



Opportunities for scaling up and strengthening the health-in-all-policies approach in South-eastern Europe

Abstract

As an approach, Health in All Policies (HiAP) has been recognized in major European resolutions, charters and communications, treaties, frameworks and action plans.

This report aims to gauge opportunities for scaling up and strengthening a HiAP approach in 9 of the South-eastern Europe Health Network (SEEHN) countries. It is based on a review of materials prepared by SEEHN member countries' representatives for the Third Health Ministers Forum, "Health in All Policies in South-eastern Europe: A Shared Goal and Responsibility". An overview is followed by detailed country-specific studies of current policy, and challenges, opportunities and recommendations for strengthening HiAP.

Adopting a HiAP approach is an effective approach to addressing the root causes of ill-health and improving equity in the region. Firstly, at a time of economic crisis, it is economically sensible to pool resources with other sectors to address common challenges, secondly, it demonstrates how improving health contributes to the attainment of wider objective such as poverty reduction, inclusive growth and community wellbeing, thirdly it can improve the performance of health and social care systems and make them more sustainable.

Across the region there is strong political will to support HiAP, progress is being made to strengthen instruments and capacity and examples of promising practice exist. The SEEHN offers an opportunity to build on existing work, .share learning to date and strength action for health and development with other sectors. There is however, more work to be done to scale-up and improve the capacity and performance of HiAP in the region. Areas for action include a stronger focus on equity and systematically addressing the determinants of health, improved systems of intelligence for health and social care systems and further training and instruments for policy makers and health professionals. This work must be supported by continued political and financial support and further development of networks for implementation.

Key words

PUBLIC HEALTH
HEALTH INEQUITIES
HEALTH IN ALL POLICIES
INTERSECTORAL COOPERATION
HEALTH BEHAVIOUR
HEALTH IMPACT
CAPACITY BUILDING
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Executive summary

HiAP in South-Eastern Europe

As an approach, Health in All Policies (HiAP) has been recognized in major European resolutions, charters and communications, treaties, frameworks and action plans, and the approach will be an important goal of the new European Policy for Health, *Health 2020*, and the European Action Plan for Strengthening Public Health. HiAP was selected as the focus of the Third Health Ministers' Forum of the SEEHN.

This report aims to gauge opportunities for scaling up and strengthening a HiAP approach in 9 of the SEEHN countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, Republic of Moldova, Romania, Serbia and The Former Yugoslav Republic of Macedonia). It is based on a review of materials prepared by SEE Health Network member countries' representatives for the Third Health Ministers Forum, "Health in All Policies in South-eastern Europe: A Shared Goal and Responsibility". The report takes account of the political, social and economic aspects of each country, and then analyses the policy frameworks, mechanisms and tools available for HiAP approaches, as well as the information available for advancing HiAP and capacity building to support them in the future. An overview is followed by detailed country-specific studies of current policy, and challenges, opportunities and recommendations for strengthening HiAP.

Agreed terms and concepts

Countries may use different terms to refer to HiAP, and terms may be conceptualized differently. It is necessary to agree on the frameworks to be used, the common terms and concepts and the criteria for the assessing process. One aim of this study has been to agree on definitions and language, so that experience and evidence accumulated in south-eastern Europe can be used in all regions and by all countries.

Addressing the social determinants of health and equity

A HiAP approach recognises the importance wider social, economic and environmental factors have on our health. Inequalities in health are rooted in the social determinants of health, that is, the conditions in which people are born, grow, live, work and age, including the health system. They are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy and governance choices. The European Policy for Health focuses on many of the themes and issues that are at the core of the Health in All Policies approach and underpin actions to address health inequities. It identifies how health and well-being can be advanced, sustained and measured through actions that enable improved and fair daily living conditions and result in healthier environments, social cohesion, security, work-life balance and good education.

Most countries in the region have falling populations, with positive annual growth rates in only three of the nine countries. The leading causes of mortality and years of life lost in all countries are non-communicable diseases, which reach over 80% per cent of years of life lost in most countries, and in the two countries where it is slightly lower, there is a high rate of life years lost through accidents. Infant mortality has declined in all countries, but only three countries have single-digit rates per 1000 live births. There is a strong link between these current health challenges and the social and economic conditions within counties, where the effects are mediated (amplified or mitigated) by prevailing norms and values in society. This has a major impact on health equity within and between countries.

Countries have different approaches to addressing health equity. Many small scale, time limited projects exist but understanding what works and scaling up action to sustain impact remains a challenge. Macro policy approaches vary from those that seek to provide social benefits to the entire population as a basic right, while others target specific social groups or territories and use means tests to determine eligibility. This is the most commonly used approach. Such groups can be those on low incomes, children and women, the socially excluded and groups with greater risk of certain health problems. The main social determinants are access to appropriate and affordable health services, education and social protection, poor quality and affordable living conditions such as housing and

water sanitation, limited income and employment opportunities and discrimination. These in turn strongly influence lifestyle opportunities and behavioural choices as well as levels of social cohesion.

Policy-making systems and structures

Information on the administrative and political organization of the country can identify whether there is current integration of health and wider policy. Understanding the organization of the government and the formal and informal social participation and coordination of the whole government is important for identifying opportunities and possible barriers with respect to a HiAP approach.

Existing cooperation exists across the region. Education, followed by social protection, was identified as having good or very good relationships with the health sector in eight of the country studies. Positive intersectoral relationships were cited with employment and environment in six of the studies. Effective relationships with the agricultural sector were cited in five of the nine country studies, yet some countries with comparatively large rural populations have indicated low levels of cooperation with agriculture. Studies suggested that the ministry of finance is a particular sector with whom countries reported a need for cooperation but where it is currently underdeveloped.

Policy frameworks in the countries present a diversity of opportunities for multi-sectoral activities. Several countries identify their recent national and local planning and development plans as HiAP development opportunities. There are many strategies directed at particular groups or issues that provide a basis for intersectoral responses. Across the SEEHN countries these include plans related to gender equity and/or domestic violence, poverty reduction, social inclusion and the Roma minority, early child development, the environment, climate change, agriculture and illicit drugs. All countries emphasize how regional and international developments in HiAP influence opportunities for scaling up HiAP actions in SEE, underlining the importance of support by the European Commission, WHO and other multilateral entities.

Multi-sectoral working groups, such as the Joint Planning Mechanism, are present in most countries, mainly associated with specific ad hoc targets or issues. Most of them have a time-limited duration and their composition varies according to the discussed topic. The second identified mechanism is joint assessments, which are associated with specific plans or programmes, for example in the assessment of the poverty strategy in Serbia, the assessment of the *National Strategy for Drug Abuse Prevention* in Croatia, and the assessment group for *Road Safety and Domestic Violence Prevention* in the former Yugoslav Republic of Macedonia. A third set of mechanisms identified are formal structures, whether at the cabinet or parliamentary level. Three of these, national councils, parliamentary committees, and public policies units, are described in this report in greater detail.

Challenges, opportunities and recommendations

The country case studies highlight challenges and needs in order to advance the HiAP agenda in SEE and can be grouped in the following areas:

- more facilitative policy frameworks and legislation
- regional and national support for designing components of monitoring and assessment
- training for public health teams and decision makers
- HiAP research to produce evidence for debate and advocacy
- exchange of experiences among countries
- more information for decision-makers on the benefits of intersectoral action
- convincing arguments for convincing other sectors.

Opportunities for development

Using health information to support HiAP

While there are generally reliable data on demographic trends and morbidity and mortality, studies showed that none of the SEEHN countries had the ability to regularly monitor health outcomes according to socioeconomic indicators such as income, education, occupation, gender, rural/urban setting, household size, migrant status and, if permitted by national law, ethnicity. Existing socio-

economic data come from specific studies or surveys, and hence their collection is not an integrated part of the national information systems. This limits monitoring of interventions and assessments of non-health sector policies on health. It also restricts the capacity of public health ministers and professionals to implement evaluate and advocate effective policies and interventions which target the underlying social and economic causes of health and health inequities.

Very few countries use impact assessment methodologies that affect health or health equity. Environmental Impact Assessment (EIA) is a frequently used methodology, but it does not directly cover health issues nor routinely consider equity dimensions. Studies report on policy outcomes but indicate a limited use of formal health impact assessment (HIA).

Training and education

There are no regular dedicated programmes to build the capacity of policy makers, advisors and public health professionals to use HiAP in any of the countries. Training in social determinants of health takes place in only one SEEHN country and courses on impact assessment methodologies exist in only one country. Most countries indicate that HiAP is not incorporated into undergraduate, graduate or continuing professional education for health professionals.

The studies note the scarce economic and human resources available for the development of these initiatives. However, times of crisis can provide unique opportunities for coordinating and integrating related policies to improve efficiency and resources, while making changes for greater health equity.

Increase focus on determinants of health

Health sector efforts to reduce inequality in the region largely focus on improving access to health services. Several of the strategies do emphasise prevention and promotion in health services. However, focus on health services alone misses opportunities for the health sector to impact on the wider determinants of health.

Summary

Adopting a HiAP approach is an effective approach to addressing the root causes of ill-health and improving equity in the region. Firstly, at a time of economic crisis, it is economically sensible to pool resources with other sectors to address common challenges, secondly, it demonstrates how improving health contributes to the attainment of wider objective such as poverty reduction, inclusive growth and community well being, thirdly it can improve the performance of health and social care systems and make them more sustainable.

Across the region there is strong political will to support HiAP, progress is being made to strengthen instruments and capacity and examples of promising practice exist. The SEEHN offers an opportunity to build on existing work, share learning to date and strengthen action for health and development with other sectors. There is however, more work to be done to scale-up and improve the capacity and performance of HiAP in the region. Areas for action include a stronger focus on equity and systematically addressing the determinants of health, improved systems of intelligence for health and social care systems and further training and instruments for policy makers and health professionals. This work must be supported by continued political and financial support and further development of networks for implementation.

Summary of country recommendations

1. A need to prioritise public health and wider determinants of health in order to ensure continued political support for improvement and implementation
2. A need to develop and utilise existing indicators and statistical systems for monitoring health, including increased use of tools such as Health Impact Assessment.
3. Establishment and strengthening of networks at all levels, international, national and local, across all sectors and agencies to implement Health in All Policies.
4. Increased training and education for health professionals to improve knowledge and skills in HiAP methodology, and to retain staff in the health sector.
5. Secure funding for HiAP and public health, taking account of the wider determinants of health and reflecting the political support for HiAP across the SEEHN countries.
6. A comprehensive research agenda to build evidence relevant to the SEEHN countries which can guide regional policy.

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Acronyms

ART	antiretroviral therapy
ASPHER	Association of Schools of Public Health in the European Region
CCM	country coordinating mechanism
CVD	cardiovascular diseases
ECEH	WHO European Centre for Environment and Health (Bonn office)
EIA	Environmental impact assessment
EU	European Union
EU10	the 10 countries that became EU Member States in 2004
EU15	the 15 EU Member States prior to 2004
FBIH	the Federation of Bosnia and Herzegovina
FCTC	Framework Convention on Tobacco Control
HIA	health impact assessment
HiAP	health in all policies
IA	impact assessment
ICD	International Classification of Diseases
IMR	infant mortality rate
INSTAT	Institute of Statistics of Albania
LSMS	Living Standards Measurement Study
MDGs	Millennium Development Goals
MICS	multiple indicator cluster survey
MPH	Master of Public Health degree
NEHAP	national environmental health action plan
NCD	noncommunicable disease
NGO	nongovernmental organization
OPRD	Operational Programme on Regional Development
PHARE	(EU pre-accession instrument)
PHC	primary health care
PRS	poverty reduction strategy
RAE	Roma, Ashkali and Egyptian
RS	Republika Srpska
SDH	social determinants of health
SDR	standardized death rate
SEE ^a	south-eastern Europe
SILC	Survey of Income and Living Conditions
TAIEX	Technical Assistance and Information Exchange
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

^a The ten countries of South-eastern Europe that belong to the SEE Health Network are: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Israel, Montenegro, Republic of Moldova, Romania, Serbia and the former Yugoslav Republic of Macedonia.

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Foreword

This publication helps to support the implementation of Health 2020, a key pillar of which is strengthening public health services and capacity, as described in the European Action Plan for Strengthening Public Health Capacities and Services. Both Health 2020 and the Action Plan were endorsed by the WHO Regional Committee for Europe in September 2012.

Today all countries face re-emerging and new health threats, both local and global, including rising rates of communicable and noncommunicable diseases. The latter now account for the majority of avoidable years of life lost. These health threats are associated with environmental, economic and demographic shifts and socioeconomic factors (such as income, employment, housing, education and health and social protection systems) that shape lifestyle opportunities and choices. Public health services focused on health promotion and disease prevention are an ever more important tool in combating health threats, along with public policies that address the root causes and consequences of ill health and health inequalities. Nevertheless, in the past two decades both public health as a discipline and public health services in Europe have faced unprecedented challenges.

Public health in the countries of south-eastern Europe (SEE) has undergone extensive reform. If the aims of public health are to be achieved, policy and services must address the underlying causes of ill health and health inequalities. They must work with all sectors of government and all sections of the economy and society. This report examines the current status of the health-in-all-policies approach – which European Union and WHO health strategies aim to promote – in the nine SEE countries. It identifies challenges and opportunities for incorporating this approach in strategies, plans and programmes to address the determinants of health, and recommends the next steps to take.

This report reviews health-in-all-policies initiatives in the SEE countries and is part of a broader process of regional cooperation in health through the South-eastern Europe Health Network, which celebrated its tenth birthday in 2011. An earlier version of the publication featured in a background document prepared for the Third Health Ministers' Forum – Health in All Policies in South-eastern Europe: "a Shared Goal and Responsibility", held on 13–14 October 2011 in Banja Luka, Bosnia and Herzegovina.

All countries in the WHO European Region face new challenges in public health. Population ageing and the large share of the disease burden accounted for by chronic noncommunicable diseases pose many challenges for health and social services. A key question for public health is to what extent the increased life expectancy in the Region comprises years spent in good health and places a burden on health systems and finances. Research shows that both life expectancy and healthy life expectancy are increasing.

Europe also faces the challenge of both wide differences in health threats and disease burden among countries and significant health inequities (unfair health inequalities) in all countries. The recognition that health and health inequities are rooted in broader social factors is being seen as a basis for understanding health as a social phenomenon, not just an individual or epidemiological one. Despite the growing resources devoted to the health sector in some countries, health gaps among groups within society are significant and in some cases growing, and display a marked social gradient.

