenda, and we are now shifting towards seeing health as a resource for society”. This framing of health as a resource is crucial for the 21st century and it relates to support-led policy.

Adam Smith said that wealth is a resource to live well in a society. Now health and wealth must be brought together as the social agenda in which health is seen as a resource, not only for the individual but also for the community and society to achieve something jointly.

### *John Wyn Owen*

Just a few days ago I received by internet an account of a crisis meeting in California, where all the leading health economists were gathered. It was a crisis of ideas; all their pet ideas to date seem to be failing. They were meeting to discuss the crisis of managed care and what to put in its place, and their feeling was that they do not actually have anything to offer.

Then there was an article in yesterday's *Sunday Times*, which I thought was extraordinarily depressing. It built on a series of interviews conducted in the constituency of the present health minister, where access to medical care has been frustrated in one way or the other. The article was in heavy print, and the references were to the sort of people that we normally hear talking about the demise of the health service or the problems in organisation and funding health care.

Yet, as Ilona Kickbusch challenged, what happens when you take a completely different set of perspectives, not those of expenditure but those of investment and where and how to invest? Our primary concern is about people's expectations and about sustainable financing, but one can easily switch to investment in that context.

## **International dimensions of the Nuffield Trust project**

### *Keith Barnard*

Today is the 13th of December, St Lucia's day. Lucia was a 4th century martyr, and her name means "light". She is celebrated today in Sweden when the light starts to return under the old calendar. I think that is an appropriate symbol for what we are engaged in at this meeting. Another interesting fact that I came across very recently is that astrology was one of the most highly rated academic disciplines in medieval Oxford. It may just be that futures studies will be the new astrology of the modern era – led by Cambridge!

That's not entirely facetious because a lot of people invested in astrology, just as a lot of people are investing in futures studies now. That gives us cause to reflect that what we are doing is of growing significance. All the effort that we see being put into the government-wide Foresight programme, with major foundations becoming involved and universities taking up the issue, suggest there is a movement now. We need to make sure that it moves in the right direction – one that serves science, but also serves society.

The points I will make now are more fully developed in the paper I have written as a response to the *Pathfinder* document. Any good futures study should create controversy. It should shake people's thinking up. It should not produce answers that are taken for granted. It must be the first step in a process of rethinking what we are doing and where we are going. I hope that we

have already had enough in the discussion this afternoon on the *Pathfinder* document to justify my saying that.

I want to underline the importance of what the team has done in producing a synthesis. I should like to contrast the synthesis paper with the ten background technical documents that were commissioned. The papers are written from discipline-based perspectives – a tunnel or funnel that people are looking through. Those ten documents by themselves are not very helpful. The synthesis is needed to bring it all together in focus, so that people can see that it tells us something about the problems we can see on the horizon and about where policy should be going.

A synthesis such as the *Pathfinder* document sets it all out in a way that we can respond to. I applaud the way they have done it and the way they have explained what they have done. The documentation we have been given means that we in WHO can point to this work and demonstrate to others that this is a task that can be done, that is worth doing and that produces these kinds of responses. It opens up these kinds of possibilities.

We have been talking about benchmarking and that's very much part of what I am thinking about. If we can see these kinds of studies and the way thinking is going in different countries it will expand the range of possibilities for all of us. We will all be able to see the different options and different ways of looking at issues.

I suggest that there is a cluster of issues that we might want to reflect on. What is the actual market for futures studies? Who are we selling to, and what do they want to buy first? If you are a minister, what kind of picture of the future do you want to see, and how do you want it packaged? A related question is the world of futures that we adopt – our particular mindset as scenario writers or the frame of reference we use as scriptwriters. I think we ought to be aware of ourselves, as well as the people we are selling to.

The next issue I find very significant is what I call the future of order. There is a family of related concepts such as governance and stewardship, but they are all about the future of order. How are we ordering ourselves as a society and how will that evolve in the future?

Then we need to be aware of the mistakes of futures. There is a very good paper by Ringland and others in *Long range planning*, the journal of the Strategic Planning Society, on the mistakes that are traditionally made in futures work, scenario writing, etc. One of the biggest sins is to see the future as a continuation of the present. I think we need to ask ourselves whether we are entirely free of that particular problem. A further issue we need to be aware of is how can we do this better – what I call the future of intelligence.

On the concept of health (and this has been well discussed already in this meeting), do you see the need to focus on the health care system and medical services or on those other issues that can produce, sustain and improve health? It has been a conscious effort in the presentation of the HEALTH21 document to make sure that these two aspects are in one sense in balance. The developments that, on certain assumptions, could be taken up in the Region to improve health *and* the delivery of health care are all set out there, together with the rationale, the opportunities and the possible means.

But if you look at the way HEALTH21 is presented, it is the issues *external* to health care that are given emphasis. These are the whole range of health promotion and protection

programmes that create conditions for healthy living and give people opportunities to make healthy choices. They are all put up front to counter the temptation in countries, and by politicians and the public, to think about health care first. Let us first think about the other things that create health, and then about delivering health care.

One useful image is to see the whole health field as if through a pair of binoculars. Through one eyepiece you should be able to see the image of health and better wellbeing, and through the other disease and disability. In practice, we block out the former eyepiece and only use the latter. It is as if we only had a telescope and used it to look at disease. We should unblock that eyepiece and use the binoculars.

I call that the functional frame of reference. We also need to be aware of the geopolitical frame of reference, and the non-inevitability of the train of current developments. We must become aware of the fluid nature of the geopolitical situation – not only the geopolitical situation in Europe but also the situation on a global level. We live in a world in which the G7 countries cut up the world's cake and the majority of the world at the moment stands by with the begging bowl. But what happens if the third world strikes back? The early 1980s novel from William Clarke, *Cataclysm, the north-south conflict of 1987*, offered a chillingly plausible scenario.

I want to bring the geopolitical question back to the United Kingdom. There is a process of political restructuring that started with Scottish and Welsh devolution and that could continue with regional devolution in England. This is going to create a wholly different environment in which policy is conceived, fashioned and implemented than we have traditionally had in the United Kingdom, which has hitherto been highly centralised.

Last week agreement was finally reached (or so we must fervently hope) on a new power-sharing administration between loyalists and nationalists in Northern Ireland. The question is, does the fact that this step forward has been made mean we are seeing the first weak signals of a new kind of political and social culture? In all spheres, we are trying to “use our nose” to see whether something is going to be significant and how it might be significant.

To express this in our more abstract terms: are we going to see in the future the old ideological politics, which tend to be about whether we privatise or we revert to state planning, or do we become fragmented into a kind of pragmatic issues-based politics: animal rights, gay rights, minority rights, etc. Self-contained issues mobilise certain people and they are an embarrassment to government, and so government responds. But that is as far as it goes.

Alternatively, are we going to have some new kind of values- or ends-based politics with the emphasis on social justice and equity? Can we get people to accept that this must be the starting point in our thinking? This is the test against which we will judge any ideas that come forward. WHO has been trying to feed that view of the policy process into the public and political consciousness from the beginning, when Mahler launched health for all in the late 1970s.

We can relate our worrying about whether old ways will be perpetuated or not to the way services are organised and the way leaders and managers respond to the challenges and demands on them. In the future, will organisations continue to follow the model of the classic hierarchy we have all experienced?

There was a nice piece of cynicism offered as an end piece in the *Financial Times* some time ago, which traced how perception changes as you go down the hierarchy. We could say that in the public sector at large, a prime minister offers a strategic vision. A government department drafts a policy statement (sometimes called a consultation document) which, when it gets to local health authorities is a top management directive: As you go down inside the local organisations to the real operational level, reactions eventually become unprintable.

There is a huge perception and communication gap between the public statement of a head of government or even a corporation and the response of the people trying to do a daily job who face all the pressures, complexities and contradictions. But that is just one example of a general bureaucratic phenomenon – the bigger the enterprise the bigger the problem. Strategies of so-called “good communication” change nothing. We need to look at purpose first and then decide on organisational and communications arrangements.

The Healthy Cities agenda gives us a good example of the challenge at local level. We are trying to give preferential consideration to people with chronic health problems and members of vulnerable social groups. We are trying to do something about the environment. We are trying to give them a chance that they can lead their own lives, choosing their own healthy patterns of living. And we want to make sure there are appropriate services to meet their needs and that they have access to them.

How do we get a new kind of organisation that enables that to happen? Can we really expect that kind of outcome if we continue with our present patterns of thinking and present patterns of organisation?

I mentioned earlier the work of Ringland and others on why futures go wrong and why, almost invariably, forecasters get it wrong! That is partly because of the “Tina” (there is no alternative) complex of straightjacketed minds that are unable or unwilling to contemplate other possibilities!

There is an observation, attributed to Maslow, that if your only tool is a hammer you tend to see every problem as a nail. If you see health care in terms of financial sustainability (because demands for services are outstripping the likely available financial resources) you are going to get one set of solutions– that is the nail and your hammer will be private financing or something of the kind. There is no alternative. If you think outside the box, if you can manage to unbuckle the straightjacket, you may find another tool to construct another piece of furniture.

We can break out of the box. We can look ahead. I suggest we look for new economic reasoning, new forms of organisation and a new readiness to share information – not competition but collaboration. Can we see the first weak signals?

When we are faced with a picture such as the Nuffield Trust/Judge Institute has given us, I suggest there are certain things that we could and should do. We would then be serving our own best interests as a society. First, keeping our mind open, we could use it to explore further possibilities and make it an occasion for reflection. Second – and this is directed to the bureaucrats among us, although it will likely be difficult – we could try to use it to shake policy-makers out of their “comfort zone”, the current assumptions and responses they make to challenges and problems. Third, if we keep scanning for early warning signals, we can try to

build a broad-based awareness of the significance of acting or not acting on those issues that we have judged demand attention.

My last point is a restatement of the experience that we have had in preparing HEALTH21. We use our futures thinking to find the assumptions on which to build policy proposals. We feed in our intelligence to the decision-making bodies to evaluate and decide what actions would be appropriate. The fundamental point is that it is a repeating process. John Wyn Owen was saying earlier that the Nuffield Trust intends to launch its policy futures and then publish an annual statement every year after that. That's exactly what I am getting at.

***Ron Zimmern***

Keith Barnard has identified a tension, “health versus health services”, but working in the Nuffield Trust’s genetics project has made me think about another tension, which is whether structural or individual approaches are going to be more effective in the future world.

If we emphasise individuals and empowerment, and recognise that individualisation is coming along, what should be the balance of techniques between the individualistic and the collectivist in the 21st century? It may be a different balance to what might have pertained in the last 10 or 20 years. There may be a discontinuity, which will be exacerbated by the new genetics. Therefore all this business about guidelines and evidence-based medicine, which applies to groups of people, may actually be the wrong approach given the individualisation of society. I do not know the answer.

***Sandra Dawson***

Keith Barnard has drawn attention to the dangers of living in the past when we go into the future. None the less, drawing parallels with past experiences can sometimes help our understanding. And I want to link that with another point he made – the significance of which frame of reference is used. I am thinking about some experiences I had in the 1980s in local community development in east London. This was in the realm of social responsibility within the Church of England’s London diocese.

There had been an awareness of social exclusion (although it was not called that) and there had been a very paternalistic form of development. It cost a lot of money, but the paternalism actually achieved nothing at all. Community development meant giving up the paternalist agenda, enabling *people* to set the agenda and then working with it. It meant they might see things in ways that were not necessarily the ways that “the powers that be” wanted them to be seen.

It really was a profound shift of power to a form of community development that was owned by some of the minority groups in east London. It happened partly because there was not a very strong professional base for the “powers that be” to retreat to. But in health there’s an enormously strong professional base, which appears to have the power of life and death.

I was also thinking about a student who was working on health sector reform in India. There the neo-colonial style paternalistic approach has been shown to cost enormous sums of money and not necessarily reap any reward. Now she’s working in India with very different models concerned with empowerment, facilitation and taking different views into account.

***Keith Barnard***

Regarding the failure of paternalist community development, there was an interesting book by Susan Rifkin some 15 years or so ago about community health planning. She had had

extensive experience of developing countries and she wrote it up as a series of case studies. As I remember, one of her negative conclusions was that, even though the planners may have been trying to promote self-development/do-it-yourself programmes in the communities, the communities themselves wanted to be dependent on the professionals. It is the two scenarios that John Wyn Owen presented. They were hooked on the “trust us” scenario, relying on the professionals, while she invited them to go for the “find our own way” scenario.

*Sandra Dawson*

One of the reasons why the “find our own way” scenario is often resisted is that it is interpreted as a money-saving exercise, getting ordinary people to do what should be done by professionals.

*Laura Balbo*

Compared to fifty years ago, people are so much stronger in the way they are able to define their problems and decide who they give their trust to. If we just changed our way of thinking and naming, I think we would see that people are better educated, informed and capable of coping. We talk about prevention, by which we mean giving information or providing education. We should remember that people know how to handle most of their day-to-day problems. When we talk of rising expectations, we should not think that people always expect somebody else to take care of them; even those who are excluded have a lot of expertise in surviving.

We are not used to thinking of people as having their own resources because we are bound by top-down planning structures. This is especially so in the health field, where the professionals are supposed to have (or do not have) the answers. They tend to assume people are selfish and non-community minded. But I believe the great majority of people in our countries are intelligent social actors and they have resources to give to their society. We should keep our eyes on these new social actors.

*Sandra Dawson*

We should look at businesses as social actors, and what happens when they shift their frame of reference. When I began working with commercial companies in the area of occupational safety and health, it was very much seen as a cost. Agitators, as they were perceived, had demanded that attention be paid to it, so the idea was to minimise the cost.

Then it became apparent that there was a business case to be made for health and safety. Boardrooms became attracted by the idea. It was a combination of external regulation, internal development, local agitation and a whole range of different things, which transformed the way in which most large corporations now view occupational safety and health and the physical environment.

Now we are beginning to see a change in the way they perceive the social agenda. Keith Barnard made a point about spotting weak signals. Let me give you one that I am picking up. Some of the large multinationals are coming to our Business School and saying, “We understand about the financial balance sheet, we also understand the environmental balance sheet, but this social agenda is jolly difficult for us”.

Then they explain what they mean. Wherever a transnational company makes an investment, whether it is oil exploration or a large infrastructural project, they bring with them such



benefits as employment, good water and the Internet into these communities. This is all very well, but with it comes kidnapping, drugs, prostitution, and very different ideas about the time scales for completing work.

***Ilona Kickbusch***

I agree very much with that. The signs of innovation are coming either from the private sector or the NGO sector, and in some cases it seems that even the NGO sector has become conservative rather than innovative. While I was at WHO we had meetings with a range of people from the private sector and also, with the help of the Prince of Wales Business Forum, with multinational companies. In some cases they were not weak but relatively strong signals. Even the relatively fragile new alliances in health, such as for malaria, show an engagement from the private sector. There is also the rather large investment that a number of companies – and not even traditional health companies – are making in community health and the environment.

Then there is the new type of balance sheet that some companies are presenting, in the form of a social report. I think the Body Shop started it, and others followed. The private sector has started to develop a new type of accountability, which the public sector has not yet picked up. It will be interesting to see whether these leaders can start influencing both other parts of the business sector and the public sector.

***Keith Barnard***

On the same theme, there was a very interesting report in the *International Herald Tribune* at the weekend about UNDP and its strengthening ties with the private sector. There seems to be a meeting of minds, or they have compatible agendas. The private companies realise they have got to address the social agenda; they do not have the techniques, they do not have the experience and they are looking to bodies like UNDP that can give them the tools. It is a win-win environment that is being created.

***John Wyn Owen***

I have two points to bring this session to a close. At the Trust we are in the business of finding those early signals of change. Where and who are the people we need to encourage? How do we make sure that we engage them in the thinking needed? If the Trust were able to provide an opportunity in the United Kingdom, then I think it would serve our tradition. I think we would like to put on record that this is something we should feel almost our bounden duty.

My second point is the issue of trust in society. Probably as a result of scandals of one sort or another, or because we want to see the demise of professionalism, we have moved dramatically to low-trust organisations. Even Adam Smith had the concept of trust. We need to find ways of re-engaging and creating a society with high levels of trust.

***Herbert Zöllner***

It has struck me, as the discussion has gone on, that despite all the consultation we had with governments, NGOs and others over HEALTH21, the document will seem to some a little old-fashioned. Given the new ideas about health that have been put forward, one thing is clear: health and wellbeing have to come together. We cannot just be health fascists. The notion we can really focus on is investment in health *and* wellbeing. Investments are, by nature, future-oriented.



When we go out and argue for our agenda, we need to know with whom are we talking. Who are the “people” and what do we know about them? I would agree with Laura Balbo’s perception of people today, at least in the western countries of our Region. The problem is that what we can say about western countries may not hold for the rest of the WHO European Region. We can never allow ourselves to forget that Europe is not just one Europe. There are many different challenges we have to face, as we will no doubt hear in the next session.



# KEY ISSUES FOR EUROPE

## The future of Europe in the light of geopolitical and economic developments

*Drago Najman*

After a year marked by Kosovo, East Timor, Seattle and Grozny – and I could continue the list – we are at the end of a century characterised by the end of certitudes and a shock to identities, and the disappearance ten years ago of a framework of acting and thinking to which we had become accustomed.

Who could have predicted, ten years ago, the fall of the Berlin wall? I worked for about 13 years with former Chancellor Schmidt of the Federal Republic of Germany, for whom I still have immense respect. He never dreamt that the wall would disappear during his lifetime. He saw it happening some time in the 21st century, very far away. And this is the explanation of some of his policies in regard to the German Democratic Republic and to his brothers and sisters living on the other side of the wall. It is not the justification; it is an explanation.

Who could have predicted, based simply on GNP, not only the disappearance of the Soviet Union but also the incredible rise of China as a world power? Moreover, China has become one of the three major strategic powers in the world today, not only because it has nuclear devices (India, Pakistan and many others also have them) but because it now has the vehicles capable of delivering those nuclear devices to any part of the world. We have witnessed the transformation of the G7 to the G8. People are already talking about China joining the G8 and about the G9 becoming the new leadership of the world, and this might come “the day after tomorrow”.

We have witnessed this year, first the changing role of NATO and then, only a few months later, a radical change in NATO. The speed of those changes is staggering. We are living in a world where it is difficult, simply by reading the newspapers, to appreciate the tremendous

changes occurring every single instant of our lives. So, I will refrain from forecasting but I will attempt to describe the present and some of the options for the future.

In 1513 Machiavelli said in *The Prince*: “There is nothing more difficult to carry out nor more doubtful of success nor more dangerous to handle than to initiate a new order of things.” The world today is undergoing a period of transition, in which, whether we like it or not, the objective is initiating a new order of things. We should not be in the least surprised about the difficulties involved, because nearly five centuries ago Machiavelli told us, among other things, to be careful when we entered such a period.

This is indeed a period of formidable transition. We have moved from a situation of balance of power among sovereign states, going back to the Treaty of Westphalia in 1648, to the beginning of blocs at Yalta (an unsatisfactory but stable and predictable set of relationships based on nuclear threat and – on the other side of the coin – coexistence) and then to the fall of the Berlin wall and the disappearance of the Soviet Union.

And more important, as I said at the beginning, this is the disappearance of the classical world order, the disappearance of a framework, of our way of thinking and acting. So not only has the content disappeared, but the framework has disappeared. And what remains is a situation without a framework, which is more important than the content. So we have entered into an unstable and unpredictable set of international relations.

We are witnessing an acceleration of history at a rate that I think we have never seen before. In less than ten years, we have seen the defeat of centrally planned economies, the formidable rise of nationalism, an incredible development of communication technologies (which in fact led to globalisation), and the worldwide transition to liberal democracy and the market economy – together with an acknowledgement that that market economy is unable to solve all our problems.

The market economy cannot deal with poverty, the environment or social welfare. In other words, what we are capable of managing is growth, and we have created a system in which economic growth is the *only* objective. We know that this cannot be – and in reality is not – an objective conducive to human beings learning to live together.

Now what lies ahead? I would say not the creation of a new world order but simply the re-creation of a world order that has disappeared. About five years ago I was invited by WHO to a seminar in Copenhagen and I was asked to lecture on “Can the United Nations turn the tables?” Those who were there will remember that I said that if the United Nations does not equip itself with what is foreseen in its Charter, i.e. a capability of military intervention, then there were several other candidates waiting to take over, and I specifically singled out NATO. Five years later, what I thought would happen had happened.

Now we have witnessed, in a way, the rise and fall of NATO in less than a year. In fact, the member states of the European Union have decided to develop a more effective military capability. The objective for the European Union is to have an autonomous capacity to take decisions and then to conduct military operations in response to an international crisis. I should like to quote you the following from the European Union Council’s final statement. This is the key sentence marking the difference between NATO and the newly decided European Union military capability. It reads:

“The Union will contribute to international peace and security in accordance with the principles of the United Nations Charter. The Union recognises the primary responsibility of the United Nations Security Council for the maintenance of international peace and security.”

We will be talking about that sentence for years to come. But it is certain that it marks a great change from the situation created by the intervention in Yugoslavia on 24 March 1999.

Some major problems and issues are still without solutions, at least in the foreseeable future, in the security and geopolitical area. The rejection of the Comprehensive Nuclear Test Ban Treaty by the United States Senate has set us back dozens of years, especially in a situation where new nuclear powers spring up like mushrooms.

Ratification of the various non-proliferation treaties by the Russian Federation is today more jeopardised than it ever was before. The problem started the moment that the decision was taken to enlarge NATO to admit the Czech Republic, Hungary and Poland.

After 24 March 1999, we are farther than before from the attainment of any resolution of these questions. And I submit that we have entered into a new, more unstable and dangerous international situation than in the period before the arrival of Gorbachev at the helm of the then Soviet Union. The Kosovo conflict did not make the international climate deteriorate. International relations had been steadily deteriorating for some time, and the Kosovo war only demonstrated and highlighted that deterioration.

I should like to be quite clear. I am in favour of the right – I call it the duty – to intervene in cases of massive violations of human rights. Not only am I in favour now, I have been in favour for years, and I advocated it in relation to the former Federal Republic of Yugoslavia in 1991.

Prime Minister Blair called the latest conflict a war not of interests but of values. The values were accepted by the United Nations years ago. A resolution on the right of humanitarian intervention was adopted by the General Assembly and so it is on the record. What is at stake are the answers to the following questions.

Whose human rights are worth waging a war to defend: Algeria, Chechnya, East Timor, Liberia, Rwanda, Sierra Leone, Sudan, Tibet? Who is to take the decision? Who is to intervene?

In the “old order”, all this was clear. The Security Council was to take the decisions, and a force assembled by the Security Council was to intervene. I spent five years in the Congo in the second major United Nations operation from 1960 to 1965. There were 30 000 military personnel under the command of the United Nations with one single objective: to prevent the secession of Katanga. Nothing else was at stake; and it was done. With the passing of the “old order” those questions are now totally open.

The marginalisation of the United Nations is important not only *per se* – because we are attached to the idea of the United Nations and collective security – but because there is nothing to replace it. We have not prepared anything for the next phase, and this is what I was trying to explain five years ago in Copenhagen. The question is not who is going to do it if not the United Nations; it is that if we do not want the United Nations as it is today we should think about something else that would be acceptable to most people.

The tensions with China are serious, and tensions with the Russian Federation are getting worse every day, starting with the enlargement of NATO, then Kosovo, then Chechnya, and so forth. Those are tensions with two other strategic powers. This is not Albania, East Timor or Yugoslavia. We are talking of countries with a capability of transforming us all into smoke in no time at all.

When we look at the Indian subcontinent, again we see things going from bad to worse. Yes, there have been years of conflict, in fact since the independence of India and Pakistan in 1947. But for the first time the conflict has a nuclear backing without the other side of the coin – coexistence. We have indeed entered into a new type of international relations, different even from those we witnessed after the end of the Cold War. There were attempts at consensual settlement of disputes after the fall of the Berlin wall. Somalia was not a success in terms of the outcome, but there was no conflict over the decision to intervene. There was a wide coalition supporting action against Iraq. Action in Bosnia and Herzegovina, only five years ago, was the result of a decision of the Security Council acting under Chapter 7 of the United Nations Charter.

Those are examples of consensual attempts using diplomacy, negotiations, the existing international structure *and* force as the last resort. It is possible, provided we know who is doing what and why. I cannot resist the temptation to quote you from *Nouvel Observateur* a few terrible sentences about the results of the Kosovo enterprise.

Undertaken to defend the Albanians from Kosovo and facilitate a return to the coexistence between Serbs and Albanians, the operation has ended, on one side, by increasing the unhappiness of the Albanians, and on the other by ethnically cleansing the Serbs. In simple terms, this war was badly prepared, badly thought out and those who were leading it had not the slightest idea about the consequences. We are impotent in the terrible Chechnian conflict and incompetent in the Kosovo war.

We are witnessing the marginalisation not just of the United Nations but, more generally, of international law. In the case of Kosovo, there was a violation of Article 53 of the United Nations Charter and a violation of Article 2 of NATO's Charter, which says: "NATO provides deterrence against any form of aggression against the territory of any NATO Member State." There was also a violation of Clause IV of the Helsinki Final Act of 1975, proclaiming territorial integrity.

The fact that at the end of the war it was necessary to bring the matter back to the Security Council begs the question of why it was not done in the first place. It is argued that there would probably have been a veto, but looking at the record of the number of vetoes in the past 15 years I am not at all certain that there would have been a veto. Neither in China nor in the Russian Federation was there much sympathy for the then leadership in Yugoslavia.

We have to ask where this is all leading. Well, it leads to a repetition of the same phenomenon, because we have to understand that the histories of western and eastern Europe are totally and absolutely different. If we look at the historical roots we will understand a little better.

In western Europe, the nation state was created through rivers of blood and centuries of history. At the same time in eastern Europe, including Russia, there has been a sequence of imperial powers – the Turkish Ottoman Empire, the Austro-Hungarian Empire, the Russian and then Soviet Empire – that have hindered the development of the nation state.

In western Europe, the nation state has lived its useful life and countries are renouncing important parts of their sovereignty, notably in favour of the European Union. In eastern Europe, with the exception of the Russian Federation, nation states are only now being created. What we have witnessed in Kosovo and Chechnya, I submit, is only the beginning. And this is why we have to get organised in a different way. We have to be ready for it. We should not be thinking that what we have seen so far is the end.

Now to the risks and opportunities of globalisation. I will quote J.K. Galbraith who, only a few months ago, wrote a very interesting article on globalisation. This is his conclusion, which happens also to capture my own assessment.

Most of all, and in summary, we must give up illusions. The neo-liberal experiment is a failure and it is a failure not because of unforeseeable events, but because it was and is systematically and fundamentally flawed. We need many changes from this naive and doomed vision of an ungoverned world order. We need large changes and the need is great while the time, I believe, is short. We must bring the Reagan era to a final end. We must return to development policies for the people whose needs matter most in the large scheme of things, namely the millions of hard working people.

Finally, I have some observations about international institutions, beginning with the United Nations system. The emergence of a unipolar world has weakened its centre, the United Nations itself, and particularly the Security Council. The future of the United Nations as a political organisation is unclear, and hence the strong reaction of many at the recent European Union Council meeting in Helsinki. But globalisation has strengthened those United Nations agencies that are at the helm of man-made systems. This is the case for the International Telecommunication Union, the Universal Postal Union the World meteorological Organisation and the International Atomic Energy Agency. It is also true for WHO in those aspects of its role where it is at the helm of a man-made system: communicable disease control and all the other problems where somebody has to manage the response.

As far as the European Union is concerned, there are now 13 new countries from central and eastern Europe, plus Turkey, now on the way to accession. In practical terms, this means that the Union has decided to proceed with enlargement *and* the reform process simultaneously. There had been a long theological discussion on what comes first. The long-standing majority view (before the Finnish Presidency) was that internal reform should come first, followed by enlargement. We have to understand that that decision to proceed simultaneously reinforces the elements of the European Union as a union of *sovereign states* at the expense of those elements that would lead to a *federation*.

As for other organisations, we have not recovered from an endemic sickness, lasting for 50 years now, of creating a new organisation each time we identify a new problem. The latest – and totally useless in my opinion – is the stability pact for south-eastern Europe. I do not see any reason for creating this new institution. Instead of entrusting the task to the existing European organisations, with their wealth of experience, we continue with this trend of multiplication.

*John Wyn Owen*

One of our tasks here at the Nuffield Trust is to gain some understanding of what actually



happens outside this country, in order to inform United Kingdom health policy. We are aware that understanding is essential, but until now we have tended not to look too far. This came home to me last week at the meeting we had with WHO in Copenhagen.

We were looking at what could be three big newspaper stories on health next year, and I identified three for the United Kingdom that come through clearly from our policy futures work. But when you consider the whole WHO European Region from the Atlantic to the Pacific, the concerns are radically different: war, refugees, poverty and the environment.

And on successive visits to Copenhagen we have seen how WHO has had to respond to that continuously changing situation. It is the same challenge for national health policy-makers: they cannot take the narrow view of their own country, they have to see the full context within which they formulate policy. So I think the overview Drago Najman has given us is particularly important as we try to develop the appropriate health policy responses.

Which institutions are going to exercise most influence in the health area? I am not always sanguine. When there was Asian flu in Hong Kong, a team from CDC flew from Atlanta to Hong Kong. They established themselves, took down the WHO flag and hauled up the Stars and Stripes, and went about their work. Then they sent their findings back to Atlanta. Five weeks passed before information was shared with colleagues in Europe.

What about man-made threats to health – bioterrorism? You will remember the bomb that exploded during the Olympic Games in Atlanta in 1996. That alerted those of us involved in preparations for the next Games to the threat of terrorism in Sydney in 2000. I was Chair of the Olympic Health Committee, and we met the Australian Intelligence Service. We learned from them that preparations for the gas attacks that had been carried out in Tokyo had been made in the Australian Great Western Desert. We followed up with a trial, an exercise, taking a gas attack in Sydney as the scenario.

Last year, President Clinton allocated US \$210 million for civil defence emergency planning against bioterrorism. I ask myself how well prepared the United Kingdom would be against bioterrorism. Just suppose the terrorists changed planes here on the way to the United States. We need more thinking about institutions, the way they work, and the nature of attacks against people – they may all be different in future.

Then there is the whole trade issue and the extent to which trade in health care and health products develops. Some of the street demonstrations in Seattle just ten days ago are an indication that not everyone agrees with globalisation.

Let me identify three further considerations to reflect on in the context of what Drago Najman has described. First, will capitalism really work? Second, many people will live in cities of 20 million; they will normally be very poor communities where the disparity between the poor and the wealthy may very well lead to potential threats, not just to health but to security. Third, there is the issue of migration and refugees and what we can expect in the future.

Finally, the head of INSEAD has pointed out that almost 10% of the world's product is associated with health in one way or another. Business is going to make profit, and much of it is going to be done on the basis of people. Life-science industries are going to require a good philosophical and ethical understanding of the implications of exploiting the human body for profit, and that will require quite different understanding by the world of business.

*Drago Najman*

U Thant said pessimists are well informed optimists. My objective in my presentation was not to be a pessimist, but rather by painting the situation as I see it (we are living in a world of perceptions, and this is my perception) to try to encourage a positive, not a negative, reaction along the lines of: “we have to do something about this.”

The international community has tried to do something. At the Rio Conference and other United Nations conferences on development, agreement was reached on the minimum funds necessary to implement a consensus on what should be done in the fields of population, the environment, education and social development. But not a penny was provided. We agree on everything, but then there is no money. This is characteristic of globalisation, the erosion of the power of the nation state in favour of financial markets and the multinationals, and the weakening of the international system that we put in place 55 years ago.

*Cristina Puentes-Markides*

In Latin America, and in many other places, governments sometimes adopt policies that in the end are not representative of the interests of the people, but rather of global interests that may be contradictory or even detrimental. Some of our brightest minds participate in countless intergovernmental meetings and summits, but on their return the implementation, or even the design, of some of these initiatives is impossible owing to political and economic interests.

*Drago Najman*

Governments have been elected or appointed to manage the nation state, or what is left of it. But the problems are more and more globalised and outside of the decision-making power of the national government. There is no manager for those problems. So we had those United Nations conferences at which *governments* agreed on everything. The programme was adopted, but there was nobody to manage the programme and nobody to provide resources.

So much is globalised and no longer within the power of nation states. This would lead us to the conclusion that we need, and I am not hesitating to use the word, *supranational* management of globalisation. I wrote, with a colleague, a book about global taxation a few years ago. I was very proud that it provoked an eruption and even a resolution in the United States Congress! But we will have to come to global taxation in order to implement global objectives.

*Morton Warner*

It does seem that national governments are under threat when you have, on one hand, globalisation and talk about the need for a new managed world order, and on the other hand emerging subnational power blocks within countries.

In the United Kingdom at the moment, we are very aware of the devolution of powers in Scotland and Wales; it is putting pressure on national government. We are seeing in many ways the powers of the national government being pulled away in two directions. Would you then really expect national governments to go back from these international meetings and comply with the agreements reached, when they have got so much to lose? They are being pressured from all sides. They have become the middleman.

*Drago Najman*

Even if that is the correct analysis, what is the alternative? If we agree that global issues need to be tackled in a global way (and this is already done in certain areas in the private sector), then it is very difficult to see how they can be tackled except by organising meetings of the sovereign actors, if I may so call them. Now the non-implementation of conference agreements is a real problem. And in spite of conferences being organised every five years to see what was implemented or not, the non-implementation is the result of the absence of global management.

In some areas, this global management is about to occur. For instance, the national authorities in charge of regulating the stock market are very efficient in developed countries – France, Germany, the United Kingdom and the United States. The problem is that the financial markets are now global, functioning 24 hours a day with thousands of billions of dollars circulating over a 24-hour period. And there is no global management that would enforce the same rules as the various regulating bodies are enforcing at the national level. There is now a definite trend that recognises that something has to be done about this. I believe this will happen in the very near future, because we cannot continue to have totally deregulated global financial markets when national financial markets are still, in some instances, very strictly regulated or observed.

Look at the following figure. Each and every 24 hours, US \$1500 billion are exchanged on one of those markets, such as the foreign exchange market. Now we are playing with billions and thousands of billions. If you started counting today you would need 33 years to count to one billion, and thus about 50 000 years to count the number of dollars that are exchanged in 24 hours on only one of the five big financial markets (i.e. the foreign exchange, stock, bonds, commodity and derivatives markets). On each of them, hundreds and thousands of billions of dollars are exchanged over a period of 24 hours.

Now it is not astonishing that those who are forecasting doomsday are forecasting it each and every day. I have a friend, a British journalist, who phones me every two weeks and asks when the market will collapse. I say I do not know. And the worst thing is that nobody knows.

But something might happen. Helmut Schmidt had a theory, which I still think is valid. The crisis will start in one of the offshore markets where there is no lender of last resort. If something goes wrong there and you have a domino effect, it will be terrible. What is the positive side of the problem? More and more people do realise that there is a need to do something. This will then trigger some other types of management institution.

Let me say immediately that the International Monetary Fund cannot do it. It simply is not equipped and the charter of the IMF does not allow it. But we have an institution called the Bank of International Settlements (BIS) in Basle, which was created to manage the reparations after the First World War. BIS is capable of doing it, and publishes every three years an incredibly interesting report showing the increase in financial transactions.

Only 37 countries are BIS Members, but they have 98% of the world's GNP. The other 150 countries do not count in financial transactions. So the picture is not as bleak as it might appear. But we have to try and find those beginnings of a change in the real-life areas, where global management will slowly appear, and is appearing.

## People, alliances and partnerships in the future Europe

*Ilona Kickbusch*

I have made two papers available.<sup>4,5</sup> One looks more in detail at the issue of partnerships and how partnerships, particularly with the private sector, should be developed. The other paper discusses issues of globalisation of governance. What I am going to highlight refers back in one way or the other to both of those papers.

The discussion of these issues relates to a whole range of ways in which we might frame the new context in which health and health policy is going to be conducted. Drago Najman has already outlined some of these factors that people see as the context for the new health policy, which is the general political context. There are a number of others that we need to highlight in health.

There is the whole realisation (which is historically not new, but people have rediscovered it) that trade and health are very closely linked. International health was basically created in relation to trade, whether you go back to the Venetian Republic or no further than the 19th century. But we seem to have forgotten that. Accounts of the discussions around the World Trade Organisation and health issues make them appear as if they were totally new. They are new to some extent in the sense of globalisation, but that is one of the new contextual factors.

Another contextual factor is the information revolution, and what it means for health in a number of ways. It means, in various parts of the world, a different type of access to health information, both for professionals and for others, but it also means access to products. And that means it can undermine a whole range of rules and regulations that have been set up by countries in relation to health products.

There is also the context of the health research and technology revolution, and the fact that most health research is private, not public.

There is the increased privatisation of health and globalisation of health care and services, and at the same time there is a notion of a broader understanding and accountability for health.

If you had followed the United Nations conferences of the last 10 years or so, you would have seen that whenever there was any discussion of accountability, or of how to measure progress, it usually led to epidemiological data and health statistics: longevity, infant mortality and so forth.

It is now very fashionable in every United Nations agency to talk about partnership, but I feel that is too narrow an issue. It implies that something is changing and that things should be done together. But the issue at stake is much larger – it is governance.

Whether you look at the big political picture as Drago Najman has described it, or the smaller but nevertheless still big picture in the health sector, you find that while the context has changed significantly in so many ways, the institutions have not kept up, neither the international nor the national institutions.

The number of actors in the international health arena has increased. These actors include the many new NGOs, private health companies and major health consultancies. Not just WHO but many of

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4. KICKBUSCH, I. The development of international health policies – accountability intact? *Social science and medicine*, **51**: 979–989 (2000).

5. KICKBUSCH, I. & QUICK, J. Partnerships for health in the 21st century. *World statistics quarterly*, **51**: 68–74 (1998).

the other United Nations agencies are involved in health in a variety of ways, together with the development banks and regional organisations such as the European Union. There is a multiplication of actors in the health arena, and nowhere have they been mapped systematically as to their interrelationships, the streams of power between them and the ways agendas are actually set.

In Europe 20 years ago WHO was more or less “the only game in town”. Now, at the end of the century, it is one of a multitude of voices, and not necessarily the loudest and strongest, the most credible or the one people really want to listen to. So there is an issue of political and institutional fragmentation, a total lack of order and reliability in that system, so that anybody who “enters” cannot really know which voice to actually trust.

There is also a nearly total lack of accountability of most of these actors. And even if they are the most well meaning, things can go dreadfully wrong. In the summer I was in Albania and learned from the Minister of Health how, in the course of two days, 350 NGOs descended on Tirana like a swarm of wasps to help the Kosovo Albanians, thereby destroying any infrastructure the Albanians thought they had. No mobile phone worked any more, and no taxi, car or hotel room was available in the whole of Tirana.

It was an extraordinary situation and it describes how helpless these nation states are in the face not just of the bad will of globalisation, but of the good will of the helpers. There seems to be nobody within that system that can take on the coordination and has the authority or the legitimacy to do so.

So we should keep in mind both the political fragmentation that is happening in the health arena and the lack of accountability. We see very clearly in the health arena that those mechanisms of health governance that we have do not quite seem to work.

One issue that is discussed very regularly in the international arena is the “sovereignty paradox”. It is a comment on the nation state. Much of international cooperation, and all the alliances that have been built up, and all the regimes that have been developed at the international or regional level, need the nation state in order to proceed. But at the same time, the nation state has lost power.

We see very clearly in the behaviour of nation states in the WHO governing bodies that they are not willing to pool their sovereignty in order to approach global health matters in a responsible way. Despite the fact that disease seems to be one of the most naturally global issues, health policy seems one of the areas that is most guarded nationally.

These very same countries close their eyes to the immense globalisation of the health care industry, and particularly the attack that Europe will be under in the next ten years. The American health care industry has a desperate need to expand, because its profits in the United States are going down. It is very systematically entering the European arena in order to make profits there.

The lack of willingness of nation states to come together to sort out issues is then reflected in the lack of architecture to do so. This was very clearly reflected in Seattle. Their responses are in a way very traditional. They either become protective and revert back to nationalist strategies, or they become competitive: we are cheaper than our neighbour, come and invest here.

But what is done least is pooling of resources and any attempt at global public policy. That is the issue that we should be addressing in the international health arena, globally and at the regional level of Europe. In what way do we construct global public policy in health and in what way do states pool sovereignty and bring in the other actors? It is very clear that the old type of multilateralism, which can be seen as a vertical sovereignty model, does not work.

The argument would be that we are moving from vertical sovereignty to horizontal sovereignty, and that what is needed to structure the future order is a mechanism that brings together in new ways the voice of nation states as one actor, the voice of international business as another actor, and international civil society as a third actor.

If you look at the international scene and the three actors – NGOs, the private sector and sovereign states (represented through the international agencies) – you see that the best organised seem to be either the NGOs or the business community. They also seem to use information technology most creatively, be it the business of protest or the business of profit-making. They are very clever in the use of the media and in the use of experts, and they are ready to enter unusual coalitions.

If you look at the workings of the United Nations agencies, you can identify a number of gaps there. There are rules that make it difficult to enter into unusual coalitions (see my partnership article). They refrain from using experts because of rules to be observed in maintaining the balance of nationalities. There is a lack of organisation, and of a clear agenda and priorities, and there is a very poor approach to the use of the media.

There is a very clear power shift, which can be seen as a marginalisation of multilateral institutions. We are witnessing a qualitative transformation: if you take those three actors, two are working more or less independently of territory. NGOs and international business do not need territory. It is the nation state that needs territory.

Therefore you have three players of which two work, in a sense, to the same principle. The third cannot, or does not. In order to be able to play the game together it would mean, not that nation states disappear, but that they find new ways of coming together and pooling, so that they can respond to this extraterritorial activity.

In terms of getting health on the agenda, we should expect that the political strategies of the 21st century will be very different from those we are used to. We sometimes forget how incredibly new the organisation of workers was in the 19th century, how new the women's movement was and how new those 1968 demonstrations were.

If you think back to the sixties and seventies, the standard strategy of political mobilisation was to go out in the street and demonstrate. The new strategy is what is called the "NGO swarm". The analogy is a swarm of bees or wasps. You give out a signal on the Internet with a goal, a direction and an agenda, and everybody responds through e-mails, letters, all kinds of activities. We saw the result in Seattle.

Something new is developing in terms of opposition. Partly it is becoming much more difficult to say who the enemy is. You need the support of some entity to move one part of your agenda ahead, while you are actually opposed to that entity in another part of your agenda. For example, we need the pharmaceutical industry in the fight against disease, while at the same time we are scared of what they are doing in genetics and life sciences. We are witnessing a



qualitative transformation in how partners relate to each other. It is a constant shifting of alliance and allegiance. That relates back in another way to the issue of insecurity and trust: relationships are now built around issues, not around continuity.

Keith Barnard contrasted the politics of means, of issues and of values and ends. If you look back, the first debate about partnerships was around intersectorality. I would say that was about means. Since then the partnership debate has moved to issues. If you go to the WHO Web site you will see how many disease-specific partnerships WHO has built up. For virtually every disease there is an alliance, a partnership or a project – partly with more-or-less the same players, partly with different ones.

What are the consequences of these issue-based partnerships? They may be useful in terms of tuberculosis, poliomyelitis or malaria, but what do they mean in terms of a stable infrastructure for global health and for national health services? Why is it that, at this point in time, the only way to manage international and global health is through a set of reasonably discrete, disease-focused projects and alliances. It seems that we cannot talk about infrastructure or policy in the international health arena any more.

Keith Barnard's third politics was that of values and ends, and that's where a very interesting new discussion has emerged. It is coming out of the United Nations Development Programme, with a focus on governance. The debate is about global public goods. It is an attempt to fill a void and to develop a new operational sphere, to frame these issues in a new way that makes it possible to pool and bring together the actors and the alliances around larger challenges.

We need to further develop this idea of global public goods, and determine what kind of organisational capacity we need to deal with such goods (within this context health is defined as a global public good).