All of these challenges imply the need for a broader approach to protecting and promoting health, preventing disease and systematically considering equity in health and other policies. Health is affected by activities outside the health system itself. It is a vital part of public health that health

ministries and other responsible actors advocate, lead and support selected intersectoral actions; and create incentives to sustain collaborative work to improve policies that lie outside their direct control but bring benefits to many sectors, including health. This may include action in such sectors as education, transport, labour and various regulatory bodies, energy and the environment. The intersectoral, multiple-setting dimension of the delivery of public health services is an essential component of health promotion and disease prevention. Intersectoral action is therefore recognized as essential to the effectiveness of public health action to prevent disease, promote health and reduce health inequities; this increases the attention paid to a health-in-all-policies approach to tackling major health challenges in Europe today.

The involvement of non-health sectors is important because they can take action that undermines health. An important tool at the disposal of policy-makers is assessment of the impact of these sectors' policies on health: the health impact assessment (HIA). Increasingly incorporating an "equity lens" into HIA can help to ensure that government policies and actions do not contribute to deepening health inequities, and may highlight how they may contribute to improving health.

Health-sector actors must make the case for the other sectors' taking health into account when making policies, and exert influence (coordinated with partners) by collaborating and building coalitions across and outside government sectors to advocate the health-in-all-policies approach, attain public health goals, promote initiatives to improve health and address important social determinants.

Cooperative work within the European Region seeks to meet these challenges by sharing information and developing joint approaches to common problems. This report and the project it describes seek to review intersectoral cooperation in the SEE countries and identify ways to scale up and strengthen the use of the health-in-all-policies approach.

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Introduction

The purpose of this report is to review *health in all policies* (HiAP) initiatives developed by member countries of the South-eastern Europe Health Network (SEE Health Network) and to identify entry points and next steps for scaling up and strengthening HiAP in south-eastern Europe. An earlier version of this report featured in a background discussion document to the *Third Health Ministers Forum on Health in All Policies in south-eastern Europe: A Shared Goal and Responsibility, 13–14 October 2011 in Banja Luka*. The SEE Health Network countries are: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, Republic of Moldova, Romania, Serbia and The former Yugoslav Republic of Macedonia.

The report begins with an explanation of key concepts for analysis of HiAP. It explains the sources of information reviewed through the analysis, as well as the conceptual framework, applied definitions and criteria used. It presents challenges and next steps for scaling up HiAP in south-eastern Europe and includes nine individual reports on the situation in each of the countries.

The report discusses the findings of the analysis in relation to: the country context; the policy framework and the sectors involved, with key aspects of design and implementation; joint working mechanisms; impact assessment methodologies; information and monitoring; and capacity building to develop HiAP.

The selection of HiAP as the focus of the Health Ministers Forum synergizes with other policy relevant processes currently underway in the WHO European Region. The importance of the HiAP approach has been recognized in major European resolutions, charters and communications, treaties, frameworks and action plans. Building on these, HiAP will be a major goal of the new European policy for health (Health 2020), which defines a framework for accelerating the attainment of better health and well-being for all that can be adapted to the different circumstances in the European Region. It identifies how health and well-being can be advanced, sustained and measured through actions that enable improved daily living conditions and result in healthier environments, social cohesion, security, work-life balance and good education.

In line with Health 2020 and in support of the HiAP approach, *Strengthening Public Health Capacities and Services in Europe: a Framework for Action* renews the focus on public health in the Region, advocating commitment to and investment in disease prevention and health promotion. A key component of Health 2020 is bolstering public health to integrate its principles and services more systematically into all parts of society, including through HiAP. The Framework draws on a comprehensive assessment of health needs and public health capacities across society. It highlights eight major avenues that the WHO Regional Office for Europe intends to take in order to strengthen public health capacities and services and secure the delivery of ten essential public health operations in an equitable way across the whole Region. The outcomes of the Third Health Ministers Forum, held on 13-14 October 2011, and the commitments made by the 10 governments through signing the Banja Luka Pledge are relevant to implementing the Framework.

I. Cross analysis of HiAP in South-eastern Europe

1. Conceptual basis

The origin of health inequities is rooted in the social determinants of health, which are the conditions in which people are born, grow, live, work and age, including the health system. These are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. As pointed out in the recommendations of the global Commission on Social Determinants of Health: “The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries”. The Commission’s final report, released in August 2008 and endorsed by World Health Assembly resolution 62.14 in 2009, contained three overarching recommendations:

1. improve daily living conditions
2. tackle the inequitable distribution of power, money, and resources
3. measure and understand the problem and assess the impact of action.

The three recommendations involve actions, programmes, strategies and policies that go beyond the health sector and, even more, require actions arising directly from other sectors and areas of public policy and society. For the health sector, this involves coordination with other sectors, reviewing the prominent health vision within a given society and within the health sector itself and reviewing the core values behind the distribution of power, money and resources in society and the mechanisms and rules by which they are governed.

HiAP is central in addressing social determinants of health and health inequities. “HiAP”, “intersectorality”, “multisectorality”, and “join up” are terms that have been used interchangeably to refer to the perceived need for joint efforts from various sectors. However, they respond to different contexts and times, where the emphasis on addressing equity and social determinants of health have not always been emphasized and implemented as a priority or in an explicit way. The major international milestones in this process were the Alma Ata Declaration, emphasizing “health for all”, the Ottawa Charter, emphasizing health promotion, and the launch of the WHO Commission on the Social Determinants of Health, emphasizing health equity.

A HiAP approach is also advocated in other literature and policies: the 1986 WHO resolution *Intersectoral Cooperation in National Strategies for Health for All* to the 39th World Health Assembly, the 1986 WHO/Nordic School Public Health document *The Role of Intersectoral Cooperation in Combating Inequities In Health In National Strategies For Health For All*, the report of the *Conference on Intersectoral Action for Health – A cornerstone for health for all in the Twenty First Century, Halifax Nova Scotia, Canada, 20–23 April 1997*, the Finish Presidency of the European Union’s launch of health in all policies in 2005 and the WHO/Government of South Australia 2010 *Adelaide Statement on Health in All Policies: moving towards a shared governance for health and well-being*. However, there is limited literature on the theoretical framework or facilitating mechanisms for initiating and sustaining a HiAP approach, in spite of the numerous experiences and recommendations. As Solar et al. (1) noted:

Intersectorality is one of the recurring issues in public health management, however there is very little documentation and systematization of its practice, especially within the health field. Nor is there an explicit theory on which to build a framework for analysis of which types of intersectoral action are more feasible under different scenarios and which type of intersectoral action are needed to address social determinants of health and reduce health equity. (1)

This chapter seeks to contribute to the better understanding of the mechanisms that facilitated these initiatives, as well as those contributing to sustainability. The analysis has focused on identifying opportunities to develop HiAP, including contexts and organization, policies and promising development strategies as entry points, exploring issues such as how the social determinants of health

(SDH) and equity integrated. All these aspects would ease the development of a work plan to facilitate and enhance these opportunities and address present weaknesses, as well as give a methodological framework for mapping opportunities of HiAP in each country and a basis for discussion of the various entry points and possible approaches.

2. Methodology

This analysis is based on a review of materials prepared by SEE Health Network member country representatives for the Third Health Ministers Forum. These materials included presentations and 10 case studies that address the current state of HiAP in each of the SEE Health Network member countries. At the first preparatory meeting for the Forum, held in February 2011 in Banja Luka, a guide for case study development was created and reviewed by a dedicated working group. This guide specified that the national studies were to include the following sections:

- summary
- country context
- policy frameworks for HiAP
- mechanisms, tools, instruments and platforms for advancing HiAP
- information for HiAP
- capacity building for HiAP
- challenges, opportunities and recommendations.

At the second preparatory meeting for the Forum, in Bled in April 2011, country representatives presented the main contents of their emerging studies. For the third preparatory meeting, in Sofia in June 2011, countries analysed emerging themes from cross-analysis and areas to strengthen in finalizing national HiAP. One topic was the need to give more details in the national reports regarding the focus of policy processes and mechanisms for equity and social determinants; another was to a common SEE Health Network conceptual approach to HiAP. The country-specific feedback sheets were received and all countries were in full agreement to revise cases, taking into account their country specific comments. The last versions of the case studies and presentations were used as one of the main sources of information for the present analysis.

In the SEE Health Network country reports (case studies) used different methodologies, some entailing creation of working groups with substantial participation from academia and other sectors, while others used surveys, workshops and expert panels, often of an intersectoral nature. For example, Romania and Bulgaria included different sectors and methodologies.

The analysis in this chapter is developed from a framework elaborated through prior work of Solar et al. (1) to typologize entry points that governments can use to implement intersectoral action for health equity, modified in 2010.). This analysis also draws from empirical sources. Using a clear conceptual framework for this analysis served as a tool to explain complex processes and relationships such as those at play in intersectoral collaborations. As Judge et al. (2) comment, such frameworks:

...provide a language and frame of reference through which reality can be examined and lead theorists to ask questions that might not otherwise occur. The result, if successful, is new and fresh insights that other frameworks or perspectives might not have yielded. Conceptual frameworks can constitute an attempt to establish a paradigm shift.

Countries may use different terms to refer to HiAP, and terms may be conceptualized differently. Although implementation and design are specific to the historical and social contexts of each country, it is necessary to agree on definitions and language, so that experience and evidence accumulated in SEE can be used by other countries and regions. Hence, a very important first step for the analysis has been to identify the HiAP definition used, aiming to reflect that used by countries in their case studies as well as to draw from empirical sources. The following definition was included in the guidance for case studies produced at the first preparatory meeting in February 2011, and serves as the base definition for the present analysis and many studies.

The concept of HiAP approaches health improvement and strengthening as a shared societal goal across all parts of government. It addresses complex challenges of health and well-being by promoting an

integrated policy response across sector and portfolio boundaries, incorporating concern for health and health equity impacts into the policy development process of all sectors and agencies. This allows government to address the key determinants of quality of life, well-being, health and health inequities in a more systematic manner, as well as take into account the benefit of improved population health for the goals of other sectors. (Guidelines for preparing case studies, unpublished)

In addition, the analysis drew from the following two definitions that enable key aspects of the HiAP approach to be further elucidated through case study examples. Box 1 outlines criteria used in this report for the assessment of HiAP.

The core of HiAP is to examine determinants of health that can be altered to improve health but are mainly controlled by the policies of sectors other than health. Health in All Policies is an encompassing approach which goes beyond the boundaries of the health sector. The core of HiAP is to examine determinants of health, which can be influenced to improve health but are mainly controlled by policies of sectors other than health. The focus of this approach extends beyond individual factors and lifestyles. (Finnish Presidency of the European Union, 2006)

Other policies have other aims and priorities, and integrating health considerations in other policies requires a solid information base, personnel with appropriate public health training and a good knowledge of the policy-making system and structures, as well as negotiating skills. (3)

Box 1. Criteria for assessment of HiAP

1. Intersectoral action across all parts of government
2. Enhanced health equity as an explicit goal in policies, strategies and plans
3. Action to address social determinants of health (influencing areas controlled by the policies of other sectors and extending beyond individual factors and lifestyles) and the informal and formal structures for doing so
4. Application of a universal or mixed approach to health equity
5. A solid information base to analyse health equity and health determinants
6. Personnel with appropriate public health training for HiAP
7. Personnel with adequate knowledge of the policy-making system and entities across government
8. Personnel with negotiating skills and access to formal or informal structures to negotiate

3. Country context

As highlighted in the below quote, the country context (social, economic and political) is important for understanding the entry points and opportunities for scaling up action on HiAP.

[Context] is a deliberately broad term that refers to the spectrum of factors in society that cannot be directly measured at the individual level. "Context" therefore encompasses a broad set of structural, cultural, historical and functional aspects of a social system whose impact on individuals tends to elude quantification but which exert a powerful formative influence on patterns of social stratification and thus on people's health opportunities. Within the context in this sense will be found those social and political mechanisms that generate, configure and maintain social hierarchies, such as for example the labour market, the educational system, and political institutions including the welfare state. (4)

Information on the administrative and political organization of the country is of great importance since it can identify the extent of vertical policy integration in the management structure. It can also illuminate opportunities for local authorities to be more involved in advancing HiAP, depending on their power and responsibilities. Additionally, the historical processes of public health and political changes that have occurred in countries play a significant role in the design of HiAP.

Due to space constraints and the limited production time, the case studies only capture elements of the context (e.g., the demographic and epidemiological characteristics of each country) in the first version.

In further work, more in-depth analysis of the country context was developed through the additional questions. Information from responses to these is included in this report, but more analysis and information from each country could be opportune.

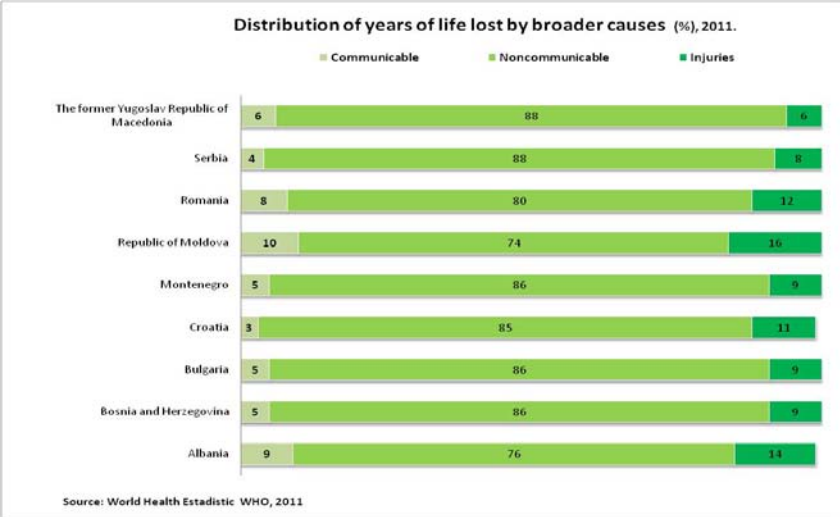
It was not possible to analyse the structure and evolution of labour markets from the case studies, nor the educational system or political institutions including the welfare state, which are important for analysing the context. We believe that the time constraints and the complexity of the subject limited its development and analysis. The organization of the government and the formal and informal social participation and coordination of the whole government need to be known in order to identify opportunities and possible barriers for HiAP. This information was gathered in part by the case studies, and some of its conclusions will be shown in the following chapters.