A last thought is that what we are interpreting or defining as political fragmentation, and seeing as negative, might be the form of the future. Just as perhaps in the 16th century it was impossible to envisage what a nation state was, it is incredibly difficult for us to envisage that a society in the 21st century might actually do business very differently. It could well be that the new operational sphere will be the network.

If so, we will have to get used to the fact that the new governance will be characterised by shifting alliances, by a lack of stability and blurred lines of responsibility. The network transcends time and space and, very importantly, redistributes power among the three actors – governments, business and civil society. The challenge is finding the framework within which these networks work.

At present we see these networks and alliances developing but, because of the marginalisation of the United Nations system, there is no frame within which they act. This is the issue – global public policy and public goods – around which people are trying to develop such a frame.

The World Bank has developed cooperation with both the NGO and the private sectors and they are at present financing a large-scale project on global public policy networks. This brings together the debate on partnerships, alliances and networks, and asks what the institutional frame and value frame is within which these global public policy networks should function, and in what way can one develop their accountability.



*Cristina Puentes-Markides*

Our experience in Latin America indicates fragmentation in the countries, not only at the level of the government in terms of politics, but also at the level of the health care systems. There are some exported models of care<sup>6</sup> that are being implemented in our countries, which have not fully proven their benefit in terms of health outcomes, and that in fact may be more detrimental than beneficial without certain checks in place.

What should be the role of our organisation, AMRO/PAHO,<sup>7</sup> as part of WHO? We have facts that confirm that the implementation of some of these schemes is not always in the best interest of the people. Sometimes I wonder if governments could sue the Organisation for negligence, in cases where we possess that information and do not share it. There has been some talk of expanding the composition of our governing bodies to include more NGOs, and perhaps even private-sector representatives. This may be a positive move to improve accountability, do a better job and ensure that countries have full representation – not only through the government – and are able to access all the information they need.

My next point is that the risks are global and the need for partnerships is undeniably valid. Beyond that, governance is still more important. If we talk about new economies, we are also talking about new geopolitics; what will be the nature of these alliances, what will be their nature, and will they be based on ethnic connections or on religious preferences?

Up to now, market-driven forces have been very strong and have redefined these alliances in terms of trade, profits, etc. But other alliances may override those in the future. How will blocks be built, or rebuilt? This is one of the roles of think tanks such as the Nuffield Trust, and still also of governments, to look at where these alliances will happen and how.

How are governments looking at some of the issues of concern? I was invited by the United States government to work with the US Army Environmental Policies Institute in Georgia, within the Georgia Institute of Technology. It was a fascinating experience that involved a number of people from different walks of life, including people involved in military health systems and health promotion and preventive services. They wanted to explore the important environmental health issues for the United States Army.

The most important issue identified was water: how scarcity of water would create conflicts, within the United States and outside. The scarcity of water is a well known problem worldwide. The group envisaged what would happen if this scenario came true, when there are already issues of river water rights in some states. What would be the possible role of the army in solving a conflict? This issue, which is also an issue for other nations, raises questions about governance and the “sovereignty” of the states under the Constitution.

The Institute of Medicine published a paper last year called *America's vital interest in global health*, which highlights the global nature of health and the possible impact in several countries. In terms of futures, a great deal of work was generated in the United States in the forties related to national security issues. This was not the case in Europe, where the prospective work was more related to social issues.

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6. CAPPs, L. Managed care arrives in Latin America. *New England journal of medicine*, **341**: 702 (1999).

7. WHO Regional Office for the Americas/Pan American Health Organisation.

Ilona Kickbusch showed how NGOs and the private sector are able to use technology in their best interests. And I think in the case of NGOs it goes with their commitment, the moral commitment to a cause that we may lack as international organisations. Maybe our moral commitment has been eroded.

An anecdote by Jeff Goldsmith, a futurist, really stuck in my mind since it bears on our guiding values or their erosion. Making the comparison between Starbucks, the chain of coffee houses, and United States health care he said that Starbucks was able to take a commodity – coffee – and make it into a social value; the health care system had managed to take a social value and make it into a commodity.

*Pam Garside*

Ilona Kickbusch has pointed out that the health care industry in the United States is trying to go abroad. As a consultant, I have had clients in the industry, and they are not doing very well in Australia, Europe, Latin America and South Africa. They can never make the margins they make in the United States, the margins that Wall Street requires, and I think their structure will change as an industry. What I find more sinister is the way the multilateral agencies jump on the concepts of managed care and proselytise them in places where they do not work.

## **The future of work and health in Europe**

*Jorma Rantanen*

A number of challenges are faced by both enterprises and workers as they try to adapt to a new world order and a global economy running 24 hours a day. The factors that will shape working life and associated developments include a new political climate, demographic social change, ecological threats, technological developments, new and rapidly growing economies, and changes in the workforce and the structure of enterprises. Global companies merge and may come to administer larger economies than certain medium-sized countries. National-level enterprises seek survival through outsourcing, subcontracting and networking. The detail of my argument and all the implications are laid out in my paper.

We move into the next millennium in an economic, political and social atmosphere totally different from the situation no more than 10 years ago, and the pace of change is likely to continue. Simultaneously, we have new work organisations, new technologies, new materials and energies and new work practices, associated with new types of diseases and burdens such as musculoskeletal disorders, hypersensitivity and allergies, occupational cancer, and age-related and reproductive disorders.

One of the key processes is the search for flexibility by companies – flexibility in organisation, in working hours and working practices, and in the competence and skill of personnel. Many of these changes are positive, but we have also detected negative aspects, such as more adverse working conditions, lack of learning opportunities at work and lower pay.

Dozens of old occupations have disappeared and yet more will disappear as a result of change. The working methods and practices in virtually all jobs are changed by new technology. The job content is increasingly becoming mental and social rather than muscular and manual as it was in the past. Just as the human brain is becoming the most important “engine” of the

working world, the conditions of mental work are also becoming more important. How can we optimise the work of the human brain in the new information-rich and highly technical environment?

Information technology (IT) provides excellent opportunities to search for information throughout the world that will facilitate the protection and promotion of health. Many highly hazardous exposures and conditions can be avoided with the help of automation and mechanisation of dangerous work processes. But IT also makes new demands. There are three main challenges associated with the human–IT interface: visual ergonomics; cognitive processes in computer–human interaction; and psychomotor and keyboard ergonomics. In addition to the interface problems, information overload and time pressures may occur and seriously affect the productivity and quality of information-intensive work. That is why in Finland we have designed a large research programme on information-intensive work.

It has been calculated that the workforce is renewed at the rate of 2% a year while knowledge is renewed at 7% a year. This implies that in the year 2010 we will have over 80% of the present workforce still employed while over 90% of today's information and knowledge will have been replaced. Rapid changes at the workplace mean that all people participating in working life need continuous development and life-long learning.

Investing in competence improvement has been found to be profitable, not only economically as an effective way of improving productivity, but also in enhancing subjective wellbeing and prevention of stress. Work-related stress is, without any doubt, one of the new occupational epidemics. It affects health, wellbeing, quality and productivity at work. Many occupational health service units report an increased risk of psychological burn-out.

Several factors cause stress at work. They include time pressure, the competence gap (a major stress factor for many older workers), external pressures and higher performance demands, information overload, understaffing and threat of violence.

Some 30–50% of Finnish and other European Union workers report work-related stress derived from several simultaneous factors involving time pressure, competence problems, job insecurity, high work demands and continuous change. Over 50% of European Union workers suffer from time pressure at work; and in Finland, depending on the economic sector, 50–75% of workers experience time pressure that makes it difficult to meet quality standards.

Working hours are getting longer, with unconventional working hours and night shifts becoming more common. Over one third of workers in Finland work more than 45 hours a week, and 8% work 65–80 hours. The shortage of personal time will be compensated for by sleeping less, which may lead to lower productivity and risks of errors and accidents. We should be cautious not to exceed the psycho-physiological limits of humans. This is essential for concentration, safety, learning and innovation.

The need to develop health and safety at work is shown by the fact that 5 million occupational accidents with 6000 fatalities occur each year in the European Union, and the fact that occupational diseases and work-related disorders lead to the loss of between 100–200 million working days annually. Altogether, occupational health reasons lead to the loss of 600 million working days in the European Union each year, corresponding (according to one estimate) to a loss of €60 billion or almost 1% of the total GNP of the European Union. This figure may be

an underestimate, since the total economic loss from occupational accidents and diseases in Finland is estimated at 4–5% of GNP.

Occupational health services (OHS) are one of the most relevant ways of responding to the health problems of the working populations in modern society. It is a common observation of all European Union member states that the implementation of Framework Directive 89/391 on Safety and Health at Work has provided a stimulus for the development of preventive and occupational health services. This is the experience both of countries with a high level of OHS development and those whose level of OHS still lies below the European average.

The new needs brought about by rapid developments in working life are not necessarily covered by the Framework Directive, particularly problems of a psychological and psychosocial character, fragmentation of working life, the growing numbers of self-employed, short-term and casual workers, and the needs of groups such as older workers. We need both to:

- prevent and control the current and traditional hazards such as “old” chemicals, including lead, solvents, mineral dusts, heavy physical work and noise (the Framework Directive and the daughter directives provide strong support to this); and
- meet the new challenges (new technologies, new radiological, chemical and biological factors, allergens, “new” musculoskeletal disorders, psychological and psychosocial problems, violence at work, and problems of working ability in older workers).

The changes in the nature of the problems require changes in the content of the services. Advice and consultations on complex problems of psychological and psychosocial stress, social life in the workplace, motivation and working ability will be increasingly needed.

New training requirements need changes in strategies and methods, including the use of guidelines on good practice and supervised work on site, and distance learning through the use of telematic training systems and multimedia. The latter provides several new possibilities for practitioners who cannot be released to attend courses.

With a few remarkable exceptions, the human resources of OHS are still predominantly monodisciplinary – medical in most cases and sometimes technical. Roughly speaking, there are some 100,000 people (including physicians, nurses, other experts and support personnel) working in OHS in the countries of the European Union and the European Economic Area. If the 140 million working people in the European Union were to be adequately served by multidisciplinary services, the need would be as many as 250,000–280,000.

There is a need to revise and harmonise the curricula and the principles of formal recognition of experts throughout the European Union, although to what extent harmonisation can be realised in practice remains to be seen. The training curricula for physicians, nurses, occupational hygienists and safety engineers are well developed in some countries, but there is a lack of systematic training for all others in the multidisciplinary team.

Some countries are adopting new development- and promotion-oriented approaches that deal with workers, the work environment and the work community together. Inevitably this leads to the use of multidisciplinary teams and a change from a limited, predetermined service content to a flexible, comprehensive content corresponding to the needs of the enterprise, its management and its personnel.

In addition, this new approach is likely to lead to much richer contacts, collaboration and networking of OHS with other related activities. Thus OHS, which has sometimes been an isolated activity, is combining with other related activities within and outside the company. In addition to preventing risks to health at work and the promotion of health, one of the objectives of OHS will be to support the overall development of the company.

In Finland, we have developed a strategy of “maintaining work ability” as a comprehensive approach in OHS, linked to the development of the enterprise as a whole. The strategy integrates earlier efforts in occupational health and safety, organisational development, development of competence and even the development of an organisational culture. Some enterprises have successfully combined this strategy with their quality management systems. The key is the comprehensive, integrated approach instead of running health and safety, organisational development and training activities separately.

Europe has been described by many as a continent lagging behind technically and economically. It is nevertheless likely that final success in global competition will be won not by technical innovations, but by combining the social with the technical and economic dimensions.

The importance of the social dimension is seen very clearly in the attitude towards the employment of the older worker. Most industrialised countries will experience a relatively rapid aging of the workforce. While younger individuals are strong in so-called “liquid intelligence”, which is based on a good short-term memory, the “crystallised intelligence” and “silent knowledge” of older individuals can be a most valuable asset to an enterprise, and not least in times of rapid change and turbulence. Older people should be seen as stabilising forces in the management of change. They represent longer-term organisational memory, which industry finds of utmost value when hit by external or internal crisis.

The leaders in implementing IT systematically are predominantly the countries with high social capital, and with social policy objectives to ensure universal service provision. In a study of how Finnish enterprises managed economic crisis and survival in a recession, the characteristics that were found to be of high importance could all be counted as factors in social capital. This was true not only of managing in a crisis but also in the management of rapid growth and development after recovery. Such characteristics include: a competent, open-minded, human and client-oriented leadership; a tolerant and encouraging culture; an ambitious, development-oriented strategy implemented by dedicated management; competent staff; a flexible organisation; and active participation by staff in decisions and actions related to change.

Countries with a one-sided technical or economic dimension seem to be concerned only with the positive impact of IT on the elite rather than the whole population. In this respect Europe, with its strong social dimension, is likely to be the winner. We have good reasons to expect that with its social dimension, Europe will remain a good place in which to live and work.

#### *Morton Warner*

Jorma Rantanen looked at the structure of economies as they have changed over time, and now we are moving into an information-based society. So, in essence, whatever the continuing traditional occupational health problems, there will be a whole new range of health issues for a group of workers we might refer to as the new information “managers”.

I visited a British Steel plant recently, where I discovered that 100 tonnes or more of steel is made in one day by one man, one woman and two people on the floor. They are able to do this through complete information management. I must admit, I was full of admiration for these people and their ability to use the information they had.

In respect of the new information management, we should be linking education and training with health. If people are not well prepared, then we will be encouraging high-level stress, with all its consequences in terms of the increasing needs for health and social care services.

One point that struck me in the area of cognitive functioning relates to an article in *The Lancet* last week by two scientists from the National Institutes of Health, which talks about the importance of deficits in executive functions. There is a reduction in executive functions within the brain as part of the normal aging process.

There is also, of course, a progression by age in relation to role, so that you go from a junior professional to master to coach to ambassador to storyteller. And yet what we are asking people to do, for longer and longer in their working lives, is to be handlers of information and to be involved in the executive function. So there are quite serious health-related questions about how people are helped to adapt by being retrained or “reconditioned” in some way; if nothing is done we will see a very large increase in stress-related conditions. How long is this going to go on for? Probably for the next 20–30 years until we get that group of informatics literates, who are our children and grandchildren, fully engaged in the workforce.

We have already talked about networks, and in the information society we are starting to deal with networks of people and networks of information. The old characteristics of work – going to a job in a building and being enclosed by the security of four walls – start to disappear. How do people adapt psychologically when they are forced into network-type behaviour? There are some people who take easily to it – it is a relief, a new freedom – but there are others who are deeply stressed. And there is a third group who will start working in isolation, cutting themselves off rather than being able to join in.

Next there is the burden of disease. If one looks at the work on gender and disability-adjusted life-years (DALYs) in the year 2020, the top item for women is mental illness. When these data first came out there was a lot of discussion as to why this was so. One reason put forward was the multiple roles and functions that women are required to play, both at home with their children and at work and elsewhere. In terms of possible policies for giving them support, so far there seems to be no relief in sight.

Jorma Rantanen offers what I see as a rather classical provider model in his paper, one of training more occupational health physicians, more occupational health nurses and various others. This does not seem to fit well with people being able to empower themselves through information, through forming various psychological and other alliances and networks.

My final point is that we should not forget the needs of what we might call “occupationless” health, the health of the large number of long-term unemployed in Europe. The potential consequences of long-term unemployment were outlined at a WHO futures consultation in Bratislava in 1995.<sup>8</sup> In South Wales a lot of new employees are women working part-time

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8. *Third Consultation on Future Trends and the European HFA Strategy. Report on a meeting, Bratislava, Slovak Republic, 26–27 October 1995.* Copenhagen, WHO Regional Office for Europe, 1996 (document EUR/ICP/EHFA 94 01/MT01).



and we still have extremely high levels of unemployment, a picture found elsewhere in Europe.

### *Ilona Kickbusch*

The issue in women's mental health is not the plurality of roles; there is research evidence that shows that women cope much better after mental illness because they have multiple roles, in contrast with unemployed men who have been thrown out of their only role. The issue is that of multiple roles and identities without the power, autonomy and choice to go with them.

## **Equal opportunity in a future Europe**

### *Laura Balbo*

I shall first summarise some of the obvious trends and projections of what is likely to happen in the future to the European population. I suggest the key words are diversity and plurality. Then I shall focus on the concept of equal opportunity or, as I would rather say, *equivalent* opportunity. I suggest, that in order to be able to govern our future Europe, we should try to reframe our thinking, exploring mechanisms of empowerment and equal opportunities.

I say, in the softest possible way, that we should go beyond the rhetoric of equality. Equality is not around the corner; possibly the idea of an "opportunity mechanism" may be of help. Then I shall come to issues of health promotion and quality of life, which can be related to our earlier discussions.

In terms of alternative scenarios, a number of trends make up the background of our futures thinking. Most reliable are those concerning demography, since the direction of change is understandable as of now. Other trends, resulting from economic and social factors, may be more difficult to anticipate yet, as we know, these are taken into great consideration by most observers. I'd like to define them as issues of quality of life. They have to do with work, health and everyday life – a number of personal experiences that we all share.

We should always remember that an important feature since the Second World War in our part of the world has been the general improvement in living conditions and access to education, as well as our subjective positive attitudes concerning health and our physical, mental and social wellbeing. This is something we should never forget when we see these very pessimistic scenarios for the future.

Comparative research and survey data indicate that the majority of women in all European countries agree that their lives are greatly improved compared to those of their mothers' generation. Concrete aspects of daily life are mentioned, as well as economic conditions, the impact of new technologies (particularly on health, giving birth and aging), the transformation in the organisation of family and work, and changes in gender roles. All this was made possible by and led to crucial changes in the demographic structure and the organisation of the family and personal lifestyles.

Another aspect is the aging of Europe. A futures study carried out by the Forward Studies Unit of the European Commission makes the point that we are approaching a situation without parallel in history: a reversal of the proportions between the young and the old. Apart from all the other details, this is the new structure of the European population. But I think, here again,



we should understand these new actors – these young and these old. And this is a factor of diversity in lifestyles and in social and political participation, and what they have to say in the future Europe.

We know that the global income distribution gap is becoming more skewed, and that primarily (but not only) as a consequence migration is bound to be a lasting component of our future Europe. This may lead us to conclude that discrimination, xenophobia and harsh competition among social groups are likely to develop. We can then anticipate a scenario of unemployment, poverty and urban decay, which will affect the quality of life of great numbers of people. In the background, feelings of anxiety and anger are to be expected as a widespread phenomenon. Unprecedented patterns of diversity and continuing inequalities will be a major component of the social fabric in the years to come.

The way I choose to put the question is: Are we in a position to set up institutional and cultural arrangements that may counter a “blade-runner” scenario of domination with discrimination with an alternative scenario that of a “learning society”? The anticipated changes we have identified are such that, unless all our institutions and ourselves as individuals can adopt or achieve this learning society, the other alternative is possibly the only one we can look forward to.

The fact of inequalities is not new. Coexistence in the nation state of social groups experiencing different conditions has been the prevailing model of society. Neither individuals as members of social groups nor the groups or communities were taken to be, or have a right to be, considered as all equal. Democracies from ancient Greece onwards have always had built-in mechanisms of exclusion – slaves, denizens, the property-less, the illiterate, those in certain age groups, and women.

If we look back, we should not really feel too depressed. The mechanism of exclusion and inequalities have been part of the history of society, but what worries us in our contemporary societies is that we have become increasingly aware of the fact that mechanisms are at work that generate and reproduce unequal conditions. Some of these have long been with humankind, and some are newly created in the global context that we are part of.

It is also clear that Europe faces growing inequalities and processes of exclusion, which appear to be increasingly difficult to handle. The hope is that, if we become fully aware of the dynamic nature of society and develop realistic approaches to the complexities of our times, we shall perhaps be able to create a system of vigilance and develop much needed counter-mechanisms capable of enhancing empowerment and equal opportunity. We can then aim to move towards the goals that are the basis of our social and political tradition – equality, democracy and solidarity.

There is a lot of rhetoric, but we cannot just take it for granted that our societies are aimed fully at realising equality. Perhaps if we were to acknowledge all the trends that are going in the opposite direction, then we should be able to develop new institutions and new patterns of transition from our present society to a better society. But in between, there is a great need for social investment, exploring what new actors and new institutions could do towards establishing a diverse society that is also a society of equal opportunity. We are not giving up the basic goals of our society but we are not taking them for granted; and we are not taking it for granted that we know *how* to govern these processes of change.

I want now to refer to the conference being organised by the Danish Ministry of Health and WHO in the summer of 2000 on the subject of “Reducing social inequalities in health”, which seems to cover much of what we have been concerned with here. But while we cannot but share their concern about the unequal distribution of health, I think we should restate all those topics – reproductive technologies, health, work and leisure – as issues of daily life. We should then focus on the fact that in coping with such issues, social actors are continuously learning.

Here I find myself much closer to the Nuffield Trust’s “Policy futures for UK health” and the European Union’s “Health and care in 2020” projects. There, patients are informed and demanding customers (which implies that the users of services are educated). The focus is on the role of consumer associations, information and health, primary and community care networks, home care, medical technology and the use of pharmaceuticals of the future. All these topics go in the direction of what I would like to emphasise.

When dealing with health issues we should consider learning – by which I mean lifelong learning and reflection – to be a crucial resource for the population. I mentioned a number of trends earlier: demographic and social changes, migration and the effects of new technologies in all spheres. These require continuous adjustments and learning practices. The aged and the aging, young people, immigrants and locals – we all require, and do acquire, skills to cope with plural lifestyles, identities, needs and the continuing changes in society and in our everyday lives.

If we consider European patients and caregivers and customers of health services, terms such as “user involvement”, “empowerment” and “learning” are crucial to describe this population. So far, the personal and collective resources needed to live in and cope in a changing society have not been seen as a relevant item in research and in political agendas.

Many thinkers, Anthony Giddens being one, have stated that of course we are an information- and knowledge-based society. Education is no longer restricted to a short stage in one’s life. Adult continuing education is needed in the public as well as in the private context of our work and daily life.

We have to consider the resources that a population of well educated, informed, reflective women and men can and do offer to our future Europe: professionals of all kinds, media people, caregivers, adult women handling their families and daily lives, and those in medical research and practice, in the helping professions and in communication related to health and health promotion. I am thinking not just of individuals – institutions at all levels need to be seen as learning organisations.

The tasks of research and teaching agencies are to raise issues, develop critical thinking and set a new public political agenda. In this perspective, we need to be concerned with processes of construction and deconstruction of messages, images and indeed all forms of communication. It is crucial that such institutions also unlearn, in other words erase part of the acquired individual and collective attitudes and rules of behaviour in interpersonal relations and professional lives.

We should put forward the idea that a society with plurality and diversity has crucial resources and strategies for health and wellbeing, precisely because it is a learning society. It has

unprecedented individual and collective potential that ought to be put to full use. I stress this because otherwise the perspective is rather gloomy, and I think that within the European Region as a whole there is potential. We forget that beyond the health or social establishment there is so much going on, on the part of the social actors involved. Organising convergence and empowerment is something we need to look at for the future.

*Ann Taket*

I welcome warmly the note of optimism in Laura Balbo's presentation. I link that to a point I want to make about the use of language. We have heard a lot about the challenges that face us in the future, and I would not want to downplay any of them. Nevertheless, we have a very important chance to move towards the future of our choosing, depending on the language we use to recognise and respond to those challenges.

One example Laura Balbo illustrated very well is this issue of diversity – to see it not as a problem but as an opportunity. I was also reminded of the Chinese curse that says, “May you live in interesting times”. I think that what we need to do is to take that diversity not as a curse but as a blessing, and as a message of hope. That requires a change of attitude, and the presentation offered clues to how to achieve that change, including the notion of *equivalent* opportunity to replace equal opportunity.

As pointed out, we face increasing diversity in terms of patterns of work, and of family formation. People are choosing or being forced to live their lives in an increasingly diverse range of ways. We have just heard about the two gay men who have now been named as “parent one” and “parent two” on the birth certificates of twins born by artificial insemination, and the biological mother will not be named on the birth certificate at all. This illustrates very graphically that we are moving towards an increased variety of families. We no longer need to talk only about the biological family, but perhaps introduce the notion of “families of choice”.

We see diversity in work, family and social life, and we would like to see that diversity within a context of the values and principles of equity, democracy and solidarity. How do we recognise, respect and respond to diversity in a way that does not imply that we are going to reduce or remove diversity – but that we are going to reduce or remove inequity or lack of equal or equivalent opportunity?

We have to acknowledge the reality of an enormous legacy of past inequalities and inequities, a lack of equal opportunity. The challenge to us is that recognising the opportunity provided by diversity and by plurality must not be turned into victim-blaming – seeing, for example, the problem of racism as a problem of black people. It is not; it is a problem of white people, a problem that white people must tackle. We have a long legacy in health promotion of trying to tackle the issue of victim-blaming, and we can draw on that here.

If we are to move into this new vision of lifelong learning, with support at all levels of society for the individual and for social and business organisations, we need to strike an appropriate balance between recognising the potential that all individuals have and actually providing support through resources – and seeking to provide equivalent opportunity to support those individuals in developing their capacity.

It is important not to pretend that they do not have that capacity. Some of the most creative life solutions are actually found in populations living under the most tremendous burdens of

inequality and marginalisation. It is very important that we are not patronising in adopting empowerment rhetoric – we do not empower people, they empower themselves. We can facilitate, we can support, but the empowerment is actually carried out by those on the receiving end of some of our most oppressive structures.

So we all need to become actively involved in a process of critique at all levels. This notion of equivalent opportunity draws attention to the fact that processes of empowerment or capacity-building do not entail providing each person with an equal opportunity; it means providing them with an equivalent opportunity. There is a subtle difference there.

We need to be creative in the processes that we use. I take, as an example, participation in all areas of life. Think about the processes by which we usually invite people to participate. In the health arenas in which I work, this means you invite people along to a meeting that takes place at a set time and has set rules of engagement, and is formally conducted. We need to think much more creatively about alternatives to that.

The means of organising that are now offered to us, with the potential of communication technology and so forth, lead to much wider possibilities. These include processes by which we might create and maintain networks that can help empower and serve to utilise productively the diversity that exists. I think in doing that we perhaps have to give up one of our goals, which is to know and understand and map precisely these new forms of organisation.

Looking at the protests during the World Trade Organisation meeting in Seattle, we were seeing a new form of organisation in which we could not even map the connections that gave rise to the action that emerged. They were far more varied than we could ever hope to understand. So I think we have to give up this notion that we want to seek a precise description of these new forms of organisation, and we have to learn to work with them rather differently.

## Further reflections

### *Sandra Dawson*

We began this session with a not overoptimistic picture of the immense geopolitical forces in Europe. We then moved on to networks and governance and looking for new ways of working. Then we went on to aspects of health and working life, and now to equivalent opportunity and diversity. I sense there's a fair degree of agreement around the table as to what we need to do.

### *Ilona Kickbusch*

I think that the future will not only be one of diversity in terms of the many different people; it will be diversity in ourselves.

We need to look at how society provides the opportunity to live with two levels of diversity, and also where society *forces* us to take multiple roles. These are issues of choice and freedom and of coping and developmental health. How can we prepare ourselves to live in that society, and to make use of choices where they exist and not to be frightened by them, and how can supportive policies help us manoeuvre through that new environment?

That leads me to what is happening to the old idea of a career, where you start as an apprentice and end up as a director-general. That does not work any more. Now, at different points in your life, you will play different roles with different amounts of power, and that power is not continuously increasing. You might be very powerful at 30, much less so (but much happier) at 50, and then go back to being powerful at 70.

So with diversity there is the loss of the continuous life role in the sense of an automatic progression. What you do at what stage of life and what you do at what age is changing. At present it is changing more for women, who seem to be able to use these changes more than men. It is interesting that in the United States it is feminists who are writing books about identity crises that men are now facing, because men are much less prepared in our society for these multiple roles.

Very interesting research into health determinants is being reported from Canada, in an area referred to as developmental health. This has brought together, in a very innovative and productive way, research from the neurosciences, economics, education and health. It shows how, for the future learning society, we need to invest in young children and in developmental policies that actually support cognitive development and the intellectual capacity and potential that people will need in order to survive in the societies of the future. That also relates to the question of political expression: how one expresses political interest in this variety of networks and communication streams. We are looking at a new type of person.

#### *Graham Lister*

I recall that Ivan Illich said something to the effect that good health arises when people have the ability to improve their own health. One of the temptations of the technological society is to think that you achieve that by giving them access to the Internet or some other technology. And yet we know this is not enough – that to be empowered, people need to be able not just to use information but to take social actions that actually enable them to improve their health and that of their community.

The challenge is to find ways of supporting civil structures that enable and empower people to improve health, while avoiding the other side of empowerment as a sort of derogation – “it’s over to you; it’s your personal responsibility”. We have to find ways of supporting all sorts of different structures such as women’s health movements, European patient organisations, and people-to-people health contacts between the first and third worlds. These can all be supported by technology, but they need investment in social capital (organisations and people) to make them work on a community level.

#### *Cristina Puentes-Markides*

We should remember that societies are not homogeneous only because they share a language or a geographical area. People who are discriminated against may also be racist themselves.

There may be a danger in our discussion of exaggerating the “us and them” dichotomy, in part because the group here shares similar middle-class values and levels of education. None the less, it is precisely because of our concern for the future and for others that we would like to see the distinction between us and them become progressively less pronounced. The impact of globalisation on the health of the most disadvantaged is making an impression. Will a new type of health governance be able to generate enough pressure on countries that condone child labour, for example?

*Laura Balbo*

Governments do not do much, but every time they do something they say they have the solution and then simplify the issues. That worries me, because they cannot do things any differently, especially when they address the issues of the developing countries and the gap between “us” and “them”. Offering reassurance is a very old-fashioned way of addressing these issues. What might happen in the developing countries in the future? Suppose the majority of the young people in Africa or Latin America decide that they need to get organised and there is a big conflict. That’s one possibility I think we have to keep in mind. There is a risk of us in Europe trying to say things that have no value for the rest of the world.

But here we are talking about Europe, and Europe has privileges and advantages. What could the European population provide the rest of the world in terms of setting and contributing to a new agenda? What could the new social movements be, and what role could they play? We have NGOs, but it is not clear whether they are really social movements any more. They reflect the old models of participation, but apparently that is the only way people in our countries can participate. And now we have the Seattle model, but we do not yet know much about it.

*Sandra Dawson*

I always go back to my own experience, and in every piece of academic supervision I do there is always an issue about what the level of analysis should be. And today there is an issue as to what the level of policy intervention should be.

There is no doubt we need to see the big picture; we need to grasp the scale of the global issues. But in terms of working out where the levers are, that we as individuals or collectively may be able to pull, we have to think about the various different levels. We have to keep them all in mind: the global level, the transnational corporations, the multinational agencies, the national governments, the organisations directly involved in providing care, and our communities, families and individuals.

None of us can address all of those at the same time. Each of the parties has to decide where the levers are that it can pull, knowing that pulling the levers is likely to be more effective if we are aware of their interconnectedness.

Allow me one personal comment about going to Cambridge to build a business school, with great expectations and very few resources. I had endless visits in my first year from people promising resources if only I’d realise their dreams. And I used to go home feeling a complete failure, because I could not work out how to realise their dreams even though their dreams were clearly so important.

But of course one is there not to realise other people’s dreams – one is there to realise one’s own, worked out in the groups of which one is a member. And that has come through to me very strongly during this session. We have been shown the enormity of the problems, but also the enormity of the opportunities and the possibilities for action within them.





# PREPARING FOR CHANGE/IMPLEMENTING HEALTH21

## Building on the past: lessons from the Americas

*Cristina Puentes-Markides*

I have been asked to speak about health for all in the Americas, the experience with health futures of the Pan American Health Organisation (WHO Regional Office for the Americas, AMRO/PAHO), and the “Healthy people 2010” initiative in the United States.

Although the goals of health for all and primary health care may be invoked politically in our Region, their concrete expressions are more difficult to trace. After the approval of health for all in 1977, the countries of the Americas found themselves in the midst of a dire economic crisis – and neither health for all nor primary health care were uncomplicated or inexpensive propositions.

Structural adjustment measures squeezed the public sector and eroded services. Moreover, the breadth of and the lack of measurable objectives encouraged contradictory interpretations of health for all and primary health care. This was further diverted by the discussion about vertical vs. horizontal programmes and the subsequent application of selective approaches. The medical profession was not supportive, and some viewed health for all and primary health care as threats to current medical practice and to hegemonic medical knowledge.

In addition, the health sector’s participation in intersectoral activities was limited. National governance had weakened, and decentralisation was not profound enough to sustain changes and generate self-sufficiency. During the early 1980s, the slow transition to democracy strained even more the limited capacity of the public services. Finally, health for all was not communicated successfully to non-health sectors; it was often presented as an absolute truth centred on the functions of the state.

AMRO/PAHO's Regional Strategy for Health for All and the Regional Plan of Action (approved in 1980 and 1982, respectively) were ideally to lead national policies and programmes towards greater equity and effectiveness, but they were never implemented. In addition, the links of health for all to treaties, declarations, global summits, and mandates that guide social and economic development internationally, are weak. Being very inclusive, our work may be considered – generously – as cooperation guided by health for all.

The renewal of the call for health for all was initiated in 1995 as part of a global effort. The undertaking produced a document enriched by consultations and recommendations from an advisory group, and PAHO's Directing Council approved a final resolution in 1996. The regional policy framework for achieving equity, solidarity and sustainability included policy orientations but no targets.

Two regional meetings increased knowledge and experiences about health for all and stressed its value in overcoming health challenges. The first took place in Montevideo in June 1966,<sup>9</sup> and the second in Washington, DC, in February 1998.<sup>10</sup> The countries wanted to revalidate health for all and stressed the values of equity, solidarity and sustainability. I think it is now more important than ever to continue and give content to the initiatives with measurable objectives.

The WHO European Region's experience in linking futures approaches to health for all served as an example for our Region. Activities within PAHO have attempted to involve colleagues and to gain support from higher management. We have had some success, although not as quickly as we would have wanted. None the less, the functions of our unit (Office of Analysis and Strategic Planning) now include foresight and scenario development.

PAHO has translated, published and distributed material on health futures, primarily in Spanish, and provided cooperation in this area to the countries of the Region. This includes workshops, linking futures to policy formulation and planning and to PAHO's strategic and programmatic orientations, setting up a web site, developing a participatory publication about PAHO of the future, and scenarios for PAHO.

We have worked with a variety of partners, including the European Region of WHO (several consultations on future trends and health for all), the International Health Futures Network spearheaded by WHO, the Foundation for Future Health Scenarios and the Institute of Alternative Futures (which were responsible for the Belmont vision for health care in America) and the Health Forum (formerly the Healthcare Forum).

Another beneficial partnership has developed with the Millennium Project of the United Nations University, an NGO that has been increasingly active in futures activities and publishes an annual report on the state of the future.<sup>11</sup> This report includes the opinions of over 300 futurists in developing global scenarios and identifying trends and challenges.

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9. *Regional Conference on Future Trends and Renovation of Health for All: final report*. Washington, DC, Pan American Health Organisation, 1996. (document OPS/DAP96.10.28).

10. *Symposium on National Strategies for Renewing Health for All*. Washington, DC, Pan American Health Organisation, 1998 (document PAHO/DAP/98.3.39).

11. GLENN, J.C. & GORDON, T.J. *State of the future at the millennium*. Washington, DC, United Nations University, 2000 (<http://www.geocities.com/~acunu/millennium/sof2000.html>) (accessed 18 March 2002).

Working with the Disney Corporation through the International Health Futures Network and the Healthcare Forum in the initial meetings to design “Celebration Health”<sup>12</sup> was a fascinating experience. We also work with colleagues engaged in futures work at the Rollins School of Public Health; we have collaborated with the Institute for Alternative Futures, SmithKline Beecham and FUNSALUD in the production of a book on health for all in Latin America.<sup>13</sup>

Let me move on to my experience at the US Department of Health and Human Services, where I worked part-time from 1996 to 1998 and have continued to participate in their activities concerning “Healthy people 2010”.

“Healthy people 2010” is the United States’ health promotion and disease prevention policy that will be launched publicly during a conference sponsored by the Partnerships for Networked Consumer Health Information, in Washington, DC, in January 2000.<sup>14</sup> It is not an initiative to change the health care system, but rather to develop a framework to define objectives and targets around specific goals for health. The first generation of objectives dates from the healthy people: report of the Surgeon General on health promotion and disease prevention, issued in 1979. This is now a 20-year-old project, and every ten years the process and goals are renewed. Despite “Healthy people 2010” being a health promotion agenda, when you look at the areas covered it still has remnants of a biomedical framework.

The experience is particularly interesting because of its participatory nature in the formulation of health policies, the construction of alliances with a broad variety of sectors, the bipartisan political support (through four administrations), the utilisation of the scientific evidence, and the impressive strengthening of data collection and analysis. This has been possible in a vast nation, with an ethnic and racially heterogeneous population of over 270 million inhabitants, that exhibits disparities in health.

The framework for 2010 proposes a vision of “healthy people in healthy communities” and two broad objectives for the nation: increasing years of healthy life and eliminating disparities in health. Twenty-eight areas of emphasis and more than 400 goals have been defined.

The establishment of goals with shared responsibilities among government agencies brings together community efforts. They motivate, and give cohesion to the work, being in addition instruments of communication with the public, decision-makers and community leaders.

“Healthy people 2010” is a federal proposal, but federal government programmes have difficulty reaching states and local communities. The idea was not to push a federal agenda or to include “how” for any of the objectives. It was to be a broad national menu from which every state or local community could pick and choose which objectives were relevant to their particular context.

With every version of “Healthy people 2010”, the stakeholders (citizens, health care providers, schools, employers, industry, business and communities) have increased their participation. The internet allowed the participation of the public during 1997 and 1998. Some 10,000

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12. *Celebration health and the IHFN: 21st century health systems: principles and visions*. Disney Corporation, 1993.

13. PUENTES-MARKIDES, C. Renewing health-for-all: preferred scenario. In: *Latin America and the Caribbean: the prospects for health-for-all*. Institute for Alternative Futures, SmithKline Beecham Pharmaceuticals and FUNSALUD, 1998.

14. <http://www.health.gov/healthypeople/default.htm>

people attended public audiences and submitted observations on the content of the objectives and goals. The public consultation expanded through the creation of a Healthy People Consortium, with more than 350 national associates representing 59 million people. The Healthy People Business Advisory Council links the private sector and is a valuable instrument in community health promotion.

The coordination mechanisms include The Secretary's Council for National Health Promotion and Disease Prevention Objectives for 2010, led by the Secretary of Health, with participation of Under Secretaries of Health of four previous administrations and the current chiefs of agencies of the Department of Health and Human Services. The Healthy People Steering Committee is chaired by the Director of the Office of Disease Prevention and Health Promotion, and includes the coordinators of the working groups for each of the areas. The periodic evaluations of each area are chaired by the Under Secretary of Health/Surgeon General.

Their process of developing the objectives is very interesting, and the criteria for choosing objectives very important. There are some lessons to learn from how this was done, at least for us in Latin America. One criterion was that an objective should be seen as relevant, and be understood by most people. It should be measurable, science-based and prevention-oriented. Most objectives have a baseline; those that do not are called "developmental" objectives, on which more work needs to be done. An objective should also provide some continuity and comparability between the states, enabling them to benchmark. In this area, the lesson learned from "Healthy people 2010" is that data development pushed policy development, and that objectives should drive action.

Measurement of disparities was one of the central issues, and long discussions ensued about how best to measure them among different population groups (low-income, racial/ethnic minorities, etc.). Eliminating health disparities was long debated. We could have suggested reducing inequities or increasing health equity rather than eliminating disparities, but equity has a more political and debatable social dimension. It may not have been in the best interests of maintaining broad support for the initiative, but the biggest achievement was to maintain the goal of eliminating rather than reducing disparity. Quality data acquisition is one of the greater challenges, and the existing gaps in information have mobilised efforts to develop areas that needed it.

The contribution of futures to the initiative was done through the development of three scenarios carried out by the Institute of Alternative Futures to test the feasibility of the two overarching goals (increasing years of healthy life and eliminating disparities). I do not know whether or not the scenarios will ultimately be included in the final document, but I think they could really give the document an interesting forward view of the initiative.

One point of particular interest to us is that there is an explicit reference to health for all in the draft of "Healthy people 2010". The global vision is health for all, whether or not it remains in the final document. "Healthy people 2010" illustrates a commitment to equity through the elimination of health disparities, to solidarity by focusing on participation and partnerships, and to sustainability by centring efforts throughout society to guarantee future outcomes.

***Pam Garside***

Since we are anchoring ourselves in our own contexts, let me say that in my constituency of hospital managers, the pragmatists are trying to make reform happen. That is my bias and I was very pleased that Cristina Puentes-Markides' paper started with the challenges to implementation of health for all; and that within that, she identified leadership as the key. She also used words such as useful, relevant, understandable and "driving action". My angle on our futures work at Cambridge is unambiguous: we have to make it understandable and usable.

In my mind, a key question about health futures is how something so woolly and fuzzy can be used to help agencies and those responsible for implementation. Consequently, the job for people like me is to make things tangible. Futures can be very frightening and very depressing but it can also be a tremendous catalyst for action, and there are always opportunities. Rather than adopt a strategy of frightening, it is much better to go for continuous re-evaluation – "re-looking" at the future in an ongoing way.

Earlier speakers have reminded us that we see things through the prism we are trapped in – the tyranny of the present – and I think it is our job to liberate people from all that. We have to make futures digestible: and that means using techniques of marketing and promotion to get the message across. My job with our futures work at Cambridge was to create a "popular version" for people to grab and to be grabbed by and understand. I think as futurists we are using too much jargon. I think we have to break out of that if we are to make the work useful for the people out there doing real jobs.

Futures can be a way of building consensus, and a way of helping pragmatic people in various management situations to think strategically. I have no hesitation, when we are working with very local people in the United Kingdom, in bringing in the outside context. A window open to the outside world out there enables one to think and become more strategic. We really need a call to action to keep using futures to widen perspectives and to keep minds open.

**Lessons from Wales*****Morton Warner***

We are talking here about building on the past and about future possibilities for implementing HEALTH21.

Reflecting on the past in Wales, there has been – in common with many other places – a slow realisation that progress is not made by reorganising things. This is part of our learning, and I wished we had learned that five years ago because we have been consistently reorganising and now people are asking what good it did.

My own view is that our history in the National Health Service (NHS) has shown that the essential issue is to *redesign*, being sure what we want to do and putting function before form. Our conclusions now are that if we want to progress further on the health agenda, then networking rather than hierarchical arrangements will probably be the key. Target 14 of HEALTH21 refers to multisectoral working. I am going to talk about the operationalisation of that as we implement our own version of HEALTH21.

In the mid 1980s we had a health promotion strategy known as “Heartbeat Wales”, and by the end of the 1980s we had developed a strategic statement for the NHS in Wales: working with others, the NHS will take the health of the people of Wales to a level comparable with the best in Europe.

“Working with others” was something that we recognised we needed to do at that time, but we could not go as far as talking about “working together”. The view was you had to start somewhere, and if we talked about working together there would have been all sorts of territorial battles.

Very importantly, in addition to our statement of strategic intent we had what were referred to as local strategies for health. While we were drafting a high-level statement, we were also recognising that, in fact, things have to be developed at the ground level, and this meant local strategies for the health authority areas within Wales.

We also combined the idea of a strategic intent with the notion of “strategic direction”, with three strands. One referred to health gain, in terms of reducing unnecessary early death and of improving quality of life (recognising that the health service was far more concerned and able to do something with the second than it was with the first). The second strand was putting people at the centre of our NHS activities – we had not been as good at that as we might have been. The third strand was using our resources effectively. I should say that, even to this day, there is confusion about resources; people insist that resources equal money, but resources are, of course, what money buys.

Over time, we developed protocols for investing in health gain. We specifically used the expression “investment”; we were promoting the idea that if you have an investment you should have some sort of return. We had both longer-term targets related to health gain and shorter-term targets, which we referred to as “service targets” – those things that you should be doing on Monday morning. If we achieved those, a belief might grow that we would achieve the longer-term health gain targets.

The United Kingdom National Audit Office, when it conducted an evaluative review, looked rather favourably on this work, speaking of it as a strategy that was actually woven into the management process. It also commented about the NHS “working outside the box”. This was very much an aspect of local strategies. If we were looking for evidence of success in working outside the box, we found that it happened much more locally than centrally. At the local level, people knew they had to go after the practical things that they could get done. They did just that.

Since 1990, across the United Kingdom, we have had the NHS internal market with health authorities “purchasing” services from providers, and all the consequences for collaboration that this brought. And we have had further reorganisation in the NHS and local government. Now we have “local health groups” both planning and providing. At the moment they are advisory to our health authorities. Later, they will be taking over the majority of the spending programme.

In Wales, we have contiguous boundaries for local health groups and unitary local government authorities, so there is a possibility of doing things together; and we also have a rather well developed voluntary sector. For health systems redesign we should also add in other factors, including the role of research and development, ideas of new social contracts and new partnerships, and the notion of values in a civic society.

So where are we now in our thinking? Gareth Morgan talks about the organisation being a psychic prison. For us, that means that existing organisations constrain efforts to pursue the public's health. We were talking in an earlier session about institutions at the global level that have not kept up with the demands now being made of them, and about political and organisational fragmentation. At the local level within Wales there are exactly the same kinds of problem.

This is being recognised, at least in some of the new language now being used, such as talk about “healthy alliances”. There is promise of a certain degree of more flexible financing. And there are attempts to develop a joint agenda between primary care services and public health. It has taken us a long time in the United Kingdom to discover Alma-Ata for ourselves!

This brings me to what I call “virtual reorganisation” by design, which is being developed for the period 2000–2020. In the small area around the university where I work, we have very good links with the local health group and with local government. When it comes to implementing HEALTH21, or specifically implementing our own “Better health – better Wales” programmes, virtual reorganisation is what we are talking about.

At national level we have health and social gain targets, which the Welsh National Assembly is responsible for setting. When we move to the local level – and this in line with what we learned through our local strategies for health programme – essentially the need is to customise the process. That means asking the question: within the overall framework of target setting, how would you set targets that recognise the priority issues in your locality?

And then we come to methods of “networking”: asking local organisations to describe, in the first instance, how they are already contributing to local target achievement. (Note the assumption that they are *already* contributing something.) We base that on our assessment of the “Health of the nation” strategy in England. We discovered that people were doing things, but they were not telling anyone else about it. So the appeal to them is to come together in a “virtual reorganisation”, with a design feature (targets) built in.

When I described this to the Chief Executive of a Swedish County Council, who was proposing to reorganise everything in his county, he was very positive: “I like this very much, this way I do not get blood on my head”. This is quite important, because it is saying to those who are already in the management structures that they do not have to give up power. We are talking about the business of contributing effort, of cooperation and how to bring things together, of how to move from the vertical fragmentation that we have at present to some form of horizontal arrangement.

This leads me to the issue of governance. There is an extensive literature not only about networking, but also about network governance, and in it I found this definition:<sup>15</sup>

Network governance involves a select, persistent, structured set of autonomous firms or non-profit agencies engaged in creating products or services, based on implicit, open-ended contracts to coordinate and safeguard exchanges; these contracts are socially not legally binding.

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15. JONES, C. *ET AL.* A general theory of network governance: exchange conditions and social mechanisms. *Academy of Management review*, **22**: 911–945 (1997).



There is a lot that is attractive in this definition, because it gets away from all the territorial fighting. It allows people to talk about their contribution, but also to retain the managerial accountability within their existing organisations. What we have yet to do is to actually work out what network governance means in practice, in terms of the behavioural change required. But potentially it looks like a very productive way to go.

I should also comment on the end phase of this approach of “joined-upness”. It is then that the parties – health and social services, the voluntary sector bodies and others – start to make plans to counter fragmentation, and to look ahead in terms of “five C’s”: what are they going to *communicate* to each other and when; how are they going to *coordinate* certain actions; how are they going to *collaborate*; how they will bring spending power together as *consortia* to do things; and ultimately, being *combinational*, maybe bringing staff together to work in one new organisation. It may actually mean merger, but if it does happen it comes about organically rather than as a result of somebody telling them to reorganise.

I conclude with some speculation. Before I came to this meeting, I was reading a piece in *The Observer* about a new United Kingdom Government Cabinet Office paper that presents a view of the future in the United Kingdom. It talks about the post-materialistic generation – a generation distrustful of law and authority, wanting to disengage from mass democracy, having requirements for individualism and self-expression, and above all, wanting to improve quality of life. The paper also talks about some technologies, one of which is “soft” computing – computers that speak, listen, understand and are tolerant of imprecision, uncertainty and partial truth.

If you start combining these possibilities, it seems to me that what you get is the expression of something that I will call “individualistic altruism”. Individuals in the future will be able to gain all sorts of information on their own behalf through dialogue with some form of computer system. There will be various other things that feed into the notion of developing the civic society, and promoting the public health, through civil organisations and constituencies and electorates. You then have the possibility of individual thinking, building up to a pattern of the public’s health rather than top-down drip feed and campaigns.

#### *May Hansen*

Reading Morton Warner’s paper made me realise the enormity of the task we have given ourselves, particularly in explaining and persuading others what needs to be done. It came to me that Wales has been engaged in the health for all process and using the framework for as long as I have been involved with drafting health for all documents in the WHO Regional Office for Europe, that is the last 15 years. I am an insider. I have had the advantage of having participated in several meetings like this. I am also used to hearing different views, even within the Regional Office. Depending perhaps on a person’s professional education, there are quite different views put forward on how to go about things.

And yet, despite my advantages and despite a conscientious effort, there are things in the paper that perhaps I do not quite understand. Certainly I have difficulty in seeing how they can work. I find that worrying because I am actually one of the people that you are trying to reach, not so much me as a WHO staff member but me as a person. How are you going to reach the people out there?

You are saying that people in local government are one set of actors in this virtual reorganisation by design. But will not you run into difficulty there? In local government the

policy-makers are ordinary people like me, who are elected on different political platforms. Those people are not public health experts, nor are they interested in organisational design. Their interests are much more specific.

Just suppose I have become involved in politics because I want to do something for kindergartens in my community and I have been elected on that platform. You are the advocate of change. How do you reach out to people like me, and all the other politicians with their different agendas? How do you design us into your local strategies?

*Morton Warner*

One of the big errors that was made within the English “Health of the nation” strategy was that it tended to ignore local government. If you look at the services that local government provides – typically social care, education, school meals, sewerage, road cleaning and others – they are very much about health and community support. Second, in the United Kingdom, the National Health Service is not run by democratically elected people, whereas local government is. And such is the nature of health in the United Kingdom that there are very few local government people, elected politicians or officials running departments and services who do not have some sort of interest in health. So it is part of an accepted agenda.

In practice it has not been difficult to get these ideas across. One group of newly elected politicians, who we wanted to involve in our project, found our presentation of Margaret Whitehead’s determinants model the most persuasive material they had ever seen. They had never thought of social determinants of health in that way. They now see that they have a real contribution to make in the spending of money and through their activities.

*Ilona Kickbusch*

My comment relates to agenda-setting, and I am linking it to individualistic altruism as we see it on the international scene. The Bill and Melinda Gates Foundation probably has as much to spend on health as WHO has in its regular budget. Think of what the Turner and Soros Foundations are bringing (as one says so nicely) to the table, and you quickly realise that they decide the agenda.

But if these individualistic altruists, as the new philanthropists, set the agenda and blot out the electorate and other interests, just what does that mean? I sat in a meeting recently at one of the very large foundations, where they just shrugged and said, “we do not like what WHO is doing in this area; we are going to do what we want to do”. That may say something about WHO and its credibility; it certainly says a lot about the ability of these new actors.

*Morton Warner*

My sense of individualistic altruism is tied in with the new information technology. I see a contrast between what we tend to do now with the technology and how it might be in the future. At the moment we have mass communication, where the social distance between those sending and receiving messages is often quite great. We are not quite sure how effective the process is. In the future, for example, the parents of a newborn child will say, “We have heard about immunisation, but what we want is a direct dialogue through the soft computing process; we want to have an opportunity to discuss it – to be able to go backwards and forwards in the dialogue – and come to our conclusion”. And they come to a conclusion: “Yes, we want to have our child immunised.”

Assuming the information available to them is sufficiently well based, then the consequences of the technology is that you have people making those individual decisions in a way that they have not made them before. If there is this individualistic altruism, there will be an understanding on their part that if we do not get herd immunity then potentially we are injuring our community. It is a participative process of a quite different type. We have been talking about new ways for people to participate, and this is one of them. The Information Age brings new possibilities for health action.

## Looking forward: combining clinical and public health knowledge

### *Fusun Sayek*

Before I explore why clinical and public health research are not used as widely and as efficiently as we would wish in support of health protection and promotion, let me first describe my context. Turkey is a country of 65 million people, some 64% of whom live in urban areas. The GNP per capita is around US \$3000. Some 30% of the population live under the poverty line and 13% have no job. There are huge inequalities, economically, geographically and socially, as shown by the human development index (HDI) values by province. Democracy is not yet fully established in Turkey, and abuses of human rights are common.

One of the biggest problems is individualism and a lack of idealism, dedication and motivation. We need to find a solution to that. And there is also nationalism, by which I mean negative nationalism or racism. In Turkey, especially the last 15 years, we have experienced a “silent war” between the racial groups. This promoted racism. Religious fundamentalism is also a problem for Turkey and countries in similar circumstances. I think WHO’s role is becoming much harder because of this fundamentalism and racism.

The birth rate is 22% and death rate is 7%. The infant mortality rate is 43 and the under-5 mortality 52 per 1000 live births. Only 50% of deliveries are assisted by a doctor or midwife. The rate of population increase is 1.6 and the population doubles every 45 years. Life expectancy is only 71 years for women and 66 years for men. Some 6% of the population is over 65, a figure very different from that found in western Europe. About 32% of the population is under 15 years of age, and 40% have no health insurance cover. Health is allocated only 2.7% of GNP (110 dollars per capita), very little compared to western European countries.

Abortion is a common method of birth control, since there is an unmet need for family planning. Knowledge of family planning is universal – according to studies 97% know about methods – but the number practising is low at about 60%. This reveals a lack of provision of materials such as condoms and birth control pills.

Illiteracy is a problem, especially among women, some of whom cannot read and communicate. Children whose mothers have less than primary education are 1.6 times more likely to die in the first year of life than those of educated mothers, and in rural areas the problem is worse. Only 58% of children are vaccinated and 16% are stunted because of nutritional problems. People die very young owing to preventable diseases, and the quality of life does not compare with that in western European countries.

Public health is defined as the improvement of health through the organised efforts of society and through social intervention. “Social interventions” are those that cannot be undertaken by

individual members of the public or individual clinicians, although of course we need their contributions. These interventions include, for example, immunisation and environmental protection programmes. For all this, primary health care institutes are very important. Without primary health care and a referral-based health care system, it is very difficult to initiate health promotion and prevention activities or to carry out the research that should support them.

In Turkey we have a law that is intended to enforce a referral-based health care system, but there is very little communication between primary, secondary and tertiary care institutes. This problem affects not only patient care but also health protection and promotion and disease prevention activities based on research.

There is an Arabic proverb that says, “He who has health, has hope; he who has hope has everything”. We need hope. We need optimistic examples. In my paper I have presented some optimistic examples from Turkey. These happen to be vertical programmes, but we can fit them into the health for all concept.

All the successful examples are those that involve both the primary and secondary care levels. As one example, in phenylketonuria screening, academics, primary health care physicians, midwives and the public are all involved together. A second example is education of health care providers and researchers. A third is fostering a culture of teamwork, which has been lacking in our country. A fourth is clinical research, now a preferred type of research for which financing by the pharmaceutical industry has been increasing.

Of course these all need economic resources, infrastructure and information technology. We need to pay attention to the ethical dimension, especially where pharmaceutical and other private companies are involved; and to the dissemination of research results to practitioners, managers and the community, which is still not wide enough. The capacity of the health authorities and the health services to identify priorities for research is not enough, and evidence-based analysis is very seldom used by them. We need a bigger contribution to this field from NGOs and international organisations.

In the Turkish culture people are used to telling the future, if you mean by this fortune telling. You drink your Turkish coffee, reverse the cup, and see the future. And, as you can imagine, the future is always very dark because that’s the way Turkish coffee is made. I am ready to accept that scenarios can be very useful, especially when you want to scare the politicians. Unfortunately, you may say, we have recently had some very brave politicians who are not scared by scenarios.

There are good reasons why scenarios written for countries like Turkey are less likely to thrive. It is because in such countries everything can change drastically and very suddenly, and even natural disasters are common. After we lost more than 20 000 people in an earthquake, the only scenario on our agenda was future earthquakes.

To be able to use scenarios you also need to have a politically and structurally stable system. Developing countries do not have this stability: for example, the average term of office of a Minister of Health is only 15 months in Turkey. Moreover, we are under the influence of economic globalisation but we do not benefit from the opportunities of that globalisation.

The gap between countries is widening. You say, “human genome”; I say, “salt iodization”. You say, “sophisticated patients” and “intelligent social actors”; I say, “women who do not even

“speak Turkish” (they speak their own mother tongue and we cannot communicate). You say, “AIDS”; I say, “polio”. I notice that when I try to speak at meetings, the gap is widening even in the terminology that we use. I think there is a need for people working in the international arena to do more research that would help reduce the gaps between us, to analyse honestly the reasons for those gaps, and then to think very carefully about possible new approaches.

We need trusted groups to speak more openly, and more loudly. In this meeting we have been talking about different subjects, but we should have talked even more about structures for health care, for public health, for health protection and promotion and for funding health care. We should say more about privatisation in health care.

I think we have to be more honest than we often are. For example, when we show how much money is spent on arms in an effort to pressure governments to divert funds to health, too often the response is “my government is fine but some other governments are silly”. We have to get more open and we have to support each other more.

***Jorma Rantanen***

The question as to why the application or implementation of research does not work very well is valid for all of us. Füsün Sayek has identified a number of gaps that I find are equally relevant for Finland, and even for my organisation where we have a combination of research institutes and clinics for occupational medicine. She points to awareness and information, coordination, education, implementation and innovation; and also the lack of incentives for researchers and practitioners. What should we do? I think the first step is to identify *why* it does not work well.

I have been surprised by the really poor application of our most recent research in clinical and public health practice. It is a huge gap in terms of both time and substance. Links usually do not work. We are too sectoral and isolated at the different levels of the health service system.

Second, problems tend to be very multidisciplinary in character – not purely medical, not purely technical – but multidisciplinary action does not work. That is a reason for weak functioning.

We have variations in traditions, competence and culture, which are not very easily overcome. Individualism was mentioned, but lack of agreed priorities may also be a reason, because maybe those who apply science have totally different priorities than the researchers. Then there is poor leadership; usually very junior people are assigned to be responsible for applications and they get no guidance from their seniors. The chief medical officer or senior physician is very busy and does not have time to guide the younger staff.

A lack of information is not usually understood nowadays as an inability to obtain information but one of using and applying the information available. We also have, at least in the Finnish health system, an enormous shortage of time. More than 75% of the people in the health sector in Finland report that they are so busy at work that they do not have time to do the work well. This is the result of cutting resources when needs are growing at every level of the system.

What might be the solutions? One need is to understand the role of the research process in the whole system. This does not apply only to the health system; any societal system needs to analyse how research is really supporting and developing practice. We can trace a certain

continuity in the process that starts with problem identification and continues by studying the mechanisms, generating solutions, making practical trials (not only in the clinical but also the public health field), setting up and running field pilots and evaluating them, and distributing results.

In the distribution exercise we need to show three different types of relevance: scientific, practical and social. If any of these is zero, the whole product is zero. We have to meet all three criteria.

How we try to bridge research and practice is, at the moment, very dependent on the generation of guidelines and codes of good practice. This is a current issue in the whole of Europe. So how do we in occupational health try to bridge the gap between research and practice? We utilise scientific evidence as much as possible. We try to implement the multidisciplinary approach in finding proper applications. We analyse very carefully the needs in the field and in the system – the needs of clients, populations and workers – in order to respond to the criterion of social relevance. We try to develop a working infrastructure, which is then able to use those applications.

I would like to remind everyone that we also have another continuum. We have “corrective care”, prevention and control, and promotion and development. But these are not separate actions; they are part of a continuum. I think we should find the way to analyse and understand the rules in the direction within this continuum. I think that’s the weak point we should look at further.

## Using research and evidence in moving ahead

### *Ann Taket*

I am going to talk about how we use research and evidence in moving ahead in implementation, in achieving change and in action.

As my starting point, I note that it is a recurring theme in HEALTH21 that policy, service development, organisational arrangements, managerial decision-making and professional practice should all be built on the strongest possible knowledge base. So we are looking at evidence-based health policy, evidence-based health services and evidence-based health practice. The problem is that a lot of work has been done on evidence-based medicine, and there are some differences between evidence-based medicine and the evidence bases I would argue we need to adopt for HEALTH21.

Dynamic situations require flexible and adaptive resources. The environment for policy implementation in countries is never static at any level; regular monitoring is needed to compare policy practice in action with the original intent, and to assess the implications of any divergence. So what we need is reflective practice. Foresight and monitoring can be used to detect weak signals of any change in the operating environment.

There are a number of different challenges that we have to face if we are to create evidence-based health policy, health services and health practice. These can be thought of as requiring response at various levels: at the policy level, at the strategic level and at the practice level and also, in terms of geography, at the international, national and local levels.



These are challenges that also require responses by at least three overlapping and interacting groups of actors, defined by their relationship to research and evidence. There are, first, those who commission research, i.e. the generation of evidence. Second there are the researchers themselves, who generate that evidence, and thirdly those who use the research. There are a number of different user groups: policy-makers, decision-makers, health professionals, health service users and health service non-users. Looking towards the future, we hope they will all be users of research and evidence, perhaps by soft computing or in other ways.

Each of these challenges has to be met in a different way by each of those different groups. First there is the challenge of valuing appropriately different types of evidence. This applies at all levels and to all actors. Evidence can be scientific, in that it can result from the natural, biomedical or social sciences. It is particularly important that the social scientific evidence – the evidence resulting from policy sciences and the broad range of social sciences, including that gleaned from appropriate case studies – is not neglected. Our major challenge is that when we meet a term such as “science-based” or “scientific evidence”, it is taken to be the natural and biomedical sciences and not the policy or social sciences.

Thus a challenge for the future is to ensure that the criterion of appropriate evidence is applied. And corresponding to each of those sciences we have different criteria for validity that must be called into play. Alongside that is a recognition that different types of science require quite different types of research methodology. In particular, we have to put more value on qualitative methodologies if we are to answer some of the questions that face us.

This brings me to the challenge of responding to gaps in research and the evidence we have. Again, this applies at all levels and particularly requires a response by commissioners of research and by the broad community of researchers. There are significant gaps in our knowledge in a number of areas: how we organise health promotion, primary health care and public health; and how we develop and implement a “healthy public policy” and multisectoral action.

We are particularly short of good demonstration and dissemination studies. The gaps are strongly related to problems arising from the way research is funded, which values biomedically-based research over the health services research and the social science research that we badly need at the moment. Every time I sit in a research funding committee and I hear the discussion, I notice how my colleagues are valuing different types of research quite differently and, I would argue, often quite inappropriately.

The next challenge is that of creating appropriate, accessible and quality-assured evidence bases or research databases. These need to be quite different in order to respond to the needs at the different levels and of the different actors. Here we need the soft computing databases that individuals in the community can consult to help them decide what health action they take or do not take. We also need to provide databases for health professionals to aid them in their work.

I think that here we have a challenge of making those evidence bases action-oriented, particularly for the practice level. An article appeared recently in the *Health Service Journal* on the new United Kingdom National Electronic Library for Health, which is to be the United Kingdom evidence base. It presented an example of what a clinician might see when typing in a query about management of diabetes for a 45-year-old man. The first item was, “Shared care



works provided you have a good information system”. Now, that to me is content-less. What exactly is a good information system? Without further interrogation of that database, I would argue that that item of evidence is really useless.

The same article suggested that the appropriate time of retrieval, which would allow clinicians to use information, is 15 seconds. In other words, if useable information does not come back from the system within 15 seconds health professionals will not use it. They will not have sufficient time to actually do the job well – to use that evidence base.

My final challenge is that of building capacity, particularly of the third group of actors, the users of research or evidence. You will recall that I defined those as extending from the community through health service professionals to policy-makers at all levels. How far do we want health professionals to become generators of research, i.e. researchers as well as the users of research?

All health professionals have an enormous opportunity to generate evidence by reflecting on their everyday working practice. Do we want all health professionals to be researchers? The challenge of building capacity in those who use research and evidence means achieving and sustaining a significant cultural shift. It requires a major change in attitude towards health services research and development. It requires a major change in the notion of what constitutes scientific evidence.

#### *Ron Zimmern*

Let me say that I agree with the argument Ann Taket has made in her presentation of this field. In response the first point I would make is that we should not forget basic science. Some of the really major findings that are of use to public health come from basic science and do not at first sight appear to have any sort of applications.

“Effectiveness” is one of these values that we bandy about, and when one talks about effectiveness to medical students they immediately think this is the one thing that is not a value – this is about something concrete, something absolutely objective.

What is effectiveness? By definition something is effective when it achieves the objectives for which it was designed. You cannot say whether it is effective or not until and unless you have defined the objectives. Of course, the definition of objectives is in itself very laden with values. A cancer drug may be totally ineffective if you define your objective as cure, but highly effective if you define your objective as palliation for six months. So there are these issues of terminology, which are very important in this field of evidence and research.

We should not forget that medicine and caring are an art as well as a science, and that is very much taken account of in the definition of public health. I wonder if that is not one of the reasons why in the United States more consultations are made in the field of complementary than orthodox medicine. Has it something to do with art and science? I think we too often, in this day of evidence-based medicine, forget about the art of science or the art of public health, which may be seen as population medicine.

Very often, in making policy decisions, we do not distinguish between knowledge and judgement. I think this is probably what has gone wrong with some government policy, in that this differentiation was not explicitly made. The evidence, knowledge and confidence intervals concerning BSE are there for everybody to see. It is just the judgements that people make

about it that are different. One is in the field of art and value and judgement, while the other is actually some degree of scientific fact. When you confuse this you get all sorts of nonsense about science not being science.

My final point is about motives and it responds to Ann Taket's question, "what are you using the science for?" How should we understand the recent establishment in the United Kingdom of the National Institute of Clinical Excellence? What is the intention behind it? Should we accept that this is to be something that is totally value-free, or should we be slightly cynical about why it was set up, what it accepts as strict evidence, and what statements are then made about it? To put it another way: do we not sometimes distinguish issues of effectiveness from issues of affordability?

*Cristina Puentes-Markides*

I welcome Ann Taket's approach to what we actually know or do about evidence-based policy and action. A meeting on "Translating evidence into practice", organised in Washington, DC by the American College of Preventative Medicine, highlighted current experiences as well as the benefits and possible risks of using this.

In spite of the recognised values of the approach, the risks are particularly pertinent when it is true that testing absolutely everything is impossible, and that we can never be certain that the design of the trial is always perfect. The flaws may lead to wrong decision-making.

It was pointed out by the participants in the meeting that the population in which randomised controlled trials are applied is significant; reactions to drugs can be very different in different population groups. In fact, randomised control trials using women, for example, is a recent phenomenon, and there are very few based on minority populations. In fact, most drugs had been tested only on white men. The participants also mentioned the problems that may arise for a physician who uses evidence-based medicine on patients with several concurrent conditions, including the possibility that the doctor may not be up to date on the literature or that he or she may not have the same commitment to using evidence-based medicine correctly.

*Sandra Dawson*

We have been working with a group of people in Cambridge on evidence-based medicine and evidence-based practice. Part of our work is at the highly qualitative end, on subjective evidence of how clinicians account for their practice. These accounts are all in terms of experience and judgement rather than on formal notions of evidence. This prompted me to write something about different worlds. If we take evidence-based medicine, we are looking at the world of natural scientific research, but we could also look at the other world of guideline production for different patient groups or carers. There has been very little connection between those worlds, and that's just in the realm of clinical decision-making. How much more divided, blinkered and closed-in are the different worlds in the broader scenario that we have been talking about?

*Jorma Rantanen*

Ann Taket emphasised the new approach of qualitative studies. I acknowledge that this is the way to understand something rather than merely knowing it, and therefore very important. Many of the studies are excellent, but it seems to me that the quality of qualitative research is not always very high. I would argue that we need to set some standards for qualitative research; otherwise we might be in a mess in using those data. We positivistic biomedical

people have difficulties in judging what is good qualitative research and what is not. In order to use the research as a resource, we need quality assurance for qualitative research.

#### *Ann Taket*

I think standards for quality of research do exist, in the same way that we now have a lot of guidance about how to critically appraise “quantitative research”. A lot of effort has gone into producing a comparable guide on how to appraise qualitative research, so both sets exist and can be used. Among the main sources are the following.

- BLAXTER, M. Criteria for the evaluation of qualitative research papers. *Medical sociology news*, **22**: 68–71 (1996).
- POPAY, J. ET AL. Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative health research*, **8**: 341–351 (1998).

I am in a position to see some extremely badly designed quantitative research. The examples that Cristina Puentes-Markides gave about problems with randomised control trials are very salutary. We should resist the temptation to take them as a gold standard; when we delve beneath the surface, we find that they are far less convincing than we had previously thought. Good guidance can be found in, for example, the following.

- SACKETT, D.L. ET AL. *Evidence-based medicine: how to practice and teach EBM*, 2nd ed. London, Churchill Livingstone, 2000.
- *Undertaking systematic reviews of research on effectiveness. CRD's guidance for those carrying out or commissioning reviews*. York, NHS Centre for Reviews and Dissemination, University of York, 2001 (CRD Report No. 4, 2nd ed.) (<http://www.york.ac.uk/inst/crd/report4.htm>).

#### *Cristina Puentes-Markides*

My point was that, in some contexts, there can be problems with evidence-based medicine. I very much like the idea of using the results of experience and social experimentation to feed into decision-making.

#### *Ilona Kickbusch*

If evidence – whatever that is – replaces judgement, how does that relate to the political risk that elected officials as policy-makers are supposed to take in terms of making judgements? I personally consider it very dangerous to think that evidence can replace judgement, but it is also related to the current focus on issue politics. Some people think it positive that there are no longer any ideologies, but to me there is something very seriously wrong in the policy process. There is this notion of the “technocrats’ republic”, which I think would be a very negative utopia.

#### *John Wyn Owen*

The Canadian government is undertaking experiments to engage the community in debates about policy, particularly policy that involves risk. Normally, and certainly in the United Kingdom, these are handled within government and the documents are not made public. The Canadians have embarked on a much more open development of policy. I was quite intrigued to see how much risk the politicians were actually going to take in developing that process.

#### *Jorma Rantanen*

I think we should ask about applying knowledge at the policy level, or rather the lack of action

even when the evidence is there. Why do so many people find themselves excluded from services? In my own field, in spite of very evident need, 70 million European workers do not have any occupational health service. That makes discussion on quality, priorities and effectiveness irrelevant for them. You must first have the service before you can discuss quality and effectiveness.

*Richard Walsh*

I want to address the issue of applying knowledge and judgement in policy-making, because there is more to it than that. There is something that in the United Kingdom civil service is called “handling”. It is included in all submissions to ministers and it means presenting the policy and anticipating the reaction. Take an issue such as BSE. Ministers will have the evidence before them from the expert group. They have to make a judgement, and their judgement is based on that evidence, but they are also thinking about how they are going to present that evidence to the media and the public and how the public and the media are going to react. Their judgement needs to take account of all those things.

*Sandra Dawson*

I have no doubt that the United Kingdom government has a very clear commitment to act on issues and to bring together interdepartmental, interdisciplinary groups to work on those issues. But as Richard Walsh has illustrated, the fear of failure, partly exaggerated by the media, is so great that the issues become narrower and narrower. What we have identified at this meeting is the need to get away from that narrowness and work on the bigger picture.

We could usefully look at the Prince of Wales International Business Leaders’ Forum. It has done some excellent work on partnerships between civil society, the public sector and business in terms of concepts, strategy and educating people about partnership-building.

*Ann Taket*

No matter how much evidence you have, it will never remove the need for judgement. The observation I would make is that we also need to ask who participates in this judgement. That brings us back to our other issue of changes in notions of governance and changes in the role of civil society. There have been the debates around the role of citizens’ juries in priority-setting. Those are efforts to put some participation into the process of making judgements, and I think more needs to be done there.

I think the United Kingdom civil service’s notion of “handling” that Richard Walsh referred to is part of an old model, whereby the policy decision is made with a view to how the public will react but not with their participation. I think we are beginning to see signs of recognition that that model ought to change, but I do not think we have yet considered what the new model might be and how it might actually be enacted.

## **Further reflections**

*Sandra Dawson*

So far we have only talked about the “above-ground partners”, the actors who are trying to do good. We also need to look at the global “black health market”: trade in illicit drugs, human organs, sex, unsafe medicine, tobacco and ill health in general. This could even be said of some of the health consulting, exporting managed care to places where it is definitely not appropriate. There is a lot of money in those systems; and information

technology and globalisation support them, such as in the way the Internet is used for marketing. We need to look much more systematically at those kinds of actor, and make this dark side visible.

*Jorma Rantanen*

I should like to follow that perspective on globalisation with a further comment on Seattle. I was discussing with the Director-General of the International Labour Organisation, who was also President of the 1995 World Summit on Social Development in Copenhagen. His interpretation of Seattle was that we do not listen to people any more, and the people are starting to react. The factor behind the Seattle unrest was that the gap is becoming more and more evident between those who benefit from globalisation and those who experience a disadvantage. If this is true, I think it is extremely important for us also, in terms of responsibility in fighting exclusion and promoting equity and solidarity.

*Ron Zimmern*

One issue that has not been made explicit has run right the way through this meeting. It is the concept of public health leadership. This meeting has somewhat shaken some of my conceptions about what I do as a public health physician, which in the United Kingdom is incredibly limited because it is confined to the NHS, that is to the health services rather than health. Even worse, we are part of the political system.

We have to do some real thinking in the United Kingdom, and I suspect in the rest of Europe as well, about public health training. We need to decide whether it should change as a result of some of the issues raised at this meeting, who should be involved, and its relationship to medical training. The history of schools of public health and schools of medicine shows them diverging since the beginning of the 20th century.

Yet physicians, even now, are some of the most politically powerful people in society. It is essential that they regain the population perspective, not just the scientific model but also the new public health model that we espouse. We need to think through these issues of creating public health leadership, both within and outside of the medical profession, and their training implications.

*Ilona Kickbusch*

In the United States we are starting a small initiative to ensure that global and international health, which has been a specialty on the side, becomes a basic element of public health training. Nobody can be engaged in local, regional or national public health without having an understanding of at least some of these global and international health issues. It is something we want to launch and maybe the United Kingdom, with its historical role in public health, would want to consider looking at as well.

Public health training in the United States is much more interdisciplinary than it is in the United Kingdom. In our classes physicians are in the minority, which has its good and bad sides. But it is still very difficult to gain acceptance for the teaching of strategy and policy in the face of the dominance of epidemiology. There is much more to do on that count. We now have a joint degree involving the school of management and the school of public health. I think there could be some future in that, as one of the means to bring about a change of attitude.

*Sandra Dawson*

On the notion of the public health professional I am reminded that in the United Kingdom it was a highly radical outsider, very much not part of the establishment, who agitated for clean water and sanitation. Contrast that with the professionals who sought to get (as it was thought) closer to the seat of power, and have consequently become increasingly co-opted and now do not engage with these broader issues at all.

We can reflect on that in terms of the discussion that we have been having. We are all the time searching for ways of changing the mindset, of bringing in the fantasy, of thinking the unthinkable, of saying that traditional forms of organisation and types of assumption are not good enough for the agenda that we have to tackle. But we know that whatever we invent here is likely to be co-opted at some point in the future.

We might want to see radical fantasy – very challenging and difficult for the establishment – followed by co-option by the establishment as alternating phases of a cycle. We might argue, from a rational point of view, that this cycle is necessary to get near the seat of power. But when you get so near the seat of power, everything is so compartmentalised and task-oriented that you forget the big picture. So I think that we can look at the history of public health and think about the way we would like to take this agenda forward, and realise that at best there will be a balance between co-option and power on the one hand, and playing the court jester and saying the unthinkable on the other.

*Graham Lister*

If you cannot solve a problem – and let's face it, we are dealing with essentially intractable problems – I find it helpful to try and think of a team of heroes that might solve them. As a start I would suggest Willy Brandt, to remind us of the moral responsibility of rich nations to poor; Robert McNamara, to provide all those good American values of efficiency and getting things done; Hans Seehofer, the former German health minister, to show us how to reform the health system without anybody noticing; Joseph Chamberlain, to create civic links and a sense of civic responsibility as the real basis of health; Fons Deckers, for his vision of creating a patient consumer movement in the Netherlands that is second to none. And finally Mahatma Gandhi, to remind us to go back to the village; it is in our communities that real health is determined, and it is within us that health has a spiritual meaning and value.

*Richard Walsh*

My final observation is how challenging a lot of the discussion in the meeting has been to me as a central government policy-maker, and I found that quite surprising. In the course of discussion we have looked at globalisation, the changes in the role of the nation state, devolution, increasing complexity, the effect of empowerment, and changing public perceptions. Some of this I have thought about before; some I am intending to do work in. But it is the first time that I have heard all this articulated in one forum. If that is how it is for me – and I am supposed to be a strategic planner – I suggest that the experience would be even more extreme for the vast majority of policy-makers who are working in individual policy areas.

If all this discussion means that we are moving into a period of rapid change, where the current power structures are not going to be appropriate in the future, then we must find some way of engaging these policy-makers in this kind of thinking before their policies cease to be relevant and thus effective. Our discussions have brought that home to me.



The United Kingdom government White Paper *Modernisation of government* helps in some respects, in that it identifies the need for longer-term thinking and for adopting a more outward-looking perspective.

## The emerging picture

*Keith Barnard*

I have been charged with offering an immediate impression of what has happened, and of the issues that have emerged during our meeting. We started off by addressing the need for futures and how we use them, what we hope to achieve by them, the particular audiences we are directing them at, and whether we are trying to raise awareness in the public at large or to send a message to particular groups within the population and specifically to policy-makers.

We have talked about the need to get ministers involved and to help ministers become focused. This is why we use scenarios. We must also remember that the emphasis must be on policy content and relevance to problems, not on the quantity of policy proposals. Historically, that is a trap some political parties in opposition have fallen into. It is never a question of quantity but of what policy is trying to achieve. That demands vision.

There is a cartoon that I have kept – it is of WHO origin – of which the caption reads: “Exactly how much vision can you have from down here: it is physically impossible to keep your nose to the grindstone and scan the horizon for new opportunities at the same time.” I think that’s worth reflecting on. One of the real practical values of scenarios, which I hope the Nuffield Trust/Judge Institute scenario will achieve, is to get people’s noses up from the grindstone.

A particular comment to make about the Judge Institute/Nuffield Trust scenario is that it came across to some of us as being too focused on the NHS. Let me conjure up an image that encapsulated my impression. There are two boxes, one marked health care and one marked environment (environment meaning all kinds of environments, not just the physical). We may have a well filled-in box of possibilities within the health care system – about the future of professional education, the future of technology, the kinds of facilities we are going to have and how we are going to use the workforce to provide services that meet the public’s expectations. We can generate many scenarios in that box and plenty of challenges to ministers. But the environment box is empty. We have nothing on all those other factors that contribute to improved health, which in one way or another are health promotion and protection interventions, strategies and measures.

When we got into the discussion we found that, in fact, the team had been very aware of these issues and there was no problem in the way they had gone about their task. I am sure that the end product will show a balance and all the boxes will be filled in. But I mention this concern again because this is an important distinction we have been making in WHO, and we want to see both boxes filled in when designing our vision of future health.

There is a companion message on vision in another cartoon that I have. It depicts a board-room meeting in which the Chair addresses an earnest junior member saying, “That was a very realistic proposal; we’ll just shelve it until we’ve finished fantasising”. You have to first generate the fantasy, excite the imagination, and then look for possibilities and look beyond



the realm of possibilities. Then, when you have the richness of ideas, you can start filtering them and applying feasibility tests. You cannot do it the other way round. You cannot start by being realistic and hope you are going to excite the imagination afterwards. Realism blocks fantasy. It is quite critical that you have the ideas first and then you become realistic in drafting proposals.

At this point our needs change. And so we have talked about the importance of evidence, of having scientific foundations for policy proposals and a sound analysis. But we also know how elusive this can be in practice. There are different types of information, and different types of science. What type of evidence do we go for, and how do we capture it? I think we were hearing very strongly, from all the contributors who spoke in the last session, that we need to be more aware of the *range* of evidence, the range of sciences that can be drawn on and the way to integrate findings from those different sciences, and then to formulate potential applications and put a set of proposals to decision-makers.

Within the world of public health, we need to think what policy-making and programme management will be in the future. Organising and providing services – reaching out to people – will be different in the future for many reasons, not least because of people's access to information. This will change the assumptions we have to make as insiders.

We have got to keep in mind the need for balance between our two sets of intermediate ends: having a health care system based on primary health care principles that is concerned with achieving improved health outcomes; and pursuing a whole range of interventions and actions that we are now calling “sustainable health”, which picks up the agenda of health protection and promotion. The ultimate end is better health for all – the goal of HEALTH21.

In WHO's European regional perspective, we have offered a challenge to the Member States in HEALTH21. They have accepted that challenge in the sense that HEALTH21 has been formally endorsed by the Regional Committee. The framework of our HEALTH21 policy, and the strategy for implementing it, is built on values – equity, solidarity, accountability and ethics – which we have reflected in our discussion in this meeting. We are talking about mobilising for health in HEALTH21, and we have had a lot of discussion about identifying which people we should be mobilising, and how we can reach out and establish contact and dialogue with them.

In the discussion of the geopolitical and other dimensions of the macro environment, we tried to understand what that meant in terms of building up a picture of who the actors are and their relationships, and their sources of power and their ability to influence the agenda and outcomes. The starting point of this was the loss of certainty. It goes back to the dissolution of the USSR and the end of the stable bipolar geopolitical world, and its transition into something that is fragmenting and whose significance we cannot grasp. We are beginning to recognise that all the assumptions we made in the days of the bi-polar world are behind us.

Our attention is still gripped by Seattle. Where is the world going after Seattle? Have we seen the first sign of the end of deregulation? Will the global actors – typified by Bill Gates and others – carry on and control the world, or are we going to see a sustained protest from the people, or whatever? Is this the fork in the road? Is it a weak or strong signal? The judgements we make as we respond to those kinds of question will shape the assumptions we make about whom we respond to, how we have dialogues with them, and what we expect from those dialogues.

We are not going to recreate the world as we long knew it, and we have to find a new kind of framework. We do not know what that new frame is going to be, but we have a lot of ideas coming out of our discussions about pieces of that frame – the new actors, the new interrelationships and the new possibilities for constructing agendas that people will own and see the benefits of. We have to find a place in the frame for the individual level and institutions within countries, supranational institutions, transnational corporations – all those actors that have been mentioned during the course of the meeting – and to see and understand the linkages and the flows of influence and communication between them.

There was recently an interesting article in *The Guardian* by the art critic John Berger, who was commenting on the Hieronymus Bosch painting *The Triptych*, and specifically the panel depicting hell. He was arguing that although this was a 16th century vision, it was uncannily like society today. The image is of a lot of pointless activity, with no connection between things, no horizon and nothing to look towards. If it is true that this is a vision of the life we are moving into, then the overriding challenge is to make sure that that does not happen. If we can break out of that, then we might have the beginnings of a new societal approach. What we do for health has got to be one element of a societal approach: not the future of health care, but the future of society.

We have had some interesting leads showing the potential of new forms of organisation, especially in the concept of virtual reorganisation by design. We certainly need new patterns of internal structure and control. I am not sure that control is the right word any more, unless it is self-control or self-management. We should not be bound by hierarchy but think in terms of lateral relationships inside organisations and between organisations, whether we call those networks or use some other label.

We need new ways of anticipating and planning for the future and we know that the Nuffield Trust and the Judge Institute are already beginning to think about this, with the commitment to publish annual updates.

My final point is that we need to find a new way of seeing how competition and collaboration can live together. I have no doubt in my own mind that collaboration is the more important. The value I see in competition is not the drive it generates to destroy the other party, but the link with the idea of benchmarking. Competing in the sense of wanting to be as good as the best in class is a constructive form of competition. It means that everyone is seeking to do better.

## Continuing collaboration

*Herbert Zöllner*

This meeting has convinced me that our two institutions, the Nuffield Trust and WHO, should continue putting their heads together. I think we prepare a publication based on this meeting, bringing together the papers that have been prepared and capturing the full essence of our discussions. There has been a richness in the contributions that we do not want to lose, and we will not capture in a conventional report of a WHO meeting. We have a precedent for a publication: the WHO/Nuffield Trust book *The pen is as mighty as the surgeon's scalpel*.

I also hope there will be continuing cooperation. The agenda we have identified cannot be addressed all at once. We have made a start in this meeting. The Trust has instituted a “window to the world”. Perhaps we could open the window again.

*John Wyn Owen*

I think that the Trustees will be very keen to see us encapsulate the work of this meeting.

One of the interesting features of this meeting has been the focus on various futures exercises that have been undertaken. I think there is scope at some time to look at the different futures exercises that have been going on in the United Kingdom and in Europe, and see if there are some common lessons to be learned from them or whether there are big differences. This meeting seems a really good example of what can be achieved by collaboration between organisations in this field.

We also asked at some point who some of the radical thinkers on these issues might be. We would like to pursue that with WHO and the Judge Institute: some useful ways of taking forward the work of this meeting.

*Cristina Puentes-Markides*

Perhaps it might be possible to arrange for a Spanish translation of the publication, to make the richness of these discussions available to the countries of the Americas. We have a commitment to health futures, and it would also strengthen the likelihood that our own colleagues become more engaged in the process if they recognise its use in other countries and settings. We are very interested in moving forward with the work we have been discussing. So we would need all the help we can get and this may be a way to help change practices in our own organisation.

*Herbert Zöllner*

In the WHO perspective it would make sense for our American and European Regional Offices to work together on information exchange, and also to take this work forward. That leaves me to thank our Nuffield Trust colleagues for their hospitality and excellent organisation of the meeting. If this is the collaboration that is shaping up, I look forward to much more of it.

*John Wyn Owen*

I am particularly grateful to Sandra Dawson, Charlotte Dargie and Pam Garside, who have been leading the policy futures project in Cambridge. The benefit of a meeting like this is that it helps to make contact with people who have an interest and can make real contributions to help us take the project forward. International contacts are crucial for us, so we are very grateful to the WHO team for working with us and giving us the opportunity to host this meeting.

# PART II: THE CONTEXT

## THE INTERNATIONAL CONTEXT

### HEALTH21 as a future-oriented policy framework for Europe

*Herbert Zöllner*

#### **A global vision in Europe**

The World Health Organisation, a member of the United Nations family, has one constitutional objective: the highest attainable level of health by all peoples. There is no time horizon given – it is something that we constantly work towards.

The Constitution lays down a number of functions by which WHO pursues that objective. Some are quite technical (such as the International Classification of Diseases) while others are without boundaries, such as assistance to countries. WHO also has a role as the directing and coordinating body in international health work; this gives it legitimacy in taking initiatives onto the international stage.

Initially, WHO focused exclusively on the technical tasks. By about 1970, however, it was realised that a new approach was needed and that WHO had to establish an international policy agenda to support the Constitutional objective, steering the reorientation of its efforts and those of others, including the countries.