The first item to note from the demographic data is the magnitude of the population, who, in theory, are more or less accessible to the coordination and cooperation among various sectors and actors in all of the countries. At the same time, there are population differences. The proportion of the population 60 years old and over and the proportion of infants varies across network countries. In half of the countries, the population over 60 represents over 19%, and is 24% in Bulgaria. The child population reaches 15% of the population in all countries, and 24% Albania.

Only three countries show a positive annual growth rate: Albania (0.3%), Bosnia and Herzegovina (0.4%) and the former Yugoslav Republic of Macedonia (0.2%). Another aspect to consider is the proportion of the rural population, as it plays an important role in defining the priorities and contents of the public agenda. All countries have about 39% rural population, reaching 55% in Albania and 58% in Republic of Moldova. Life expectancy at birth has improved in all countries over the past 20 years, with the exception of Montenegro, where it decreased from 73 years to 72 for men and from 79 years to 77 for women, although a lower life expectancy is found in Republic of Moldova, at 65 years for men and 73 for women.

The second issue to note is the leading causes of mortality and life years lost in all countries, noncommunicable diseases account for over 80% of lost years of life, except in the Republic of Moldova with 74% and Albania with 76%. In these countries, the numbers of injuries reached 16% and 14%, respectively. Infant mortality has declined in all countries, but only three countries have single-digit rates per 1000 live births: Croatia (5), Serbia (6) and Montenegro (7). See Fig 1

Fig. 1. Distribution of life years lost, by causes



The third notable item is the indicators of income and its distribution, which show the limitations of the material conditions for progress on HiAP. This has great relevance when addressing health equity, since from the SDH and HiAP perspective, the approach cannot be reduced to the analysis of income, but takes account of the mechanisms of income distribution and access and availability of

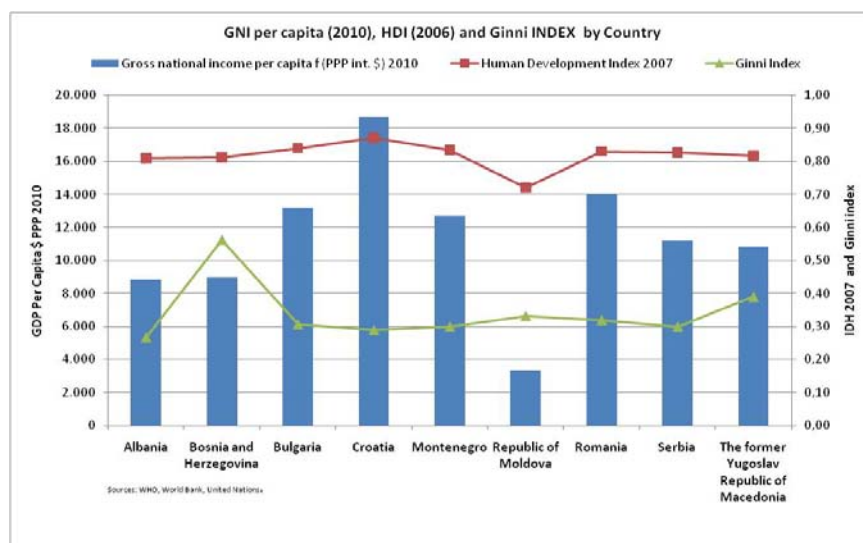
opportunities to participate in and contribute to society, through for example education and employment

One limitation noted by the authors of the studies is access to information, broken down by socioeconomic status, such as income and education on the basis of quality of life, morbidity and mortality, which limits monitoring and assessments of interventions. This is crucial because HiAP is centred on joint work for the reduction of health inequities through addressing the SDH.

The three items above are analysed in more detail in the following chapter.

Figure 2 illustrates the Gross National Income, Human Development Index and Ginni Index for the SEEHN countries. These provide indicators of income and inequalities and their relationship with development. In particular, it is possible to see that low GDP in Republic of Moldova is associated with lower level of Human Development indicators.

Fig. 2. Per capita indices by country



4. Policy frameworks

The case studies identified policies, strategies and plans relevant to HiAP. Table 1 comprises a synthesis of these, which can be referred to collectively as preliminary entry points and opportunities for HiAP development.

Several countries identified their recent planning and development plans as HiAP development opportunities, including Albania, Croatia, Bosnia and Herzegovina (both Federation of Bosnia and Herzegovina and Republic of Srpska), Romania and The former Yugoslav Republic of Macedonia, which notes that its “Ministry of Health and Ministry of Labour and Social Affairs are running a joint Memorandum of Inclusion coordinating all other sectors in Implementing Health in all Policies during the accession process”. Another example is that of Bulgaria’s *National Strategic Reference Framework 2007–2013*, under which a working group was set up to prepare the Operational Programme on Regional Development (ORPD). About 50 relevant stakeholders took part in the elaboration of the programme. Although the cooperation among stakeholders was considered satisfactory and the Ministry of Health involvement was ensured, a thorough review of potential health impacts of the planned investments was not carried out as part of the development process. In the current operational programme, public health impacts are mostly measured through non-health indicators, since health indicators are not foreseen in the operational programme for non-health investments. The OPRD is meant to give priority to the social, educational and health problems of Roma minorities and measures for preserving the Roma cultural identity, to improve living conditions of citizens and contribute to

social inclusion of disadvantaged and vulnerable urban communities. Apart from the direct benefits, the interventions will also be expected to have positive impacts on public health. It is not expected that the public health impacts of non-health interventions will be considered in a more coordinated and systematic way under the ongoing process, which will require a review of current practices in this respect. Such a review can be ensured through a straightforward and targeted guidance, or explicit obligation for the preparation of the OPRD. The Republic of Moldova recommends that these opportunities be identified in fields of action beyond the direct mandate of the health sector and that a strategy be developed to prevent or minimize any unintended negative health impact from other policies.

A second group of countries identified health sector strategies or plans, with Bulgaria and the Republic of Moldova noting that they could be used as opportunities for advancing HiAP, in light of a focus on wider determinants and inequities. Bosnia and Herzegovina (Republika Srpska), Bulgaria, Croatia, Montenegro and Serbia all identified strategies and plans to address specific health problems such as chronic noncommunicable diseases, diabetes, mental health and HIV/AIDS. Health promotion strategies and plans (linked to changes in habits or lifestyles and nutrition) are referred to as entry points by Croatia, the Republic of Moldova, Montenegro and Serbia.

Albania, Bosnia and Herzegovina (Republika Srpska), Croatia, Montenegro, Serbia and the former Yugoslav Republic of Macedonia identified strategies and plans related to gender equity and/or domestic violence as potential opportunities for advancing HiAP. Bosnia and Herzegovina included a strategy to improve sexual and reproductive health and rights as a HiAP opportunity.

Albania, Croatia, Montenegro, Serbia, and the former Yugoslav Republic of Macedonia identified plans and strategies related to poverty reduction, social inclusion and Roma minority. Serbia made specific reference to government commitments to poverty reduction and social inclusion linked to the European Union integration process.

Bosnia and Herzegovina, Croatia and Montenegro indicated strategies or plans related to early child development, There is a strategy focusing on childhood malnutrition in Albania..In Serbia and the former Yugoslav Republic of Macedonia also included the elderly.

Albania, The Federation of Bosnia and Herzegovina, the Republic of Moldova and Romania identified strategies and plans related to the environment, natural resources, forestry, water, climate change and agricultural development. Montenegro, Romania and Serbia describe anti-drug strategies or plans and strategies and Croatia and the former Yugoslav Republic of Macedonia, those for road safety.

All countries noted that the Regional and international HiAP agenda influences opportunities for scaling up HiAP action in SEE countries, underlining the importance of support by the European Commission, WHO and other multilateral entities.

Information on each policy, strategy or plan was limited in the studies, so it is difficult to ascertain if each addressed all of the eight HiAP criteria in Box 1. Further analysis and discussion is required, along with agreement on the criteria and their interpretation. Nonetheless, it has been possible to select some strategies and plans in different stages of development, to illustrate promising policies. The selection was not based on the effectiveness or good performance of HiAP development, but rather on identification of different development or implementation models that could inform future work and a common understanding and approach from which to advance HiAP. From the selected strategies, the following aspects were discussed and are described in detail below:

- sectors involved in developing promising policy for HiAP
- key aspects of management during the design and implementation of policies
- the equity perspective of promising policies.

Sectors involved in developing promising policy for HiAP

The case study guidance specifically requested authoring teams to identify the sectors with which there is currently the greatest intensity of cooperation, as well as those sectors where there is the greatest need and/or opportunities for intensifying cooperation. The teams were asked to consider a range of sectors including but not limited to education, transport, labour/employment, urban planning,

housing, environment, culture, finance, social protection, economic development, rural development, and migration. As evident, this list includes both the traditional “social sectors” with whom cooperation may be easier, as well as those sectors where there are fewer obvious synergies and or where building relationships may be more challenging. The review of studies also considered other key partners including academia, civil society and the private sector.

Comparison of Table 1 and 2 illustrates where potential areas of greater partnership working could occur. For example, 6 of the 9 countries identified violence prevention as opportunities for HiAP development, whilst relationships with the police or justice sector were only described as good in two countries. Studies also suggested that the ministry of finance is a particular sector with whom countries reported a need for cooperation but where it is currently underdeveloped. Advancing HiAP in SEE would benefit from further analysis of the type, scope and extent of the existing relationships with the finance sector in general and specifically in relation to strengthening policies and investments that improve health, address social determinants and reduce inequities.

The case studies used different terms to define positive relationships with other sectors. Most studies referred to “cooperation” for positive relationships with other sectors, while Bulgaria and Croatia referred to “partnership (collaboration)” and Romania referred to “communication and collaboration”. In the next stages of scaling up work, for the sake of facilitating cross-country comparisons, it may be worthwhile to explore in detail the use of terms related to the levels of cooperation between individual sectors. Box 2 below describes differing relationship patterns with individual sectors.

Box 2. Relationship patterns with individual sectors

Informative: A one-way relationship where instructions from one sector are communicated to passive recipient sectors. May be the first step in the intersectoral process of building a common language for dialogue.

Collaborative is working together to achieve a goal or process where two or more organizations work together to realize shared goals. Does not include efficiency in their actions.

Cooperation: Interaction between sectors to achieve greater efficiency in their actions. Aims to optimize resources while establishing formalities in the work relationship; results in a loss of autonomy for each sector.

Coordination: Adjusting the policies and programs of each sector to improve efficiency and effectiveness. Leads to increased horizontal networking among sectors. Usually uses a shared financing source which creates synergies within administration but leads to a greater dependence between sectors and loss of autonomy.

Integration: A political process where a new policy or programme (representing the work of multiple sectors) is defined in conjunction with other sectors. This entails the integration of objectives and administrative processes and the sharing of resources, responsibilities and actions. This ultimately results in the collapsing of ‘closed fiefdoms’.

Sources: Meijers, Stead (5); Solar et al. (6)

Table 1: Preliminary entry points and opportunities for HiAP development

Preliminary entry points and opportunities for HiAP development			
	Promising policy experience/practice	Opportunities for implementing a HiAP approach	
Albania	<ul style="list-style-type: none"> • National Strategy for Development and Integration, 2007–2013 • National Strategy for Social Inclusion, 2008 • National Strategy on Gender Equality and Domestic Violence, 2007–2010 • Strategy for Improving the Living Conditions of the Roma Minority • National Environmental Action Plan • Strategy for Consumer Protection and Market Surveillance • Food and Nutrition Action Plan, 2003-2008 • Reduction of Malnutrition in Albania Children, 2009–2012 	<ul style="list-style-type: none"> • There is good cooperation among institutions in the development of joint plans and strategies (Parliamentary group for health, different national committees). • There is a lot of data, but this should be made more accessible for use by decision-makers. 	
Bosnia and Herzegovina	Federation of Bosnia and Herzegovina	<ul style="list-style-type: none"> • Policy for early childhood development of May 2011 • Strategy for Improvement of Sexual and Reproductive Health and Rights, 2010–2019. • National Strategy for Equalization of Opportunities for Persons with Disabilities, 2010. • Federation Environmental Conservation Strategy, 2008–2018 • Federation Water Resource Management • Midterm Federation Agriculture Sector Development Strategy • Project Sarajevo Healthy City 	<ul style="list-style-type: none"> • Existence of the SEE Health Network and cooperation of health ministers in the SEE region • WHO Regional Office for Europe policy for health – Health 2020 as a platform for continued improvement and implementation of HiAP
	Republika Srpska	<ul style="list-style-type: none"> • Policy for Early Childhood Development, 2011–2016 • Family Development Strategy, 2009–2014 • Youth Health Policy, 2008–2012 • Mental Health Policy, 2008–2012 • Strategy for the Enhancement of Social Welfare of Children without Parental Care, 2009–2014. • Strategy for Family Violence Control, until 2013 • Strategy for Culture Development, 2015 • Plan for Water Resources Development • Energy Development Strategy, to 2030 • Forestry Development Strategy, to 2020 • Agriculture Development Strategy, 2015 	<ul style="list-style-type: none"> • Strong political will of the government, supported through the tradition and firm foundations of the public health system, provides opportunities to ensure a more active involvement of community members in decision-making in health care.

Preliminary entry points and opportunities for HiAP development		
	Promising policy experience/practice in relation to HiAP	Opportunities for implementing a HiAP approach
Bulgaria	<ul style="list-style-type: none"> • National Health Strategy 2008–2013 • National Programme for Prevention and Control of HIV and STI 2008–2013 • Operational Programme on Regional Development (OPRD) 	<ul style="list-style-type: none"> • Traditions and good practices have been developed in the implementation of intersectoral cooperation. • The existing international experience, particularly in the assessment, could be used. • Capacity building could be further developed for implementing HiAP.
Croatia	<ul style="list-style-type: none"> • Strategy for Sustainable Development of the Republic of Croatia, chapter on Public Health • National Plan of Activities for the Rights and Interests of Children (2006–2012) • Overweight Prevention and Reduction Action Plan 2010–2012 • National Strategy of Protection against Family Violence (2011–2016) • Croatian food and nutrition policies • National Road Traffic Safety Programme 2001–2010 • National Programme of Health and Safety at Work 2009–2013 • National Mental Health Strategy • National Strategy against Disorders Caused by Excessive Consumption of Alcohol • National Decade of Roma 	<ul style="list-style-type: none"> • Existing public health organization enables a comprehensive approach to the most important public health issues. • A tradition of successful experience in public health capacity building is a prerequisite for reducing health inequities. • Developing programmes for health promotion including the reduction of health inequities can use available international funds and cooperation.
Montenegro	<ul style="list-style-type: none"> • Poverty Reduction Strategy and Action Plan, 2003 • Strategy for Prevention of Chronic, Noncommunicable Diseases, 2009 • Strategies for Controlling Smoking Habits, Mental Health, HIV/AIDS • Action Plan for Prevention of Violence • Food Safety Strategy • Decade of Inclusion of the Roma Population • National Strategy of Sustainable Development, 2007 • Drug Abuse Action Plan • Action plan for Children 	<ul style="list-style-type: none"> • Establishing the organizational structures supporting HiAP or introducing new duties related to implementation of HiAP within existing structures • Defining the action plan on national level for all sectors, for implementation of HiAP • Ensuring strong evidence for health determinants impact on health (not only in health sector) and introducing health criteria into new sectors; use of existing data in a more appropriate and more HiAP directed way (e.g., health equity data from HIS) to inform health and other sector policies • Using knowledge and experiences of foreign professionals • Directing current public health personnel to coordinate activities in all sectors • Adjustment to EU standards in all sectors

Preliminary entry points and opportunities for HiAP development		
	Promising policy experience/practice in relation to HiAP	Opportunities for implementing a HiAP approach
Republic of Moldova	<ul style="list-style-type: none"> • National Health Policy, 2000–2021 • National Programme on Healthy Lifestyle Promotion, 2007–2015. • National Diabetes Control Programme, 2011-2015 • State Programme of Public Health Institutions Technical Development, 2012–2016 • National Environmental Health Action Plan 	<ul style="list-style-type: none"> • Strong political will for public health reforms, confirmed in Governance Programme approved for 2011–2014, with a strong health component • WHO and EU support, including financial and technical expertise in main public health issues • Already initiated reorganization of health sector, with focus on public health • Opportunities to increase qualification of public health professionals through training programmes
Romania	<ul style="list-style-type: none"> • The National Sustainable Development Strategy, to 2030 • National Strategy for Improving the Elaboration, Coordination and Planning of Public Policies in Central Public Administration (2006) • National Strategy for Climate Change, 2004 • National Anti-Drug Strategy, 2005–2012 	<ul style="list-style-type: none"> • The international context and support for HiAP is very important. Consequently one clear opportunity is represented by the political support for the HiAP process at the WHO and EU levels, and the possibility to integrate and develop requirements for the HIA within the IIA mechanisms. • Another important opportunity is represented by the development of knowledge and models for quantitative HIA and by examples of in-country implementation models.
Serbia	<ul style="list-style-type: none"> • Poverty Reduction Strategy, 2009 • Health Care Development Plan • National Aging Strategy; National Strategy for Youth; • Tobacco Control Strategy; Strategy for Development of Mental Health Care; • Strategy for Stimulation of Births • National Strategy for Empowering Women and Improvement of Gender Equity; • National Strategy for Prevention and Protection of Children Against Violence; • Strategy for Fighting Drug Abuse and Action Plan, 2009 to 2013; • Public Health Strategy 	<ul style="list-style-type: none"> • Workforce preparedness in new public health is improved by the establishment of the School of Public Health and Health Management, but still there is a need for better recognition of competences and the importance of training professionals, particularly among politicians and decision-makers. • Periodic assessment of vulnerability, poverty and health status of the population is provided by many representative surveys, with international support. • Although capacity to provide the essential public health services to every community is improved, there is an urgent need to focus more on the poor, rural elderly (particularly women), the unemployed and those with lower educational status.
The former Yugoslav Republic of Macedonia	<ul style="list-style-type: none"> • The review National Programme for Adoption of the Acquis Communautaire, 2011 • National Strategy for Reducing Poverty and Social Exclusion, 2010–2020 • National Plan for Gender Equality, 2007–2012 • National Strategy for the Elderly, 2010–2020 • Social Inclusion and Human Rights Project • Conditional Cash Transfer Project • Road Safety-National Council for Road Safety, 2009–2014. • Domestic Violence Prevention, 2006 	<ul style="list-style-type: none"> • Creation of strong partnership and alliances among the sectors is emphasized in the Public Health Act and other strategic documents and more efforts are needed from other sectors for government to move in this direction. • Strengthening multisectoral approaches and processes at national, regional and local levels by establishing the National Public Health Council and local public health councils will enable public health impact to be effectively considered in all policies. • The intensification of the collaboration among the sectors and with the World Health Organization, European Commission, International Organizations and other relevant partners will speed up the implementation of health conductive policies in other sectors, ensuring efficiency and equal opportunities.

Table 2. Sectors involved in the development of HiAP

		All government sectors are involved	Sectors with which there are currently good or relationships	Type of relationship	Sectors with the greatest need
Albania		No	Ministry of Labour, Social affair and Equal Opportunities, Ministry of Youth, Culture, Tourism and Sport and Education	Intersectoral Cooperation	Not specified in the report
Bosnia and Herzegovina	F. of Bosnia and Herzegovina	No	Education, Social Protection, Environment, Agriculture, Police, Finance, Media	Cooperation	Transport, labour/Employment, Urban Planning, Housing, Culture, Economic Development, Rural Development, Migration, Tourism
	Republika Srpska	No	Education, Agriculture, Transport, Finance, Social Protection, Media	Cooperation	Labour/employment, Urban Planning, Housing, Environment, Culture, Economic Developments, rural Development, Migration, Tourism.
Bulgaria		No	Ministries of Finance, Environments and Waters; Agriculture; Transport; Labour and Social Policy; Justice; Education; Culture; Physical Education and Sport; Defence; Interior; and Foreign Affairs	Collaborate with the Ministry of Health	Not specified in the report
Croatia		No	Fisheries and Rural Development, Ministry of Science, Education and Sports, Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity	Intersectoral collaboration	Not specified in the report
Montenegro		No	Ministry of Labour and Social Welfare, Ministry Tourism and Sustainable Development, Ministry Agriculture and Rural Development, Ministry of Sport and Education	Good cooperation	Not specified in the report

Table 2: Sectors involved in the development of HiAP (continued)

	All government sectors are involved	Sectors with which there are currently good or relationships	Type of relationship	Sectors with the greatest need
Republic of Moldova	No	Ministry of Finance, Ministry of Education, Ministry of the Environment, Ministry of Youth and Sport, Ministry of Social Protection, Labour and Family, Ministry of Regional Development and Construction	Intersectoral Cooperation	Agriculture, Labour/Employment, Economic development and Finance.
Romania	No	Ministry of Education, Research, Youth and Sports, Ministry of the Environment and Forestry, Ministry of Work, Family and Social Protection	Communication and collaboration	Transportation, Agriculture, Economic Development, Finance, Culture
Serbia	No	Media, Social Protection, the Environment, Education, Labour and Employment	Collaboration and Cooperation	Opportunities: Agriculture, housing and rural development, Greatest need: finance sector and economic development
The former Yugoslav Republic of Macedonia	No	Ministries of Labour and Social Protection; Environmental Physical planning; Local Self Government; Education; and the agencies of Youth and Sports and Food Safety	Cooperation	Not specified in the report

Key aspects of management during the design and implementation of policies

Of the six groups of strategies and policies mentioned, two were examples of national development plans or strategies, two were plans associated with the health sector itself, one related to poverty reduction and one to social inclusion, one related to early child development and the agricultural development strategy were selected. The analysis focused on the dimensions that were available in case studies or that could be easily concluded from them, specifically:

- whether the policy originated in the health sector or others sectors
- the level of policy response implementation
- whether the process began from the top-down or bottom-up
- whether the health sector joined up during formulation and implementation
- the role of the health sector
- sectoral leadership of the policy.

Table 3 summarizes the findings in the revised plans or strategies of the points raised.

The origin (sector or institution) of the strategy, policy or plan is an important issue because it indicates the level of integration of others sectors than the health sector, as well as the political will present in other sectors. From the operational aspect, it relieves the health sector need to know in

better details the plans and objectives of those sectors; the languages and cultures of others sectors needed to be considered in HiAP construction. The government level where the plan is implemented shows its scope, and the feasible initiative to supplement from the health sector, at national, regional or local levels.

Closely linked to this is the direction of its implementation, i.e., whether the process allows participation or local development such that HiAP can be carried on the local level with the possibility of scaling up to a national, sustainable process (7). Initially the direction of implementation was described as “top-down” or “bottom-up”, The choice of which (or it can include both) is strongly linked to models of PHC and to public governance models in each country. This is an important dimension to consider in future analysis and development of health in all policies within member countries and across the network.

The timing and mode of the relationships between the health sector and other sectors are of great importance. The health sector should be present in all processes, from a HiAP perspective. Whilst this study indicated that some policies found the health sector was only engaged in the implementation stage. Other experiences have emphasized coordination toward a common vision, and that does not necessarily imply a close relationship in the implementation process. This was the case of Sri Lanka and Cuba in PHC and intersectoral work (8). This is an important point about the role of the predominant state ideology and public policies.

The other aspect considered is the role played by health with respect to the other primary sectors and groups involved (9). The health sector’s role can be that of a leader (in areas where it has both knowledge and control over the effective means), that of a negotiator (where it has knowledge of effective means but no control) or that of a partner (where it has knowledge about adverse or positive health impacts of other sector policies, but neither control of the means of implementation nor exact knowledge about how measures should be framed). It is necessary to recognize which sector has been effectively leading the process; leadership must be exercised, but that does not mean leading all of the process. Leadership from other sectors is highly relevant for addressing the SDH and inequities.

In strategies and plans developed on the national level, from the top down, the studies indicated how the health sector’s participation is predominant in the implementation stage, although it is noteworthy that in Early Child Development, Poverty Reduction Strategy and Review of the National Participation Programme, the health sector was also included the formulation stage. In most of the strategies, plans and health policies, the health sector played a partner role. The leading sectors have been the Ministry of Labour, Equal Opportunities and Social Affairs, the Ministry of Agriculture, the Ministry of Environment and Sustainable Development and the rest of the Deputy Prime Central Government Ministry directly.

As noted above, the level of decision and autonomy, local and regional levels in each of the countries have been linked to the decentralization of the state. Many of them have accompanied the reorganization of the government apparatus and of the health system in particular. These aspects influence the design and organization of the strategies and policies.

Some case studies highlight successful local experiences, built on the progress and achievements in health outcomes. Having the local governmental apparatus coordinating with Primary Health Care facilities was crucial to these results. For example, the 2000 Sarajevo Healthy City project, developed by the Sarajevo City Administration (Office of the Mayor) was financially supported by Sarajevo Canton budget funds. By recommendation of the Sarajevo Canton Ministry of Health, between 2000 and 2002 representatives of the project actively participated in the work of the Environmental Council formed as an intersectoral working group of the Sarajevo Canton Ministry of Spatial Planning and Environmental Conservation. The purpose of their involvement was to make sure that the environmental conservation policy and spatial planning was based on experience of intersectoral cooperation and responsibility for health.

Table 3. Key aspects of management during the design and implementation of policies for HiAP

Promising policy	Policy's origin	Implementation level	Top-down or bottom-up	Health Sector join up during formulation and implementation or only implementation by others sectors	Health sector role	Leading actor
The review of National Programme for Adoption of the Acquis Communautaire, 2011 The former Yugoslav Republic of Macedonia	Central Government	National	Top-down	Was revised to comply with a HIAP approach, considering the potential impact on health or health systems when formulating new policies in other sectors such as labour and social policy, transport, agriculture and the environment	Partner	Central government
The National Sustainable Development Strategy, 2013–2020, to 2030 Romania	Prime Minister and other actors	National	Top-down	Implementation	Partner	Ministry of Environment and Sustainable Development
National Strategy for Social Inclusion, 2008. Albania	Other sectors	National	Top-down	Implementation	Partner	Ministry of Labour, Social Affair and Equal opportunities
Poverty Reduction Strategy, 2009 Serbia	Deputy Prime Minister	National	Top-down, but the local level is very important in implementation	From the beginning, in formulation, implementation and monitoring activities	Partner	Deputy Prime Minister

Table 3. Key aspects of management during the design and implementation of policies for HiAP (continued)

Promising policy	Policy's origin	Implementation level	Top-down or bottom-up	Health Sector join up during formulation and implementation or only implementation by others sectors	Health sector role	Leading actor
Policy for Early Childhood Development in the RS 2011–2016, Federation of Bosnia and Herzegovina	Central Government	National	Top-down	Formulation and implementation; New form of planning, designing and implementing integrated programmes for early childhood	Partner	Deputy Primer Ministry
Agriculture Development Strategy, 2009–2015 Republika Srpska	Central Government	National	Top-down	Implementation	Partner	Ministry of Agriculture
National Health Policy for 2007 – 2021. Republic of Moldova	Health Sector	National	Top-down deconcentration, decentralization and responsibilities; ensuring community in a bottom-up process.	Formulation and implementation	Leader	Government
National Programme for Prevention and Control of HIV and STI 2008-2013. Bulgaria	Health Sector	National	Top-down	Formulation and implementation	Leader	Ministry of Health

In 2004, Sarajevo City Council formally approved the *Health Plan for Citizens of the City of Sarajevo*, which outlines the city's political commitment to a multisectoral, interdisciplinary approach to activities aimed at improving the health of the population of Sarajevo Canton. The Plan was developed by experts with the Sarajevo Canton Public Health Institute. Development of this strategic document was preceded by two studies, the *Health Profile of the Population of Sarajevo Canton* and *Overview of health Status of the Population of Sarajevo Canton*, both developed by the Sarajevo Canton Public Health Institute and financed by the Sarajevo Canton Ministry of Health. They represent a significant contribution to a holistic understanding of health, improvement of multisectoral responsibility for health and development of a healthy city concept for Sarajevo. Activities are now conducted on a smaller scale in the city, through its city council.