This is the background to the original health for all resolution of the World Health Assembly in 1977 (resolution WHA30.43), the Declaration of Alma-Ata on primary health care in 1978<sup>16</sup> (as the necessary means to achieve health for all) and the subsequent commitment to develop health for all strategies.

This is where the regional organisations came into the picture, to work with the Member

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16. *Alma-Ata 1978: primary health care*. Geneva, World Health Organisation, 1978 (“Health for All” Series, No. 1).

States on a common health policy. Since 1980 we have been engaged in a continuing policy and evaluation process.

**HEALTH21 is intrinsically and in essence future-oriented**

Health for all and other international visions are by nature future-oriented, so much so that Ivan Illich once commented to me that United Nations organisations such as WHO lived exclusively in the future.

***Changing time horizons: from 2000 to 2020***

The year 2000 horizon that WHO adopted in launching the health for all movement has been a problem in one sense, in that it has been used by some critics to discredit the health for all initiative. But that time horizon should be seen in perspective: the health for all resolution was intended to lift everyone's eyes up to a time horizon – the year 2000 – that everyone could grasp. It was to project a vision of what was worth pursuing in one generation.

The year 2000 created a time frame for action, a sense of purpose, even urgency. It was not an unqualified goal of health for all, but one of enabling people to lead productive or satisfying lives. In a sense the year 2000 was a milestone, nothing more, on the road to the ultimate objective of the Constitution, which in practical terms is an endless journey.

We saw our task in the European Region as creating a movement for health for all. It stimulated us to look ahead and get a hold on what was worth pursuing: the specifics that we needed to address and how close we could come to achieving our goal. Hence the need to express the goal in practical terms: the conditions that should be created to enable people to lead healthier lives, the services that should be provided, and so forth.

We have no problem in rolling forward the time horizon from 2000 to 2020. This will leave us with much the same time frame – 20 years – that we had when we started in 1980. In fact we thought of rolling forward when we updated the targets in 1991, but we could not jump too far ahead of the rest of WHO.

Health for all beyond the year 2000 is the renewal of a continuing commitment by WHO and its Member States and other partners. We are still focusing on the policies, actions and ways of working that best serve to secure further improvements in people's health.

***Sensing the future***

Our role in the Regional Office is to create a climate of thinking about these issues that we then share widely, and thus help to identify specific ways in which we can support countries: by information, advocacy, technical advice and practical assistance (though not finance on any significant scale, since we are not a funding body).

Hence the importance of trying to be as clear-headed and systematic as possible in sensing what might be ahead, or what is often expressed as “taking stock and looking forward and around”. This includes and goes beyond a data-gathering or monitoring exercise; it also requires one of intuition and imagination.

That is what we have tried to do in a modest way in the successive futures exercises that we have conducted over the past decade, and that we have described in an informal paper for this meeting: *The use of futures in European health for all policy development*.

As the background paper also describes, we have used the product of these futures exercises as the start of a consultation process with the stakeholders in Member States. We have done this to reach some common understanding on the assumptions we should make in policy-making and the targets we should set ourselves as a Region, which the countries themselves can use as inspiration and a framework for their own policy development. We do not gloss over the unfinished business. The shortfalls in achievement in some domains of our policy have been documented in *Health in Europe 1997*.<sup>17</sup>

It is not surprising that the gravity of problems varies between parts of the Region and within countries. It relates to the burden of communicable and noncommunicable disease, disability and premature death; to people's states of social and psychological wellbeing and the environmental hazards to health to which they are exposed; and to difficulties of access to appropriate care of good quality. There are challenges in each domain of our health for all policy, continuing challenges where – in Europe and in countries and communities – we need to do better. We seek to do better in a climate of continuing and new threats: threats to the economic wellbeing of countries and their ability to care for and support an aging population and to finance adequate health care for all; the resurgence in communicable disease and drug resistance; the burden of noncommunicable disease, with its roots in unhealthy patterns of living whatever the cause; and the resilience of the tobacco companies. The list of threats goes on, but there are also opportunities and positive factors.

We are especially encouraged by the continuing vitality and appeal of the health for all idea, which makes the present policy climate much more favourable than it might have been. The climate of the past 20 years has not always been one that naturally embraced the essence of health for all, and yet it survived.

There is the growing acceptance that poverty, social exclusion and denial of human rights are intolerable in a modern society, together with the recognition of the importance of efforts to improve health as part of the campaign against poverty.

Increasingly, with the lead given by the World Bank and its many partners, expenditure on health and health care is no longer seen purely as consumption. Health is also seen as investment in a society and its economy – the idea of social capital. There is a growing acknowledgement that health is everybody's business, and we can more easily have a dialogue with actors in other sectors over the practical implications of that.

And last, I should mention the potential of technology, especially biotechnology and information technology. These could transform the health care sector in terms of what we do and how and where we do it. It may even be possible to reduce costs!

### ***Sustained health for all values and commitment***

One of the positive trends of the past decade has been the growing recognition of the importance of values as a guide to determining objectives and ways of working; and the need for shared values within an organisation to implement its policies, and respond in a coherent way to changing circumstances. We see this trend as positive, because it has always been one of our concerns to stress such issues in the context of health for all policies.

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17. *Health in Europe 1997*. Copenhagen, WHO Regional Office for Europe, 1998 (WHO Regional Publications, European Series, No. 83).

We have a set of values that can be traced back to our Constitution, and on which we remain firm. We can reinterpret these in the sense of applying them to provide a justification for a particular policy proposal, but we have not seen fit to change them. We will continue to be guided by these values in the future.

HEALTH21 makes the position quite clear: health outcome, equity, ethics, solidarity and accountability are seen as being closely linked together. Basically this means that all partners or stakeholders (whatever we call ourselves) understand the importance of:

- orienting all economic, social and political action towards a health outcome (not only health care but also health protection and promotion, whether or not a programme is carried out in the health sector itself);
- acting to secure the ethical foundations of health development;
- reducing inequities in health between and within countries;
- strengthening international solidarity (supporting countries in need, collaborating on common and transboundary problems) and partnerships for health inside and across countries; and
- actors in all sectors of society accepting responsibility and accountability for the health consequences of their actions, and acting accordingly.

We also attach importance to the statements of Member States in the WHO Regional Committee for Europe (resolution EUR/RC48) and the World Health Assembly (resolution WHA51.7), which express their political commitment to the policy of the Organisation and the values and principles that underpin it.

### ***Setting targets and monitoring progress***

Following a baseline study of where we stood at the outset, and an exploration of desired directions and trends, targets were drafted and revised in line with scientific evidence and the preferences of the Member States. These targets specified the actions to be taken and, where appropriate, levels of intended achievement.

We also built in the means of monitoring progress towards them, using agreed indicators. This enabled us to review and revise the targets in the light of experience and changed circumstances. Thus from the start we were future-oriented in a practical way, not merely giving voice to general aspirations.

As the Secretariat, we act in accordance with the mandate we receive from the Regional Committee. It is in everyone's interest that the targets are perceived as reflecting objectives that are worth pursuing, and that they are believed to be feasible. Feasible does not mean easy; those of us who have worked with them have always understood that targets should contain a challenge.

Naturally, there can sometimes be tension over matters such as the focus, the detail and the frequency of reporting of the chosen indicators. Such matters need to be resolved diplomatically. As with the targets, we have a mechanism for reviewing indicators, for amending or changing them if collectively we see fit.

But we have always had as a point of reference the highest level of performance that has been achieved, or the acknowledged best practice to be found, somewhere in the Region.



Alternatively we have proposed a new level of achievement, which, on the available evidence, is confidently judged to be attainable.

I recognise that other views are held, but we find great merit in virtually continuous monitoring of progress through selected indicators. We see this as an important means of strengthening the evidence to support decision-making at the various levels, and of ensuring that further implementation of policy is sensitive to the impact of steps already taken in particular contexts. The commitment of all countries to report their progress, using standard indicators, is one of the most powerful and valuable means we have for gathering health intelligence, for its analysis, and for disseminating the results to the Member States.

It is a process of collectively tracking progress in the Region, looking for evidence of where things are going well and spotting signs of difficulties. It is not to give good or bad marks, but to point out the positive and negative experiences that should trigger closer inquiry into what is happening and what should happen next.

It also provides a means for countries to do their own benchmarking against other countries, thus deciding where and how they can learn from each other. It also ensures that our various technical units working with countries at national and subnational levels are well informed on the situation facing their country counterparts.

### ***Towards a new ethos of health***

In many countries, the financial “ethos” of eliminating budget deficits and lowering “excess” labour costs has long dominated political and public discourse. There are no corresponding indicators of health and social deficits that have so captured people’s attention. Consequently, attention has focused on cost-containment and cost-sharing. A new health ethos calls for widening the responsibility of the health sector to reach out and mobilise all sectors and settings of daily living, persuading them to become accountable for their impact on health.

### ***Putting health higher on the political agenda***

Better health contributes to a good economy and society; and a better economy and society creates health.

We want politicians to take health consciously into account when they make their policy decisions on priorities and the allocation of resources. If we manage to provide firm justification for what we do, it will be that much easier to achieve what some have long been advocating: that health should be placed much higher on the political agenda. As advocates for health, we have two issues to consider.

Certainly we want to be heard when we advocate good health as a primary objective in a given public policy. We do not discourage politicians who commit themselves to health for all policies, believing that health has high value for its own sake. Health is a resource for living and good health is essential for quality of life. Good health in this sense is not just for the young and fit; the elderly and people with disabilities also can enjoy good health.

The second issue is that we need to strengthen our advocacy of the contribution that better levels of population health make to social and economic development generally. The evidence is compelling that a focus on maintaining autonomy and minimising dependency, and on emphasising the promotion and maintenance of health, provides a key to improving economic development.

We can also support activities in other sectors that produce better health as a spin-off from their main objective. For us, it may be as important that health is a consequence as well as an objective.

### ***A proactive health sector***

If the health sector is to succeed in making health a dominant political issue, it needs to be much more active in external relations with other sectors and the settings of those sectors – workplaces, leisure centres, housing developments, etc.

The health sector will of course only be credible if it puts its own house in order, so that care reforms adhere to HEALTH21 principles (see the Ljubljana Charter)<sup>18</sup> and so that health care really restores and maintains health in an effective and equitable way, and has sufficient evidence and influence to convince other sectors and colleagues.

It implies greater emphasis than hitherto on the health ministry's advocacy, negotiation and cooperation function, rather than on the regulatory or managerial responsibility for health care that we find in many countries.

Emphasis in public health policy on bringing the dimension of health into social and economic development requires that health ministries take the lead in identifying and maximising opportunities for marrying health and development, wherever they arise. We believe that the health ministry should be given, and be accepted as having, a cross-sectoral responsibility for health development in its fullest sense. While I have spoken here about the national level, the same is true at regional and local levels inside the country. At the local community level, for example, a well understood primary health care strategy will include people, their homes and families, community settings and institutions of daily living, and the political, social and economic organisation of the community, as well as its public health infrastructure and programmes.

### ***Mobilising sectors, settings and partners for action on determinants of health***

The goal of health for all is to give all people the opportunity of a satisfactory quality of life throughout their life. Functional health and quality of life go hand in hand. The life course approach recognises that there is a complex interaction throughout life, between major life events, biological risks and the socioeconomic and environmental determinants. At any point in time it is access to health resources – such as knowledge, skills, social relations, economic assets and environmental safety – that matters for health promotion and disease prevention. Settings of daily living such as homes, neighbourhoods, schools, workplaces and tourist areas are especially important for creating, rather than destroying, health

In HEALTH21 we argue that a health policy based on addressing the determinants of health means that responsibility does not lie solely or even primarily with the health sector. An effort to make the healthy choice the easy choice; enhancing people's own capacity for health and coping; a sustained healthy environment; fiscal and monetary policy to manage the effects of economic cycles; regulation of the labour market; education and training opportunities; assistance to people in economic or social difficulties; and several strategies to counteract poverty, crime and other social ills – all of these can all have an impact on health.

In this context, policy-making necessarily implies being alert for the effects on health of decisions and investments in all sectors. It would be greatly assisted if health impact

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18. *The Ljubljana Charter on Reforming Health Care*. Copenhagen, WHO Regional Office for Europe, 1996 (document EUR/ICP/CARE 9401/CN01).

assessments in and across sectors and settings became an integral part of all public policy-making, and the people's voice on these matters was made to be heard.

The sharper emphasis in HEALTH21 on addressing the determinants of health underlines the need for a shift of responsibility from the health sector alone to coalition-building and collaboration between sectors and settings. We will have to find means of introducing health into the vocabularies and value systems of other sectors in ways that are acceptable to them.

HEALTH21 has four main messages on the issues of responsibility and accountability. In the future, gaining acceptance of the principles in practice will depend on innovations and initiatives that involve:

- encouraging the mass media to become active partners in informing and involving the public in public health matters, so as to develop consensus for action;
- making health improvement a positive message for industry and commerce so that it becomes an objective of investment, and identifying mutual (“win/win”) benefits of investments;
- establishing new strategic alliances of various kinds to tackle the determinants of health: with decision-makers in all economic and social sectors, and with community groups (as well as health and other professionals); and
- promoting and strengthening existing partnerships for health (such as networks of regions, cities and local communities, schools and workplaces).

### **Innovation in HEALTH21 implementation**

Now that HEALTH21 has been formally adopted as regional policy, our emphasis in the Secretariat moves from developing the “what” of policy content to supporting the “how” of policy implementation. This includes supporting the key actors responsible for implementation, whether they are strategists steering the overall HEALTH21 process or managers launching a particular programme.

### **Principles**

The challenge is to promote the implementation of HEALTH21 policy in line with health for all values, such as equity and solidarity. Among the principles are:

- informed, judicious decision-making (a mix of intuition, evidence and judgement);
- participation (those who will be affected or could act are part of the agenda-setting and the making of decisions) and responsibility (conscious acceptance of a duty to carry out a role, task or function);
- transparency (being able to “see” how decisions and actions are taken) and accountability (a requirement to justify decisions and actions in terms of achievement and resource use);
- effectiveness (in terms of population health outcomes), sustainability (of resources and other conditions to achieve given ends over time) and efficiency (appropriate allocation of resources and their use for outcomes reflecting values); and
- innovation (learning from the past and looking ahead).

What will these mean in practice? How can we stimulate actors to observe these principles and make them operational? What would be appropriate ways to give recognition to those who fulfil their obligations? What sanctions could there be against those who fail to deliver? While

tomes could be written on each of the topics, it is even more important to learn from practice across Europe and to develop “best practice” for specific contexts.

### **Future of evidence**

We need to intensify our efforts to get good feedback from all levels of the experience of policy-making, of initiating action on targets, of developing and running services, of creating partnerships and political allies, and of the whole range of initiatives that will be taken.

One key step will be to put still greater effort into continuously building up the evidence base. There is the potential of meta studies; ordering and distilling reported experiences from different locations would be one example of what I have in mind.

We need to do more research and innovation on implementation. We need to look at ways of continually getting and assessing feedback from different action-oriented research and development programmes. We have more than 50 national laboratories ready to cooperate with us. Extension of the Secretariat, through the establishment of European centres in key HEALTH21 areas, will allow research and development to focus on monitoring and implementing policy. In focusing research on policy implementation, we will be sure to include what we might call “contextual analysis”. This includes scanning the environment, including noting what happens in socioeconomic trends, shifts in the ethics and behaviour of key actors, changes in society’s attitude to equity, and the implications for public policy.

We will need to be continuously sensing the environment, using early warning systems. This also includes finding means of engaging the help of those who can think in the long term. We will need to identify and develop lead indicators that are particularly sensitive to changes in health levels, political attitudes, etc. We will also need to work on pattern recognition of small, significant shifts in the phenomena we are monitoring.

Getting these mechanisms in place will be an essential step if we are to keep the health for all policy relevant. Our task is to make sure that it continues to reflect both people’s needs and aspirations and the realities of the operating environment in which policy is made and implemented.

### **Conclusions**

Let me conclude in these terms:

- In HEALTH21 we are pursuing an objective – the highest attainable level of health for all people – that is not restricted in time but that requires us to continuously look ahead, to anticipate as best we can the difficulties and opportunities facing us.
- The key features of HEALTH21 are the following:
  - It has a comprehensive agenda for health policy development – a challenge not only to health care providers and the health sector but also to actors in all sectors who can contribute to improved health and build coalitions accordingly.
  - It is underpinned by values of equity and solidarity, and operating principles that reflect the requirements of successful implementation.
  - It seeks to blend vision with practical realism, and stresses the importance of objectives and targets to be achieved.
  - It includes the tracking and assessment of progress as a learning mechanism, allowing timely adjustments to objectives, approaches and procedures.

- For WHO, the immediate tasks ahead are:
  - to support HEALTH21 implementation that Member States will find helpful; and
  - never to stop learning from experience and to continue to look ahead and around, understanding the origins, complexity and potentially far-reaching implications of the changes in train in Europe.
- My personal hope is that economists, sociologists and other social scientists on the one hand, and the various public health disciplines on the other, all join together with more enthusiasm than in the past. We need them to pool their perspectives and analyses to reveal fresh insights and new possibilities for action.
- Finally, at the policy level, it is essential that countries individually and collectively build up a foresight capacity that becomes the basis of a comprehensive health intelligence gathering and analysis function.

## The use of “futures” in European health for all policy development

*Keith Barnard*<sup>19</sup>

*This chapter reviews the experience of the WHO Regional Office for Europe in using futures in policy development. It puts that experience in the context of a changing geopolitical environment – the transformation of the Region that came with the end of the cold war and prompted a different approach to policy-making.*

*The particular approach to futures is explained. This involved using external specialists to review their fields. These were principally different aspects of the macro environment of the health sector (ecology, technology, geopolitics, etc.). The futures product emerged from a general interaction involving all the specialists, Regional Office staff, representatives of Member States and other interests.*

*It was decided to make consultations a continuing process, to be repeated at intervals.*

*Appendix 1 contains extracts from an early draft of a chapter of the document that, in its final form, became HEALTH21. It is included to show how material generated in the futures consultation process, together with that from other sources, was put together to lay out the present and possible future policy environment. For the first time, contrasting (positive and negative) scenarios as alternative “histories of the future” were prepared to draw attention to the range of possibilities facing policy-makers.*

*The ideas presented did influence the final HEALTH21 document but the draft chapter presented here, although reshaped and revised, did not survive. Strategic and pragmatic reasons for this are suggested, principally the need to present one consistent positive prospect for Member States to respond to.*

*Appendix 2 is intended to convey the flavour of ideas emerging from WHO futures consultations held in 1990, 1992 and 1995 and the meeting of the Regional Health Development Advisory Council in 1997, all of which were important steps in the policy renewal process.*

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19. The views and interpretations of events set out here are solely those of the author, whose role throughout has been that of a consultant working on a continuing basis with the Secretariat.

Policy development is both simpler and more hazardous for the secretariat of an international organisation than for policy-makers in its Member States. It is simple in that it does not have to address the specific political economic and other realities that constrain national policy-makers. It is more hazardous in that it must couch proposals in terms that make apparent their relevance to the different conditions and circumstances of the Member States, and present them so that all can find them acceptable. This is only possible if the emphasis is on the “what” of policy, offering them signposts and hopefully inspiration. Although it is possible to offer guidance, the “how” of policy – adapting the substance and planning its implementation – should be left to the Member States.

### **Health for all policy and the response of Member States**

The Secretariat of the Regional Office has been engaged in preparing health for all policy proposals for approval by the governing body, the Regional Committee, for some 20 years. A framework, the Regional Strategy for Health for All adopted by resolution in 1980, was elaborated in 1984 into a policy document, *Targets for health for all*,<sup>20</sup> which presented a comprehensive set of medium- and long-term objectives. It provided a point of reference for the Office’s programme of work and a model for the guidance of Member States in developing their own national strategies, a task to which they had made a formal commitment in the World Health Assembly. It was updated in 1991 and renewed in 1998 as HEALTH21.

Although resolutions of the Regional Committee are non-binding, the regional health for all policy has been an important influence in health policy-making in countries. It would also be fair to say that Member States are selectively adapting rather than comprehensively adopting the full set of policy targets that their delegations approved in the Regional Committee. Nevertheless, the impact is an impressive achievement in refocusing thinking about health policy. Its influence has been acknowledged, for example, by successive United Kingdom governments.

Whatever the levels and variations of achievement so far in and by countries, the essence of the strategy and the analysis underpinning it have so far stood the test of time and experience. Political, economic and other trends may imply the need for new approaches to implementation; technological developments have opened up new possibilities for action, but none of these has yet given any reason to change the main agenda. What we have seen have been shifts in emphasis, refinements or new elaborations strengthening the coherence of the policy, all in response either to cumulative experience or changing circumstances.

The basic sense of continuity that we have experienced might be thought surprising. During the interval between the framework strategy in 1980 and HEALTH21 in 1998, the policy environment in the Region changed dramatically, including the nature of the Secretariat’s relations with many Member States. The approach to the task and the assumptions to be made had to be discovered afresh and then refined by experience.

Two initial observations may be made. First, experience with the implementation of the policy has been kept under scrutiny by a built-in reporting and monitoring process. Second, there has been a generally constructive tension between the proponents of two schools of thought: those who believe that achieving better health for all depends on a sustained effort to achieve the

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20. *Targets for health for all. Targets in support of the European regional strategy for health for all.* Copenhagen, WHO Regional Office for Europe, 1985 (European Health for All Series, No. 1).



specific targets or objectives that have been adopted; and those who consider that it is more important to respond to the particular concerns, priorities and circumstances in Member States. The emphasis after 1989 on working with countries has supported the latter view, although the integrity of the scheme of targets has been maintained.

### **In the beginning**

Having established the context, we can now trace the evolution of the approach to health policy development and planning. Within the WHO Secretariat at the time when the framework of 1980 was elaborated into the 1984 targets, there was an uncomplicated espousal of formal planning, although it was recognised that circumstances varied considerably within countries. These ranged from the Soviet Union and its allies, where planning ideologically had a central place; to countries in the west of the Region where planning was adopted more pragmatically as a necessary component of policy-making and action; to those where formal planning was a weak tradition or even treated with cultural or political hostility. Nevertheless, any opposition to the idea of target-setting was muted in the Regional Committee's endorsement of the Secretariat's proposals.

There may have been some diversity of view among Member States, ranging from "it's what we are doing anyway" to "it provides helpful guidance" to "it's primarily for the Secretariat". In retrospect, this was less significant than the achievement of getting the Regional Committee to adopt the targets as the policy for the Region, thereby bringing them into the public domain. The importance became clearer later when NGOs, health lobbies and local authorities started citing the targets as a way of putting pressure on national governments. Regional Committee delegations would thereafter look carefully at draft policy commitments.

### **Policy development after the loss of certainty**

But there had also been two other significant developments. The Member States had committed themselves to regular reporting and evaluation of their progress towards the achievement of the targets. They were also committed to their periodic revision and updating. The first scheduled update was due in 1991. By then the Region was in the midst of a largely unforeseen, massive geopolitical change and the imminent end of the cold war – till then the principal factor determining what would or would not be feasible or acceptable as regional policy.

This new environment posed a particular challenge in crafting policy proposals for the updating of the targets. The old certainties, the necessary basic assumptions that provided the starting point, were no longer there. It was not clear whether the governments of the new Member States would want to continue the commitment to health for all. It was unlikely that they would support anything that implied the extrapolative "straight-line" planning that was their predecessors' idea of policy-making.

Meanwhile, in the western European countries, public sector planning was widely discredited as being both *dirigiste* and an inefficient way of determining the allocation of resources. "Let the market decide" was increasingly the idea in currency. However, this did not remove a basic concern. Any government policy, even one of abrogation or devolution to other bodies, must be based on some assumptions about government's residual role and the future operating environment, i.e. what might happen, what should be encouraged and what must be prevented. All this implied the need for new ways to prepare for the future. It was felt that we



should explore what might lie ahead as a first step towards crafting policy proposals that would shape the Regional Office's programme of work and offer guidance to countries.

This was the challenge for the first futures consultation organised by the Regional Office in 1990. Having no experience, we adopted a modest approach. We launched a brainstorming involving WHO staff members and invited experts, who were asked to speculate in their fields of expertise. The fields that we identified, after some reflection, related to possible changes in the health sector's external world: ecology, technology, geopolitics, the macro-economy, social structure and demography, married to an epidemiological review of progress to date in achieving the targets adopted in 1984.

### **Futures consultation 1990 – using the product**

The ideas generated went through various filters in a review process involving other insiders and outsiders, including a formal body established for the purpose, the Regional Health Development Advisory Council (RHDAC). A refined set of assumptions and prospects became the basis for the proposals for updated targets and the content of a draft first chapter of what would be the new policy document, *Health for all targets: the health policy for Europe*.<sup>21</sup> The process whereby the overview of future possibilities became transformed into a shape and contents acceptable for inclusion in a regional policy document was sometimes a painful learning experience.

A consultation was held with representatives of Member States, the then Consultative Group on Programme Development. Their reaction to the draft chapter was quite negative: “nothing here that is not already well known”. Whether or not it was true, it was not clear why this in itself made the draft unacceptable. It was followed by “make sure it strikes an optimistic note”. It became apparent that our clients (representing their ministers) were not engaged by the idea of policy-making based on a reflection on alternative pictures of the future. They were even less interested in any projected unfolding of events that implied that their ministers' policies might not be successful, or that presumed difficult, perhaps intractable, problems lay ahead.

The text went through several redrafts before being resubmitted to a supervisory group appointed by the Regional Committee to approve the final text for publication. Having struck the expected optimistic note, as well as de-emphasising alternative futures, we were once again wrong-footed by being accused of being so optimistic that we were naïve!

The response to the target updating was interesting in other respects. Despite the new policy environment, there was resistance to any radical change. The number of targets was to be kept at 38. This was somewhat surprising, since some Member States had been earlier (and would be again later) quite vocal in their view that there should be many fewer targets and that more “realistic” intended outcomes should be proposed. Second, the order should not be changed (even though this would have been a sensible adjustment in many cases) and substantive changes in the formulation of targets should only be made when “really necessary”.

Here was persuasive evidence that the targets had acquired a high recognition factor. The credibility and acceptability of the updating process hinged on the new product looking the same as the old. Although, within the limits set, a number of changes were made, the substance

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21. *Health for all targets. The health policy for Europe*. Copenhagen, WHO Regional Office for Europe, 1993 (European Health for All Series, No. 4).

and coherence of the original policy was preserved. Only one completely new target was included, on ethics. Even here it could be argued that this was no more than to convert an implicit concern into an explicit objective.

In one perspective, the idea of sharing futures with a wide audience, through the medium of a published policy document, now seems less important than the value of the exercise in focusing the thinking of the Secretariat, especially those members steering the internal process of crafting policy proposals. By drawing attention to uncertainties and alternative possibilities, they could try to warn more single-minded colleagues who saw only one path ahead (see Appendix 1).

### **Building on the initial experience**

The second futures consultation in 1992 focused on the prospects for implementing the updated targets, looking (again) at the outside world with the help of external experts and also (as we had not done before) trends inside the health sector. The third consultation in 1995<sup>22</sup> repeated the focus on the external world and the health sector, but also took into consideration trends in the countries of central and eastern Europe (CCEE) and the newly independent states of the former Soviet Union (NIS), where the difficulties and opportunities in those countries were then becoming clearer.

The third consultation was also (like the first) intended as a preliminary step in the process of reviewing and renewing the Region's health for all policy. The process followed in principle a similar course to that of 1990–1992. It was decided to keep the same general framework but with certain refinements; and if they were available, the same experts were retained. This might be seen as a strength or a weakness. We were thereby bound by their world view and their own strengths and weaknesses, but we could ask them to detect shifts and continuities in experience and expectation since the previous consultation. We were engaged in a continuing process, working within a frame of reference though alert to the possibility of the need to rethink that frame.

Papers were commissioned from and circulated to the experts, who were asked to comment on the other papers and refine their own if necessary. The papers were then distilled down by the Secretariat into an overall commentary on the whole set. This was in turn distilled into a set of generally provocative slogans, to focus on what we judged were the issues for debate. The commentary and slogans were then passed to a graphic artist, who produced a set of visual presentations of the issues. We again used graphic artists at the consultation itself, to capture the spirit of the debate and where it was leading.

Other presentations were made at the consultation, such as the United Nations agenda being fashioned at the global summits from Rio onwards, the European Union's emerging health agenda (post-Maastricht), and experience from another WHO region (the Americas). After a presentation of the Secretariat's commentary, all the experts formed a round table at which ideas were further explored and clarified, criss-crossing between the different perspectives (see Appendix 2).

The second phase of the consultation was a "visioning" exercise, which involved all of the

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22. *Third Consultation on Future Trends and the European HFA Strategy. Report on a meeting, Bratislava, Slovak Republic, 26–27 October 1995.* Copenhagen, WHO Regional Office for Europe, 1996 (document EUR/ICP/EHFA 94 01/MT01).

participants. These included representatives from Member States, especially from the CCEE/NIS. Three parallel groups were invited to vision the future that they would like to create for, these respectively being, health care (a priority concern, especially for CCEE/NIS, but also where they were in uncharted waters); public health (we wanted to keep hold of the “whole” in policy development); and research and development (to prepare for the future). Their products are in the report of the meeting.

As in 1990, the ideas generated at the consultation were used to prepare a draft scene-setting chapter for the new policy document, which was submitted to the RHDAC in April 1997. The approach adopted was to lay out the evidence of developments and trends and to speculate on the consequences of those trends continuing, and to highlight the need for new policies and actions. This draft was coolly received by the RHDAC as too unremittingly pessimistic. Views expressed at the RHDAC were later a valuable source of material (see Appendix 2).

### ***Scenarios as histories of the future***

At this point, a fresh approach was adopted. The object was still to lay out the evidence and assumptions, capturing the essence of the experts' assessments and other information taken into account then moving to the potential implications for health. The new step was to sharpen the challenge facing policy-makers through the use of scenarios. We conceived two starkly contrasting scenarios, to highlight the range of possibilities and to concentrate minds on the steps to take to encourage desired trends and developments and prevent the undesired.

This enabled us to give equal weight both to optimistic assumptions of the future and positive developments, and to our initial pessimistic reading of trends! A further refinement was to present these contrasting pictures as “histories of the future”, written from the vantage point of 2030.

Scenario 1 is based on the assumption that present trends, such as globalisation and privatisation, would continue, justified by policy-makers as “there is no alternative”. From the vantage point of 2030 these are seen to have had negative effects on equity, health and social development. Scenario 2 records the positive results observed in 2030 in terms of social cohesion and economic development that followed a sustained effort by the international community and countries to act on the agendas of the United Nations summits of the 1990s and to take equity seriously in public policy-making.

The paper *Learning from the past, preparing for tomorrow's realities* was the product of this process. Appendix 1 provides extracts from the very early draft form of the document to show the transformation of the selected raw material into coherent histories of the future. The technical content and speculations, with all their shortcomings, are unchanged.

### **Promoting a vision of the desired future**

In the event, it was decided not to include a chapter with this scope and characteristics in HEALTH21. The acceptability of the text was a crucial consideration. It was feared that the graphic terms in which the negative scenario was presented, as the experience of one family, might be too raw for a document of this kind. The assumption is that policy-makers feel more comfortable with generalised statements, even if they are essentially negative.

It was felt to be inherently undesirable to include speculations that contradicted the overall

message of the action-oriented United Nations summits, giving credence to the possibility of failure (It might be noted, though, that the positive scenario is based on the regeneration of the United Nations family, in which the goals of the 1990s summits are triumphantly achieved.)

Pragmatic reasons for not using the material in its existing form included the effort that would have been required to collate and order all the information to support all the assertions. This would have included a more detailed assessment of the costs incurred by and the benefits accruing to different stakeholders under the different scenarios.

The judgement not to include the chapter can also be seen as reflecting common political prudence to present an unequivocal set of messages in a document intended to be adopted as an organisation's policy. The decision was taken to give a strong emphasis to the opportunities and challenges ahead, inviting Member States to respond to the positive prospect. Uncertainties and obstacles were not ignored, but nor were they to be allowed to obstruct the vision. Many of the assumptions on which various policy proposals are founded could be traced back to material included in *Learning from the past, preparing for tomorrow's realities*.

Whether the alternative scenarios could or should have been disseminated separately or in another form can be seen as a separate matter.

## Appendix 1: Learning from the past, preparing for tomorrow's realities<sup>23</sup>

### Progress towards achieving health for all

*Note: The original draft had, as its first section, a summary of epidemiological and other trends related to the attainment of the targets adopted in 1984 and 1991, highlighting priorities for action if the goal of better health for all in the Region were to be attained. This foreshadowed the substantive content of the policy chapters of HEALTH21.*

### A conceptual model of the macro influences on health

The pursuit of progress towards the achievement of health for all has focused on determinants of health and disease. Development is the major underlying factor or determinant. It is a difficult and complex task to foresee development over the next decades. Only selected factors or aspects of development are highlighted here, conscious as we are that these are highly interrelated: economic, social, political, scientific and technical. These have been chosen on the basis that they cover the principal concerns that shape public policy.

In anticipating future events, we know that strategic decisions taken in different fields can have a long lead time before the effects become visible; various trends are now firmly established and the course is set for at least the medium term, as in the case of population age structure. It is also important to recognise the possibility of chance happenings, or unanticipated events of significance, such as the collapse of regimes in the east of Europe at the end of the 1980s.

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23. Extracts from the original internal draft of 1997, with annotations.

### **Health on the international community's development agenda**

*Note: This section argues that the essence of a development agenda that addresses health issues has been fashioned by the United Nations summits of the 1990s.*

Although it is its efforts in maintaining peace and security that attract public attention, in recent years the United Nations has been building an agenda that could become a powerful vision of human development.

Throughout the series of United Nations conferences and summits involving heads of state and government, issues linking the themes of health and human development have been put on the policy agenda. This is not an occasion to review them all extensively; the citations in Table 1 (*opposite page*) of principles and desired objectives, presented at various international conferences, illustrate that these themes have been woven into events at the highest level.

Member States have in fact adopted a set of resolutions and plans of action at these meetings, which can be seen to respond to trends and assumptions such as those outlined above. Some of these resolutions and action plans have attracted media attention. This has usually been because of specific controversial proposals, mostly related to the field of reproductive health, rather than the general thrust of the action plans.

The Copenhagen Declaration on Social Development<sup>24</sup> warrants particular attention. It includes a commitment to promoting and attaining the goals of the highest attainable standard of physical and mental health, and the access of all to primary health care, making particular efforts to rectify inequalities relating to social conditions and without distinction as to race, national origin, gender, age or disability. Associated actions at the international level included a request to specialised agencies, including specifically the World Health Organisation, to give greater emphasis to the overriding goals of eradicating poverty, promoting full and productive employment and fostering social integration.

### **Interrelationships between health and the economic, political and social environments**

*Note: This section takes the first steps towards presenting a coherent picture of the likely or possible future environment for health, by focusing on the objective of development strategy and the criteria by which the outcomes of public policy and the quality of life created should be judged.*

For the United Nations family as a whole, the twin goals of development are the improvement of people's material conditions or *level of living* and the maintenance of *social cohesion*. At the macro level, there is a tension between optimistic and pessimistic views of trends and possibilities within the European Region. The evidence on progress in the European Region in recent years is mixed, and for quite obvious reasons.

In terms of equity, the fundamental United Nations ethic, severe challenges are now posed by evidence of gaps between population groups in income distribution, access to employment, access to resources, and freedom from threat of war or social disturbance. But there are also a number of positive signs, linked *inter alia* with changing perspectives on participation and governance and the still untapped potential in the use of technology in tackling problems.

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24. <http://www.visionoffice.com/socdev/wssdco-0.htm>

**Table 1. Selected United Nations international conferences and summits**

<p><b>1992</b> <b>Rio de Janeiro</b></p>	<p><b>United Nations Conference on Environment and Development</b>  “Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature.”  “The right to development must be fulfilled so as to equitably meet developmental and environmental needs of present and future generations.”  “In order to achieve sustainable development, environmental protection shall constitute an integral part of the development process and cannot be considered in isolation from it.”  <i>(Rio Declaration on Environment and Development, Principles 1, 3 and 4)</i></p> <p>“... to coordinate the involvement of citizens, the health sector, the health-related sectors and relevant non-health sectors (business, social, educational and religious institutions) in solutions to health problems.”  “... to minimise hazards and maintain the environment to a degree that human health and safety is not impaired or endangered yet encourage development to proceed. Specific objectives are: to incorporate appropriate environmental and health safeguards as part of national development programmes in all countries; ...”</p>
<p><b>1992</b> <b>Rome</b></p>	<p><b>International Conference on Nutrition</b>  “Healthy and properly nourished people are both the result of successful development and contributors to it. Nutritional well-being should be adopted as a key objective in human development and must be at the centre of development strategies, plans and priorities.”</p>
<p><b>1994</b> <b>Cairo</b></p>	<p><b>International Conference on Population and Development</b>  “... to increase the accessibility, availability, acceptability and affordability of health care services and facilities to all people in accordance with national commitments to provide access to basic health care for all.”</p>
<p><b>1995</b> <b>Copenhagen</b></p>	<p><b>World Summit for Social Development</b>  “Support progress and security for people and communities whereby every member of society is enabled to satisfy his or her basic human needs and to realise his or her personal dignity, safety and creativity.”</p>
<p><b>1995</b> <b>Beijing</b></p>	<p><b>World Conference on Women</b>  “... providing appropriate social services to enable vulnerable people and people living in poverty to improve their lives, to exercise their rights and to participate fully in all social, economic and political activities and to contribute to social and economic development.”</p>
<p><b>1996</b> <b>Istanbul</b></p>	<p><b>United Nations Conference on Human Settlements, Habitat II</b>  The Conference identified as its seven priorities: unsustainable consumption and production patterns, particularly in industrialised countries; unsustainable population changes; homelessness; unemployment; lack of basic infrastructure and services; growing insecurity and violence; and increased vulnerability to disasters. These are all factors that are connected to levels of health in populations.</p>



**Level of living (material wellbeing)**

In today's Europe, there is a rising proportion of people living in poverty. Lack of income and job insecurity prevent them from accessing the potential benefits afforded by technology, and limit their participation in civil society and even their ability to use health services. Increasing numbers of people are living in absolute or extreme poverty, unable to cover the cost of basic needs such as food and shelter and thus facing direct threats to their health.

Levels of (particularly long-term) unemployment combine to create a situation whereby a growing proportion of the workforce earn extremely low wages. Low wages dominate in most parts of the informal economy and also disproportionately affect women, migrants and the disabled. The structure of the welfare benefit system and limited opportunities for paid employment combine to keep certain groups in a poverty trap.

Recent changes in many welfare systems have removed certain categories of people from eligibility for benefit, such as some types of migrant, political refugees or asylum seekers, and those deemed to have intentionally made themselves homeless. The real level of many benefits has often not been maintained against inflation.

**Social cohesion**

In terms of the social structure of European societies, there are a number of new issues to address. One is change in family structure (single-parent families, divorce, commuter families, etc.) and the fragile social and family support networks that are a continuing reality in most countries in Europe.

The rediscovery of poverty in the midst of affluence is an important factor that fuelled the growing interest in the influence of the social and economic structure. The importance of social support, the ability to cope and maintain dignity and the sense of control over one's life are now more fully recognised.

There is general concern at the growth in all parts of the European Region of violence at home and in the streets as a result of deteriorating social and economic conditions and dislocation; and at the growth of organised violence.

There is a spectrum of social consequences of violence. At worst it would mean social disintegration and breakdown of infrastructure. There is also the sense of perceived threat that may be engendered by the awareness of interpersonal violence, even though it may not have been directly experienced or witnessed. In political and policy terms, this can be translated into demands for increased surveillance and policing aimed at the manifestations, rather than more positively oriented preventive programmes aimed at the causes of social breakdown.

**Equity**

Poor economic growth together with rising unemployment, job insecurity and poorly paid work lead to widening income gaps and rising social inequality. Increased inequality imposes economic, social and psychological burdens that reduce the wellbeing of society and threaten social cohesion and solidarity.

There is a clear relationship between economic performance, income distribution and the health status of a nation. Inequity in health is strongly associated with social position,



occupational status, ethnicity, gender and generation. The major improvements in mortality that have occurred in the developed world are strongly linked to social and economic development. The earlier reductions in infectious disease mortality were brought about by changes in the environment, improved lifestyles (e.g. better nutrition), improved living conditions (e.g. better housing and sanitation) and other factors related to social and economic development.

Above a certain level of wealth, it is not the richest societies that have the best health but those that have the smallest difference in income between rich and poor. Health improvements are more rapid in countries with smaller income differentials, and this greater equity is also associated with faster economic growth. Improvements in the population's health are predicated on widely shared economic prosperity, on the development of a supportive community life and on investment in people.

Education is a key factor, not only in promoting greater equity but also in greater personal fulfilment and health for individuals.

It is important to examine the implications for equity of different policy directions. These may include, for example, how to ensure that trends in the use of new technology do not selectively benefit only certain groups in society, and how to gain political acceptance of the need to take action to move towards a more equal distribution of income and access to resources.

There is thus no reason for making the false choice between greater equity and economic growth; investment in "social capital" increases efficiency by lubricating the economy and society.

### **Scenarios for European health policy development**

***Note:** This section consolidates the issues into a challenge to policy-makers through the device of scenarios. First, an explanation and justification for the use of scenarios is offered (to draw attention to the range of possibilities facing policy-makers). Then the material previously presented is reworked into two coherent, strongly contrasting pictures of the future that subsume two contrasting policy responses.*

The build-up of an international agenda for economic and social development is only one, albeit vital, preliminary step. An equally demanding task is to stimulate policy-making at all levels in a way that encourages decision-makers and stakeholders not only to articulate their views of the desired future but also to think through the implications of various trends and possible courses of action. Herein lies the value of the "scenario" as a picture of the future and the need to prepare different scenarios.

Scenario writing is a well tried and proven means of addressing complex issues and coping with the inherent uncertainties in policy-making. The term "scenario" is used in various senses, but these only reflect levels of sophistication and detail, especially in the quantification and analysis of the different factors that are taken into account. The basic idea is that a scenario, as "a picture of the future", is a synthesis of evidence, ideas and assumptions whose nature should be immediately apparent to any reader. Scenarios are *not* predictions, but products of imagining what the future might or could be.

***Note:** The implication of the last observation is that there is no such thing as a “correct” or “incorrect” scenario. It may also be argued that there is no objectively “plausible” or “implausible” scenario: plausibility is in the mind of the reader or receiver. This is not an insignificant point. There is always the risk that the receiver will reject a scenario that does not accord with what he or she would like to hear, however well the scenario is presented. This could present the writer with a dilemma: to present only a scenario that supports the policy status quo or to find some new, imaginative way of drawing less welcome possibilities to the receiver’s attention. This would be particularly urgent if the writer felt obliged to draw attention to circumstances when the costs (to the policy-maker) of inaction would be greater than any costs incurred in a change of policy direction.*

*For purposes of demonstration, the present text proceeds as though gaining the policy-maker’s attention through scenarios is not a problem.*

The crafting of a set of scenarios provides policy-makers with a sense of the range of possible futures. These scenarios would have different emphases and sets of assumptions. One mode of presentation is to consciously write a scenario as if it were history, by projecting forward in time, and developing an imaginative account of how history unfolded from the present time.

The simplest approach, which for purposes of demonstration will be adopted in this paper, is to present just two strongly contrasting scenarios that – we can assume here – have been drawn from a more extensive set that has been considered. Contrasting scenarios underline the spread of possibilities. They serve to focus policy-makers’ attention and to provoke a response in terms of action to be taken, either to create what is desirable or to prevent what is undesirable.

A picture of the desired future that mobilises people to work together to bring it about can have great political power. In some organisations and settings it is presented as the “vision”. Among policy-makers it is also referred to as the “preferred scenario”. The current work within WHO to launch the renewal of health for all could be understood as the preparation of the Organisation’s “preferred scenario” for health and development.