Another example is that of Medimurje County, Croatia. A case study on inequalities of health was undertaken by the Croatian National Institute of Public Health, and showed that per capita GDP at the county level was negatively correlated to the standardized death rate (SDR) for cardiovascular diseases (CVD), meaning that the CVD SDR was higher in counties where GDP was lower. It should be mentioned that the counties having a lower SDR than national average were in the coastal region, with the exception of Zagreb. The results of the study were presented to the representatives of county public health institutes, calling for strengthened the health promotion and CVD prevention programmes especially in counties with high SDRs, i.e., 565.8/100 000 in 2002, compared to the Croatian average of 487.2/100 000). Comprehensive prevention programmes were launched, involving the counselling unit for CVD prevention in the County Institute of Public Health. In 2009 Medimurje County had CVD SRD of 473.8/100 000, lower than the national average of 483.0.

In Montenegro, the implementation of all activities at the level of social and health support is coordinated by the government, with implementation by the Ministry of Health and Ministry of Labour and Social Welfare. Much of the responsibility is transferred to local administrations, in order to fully implement the activities in all sectors, but budget limitations often determine the centralization of the system at the state level. At the regional level, before introduction of the *Strategy for Prevention and Control of Noncommunicable Diseases*, public debates were organized in three regions of Montenegro, where the results of the 2008 National Health Survey were presented. Ordinary citizens, journalists and non-government representatives took part in these debates. The Strategy's action plan outlined many of the activities to be undertaken in sectors other than health, such as the construction of recreational facilities including cycling and running tracks for citizens and the introduction of healthy meals for children in schools.

Equity lens of HiAP

The analysis seeks to clarify health equity is addressed and which social determinants are expected to receive intervention. The report was restricted to the dimensions of policy priorities, the main approach to addressing equity, addressing social determinants of health and the coverage approach ie targeted, universal and or mixed approaches. The priorities focus of policy action describes the main policies, strategies or plans (10). The main approach in the literature to addressing equity reveals the policy orientation, for example tackling inequities across the social gradient or improving the situation of the most vulnerable(11,12). In addressing the SDH it is useful to identify the type of determinants included in the strategy or plan, for example, addressing structural or mainstream determinants, or intermediate determinants, such as lifestyle, working conditions and housing or those related solely to the health system, such as access to health services (4,13). The coverage approach includes, for example, whether coverage is universal, targeted to specific groups or regions, involves means testing or comprises some combination of these(14). An additional strategic consideration is the choice of a universal population-targeted strategy versus an individual high-risk strategy or a strategy directed towards specific target groups such as residents of socially very disadvantaged areas, etc. (see Table 5).

This study found the main approach by the health sector to address inequalities focuses on access to services, although several of the strategies and plans have an emphasis on prevention and promotion. This view can unintentionally restrict the integration of the health sector with a broader set of social policies capable to impact on different determinants of health and address the needs of different

population groups in a holistic way.. However, it is important to note that in Albania's social inclusion strategies and Serbia's poverty reduction strategy, health is given a broader role, than just improving equity in service access. At the same time is important to analyse the approach used in the Federation of Bosnia and Herzegovina's early childhood development policy, as explained in their report.

To move from the current sector-based approach to the new forms of intersectoral integration and coordination requires developing new forms of planning and designing and implementing integrated programmes for early childhood growth and development, which is the main focus in the document *Policy for early childhood development in the Federation of Bosnia and Herzegovina*, adopted in May 2011.

Integrated Centres for Early Childhood Growth and Development for Parents and Children aim to bridge the gaps in the existing health, education and social welfare systems, and establish links between the services of the existing system and the parents who can be strengthened through the centres, and trained in responsible and stimulating parenting skills. They promote integrated services and even an integrated approach to service delivery based on a holistic view of child development. This means that the sectors must be well connected and offer a comprehensive package of services that will enable children to have optimal conditions for growth and development. This creates a space of action for innovative forms of service delivery for children and families, which do not aim to replace existing system facilities, but to make them more accessible to citizens and fill perceived gaps in the system.
(p.62 below)

It is important to expand the vision of health and the focus of this action, which is present in other sectors, for example Republika Srpska notes that:

Health should not be a concern of the health care sector only, but of all sectors, and investment in health should not be considered an expenditure, but an investment in the overall development of the country.
(p.70 below)

In all equity strategies, the most socially vulnerable groups are the main focus. The main social determinants addressed by all the strategies are the intermediate or proximal determinants such as access to health services, lifestyle or behaviour, living conditions and social cohesion/exclusion. The poverty reduction strategy of Serbia and the national health policy of the Republic of Moldova show an approach that includes structural or mainstream determinants, for example, the latter's emphasis on solidarity in health, equal opportunities for health and right of health and the former's development of employment, social security and access to housing and education.

Drawing learning from other countries can help to shed light on ways to improve the approach to HiAP to reduce inequities in health in the future. England is the country that for the longest time and most persistently has had a scientific, political, administrative and professional focus on reducing health inequalities, but these efforts, which have been particularly intense over the past 15 years, have not achieved the expected effects (15). The Marmot Review makes the following observations.

- Even though expert reports have stressed measures against social determinants, policy initiatives have, in practice, been focused on targeted social groups and behavioural or lifestyle factors, e.g. via smoking cessation courses, physical activities.
- While the problem has been discussed in terms of the social gradient in health, initiatives have often been targeted at smaller, socially marginalized groups.
- Initially, universal programmes and services have primarily been utilized by more advantaged groups.
- Far too many initiatives constitute single temporary projects in local deprived areas. Only seldom do they have to do with influencing other central policy areas with health policy potential, i.e., mainstreaming.
- Effective efforts not only require incorporation of many different policy areas but also a common political and administrative target setting, management and coordination. (15)

These aspects were also highlighted in some studies, for example, the former Yugoslav Republic of Macedonia indicates:

Evidence from international comparisons suggests that countries that have consistently pursued redistributive policies generally have lower rates of poverty and better health outcomes. Although economic growth is central to reducing massive poverty, economic growth alone is insufficient to

reduce poverty for marginalized groups. An institutional framework and social structure for redistributing the benefits of growth to all in society is also required. Despite arguments to the contrary, social spending has not been shown to inhibit growth. (p.151 below)

In relation to the coverage approach or strategy, most of the plans and strategies have included vulnerable target groups or individual high-risk strategy. Some of the case studies refer to universal approaches, although the information was insufficient to properly define the role of the universal or population strategy. Table 5 provides examples of the range of country approaches to addressing inequalities, showing an emphasis on targeting high risk vulnerable populations.

Finally, the countries indicate the importance of the EU integration process, setting health on the agenda of economic development and consumer protection. The former Yugoslav Republic of Macedonia discussed the HIAP approach within the context of the EU integration process, in Table 4.

So far the strongest is collaboration with social policy and protection, while the weakest is in the area of informatics, society and media; transport policy; statistics; and science and research (in the context of EU integration). There are sector policies in all other sectors which often do not address health explicitly. The same conclusion is drawn for financial support through EU mechanisms, as presented in the *Document Review of Current And Planned Foreign Assistance, 2010–2012*. There is a big potential for establishing a solid legal framework for implementation of a HIAP approach to national legislation harmonization with the EU (2009–2014), which requires continuous engagement and strengthened capacity of the Ministry of Health for HIAP promotion. (Country study response)

Table 4. Overview of the EU integration process HIAP approach from the perspective of the former Yugoslav Republic of Macedonia

Chapter	Title	Public health aspects	Level of collaboration
2.2	Human rights and minority protection	Right on health, antidiscrimination, human rights (children, women, vulnerable population)	Regular formal
4.1	Free movement of goods	Health safety of food, medicines, cosmetics, chemicals	Regular formal
4.2	Free movement of workers	Human resources in health	Regular formal
4.3	Freedom of service provision	Conditions for health institutions	Regular formal
4.4	Free movement of capital	Foreign investments in health	Regular formal
4.7	Intellectual property rights	Protection of intellectual property for discoveries in medicine, medicines, generic drugs etc.	Regular formal
4.10	Informatic society and media	Information technology in health sector, media and health	Lowest
4.11	Agriculture and rural development	Safety in food production; access to health services in rural areas; rural health development	Regular formal
4.12	Food safety, veterinary and phytosanitary policy	Food safety for human and veterinary use	Regular formal
4.14	Transport policy	Physical access to health services	Lowest
4.18	Statistics	Health statistics	Lowest
4.19	Social policy and employment	Health of vulnerable groups; open coordination of social sectors	Strongest
4.23	Justice and fundamental rights	Drug abuse; prison health	Regular formal
4.25	Science and research	Health research	Lowest
4.26	Education and culture	Health education; health culture	Regular formal
4.27	Environment	Environment and health	Regular formal
4.28	Consumer protection and health protection	Health care development through activities in the health sector in the context of the patient as consumer (public health)	Strongest

Table 5. Equity lens of HiAP

Country	HiAP	Target group	Health determinants	Comments
The review of National Programme for Adoption of the Acquis Communautaire, 2011 The former Yugoslav Republic of Macedonia	Economic growth, reduced unemployment improved living standards including public health, health statistics and consumer protection issues	Improving the situation of the most vulnerable groups and social inclusion	Addressing intermediate determinants: living and working conditions, lifestyle, social inclusion and access health services and social protection.	Especially inclusion vulnerable groups Target approach
National Health Policy, 2000 –2021 Republic of Moldova	Equity and solidarity; assurance of equitable and affordable access to health services for all citizens	n.a.	Addressing intermediate determinants: health services delivery (equity in access); solidarity in health and equal opportunities for health and right to health	Universal or mixed (with target approach)
The National Sustainable Development Strategy, 2013–2020 to 2030 Romania	Improved access to health services	Approach the vulnerable groups	Addressing intermediate determinants: lifestyle and access health services delivery	To concentrate prevention and provision of basic care services and minimal packages for vulnerable segments of the population; Target approach
Poverty Reduction Strategy (PRS) 2009 Serbia	To decrease poverty and to improve health of vulnerable groups	Approach the vulnerable groups	Addressing intermediate determinants: living and working conditions, housing, education, social inclusion, agriculture develop, access to health services and social services	The disabled, children, youth, women, elderly, Roma national minority, uneducated, unemployed, refugees, internally displaced persons and the rural population
National Strategy for Social Inclusion 2008. Albania	Social inclusion Poverty reduction	Improving the situation of the most vulnerable.	Addressing intermediate determinants: Living and working condition and access Health Services delivery.	Vulnerable individual, family and groups in the community. Target approach.
Policy for Early Childhood Development in the RS 2011–2016 Federation of Bosnia and Herzegovina	To make a bridge between the existing Systems of health, education, and social welfare, and establish links between the services of the existing system and parents and children	Improving the situation of the most vulnerable and Minority groups of children and parents	Addressing intermediate determinants: Living and access Health Services delivery, social service such Education, Social protection; integrative services and an integrated approach to service delivery based on a holistic view when it comes to child development; the sectors, especially health, education and social protection sector, must be well connected and offer a comprehensive package of services that will enable children optimal conditions for growth and development	The following population groups: youth, future parents, pregnant women and mothers with young children, families with children and children of age 0–3, 3–6 and 6–10 Target approach
National Programme for Prevention and Control of HIV and STI 2008–2013 Bulgaria	Prevention and control of HIV, tuberculosis and sexually transmitted infections	Improving the situation of the most vulnerable	Addressing intermediate determinants: access to and coverage of services for HIV prevention, treatment and care, and support to the people affected by the disease	Groups most-at-risk (injecting drug users; sex workers; young Roma people with risk behaviour; men who have sex with men; prisoners and children at risk out of school), as well as care and support for people living with HIV; High risk and target approach

5. Joint working mechanisms to develop HiAP

Various forms of joint working arrangements were identified in the studies, as well as supporting formal and informal structures (16). A summary of this is presented in Table 3.

Multisectoral working groups, such as the Joint Planning Mechanism, are present in most countries, mainly associated with specific ad hoc targets or issues. Some groups, for instance in the case of Bosnia and Herzegovina (FBIH), were formed for the purpose of designing strategic documents, primary and secondary legislation and developmental projects. In Croatia, they were formed during the development and harmonization process of strategic and policy documents. This implies that most of them have a time-limited duration and that their composition varies according to the discussed topic.

The second identified mechanism is **joint assessments**, which are associated with specific plans or programmes, for example in the assessment of the poverty strategy in Serbia, the assessment of the *National Strategy for Drug Abuse Prevention* in Croatia, and the assessment group for *Road Safety and Domestic Violence Prevention* in the former Yugoslav Republic of Macedonia.

A third set of mechanisms identified are formal structures, whether at the cabinet or parliamentary level. Three of these, national councils, parliamentary committees, and public policies units, are described below in greater detail.

National councils are described in the studies from Albania, Bulgaria, Serbia and the former Yugoslav Republic of Macedonia. In the last, it is described for a specific subject such as Road Safety. It is important to highlight that the National Council of Public Health in Albania will have representatives from all ministries, functions are described in Box 3. The composition, selection criteria for members, powers, duties and manner of operation shall be determined by the Council of Ministers.

Box 3. The Albanian National Council of Public Health has the following functions:

- analysing public health policies;
- proposing policies to improve people's health by integrating other sectoral policies;
- coordination of development strategies in specific areas of public health for the realization of adopted policies;
- evaluating the effectiveness of existing legal provisions;
- proposing amendments to existing legal provisions;
- giving opinions on draft normative acts and their public health impact;
- formulating positions on issues important to public health;
- establishing working groups for specific needs; and
- reviewing biennial public health report, before submission of the Ministry of Health Assembly.

Another example is in Bulgaria, which since 2002 has had the active Country Coordinating Mechanism (CCM) to Fight AIDS and Tuberculosis, established on the basis of the existing National Committee for Prevention of AIDS and STDs of the Council of Ministers. The CCM is a forum to promote coordinated multisectoral partnership and active involvement of the nongovernmental sector. Governmental institutions, civil society, organizations working with most-at-risk populations, donors, local authorities and people affected by the diseases participate in the decision-making process and monitoring and reviewing the progress of the national HIV/AIDS response. The chair of the CCM is a vice prime minister. In 2010, the CCM consisted of 14 members (35%) from the government sector, 6 (15%) from academia, 9 (23%) from NGOs, 5 (13%) from international organizations, 2 representatives (5%) of people living with HIV, 2 representatives (5%) of the private sector and 2 observers.

Parliamentary committees are described by several of the countries, including the Committee on Health, Labour and Social Policy in Bosnia and Herzegovina (RS), the Parliamentary Committee for Health,

Labour and Social Welfare in Montenegro, the Committee on Health and Social Protection in the Republic of Moldova and the committees on Health and Family, Poverty Reduction, Children Rights and Gender Equality in Serbia.

Public policies units have been established in each ministry in Romania to contribute to increased coordination, transparency, collaboration and substantiation of public policies within the whole government. They are comprised of multidisciplinary teams of doctors, economists and lawyers with expertise in project management and policy processes, and they ensure technical support for public policy elaboration, adoption and monitoring. They closely collaborate with the General Secretariat of the Government and the partner ministries for the adoption of all national public policies. They are responsible for impact assessment procedures and guidelines, so are well positioned to influence other sectors.

In addition, the studies identify **legal instruments** such as regulatory frameworks, as HiAP working mechanisms. These are present in most countries in the fields of health promotion and healthy lifestyles. However, not all of them are cited as facilitating HiAP work. Table 6 summarizes some of them. Montenegro describes an additional mechanism, the obligation of the Ministry of Health to comment and review all legislation prepared by other sectors in order to increase the intersectoral approach. However, implementation of the process has been difficult due to a lack of human resources. It has been suggested that there is the need to make better use of the existing institutional experience and define the responsibilities of each sector and institution.

Table 6. Joint working mechanisms to develop HiAP

	Legal instruments, regulatory frameworks and bodies	Cabinet or parliamentary committees, etc.	Accountability frameworks	Joint planning mechanisms
Albania		The National Council of Public Health has representatives from all line ministries		
Bosnia and Herzegovina	Federation of Bosnia and Herzegovina	Health Committee of the House of Representatives of the Federation Parliament	Surveys designed to obtain relevant evidence for further creation of sector-wide policies	Intersectoral working groups and bodies are formed in designing strategic documents, primary and secondary legislation and developmental projects
	Republika Srpska	Secretariat for Legislation and National Assembly	Committee of Health, Labour and Social policy; Committee for Equal Opportunities	Multisectoral working group for specific purpose
Bulgaria		Council of Ministers: for Reducing and Preventing Smoking, Child Protection and CCM		Interministerial working groups for specific themes
Croatia		Parliamentary Committee	Evaluation of the National Strategy for Drug abuse prevention	Multisectoral working group, during development and harmonization of policy and strategic documents
Montenegro	Regulatory bodies and agencies for health	Parliamentary Committee for Health, Labor and Social Welfare	Board of Health, Labour and Social Welfare	Numerous ad hoc multisectoral working groups and advisory bodies for

				legislation, administration and enforcement
Republic of Moldova	Law on State Public Health Surveillance 2009	Parliamentary Committee on Health and Social Protection		Intersectoral committees or working group for implementation of national programmes
Romania	Legal requirement of IA.	Public policies unit in each ministry.		Interministerial working group for specific themes; a permanent interministerial Council on Health, Consumer Protection and Social Affairs
Serbia		Parliamentary Committee for Poverty Reduction; Parliamentary Committee on Health and Family; Gender Equity Committee; Local Self-Government Advisory Committee	PRS joint evaluation	Multisectoral working groups develop and implement strategic documents and programmes, for example Children Rights Working Group
The former Yugoslav Republic of Macedonia	Secretariat for Legislation; The new Law on Public Health 2010 has Public Health Councils to coordinate activities locally and centrally.	National Council for Road Safety; National Council for Occupational Safety and Health.	Joint Evaluation Group for Road Safety and Domestic Violence Prevention	Joint Committee for Family Violence; Joint Memorandum of Inclusion (JIM); Governmental national coordination on domestic violence prevention

6. Impact assessment methodologies to develop HiAP

As evident from Table 7, only Montenegro, the Republic of Moldova, Romania and Serbia are using assessment methodologies that account for impacts on health and health equity. Three of them reported that environmental impact assessment (EIA) is the more frequently used methodology, but it does not cover health issues. Studies indicated a limited use of health impact assessment (HIA).

Examples of implementation and impact assessment include the Impact Analysis of Policies for PRS, Employment Policy and Active Labour Market Programmes in Serbia, the Integrated Impact Assessment (IIA) in Romania and the Republic of Moldova's Regulatory Impact Assessment (RIA) instrument managed by the Ministry of Economy for promoting Health policies and influencing policies of other sectors, which can be effective for new or modified documents but not for already existing policies. It would be important to know in more detail the experiences of these assessments, since they could present opportunities for advancing HiAP.

The former Yugoslav Republic of Macedonia recommends strengthening the use of HIA and promoting the use of available methodologies at national and local levels, integrating them into already existing assessment frameworks. HIA should be introduced using the online tool, which offers methodology and background information on key policy areas in relation to impacts on health systems.

Table 7. Impact assessment methodologies to develop HiAP

		Type of HIA: EIA, Social IA	Are there sanctions or incentives for conducting them?
Albania		No	No
Bosnia and Herzegovina	Federation of Bosnia and Herzegovina	No	No
	Republika Srpska	No	No
Bulgaria		No	No
Croatia		No	No
Montenegro		<ul style="list-style-type: none"> • Health impact assessment • Environmental impact assessment 	There are no sanctions or incentives to develop IA.
Republic of Moldova		<ul style="list-style-type: none"> • Regulatory Impact Assessment instrument managed by Ministry of Economy 	No
Romania		<ul style="list-style-type: none"> • Integrated Impact Assessment: policy impact assessment and regulation impact assessment • Environmental impact assessment • Health impact assessment is not systematically addressed or only for industrial regulation 	There are no sanctions or incentives to develop IA. IIA could be a good opportunity for addressing health in other policies
Serbia		<ul style="list-style-type: none"> • Impact analysis of policies for PRS • Impact analysis of employment policy and active labour market programmes • Impact analysis of health policies on the health care of the Roma Population • Study about air quality monitoring in NIS (Serbia) and health impact assessment 	There are no sanctions or incentives, usually performed with support of international agencies or as research studies by academic professionals. Not regular, only regarding specific programmes or policies.
The former Yugoslav Republic of Macedonia		No	No

7. HiAP information and monitoring

The case studies reported on access to HiAP information that would permit monitoring and assessment of strategies or plans, and the analysis of health equity by different indicators of socioeconomic status ie social stratifiers. Studies showed that none of the SEE Network countries had the ability to regularly monitor health outcomes disaggregated by a comprehensive set of socioeconomic indicators including income, education, occupation, gender, rural/urban setting, household size, migrant status and, if permitted by national law, ethnicity. Existing disaggregated data come from specific studies or surveys, and hence their collection is not an integrated part of the national information systems.

Table 8 illustrates the types of data available, or not, for monitoring inequalities related to the wider determinants of health for the SEEHN countries.

Table 8. Information for developing HiAP through equity analysis

Albania		The health system does not permit disaggregation of data on health status, health behaviour or utilization of health services by income level. Two surveys are the main sources of information for SIS: the Living Standards Measurement Survey (LSMS), a nationally representative household survey, first conducted in 2002, repeated in 2005 and 2008, and the Labour Force Survey (LFS), a national survey first conducted in 2007.
Bosnia and Herzegovina	Federation of Bosnia and Herzegovina	There is no capacity to disaggregate the data by socioeconomic variables. However, sometimes it is possible to obtain data through research studies.
	Republika Srpska	Mortality and morbidity data are disaggregated by gender but there is no disaggregation of data by income, education, occupation, household size or socioeconomic groups. The Multiple Indicator Cluster Survey (MICS) 2005–2006 shows the overall situation of children and women in health, sanitation and social aspects of life. Data obtained in this survey have been used in creating a variety of strategic documents such as: the <i>Policy for Early Childhood Development, 2011–2016</i> . This study has had an important influence on improving data quality for information system development relating to the health of vulnerable population groups.
Bulgaria		The existing information systems does not provide data on the relation between health and lifestyle, access to the health system, level of education, employment, gender, etc. Only special research does so.
Croatia		WHO ICD diagnoses permits disaggregating data for age, sex, county residence, marital status, employments status and education. All other information is only by special research.
Montenegro		Health and behaviour data related to health, well-being and health system access are divided by educational level, gender, age groups, rural-urban settling, education level, etc. from health surveys (latest data, 2008)
Republic of Moldova		Health reports use disaggregated data on health status by age, gender, rural-urban setting. Such data as health status related to household size, health behaviour, quality of life and well-being, health system access by income level, education level and occupation are produced by special survey. There is no health data related to ethnicity.
Romania		The report is not clear about capacity to analyse disaggregated data from socioeconomic indicator, etc.
Serbia		Routine system only disaggregates data according to administrative level. Additional data are available by survey. There is no disaggregation of data on health status, health behaviour or utilization of health services by income level. However, this gap was partially resolved by National Health Surveys undertaken in 2000 and 2006.
The former Yugoslav Republic of Macedonia		The defined basic data set as well as specific data will enable disaggregation by health status, health behaviour, quality of life, well-being and health system access by income, education, occupation, gender, rural-urban setting, household size, migrant status and ethnicity. Still, there is lack of data on lifestyle, socioeconomic categories, access to health and ethnicity..

Most of the countries lack mechanisms (legal, technical) for joined-up monitoring and assessment of intersectoral interventions and HiAP. However, studies highlight some initiatives that could facilitate these actions, as seen in Table 9.

Table 9. Monitoring and assessment of intersectoral interventions and HiAP

Albania	Medium- to long-term monitoring indicators and an annual bulletin with information on progress will be produced. The Social Inclusion Advisory Group (representative of NGOs) will provide a formal channel for feedback on social inclusion policies for the bulletin. Currently there is a gender officer in all institutions who report semi-annually on all the indicators specified in the gender strategy.
Bosnia and Herzegovina	None
Federation of Bosnia and Herzegovina	The study describes opportunities and mechanisms at the cantonal and local levels.
Republika Srpska	None
Bulgaria	None Regional reports are elaborated and presented to the regional administration. In some cases such reports are also prepared at local level and discussed with the municipalities. As a result of the problems identified in the report, programmes are designed for risk reduction at national, regional and local levels. In certain cases the population can directly request management of a certain health issue from particular institutions.
Croatia	It is planned as part of the surveillance of the implementation of the Overweight Prevention and Reduction Action Plan.
Montenegro	No The case study suggests that MDG monitoring could be an example, but yet there are no established concrete mechanism for joint monitoring and evaluation HiAP process.
Republic of Moldova	None
Romania	None
Serbia	None
The former Yugoslav Republic of Macedonia	None The EU integration process and harmonization with EU directives is the only existing mechanism in place for joined-up monitoring and evaluation of intersectoral interventions.

8.Capacity building to develop HiAP

Most countries reported no regular dedicated programmes to build policy-makers’ or public health professionals’ capacity to use HiAP. SDH training is only emphasized in Serbia, and courses in impact assessment methodologies are only underway in Romania. Most countries indicate that HiAP is not incorporated into undergraduate, graduate or continuing professional education for health professionals. Only Bosnia and Herzegovina (Republika Srpska) and the former Yugoslav Republic of Macedonia reported some partial incorporation of these issues.

Table 10 summarises capacity building activities for HiAP in each country.

Table 10. Capacity building for HiAP

	Are there any specific programmes dedicated to building the capacity of policy-makers/advisors and public health professionals to use HiAP?	Is HiAP incorporated into undergraduate, graduate and continuing professional education for health professionals?
Albania	No, there are no specific programmes.	No
Bosnia and Herzegovina	Federation of Bosnia and Herzegovina	No, none of the educational curricula include HiAP methodology.
	Republika Srpska	No
Bulgaria	No	No
Croatia	No, only specialist in Public Health and post graduate training in health promotion include some themes.	No
Montenegro	No, but some seminars on the topic have been organized. HiAP programmes are not incorporated in regular education, but within public health there is a programme in health policy.	No
Republic of Moldova	No	No
Romania	One course of IA of health policies in 2009	No
Serbia	No SDH training	No Undergraduate education in Serbian schools of medicine incorporate lectures about health determinants, particularly SDH, that include students from different disciplines.
The former Yugoslav Republic of Macedonia	No There are some HiAP elements in the School of Public Health's Management and Leadership in Health programme for 800 trainees.	HiAP is partially incorporated into post graduate studies of public health (MPH programme established in 2003) but not in the continuing professional education for health professionals.

9. Challenges and next steps

The case studies highlight challenges and needs in order to advance the HiAP agenda in SEE. While an overview of needs extracted from the studies can be seen in Table 11, they generally can be grouped in the following areas:

- more facilitative policy frameworks and legislation
- regional and national support for designing components of monitoring and assessment
- training for public health teams and decision-makers
- HiAP research to produce evidence for debate and advocacy
- exchange of experiences among countries

- more information for decision-makers on the benefits of intersectoral action
- convincing arguments for convincing other sectors.

The case studies note the scarce economic and human resources available for the development of these initiatives. However, times of crisis can bring unique opportunities for coordination and integration of policies, while also making changes for greater health equity. Major efforts are needed to effectively address health determinants, reaffirming the expressed commitments to EU strategies. Health determinants should be addressed as mediators between policies and health outcomes and equity considered as a core value. The case studies also indicate the need to strengthen information systems to better monitor health equity and the SDH, and underline the need for training for monitoring indicators and HiAP assessment.

From the legal perspective, the case studies emphasize the need for safeguards to ensure cooperation across sectors and institutions. Hence, legislation at the country level would be a facilitator and would support equity monitoring and HiAP development throughout the region. Likewise, there is a need for training in health equity, the SDH and HiAP for public health teams and decision-makers at national and local levels. Training is required for a better understanding of HiAP, its design and implementation, and its study at governmental and nongovernmental levels.

As for the next steps, the case studies can be useful tools for advancing the HiAP agenda, as present a range of opportunities for deeper analysis that could further clarify facilitating factors and barriers for the initiation of HiAP work, illuminating how favourable conditions in a given context have facilitated action and indicating further entry points for action. Deeper analysis can also respond to a number of key questions, such as the following.

- What mechanisms facilitate the start of the process? What are the main barriers?
- What mechanisms sustain the process?
- How does HiAP contribute to reducing health inequities?
- What is the health sector's role in the HiAP process?
- Which new capacities do health workers and policy-makers need?

Individual country needs are summarised in Table 11.