### ***The rationale for selection of scenarios***

Health is not an end in itself but a necessary condition for human development. At the individual level, it is the means for enabling all people to lead productive and fulfilling lives. At the policy level of collective benefits, it is instrumental in achieving society’s social and economic goals. Policy-making within the framework of health for all identifies the contributions of various measures to promote, protect and restore health in the individual and in communities.

People-centred development adheres to and reflects the basic values of the United Nations family: everyone is of equal worth, everyone’s autonomy is to be respected, and everyone should be enabled to meet their basic needs. This suggests that certain assumptions about society underpin the pursuit of the goal of health for all. The quality of life in that society can be assessed in terms of its achievements – in terms of the level of equity, material wellbeing (level of living) and social cohesion or sense of security. Those achievements can be assessed using levels of health as a benchmark: the greater the level of achievement, the higher the level of health enjoyed by the population.

Below are two simplified fragments of “history scenarios”: alternative futures (in which people will use whatever health potential they have in attempting to lead satisfying lives) that reflect these three dimensions of equity, level of living and social cohesion. They are written from the vantage point of 2030, far enough into the future for the effects of trends to have become clear and for the benefits of policy shifts and changes in culture to have come through.

The contrast between them happens to reflect the tension found in the mass media and in public debate between optimistic and pessimistic views of trends and possibilities. They can be depicted as taking the United Nations seriously as the voice of the world community versus muddling on in a reactive, passive mode to trends and pressures.

***Scenario 1. Business as usual – “muddling on”***

In the early years of this 21st century, continuing migration, urbanisation, chronic unemployment and falling birth rates further eroded family structures and established communities. Meanwhile, the informal economy flourished and violence was endemic, despite strong private security and public law enforcement agencies.

Politicians were unable or unwilling to envisage any alternative to the existing economic and social order. A continuing lack of confidence in the ability of governments and the responsible international financial institutions to manage economic development ensured that the already existing momentum for globalisation, privatisation and deregulation not only continued but accelerated. Capitalism’s basic law of obligation to protect and enhance shareholder value determined that decisions on productive capacity would be governed by opportunities to automate and to relocate to where labour costs could be minimised.

Virtually all controls on health hazards, whether in the environment or in the sale of goods known to be harmful to health, were relaxed under pressure to remove “unnecessary” production costs or restraints on trade. In health care, the profit motive replaced the public service ethic: technology development was skewed in favour of innovations that offered the most promising returns on investment rather than health gain for the population.

The fleetingly fashionable concept of an enterprise having responsibility for, or accountability to, multiple stakeholders was rejected – by governments, industrial pressure groups and think tanks alike – as self-defeating and unworkable. It was deemed to be against individual freedom. Now, 30 years later, the idea is barely even contemplated and then only by a few communitarian utopians. All the prevailing assumptions about what is best for the economy and society have been shielded from counter-argument by assertions, proclaimed as self-evident, that in an economy unrestrained by political interference human ingenuity, individual initiative and spontaneous voluntary action would take care of society’s problems.

The reality of our modern times is that only a few have prospered: the well connected, natural entrepreneurs and perhaps also those with skills that were temporarily in great demand. There are fewer and fewer people in regular employment and a growing proportion of those are on low wages. The real level of many benefits provided for in social security systems has not kept up with inflation. Changes in eligibility rules over the years have reduced the number of people with entitlements to benefits. Lack of income constrains people’s access to the potential benefits and conveniences afforded to the consumer by technology, and limits their participation in civil society. Increasing numbers of people are unable to meet basic needs.

Rising unemployment, job insecurity, low pay and the deterioration of public as well as traditional family and other informal support systems have led to widening income gaps and to greater social inequality. Increased inequality imposes economic, social and psychological burdens that reduce the wellbeing of society as a whole, even the employed, and threatens social cohesion and solidarity. Social polarisation and the marginalisation and social exclusion of particular groups, such as young people who have never experienced steady employment, migrants and minority ethnic groups, have resulted in increased levels of social conflict.

Low levels of remuneration also characterise most parts of the informal economy. While the informal sector may have offered to low-income groups earning opportunities that would not otherwise have existed, such people work without the protection of employment legislation, safety standards and any entitlement to social benefits. There are also additional dangers posed by the involvement of organised crime in the informal sector.

For some time now there has been deep fear at the growth of violence at home and in the streets, as a result of deteriorating social conditions and economic dislocation. There is also organised violence orchestrated by groups motivated by specific political, economic or social objectives, including racial or religious aggression. It feeds off expectations that cannot be met.

Violence disproportionately affects women, children, older people and various poor and socially marginalised groups, especially migrants who are invariably impoverished, unwelcome and reluctantly supported by the receiving countries and communities. As always in periods of economic difficulty, migrants provoke severe hostile reactions. In political terms, the population demands even tighter surveillance and policing measures, paradoxically ensuring that, despite cuts in social expenditure, overall public expenditure remains unexpectedly high.

A profile of one family recently appeared in the newsletter of a proscribed radical reform group trying to mobilise support for a return to active democratic government. Its leaders are committed to re-instituting properly funded and organised public services. This profile, used in an edition brought out to mark World Health Day, was prepared by a journalist writing under the name of Eric Blair.<sup>25</sup>

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25. Eric Blair is the pseudonym of a rising star in the BBC World Service, George Orwell, willing to put at risk his career in the mainstream media.

***Survivors' Tales – Dateline Metropolis, 7 April 2030***

Anna and her family now live in a shanty town just outside one of the protected enclaves of our capital city. They have been successful in avoiding the violence and involvement in any of the shanty town gangs, but they are not sure how long it will be before they have to move on.

They recently lost their small flat in the enclave itself, that neighbourhood referred to with affection by some of its residents as “Wigan Pier”. After many months, during which they had not found much work, even in the informal economy, they were no longer able to pay the fees to the private security forces.

She says they would have had to move out soon anyway, since the utilities to the flat had all been cut off, and at least outside the enclave they can collect water more easily and forage for things to sell. And in the shanty towns there are still some United Nations Aid points dispensing food rations. These rations are no more than basic, but Anna is grateful for what she gets when she can get it. Of course, it means queues and coping with the intimidation of the “heavy boys” as she stands in line. They belong to the gangs of jungle capitalists who are attempting to corner the market in food. Fortunately, in the past few weeks the gangs have been mainly engaged in fighting among themselves for control of this area. This has meant less harassment of the United Nations aid workers and those in the queue.

Anna and her family still consider themselves lucky. There are six adults, in reasonable health, and none of them is addicted to drugs or alcohol. Out of the ten children born, six still survive. They have been discussing whether they should solve their cash problems, at least for a while, by selling a kidney or something else, assuming they could pass the health screening. There is a booming market in human organs now that medical science has solved the rejection problem – the “new prostitution”, as this trade has been sardonically called, giving a new meaning to the idea of selling your body.

How different from Anna's is the life of the affluent few, quartered in luxury homes inside protected compounds seeking perpetual youth and perfect health. On the word of their equally affluent medical advisers, they will quite happily bid for replacement organs at the auctions held in the “transplant bordellos”. This is the name cynics give to the tastefully appointed reception areas of the commercial surgical suites where these singular acts of exchange are completed. There are limits to how much of one's body one can sell off in this way. But perhaps more to the point in Anna's mind is that it may be better to act now before the biotechnology corporations develop safe, maintenance-free artificial body parts at a price below that which human organs usually fetch at the auctions.

Anna has just buried her grandmother, who at 55 fell victim to what they assume was TB; there was no money to get a proper diagnosis, let alone treatment. Two of the younger children are now showing signs of illness. Anna and the other adults will soon have to decide whether they should sell a kidney or find the money some other way to be able to take them to the medical post; if not they'll trust to luck.

**Eric Blair**

**Scenario 2. Making policy as though development really mattered**

We have seen a remarkable change over the past 30 years, both internationally and in the societies of Member States. Closer cooperation between countries, within the United Nations system and within regional integrational institutions such as the Council of Europe and the European Union, has proven to be an effective strategy against any danger of international conflict. The international community has begun to move beyond its first concern with security to the United Nations' other concern, human development; it has been responding to the fundamental ethic of equity at the heart of the United Nations Charter.

Many separate events and issues combined to effect this shift in focus. To cite one case, recognising the significance of the globalisation of the economy, some health policy-makers began to voice the question: can we make the healthy choice the competitive choice and use the market to turn the new global stakeholders into partners for health for all? Such questions did not produce instant answers, but in the circumstances they helped to change the terms of debate.

The first visible signs were noted in the very early years of the century. The United Nations system as a whole had been dislocated by the end of the cold war. The learning of new patterns of behaviour in the new United Nations system was not without difficulties and false starts. But eventually a critical mass of concerned people was formed, keenly aware that the world was off course politically, economically and ecologically. This happened in the developed countries, partly as a consequence of the flow of information made possible by global communications. Equally important, it was a result of continued pressure from people in developing countries who had understood the issues for a lot longer. In particular, rising ecological awareness and demands for empowerment of less privileged groups led to the creation of many new interest groups and organisations.

There was now much more than lip service being paid when political leaders acknowledged the severe challenges to the stability of the international order and the cohesion of societies. They saw the danger posed by gross differences between population groups in disposable income, employment opportunities, access to resources, and freedom from the threat of war or social disturbance. There was also a delayed but cheerful realisation that the international community had in fact done the necessary preparatory work for tackling these problems: in its various summits and conferences in the 1990s, and in the detailed preparations of the individual United Nations programmes, funds and specialised agencies, not least WHO and its commitment to the renewal of health for all.

Then, many additional positive signs emerged, linked with changing perspectives on participation and governance and the still largely untapped potential in the use of technology in tackling problems. People began to picture how, in the future, people might use their health potential to lead satisfying lives in a healthy society that manifests high levels of equity and material and other resources.

Governments taking a fresh look at problems saw that not all changes required massive expenditure. Lack of funds was no longer an automatic justification for taking no action. The intellectual and political paralysis that the preoccupation with funding had induced gave way to much more imaginative and participative responses to hitherto intractable problems. There was a new and beneficent opportunism in public policy, seizing on events and responding to



other players, encouraging them to take new initiatives to improve people's quality of life. Governments came to see that there was no reason for making the false choice between greater equity and economic growth; investment in "social capital" and in reducing inequities increased efficiency.

The inequity debate was no longer seen as the politics of envy, or the simplistic division of people into self-reliant individuals who were the deserving "haves" and the feckless underclass who were the undeserving "have nots". Politicians had come to understand that differences in health, level of living and quality of life were better understood as a gradient involving a number of different social groups; with the exception of the group at the "top", each was worse off than the groups above them. Reducing inequities was now almost everybody's concern.

In the reshaping of the governance of social and public institutions, attention was given to fostering the development of "reflexive" social actors who could deal with risk and uncertainty, and encourage changes in the behaviour of individuals and institutions so that they became more adaptive and self-monitoring.

The reshaping of governance implied new roles for partners involved in the political process, including interest groups and NGOs as well as the individual citizen. There was growing political commitment to tapping the energy and resourcefulness of the entire community, and recognition that this would be facilitated by various developments in communications technology. This was seen as essential in moving towards greater democratic participation, both in defining problems and priorities and in implementing solutions.

The political rediscovery of poverty in the midst of affluence fuelled the growing interest in strengthening social and economic structures. The importance of social support – the ability to cope and maintain dignity and the sense of control over one's life – was once more fully recognised. There was a readiness to address issues and to consider the implications for social policy. One example was the realisation of how fragile social and family support networks had become in most countries in Europe, and the recognition of diversity in family and community structures.

Policy analysts and political advisers, and then politicians themselves, came to see that there was a clear relationship between economic performance, income distribution and the health status of a nation; and that inequity in health was strongly associated with social position, occupation, ethnicity, gender and generation.

It was then remembered – and fully acknowledged – that the major improvements in mortality that had occurred in the developed world were strongly linked to social and economic development. The earlier reductions in infectious disease mortality had been brought about by changes in the environment, better nutrition and better housing and sanitation. Policy analysts and researchers have been looking again at the connections between the physical environment, urbanisation and health.

In recent years, health improvements have been more rapid in countries with smaller income differentials. It has been observed that greater equity is associated with faster economic growth. In social policy terms, education is now recognised as a key factor, not only in promoting greater equity but also in greater personal fulfilment and health for individuals.



We can now see clearly that, above a certain level of wealth, it is not the richest societies that have the best health but those that have the smallest income difference between rich and poor. Population-wide health improvement is predicated on widely shared economic prosperity, the development of a supportive community life and investment in people.

### **Foundations for health policy development**

***Note:** This section offers a comment on the two scenarios, and suggests that there are certain issues that must be addressed if there is to be effective policy-making and action for health in the future. This anticipates the case for public health infrastructure presented in HEALTH21.*

The two scenarios differ considerably regarding their opportunity for health gain. It bears repeating that neither scenario is presented as a prediction; both serve to signal different obstacles and facilitating factors. The two scenarios differ considerably regarding the opportunity for better health and quality of life that they present. What makes the difference?

The “pathogenic” scenario signals the consequences of a lack of political will, a disregard for the evidence of the effects of current trends, and drift rather than a purposeful focus in policy-making. The “healthy” scenario takes development seriously. It requires the commitment of government as a whole, all sectors and all parts of the community.

### **Developing a foresight capability for policy-making**

Understanding the origins, complexities and far-reaching implications of the changes in train in today’s Europe is a prerequisite for building public policies that protect and promote wellbeing. It is essential that economists, sociologists and other social scientists join with public health experts to pool their perspectives and analyses in ways that will reveal fresh insights and possibilities for intervention.

It is essential that countries, individually and collectively, build up a foresight capacity that would include monitoring and analysing trends and picking up early warning signals relating to public health, i.e. a comprehensive health intelligence gathering and analysis function.

### **Rethinking the politics of health**

Inequalities in health associated with economic imbalances are still to be found, not only among but also within the Member States in a transformed European Region. This is a major policy issue, requiring action on the key determinants of health: economic development, environmental protection, education and employment, housing and other aspects of living. There is need for more public debate on the most effective means to be adopted, including the political and budgetary choices that must be made.

As was suggested by the “healthy” scenario, there is an urgent need to reposition health in social and economic development. The term “repositioning health” implies addressing the factors that create health and that yield the maximum health gains.

The new, sharper emphasis on addressing the determinants of health has underlined the necessity for a shift of responsibility from the health sector alone to collaboration between sectors. This means introducing health into their vocabularies and value systems, and rethinking the way strategies are built and negotiated. In this context, policy-making necessarily implies being alert to the health impacts of decisions and investments in all sectors. A policy emphasis on “development for health” – putting health into development –

requires health ministries to take the lead role in identifying and maximising opportunities for health and development, wherever they arise. They would be greatly assisted if intersectoral health impact assessments became an integral part of all public policy-making.

There is compelling evidence that the key to improving social and health conditions, and thus the economic development of European societies, is to focus on maintaining autonomy and minimising dependency and to emphasise the promotion and maintenance of health. What are the most effective means of achieving this, and what political and budgetary choices should be made?

The ways in which governments use fiscal and monetary policy to manage the effects of economic cycles, regulate employment, provide education and training opportunities, assist citizens in times of economic or social difficulties, and adopt strategies to counteract poverty, crime, and other social ills can all have a decisive impact on health.

In the transformation of our political and economic institutions, we are witnessing a rapid blurring of the old distinctions between public, private and not-for-profit agencies and enterprises. At the same time, we are coming to terms with the irrelevance of other fixed boundaries, such as those between sectors, professions and institutions. These developments cause uncertainty, but they are also opportunities to be seized by the leadership of the health sector to rethink how better health for all can best be pursued and to nurture the multi-partner actions, the alliances and the new, adaptable organisational structures that will be needed.

It implies greater emphasis than hitherto on the health ministry's advocacy, negotiation and cooperation function. Re-ordering the politics of health requires an act of political will at the highest level. The health ministry must be given – and be accepted as having – cross-sectoral responsibility for health development in its fullest sense, and not only political regulatory or managerial responsibility for health care. This will give the health ministry a secure base for political initiatives reaching out to other sectors, and establishing dialogue with health leaders at all levels as the basis for future cooperation and coordinated action. This is the new reality of the politics of health and the leadership expected from the health sector.

## **Appendix 2: WHO futures consultations and other debates, 1990–1997**

### *Health futures*<sup>26</sup>

In 1990 the Regional Office brought together staff members and outside experts in the fields of ecology, technology development, political science, macroeconomics and social structure to explore health futures. This consultation proved particularly valuable in identifying and putting into focus possible medium- to long-term developments that would have an impact on the Regional Health Organisation.

A follow-up exercise was conducted in Prague in 1992; it took into account the updated health for all policy approved by the Regional Committee in 1991 and considered the trends emerging in the now transformed Region, particularly those affecting each country's health sectors.

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26. This text is an extract from the Regional Director's report to the forty-fourth session of the WHO Regional Committee for Europe, September 1994.

A number of positive factors were highlighted, such as innovations to improve the quality of care and the longer-term potential of biotechnology and information technology if the right investment decisions are made. Other conclusions were concerned with:

- worrying epidemiological and demographic evidence of persistent inequities in health;
- continuing economic difficulties for many countries of the Region, with direct and indirect consequences both for health status of the population and for resources of the health services, thereby highlighting the need for health-supportive macro public policy and for patterns of organisation and methods of financing of health services that minimise “dead” administrative costs, promote effective and efficient overall use of all resources, provide fair rewards to personnel, and ensure equitable access to and encourage rational use of services when needed by the population;
- the need for greater attention to human ecology issues, more watchfulness in monitoring the physical environment for adverse health effects, and advocacy of policies for health protection on the basis of probabilities suggested by considering the weight of evidence available rather than waiting for ultimate proof;
- the risks of alienation, social conflict and breakdown, and an exacerbation of social inequities as a result of the current, well established political, economic and social trends which – if not corrected by timely policy interventions – would have serious health consequences, particularly for already disadvantaged groups; and
- geopolitical instability in parts of the Region and the probability of civil unrest and conflict between and within countries in continuing disputes over the rights of ethnic groups to their own territory and to the status of the nation state.

These findings were generally corroborated by a global futures consultation convened by WHO headquarters in 1993.<sup>27</sup> The three futures consultations have proved their value. They firmly underpin the Regional Office’s strategic planning by generating the intelligence needed to prepare realistically for possible futures and to craft rational rapid responses to developments in the Region as they occur.

#### **Round table on health futures at the third WHO consultation held in Bratislava in October 1995** <sup>28</sup>

The following is a minimally edited transcript of the notes taken by a journalist while the round table was in session.

Members of the round table had been commissioned to prepare background papers on major factors influencing health for the foreseeable future, that should be taken into account in the forthcoming policy review and updating to take health for all in Europe beyond the year 2000.

The round table had been asked to:

- think in terms of “super-tanker” trends and other less probable but potentially high impact events and trends;

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27. TAKET, A. *Health futures in support of health for all. Report of an International Consultation*. Geneva, World Health Organisation, 1993 (document WHO/HST/93.4).

28. *Third Consultation on Future Trends and the European HFA Strategy. Report on a meeting, Bratislava, Slovak Republic, 26–27 October 1995*. Copenhagen, WHO Regional Office for Europe, 1996 (document EUR/ICP/EHFA 94 01/MT01).

- reflect whether assumptions about the future made at the 1992 round table were still valid; and
- identify the signals coming through that should make one pause and rethink.

*Speaker 1*

Climate change is a super-tanker trend. The signal from younger people is they are going to be the hope of the future, that they will repair the mistakes we and our forefathers have made.

*Speaker 2*

Biotechnology will continue to develop extremely rapidly, as will microelectronics and information theory. Ideas from biology are being used in information technology, such as in the construction of circuits at molecular level.

A crisis can be foreseen as non-renewable resources are exhausted by a growing population – maybe even an overshoot and population crash.

*Speaker 3*

I am a political scientist and professional pessimist. Optimists years ago talked of the “end of history”. What we have observed is that history and geography have reasserted themselves as the old nasty power games of territory, war and expansionism.

There must be some sort of peace in the former Yugoslavia. It will not be positive. Ethnic cleansing has been justified. If there is a new war, new ethnic cleansing will be accepted. Borders are drawn where the fighting ends.

It is extraordinarily important for health in Europe. Ethnic cleansing means thousands of people have been forced from their homes. They will be resentful for the rest of their lives, and those who have moved in will never feel secure. That is a mental and psychological disaster.

How can we get intergovernmental cooperation to manage these problems? The European Union has been immensely influential. There will be no wars in western Europe. Enlarging the European Union would be good.

*Speaker 4*

We have a labour-market dilemma. Before the 19th century unqualified people went to agriculture. Then they went to industry. Now they have nowhere to go. When you have technical progress, and consumers want quality products and services and international competition, there is no more room for unqualified young men (and there are many more young men than women).

The United States has pushed them into work because there is no social security. There is an emerging working poverty with no health insurance but a very active labour market – everybody can find work in three months. Europe has social security to protect people. It creates long-term exclusion from the labour market – the non-working poor.

Which is better for health? The United States system is worse short-term, but Europe's is perhaps worse long-term. Structural unemployment has developed in Europe but not in the United States, where salaries have stayed low but jobs have increased. In Europe, salaries have risen while employment has stayed low.

The death rate among young males aged 14-25 is higher now than in 1955. They are dying of industrial epidemics – illnesses caused by the effects of some industries. Eastern Europe is very

weak on this, with motor accidents, drugs, tobacco consumption pushed by industry and also pollution.

The excess mortality rate of young men is rising – 3.5 times as many young men as young women die. There is a very worrying return to the expression of masculinity, with young men smoking, drinking and driving too fast.

Should health and social problems be addressed by a change in economic policy, by dismantling the welfare state or by pushing people into work? Or should we find something to bring people into society?

People in the east of Europe have been pushed into that solution very quickly. They have already had to dismantle the welfare state because there is very little money to distribute.

The Marxian war between social classes will be replaced by an inter-generational one.

*Speaker 5*

The main super-tanker trend is the real issue of inequity in health status within countries – access to income etc. That remains with us for the future.

Dealing with the health consequences of social conflict and marginalisation are main issues for the future.

*Speaker 6*

The major goal of WHO is equity. There is a lot of evidence that within and between countries you are getting further away from that.

*Speaker 2*

We have relied traditionally on the expansion of the economy to deal with unemployment. If technology produces unemployment, we have been confident that economic growth would pick up the slack and use these people in new industries. But exhaustion of resources and ecological problems combine to make continued economic growth very problematic. We are reaching the limits of growth.

*Speaker 4*

But although growth is slowing in the West, the very dynamic economies of the Far East are growing very fast.

*Speaker 7*

Lack of equity creates dual social structures, and this will happen increasingly.

There is growing reflexivity in our society. The behaviour of individuals and institutions is adaptive, self-monitoring and informed as to technological change. We are not overwhelmed by it any longer. There is much greater uncertainty than in 1992, the main cause being war. In 1992 we did not expect it to be so close to us or so much a part of our future. But a risk society leads to reflexivity – does that create optimism?

*Speaker 8*

From the “city perspective”, the outcome of the Rio Conference has been confirmed: a major challenge is to focus on urban conglomerations. We need to conjugate three elements – economic development in cities, a social way of living (the community) and an environment that is sustainable.

The Healthy Cities network has ideas for improving wellbeing in urban conglomeration. In Europe there is some injection of entrepreneurial spirit, and if that can be encouraged the risks can be limited.

*Speaker 3*

Successful health policy needs a strong state, but states are getting weaker because of the growing strength of world markets. In Sweden, for example, the welfare state has been undermined by international forces. We may end up taking the American route whether we like it or not.

*Speaker 4*

France is taking the American route without telling the population. People are paying 40% of the cost of pharmaceuticals and 35% of the cost of seeing a doctor.

*Speaker 8*

But there is a growing reality locally that is organising things differently – self-help. At local level there is power to use local resources and direct them, such as for health promotion.

*Speaker 6*

Society is losing a sense of coherence and how to adapt and cope with economic change. We do not invest in society; we invest in the economy.

We have young people who have no hope and no future, such as young black people in the United States. It is different in the Hispanic society, which has the same economic situation but is able to cope with it.

*Speaker 9*

We should have invited MTV or Nike – no-one can tell them what to do.

The global agenda has become more global. Players have repositioned themselves with even more power, such as the global leisure, media and health-care industries. The health-care industry is becoming more integrated. The pharmaceuticals industry is now interested in health promotion and in owning hospitals.

There are tremendous changes in production and consumption. Europe is not necessarily going to be at the top of the new global structure.

There is greater coherence and integration through consumption. Marketing people speak of the “global teenager”, who wears the same shoes and jeans and listens to the same music, and who has both a global and a local identity.

I asked my 12-year-old son how he saw his future. He is definite he will live to 140. He is very worried about the environment. He is absolutely clear he can communicate with anybody he wants to, and he thinks he will have a normal job like his mum – a global job. That is what kids are starting to see as very matter-of-fact.

Nobody controls these global players. There is no standard-setting. The only agenda, if any, comes from the World Trade Organisation. There is no agency to take social issues up.

If the new global forms of consumption and production are running the social development agenda, in terms of social cohesion and economic development, there needs to be some form of global corrective – something we still need to invent. Let us not always run behind the agenda.

*Speaker 4*

Young people are not aware of modern dangers like drinking and driving, smoking or the Pill. The problems of modern life are the problems of men. Women cherry-pick the good things in modern life. Boys are subject to industrial advertising.

*First speaker from the floor*

There needs to be more emphasis on interrelations between Europe and the rest of the world. Europe needs to look at what is happening elsewhere.

*Second speaker from the floor*

Capitalism seeks absolute advantage. Healthy choices need to be made to look advantageous for global industry.

*Third speaker from the floor*

People have lost trust in the economy and the state. There is a polarisation between men and women. The Russian Federation is becoming a matriarchal society: over 50% of women are getting rid of their men. They are taking power, saying, “we are not strong, but the men are so weak”.

**Postscript**

Subsequently, the Bratislava material was used opportunistically with a group of public health/health care professionals in the Nordic countries. They were asked to reflect on the material and give feedback on their feelings and conclusions. The following summarises their feedback.

*Questions needing answers*

- How do we get more political attention paid to the prerequisites for health?
- How do we make contact with “power”, i.e. decision-makers in the “heavyweight” sectors and in the major countries who make crucial decisions that have significant health consequences but who are unaware of, indifferent to or discount the health impact in calculating benefits?
- How can we create a positive approach (especially at local level) when the prospects post-2000 look so gloomy?
- How can we get the message across that problems require a common effort, i.e. a change in everybody’s behaviour and (re)discovery of international social and intergenerational solidarity?
- How can we avoid relapsing into seeing health in medical or disease terms?

*Answers to some other questions*

- The crucial issues are:
  - the prerequisite of peace;
  - sustaining a healthier environment – *the* priority on which to focus action;
  - sustainable economic development; and
  - public policy that recognises the implications of demographic trends, and that takes the health status of the population as a matter of serious concern.



- The present underlying structure of the WHO European policy and targets is basically sound and still relevant. It should not be abandoned lightly. Nevertheless, *action* should be much more focused on a selected set of issues.
- Priorities for action should be selected based on the problems that have the greatest impact on the greatest number of people, and the interventions that would benefit the greatest number of people. The interpretation of these criteria would need to be tempered by the overriding criterion of equity.
- National-level action needs to be reconsidered in terms of:
  - which matters might be more appropriately addressed internationally (e.g. drawing up conventions, standards, procedures etc. to be universally observed); and
  - which matters might be more appropriately addressed locally, identifying what needs to be done to empower and energise local communities to take control of and assume responsibility for their own health.

### **Regional Health Development Advisory Council, 1997**

Following the consultation in Bratislava, the Secretariat went on to prepare proposals for the 1998 health for all update. A cross-office steering committee was established to supervise the process, and a small team was put together to do the work. The team was augmented by a group of part-time consultants from various backgrounds, who were experienced in health for all policy (some were former WHO staff members and some were or had been working in health ministries). The Standing Committee of the Regional Committee was also involved at key stages.

In April 1997, the RHDAC was convened to review the first draft of the new policy. The RHDAC were told that the draft would be reviewed in light of its comments, and sent to Member States and other interested parties for consultation.

The flavour of the debate in the RHDAC is conveyed in the following comments made by members during the plenary sessions, as noted by a journalist taking part. These are clustered under certain significant issues. The Rapporteur's summary of the RHDAC's conclusions made at the end of the meeting is also included.

#### ***Health sector responsibilities and the determinants of health***

##### *Speaker 1*

It will be difficult to convince politicians that the health sector should take responsibility for preventing conflict and poverty.

##### *Speaker 2*

The health sector must not just ask others for help. It has a lot to offer in linking health to the development agenda of other sectors – and we are very good news.

##### *Speaker 3*

WHO needs to link with other United Nations agencies to spread the message to non-health ministries in the Member States.

##### *Speaker 1*

Market-oriented sectors such as agriculture pose more of a challenge than those such as social welfare. We need to create incentives for those sectors. It could be done with a creative dialogue at national level between the two sectors.

*Speaker 4*

Would it not be strategically undiplomatic to produce a document suggesting actions/strategies for/with other sectors without consulting those sectors first?

*Speaker 5*

Informed, knowledgeable consumers will put pressure on other sectors to pick the healthy option. This will persuade other sectors that there is an economic benefit.

***Life-cycle or disease programmes***

*Speaker 4*

A life-cycle approach would make the document easier to use and easier to relate to. People are used to thinking about different phases of life and the problems affecting them. It would make it possible to bring in values such as the need for a safe, nurturing environment to give a child a fair start in life.

It would also bring out the equity issues more strongly, because they are cumulative – a disadvantaged infancy can easily lead to a disadvantaged old age.

*Speaker 6*

We must involve population groups such as adolescents to comment on the section on their particular phase of the life-cycle. Adolescents should be seen as a resource, not adolescence as a disease.

*Speaker 7*

I am happy with the life-cycle approach, but we must make visible the major disease problems and must address groups with special needs.

**The determinants of health in relation to the life-cycle <sup>a</sup>**

<b>Determinant of health</b>	<b>Infancy</b>	<b>Adolescence</b>	<b>Adulthood</b>	<b>Old Age</b>
Economy and environment	X	X	X	X
Living and working conditions			X	X
Social and community influences	X	X	X	X
Individual lifestyle		X	X	X
Gender	X	X	X	X
Hereditary factors	X	X	X	

<sup>a</sup> This matrix, attempting to relate the life-cycle to the determinants of health, was conceived during the RHDAC meeting as a summary of the issues as one member saw them emerging in the debate.

***Participation***

*Speaker 6*

Some 85% of health care takes place in the home. The bathroom is a health-care facility! We must think of the family as a health-care-providing resource. How can we strengthen it?

***Knowledge and human resources development***

*Speaker 8*

Over the next 10 years 80% of our knowledge will be replaced, but only about 7% of our human resources will be replaced. That is a huge training and reorientation challenge.

**Public versus private health care systems***Speaker 7*

A two-tier care system is unacceptable. You cannot be separate and equal.

*Speaker 9*

Once the door to a commercially privatised system has been opened, it is very difficult to close it again.

*Speaker 10*

Privatised financing is one of the biggest threats to equity you could imagine. There are a lot of vested interests and a lot of misinformation.

*Speaker 11*

It does not matter who does the job, so long as responsibility is in government hands and it is being monitored. WHO should propose scenarios of alternatives, not a single method; we cannot tell countries what system to adopt.

*Speaker 12*

Some eastern European countries have already made decisions to change from public to private. And some people are deprived of even basic health care provisions

**Summary of RHDAC conclusions**

At the end of the meeting, in a summary of the conclusions, the Rapporteur identified the need for:

- a clearer, more sharply focused document, more tightly written and with clarification of priorities;
- the challenges and opportunities for better health to be placed up front together with the socioeconomic determinants of health;
- an unequivocal assertion of values;
- recognition of the diversity in the Region, avoiding unflattering comparison between countries;
- recognition of the role of other IGOs, and especially the European Union, the Council of Europe and the rest of the United Nations family;
- rooting our ideas for better health in current and expected realities, and identifying the possibilities, needs and expectations;
- a pedagogical rather than prescriptive approach giving possibilities of how to identify needs and innovate;
- removing unsupported assertions and citing evidence;
- affirming that health for all is a multi-stakeholder business, with the need to act accordingly; and
- recognition that we need a global as well as a European perspective.

## Experience from the Americas

*Cristina Puentes-Markides*

### **Health for all in the Americas**

The WHO Region of the Americas began the renewal of health for all in 1995 as part of a global process. The final product included inputs from consultations with the countries and recommendations from an advisory group to the Director of the Pan American Health Organisation (PAHO). It became the regional contribution to WHO's global health for all policy in 1998.<sup>29</sup>

### ***Challenges to the implementation of health for all***

Although the goals of health for all and primary health care continue to be embraced on political levels, their concrete expressions are more difficult to trace. After the approval of health for all, the countries were in the midst of an economic crisis, and neither health for all nor primary health care was an inexpensive or simple proposition to tackle. Structural adjustments requiring deep reforms of the state squeezed the public sector and eroded services. Then there were additional complications. First, the breadth and lack of measurable objectives encouraged contradictory interpretations of health for all and primary health care. This was further complicated by discussion about vertical versus horizontal programmes and the application of selective primary health care approaches. Second, the medical profession was not supportive; some viewed health for all and primary health care as threats to the “traditional” practice of and the hegemonic knowledge of medicine. Third, in spite of the availability of theoretical frameworks, the health sector's participation in intersectoral activities was limited. Fourth, decentralisation was not profound enough to sustain changes and generate self-sufficiency, and national leadership had weakened at a time of crisis. Moreover, the slow transition to democracy added constraints to the already strained capacity of the public services to support and supervise technical and logistical activities at the local level. Finally, health for all was not communicated successfully to non-health sectors; it was often presented as an absolute truth centred on the functions of the state.

### ***PAHO's role in the implementation of health for all***

The Regional Strategy for Health for All and the Regional Plan of Action (approved in 1980 and 1982, respectively) were to ideally lead national policies and programmes towards greater equity and effectiveness, but they were never implemented. Effective follow-up activities to establish goals and priorities, with a baseline that would have allowed measurement of progress, were not carried out.

The lack of tangible expression of health for all and primary health care is reflected in the publications on both topics. These increased immediately following the Alma-Ata Conference, with a peak between 1985 and 1989 when Halfdan Mahler left WHO, and declining from then on. Of the 55 citations in the PAHO bibliographical databases, 26 (47%) are authored by PAHO. Only one unit among PAHO's regional and country programmes mentions health for all and none mentions primary health care. Most importantly, specific research to identify threats to the achievement of health for all in the context of current health sector reforms is lacking. Priority-setting with a policy analysis approach has not led to alternative strategies and

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29. *Health for all in the twenty-first century*. Geneva, World Health Organisation, 1998 (document WHA51/5).

measurable objectives. The meaningful mobilisation of groups with ideological or economic interests in health for all is fragmented. In addition, links between health for all and international treaties, declarations and mandates guiding social and economic development, global or regional summits or conferences on the environment, population, children and women are weak. None the less, PAHO continues to be involved in many worthwhile efforts. Within a broad concept of health for all, our work can be considered as cooperation that addresses the health for all goals, and evaluation of the goal of health for all continues as part of a WHO requirement.

The developments of the past decade jeopardise health for all. International cooperation in health has been dominated by efficiency-driven approaches, which collide with equity-focused approaches, the true essence of health for all. Discussion has shifted from articulating a truly intersectoral approach (healthy public policies) to the effectiveness of medical interventions. The design criterion for health policy is, in practice, overwhelmingly cost-effectiveness rather than equity or sustainability. Health sector reforms appear at times to work against health for all, and recent literature shows that health for all has been “dismissed as outdated and inappropriate in a world dominated by economic recession and conservative ideologies”.<sup>30</sup> Supporting health for all means supporting the reduction and elimination of inequities in health. Consequently, sustaining the vision requires making it tangible through programmes, projects and objectives, and today a web site.

### **Health for all and the role of futures**

The WHO European Region’s experience of linking futures approaches to the achievement of health for all served as an example for our Region. PAHO’s Directing Council in 1996 approved a policy framework for achieving equity, solidarity and sustainability in health promotion and disease prevention;<sup>31</sup> some policy orientations were refined but no targets were set. Two regional meetings took place between 1996 and 1998.

### ***First Conference on Future Trends and Renewing the Call for health for all***

The renewal of health for all was discussed at the national level and in subregional meetings, consultations and technical discussions throughout the Organisation. As part of the broad consultation, PAHO convened a Regional Conference on Future Trends and Renewing the Call for Health for All in June 1996 in Montevideo.<sup>32</sup> The Conference was sponsored by the Ministry of Health of Uruguay, PAHO, WHO headquarters and the Regional Office for Europe and the International Health Futures Network (IHFN). The participants included recognised public health leaders and futures experts, NGOs and technical and financial cooperation agencies. A meeting of IHFN during the Conference supported the development of prospective global approaches in health. In preparation for this meeting, participants from all Central American countries participated in a futures workshop in Costa Rica, where a common subregional vision was developed.

### ***Symposium on National Strategies for Health for All***

The United States Department of Health and Human Services, the Canadian Society for

30. GILSON, L. In defence and pursuit of equity. *Social science and medicine*, **47**: 1891–1896 (1998).

31. *Renewal of the call for health for all*. Washington, DC, Pan American Health Organisation, 1996. (document CD39.R4).

32. *Regional Conference on Future Trends and Renovation of Health for All: final report*. Washington, DC, Pan American Health Organisation, 1996. (document OPS/DAP96.10.28).

International Health and PAHO sponsored this Symposium in Washington, DC, in February 1998.<sup>33</sup> The Symposium stimulated the linkage of planning processes for achieving health for all and examined the value of identifying priority areas and setting targets for health gains in the countries of the Americas. The central themes were priority-setting in health, tools for public health policy and management, and planning the prevention agenda for the 21st century. The learning objectives were to share local, national and regional experiences in setting priorities and implementing strategies, to link the strategies to key indicators that measure progress for achieving health for all, and to lay the groundwork for setting the prevention agenda for the next decade. The meeting provided opportunities to 150 participants from 19 countries to share tools and exchange ideas for processes and performance indicators, and stimulated international cooperation agencies to coordinate their support for public health policy development and implementation.

### **“Healthy People 2010”**

“Healthy People 2010” is the health promotion and disease prevention policy of the United States. PAHO assigned one professional part-time to participate in the process of formulating the “Healthy People 2010” proposal, and this proved to be an extremely useful and positive experience. A report by the Surgeon General<sup>34</sup> established the first generation of objectives. Five of these correspond to the life cycle with the aim of reducing premature mortality, and one is directed at preserving the independence of older people.

The United States has utilised quantifiable national goals of health promotion and disease prevention for 20 years. The experience is particularly interesting because of its participatory nature in formulating health policies, the construction of alliances with a broad variety of sectors, the bipartisan political support, the utilisation of scientific evidence, and the impressive strengthening of the data collection processes. This has been possible in a vast nation with an ethnic and racially heterogeneous population of over 250 million with disparities in health. The framework for 2010<sup>35</sup> proposes a vision of “healthy people in healthy communities” and two broad objectives for the nation: increasing years of healthy life and eliminating disparities in health. Twenty-eight areas of emphasis and more than 400 goals have been defined. The establishment of goals with shared responsibilities among government agencies motivates and gives cohesion to the work, being in addition instruments of communication with the public, decision-makers and community leaders.

With every update of “Healthy People 2010”, citizens, health care providers, schools, employers, industry, business and communities participate in the collective construction of national health. Thanks to the extended use of the Internet, the general public became involved during 1997 and 1998. Some 10 000 people attended public audiences and submitted observations on the content of the objectives and goals. The public consultation was expanded by the creation of the Healthy People Consortium, with more than 350 national associates representing 59 million people. The Healthy People Business Advisory Council represents the link with the private sector and is a valuable instrument in community health promotion.

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33. *Symposium on National Strategies for Renewing Health for All*. Washington, DC, Pan American Health Organisation, 1998 (document PAHO/DAP/98.3.39).

34. *Healthy people. The Surgeon General's report on health promotion and disease prevention*. Washington, DC, Department of Health and Human Services, 1979.

35. *Developing objectives for Healthy People 2010*. Washington, DC, Department of Health and Human Services, 1997.

The Healthy People initiative has been supported by both Republican and Democrat administrations during the terms of office of four Presidents. State governors endorse the objectives and the goals, and almost all of the states, plus Guam and the District of Columbia, have published their own versions of the goals. Coordination mechanisms include the Secretary's Council for National Health Promotion and Disease Prevention Objectives for 2010, led by the Secretary of Health with the participation of the Under Secretaries of Health of four previous administrations and the current chiefs of agencies of the Department of Health and Human Services. There is a Healthy People Steering Committee, chaired by the Director of the Office of Disease Prevention and Health Promotion. Periodic evaluations of each area of emphasis are chaired by the Under Secretary of Health/Surgeon General.

“Healthy People 2010” offers a national menu from which each state, county or locality can select according to its specific problems, budget and political priorities. Quality data acquisition is one of the greater challenges, and the existing gaps in information have mobilised efforts to develop areas that needed it. The inclusion of scenarios to test the feasibility of the two goals of “Healthy People 2010” offers an opportunity to increase the capacity of governments to forecast and take action. A future outlook adds flexibility and adaptability to developments in science, technology and medicine and the social aspects that accompany them.

#### **“Healthy People” and health for all**

The global vision of “Healthy People 2010” is health for all, and will be the contribution of the United States to the appeal of the World Organisation and of the Pan American Health Organisation for renewal of the goal of health for all. As a national expression of this vision, “Healthy People” illustrates a commitment to the achievement of equity by eliminating disparities and promoting solidarity and sustainability in health by focusing efforts at all levels –government, society, communities, families and individuals. “Healthy People 2010” will be launched publicly during a conference sponsored by the Partnerships for Networked Consumer Health Information, in Washington, DC, 24-28 January 2000.<sup>36</sup>

#### **PAHO's experience with health futures**

PAHO has been involved in health futures learning and activities with different partners since 1990, first as a founding Member of the IHFN. In addition, the Organisation has produced, translated, published and distributing a series of technical publications on health futures, primarily in Spanish, and provided technical assistance on health futures projects to the countries of the Region. The following activities illustrate PAHO's work and collaboration in health futures.

#### **With the countries**

- The National School of Public Health of Nicaragua used health futures methods in two workshops to identify long-term goals within the public health sector.<sup>37</sup>

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36. <http://www.health.gov/healthypeople/default.htm>.

37. SÁNCHEZ VIESCA, A. *Escenarios futuros en salud en Nicaragua. La situación de salud y organización de los servicios en los inicios del siglo XXI*. Washington, DC, Pan American Health Organisation, 1994 (OPS Information Series No. 4).



- The Minister of Health of Belize and district medical directors built a vision of health that galvanised efforts around the design of the National Health Plan.<sup>38</sup>
- In Venezuela, with the Instituto Latinoamericano de Investigación Social and support from the Ministry of Presidential Affairs, a visioning workshop developed as a prelude to the formulation of the Ninth Development Plan.
- The PAHO office in Guatemala elaborated health scenarios for the country in 1993. There are now a few offices interested or already engaged in the process.
- The Peruvian Ministry of Health used health futures methods in the feasibility analysis of its 1996 approved health policy guidelines.
- The staff and patients of a Uruguayan health maintenance organisation carried out a visioning exercise to strengthen cohesion and improve the quality of work.
- Work with the Economic Commission for Latin America led to the development of scenarios of health and equity.<sup>39,40</sup>

### **Within the Organisation**

- A workshop, with participants from all Central American countries, used visioning to identify a common integrated subregional vision of health for all.<sup>41</sup>
- A publication linked futures to the strategic and programmatic orientations.<sup>42</sup>
- The Spanish edition of a handbook on health futures and a tool for visioning in health are being prepared.
- PAHO's leadership training activities for its staff in 1996 and 1997 included information on and application of some futures tools.
- PAHO revisited its vision in the light of its new mission and responsibilities for the coming years.
- A two-year process led to: defining trends that are and will be affecting PAHO in the future; a discussion document developed with broad staff participation; a scenarios workshop; and the preparation of four scenarios for the Organisation.

### **With other partners**

- With WHO in its first consultation on health futures in 1993.<sup>43</sup>
- With the WHO Regional Office for Europe in the various consultations on future trends and health for all.

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38. ROBLES VERA, J. *Construcción de visiones estratégicas para el desarrollo*. Washington, DC, Pan American Health Organisation, 1995 (Informe Técnico OPS/DAP/95/16).

39. HULSHOF, J. *Empleo de los escenarios en el diseño de políticas a largo plazo*. Washington, DC, Pan American Health Organisation, 1995 (Informe Técnico PAHO/DAP/95.3.12).

40. HULSHOF, J. *Salud en la transformación productiva con equidad un bosquejo de cuatro escenarios plausibles*. Washington, DC, Pan American Health Organisation, 1994 (OPS Information Series No. 5).

41. *Reunión Preparatoria sobre Tendencias Futuras y Renovación de Salud para Todos*. Washington, DC, Pan American Health Organisation, 1996 (Informe Técnico OPS/DAP 96.9.27).

42. PUENTES-MARKIDES, C. What future for health future in Latin America and the Caribbean. *Futures*, **27**: 1067–1075 (1995).

43. TAKET, A. *Health futures in support of health for all. Report of an International Consultation*. Geneva, World Health Organisation, 1993 (document WHO/HST/93.4).

- With the Disney Corporation, through the International Health Futures Network and the Healthcare Forum, in the initial meetings to design “Celebration Health”.
- With Rollins School of Public Health at Emory University on a document linking futures and public health training.
- With the Institute of Alternative Futures, Smithkline Beecham and FUNSALUD in the production of a book on health for all in Latin America as a product from a workshop in Mexico.<sup>44</sup>
- With the University of Gothenburg on an article on futures and community health promotion.<sup>45</sup>
- With the US Army Environmental Policy Institute to identify threats and opportunities for the US Army in environmental health in the future.

### ***Some of the challenges***

- To truly own the vision of health for all, not only as a gold standard for technical cooperation but also as a benchmark for institutional work throughout the Organisation.
- To incorporate anticipatory approaches to the work of PAHO with a view to increasing the Organisation’s foresight in health and health care, improving decision-making and identifying and allocating human and financial resources. The new functions of the Office of Analysis and Strategic Planning include the use of anticipatory approaches in organisational planning to increase PAHO’s foresight, linked to policy analysis and strategic planning.
- To develop a system of trend monitoring in health and health care for the Region as part of the technical cooperation strategy.

### **PAHO’s partners in health futures**

#### ***Institute of Alternative Futures***

The relationship with the Institute of Alternative Futures (IAF), based in Alexandria, Virginia, dates back to 1991 when PAHO, the WHO Regional Office for Europe and WHO headquarters embarked on establishing and developing the IHFN. The Director of IAF, Dr Clement Bezold, has been very supportive of health futures and of PAHO and WHO. He has worked with WHO on a variety of activities since 1993, ranging from health promotion to biotechnology, and lately with PAHO through a “futures briefing”. PAHO has worked with IAF and the Health Forum in the design of Disney’s “Celebration Health”,<sup>46</sup> collaborated in developing some scenarios for the “Healthy People 2010” initiative and in various health for all activities. The IAF works in a variety of futures areas, such as visioning and scenarios, and also conducts foresight seminars for institutions and the general public.

#### ***American Council for the United Nations University (AC/UNU)***

The Millennium Project of AC/UNU, based in Washington, DC, defines itself as a global

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44. PUENTES-MARKIDES, C. Renewing health-for-all: preferred scenario. In: *Latin America and the Caribbean: the prospects for health-for-all*. Institute for Alternative Futures, SmithKline Beecham Pharmaceuticals and FUNSALUD, 1998.

45. PUENTES-MARKIDES, C. Application of “futures” in community-level health promotion with special emphasis to Latin America. *International journal of health planning and management*, **11**: 317–338 (1996).

46. *Celebration health and the IHFN: 21st century health systems: principles and visions*. Disney Corporation, 1993.

participatory futures research think tank of futurists, scholars, business planners and policy-makers working for international organisations, governments, corporations, NGOs and universities. The project assists in organising futures research, improving international thinking about the future and disseminating this information. PAHO has participated in the last three Delphi studies that have produced the annual *State of the future* report, and in a series of events organised by this agency. The project connects local and global perspectives via eleven regional groups of individuals.

### **Health Forum**

The Health Forum, based in San Francisco, was originally the Association of Hospitals of the Western States. It became the Healthcare Forum in the 1980s, and in 1997 transformed itself into the Health Forum as a new enterprise created through the union of the Healthcare Forum and the American Hospital Association. This organisation seeks to create new leadership and knowledge for a healthy tomorrow by enhancing the capacity of leaders to improve health through shared knowledge, innovative solutions and market insights. Its expertise centres on organisational leadership, market insight and leadership, clinical and medical leadership and community health leadership. PAHO has worked with the Forum since 1992, linking the work with Celebration Health through the IHFN and with the Health Research and Educational Trust in the area of healthy communities. The 2000 Health Forum Summit will look at the present and future of health care through the lenses of innovators, customers and stakeholders. We expect to hold a short meeting to discuss the future of the IHFN.

### **Outside the United States**

PAHO became associated with the Foundation for Future Health Scenarios (STG), based in the Netherlands, in 1991. This is now a non-profit organisation with extensive experience in the field, dedicated to futures research, developing strategic policy-options and supporting strategy development. The STG has published a series of futures studies that use models and scenarios and include policy options for decision-makers. They are used for policy development at regional, local and institutional levels. STG takes an active part in IHFN, which allows it to keep abreast of potentially interesting developments in health care globally, and to maintain connections with WHO, the European Union, the World Bank and other NGOs.

### **Trends in futures thinking in the United States**

In the United States, futures studies have followed a particular path. Unlike the European and more specifically the French tradition, which was rooted in philosophy and sociology, Americans tackled futures from a technological perspective that was strongly rooted in the pre-eminence of national security after the Second World War. The first forecast of technological capabilities for the military, ordered by General Arnold in 1944, began a tradition. General Arnold also convinced Douglas Aircraft Company to establish Project RAND (Research and Development) in 1946, which soon after became the RAND Corporation. Their mission shifted from a focus on the military to policy analysis at the national level. The Hudson Institute was created by Herman Kahn, a former RAND analyst and an expert on scenarios. Khan had introduced scenarios in planning linked to military and strategic studies at RAND, and together with Weiner described possible challenges for the US security.<sup>47</sup> Helmer was a key player in the creation of the Institute for the Future in 1966, which operates today from Menlo

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47. KAHN, H. & WEINER, A. *The year 2000: a framework for speculation on the next thirty-three years*. New York, Macmillan, 1967.

Park, California. The Futures Group, based in Washington, DC, was set up in 1971 by, among others, Theodore Gordon, today at the American Council for the United Nations University. These institutions are multidisciplinary and have strong links to the non-scientific and technological communities, leading the work in broad areas of policy.

The National Science Foundation was established in 1950, at a time when national security was still a priority and funds were available for future-oriented projects. Around the same time, policy sciences began to emerge. During the early 1960s, McNamara introduced the PPBS (Program Planning Budgeting System) in the Department of Defense. The system attempted to introduce long-range planning into the policy and budget decisions, and policy analysis units spread throughout the government. At the same time strategic planning, which had evolved from the Harvard Business School in the 1920s, became a broadly used instrument in business. In the last 20 years, policy analysis has become a commonly used tool in organisations, including local and state government. This field of knowledge has been dominated by economists and operations research, and policy analysts have had a difficult time dealing with their own values and beliefs as well as with the political constraints placed on them by their own work and the values of the “clients”. Policy sciences and future studies share approaches and tools with very different developments in academia and the private sector.

*Future shock*, by Alvin Toffler, was published in 1970. Early in that decade, Pierre Wack had made scenarios widely known through his work at Shell just before the oil crisis. The 1980s witnessed the recognition that a long-term perspective improved planning and health policy formulation, and the use of scenarios and strategic planning approaches spread to the public sector. During the 1990s, through an initiative of the Clinton administration, the Government Performance Review Act (as part of the initiative of reinventing government) was enacted and planning processes were established throughout the government. All government agency plans used strategic planning and futures tools to develop vision, mission, goals and performance measures.

Policy analysts became part of a reform process of the American system that intended to diminish the role of politics and power relationships and use social science expertise. Policy sciences relied heavily on techniques drawn from positivist social science, pragmatism and empiricism, and normative economic models. The field evolved, however, to consider the whole policy-making process, improved the way policy problems are structured, and included approaches such as organisational analysis and others derived from evaluation theory to assist policy-makers in understanding all possible dimensions of a policy problem. Scenarios were part of the field and were used in policy analysis as a supporting tool. Futures and policy sciences share similar research tools. While the former has continued to develop, touching a variety of “soft disciplines”, it does not enjoy the same grip on academia and research centres in the United States as the latter.

Futures studies gained greater visibility during the 1980s with publications such as Toffler's *The third wave* and John Naisbitt's *Megatrends*. Futurist magazines such as *Futurist*, *Omni*, *Futurelife* and *Alternative futures* became popular. The crisis of the 1980s affected the United States and the financial restrictions affected academic and government programmes, while corporations reduced their research and development budgets and the public gradually lost faith in the government and in planning. Futures work shifted from a global focus to areas of

institutional development and more diverse and narrow interests on health, information technology or community development. The field has developed to a point of having definite objectives, tools, research principals and a growing body of knowledge. Futures work takes place today in business and all types of organisations through visioning, scenarios and forecasting. There are academic programmes on futures studies, such as those at the Universities of Hawaii and Houston. There are organisations, agencies, consultant firms and professional and academic associations dedicated to a wide variety of futures-oriented research and exploration covering such diverse fields as the search for extraterrestrial intelligence, future technology, space exploration and colonisation, transhumanism, life extension, cryonics, nanotechnology, the uploading of human consciousness into computers, and megascale engineering. Other organisations engage in advanced work that include grand-scale futurism, philosophy, personal and social liberation and advanced technology.

*Futures*, *Futures research quarterly*, *Technological forecasting* and *Social change* are examples of journals dedicated to futures and forecasting. The Millennium Institute and the Santa Fe Institute seek to create a better society and/or scientific research community, pursuing emerging science through collaborative projects that break down the barriers between the traditional disciplines. The Extropy Institute acts as a networking and information centre for fostering the continuing evolutionary advance by using technology to extend healthy life, augment intelligence, optimise psychology and improve social systems. FutureWorld is a think tank for global business and technology. Magazines such as *WIRED*, *New scientist*, *Nanotechnology*, *Extropy* and *21st century* explore the future and very innovative thoughts in science and technology – the societal and individual changes that are occurring and will occur.

Today, futures tools are used in a variety of “conversations”. Institutions and organisations, private and public, are engaged in developing futures for science and technology. Futures are used within institutions and in the realm of strategic management to improve foresight, develop leadership, create visions and galvanise teamwork. At the local level, people use them to create and engage people in healthy cities/healthy communities projects, and at the state level to develop visions and strategic plans. At the national level, the use of futures is illustrated by the scenarios developed by Destino Colombia for Cyprus and South Africa, to improve participation through vision-sharing and conflict-resolution. There are also examples of scenarios for the Americas through FOCAL (Canadian Foundation for the Americas)<sup>49</sup> and SELA (Sistema Económico Latinoamericano). The United Nations Millennium Project has also developed global scenarios through its work.<sup>50</sup>

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48. *Which future for the Americas?* Ottawa, Canadian Foundation for the Americas, 1995.

49. *Millennium Project. Global scenarios from the 1998 State of the Future: issues and opportunities.* Washington, DC, American Council for the United Nations University, 1999.

# THE UNITED KINGDOM CONTEXT

## Nuffield Trust/Judge Institute project on health policy futures<sup>50</sup>

Fundamental changes are currently taking place in health. Some of these are caused by developments within the health sector, including new discoveries and new treatments in health care and a greater awareness of the effects of the environment on population health. Some are caused by developments outside the health sector, such as globalisation and the growth of the Internet. These changes are likely to increase towards 2015 and new developments will take place. Within this climate, there is a need for policy to become more informed about the context in which it operates and to take a long-term, strategic view of United Kingdom health.

This report is designed to help policy-makers and those working in, and interested in, the health sector to think about the future of United Kingdom health. It also considers some implications of developments in health and suggests options for policy on the basis of the trends and issues raised.

To summarise a “scan” of the environment of United Kingdom health towards 2015, developments in six different areas are described.

### **Disease**

There is a shifting burden of disease from young to old and from communicable to chronic disease. The aging population means an increasing incidence of cancer. There are increasing trends in obesity among the population and there are increasing mental health problems in children and young people, particularly disadvantaged children.

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50. Reproduced here is the executive summary of: DARGIE, C. *ET AL.* *Policy futures for UK health: 2000 report.* London & Cambridge, Nuffield Trust & Judge Institute, 2000 (<http://www.nuffieldtrust.org.uk/health1/health.htm>).

**Society**

Developments in society reflect increasing wealth and opportunities afforded by economic developments and changing work and family structures, alongside increasing inequalities and relative deprivation. Nearly a third of children now live in poverty compared with 1 in 10 in 1979, and there is an increasing health gap between the best and worst off in society.

**Environment**

There are positive environmental developments taking place, such as improvements in air quality from reductions in the major sources of pollution. At the same time there is increasing public concern about food safety, and factors such as globalisation of trade and travel, global warming and social trends will ensure that new infectious diseases will emerge or re-emerge.

**Governance**

Developments in governance mean there is an increasingly global aspect to health issues necessitated by a reduction in trade barriers, the development of the Internet and global mobility of capital and labour. European Union institutions are increasing their impact on health policy, and devolution within the United Kingdom is diversifying its health policy.

**Economics**

In the category of economics, there is a lower-than-average rate of increase in United Kingdom spending on health compared to other Organisation for Economic Cooperation and Development (OECD) countries (at the time of writing). There is increasing demand pressure on health financing due to technology and rising public expectations. Pharmaceutical expenditure is increasing. An aging population, along with an increasing older dependency ratio, will also place pressure on future National Health Service (NHS) financing.

**Industry**

Developments in industry cover many of the exciting new scientific discoveries relating to health, such as the human genome project that promises cures in untreatable areas, drug discoveries, screening and treatment in the area of molecular genetics. Developments in bioengineering and biotechnology are able to make useful products for medical treatment, such as artificial blood and artificial internal organs. Mergers, growth and consolidation are taking place within the pharmaceutical and private health care sectors.

Analysing these developments, the report identifies a series of six issues that are highlighted for policy-makers towards 2015.

**1. Rising public expectations**

There is increasing individual access to health information that previously depended upon professional gatekeepers, particularly through electronic information. Consumers are increasingly informed and ready to challenge professional and expert authority in health.

Expectations of health continue to rise among the population. At the most basic level, people expect to feel safe and secure. People have expectations about how long they are going to live, and also the quality of their lives. They have a range of expectations about the type of care they receive when they interact individually with health services, which might include whether they are able to be treated, when they are treated, who carries out the care and how they are communicated with, what alternatives to treatment are offered, how successful their treatment is, whether they have to contribute financially in any way, and how well they recover their health.



Information and communication developments mean that people know more about their country's health system and are able to make comparisons with alternatives.

Some of the implications of these developments might be: a greater focus on individual responsibility for health in the future, greater public involvement in prioritisation decisions in health care, and increased choice about the provision of health care.

People's expectations need to be recognised and managed. This involves deciding what people should expect from their health system and how progress towards achieving those goals is tested. It also means adapting the health system so that the health workforce can deal with an informed public. Information and communication technology could be used to include the public in debates about health in a constructive way. It could also be used to provide more effective public disclosure on health issues.

## **2. The aging population**

The United Kingdom population is becoming older and this is associated with an increase in disability and illness, particularly in the chronic conditions associated with aging. In terms of health care, this trend, in conjunction with a smaller relative working population to provide taxes to support health care, will have significant funding implications for health care in the medium- and long-term future. It also results in a shift in health care resources towards older people.

Of course, many older people live full, active lives and the demographic trends have the important implication of maintaining and promoting the health of older people. This includes participation in work and leisure activities, maintaining personal and social networks and housing, among other factors.

Some options for policy in this area might be to establish a clear policy goal for older people – for example, to maximise healthy life years and to plan policy for older people around that goal. The individual rights of older people – to dignity, to choice and to participation in society, including through work – need to be recognised, together with the important part to be played by family and friends and social networks.

Further research should be funded that looks at the profile of diseases specifically associated with aging and also that of maintaining good health in aging populations. This involves developing more meaningful quality-of-life indicators that are used to assess the health and wellbeing of older people.

## **3. Assessing new technologies**

There is increasing therapeutic potential and technical expertise as well as new knowledge about preventive strategies in health. Technology, defined as any health care intervention, is increasingly a driver in health and health care. There is an increasing role for technology in health care, both in developing the treatment and services offered and in influencing the settings in which care takes place. Technologies are developing that allow self-diagnosis and “self-treatment” or home care.

Assessing and evaluating health care technologies, in terms both of cost and of effectiveness, is becoming more pertinent.

Developments imply that individuals will be able to take greater responsibility for their own health, if self-diagnosis and self-treatment or home care develops, and this may provide

significant opportunities for helping older people. At the same time the focus of technologies on individual health, and support for their development, may lead to an intensification of the socially induced inequalities in health. There is heightened debate about the ethical issues provoked by new technologies and scientific developments.

Technologies are influencing the location of health care, with more diagnosis, treatment and monitoring able to take place outside the hospital, along with a greater concentration of specialist equipment in a smaller number of larger centres dealing with more complex cases. They are also influencing who provides care, as professionals take on new roles in new settings.

Developments in technology require sophisticated, fair and explicit systems for assessment and evaluation that take into account as wide a range of factors as possible. This should include the socioeconomic impact of new technologies. It also requires better planning for technological developments in resource-allocation decisions.

#### **4. Information and communications technology and information management**

The power of computing and telecommunications systems has been increasing as the cost has fallen. Telecommunications have proliferated and can now readily carry pictures and support interactive computing. The public can search the Internet for health information at home. More computing and telecommunications technologies can be interlinked to provide powerful distribution systems. Within health care, there are significant developments in computer use, including electronic records, telemedicine and health information databases.

These developments will force health policy to become increasingly global as individuals and organisations are able to tap into global expertise and global databases. It may be commonplace in the future to make referrals to external centres of expertise, including overseas centres. More health care will be provided remotely. There will be improved patient access to information, new roles for professionals and other health care workers and new training required.

Information technology (IT) is raising people's expectations. Patients are able to compare health services with those available outside the United Kingdom, to undertake research into conditions and treatments using the Internet, and to assess how health services make use of IT when compared with other sectors such as banking and leisure. New services such as NHS Direct that make use of technological developments have resource implications, in terms both of redirecting resources from other sectors and of stimulating a demand that requires additional resources.

Information and communication technology is an area where international policy development is relevant – for example, in developing an ethical and legal underpinning for telemedicine services, the verification of Internet sites, and standards for IT and electronic information.

#### **5. Workforce education and training**

Approximately one million people work in the NHS. Developments in the wider world of work will impact on the health workforce, both within the NHS and in the other health-related industries. They include technological change, globalisation, the shift from manufacturing to services, the increased participation of women, and the changing nature of work itself, particularly the growing diversity of work and work roles and the increased flexibility required from the workforce.

The health workforce, like the population, is aging and some cohorts are not being replenished by younger generations. Women now make up over half of medical graduates and a third of hospital staff. Technological developments may change substantially the nature and location of health care – for example, in genetic testing in primary care and remote consultation through telemedicine. There are changes in skill acquisition with continuing acquisition, particularly of new skills such as IT and genetic counselling, becoming a necessity.

Some of the implications of developments are: uncertainty over whether the health sector will be able to attract the best recruits in the future; questions over the validity of traditional career structures and recruitment planning; and questions about the sustainability of the current system of workforce planning.

Evaluation of the different models of care, including changing roles for professionals and changing locations of care, is required. There is a lack of evidence around the costs and benefits of moving services out of hospitals and in reorganising care, for example around teams.

In terms of education and training, the possibility of more generic elements in the training of health professionals might be considered, along with an evaluation of current roles and whether training and ongoing staff development fit the purpose of future roles in health care, for example in training staff in human genetics.

Among other measures, taking care of the health workforce needs to be part of an overall human resource strategy. There are worrying trends in violence against health staff, increasing litigation, and comparative studies of ill health amongst NHS staff as against other sectors.

## **6. System performance and quality**

Considering that most health care is provided within a single, taxation-funded NHS, it is a matter of concern that adequate systems do not exist for assessing performance, for evaluation, and for disseminating knowledge within the system about where resources should be allocated and what the most effective treatments and procedures are. The NHS has not been fully exploited as a resource and database for research. Given these deficiencies, system performance and quality in the health sector are becoming more important and are likely to intensify between now and 2015.

Performance needs to be compared against other developed nations and analysed for varying performance and outcome data within areas of the United Kingdom.

Policy-makers will have to defend United Kingdom health against alternatives, in terms both of population health outcomes and of the organisation of health care, as performance data become more readily available and highlight country strengths and weaknesses. There are likely to be improved mechanisms for holding government to account for how it spends public money on health, as performance is made more transparent.

For patients, developments should lead to improvements in performance, less variation in performance and greater openness. For professionals, the changes mean developing systems for measuring their own performance and those of their colleagues, along with more evidence-based treatment.

Improved international benchmarks for performance on health should be pursued. Comparable indicators that evaluate rather than simply measure activity are favoured.

Better systems for strategic planning, management and evaluation that relate to developing systems of quality and performance also need to be put in place. This includes performance on accumulating and disseminating information throughout the health system and improved coordination among different parts of the system.

### **Developing future health policy**

The report is realistic about the complex nature of health policy and about the tensions that arise in making decisions in health policy, tensions that are likely to be exacerbated towards 2015.

An example of those tensions is using knowledge from human genetics research to facilitate preventive population strategies, while at the same time preserving the rights of individuals to refuse treatment and to live their lives freely. Another is accommodating the rising technical expertise in health along with a reduced ability to communicate respectfully with individual patients.

There are conflicts between establishing national priorities and developing meaningful programmes for care at the local level. Patients are more informed and more assertive and at the same time there is increasing pressure on health professionals, which constrains the amount of time they can spend with patients and still have time to keep themselves informed about treatments.

There is increasing therapeutic potential in health but also a health workforce increasingly under pressure and continuing constraints of overall government expenditure levels. Scientific and technological processes are developing in manufacturing, process and treatment, and the public are demanding assurances on public safety issues.

Health policy operates within these tensions and, rather than trying to resolve them, the nature of policy-making becomes one of compromise, collaboration, cooperation and consultation. Policy-makers need to be aware of the environment of health that surrounds them in order to help them make decisions in this climate. They also need to look forward and a futures analysis helps them to do both these things. It is intended that a series of reports in a similar style be produced towards 2015.

## **Virtual reorganisation by design: an approach to progressing the public's health in Wales**

*Morton M. Warner*

### **Introduction**

Progress in improving the public's health is seriously constrained by the very organisations that, in a civic society, are given the responsibility for its advancement. In the case of Wales this means local government bodies, the National Health Service and the voluntary sector. Elsewhere, I have identified the enthusiasm with which elected officials “reorganise” things around them when they come newly into office. They tend to spurn “re-design”, whereby clarity about what is aimed at – the function of a social institution – takes pre-eminence over “form”.<sup>51</sup>

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51. WARNER, M.M. *Re-designing health services: reducing the zone of delusion*. London, Nuffield Trust, 1997.

It is Gareth Morgan, in his imaginative language of mental constraint,<sup>52</sup> who has taken the case further. Not only, he says, does “function” or “design” get left out of the equation, the “form” of the organisation itself becomes a psychic prison: the actions that its members pursue are constantly trapped by ancient memories of the organisation’s real or believed history.

Wales, in common with many other countries, has not been immune to the constraints imposed by a thinking dominated by existing organisational arrangements and the emotional lure of preservation. But it has none the less engaged in some interesting – some would say remarkable – attempts at social engineering. This paper documents some key activities of the past fifteen years; and it attempts, on reflection, to identify what was missed or was not possible at the point of inception, often due to the constraint of thinking mostly about organisational change as the only option.

The paper goes further, however, and views the existing health field or public health agenda in the context of current assumptions about the future, as identified by a recent United Kingdom Cabinet Office paper,<sup>53</sup> which places emphasis on important social tenets that might be represented by a post-materialist generation. Here there is distrust of law and authority, a disengagement from mass democracy and a requirement for individualism, self-expression and improved quality of life. But at the same time, essential elements of civil society – such as mutual dependence and concerns about the environment – are not to be lost.

In this somewhat paradoxical world, how is faster progress on the public’s health to be achieved? This is the question addressed in the final sections of the paper, following a brief analysis of some important endeavours in Wales in recent times.

### **Health for all developments in Wales**

#### ***The beginning and development of health for all thinking***

Two main events signalled the start of this in Wales. The first was the setting up in 1985 of the Heartbeat Wales programme in response to very poor morbidity figures and high mortality from cardiovascular disease. The second was the initiation of the Health Promotion Authority for Wales (HPAW) in 1987, which built on and considerably expanded the activities of Heartbeat Wales. HPAW was also a leader in initiating intersectoral activity and review from 1985–1993 and had some notable success, particularly in the area of food policy, involving both the training and retail industries.<sup>54</sup>

They were also the pioneers in the area of lifestyle and morbidity surveys in Wales<sup>55</sup> who established many useful baselines for 1988; and their analyses included socioeconomic distinctions. The repetition of this work was delayed to 1995, with the results of the Welsh Health Survey becoming available in 1996;<sup>56</sup> another survey is due in 2000.

The importance of a relatively systematic collection of lifestyle data over many years cannot be

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52. MORGAN, G. *Images of organisation*. Beverly Hills, Sage, 1996.

53. WINTOUR, P. Power set to drain from Whitehall. *The Observer*, 21 November 1999.

54. CATFORD, J. & NUTBEAM, D. Heartbeat Wales. In: William, K., ed. *The community prevention of coronary heart disease*. London, H.M. Stationery Office, 1992, pp. 164–175.

55. *Health-related behaviours in Wales 1985–1993: findings from the Health in Wales Survey*. Cardiff, Health Promotion Wales, 1994 (Technical Report No. 8).

56. WELSH OFFICE. *Welsh Health Survey*, 1995. London, H.M. Stationery Office, 1996.

overestimated: it laid down a bedrock of information about some of the conditions affected by the social determinants of health. Only more recently, however, have activities been apparent that have revealed the need for a broad response from the NHS and local government working together. In 1996, The Welsh Local Government Association (WLGA) initiated discussions between its members and the Health Authority, aimed at joint action to investigate the contribution that local government activities could make to health in Wales. The first atlas of health inequalities was published by WLGA in 1998.<sup>57</sup>

Both the arrival of a Labour government in 1997 and the earlier efforts by HPAW and the WLGA made possible the broad public health programme put forward in May 1998 known as “Better Health – Better Wales”.<sup>58</sup> But the NHS, too, had played a major part in strategic thinking as early as 1989. The question must be, however, whether it was more successful in developing cross-sectoral action – breaking out of the psychic prison of organisation – than the health promotion and local government activities that both preceded and paralleled its efforts.

### ***The Welsh strategic vision – equity and health***

The key early contribution towards action was the publication in 1989 of *Strategic intent and direction for the NHS in Wales*.<sup>59</sup> Specifically, strategic intent was the *management* target for the NHS through to the end of the century and beyond: “Working with others, the NHS aims to take the people of Wales into the 21st century with a level of health on course to compare with the best in Europe” (Fig. 1).

Health gain was seen as the key to achieving the strategic intent. But the three themes – health gain, people-centred services and effective use of resources – were recognised as being interdependent and therefore had to be pursued concurrently.

It was agreed that, while the United Kingdom government had not yet signed up formally to the numerical targets contained in WHO’s health for all policy document, the approach should use as a starting point the same principles – equity, access, quality of care, targeting (a form of positive discrimination) and community involvement; and these were woven solidly into the fabric of NHS planning in Wales.

Ten key areas of health gain (see Fig. 1) were identified. While the list is extensive, it was not suggested that all aspects of each area should or could be tackled at once. At the local level, objectives and priorities were to be set, guided by the incidence and prevalence of illness (actual or potential) and the corresponding requirements for promotive, preventive, treatment or rehabilitation services.

It should be noted that, throughout this period and beyond, the HPAW continued to give a major lead in developmental work and research. Its focus, however, was not confined to actions that might be undertaken by the NHS but rather more intersectoral. This gave rise to a perception of “separateness” from the NHS, of which it was a Special Health Authority member, and to some diminution of health service support.

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57. MONAGHAN, S. *An atlas of health inequalities between Welsh local authorities*. Cardiff, Welsh Local Government Association, 1998.

58. WELSH OFFICE. *Better Health – Better Wales: strategic framework*. Cardiff, Stationery Office, 1998.

59. WELSH HEALTH PLANNING FORUM. *Strategic intent and direction for the NHS in Wales*. Cardiff, Welsh Office NHS Directorate, 1989.



Fig. 1. Strategic intent and direction for the NHS in Wales, 1989



### **Protocols – the conceptual framework**

Two sets of items delineated the final form of the protocols. First, it was recognised that a balance had to be struck between the three elements of health gain, people centredness and resource effectiveness. Second, all aspects of the NHS – prevention and promotion, diagnosis, treatment and care, and rehabilitation and monitoring – were considered. Both were represented in the final statement of goals, objectives and targets.

By design, no attempt was made at this stage to think intersectorally. Tactically, the view was taken that to think broadly, and in a way that would require interdepartmental action, would be likely to result in inertia. In addition, territorial boundaries were jealously guarded; and beyond this the NHS needed to put its own house in order first to achieve a strategic reorientation.

### **Protocols – goals, objectives and targets**

Overall goals were set in each of the protocols that recognised the two elements of health gain – quantity and quality of life. For achievement in the shorter term, service targets were suggested as marker points en route to health gain: these became surrogates for the health gain targets. Managerial performance was to be measured against their achievement. Criteria for admission of targets were thus developed to ensure that they were:

- credible
- selective
- quantifiable
- timely
- capable of being monitored
- balanced across all areas of care.



But targets were always a matter of considerable debate. The following lists highlight the issues.

*For*

- Quantifiable indicators of achievement
- Inspire action, commitment and purpose
- Stimulate debate
- Encourage rational purchasing.

*Against*

- Over-emphasise “destination”, a distraction to “process”
- Encourage guesswork
- Overemphasise measurable items
- Over-optimism leads to disillusion.

In summary, the pluses outweigh the minuses; and in particular the first objection listed above was countered by the introduction of the service targets to act as short-term surrogates for longer-term health gain objectives. Nevertheless, one conclusion on which there was a high level of agreement was that most health authorities would have preferred a smaller number of targets and an indication of Welsh Office priorities, since resource constraints meant they could not pursue all of the targets at once.<sup>60</sup>

The second conclusion relates to the use of health gain and service targets as the explicit currency of the contracting process. It was felt that the purchaser–provider split and contracting, introduced nationally in 1991, provided the key to putting into operation the concepts of a health-gain-based and people-centred service. And Wales benefited also from the fact that the English *Health of the nation*<sup>61</sup> supported the thinking behind health gain. However, there was insufficient activity devoted to developing contracts with an overt orientation towards health and social gain, and political events – the change of ministers – disrupted the process.

Did, then, the Welsh strategic vision for the NHS manage to blur the boundaries between the health service and other organisations that contribute to determining health? The answer is a qualified “yes”. While the contracting process did not step outside the confines of the NHS, the important development of local strategies did.

### ***Local strategies for health and needs assessment***

Local strategy development and commissioning represented the bottom-up elements of the policy implementation activity. This involved both the assessment of community needs and the development of local strategies in order that informed contracting could take place.

Each health district set up multidisciplinary health gain teams, variously under the leadership of public health medicine or planning personnel, which included typically the voluntary, social service and other local authority sectors such as education and housing, as well as clinicians from different backgrounds. In one district team, leadership was provided from outside the NHS.

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60. NATIONAL AUDIT OFFICE. *Improving health in Wales*. London, H.M. Stationery Office, 1996.

61. SECRETARY OF STATE FOR HEALTH. *The health of the nation*. London, H.M. Stationery Office, 1991.

A comprehensive evaluation by the National Audit Office in 1996 commented “Health Authorities have been successful in some instances in persuading organisations outside the National Health Service, such as local authorities, to take action likely to improve health. There have also been instances, such as with the major water supplier [relating to fluoridation], where health authorities have not been so successful.”<sup>62</sup>

### ***The policy watershed***

The years since the election of the Labour government in 1997 have been important ones for the “new public health”. The issue of inequity has been tackled head on by a Scientific Committee under the chairmanship of Sir Donald Acheson,<sup>63</sup> the former Chief Medical Officer for England. The 1992 *Health of the nation* has been reviewed and a new White Paper, *Saving lives: our healthier nation*<sup>64</sup> has been issued. In Wales, the “Better Health – Better Wales” strategic framework<sup>65</sup> sets out the approach to be used in the Principality, alongside other initiatives.

*The health of the nation – a policy assessed*<sup>66</sup> concluded in 1998 that in England the government needed to:

- provide leadership by sending out clear, consistent “corporate signals” and ensuring cross-departmental ownership;
- establish shared ownership at all levels, both horizontally and vertically, and ensure that chief executives in health and local authorities are fully engaged and committed;
- within a performance management framework, spell out as clearly as possible agency expectations, tasks and responsibilities;
- consider carefully whether health authorities should have the lead role for delivering on the health strategy or whether this should not be a shared role between health and local authorities;
- stress the importance of joint targets and joint monitoring, with each stakeholder playing to its particular strengths; and
- ensure that primary care practitioners are engaged with the strategy.

*Our healthier nation* responded by addressing directly the issue of developing partnerships:

Successful partnership working is built on organisations moving together to address common goals; on developing in their staff the skills necessary to work in an entirely new way – across boundaries, in multidisciplinary teams – and in a culture in which learning and good practice are shared. It also means:

- clarifying the common purpose of the partnership;
- recognising and resolving potential areas of conflict;
- agreeing a shared approach to partnership;

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62. NATIONAL AUDIT OFFICE. *Improving health in Wales*. London, H.M. Stationery Office, 1996.

63. DEPARTMENT OF HEALTH. *Independent inquiry into Inequalities in Health report*. London, Stationery Office, 1998.

64. SECRETARY OF STATE FOR HEALTH. *Saving lives: our healthier nation*. London, Stationery Office, 1999.

65. WELSH OFFICE. *Better Health – Better Wales: strategic framework*. Cardiff, Stationery Office, 1998.

66. DEPARTMENT OF HEALTH. *The health of the nation – a policy assessed*. London, Stationery Office, 1998.

- strong leadership based on a clear vision and drive, with well developed influencing and networking skills;
- continuously adapting to reflect the lessons learned from experience; and
- promoting awareness and understanding of partner organisations through joint training programmes and incentives to reward effective working across organisational boundaries.

Wales has seen the development of health alliances, which broadly engage local partners to:

- gain a wider understanding of how health gain can be achieved;
- ensure better coordination between local health and environmental services;
- increase local capacity in conjunction with local health promotion specialists;
- facilitate a network for sharing health and environmental information; and
- support communities in action to improve health, living conditions and life chances.<sup>67</sup>

In both jurisdictions, the need has been recognised to develop new links between primary care and public health, accepting that they both have different tasks and perspectives as well as common themes (Table 1).

**Table 1. Public health and primary care: the conjoint agenda**

<b>Public health</b>	<b>Primary care</b>
Longer-term, strategic view	Short-term, operational view
Population focus	Individual patient focus
Larger populations (geographical)	Practice population
Prevention-orientated	Treatment-orientated
Needs assessment of groups and populations	Needs assessment of individuals
Work through others (manage change)	Direct work with patients
<p><b>Common themes</b></p> <p>Multidisciplinary and generalist approach</p> <p>Holistic and concerned with health</p> <p>Consider people not just as “patients”</p> <p>Clinical standards and quality</p> <p>Longer-term relationships and concerns</p> <p>Whole spectrum of health and disease issues</p> <p>Concerned with health/social care interface</p> <p>Achieving value for money</p>	

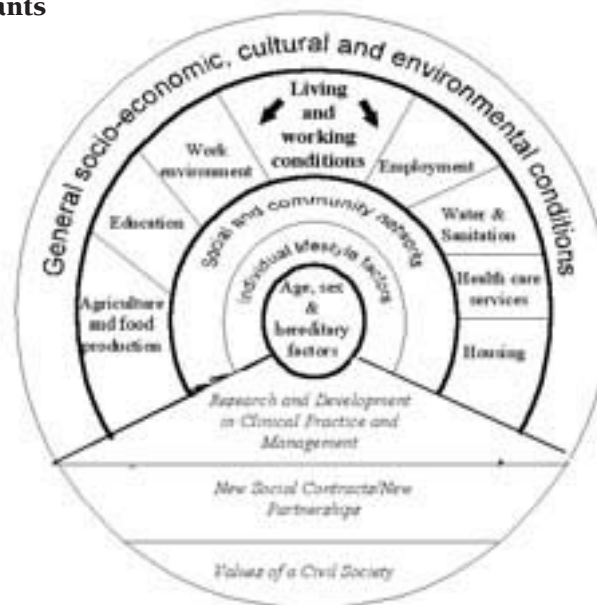
Source: *Shared contributions, shared benefits: Report of the Working Group on Public Health and Primary Care*. London, Department of Health, 1998.

67. WELSH OFFICE. *Better Health – Better Wales: strategic framework*. Cardiff, Stationery Office, 1998.

There is a consistency of language; and much of it is concentrated around “working across boundaries”, “improving networking”, “constructing partnerships” and “empowering communities”.

Göran Dahlgren has, in his now famous model, summarised the main factors that, in combination, determine the level of health of individuals and communities.<sup>68</sup> Fig. 2 shows this, and inherent in it is the language and spirit of the English and Welsh endeavours. But some new elements have been added – civil society values, new social contracts and partnerships, and research and development related to the elements and management of change – which will shape the possibilities in delivering the new public health agenda. These are now expanded on.

**Fig. 2. The determinants of health systems redesign**



Source: WARNER, M.M. *Re-designing health services: reducing the zone of delusion*. London, Nuffield Trust, 1997.

### **The futures context: threats but opportunities**

Strategic thinking requires having some idea about the world ahead – perhaps for 20 years or so – but also mapping a journey that broadly takes the right path. Almost inevitably, how we will have to do things tomorrow will be a threat to how we do them today: intermediate staging posts are useful to guide the transition and reduce the anxiety.

### **Joined-up worrying: virtual reorganisation by design through networking**

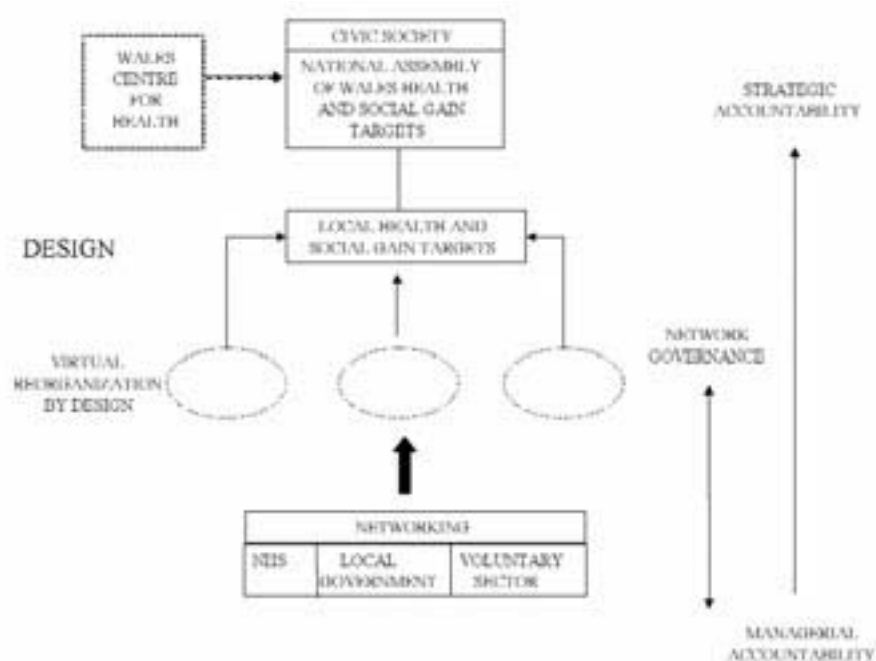
The watershed period detailed above has brought Wales to a point where the need for conjoint activities is accepted. But there is a limit to tolerance, which is exceeded when reorganisation of the NHS and local government is mooted; the tendency is to suggest that in the quest for greater democracy the latter should be supreme. The issue, then, is how arrangements are to be orchestrated that cause “joined-up” activity to actually happen.

Here, the role of health and social gain targets is important. Wales, as noted earlier, has had considerable experience of these, both at national and at local level. One practical option is for all organisations at local level to agree what contribution they can make (or most often would

68. DAHLGREN, G. The need for intersectoral action for health. In: Harrington, P. & Ritsatakis, A., ed. *European Health Policy Conference: opportunities for the future*. Vol. II. *Intersectoral action for health*. Copenhagen, WHO Regional Office for Europe, 1995 (document EUR/ICP/HFAP 94 01/CN01 (II)).

normally be making anyway) to target achievement, and to form a virtual organisation for a limited time to do it. Importantly, managerial accountability would remain in each of the participating bodies. Fig. 3 represents the arrangement.

**Fig. 3. Virtual reorganisation by design to improve the public's health, 2000–2020**



This “virtual reorganisation by design” (VRD) has the potential to reduce inter-organisation tensions; and if there are purchasers involved “leaves no blood on their head”<sup>69</sup> because any reorganisation that might occur does so over time, is organic in nature and results from local perceptions of utility rather than external pressure. New forms of social contract and partnership between organisations, communities and individuals will emerge, but important issues remain relating to organisational self-autonomy with networks and the development of network governance.

The individual organisations that are required to work together to improve the public's health are currently all hierarchical in nature, and self-autonomy is a critical component of hierarchies. Therefore, changes in the environment that threaten autonomy by requiring different work patterns and some degree of external accountability – in this case the network – will, in turn, have an impact on the nature of both inter- and intra-organisational exchanges, and could result in dissonance.

However, one important source<sup>70</sup> has predicted that inter-organisational networks will become the dominant institutional form, increasingly replacing both markets and hierarchies as a governance mechanism. The authors conclude that:

... conflict is most closely associated with loss of autonomy and the structural characteristics of networks, contrary to popular wisdom, has surprisingly little to do with either administrative coordination or task integration.

69. I am grateful to Arne Johanssen, Chief Executive of Östergötland County Council, Sweden, for this phrase.

70. Alter, C. & Hage, J. *Organisations working together*. Newbury Park, CA, Sage, 1993.

Given this, the idea of “contribution to achievement of health and social gain targets” would appear to be one unlikely in itself to engender dissonance. And, indeed, government policy in the United Kingdom, which enables “joined-up working” to occur more easily, may somewhat reduce problems concerned with structure, although certainly not entirely.

Network governance is the final but important building block. There are many examples in recent government policy documents where networking is the suggested remedy to existing deficits in inter-organisational cooperation. However, the fields of networking and network governance are little applied in the public sector, and hence their ability to support the development of VRD is not well understood. Nevertheless, there is a considerable body of research and this has been summarised to develop a general theory of network governance.<sup>71</sup>

Here, these authors suggest that network governance:

involves a select, persistent and structured set of autonomous firms or non-profit agencies engaged in treating products or services based on implicit open-ended contracts to coordinate and safeguard exchanges. These contracts are social – not legally binding.