Table 11. Country needs for advancing HiAP

Country	Needs
Albania	<ul style="list-style-type: none"> • good evidence for all legal documents related to health • legal support for HiAP • monitoring indicators
Bosnia and Herzegovina	Federation of Bosnia and Herzegovina <ul style="list-style-type: none"> • a committee for public health in the Member States, as focal point for HiAP • mechanisms for intersectoral cooperation • a network for implementing HiAP methodology within the country
	Republika Srpska <ul style="list-style-type: none"> • an environment conducive to partnerships from both traditional and non-traditional sources • a holistic and interdisciplinary approach in prevention research • participatory research that engages communities from conceptualization through evaluation • proper health data collection systems
Bulgaria	<ul style="list-style-type: none"> • policy dialogue and synchronized health strategy planning and national development plans • a shift from cooperation and coordination towards integrative policies

- transparency and public access to information
- tools to implement this policy
- increased institutional capacity
- support for regular monitoring and evaluation
- a consolidated leading role for the health sector

Croatia

- maintaining and improving a strong and stable medical care system
- support for dealing with health inequities
- evidence-based public health research
- enhancing the environment oriented to health
- skills and tools to strengthen intersectoral collaboration
- strengthened public health advocacy in the decision-making process

Montenegro

- strengthened public health capacities for advocacy
- recognition of successful public health activities in sectors other than health
- government designation of the HiAP approach as priority goal and task of all sectors
- preparation mechanisms for the realization of planned goals
- precise goals of intersectoral activities for health and engagement of other sectors
- strengthened ministry capacities to enable HiAP advocacy

Republic of Moldova

- mechanisms for promoting health policies in relevant documents developed by other sector.
- optimization of sub-legislative acts to assure the implementation of Public Health Service Act
- a continuous training system for public health professionals and policy-makers
- a sustainable financial mechanism for public health institution.
- strengthened capacities of NGOs in the health sector for putting pressure on other sectors

Romania

- knowledge of the type of specialists, projects, policies and objectives needed
- clear instruments available to all
- updated examples of best practices
- political support

Serbia

- a national public health council comprised of members of line ministries, public health experts, representatives of NGOs and local authorities
- an official statistical system for monitoring the health status of vulnerable population groups
- a research agenda and a funding estimate for building the evidence base for health improvement policy
- more integrated learning opportunities for students in public health and related health professions

The former Yugoslav Republic of Macedonia

- strong partnerships and alliances among sectors
- further structural development of the HiAP mechanisms and instruments
- improved health data and evidence, with proper disaggregation
- health determinants as mediators between policies and health
- equity as a core value
- a new role of health sector, emphasizing improvement of health governance
- public support and participation
- investments in human capacities and resources.

To respond to this set of issues and others, a first step is to further clarify the HiAP definition to be used by all SEE countries. It is important to outline the main pillars and agree on a common language, then to facilitate the exchange of experiences and learning together (17,18). In the majority of cases studies, many

of the examples only touched upon some of the assessment criteria indicated in Box 1. It is necessary to delve deeply into the case studies in order to have a more precise diagnosis of HiAP progress and status. It is necessary to agree on the frameworks to be used, the common terms and concepts and the criteria for assessing progress.

The HiAP stages summarized in Table 12 would suggest that there are currently different levels of HiAP application in SEE countries. The proposed classification of HiAP experiences in SEE contained in this report is only an initial proposal and together with the criteria for assessment in Box 1, should be further discussed, developed, amended and agreed upon by SEE country representatives in the follow-up to the Third Ministers' Forum in Banja Luka.

Table 12. Proposed classification of HiAP stages in SEE

	Criteria	Descriptions	HiAP cases	HiAP under development with good opportunities	HiAP under development
Context and Mechanisms in the beginning	Political will to develop HiAP	Yes	x	x	x
		No			
	Vision of health addressing other sectors	Vision for health embraces wider social and well-being indicators	x	x	
		Vision for health looks predominantly at diseases and care			x
	Structures, either formal or informal, for negotiating power)	Yes	x		
		No		x	x
Equity and SDH lens in the design of Interventions: Strategies and plan	Intersectoral action across all parts of government	All sectors	x		
		Not all sectors but includes more difficult sectors		x	
		Not all, only more win-win sectors		x	x
	Equity as an explicit target/ outcome of HiAP	Yes	x	x	
		No			x
	Main approach to address equity	Tackling inequities across the social gradient	x		
		Improving the situation of the most vulnerable		x	x
	Addressing SDH	Addressing structural and intermediate determinants	x		
		Addressing intermediate determinants, such as lifestyle, working conditions and housing		x	
		Not addressing social determinants or solely those related to the health system			x
	Coverage approach	Universal		x	
		Target		x	x
		Mixed	x		

Mechanism or capacity for sustainability	Solid information base to analyse equity and HiAP	Yes	x	x	
		No			x
	Personnel with appropriate public health training	Yes	x	x	
		No			x
	Good knowledge of the policy-making system and structures	Yes	x	x	
		No			x
	Personnel with negotiating skills	Yes	x	x	
		No			x

References

- Solar O et al. Moving forward to equity in health: What kind of intersectoral action is needed? An approach to an intersectoral typology. Paper for the *7th Global Conference For Health Promotion, Nairobi, 26–30 October 2009*.
- Judge TA et al. Dispositional effects on job satisfaction and life satisfaction: The role of core evaluations. *Journal of Applied Psychology*, 1998, 83, 17–34.
- Ståhl T et al., eds. *Health in all policies: Prospects and potentials*. Helsinki, Ministry of Social Affairs and Health, 2006 (http://ec.europa.eu/health/archive/ph_information/documents/health_in_all_policies.pdf, accessed 16 September 2011).
- Chung H, Muntaner C. Welfare state matters: A typological multilevel analysis of wealthy countries. *Health Policy*, 2007, 80:328–339.
- Meijers E, Stead D. Policy integration: what does it mean and how can it be achieved? A multidisciplinary review. Paper presented at the *Berlin Conference on Human Dimensions of Global Environmental Change, Freie Universität Berlin, 3–4 December 2004*.
- Solar O, et al. Moving Forward to Equity In Health. What kind of intersectoral action is needed? An approach to an intersectoral typology. Paper presented at the *7th Global Conference on Health Promotion, “Promoting Health and Development: Closing the Implementation Gap”, Nairobi, Kenya, 26–30 October 2009*.
- Timpka T, Nordqvist C, Lindqvist K. Infrastructural requirements for local implementation of safety policies: the discordance between top-down and bottom-up systems of action. *BMC Health Services Research*, 2009, 9:45.
- Shankardass K et al. *Getting started with “health in all policies”: A resource pack*. Toronto, Centre for Research on Inner City Health (CRICH), 2010.
- Torgersen TP, Giæver Ø, Stigen OT. *Developing an intersectoral national strategy to reduce social inequalities in health: The Norwegian Case*. Geneva, World Health Organization, 2007.
- Tervonen-Goncalves L, Lehto J. Transfer of Health for All policy: What, how and in which direction? A two case study. *Health Research Policy and Systems*, 2004. 2(1):8.
- Whitehead M, Dahlgren G. *Concepts and principles for tackling social inequities in health: Levelling up Part 1*. Copenhagen, World Health Organization Regional Office for Europe, 2006.
- Deaton A. Policy implications of the gradient of health and wealth. *Health Affairs*, 2002, 21(2):13–30.
- Arno P et al. Bringing health and social policy together: The case of the earned income tax credit. *Journal of Public Health Policy*, 2009, 30(2):198–207.
- Mkandawire T. Targeting and universalism in poverty reduction. Geneva, United Nations Research Institute for Social Development, 2005 (Social Policy and Development Programme Paper Number 23).
- Marmot M et al. Fair society, healthy lives. *The Marmot Review*, 2010, April (<http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf>, accessed 16 September 2011).

16. Saint Pierre L et al. *Governance Tools and Framework for health in all policies*. Quebec, National Collaborating Centre for Healthy Public Policy, 2009.
17. O'Neill M et al. Coalition theory as a framework for understanding and implementing intersectoral health-related interventions. *Health Promotion International*, 1997, 12(1):79–87.
18. Sabatier P. *Theories of the Policy Process*, 2nd ed. Jackson, TN, Westview Press, 2007.

II. Health in all policies in SEE Health Network Member States

1. Albania

Summary

Over the past two decades, Albania has changed from a centralized economy to a free market economy and the country has experienced slow but steady economic progress. During this transition, many questions related to privatization and proper business practices and regulation have remained unresolved.

The poverty level in Albania is one of the highest in Europe, and this remains a concern of the government. The social policies launched over recent years, combined with the promotion of economic development, have enabled large numbers of people to overcome poverty. The high GDP growth rates, and wage and pension increases reduced poverty from 25% of the population in 2002 to 12% in 2008.

The preparation of strategic documents and national programmes is a product of collaboration of experts from all ministries, professional institutions, civil society organizations, international partners, universities and local governments. There are also agreements in place for prioritization of problems and monitoring and evaluation, but in reality collaboration among different sectors or institutions is difficult regarding reporting, sharing information and giving feedback.

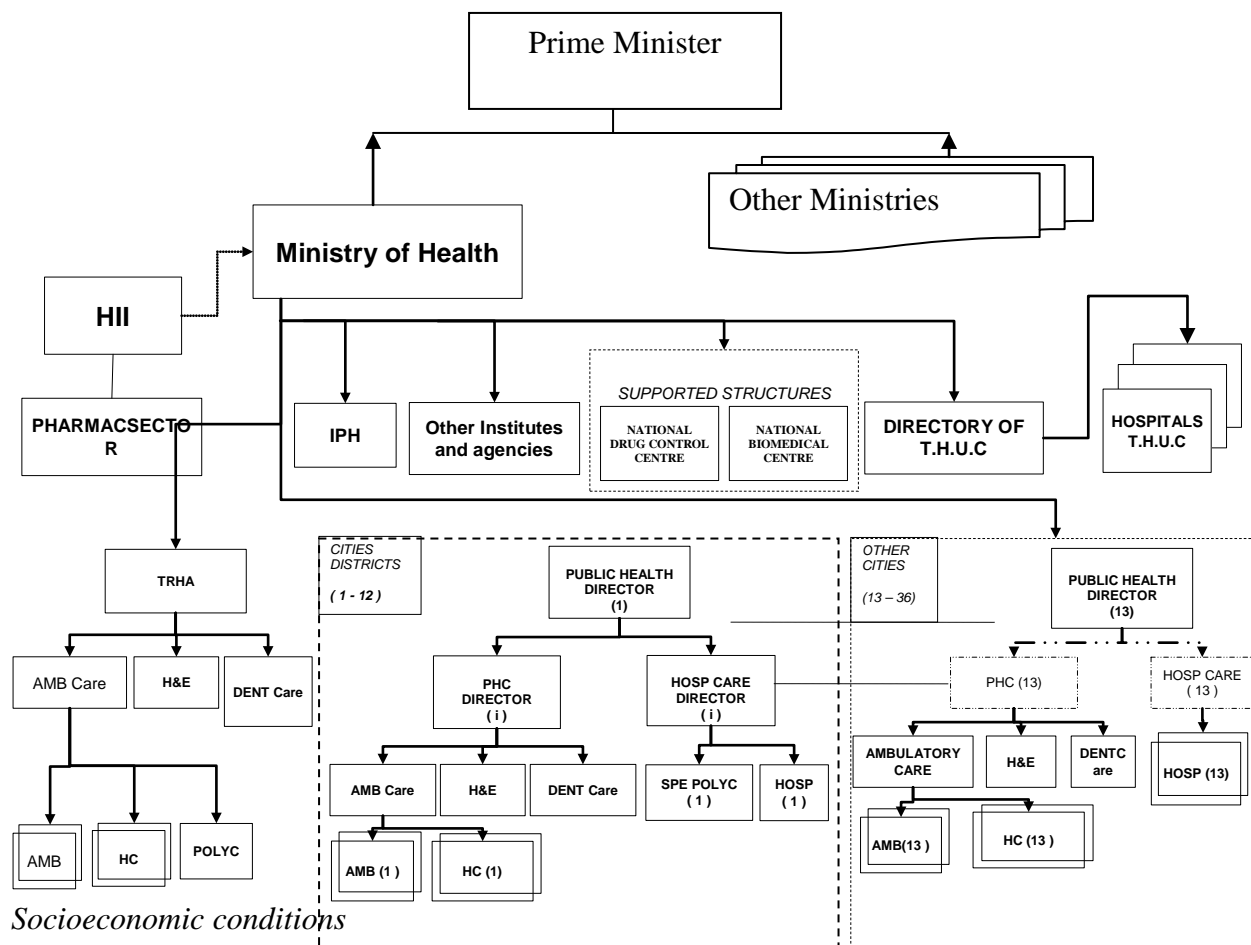
A core working group of five people from the Ministry of Health and the Public Health Institute was set up, including: Gazmend Bejtja, Director of Public Health, Ministry of Health; Elizana Petrela, Country Project Manager, Public Health Institute; Arben Luzati, Head of Sanitary Expertise Department, Public Health Institute; Antoneta Njehrrrena, lawyer, Ministry of Health; Erol Como, specialist, Ministry of Health. Relevant documentation was gathered and several meetings were organized with focal points in all line ministries, which undertook joint initiatives or activities. Meetings were held to discuss the current situation and the implementation and monitoring and evaluation of these activities or strategies. After compilation of the final report, the material was divided among group members and additions and amendments made.

Country context

Political background

Administratively, Albania is divided into 12 prefectures or counties within which there are 36 districts. The third-level administrative divisions are municipalities in urban areas or communes in rural areas. The capital is Tirana. The health sector follows the same subdivision on regional and district levels. Each regional prefecture comprises about three districts that are responsible for administering district hospitals, polyclinics and primary health care (PHC) centres through the regional or district public health departments, which are the Ministry of Health's local affiliates. Health care is supplied by a multitude of public and a limited number of private providers. The key public provider is the Ministry of Health. Other public ministries (Defence, Education, Justice) also provide some health care services, but their capacities are limited. The main ministries that have some health role in laws, strategies and programmes include: Ministry of Labour and Social Affairs and Equal Opportunities, the Ministry of Environment, Forests and Water Administration, the Ministry of Agriculture, Food and Consumer Protection, the Ministry of Tourism, Culture, Youth and Sports, the Ministry of Public Affairs, Transport and Telecommunications, the Ministry of Economy, Trade and Energy, the Ministry of Education and Science, as well as the Ministry of Finance, the Ministry of Justice and the Ministry of Defence.