Specific sub-definitions are important:

*select* – network members do not contribute to all activities, at least in the first instance;

*persistent* – network members work repeatedly with each other over time (i.e. a need for projects to develop some intensity);

*structured* – exchanges are neither random nor uniform, reflecting a division of labour;

*autonomous* – the potential for each organisation to remain legally separate;

*implicit and open-ended contracts* – the means of adapting, coordinating and safeguarding exchanges that are not derived from authority structures or from legal contracts.

In recognising these as the factors that make for successful network development and governance – leading to VRD – they must be taken into account and used as the evidence base implicit for the creation of successful intersectoral action in public health.

The Welsh Institute for Health and Social Care has developed a tool to assist cross-boundary working<sup>72</sup> and VRD, which involves rapid appraisal of current inter-agency working and a method to move ahead through structured action. In part, its aim is to expose, through discussion, the potential challenges to organisational autonomy and to develop networking arrangements and governance.

The use of VRD to achieve greater levels of public health is, however, likely to be only transiently fit for the purpose. Future conditions may require that we move on, perhaps after 10 years or so if not earlier. The opportunities will certainly be there and are explained in the next section.

### ***The context for public health in 2020 and beyond***

Any thinking beyond 20 years, or perhaps even 10 from today, is bound to be speculative. Yet this is what strategy is about: the identification of possible destinations at which society might

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71. JONES, C. *ET AL.* A general theory of network governance: exchange conditions and social mechanisms. *Academy of Management review*, **22**: 911–945 (1997).

72. *Rapid appraisal process: integration at the health and social care interface*. Pontypridd, Welsh Institute for Health and Social Care, 1997.

arrive in the future, and preparation for the journey. Actions directed at raising the public's health will not be in the lead but rather will be operating within a broader context of development.

The Performance and Innovation Unit of the Cabinet Office in the United Kingdom recently set out the forces for change sweeping western society.<sup>73</sup> Four of the five “drivers of change” identified are familiar territory for health futurists – aging, globalisation, scientific innovation and environmental degradation – although the computer technology section makes interesting reading:

- capacity will double every 18 months, at least to 2015;
- when silicon technology reaches its limit, new approaches such as DNA computing and/ or quantum computing will provide more powerful problem-solving;
- pervasive computing using inter-communicating devices will be embedded in everyday items – household appliances, consumer goods, machine tools and clothes; and
- computers using “soft computing”, it is predicated, will be able to speak, listen and understand and, unlike “hard computing”, be tolerant of imprecision, uncertainty and partial truth.

In sum, a high proportion of the population of Wales will have individual access to information (potentially related to their own and their community's prospects for health if it is prepared) and will be able to enter into a dialogue based on personal reasoning.

A fifth “driver” is somewhat new but potentially very important in the public health discussion – the development of a post-materialistic ethic. Here the paper claims that a new post-materialistic generation is emerging that will become:

- disengaged from mass democracy and more interested in individual self-expression and lifestyle;
- less respectful of political and legal authority;
- more tolerant of cultural diversity; and
- more concerned with quality of life and female values as opposed to material wellbeing.

Again, to summarise, perhaps over-cryptically, the potential impacts in the field of the public's health will be a movement against mass campaigns and even lower receptivity to communication approaches exercised by governmental and other statutory authorities; greater acceptance of the alternative health arrangements used by different cultures; and an emphasis on achieving a better quality of life related to the environment through harmonisation, rather than gratification through acquisition.

### **The really new public health: altruistic individualism and the Internet**

The “new public health” message can expect a good reception if those who seek its propagation adopt the appropriate media and tone for its delivery.

### ***The emerging civil society of altruistic individualism***

At the heart of this discussion lies a question that must be faced by those believing that they can socially engineer the public's health towards the achievement of some global (or Welsh) nirvana: what role will individuals play in the civil society that is emerging as we move into the 21st century?

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73. *The future and how to think about it: strategic challenge project*. London, Cabinet Office Performance and Innovation Unit, 1999.



The notion of “civil society” in the United Kingdom has been represented by a number of elements, and is one that:

- is based on and held together by impersonal, contractual, legalistic “civil” ties of interest, calculation and codes of conduct;
- comprises autonomous or semi-autonomous networks of associations that mediate between individual citizens and the state; and
- has an implicit social contract as well as formal constitutional, contractual or legal conceptions of reciprocal rights and obligations.<sup>74</sup>

This is changing, however, with political support for an enterprise culture and further mediation to “roll back the state” to create a “new order” that in itself needs to foster, as Perez-Diaz<sup>75</sup> suggests:

quasi-spontaneous coordination among large numbers of autonomous agents, each pursuing his or her own goals ... social integration would be the consequence not of people living together under similar conditions, or working with the same organisations, or sharing the same goals, but of critical choices made by those individuals to adhere to the rules that make possible this extended order of many-sided multiple interactions ... states, societies, nations, classes, even organisations are not normally responsible agents. Only individuals are ... (and are) the key to the problems of social integration.

And what is the likely orientation of individuals that might contribute to social integration? Here, to return to the Cabinet Paper, the answer is given as concern for quality of life, the development of trust, and acting in a way to counter acquisition of material things as an end in itself – altruistic individualism.

### ***The Internet: virtual reorganisation of public health***

In this second speculative component of the “really new public health”, some approaches currently being suggested for private sector business are examined to explore the way in which parallels can be drawn that might apply to the health field.

It was in 1990 that Hammer wrote his now-famous article, *Re-engineering work*.<sup>76</sup> The intention was to improve quality and eliminate non-productive activity by streamlining business services. Many health institutions followed his prescription. Now, in 1999, he has developed a thesis that the Internet is not just revolutionising commerce but is beginning to reshape entire industries.<sup>77</sup>

For the 1990s in business, read also many public sector activities in the United Kingdom. Hammer says companies began to break down their *internal* department “silos” and reorganise themselves around activities and processes: managed care is an example from the NHS. The next wave is about doing something for the whole supply chain – breaking down external walls between rather than within organisations. The public health sector has much the same

74. BIDELEUX, R. *Competing conceptions of a civil society: an overview*. Swansea, Politics Department, University of Wales (unpublished paper).

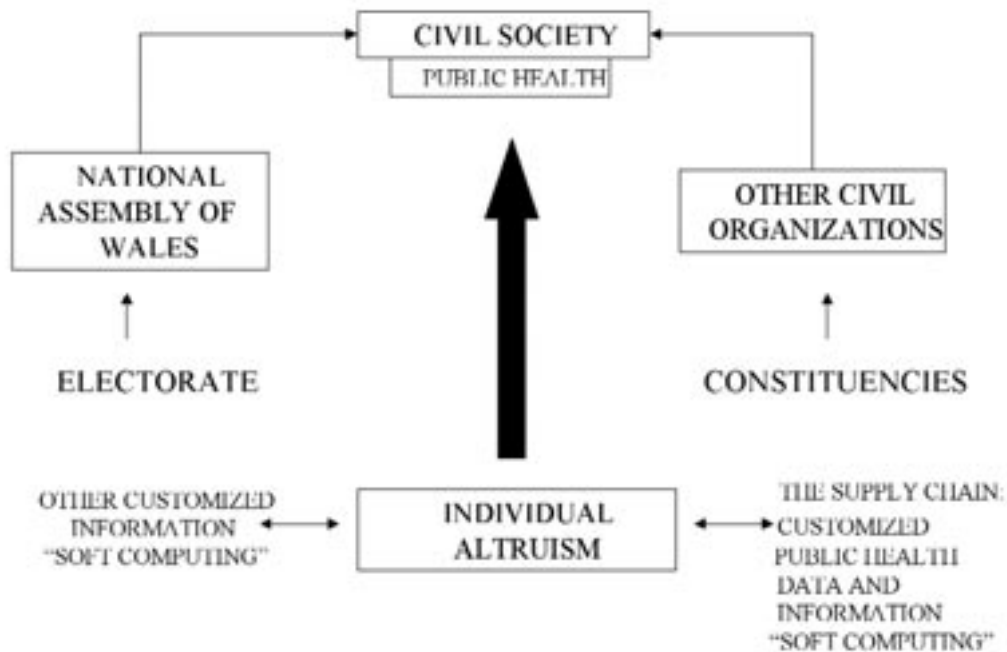
75. PEREZ- DIAZ, V. *The return of civil society: the emergence of democratic Spain*. Cambridge, MA, Harvard University Press, 1993.

76. HAMMER, M. Re-engineering work. *Harvard business review*, **68**(4): 104–112 (1990).

77. HAMMER, M. & STANTON, S. How process enterprises really work. *Harvard business review*, **77**(6): 108–116 (1999).

agenda, as described earlier. But is it ready to take the next leap – virtual integration along the supply chain to produce products that are responding to individual preference for information? A suggested customising approach is set out in Fig. 4.

**Fig. 4: The virtual reorganisation of public health customising in 2020 and beyond**



In essence, will the individuals of 2020, or thereabouts, be able to recognise a need they have within the area of public or personal lifestyle and enter into an Internet-based dialogue, where the components of the issue are automatically drawn from different information services to form a comprehensive response to which, with “soft computing,” they can interact? And will the tone and content of the communication respond to both their egocentric needs and their desire to be altruistic?

These will be the parameters under which the private sector supply chains will need to operate to gain their profit – and so too public health. The ability to respond to individual requirements – to be drawn down on, rather than to pass out information – will be integral to the “really new public health” function. Perhaps health educators, the current “sales force”, should move into the design of information programmes required in the new era!

Hammer concludes that, while it will not be easy to boundary span for purposes of VRD, *virtual integration* will be even more difficult. To apply his argument, the arrangement between organisational partners will need to shift from adversarial to partnership, transaction to relationship, win/lose to win/win, dominance to interdependence, and hostility to trust. The same elements will pertain equally to links with the public.

**Wales – the reprise**

All this, if undertaken would take Wales two stages of development further on than it is now. Indeed, in practical terms, only a breach of the outer wall of the psychic prison is possible at the moment, and this will not be easy. But Wales has a useful experience of working in health development at the community level, and the new Health Alliances Programmes of local

government and the Health Improvement Programmes of NHS Local Health Groups should prove fruitful in furthering the links between the National Assembly and the people. Virtual reorganisation by design will enhance the process, and a major pilot project has been developed in one of the areas with the poorest health in the South Wales valleys.<sup>78</sup>

It would be well to think, however, towards the next strategic phase and to engage individuals in public health, particularly through those services supplying care to individuals, notably in general practice and primary care. Here, the COMSCAN (community scan) project,<sup>79</sup> designed to link primary care physicians to public health community programmes, should prove a useful catalyst.

Ultimately, the core of the new public health is concerned with raising people's actual and perceived quality of life and increasing their self-esteem. If this is achieved, and if equality of opportunity is obtained while at the same time the advantages of mutual dependence are retained, Wales can be stronger within a devolved United Kingdom.

### **Acknowledgements**

The history of health development in Wales owes much to the pioneers of health gain, both those in the Welsh Health Planning Forum who developed the concept and the clinicians and managers across the NHS in Wales who put it into practice. Their legacy is now being built upon, and I have drawn heavily on that experience.

Thinking about how to move on, particularly for joint working in health and social care, I owe much to my colleagues at the Welsh Institute for Health and Social Care who have been involved in network development; and to Nick Gould who has been researching the subject of virtual organisations.

Lisa Griffiths, as always, provided all the support necessary to get the paper into final form.

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78. *Community Health Alliances through Integrated Networks (CHAIN)*. Welsh Institute for Health and Social Care, 2000.

79. *General practice community scan programme*. Pontypridd, Welsh Institute for Health and Social Care, 1998.



# LINKING THE UNITED KINGDOM AND INTERNATIONAL CONTEXTS

## A SCENARIO FOR HEALTH AND CARE IN THE EUROPE UNION OF 2020

*Graham Lister*

### Part 1: The Scenario

#### **The world of 2020**

The world of 2020 is a global knowledge village of almost 8 billion people. The global economy brings advantages for some: faster economic growth for multinational enterprises, sharing of knowledge and open communications on a global scale, cultural exchange and contact. Health is the world's largest industry (12% of global GDP), followed by tourism. Communication, from everywhere to everyone, enabled by electronic highways, provides entertainment, personal contact and a market for fast-changing world fashions, but also gives access to a vast knowledge capital. Well-off citizens carry lightly the key to computing power that two decades before would have required a supercomputer. They have instant access to the world's knowledge capital – and they know how to use it.

The benefits of globalisation are less obvious in the world of the poor, beyond North America, Europe, Japan and some successful Pacific Rim countries. Globalisation has increased their disadvantage. While they share the burden of environmental pollution, global warming and misuse of natural resources, they have benefited only marginally from the knowledge revolution. They provide a cheap source of agricultural produce, minerals and labour to manufacture consumer goods for rich countries. Despite real economic growth of 2% per annum, per capita income in the poorest countries has fallen as a result of a continuing population growth of 3.5% per annum. Disparity in wealth has increased: the wealth of the

richest 20% of the world's population is 125 times that of the poorest 20% (70 times in 2000, unadjusted for purchasing power).

There is a harsh divide between the health of the rich, who expect to live healthy lives into their eighties, and the poorest, who have a life expectancy of little more than half this. Failure to take early action on the misuse of antibiotics resulted in pandemics of infectious diseases in the teeming megacities of poor countries, for which “affordable” countermeasures had become ineffective. It is now realised that health is a key to economic development. Health aid (including water, education and shelter) has replaced arms sales as the major instrument of trade and aid policy. Europe has played a leading role in providing health research and information resources as well as financial and personnel support.

International agreements have finally given more than lip service to health as a basic human right. WHO now has considerably greater funding and power to intervene to protect health rights. World trade agreements now include measures to counter the disadvantage suffered by poor countries as a result of globalisation. The health impact of trade and agreements on intellectual property rights is subject to specific examination alongside environmental assessment. The release of transgenic pathogens as a result of research into xenotransplantation has also given rise to new vigilance with regard to potential health risks. Companies wishing to release new products now have to demonstrate conclusively that the environment and human health cannot be harmed, and a new international body has been established to oversee this.

Policies to address such issues are spurred by social unrest, which is fuelled by fanaticism fostered by the obvious inequality of our global society and what some see as the “cultural imperialism of global multinationals”. Tragically, this has resulted in acts of chemical and biological terrorism that have claimed hundreds of thousands of lives in both rich and poor countries. We live in an uncertain world.

### **The European Union of 2020**

The European Union of 2020 has been enlarged to encompass as full members many of the former eastern European countries (now referred to as Central Europe), some of the countries of the Balkans (South Central Europe) and, this year, Turkey. There is freedom of movement for goods, labour, information and money but it is still a Union of distinctive nations and regions. There are many important differences between countries with regard to culture, prosperity, equity and the quality and nature of social services.

Europe has enjoyed a modest rate of economic growth of 1.5% per annum (compared with a growth rate of over 3% per annum for 1980–2000) and low population increase. The slow-down in economic growth has been caused by the need to reinvest in the economies of Central and South Central Europe and the cost of reducing environmental damage. A gradual redistribution of manufacturing activity to poorer regions of Europe has occurred. Post-industrial regions have experienced more rapid growth in incomes, the cross-national regions created by the Copenhagen-Malmö link, Benelux/North German trade and the Paris-London-Brussels triangle being examples.

In our knowledge-based society, education is the main source of economic advantage. Communities that have valued and invested in universal education of a high standard, and particularly those favouring science and technology such as Germany, Hungary and

Scandinavia, have a very significant advantage in the competition between the regions of Europe. These societies are also more cohesive, though not all problems of exclusion have been overcome by education.

There remain areas of poverty and social exclusion in inner-city areas, rural areas and many of the heavily industrial regions of Central Europe. Social exclusion starts with disadvantage in education and home life and results in information exclusion and thus poverty. The difference between the income of the richest 20% and the poorest 20%, once only as high as 9.5:1 in grossly unequal societies (such as the United Kingdom during the 1980s), is now approaching this level in some Central European countries. This is reflected in health and life chances: the poorest are still five times more likely to die under the age of 65 than the richest.

Health and care systems across Europe are national in character, with distinctive systems reflecting the culture and background of each system. However, they reflect common European values of solidarity, community and equity and a legally enforceable European statement of public rights and obligations in respect of health and care. This development was demanded by, and is now underpinned by a strong European health consumer movement.

Health systems have strong similarities because they face similar opportunities (created by developments in medical and information technology) and similar problems (increasing costs, limited resources and a higher proportion of elderly people with chronic conditions). The development of European health information standards, and measurement of outcomes as well as inputs to health and care, has enabled health systems to develop much faster as they learn from one another.

### **European health**

Europeans are living longer and healthier lives. Improvements are most noticeable in Central and South Central Europe, where life expectancy had deteriorated between 1980 and 2000. Since 2000, life expectancy has risen by 7 years (equalling the increase of the previous 50 years). These improvements, however, also result in more people living with chronic diseases such as Alzheimer's disease and diabetes.

The poor health of an affluent society includes obesity, alcoholism, smoking, drug abuse, stress and poor diet, affecting 33% of people. "Convenience" foods high in fat, sugar and salt and low in fibre are consumed even in southern Europe, which had hitherto enjoyed a healthier diet than the north. Increases in cardiovascular disease, diabetes and cancer, particularly cancer of the bowel, are the result. Smoking is declining, but the legacy of 20 years still leads to an increase in lung cancer among women.

Areas of urban and rural poverty persist, despite national and European policies to counter them. In such areas, problems of poor health may be compounded by ethnic and language barriers and lack of access to social support structures, often resulting from the breakdown in family structures. Physical and mental abuse and refugee experiences cast shadows over peoples' lives. The numbers of single-parent families and of elderly people living alone are rising as a result of increased longevity. Southern European countries used to see family breakdown as a northern European problem, resulting from a decline in religion and traditional marriage, but they now experience similar problems. For some, the information and communication age facilitates work and social relationships, making non-traditional family structures (which outnumber the traditional in most of northern Europe) easier and enhancing



community structures. For those excluded from information networks by lack of skills and resources, isolation is reinforced. Depression is the leading cause of illness in Europe.

Local air quality has generally improved: with lower emissions of particulates and a decline in acid rain, damage to the ozone layer has been slowed though not reversed. This results in more skin cancers and, owing to global warming, southern Europe is vulnerable to mosquito-borne diseases such as malaria and forms of encephalitis. An increase in mean temperatures of 1 °C is a major contributor to deaths in sub-Saharan countries, directly and as a result of drought. Multiple-resistant hospital infections are a major problem owing to the misuse of antibiotics: in rich countries, where they were used in agriculture and household products; and in poor countries, where health systems came close to collapse. Health problems arise from overseas trips by European tourists despite improved precautions and monitoring.

Awareness of individual responsibility for maintaining health and fitness is reflected in health systems that give advantages to those taking positive health measures. Responsibility for poor health is brought home to tobacco companies and others who cause ill health. Punitive damages won by legal action by consumer groups finally broke the back of international cigarette manufacturers. This immense windfall gave the consumer movement the funding it required for positive action to support good health and “wellness”. The increase in awareness, knowledge and local family and community action, coupled with investment in health-related education, housing and environmental improvements and social support, are the main reasons that Europeans now live longer, healthier lives.

### **The European patient**

By 2020 almost a fifth of Europeans are over the age of 65, and this group’s demand for health services is 4–5 times above the median. The patient has changed, not only as a result of aging but, as better treatments are developed, more chronic patients are maintained in the community. Some 70% of prescriptions are repeats, indicating that the patient is receiving continuing treatment for conditions such as asthma, Alzheimer’s disease, cardiovascular diseases, depression, diabetes, epilepsy, inflammation of joints, migraine, multiple sclerosis, Parkinson’s disease and prostatic disease. By 2020, these diseases together account for 40% the total cost of health services in Europe.

Patients are no longer passive recipients of care but informed and demanding consumers. They demand better information about their condition, the treatment options and the performance of clinical teams. They are also well organised. The Netherlands led the way, with one in five citizens participating in patient consumer groups by 2000 and a well developed structure to support patient rights at local and national levels. Over the following 20 years, patient/consumer associations increased in all European countries, despite a lack of support from many existing agencies who preferred to maintain power in “professional expert” hands. The European Patient/Consumer Council now wields considerable political influence, reflecting the development of “grey power”.

Local patient/consumer organisations provide a range of information and advice services and campaign for patient rights. This entails being involved in the debate about the provision of services and the specific treatment options available. They also monitor the performance of health services from the patient’s perspective. In 1999 the College of Health was the only United Kingdom patient organisation able to track total patient waiting times. In 2020 health

providers are required by European law to supply details of performance and patient experience at every stage. Such is the strength of the patient/consumer movement that governments are obliged to fund them to enable patients to use this information. They act as patient guides and advocates, and use international contacts and the Internet to seek better treatments for their members.

It is important to stress the positive role that patient/consumer associations play in helping patients to accept responsibility for their own health. They provide advice and information about positive health and a support network for patients. German patient self-help groups led the way in this development, and strong self-help groups are now evident across Europe.

Patient/consumer associations are also engaged in debate at local and national levels concerning health and care priorities, as they have been for many years in the Netherlands, Norway, Spain and Sweden. Since it is evident that social health systems cannot afford to provide every possible form of treatment, associations debate with funding agencies the cost-effectiveness and demand for treatments. For this reason, health supply companies are careful to consult with them during the development of new treatments and drugs.

### **Medical technology**

The pace of advance of medical devices has accelerated over the past 20 years. The uptake of medical advances in Europe depends on two factors: the pace at which medical practitioners can learn and apply new skills, and the rate at which health systems can afford these developments. The first way in which health systems of 2020 reduce costs is by shifting more diagnosis, treatment and care to the primary care and home care sectors.

The most significant developments are therefore those that make it possible to care for patients at home. Patients make use of Internet and telephone advice and triage services such as NHS Direct, established in the United Kingdom in 2000. These services ensure that they have the information to manage their own health and can make optimal use of health and care services. Other developments include:

- portable patient diagnostic devices and tests;
- patient monitoring devices and services;
- patient knowledge-based systems – “home health advisers”;
- telemedicine services using video links and sensors;
- patient education and support for empowerment-based behavioural change; and
- physical and mental wellness programmes.

In primary care, near-patient testing devices and scanners often support diagnosis. A specialist opinion can be obtained by a knowledge-based system or video link with a specialist, supported by sensors and imaging systems. Medical practice is supported by knowledge-based systems, using the Internet to give access to the latest best-practice solutions and outcomes. Knowledge-based systems also support self-care and nursing care. For poor countries, specialised knowledge-based systems provide support that is sensitive to local needs, culture and resources, an important knowledge benefit for these countries.

Miniaturisation and less invasive surgical techniques, including the use of lasers and adhesives in place of sutures, are enabling both day surgery and major surgery to reduce dramatically the damage to the patient, the length of stay required in hospital and blood loss. Remotely operated devices, controlled through virtual systems, have replaced the hand-held scalpel for

many complex surgical procedures. For example, it is now usual to perform heart bypass operations by portal surgery without stopping the heart. The requirement for specialised equipment and skills has led to further centralisation of complex procedures. Simple day surgery procedures are provided locally.

Developments in genetics and bioengineering have greatly increased the potential for transplantation, by using organs grown in genetically engineered animals and miniature biotechnical devices to replace human organs.

Beyond miniaturisation, nanotechnology offers radical developments in areas of medicine where treatment was previously impossible. This involves the use of biomechanical devices roughly the diameter of a human hair. These devices are capable of mechanically attacking cell clusters and transporting drugs in minute quantities to precise locations. In 2020 this technology is still developing, is very expensive and is limited to specialist centres.

### **Pharmaceuticals of the future**

The global pharmaceutical industry of 2020 is dominated by 10 multinational enterprises funding, researching and marketing global health solutions. They work with smaller organisations in virtual networks, developing and improving health solutions. These include a range of drugs and therapies and knowledge systems for screening, prevention, diagnosis and treatment. Their source of economic advantage, and increasingly their product, is knowledge. Alongside these knowledge-based companies, a further group of multinational and regional companies supply generic drugs, the essential elements of most health solutions.

For poor countries, regional health supply companies are the main providers of health solutions. These companies work with local communities, health services and international NGOs to improve health and local provision of drugs and health information. As in Europe, the main factors contributing to health improvement are intellectual capital, in the form of knowledge of appropriate local health solutions and social capital, comprising community organisation and support for health improvement. International funding, to guarantee markets in poor countries at low prices, linked to controls on parallel importing, have supported investment in health solutions for these countries.

The pace of discovery of new chemical entities, which slowed from about 70 per year in 1980 to 40 per year by 2000, accelerated to 200 per year by 2020. The development of new drugs was influenced by three main factors. First, developments in combinatorial chemistry and equipment made it possible to screen products one million times faster than in 1995. Second, the Human Genome Project, which was substantially complete by 2002, increased the potential target applications for drugs from about 500 to 2500. Third, the market demands proof of the cost–effectiveness of health solutions. The European Medicines Evaluation Agency now requires a demonstration of cost–effectiveness that may be used by national health systems in considering whether to fund.

This has tended to favour the development of health solutions that support a switch to screening and disease prevention. This is the second way in which health costs have been restrained in Europe. The Human Genome Project was the starting point for the development of genetic screening; by 2010 screening for some 30 conditions was possible, although the practice was confined to specialist centres. The full potential was only realised once low-cost genetic screening had been introduced and primary care doctors had developed skills in

interpreting and providing guidance on the basis of genetic indicators, matching treatment to patients' genetic profiles. It was also essential to reach a European agreement on the ethical uses and ownership of genetic information.

Developments in pharmaceuticals have included major breakthroughs in diseases that had been untreatable, and a steady improvement in combination therapies and staged drug regimes for many common diseases. Vaccines for AIDS have been developed, but require guaranteed low prices for poor countries.

Other drug developments include the so-called lifestyle drugs. These include growth hormones with anti-aging properties, mood-enhancing drugs and many other treatments, for which there is high demand. However, European social health care funding pays for such treatments only in exceptional cases.

### **Information and health**

Health care has always been knowledge-based. In 2000 clinical staff spent 25% of their time dealing with patient records and information. In 2020 this process is much easier, with medical staff recording patient history, diagnostic and treatment decisions as they talk with the patient, using an intelligent system that picks out relevant information and confirms and collates it. Information recording is therefore a part of the medical process, not a further task. Use of information and communication technology is the third way of targeting health interventions and improving the effectiveness, quality and efficiency of health services.

Communications and information systems to support European health include the following:

- Patient-based health and genetic records can be accessed and searched from any location, protected by access and encoding devices held by patients.
- Commissioning and contracting systems draw on patient records without access to personal medical information, as the basis for planning and purchasing services.
- Evidence-based medical knowledge systems provide access to best-practice treatment and outcome information, linked to disease-management systems providing integrated treatment and care programmes tailored to the genetic characteristics, needs and choices of individual patients. These systems provide patients with information for education and self-care, as well as guiding clinical and care team members
- Health and care market data provide information on conventional and alternative health and care solutions, their quality and cost, and waiting times (where relevant). Used by patients and their advisers to choose options for treatment and care, these draw on outcome information and surveys of patient experience. They guide referrals and book appointments and treatment.
- Integrated health management systems schedule patient treatment and resource use in both primary and secondary care. These systems help to optimise the use of resources by prompting recommended care paths, controlling the scheduling of resources within hospitals and primary care, and providing clinical audit, cost and resource use information for management.

Since 2000, European health systems have progressed through a number of stages. It was first necessary for health providers to realise the potential of information technology and to

increase spend from 1.5% of the health budget to the United States level of 6%. It was then necessary to move from local systems to integrated solutions and from backward-looking recording systems to forward-looking health planning, medical advice and scheduling systems. A major step forward was achieved when health systems introduced Internet-based three-tier solutions. This architecture provides access from local users' systems through Internet and browser technology to health information and data analysis support tools. While this was technically possible before 2010, the confidentiality of patient and clinician records and delays in retraining medical staff meant that the full potential of communications and information technology was not realised until 2015.

### **Health and care economics and funding**

In 2020, health expenditure in Europe has increased to 12.0% of GDP. This increase has been due to a number of factors. Aging accounts for about 0.5% increase per year, and changes in morbidity and the potential to treat more diseases add a further 0.5%. Changing consumer expectations resulting in demand for higher-quality care produce a further growth of about 0.75% per annum. Medical technology and pharmaceutical developments add another 1.25% increase (equivalent to 5–7% real growth per annum in these sectors). And since staff costs are 70% of the total, wage inflation adds a further 0.5% increase per year. The increase of 3.5% per annum set against economic growth of 1.5% per annum results in a high but affordable health cost, and is a lower proportion of GDP than the United States level in 2000 of 13.6%. The increase in health costs of only 3.5% per annum in real terms has been achieved by restraint by European governments and health systems. It compares with average growth of 3–5% per annum between 1980 and 2000.

The most important reason for the restraint of health costs has been the stress placed on social welfare systems by increases in the costs of pensions and long-term social care. These costs increased dramatically in many European countries between 2000 and 2020, while dependency ratios (population under 15 and over 65 as a percentage of the total) increased from about 40% to 55%. Moreover, in the next 10 years, from 2020 to 2030, these costs will increase again and the dependency ratio will rise further.

The switch by American employers to health care based on health maintenance organisations (HMOs) was credited with constraining the cost of health expenditure. Despite this, costs rose as forecast to 16% of GDP by 2010. This was considered affordable, until an economic downturn caused a sudden increase in the number of uninsured (17% of the population in 2000) and a need to reduce social health expenditure to avoid health costs rising to 20% of GDP. The consequent social disruption was resolved by the introduction of a broader social health care safety net with clearly defined core benefits available to all. This increased United States government spending from 40% to 50% of total health costs, but reduced total health costs to 15% of GDP within five years as health insurers and HMOs offered cheaper health plans.

In Europe, where government or social insurance costs accounted for 90% of health care in 2000, a reverse trend occurred. Social health systems limited funding to health solutions of proven effectiveness, co-payments were increased, and some aspects such as adult dentistry and ophthalmology were provided only to low-income groups. In addition, some aspects of transplantation and very high-cost procedures and drugs were excluded from basic health cover. Some countries introduced age limits on certain procedures, while others limited services available to smokers.

The direct impact on health costs of exclusions was limited (only affecting 1% of costs), but this enabled governments and health care payers to influence the development of health technology. It also had the effect of encouraging private medical insurance to cover co-payments (as in France) and additional services, including those excluded from social health schemes: cosmetic treatments, spa treatments, lifestyle drugs and alternative medicines valued by patients but of no proven efficacy. Private medical and long-term social care insurance increased from an average of around 7% to over 15% of European health costs.

### **Health reforms in Europe**

The European Union has supported the convergence of health and social care since the Treaty of Maastricht in 1992. It has not attempted to replace national and regional management of health systems but has promoted a much faster exchange of ideas and information.

Competition between the regions of Europe will not allow either excessive social cost, which would discourage industry; or very poor social services, which would discourage labour. The United Kingdom (specifically in England) has increased spending, while Germany has reduced costs to come closer to the norm.

Thus health services have borrowed elements of reform from one another but have maintained their basic forms, with tax-funded systems in Greece, Italy, Portugal, Scandinavia, Spain and the United Kingdom and systems funded from social insurance in Austria, the Benelux countries, France, Germany and Switzerland. The countries of Central and South Central Europe developed hybrid solutions through a combination of employment-based insurance, tax funding and private insurance.

All European health systems operate within financial limits, and control the services of health providers through cost- and quality-defined contracts or service agreements. In both types of system there is a division between agencies commissioning and funding health and care and the providers of services. Social insurance agencies have been subject to reform and competition, as in Germany and the Netherlands. This has resulted in far fewer social insurance agencies, competing on the basis of the quality and cost-effectiveness of the services offered (risk equalisation ensures fair competition). Local health commissioning agencies in tax-funded systems do not compete but offer services matched to local needs. This often involves partnerships with other agencies to tackle the poverty and social exclusion of local groups.

While governments delegate health commissioning and provision to local agencies, they require health providers to demonstrate that the services they offer are effective and are supported by evidence-based medicine. Most countries have followed the Netherlands and Norway in setting priorities for health service provision, with the highest priority given to services that can be shown to be effective and cost-efficient. Where patients can reasonably be expected to bear personal responsibility for services this is reflected in co-payments, such as for tattoo removal and, in some cases, smoking-related diseases.

Both local health commissioning agencies and social insurers work closely with primary care networks. These serve as gatekeepers to secondary care and are involved in commissioning. Some countries direct capitation-based funding through primary care networks, as in the British system of primary care groups and the Swiss HMOs. Others provide financial incentives, as in the German *Vernetzte Praxen*. In France, Italy and Spain, local doctors form



“quality networks” with similar functions. Denmark and Sweden have patient/consumer groups responsible for commissioning health and care services.

Most European health systems have attempted to set user charges at a level that will encourage the most cost-effective use of services. For example, they followed the lead of Sweden, which by 2000 required users to pay a charge of €10 for primary care consultations. This encourages users to make use of telephone triage and advisory services for self-care. Low-level co-payment charges for hospital beds also encourage patients to seek early discharge.

### **Primary care and community care networks**

While telephone help-line services reduce the need for doctor contact, patients still visit their primary care team frequently (about six times a year). The skills needed by these teams include the ability to listen and provide guidance and training to the patient, as well as wide-ranging knowledge of medicine and health risks, particularly those relating to genetic factors and treatment options. Since patients come with a range of physical and mental health and social problems, team members must have a wide understanding of family health and social relationships. These fundamentals have not changed in 20 years, but doctors and nurses have gained new skills in using information and knowledge.

The primary care network has changed in many European countries in that a far wider range of skills is now deployed. Doctors still provide diagnostic and family medical services, but some specialise in planning and managing the primary care team and the services they commission from secondary care. There are more specialists in primary care, including paediatric, geriatric and psychiatric specialists and rheumatologists. In addition, specialists hold clinics in local primary care centres and portable equipment is brought to the centre for specialist treatments. Primary care networks operate telephone, Internet and videophone help-line services, emergency first call services, casualty rooms, community hospitals and psychiatric services.

There are many more specialist nurses operating in primary care teams. They provide advice and triage services, and give support and education for patients. Some can prescribe medicines and treat straightforward cases under the supervision of a doctor. Many nurses provide home-based care for patients. This frees time for doctors so that they can deal with more complex needs, spend more time reviewing medical conditions with patients, and provide genetic and other health prevention advice. The primary care team includes psychiatric nurses and social care advisers, where health and social care are integrated. The team may also include a pharmacist providing advice on drug regimens, over-the-counter medicines and treatments. A patient advocate is located in each centre, providing advice and guidance to patients and contact with local self-help groups.

While some have described the advent of primary care commissioning as a revolution, in which primary care practitioners would overturn the dominance of hospital medicine and lead the health services, in practice it is more like a partnership. Hospital doctors, primary care teams and social carers get together to conduct patient care audits, plan patient care and optimise treatment. Patient/consumer group members attend meetings to ensure that the patient's perspective is kept in the forefront of discussions. Social insurers/commissioners are also included, to balance other local needs and resources.

Primary care networks are supported by information systems that enable them to share patient data and the evidence-based protocols and patient care pathways they have adopted. In some cases the



primary care team may be located together in a primary care centre, as found in Scandinavia and Spain. In other countries, such as France and Germany, they operate from different offices as independent practitioners linked by communications and information technology.

### **The 2020 hospital**

Most of the European hospitals of 2020 were built before 2000, since there has been an overall reduction in the number of beds required. This was due, first, to reductions in lengths of stay to match the United States level (a reduction of 30–50%). Second, the development of “hospital at home” and primary care centres has reduced the demand for hospital admission. Third, less invasive surgery has resulted in many more day cases. Finally, even in 2000 many European countries had a surplus of hospital beds (France, for example, had a surplus of 60,000).

Although the appearance of hospitals has not changed much in 20 years, their role and operation are quite different. Hospitals operate within an integrated service, providing knowledge, diagnosis and advice by video and remote sensing and imaging links to primary care practitioners, and running outreach clinics in primary care centres. One hospital is unlikely to provide all the knowledge and support for primary care since hospital units specialise in therapeutic areas; thus knowledge support may be drawn from several different hospitals. Some medical schools also apply this principle to the education of clinical staff, with students learning on-line and by visiting different areas of medical practice including, most importantly, primary care. As the knowledge base of medicine expands at an ever-increasing rate, medical staff must first learn to use and update their knowledge.

Within a typical hospital of 2020, much has changed. Most divide their functions between emergency medicine and specialist treatment units. The emergency medical unit may be on a different site, stabilising patients and providing diagnosis and treatment planning. This often requires teleconferencing with relevant specialists. The patient’s treatment is scheduled at this stage, and if necessary the patient will be moved through to the treatment centre. If the patient can be stabilised, he/she will be scheduled for a later date and discharged to home care or a patient hostel providing low-intensity nursing. Patients do not stay longer than 24 hours in these units.

Specialist treatment units bring together the skills and resources for patients with similar requirements. They are large enough to achieve economies of scale for staff and equipment, usually about 100 beds, with a throughput of some 10,000 inpatients and 50,000 outpatients per year. A hospital complex may contain 3–7 such units. Some very large hospitals provide all specialties but most specialise in a more limited number of areas, forming links with other hospitals to provide comprehensive services, knowledge support and training. Rural areas are served by general hospitals linked to specialist units, with imaging systems and in some cases the potential for remote robotic surgery.

The development of specialist units is due partly to the increased cost and economies of scale required to utilise medical equipment, and partly to the need to use specialist knowledge and skills. They also form natural patient-centred knowledge management units. But this development is also driven by the increase in hospital infections caused by the misuse of antibiotics in the 1990s; units are therefore separated to avoid cross-infections.

Owing to the reduction in bed requirements, hospital sites often provide the location for primary care centres. In some cases they also contain positive health facilities such as fitness

centres. Some hospitals even provide the site for a wide range of alternative medical practitioners, thus forming a sort of “health supermarket”.

### **Caring for the whole person**

Care is needed by “whole persons”, for whom a combination of family history, luck and personality play an important role that cannot be explained by genetic or medical factors. Health and care remain personal services, of which empathy, trust and family/community support are essential ingredients.

Health and care services are better integrated in most European countries by 2020. Some health systems have followed the Australian model of 2000, in distinguishing between people requiring single services and those requiring an integrated response to a range of physical and mental health, social and emotional needs. In other systems, the role of the general practitioner and/or community nurse has been enhanced to ensure that the total needs of the patient are reviewed and contact is maintained.

There is a danger, however, of expecting too much from these busy front-line staff. It is also clear that health and social care professionals do not have a monopoly on empathy or knowledge. Community resources channelled by patient/consumer associations are central to the quality of care provided in 2020. It is a crucial task of health agencies to develop and support such services. In countries such as the Netherlands and the United Kingdom, patient advocates have been provided by patient/consumer groups since 2000, and they are now found in all European systems.

It is also accepted that caring for the whole person may require spiritual support. Religious and humanist organisations play a role in counselling patients and, together with patient/consumer groups and patient advocates, provide support for patients and families in making difficult ethical decisions about treatment and care options. One of the most difficult areas of decision-making concerns the right to die with dignity. Most countries now accept living wills in this regard.

While health services have increasingly focused on medical interventions of proven value, consumers have continued to purchase alternative medicines and treatments. Where alternative therapies have demonstrated their value they have been accepted for social health funding. Equally, conventional treatments of doubtful benefit (but no harm) have become new alternative therapies. Thus, for example, it is now accepted that pets have considerable therapeutic value for many elderly people, and provision is made for pets wherever possible. As a result of effectiveness studies, dilatation and curettage is now provided as an alternative therapy, funded by state systems only in exceptional circumstances.

The boundaries of health concern have expanded to include food and diet as part of health. By 2020 a vast range of “health foods”, vitamins and supplements are available and in high demand. Fitness centres have also expanded across Europe, and traditional spas have been revived to meet the needs of their new clientele. Many people have been helped to adopt healthier lifestyles by the development of the science of empowerment-based behavioural change. This emphasises the responsibility of the individual but clarifies choices and outcomes, while helping people to overcome their obstacles to change.

The role of the arts in medicine has also been appreciated, and music, painting and literature all play a role in humanising the experience of health services. And we hope theatre will play some part in bringing this message to life.

### Comparing the health systems of 2000 and 2020

There are many similarities between the health systems of 2000 and 2020, but there are also some important differences.

- Patients take greater responsibility for their own health and care, and are involved in treatment and care decisions. They face many more decisions, including options of various forms of additional treatment and care insurance. They use knowledge resources themselves and with patient advisers to help with these decisions.
- Patient/consumer associations play a much stronger role in monitoring quality and advising patients. They also help to channel local voluntary care.
- Poverty is still a major cause of poor health, problems of social exclusion being exacerbated by information exclusion.
- A higher proportion of health and care services are provided in the home or in the primary care setting, accounting for 35% of health costs (compared with 27% in 2000).
- Medical technology and pharmaceutical advances have accelerated, but developments are better targeted to provide cost-effective solutions.
- A higher proportion of costs is devoted to health promotion and disease prevention, including genetic screening, counselling, empowerment-based behavioural change and positive mental health programmes.
- Evidence-based medicine guides the development of health solutions and their application by clinical teams in primary and secondary care.
- Primary and secondary care are better integrated, working together according to agreed evidence-based guidelines. This results in greater uniformity of practice compared with 2000, when the referral rates of primary care doctors with similar patient communities would differ by some 250%.
- Professional boundaries have been reduced between patients and clinical staff, between doctors and specialist nurses and between professional carers and volunteers.
- Services are limited to those that can be shown to be effective. This is the main way in which services are rationed, although there are also some limits on very high-cost procedures and some age-related limits.
- The quality of treatment and care is much better. Long waiting lists are not considered acceptable, nor is it accepted that specialists offer private consultations because their public waiting list is too long. Junior medical staff are not expected to work excessive hours or to practise without close supervision by senior staff, either in person or by video link. The quality experience of every patient is monitored by patient/consumer groups.
- European health systems are quite similar in the way they work, with commissioning agencies working with primary care networks, even though there are still differences in the funding and structure of systems.
- Primary care forms the gatekeeper role for health services and guides patients through the health and care services.

- Hospitals provide the knowledge centres for the health care system. They are usually organised around emergency services and specialist units that bring together specialties with similar resource and skill requirements.
- Communication and information systems provide a seamless knowledge base for health and care. They are an everyday part of everyone's life.

### **Creating the future of European health and care**

This view of the future of European health and care reflects current trends and facts, and builds on experience of European health care systems and developments in primary and secondary care, medical technology and health information. But it attempts to look beyond the known facts by speculating on future changes and outcomes. It is inevitably a personal view reflecting the author's concern for global health issues and the patient/consumer movement, and indulging some fond hopes such as the demise of tobacco companies.

Projections of economic development and health expenditure are at best an informed guess. Nevertheless, it should be noted that, with an historically low rate of economic growth (1.5%) and an historically high rate of health cost increases (3.5%), health does not become "unaffordable to the state" as others have suggested. Indeed, it seems more likely that the private insurance-based health industry of the United States will become unaffordable to the economy. Thus, while some increase in private medical insurance may be prompted, this does not appear to be the answer to concerns about health costs.

Some have suggested that globalisation will solve the problems of poor countries, but the poorest countries will only benefit if subsidies to agricultural prices in rich countries can be reduced (in 2000 subsidies are €350 billion) and aid flows (€70 billion) are radically increased. In a world of rapid and general travel and trade, health threats know no boundaries. Thus for the sake of the health of Europeans, as well as the human rights of the poorest, there is no reasonable alternative to health aid – accepting that healthy people at least have a chance to contribute to economic development.

The main purpose of this scenario is not to forecast the future but to prompt discussion of how we may create it. Throughout the scenario, policy choices and decisions are referred to, but these decisions have not been taken yet and will not be taken without concerted agreement and action. Key European issues include:

- a European statement of patient/consumer rights and responsibilities;
- a European role in leading the debate on health aid and trade;
- Support for the European patient/consumer movement;
- European cooperation to assess potential health and environmental risks;
- a European approach to health and poverty;
- European health information rights;
- a review of European health rights of elderly people;
- European cooperation on cost-effectiveness of health solutions;
- a European approach to health screening;
- a pan-European study into the science of behavioural change;
- a European approach to the ethics of genetics;
- a European learning network for primary care development;
- a European hospital management learning network; and
- European health information standards and health skills.

Action is already being planned or taken in many of these fields with the support of WHO, the European Union or other leaders in thinking such as the Nuffield Trust. It underlines the important role that scenario-planning can play in creating the future.

## Part 2: The Dramatisation

### Narrator's introduction

#### *The European Union of 2020 is shaped by various forces*

- Globalisation has brought increased wealth and shared hopes, but has also deepened the divide between rich and poor countries. Will health trade and aid replace the arms trade as a major element of European foreign policy?
- The knowledge and communications revolution has brought instant access to knowledge and the ability to use it to improve health, but will it also increase exclusion and divisions between the knowledge-rich and the knowledge-poor?
- Will the expansion of the Union to include Turkey and many countries of the former eastern Europe create even greater differences in health and prosperity?
- The Union is prosperous (though with growth rates below those of the past 20 years owing to the need to invest in the expanded Europe and a growing problem of funding care for the elderly). Will we use our prosperity to improve global health or will we try to create “health fortress Europe”?

#### *European health and care systems of 2020 are facing important challenges*

- Patients take greater responsibility for their own health and care. How will they cope with these decisions, including options for types of additional treatment and care insurance?
- Patient/consumer associations play a strong role in monitoring quality and advising patients. How are these organisations supported and what new skills are required?
- Developments in genomics and medical technology can give greater emphasis to disease prevention and local treatment. How are developments evaluated and controlled?
- A high proportion of health and care services are provided in the home or in primary care, with more emphasis on health promotion and disease prevention. How is this motivated?
- Primary care performs the gatekeeping and commissioning role for health services and is better integrated with secondary care through evidence-based guidelines. How is it funded?
- Professional boundaries have diminished and new skill groups have emerged. What new skills are needed and how do we change existing roles?

Communication and information technology provide a seamless knowledge base for health care. They are an everyday part of everyone's life. Health remains the world's largest industry, followed now by tourism and communications.

From this we take our first scene, set in 2020 in a tropical temple that has changed little over the last 200 years – though the local people meeting there now wear designer clothes and watches...

**“The Tourist”**

**Narrator:** Here comes Tony, a European tourist. He is talking to his mother in Europe on a hand-held communicator, which is also a camera and computer connection.

**Tony:** Look at all this history Mum! (*points communicator at the room and diners*). I just did not think the place would be so interesting or so full of ancient relics. It's quite cool in here even though we're on the Equator. The people are so poor. Look at this beggar girl (*points at girl*).

**Girl:** (*coughs*) Udal kothikkerathu kaachchalaka erukkerathu anakku uthvungal (Tamil).

**Tony:** (*to communicator*) What is she saying?

**Communicator:** (*cheerful computer voice*) Please help me, I am weak and burning with fever!

**Tony:** (*not realising his communicator is still on*) I wonder why she has a fever?

**Communicator:** Fever may be associated with several tropical diseases ...

**Girl:** (*imitates communicator voice*) In this case tuberculosis.

**Tony:** But you can speak English!

**Girl:** Yes, and I have a nursing degree, but this doesn't stop me from being poor or hungry. I lost my job when I contracted TB because I tried to help my family.

**Tony:** That's awful – how can I help?

**Girl:** Just give me some money to help me buy the drugs I need ... And when you go home remember, we are just like you, even those of us who do not speak English. We drink the same soft drinks, watch the same films and TV in our village square, we *need* the same medicines and treatment but we cannot afford these drugs or even basic medical care.

I am dying because my mother, who first contracted the disease, did not know how to protect herself against infection and bought out-of-date medicines from her village store. We are dying of our ignorance and your neglect.

When will you Europeans help us fight disease? Like you help us to fight one another with arms and military support. Do we have to become fanatics before you take any notice of us?

**Tony:** I'm so ashamed, I just saw you as a statistic. You know (*switches on communicator*).

**Communicator:** #Average income €300 per year # life expectancy 40 years # spending less than €10 per head on health # Europe average income €36,000 # spending €3000 per head on health # average life expectancy now 80 years # health services are affordable in poor countries because # # # # # # # malfunction – this does not compute!!!

**Tony:** How could we? Why did we? Why didn't we help?

**Narrator:** Our tourist Tony went back with Fatima to her home village. What he saw there convinced him that something must be done. He went home to Mum determined to fight for health in the poorest countries.

**Narrator:** Several weeks later, back in Europe. Well-off people live in the knowledge age for

health, as we see next in this conversation between a health consumer of 2020, Clarissa, and her current partner, Peter. She has just spoken to her health insurance broker and is telling Peter about it.

### “The Knowledge Age”

**Clarissa:** So I said that, as my genetic profile shows, I only have a 3% risk of breast cancer before I am 75, so I don’t see why I need any additional insurance for cosmetic aftercare.

**Peter:** And what did he say to that?

**Clarissa:** Well he looked very confused and seemed rather cross with his communicator. He muttered something about fishing in the wrong gene pool and switched to the subject of diabetes risk. There he had a much better point about risk. He was talking about a new gene therapy option. But when I checked the knowledge base, communicator said there was no real benefit over the state-provided package.

**Peter:** Yes, much better to invest your time in positive health programmes. Why don’t you join the “Partners for Health” programme I belong to? It has increased my fitness levels, improved my ability to cope with stress and reduced my avoidable mortality risk by 31%.

**Clarissa:** You’re always trying to get me to join your patient/consumer programmes, but I’m quite happy with my health club. And it does mean that Jeremy gets to see his father George regularly, and Millie sees her father Zven there too, when he bothers to come.

**Peter:** That pain in the ... ouch! (*grasps knee*).

**Clarissa:** What was that?

**Peter:** I must call the Health Adviser about that pain in my knee (*gets out communicator*). Hi there, it’s Peter Prince here, Health Number PT7838, permission to access health file, level one granted.

**Health Adviser/Narrator:** How may we help?

**Peter:** I’ve been worried about a pain in my knee and wondered what to do about it.

**Health Adviser:** Can I take you through some questions? (*questions and answers follow*).

**Health Adviser:** From what you say there is a small but significant chance that this condition could require urgent treatment. We recommend you call in to see your doctor. Would you like to make an appointment ... Yes ... 3 p.m. ... fine. Thank you for using your Local Health Service!

**Clarissa:** Good, while you’re getting that seen you can give me a lift in to the Health Centre to talk to my Health Advocate about the complaint I raised regarding my last treatment.

**Narrator:** So the couple go that afternoon to the Health Centre. This provides a full range of local patient treatment services including Patient/Consumer Information Services, Local Care Services, Diagnostics Services and Day Surgery; there is even a live Doctor there.



**“At the Health Centre”**

**Narrator:** The Doctor in her surgery greets Peter the Patient.

**Doctor:** Good afternoon Peter. I hope it was not too painful getting here with your knee.

**Peter:** Hello Jane. It is very painful; now I can hardly walk.

**Doctor:** I understand from your call to the Health Adviser that this is getting worse and you have been feeling generally unwell (*holds up scanner*) and you have a high temperature.

**Peter:** Yes I feel really ill now but I didn't think this could be related to my knee. I looked up my last general health and genetic check and saw that there were markers for rheumatoid arthritis indicated, so I've been taking a herbal remedy I found on the Internet.

**Doctor:** Please do not believe everything on the Internet about health. A lot of it is rubbish and some of it is certainly dangerous. I don't suppose this was on a EuroQual marked site?

**Peter:** Sorry. Do you think it was the herbs that made me ill? I have a sample here.

**Doctor:** (*scans the sample*) No, nothing here but common grass. You could have got this from your back garden. I am more worried about the possibility of septic arthritis, so I've arranged a tele-consultation with a specialist from Sweden. I hope you're happy with this and can give permission to share your medical file.

**Peter:** Agreed. Health Number PT7838, permission to access health file, level two granted.

**Doctor:** Hello Lars. Can I introduce Peter? You have his file.

**Lars/Narrator:** (*appears on screen*) Hello Peter. We are just going to scan your knee and feel the swelling that I see.

**Doctor:** (*moves scanner around knee*) I think that gives us both a clear picture of the knee. I'll just feel around the joint with this sensor glove (*she and Lars both put on glove and feel. Lars's hand movements follow those of the Doctor*).

**Lars:** Yes, this seems fairly clear. Could we just check the white blood cell count and have a full microbiological investigation.

**Doctor:** (*presses scanner to Peter's ear lobe*) Yes, as we suspected. Do you agree Lars?

**Lars:** Yes, very clear. We need to proceed with some urgency. This is clearly septic arthritis.

**Doctor:** Thank you Lars. Well Peter, first can I say don't worry – we've caught this in time. Let me give you some details of your condition. I'll set up the information video in the next room, which will explain the condition, possible treatment options and outcome probabilities. You should note that I recommend the evidence-based treatment guidelines shown as option 1. We'll talk again when you feel fully informed (*they exit*).

**Narrator:** Peter was put on an immediate antibiotic regimen matched to his microbiological analysis and genetic profile. The following week he attended the Health Centre day surgery unit for an operation to clean out the infected joint. This was supervised by Lars, who had the use of remote surgery tools that would have enabled him to intervene if required.

**“The Patient Advocate”**

**Narrator:** Meanwhile, elsewhere in the Health Centre, Anthony the Patient Advocate was visited by Clarissa the Consumer. It seems she has met him before.

**Anthony:** Hello Clarissa. Good to see you again.

**Clarissa:** Hello Anthony. How are you enjoying being the local patient advocate?

**Anthony:** It has been a little strange at first, but I’m getting used to the balancing act. I report to the local Patient Council who are very supportive. Anyway, how can I help you?

**Clarissa:** I feel my patient rights have been ignored, and I hope you can help me.

**Anthony:** OK. Communicator. New file. Extract relevant notes of this conversation.

**Narrator/Communicator:** #Confirmed#.

**Clarissa:** Clarissa Good, Patient Number CG34268. During my recent treatment for migraine, I was not offered full information or the full range of treatments I was entitled to. This failure to provide best advice meant that I suffered unnecessarily for three months. It was only when I consulted the knowledge base myself that I found an appropriate treatment. Moreover, I found this treatment was recommended as a straightforward option under most of the nationally recognised evidence-based guidelines. I want to know why I was not offered the treatment or even told about it.

**Anthony:** Thank you, that’s very clear. There are of course many reasons why a doctor may not choose to follow general guidelines, though in general the doctor is obliged to explain why they are not being followed. Was any sort of explanation given to you?

**Clarissa:** The doctor said, “There’s a lot of this about. Try taking two aspirins, it generally works for me”. I asked for a tele-consultation with a specialist, who said, “There’s a lot of this about, have you tried paracetamol?” I felt that my condition was not being treated seriously. Eventually I was given a more thorough examination and tests, which confirmed serious persistent migraine. I now have a prescribed colour therapy treatment regime, which is the only thing that has helped.

**Anthony:** Perhaps you got off to a bad start with the clinical team. If you had consulted the Health Adviser telephone triage system before you came in this might have helped. I know some of the older doctors rather take offence when you ask to talk to a specialist at an early stage. And frankly, some doctors are rather sceptical about the colour therapy.

**Clarissa:** Perhaps they are, but it’s not their headache. I feel they should apologise.

**Anthony:** I’ll get both sides of the story and set up a conciliation meeting.

**Clarissa:** Goodbye. See you again I hope.

**Narrator:** No sooner has she left than the next patient is shown in. Mrs Molly Home is one of the many who seem to have missed out on the information revolution.

**“Care Options in 2020”**

**Anthony:** Hello, you must be Mrs Molly Home.

**Molly:** Yes. I come to ask about care. I’m getting so confused. I just can’t manage at home.

**Anthony:** So have you been using information technology to examine options and choices?

**Molly:** Wot?

**Anthony:** Oh I see, well perhaps I can help you to consider the options.

**Molly:** It’s up to you, anything you say. Couldn’t you just tell us what to do?

**Anthony:** No, I’m afraid it cannot work like that. These are issues only you can deal with. For a start we have to consider your objectives in life – where and how you wish to live. Then we can consider your health, care and social needs. And the resources you have, for example your housing, your skills, your social network. We also have to ask whether you have made any financial provision for your care.

**Molly:** That’s easy – no we haven’t. My son Norman has never been any good with numbers nor words neither, so he’s only had “low information skills” jobs, he’s never earned much and we haven’t got any savings. And of course I haven’t been able to work because of me weak lungs. Smoking is the only thing that clears them, though I know it’s supposed to be bad for me.

**Anthony:** And you don’t own your house?

**Molly:** Well yes I do, as it happens. It was passed to me by my father.

**Anthony:** If it were possible, would you like to continue to live there?

**Molly:** Oh yes. It’s just round the corner from the social club. I’ve always been a member and Norman does a lot to help people in the community.

**Anthony:** Well these are important resources. We should certainly try to find a way to offer you support in your own home before considering care. And if you do need to go into care you could consider how to use the value of your home to give you more choice for long-term care. Your local Patient/Consumer Association can offer lots of support for people, particularly if you are able to contribute care in other ways. All this information is available on the Internet.

**Norman:** Not if you can’t use it it’s not.

**Anthony:** Well that’s where I can help.

**Narrator:** So Anthony helped Mrs Molly Home to consider the options and choices for long-term health and social care. This involved “care swapping”, with Norman providing some additional care services to others while receiving support for his mother. Mrs Home also used the value of her house for extra care services. This could make things difficult for Norman, who will soon need care himself.

**“Dénouement”**

**Narrator:** Two more weeks pass, and Clarissa comes to see Anthony the Patient Advocate again. I am not quite sure why – perhaps we’ll find out!

**Clarissa:** Well hello again Anthony. I just came by to thank you for the help you gave me last time. I felt you really cared about me.

**Anthony:** Well thanks Clarissa.

**Clarissa:** Do call me Clary – You always used to ... remember?

**Anthony:** And please call me Tony. I hear your meeting with the clinical team went well.

**Clarissa:** Yes I felt much better about everything once they apologised. And when we got talking I could see they have a point. Perhaps my migraine was something to do with the stress I have been under.

**Anthony:** Stress?

**Clarissa:** Yes I wasn’t really happy with Peter. I’m always working and he’s so busy with the housework and that child of his. He gets stressed out too. It didn’t do much for our relationship I can tell you. The doctor said I should get more laid back ... at least I think that’s what he said. I thought, that’s where you might come in. Fancy a drink some time?

**Anthony:** Well great. I’ve been working so hard since I got back from my holiday in Asia, I must have seen two thousand patients in the last month. I’m feeling really exhausted and actually ill. It would be good to have some fun.

**Clarissa:** Hey, I don’t mean to be personal but if you’re feeling sick shouldn’t you check it out? You have used your Home Health Check surely?

**Anthony:** I’ve been meaning to, but it’s been on the blink and I never got round to it.

**Clarissa:** Well you can use my portable now if you like.

**Anthony:** That’s a really powerful machine. It has a Nanot inserter I see. Do you always carry it with you?

**Clarissa:** (*nervous laugh*) Well, I just thought ... never mind. I just “happen to have it with me”.

**Anthony:** I’m sure it’s nothing, but if it’ll make you happy (*puts finger on pad*).

**Narrator:** #Warning, positive identification of multidrug-resistant tuberculosis#. #Warning, positive identification of Vibrio cholerae Bengal 0139#.

**Clarissa:** Tony! (*runs off*).

**Anthony:** Clary, let me explain! (*runs after her*) ...

**Narrator:** Thank you for using Health Check 2020. Have a good day and thank you for listening to our scenes. I hope you enjoyed them and found some food for thought.

Thanks to the actors, Kenneth Michaels and Liz Rosa of *Heart of the Matter*, and to Dr Jessica Lister for medical input and for making the props.

**How to use the scenario**

Please feel free to use this scenario as the basis for encouraging participation in innovative health planning, free of any copyright restrictions. We ask only that you acknowledge its original author and, if you develop and improve it, send back a copy so that we may pass it on to others.

You will wish to revise the scenario to reflect national circumstances and issues. It is of course based on speculations about future trends, so you should make your own estimates and you may wish to bring in other changes, such as in the political and social environment and further health reforms. We suggest that you treat your revised scenario as a “base case”. Remember that the purpose of the scenario is to stimulate innovative thinking, so we suggest that it is a mistake to try to provide too much detail or invest too much time in this. This scenario and the accompanying scenes were produced in five days, though it is based on a lot of reading and experience. Leave the details to be filled in by the imaginations of the participants. You also need to keep it short, so that participants can read it in one sitting and keep the overall picture in their minds. We suggest you focus on the broad picture before drilling down into particular issues. You will wish to pose your own policy questions.

In planning sessions, you should encourage participants to challenge the base case and think about the main factors that could lead to alternative futures. As examples, you may wish to consider the impact of economic downturn or boom, faster or slower uptake of new technology, the rise of new disease threats, changes in the structure of civic society and family structures, or radical health and social care reforms. You could use a workshop to think through these alternative futures to give different scenarios. Alternatively, you may wish to introduce some of these radical changes as “wild cards” during the planning session. This will enable you to test policy options against a range of possible futures.

To generate ideas about the future you can use a range of techniques, such as encouraging participants to brainstorm ideas, using pictures to tell a story about the future or, as in this case, acting out scenes from the future. The scenes given here could be used as a starting point and you may then add additional scenes. For example, a health manager could discuss the social and economic case for an evidence-based protocol with suppliers, doctors and patient representatives, or the scene given here could be developed to illustrate other health problems of exclusion.

We strongly recommend that you act out such scenes and/or get the help of some actors rather than just treating this as a written exercise, as it will give you insights into how it feels to be involved in health care of the future. It is important to have fun with it, as playing with ideas is important to the creative process. The group of health policy specialists and academics from the WHO Regional Office for Europe and the Nuffield Trust certainly enjoyed the process, and encouraged us to publish the scenario and scenes so that others could make use of them.

Good luck with your scenario planning. We should be interested to learn of your experience.

## Responding to the Nuffield Trust/Judge Institute project on health policy futures: reflections in a WHO perspective

*Keith Barnard*

We cannot know what particular controversies will be generated in this meeting, but any good futures study will generate controversy. So, let it be said now that the Nuffield Trust/Judge Institute (NT/JI) futures study is an impressive achievement and we are indebted to the writers and synthesisers.

We need synthesisers to help us address the future. The consequence of specialisation in science is a compartmentalising of knowledge that does not mirror daily life or the decisions we have to make as individuals and institutions. We can only make use of this knowledge if it is synthesised to identify factors that will shape the quality of our lives.

The study has a particular value for WHO. This is (to my knowledge) the first attempt in the European Region to carry out a study that is a comprehensive attempt to look ahead and around in the health field.

Earlier efforts, such as the Swedish study on the elderly (“Time to care”) and the various studies of the Netherlands Foundation for Future Health Scenarios, have focused on possible and expected trends in specific sub-areas of policy and service development, rather than offering an integrated perspective on the whole health field.

The NT/JI study is a pioneering example of how one can use futures studies for health for all policy-making and for crafting HEALTH21 strategies. The detail given makes it especially useful for stimulating mutual learning between countries, which is a principal task of WHO.

Comparisons between the approaches of countries and communities to a given health challenge expand our awareness of the range of possibilities. For this purpose, the documentation this study provides is invaluable.

### **Issues for reflection**

I am not going to attempt a critique of the NT/JI study. I want to offer some thoughts prompted by what I have understood. The result is a mix of comments, questions and reference to what we have tried to do in the WHO Secretariat.

The issues that I think should be reflected on are the following:

- *the market for futures studies* – who are we selling to and what they want to buy;
- *the world of futures* – determining the frame of reference and the mind set of script writers;
- *the future of order* – how we organise ourselves as a society;
- *the mistakes of futures* – including seeing the future as a continuation of the present; and
- *the future of intelligence* – and how we might do it all better.

I said I wanted *reflection* on these issues. If I use that word excessively in its various forms, it is because that is my understanding of futures. It is not to rush confidently to judgement, but to reflect on where we came from and where we might and could be going.<sup>80</sup>

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80. The World Future Society, an independent non-profit body, puts it this way: “No one knows exactly what will happen in the future. But by considering what might happen, people can more rationally decide on the sort of future that would be most desirable and then work to achieve it”.

**The market for futures studies**

Reflecting on and reacting to the NT/JI study, two questions come to mind:

- What is the intention behind the product?
- How will people understand and react to that product?

***The object of the exercise***

A key decision in conceiving a product such as this is whether to offer one scenario, i.e. one set of assumptions describing a possible or a desired future, or alternative (two or more) scenarios. This depends on the intention, which could be:

- to unfold a path to be followed into the future, an explicitly or implicitly “desired future”, and therefore to influence the way people will expect the NHS to evolve (this is the “scenario with a message”, another approach to marketing);
- to identify a set of health and health care policy issues that the scenario writers judge need attention (“pedagogical scenarios” guiding recipients to what they need to do); and
- to “nudge” government policy in a particular direction by describing an expected future with implications, i.e. an intended input into present rather than more distant policy-making (“the seductive scenario” promising success to those who follow it).

Thus a related pertinent question is, “who is the primary target audience?” It could be:

- the wider community or some sets within it: the politically active, top managers and professionals in the health sector, those in leadership positions in different sectors and civil society generally (this means presenting an attention-commanding, plausible story or stories of the future);
- policy analysts and advisers within government who would (or should) expect to see the detail laid down transparently, so that they could recover for themselves the sequence from the selection of evidence, to the argument, to the conclusions (assumptions about the future) to the recommendations; or
- ministers who, given their limited attention span and absorption capacity (because of the pressures on them), will want simple succinct statements with a hard content and with clear relevance to decisions they will face in the short term.

***Pitfalls and constraints***

If the intention is to influence present policy-making, there is also a negative side. Since the story must be simplified, there is a self-imposed constraint not to open up too many issues. There is a temptation to be highly (not to say unduly) conscious of what message is likely to receive the most favourable reception. In WHO we are faced with a similar problem.

One of WHO’s objectives is to influence the ways people in the Member States see the future developing, focusing on desirable developments that should be encouraged. This is the visible end-point of the internal process that started with deciding what assumptions to make (which is when we start to apply futures thinking). We try to couch the message in terms that maximise its acceptability to all Member States.

The diversity of the Region lands us with a built-in dilemma that is perhaps not always recognised. The expectations and needs of our Member States can be quite different. This leads



us into choosing between approaches that should generate quite different products. Simply put, the choices are (a) stimulating imagination or vision-building by scanning the time horizon for possible futures (a range of scenarios); (b) giving a lead by proposing a policy direction; and (c) offering detailed guidance on policy implementation through what we believe are highly desirable strategies.<sup>81</sup>

We have not so far followed through on option (a) with a policy document that builds on “scanning the future”. (The dissemination of reports of futures consultations is more the sharing of information and ideas than policy development.) This is partly because we had signals from Member States that they did not want a policy document of that type. But it was also because the Secretariat felt it had a responsibility to deliver on (c), especially for the NIS and others without policy-making experience, while western European countries made it clear they preferred (b).

### **The world of futures**

Having settled the questions of object and target audience, we can consider the frame of reference, the scope and emphasis in our field of concern.

#### ***The functional frame of reference and the point of emphasis***

In WHO we have adopted what is in effect a standing agenda based on experience and scanning the future. This strikes a balance *between* health care, the health sector agenda of health services development, and “sustainable health”, an agenda of multisectoral and intersectoral action on health protection and promotion. In our presentation in HEALTH21, we put “sustainable health” first to emphasise the concept of health as everybody’s business.

This is a symbolic attempt to correct for the tendency in Member States, among politicians and public alike, to be concerned with medical services: how much they will cost in the future, how well will they perform, and how well will they meet the expectations of patients and voters.

An apparent difference between NT/JI and WHO can be found in the point of emphasis. In essence, a futures study can take as its principal focus the environment for health (prospects for the health for all agenda) or the environment for health care (e.g. prospects for the NHS). The point of emphasis in the presentation follows from the choice made between them. The crafters of the NT/JI synthesis and of HEALTH21 are clearly aware of this distinction, but seem to have made different choices in the point of emphasis.

#### ***The geopolitical frame of reference***

In WHO we have been concerned with the effects both on the European Region as a whole and on sub-regions such as CCEE and NIS. We need to look for trends and influences (“determinants”) and potentially significant new developments at different levels: supranational, national and subnational, and local. What are the effects of factors external to the health sector and to the remit of health ministries and administrations? How do they affect what would or would not be possible at each level?

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81. In 1980, for the initial framework health for all strategy, we chose in effect option (b). For our target documents in 1984 and in 1991, and with the concurrence of the Regional Committee, we chose option (c). In 1998, in HEALTH21, we combined (b) and (c) by producing two volumes: in the first we have a policy called an “Introduction”, which lays out the desired future and the issues to be addressed but does not proceed to the objectives and strategies.

We have recognised that we need to consider how the futures of other bodies and movements might affect the societies and economy of WHO's Member States, in terms of opportunities and constraints on social and other policy that could promote wellbeing. We have to reflect on alternative assumptions we could make about European regional organisations, especially the direction the European Union will take in the scope of its policy-making competence and the way decisions will be taken.

We should similarly look at possible futures for the United Nations family, both the specialised agencies such as WHO itself<sup>82</sup> and the Bretton Woods institutions (the International Monetary Fund and the World Bank), and for the multinationals and such institutions as the Soros Foundation for their impact on global society. These concerns, and assumptions related to them, find their way into the HEALTH21 targets, even if there is no sustained discussion of alternative futures in the text.

If WHO acknowledges its interdependence, and even dependence, Member States are presumably making calculations about how far the ship of state can and will sail on in cheerful disregard of weather conditions. The image of the ship of state that normally comes to mind is the Atlantic liner; but perhaps it is more plausibly a yacht in a flotilla, which demands a different kind of seamanship.

To change metaphors, in terms of John Donne's much quoted line, "No man is an island", we can also say that no country is an island. Politically and – with the advent of the Channel Tunnel – literally, this is as true for the United Kingdom as for any other member of the European Union.

What balance should be struck *between* taking the weather and the neighbours into account *and* focusing on internal political and other factors?

### **The future of order**

We should now move from a frame of reference to the ways and means of ordering our affairs as a society that we might adopt in future. These will have implications for the viability or sustainability of any desired future we attempt to create. We might call these the issues of governance, but there is a family of terms to reflect on; some might be synonyms and others might catch important nuances.

Notions of stewardship, stakeholding, mutualism, navigation, self-adaptation and other such terms could be explored in this context. Here, for convenience, governance is used as a general term to embrace a family of concepts.

### **The importance of governance**

There are a number of issues of governance, including the idea of public health infrastructure, to which we attach considerable importance in HEALTH21. Governance means how decisions are made and the overseeing of action, and who is involved and how. Whatever we can achieve in the future will depend on the form of governance that is in place, its efficiency and its responsiveness.

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82. One possible "weak" signal, which we might track, is the changing international stance of WHO since Dr Brundtland became Director-General. There is much more conscious, overt effort to do business with other IGOs, to court global economy players, and to be much more pro-active in WHO's constitutional international directing and coordinating role (e.g. the envisaged "tobacco treaty").

When we come to forms of governance, we all seem to be particularly challenged by the constraints of our perception of the present. Most of us take virtually for granted the constraints on the United Nations to fulfil the mandates of its Charter, the inevitability of sovereign nation states, and the preference for passive representative over active direct democracy, even at local level. Maybe we shall soon be rethinking the “who does what and how” questions.

### ***Levels and responsibility for action***

We have the Vatican to thank for the concept of “subsidiarity”, but it is the European Union that has given it political, and perhaps soon constitutional, significance. It seems accepted that there will be no further expansion of the European Union without changes in governance. Among other changes, there could be further elaboration of the concept of subsidiarity and new forms of its application. This could mean consequences within countries as well as within the machinery of the Community.

The word “subsidiarity” may not be much in evidence in WHO documents, but it has been in our minds: the most appropriate level for a given decision to be made. Although decentralisation is a fashionable philosophy, it may not necessarily be that it is always best; and despite the experience of the Soviet Union, centralisation may not always be wrong.

As one example, after the recent food safety crises it is reasonable to argue that aspects of food safety that are interrelated with the European Union single market should be handled at the supranational level. This in turn will have knock-on consequences for the scope and direction of national and local action.

What are the implications of subsidiarity for governance within countries? We can take as read that the governance of the health sector largely mirrors governance in public service institutions as a whole. What do we think will happen in the United Kingdom, or in Europe as a whole, if we continue with present “thinking inside the box”?

To the outside observer, the organisational characteristics of the United Kingdom health sector reflect the need for corporate control, supervision and regulation through a variety of devices, and close performance monitoring – all necessary features of a politically accountable national service. Such approaches might be expected to create tensions between the controllers and the controlled, who desire operating freedom.

### ***Order and the health sector***

The observer then asks: will this and similar corporate systems survive till 2015? And will its managers at all levels still be concerned with achieving ministers’ performance targets, with living within available resources and with meeting public expectations?

To answer the point in other terms: opinion poll ratings, falling unemployment rates or a rising stock market index may not be good indicators of confidence in our governors or the system of governance. A transformation of our present concept of democracy would lead us into completely uncharted waters. The Open University’s futures project,<sup>83</sup> with confidence in

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83. The Millennium Project of the Futures Observatory was run by the Open University with the Strategic Planning Society and the think tank Demos. According to its Web site, its “predictions are the most accurate (*sic*) ever made. They come from a four-year study involving over a thousand of the world’s largest organisations. It describes in graphic detail the future you will soon encounter”. Available as a book, *Future revolutions* by David Mercer, published by Orion Business.

its predictions, foresees the end of political parties.<sup>84</sup>

When in the former Soviet Union the old certainties started to give way in *glasnost* and *perestroika*, people in the Baltic states started to challenge central power. They no longer felt bound by the old rules and assumptions. I find something of a parallel when I hear young people in a Swedish television documentary, saying on camera in a country that prides itself on its political participation: “we do not have democracy in Sweden, voting is not democracy”.<sup>85</sup>

They are also not prepared to play the old political game by the old rules. Some see the future in information technology, as the new way in which people connect to one another, exchanging information and building consensus on a mass scale that will generate the drive for action.

How might the system adapt? If we are serious about subsidiarity, we might look at the thinking being applied to the science of complexity and borrow from biological systems the notion of “organising simply for complexity”.<sup>86</sup> If this track is followed, it is likely that the importance of values<sup>87</sup> and notions of coordination, reciprocity and trust will be dominant.

Of course, that may be possible only if there is a fundamental change in political culture, which currently expects power to emanate from a strong centre in a context of confrontational politics and the assumption of an available alternative, the Opposition, as a “government in waiting”. We must not underestimate the strength and resilience of an existing culture, but “government by negotiated agreement” could be an alternative. We have long seen something similar in the Netherlands and other countries. We may be seeing the first weak signals of a new political culture in the United Kingdom, in devolution to Scotland and Northern Ireland.

### ***Governance and primary health care***

There is also a specific link with primary health care, going back to the Alma-Ata concept with its emphasis on individual and collective involvement and on finding means for intersectoral action. How much can be conventional “top down” and formal inter-organisational negotiation, and how much should it be by direct participatory forms of local democracy?

This challenge was brought out even more clearly in the Ottawa Charter with its concepts of enabling and empowerment, whereby people have a sense of the “locus of control” being within them; and with its identification of strengthened community action as an imperative. None of this fits easily with conventional party-dominated democracy.

84. Richard Clutterbuck, in *Britain in agony: the growth of political violence*, asserts: “We can no longer afford the party game in which nearly 50% of our elected MPs have no better aim than to ensure that the government of the day fails to solve our problems – a game which causes increasing public exasperation and contempt for parliament”. The essential point is still valid. The engagement of the general population with the political process continues to decline if we take as indicators participation rates in elections or party membership.

85. This is currently a hot issue in Sweden. The ruling Social Democrats are beginning to acknowledge a crisis. Party activists are aging. The Social Democrats have lost significant membership in the last decade, but so have parties to the “right” of them. Only former Communists and Greens have shown an increase, both from a small base, and not on a scale that matches the others’ losses.

86 CHURCH, M. Organising simply for complexity: beyond metaphor towards theory. *Long range planning*, **32**: 425–440 (1999).

87. The NT/JI report rightly points to the problem of value conflicts between different interests as an obstacle in settling on a policy choice. WHO’s Member States have adopted a set of values that underpin health for all and can be traced back to WHO’s Constitution. One can be cynical about such pledges, but they give WHO a mandate to act as the world’s health conscience and to press the issue in dialogue with countries.

Alma-Ata and Ottawa are symbols of a sane future world that some of us still hope for. They require action at all levels. After Rio and the other summits of the 1990s, we should like to see the family of United Nations agencies given the tools to fulfil the mandates of the Charter. We are still looking for signs that the paymaster Member States really see it in the same way. No doubt they have their reasons and excuses for their hesitation. It is difficult to foresee one natural path that the course of events might take.

Why should states whose sovereignty is under challenge by global economic influences, and affected by membership of the European Union as a supranational institution, concede more power of initiative to international bodies?

But how does it look to an international organisation? WHO works in, and is supported by, the formal structure of sovereign states and agreements reached under international law, and under the terms of its Constitution agreed by its Member States. The policy implemented by the Secretariat is that agreed by the Member States in the governing bodies.

We need to appreciate that WHO policy is profoundly counter-cultural beneath its unexceptionable packaging. At the same time, respecting the conventional interpretation of the Constitution, the Secretariat is very circumspect in its activities in countries.

The paradox is that implementation of the policy – the continuing promotion of primary health care – could lead it to encourage less conventional or orthodox forms of governance as a prerequisite for the success of the policy. The consequence could conceivably be a policy success achieved by radical change in countries that Member States would be unable to control.

### **Mistakes of futures**

Having started to speculate on the future, we need to remind ourselves how problematic a task speculation is. The possibilities for errors seem countless, but two stand out. We assume unquestioningly that the frame of reference that we first adopted as appropriate or useful remains valid. We also assume that the strength of the trends of the recent past and the present point inexorably in the same direction.

### ***Frame of reference and the possibility of error***

In WHO we will be as guilty of error as anyone else if we are found to be wrong in staying with our existing frame of reference in identifying the themes we asked our keynote speakers to address during this meeting.<sup>88</sup> We think we have been sensitive and imaginative in believing that these would generate the most fruitful speculations on how we should take HEALTH21 forward. But an element of suspicion must remain that these may not be the principal or only issues we should review.

That element of suspicion is an admission that we cannot stake a unique claim to foresight. President Woodrow Wilson made the point when he said, “I not only use all the brains I have, but all those I can borrow”. So there may be value in looking at other people’s scenarios, such as:

- *OECD Future Trends 5: information base for scanning the future;*<sup>89</sup>

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88. The macro-geopolitical environment; new alliances for health; the future of health and work; and values.

89. The database covers economic development; energy and the environment; finance and investment; international relations; industry, technology and society. It includes full texts of reports prepared for OECD’s Forum for the Future.

- The United Kingdom Economic and Social Research Council's *Britain towards 2010*;<sup>90</sup>
- European Commission Forward Studies Unit's *Scenarios Europe 2010*;<sup>91</sup> and
- Millennium Project of the Futures Observatory (with a time horizon of 2025).<sup>92</sup>

The reason for looking at other bodies' scenarios is not to judge which of them is better than ours (which may not be a meaningful question), but to see whether they offer other perspectives or insights, which stimulate fresh thinking and reflection in ourselves.

### ***Learning from failure***

We might note that while we may be encouraged if other futures studies use a similar frame of reference and we all craft similar scenarios, we may all be wrong, defeated by events in the end. Events will continually either open up or constrain possibilities for decision-making to attempt to influence the future.

A helpful and reassuring contribution pointing the way in futures work has come from Chatham House, the Royal Institute for International Affairs. Chatham House is developing a scenario for 2015. In a paper related to that work, Ringland *et al.*<sup>93</sup> offer an interesting review of what they have found, focusing on the failures of organisations to learn, adapt and anticipate the future. They make two key recommendations: to produce not a single forecast but alternative scenarios, and to repeat the exercise at intervals. "Most forecasts get things wrong and all assumptions are steadily going out of date."

So repeated studies at intervals are indicated, to test how far our assumptions are holding up, for assessing the possible importance of new factors and phenomena (such as technology developments or changing fashions) or for spotting weak signals and early warning signs. This is what we have been trying to do this last decade in the Regional Office.

The failures catalogued by Ringland *et al.*, which includes misjudging the influence of different actors and factors, has four types of error now current:

- not recognising the changing role/"comparative retreat" of government;
- over-optimistic time scales<sup>94</sup> (some now discredited forecasters, such as the Club of Rome, may be right eventually, but they got their time scale wrong);
- loss of faith in our ability to deliver continual progress; and
- the increasing difficulty in making assumptions about human behaviour.

Their observation about anticipating change in human behaviour may be the most crucial. They suggest "this puts a high value on our ability to question and adapt".

However skilled we may be in scenario writing, we cannot anticipate what people will expect in 2015 in terms of public services or any consumer goods with a health dimension. Nor can

90. *Britain towards 2010: the changing business environment* (<http://www.esrc.ac.uk>).

91. A set of scenarios now in the public domain to elicit comment from outside interests as part of "the ongoing reflection on the future of European integration, both within and outside the Commission" and "of specific Community policies" ([http://europa.eu.int/comm/cdp/scenario/index\\_en.htm](http://europa.eu.int/comm/cdp/scenario/index_en.htm)).

92. See footnote 83.

93. RINGLAND, G. *ET AL.* Shocks and paradigm busters (why do we get surprised?) *Long range planning*, **32**: 403–413 (1999).

94. A subset of this issue is the time lag between the creation of a possibility and its acceptance, e.g. the time between a product of research being reported in the scientific literature and its economic exploitation. Naive futurists tend to ignore economic realities and assume that every technical possibility will be quickly taken up.



we be sure what their responses will be to wider questions of public policy and policy-making – in short what will be acceptable and unacceptable.

We should also be aware that, unless we make a huge effort of imagination, we are all stuck with perceptions of the future firmly rooted in our perceptions of the present. Among the reasons for the failure to anticipate cited by Ringland *et al.* were:

- the “tyranny” of the present mental model; it cannot contemplate anything different; it is impervious to new thoughts and it is well able to repel contrary views; and
- not understanding the organisation’s own assumptions, believing them to be “facts”.

### **Breaking out of the tyranny of the present**

There is a view held by some futurists that we should put more effort into developing “what if” scenarios that consciously assume discontinuity or a breakthrough that is not yet on any “responsible” expert’s horizon. Thus we might:

- suppose that there were breakthroughs in research and development, making it possible to plan services and support for the elderly as if the compression of morbidity thesis were valid; or
- suppose that the third world strikes back: a new ideology mobilises the populations of developing countries; there is a demand for recycling wealth from north to south and the means for enforcing it.<sup>95</sup>

We might then also reflect on recent events. How do we read, in a futures perspective, the recent multiple discords in Seattle, the so-called city of globalisation? Did we see the tide turning; could it lead to any rethinking about global governance, the International Labour Organisation, the World Trade Organisation and other United Nations bodies? Or will it soon be seen as another of the footnotes to history as we find confirmation that, after the death of Marxism, “there is no alternative”?

If we do not accept this current wisdom, we could ask what different futures continuing xenophobic nationalism and fundamentalism would produce for the global economy. Or what could follow from a presently unforeseen transformation of United States politics sparked by a black-Hispanic alliance.

We could also ask what the implications would be if a global health-promoting movement of determined, sane and humanistic NGOs were to emerge; or even an effective international trade union movement of knowledge workers ready to pursue a health agenda.

### **The future of intelligence**

Whatever our limitations of insight and foresight, we can think about the future in a rational way (meaning with a purpose in mind) by using “intelligence” in both senses of the word. We need to put together the best possible picture of where we are now and the signs of what might be ahead. This is the intelligence-gathering function. We need to assess this intelligence in an intelligent (rigorous and imaginative) way.

### ***Using intelligence to prepare intelligently for an unknowable future***

The future is literally unknowable (we only see after the event that a forecast or an expectation was prescient); the past (how we got to where we are now) is largely knowable and is understood in terms of our present frame of reference and values.

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95. We might take as an inspiration William Clark’s future documentary novel *Cataclysm: the North–South conflict of 1987*.



The present is partly knowable and partly understandable, again within our frame of reference and values. We do not necessarily appreciate the significance of what we know, but the intelligence-gathering function enables us, by reflection, to make an honest attempt.

Let us assume we can use our partial understanding of the present to think about the future, for creating a vision of 2015 or thereafter and shaping policy to achieve it. After all, the present is the point of departure, either to build on or to set about changing.

In our internal working draft *Learning from the past, preparing for tomorrow's realities*,<sup>96</sup> we set out two possible futures to focus on the implications of acting or not acting on certain issues and opportunities. We called them “muddling on” and “as though development really mattered”. We might have called them the “low road” and the “high road”. We can call this approach “the fork in the road”.

This is not because we actually have a simplistic bipolar view of the future. Rather, we try to stress the breadth of different possibilities. The probability of any of them happening hinges in part on which of the ideas now in currency will be pursued, and which will soon be discarded in favour of ideas and behaviour yet to emerge. Since this is something we cannot know, we must keep tracking the “current wisdom” and attempt to spot the first signals of change.

### ***The way ahead?***

We need to be aware of three entities:

- the nature of the vision of the future we want to have, with the emphasis on values and principles rather than specific developments (we should recognise that people's behaviour and expectations may change);
- the assumptions we make (how the future will play out from where we are now) when we move from writing scenarios to settling on a course of action; and
- the constraints we impose on ourselves by the decisions we make, in so far as we change the range of options for future decision-making.

It used to be said by its more reflective practitioners that planning was about making as few decisions as possible now (only the essential ones to set in motion action towards a goal) because decisions about the future are best made in the future. Let as many as possible be made there. As Henry Mintzberg has put it: “Sometimes strategies must be left as broad visions, not precisely articulated, to respond to a changing environment”.

The emphasis on futures studies and scenarios as histories or news of the future does not negate those maxims. The language now coming into currency is of the “kinetic enterprise” (analogous to kinetic energy), whose members, recognising what they cannot predict, are ready with hair-trigger responses, constantly evolving to meet the unpredictable future. We might reflect whether that is the kind of institution we need in our field, and if it is feasible.

In any event, we should endeavour to ensure that nothing we do in the short term makes the long-term hopes more difficult or impossible to realise. We need to think more clearly, to find the way to link our short-term decisions with the medium and long term. We should take no steps that we might reasonably suspect would jeopardise the social coherence of society and

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96. See Appendix 1 to *The use of “futures” in European health for all policy development*.

the wellbeing of the population. This is another reason for steadily rolling forward our futures study.

***Working in our own best interest***

Perhaps we need to be more committed to seeking consensus about the nature (not so much the details) of a vision of the future. This need not mean that we succumb to “group-think” in which no-one dares challenge received wisdom. We can still debate, vigorously if need be, how best to beat a path to the future – but probably not through confrontational politics, which already seem to some observers to be alienating the next generation.

We can best serve our own interests as a society:

- if, when faced with a picture of the future such as that provided by the NT/JI study, we keep our minds open and use it to further explore possibilities, i.e. it becomes an occasion for reflection on the future;
- if we can shake policy-makers out of the comfort of current assumptions and ways of responding to challenges and pressures;
- if we keep our sensors active, scanning for early warning signs and weak signals; and
- if we can build broadly based awareness of the significance of acting or not acting on the issues we have judged demand our attention in our scan of possible futures.



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