Figure 3. Structure and organization of the government in the area of health



Socioeconomic conditions

The end of communism occurred later in Albania than in most of the rest of eastern Europe. It was accompanied by economic turmoil and extensive emigration, particularly to Italy and Greece. Since then, the government has made economic reform its key policy and has led the country towards becoming a market economy. As part of the reforms, most agriculture, government-owned housing, and small industry were privatized. This was followed by the privatization of transport, public services, and small and medium-sized enterprises. Many questions related to privatization, proper business practices and regulation have remained unresolved.

During recent years the country has experienced slow but steady economic progress. Per capita GDP rose from US\$ 1092 in 1996 to \$2622 in 2006. Many of the socioeconomic conditions in the country impact directly on the health of the population, including the provision of water and basic nutrition. The social policies launched in recent years, combined with the promotion of economic development, have enabled large numbers of people to overcome poverty. The high GDP growth rate, and wage and pension increases have caused a reduction in poverty, but it remains a concern of the government, as the poverty level is one of the highest in Europe. The proportion of the population whose monthly per capita consumption is below 4891 leks¹ (in 2002 prices) fell from 25% in 2002 to 19% in 2005 to 12% in 2008. This means that roughly 200 000 out of about 575 000 poor people were lifted out of poverty by 2005. The extremely poor population – defined as those with difficulty meeting basic nutritional needs – decreased from about 5% in 2002 to 4% in 2005 to 1% in 2008 (1). More than half of Albanian households (52%) own agricultural land.

Health system

¹One lek = US\$ 103 as at 19 September 2011.

The health system in Albania is mainly public. The state is the major provider of health services, health promotion, prevention, diagnosis and treatment. The private sector, which is still developing, covers most of the pharmaceutical and dental services, as well as some clinics for highly specialized diagnosis, mostly in Tirana and one or two other major cities. The Ministry of Health is the leader in health policy development and planning and implementation of health strategies. There is a well-developed health system with extensive facilities providing maternal care services and childhood vaccinations. Overall, 95% of children 18–29 months old are fully vaccinated and less than 1% have never been vaccinated.

Albania has a health insurance based financing system, regulated by the Health Care Act and the Health Insurance Act. However, the funds earmarked in the Ministry of Health budget are not sufficient. Health insurance has been institutionalized since 1995, and this is an important element of the health system reform, crucial to financing health care, increasing health resources, and ensuring improvements in the quality of health services.

Demographics

According to the latest census data of April 2001, the total population was 3 069 275 million inhabitants (2). In 2008 the population was estimated at 3 170 048. The pre-1991 growth rate was high, given the pro-natalist policy of the previous regime. The fertility rate has been declining steadily, from 6.8% in 1960 to 2.2% in 2005. The population is relatively young, with an average age of 31.4 years in 2001. One third of the population are under 15 years old and 40% are under 18. Half of women are of reproductive age (15–49 years). The under 15 population is decreasing and the over-65 population is growing. The majority of people, approximately 55%, live in rural areas, with one-sixth of respondents in Tirana. The average household has 3.8 people. Sixteen per cent of households are headed by women. Three per cent include orphans or foster children. From 2001–2005, life expectancy at birth was 72.1 years for males and 78.6 for females (3). In 2002, WHO estimated a healthy life expectancy of 61.4 years: 59.5 years for males and 63.3 years for females. Albania is an ethnically homogeneous country. More than 98% of the population is ethnic Albanian with small groups of Greeks, Macedonians, Vlachs, Roma, Bulgarians and Serbs.

Burden of disease

The infant mortality rate (IMR) and under five mortality rate in Albania are relatively high compared to other European countries, even though both rates have decreased steadily in recent years. Maternal mortality is also high compared to other European countries, at an estimated 17 deaths per 100 000 live births in 2006 (4). With about 35 000 live births per year, there were six maternal deaths in 2006. Results from the 2008–2009 Adult Dental Health Survey (ADHS) indicate that there had been a decline in childhood mortality over the five years preceding the survey (5). For example, infant mortality has declined from 26 deaths per 1000 live births for 1992–2002 to 18 for 2005–2009. There has been a similar decline in under five mortality from 32 to 22 deaths per 1000.

Albania presents some peculiarities in its epidemiological profile. While the mortality patterns are similar to those observed in developed European countries, the morbidity patterns are more similar to those of developing countries. There is a high prevalence of infectious diseases such as diarrhoeal diseases that are related to poor environmental conditions, while at the same time vaccine-preventable diseases such as diphtheria, measles, rubella and neonatal tetanus are well on their way to being eliminated from the population or, like polio, have already been eliminated. While the burden of communicable diseases is generally decreasing, cases of HIV infection and tuberculosis are increasing. There are 0.7 new cases of HIV infection and 18 new cases of tuberculosis per 100 000 population per year, although HIV infection is low in Albania. Most cases of HIV have been diagnosed among women and men 25–44 years old. Since 2000, however, the proportion of women who have contracted HIV/AIDS has increased.

Overall, the incidence rates of STIs are generally low compared to European Union countries. Brucellosis has remained stable during the past two years after more than 10 years of an apparent epidemic increase. The relatively high incidence of hepatitis A infections is related to the main route of transmission, person to person (the faecal-oral route) and the high prevalence of diarrhoeal diseases. The incidence rate of

hepatitis B is more than 8 new cases per 100 000 population per year, which puts Albania in the high endemic category. However, there has been a steady decrease in the incidence and morbidity related to hepatitis B since the mid-1990s due to the mandatory vaccination of all children since 1994, as well as the ongoing improvements in medication procedures. Communicable diseases cause about 1% of all deaths in Albania (6).

The prevalence of cardiovascular diseases and cancer is increasing. CVD are the leading cause of death, accounting for 52% of all deaths. Within this group, the leading cause of morbidity and mortality is ischemic heart disease, accounting for 7% of the disease burden and 15% of all deaths (128 deaths per 100 000 population per year). These rates are lower than those reported by other central and eastern European countries but higher than in western European countries.

The breast cancer incidence rate is 20 new cases per 100 000 population per year, which is lower than in EU countries. However, the rate is increasing and the increase cannot be explained by recent demographic changes alone. Furthermore, there are 13 new cases of lung cancer and 4 new cases of cervical cancer per 100 000 population per year, a rate slightly higher than that in the EU.

Mental health has also been affected by recent demographic, social and economic changes in. There are 4 suicides or self-inflicted injuries per 100 000 population per year, which is lower than in EU countries, but the rate is increasing. Neuropsychiatric disorders account for 20% of the total disease burden and 3% of all deaths. Unintentional injuries are responsible for 43 deaths per 100 000 population per year, a figure much higher than the rates reported in western Europe. In Albania, injuries from traffic accidents cause 12 deaths per 100 000 per year. Respiratory diseases cause 6% of all deaths, or 47 deaths per 100 000. Smoking alone accounts for 22% of the disease burden, alcohol consumption causes 6%, obesity causes an estimated 10%, and physical inactivity causes 5% (7).

Policy frameworks

The government has established the *National Strategy for Development and Integration 2007–2013*, a document that unites the principal agendas in which health is a component into a separate chapter, identifying it as a priority. Many legal documents, strategies and programmes in different sectors also identify health as a priority:

- *National Strategy for Development and Integration 2007–2013*
- *Common Strategy on Consumer Protection and Market Surveillance*
- *Agriculture and Food Sector Strategy, 2007–2013*
- *Common Rural Development Strategy*
- *National Waste Management Strategy and Action Plan*
- *Air Protection Act, no. 8897*
- *National Strategy for Social Inclusion*
- *National Strategy for People with Disabilities*
- *National Strategy for Gender Equality and Preventing Domestic Violence*
- *Strategy for Improving the Living Conditions of Roma Minority*
- *Labour Inspection Act, no. 9634*
- *Safety and Health at Workplace Act, no. 10237*
- *Gender Equality in Society Act, no. 9970*
- *Measures Against Violence in Family Relations Act, no. 9669*
- immigrant integration measures
- city planning regulations
- zoonosis control measures
- consumer protection measures
- water quality control regulations.

Documents and strategies that have been implemented or are in implementing phase include the following.

The *National Environmental Health Action Plan* (NEHAP) of 10 June 1999 was prepared by the Ministry of Health in cooperation with other actors such as the Ministry of the Environment, Forests and Water Administration, the Ministry of Public Affairs, Transport and Telecommunications, the Ministry of Economy, Trade and Energy, the Ministry of Agriculture, Food and Consumer Protection. It is based on the model of the European Environmental Health Action Plan (EHAPE), approved during the *Second Conference of Environment and Health Ministers in the European Region, June 1994*.

The *National Environmental Action Plan* of 28 January 2002 was led by the Ministry of the Environment in cooperation with the Ministry of Health and others.

The *Children's Environmental Health Action Plan for Europe* (CEHAPE) was approved during the *Fourth Conference on the Environment* in June 2004. Implementation of all four CEHAPE priorities has been addressed through cooperation with WHO and other SEE countries.

The *Consumer Protection and Market Surveillance Strategy* of 14 December 2007 was led by the Ministry of Economy, Trade and Energy, in cooperation with the Ministry of Health and the Ministry of Agriculture, Food and Consumer Protection.

The *Food and Nutrition Action Plan, 2003–2008* was drafted based on the *European Action Plan for Food and Nutrition* and the WHO Regional Office for Europe's *First Action Plan for Food and Nutrition Policy, 2000–2005*, approved by the Regional Committee in 2000.

The *Situation Analysis and Food and Nutrition Action Plan for Albania 2003–2008* of 10 June 2003 was drafted by the Ministry of Health in cooperation with other ministries including the Ministry of Economy, Trade and Energy, the Ministry of Education and Science, the Ministry of Labour and Social Affairs and Equal Opportunities, the Ministry of the Environment, Forests and Water Administration, the Ministry of Finance, UNICEF, WHO and the Albanian Institute of Statistics of Albania (INSTAT).

Guidelines on Healthy Nutrition in Albania was prepared by the Ministry of Health within the framework of the Stability Pact Project *Strengthening of Food Safety Services and Nutrition in countries of South East Europe* in cooperation with the Ministry of Agriculture, Food and Consumer Protection and the Ministry of Education and Science. During the process we cooperated with other countries in the region, always considering WHO guidelines and recommendations. The Guideline was approved by the Minister of Health in March, 2009.

Reproductive health

Reproductive health in Albania is understood according to the WHO definition, approved during the *United Nations Conference on Population and Development* in Cairo in 1994. Policies to improve reproduction health have aimed at integrating the services of mother and child health with other of services such as family planning, STI and HIV/AIDS services and prevention and treatment of violence, and making them available for everyone on the basis of gender equality, specifically for the most affected and vulnerable groups. Reproductive health services include cooperation between different existing primary care services, such as mother and child centres, family planning centres and laboratories, STD control centres and others. Services are offered from health centres in cities and villages as part of the PHC package. The staff of the centres, including family doctors, nurses and midwives, is trained in different areas such as mother care, child care, family planning, HIV/AIDS and prevention and treatment of violence.

The National Committee of Reproductive Health (NCRH) was established by the Minister of Health in 2006 to facilitate the continuous contribution of the health sector and other sectors such as education, labour and finance to reproductive health services, which are integrated at the local administrative level. Its role as a consultative and decision-making body of the Ministry of Health is to prepare the *National*

Reproductive Health Strategy and Action Plan, and to consider, approve, analyse and coordinate projects, national programmes and activities in the field of reproductive health, in cooperation with donors, international organizations and NGOs and to make a continuous evaluation and analysis of reproductive health, especially that of mother and child. The committee is made of different actors and sectors representing the main directorates of the Ministry of Health, the Institute of Public Health, the Faculty of Medicine, the National Centre for Accrediting, Standards and Quality, Ministry of Labour and Social Affairs and Equal Opportunities, Ministry of Youth, Culture, Tourism and Sports, the Health Care Insurance Institution and international partners and organizations such as WHO, UNICEF, UNFPA and USAID.

The aim of the strategy is to offer affordable, high quality services that include all reproductive health components, in order to improve health status and reduce disease and mortality. The strategy has focused specific interventions for the population during different stages of life. It is based on a few leading principles, including intersectoral cooperation and participation of the community and interest groups. There are several programmes that involve donors, international agencies and different sectors.

The *Integrated Management of Childhood Diseases Programme* is a WHO and UNICEF global strategy focused on the well-being of children during the important period of early childhood, 0–5 years.

The *Friendly Services for Youth Programme* of UNICEF, the Ministry of Health, the Ministry of Tourism, Culture, Youth and Sports and the Directorates of Public Health aims to establish friendly services for youth in some pilot centres integrated into PHC, with multidisciplinary health teams.

The *National Programme for the Reduction of Malnutrition in Albanian Children, 2009–2012* is financed by the Spanish government and implemented with the technical assistance of UNICEF, FAO and WHO, and approved by the Minister of Health and the Minister of Food and Consumer Protection in 2009.

Health inequalities

Article 55 of the Albanian Constitution considers health a basic human right and it is elaborated through several laws that address inequalities in health and health determinants (8, 9, 10, 11), for example, the poverty reduction or economic development strategies, which give a significant role to health and health determinants, as well as social cohesion and inequality. The law extends the guarantee of equal rights to health care, based on non-discrimination with a health care system based on efficiency and quality of services, ensuring patient safety and equity, the participation of patients, customers and citizens and accountability to citizens (9).

Healthy lifestyle

There are legal, regulatory and administrative provisions in force to promote healthy lifestyles. Article 55 of the Constitution states that the citizens shall be equally entitled to the right to health care. Everyone shall be entitled to health insurance under the procedure established by law. In Article 59, the State aims at the highest possible standards of physical and mental health; education and training of children, youth and the unemployed; a healthy environment; care and assistance for the elderly, orphans and the disabled; development of sports and recreation activities; health rehabilitation, specialized education, social integration of the disabled as well as a continuous improvement of their living conditions.

There are a number of strategic documents on a healthy lifestyle including the *Public Health Strategy* and the *Health Promotion Strategy 2002–2010, Towards a healthy country with healthy people*(12), and the *National Anti-drug Strategy, 2004–2010*(13). There are also other laws supporting a healthy lifestyle including the *Reproductive Health Strategy*, recommendations on healthy nutrition from Ministry of Health and the *Common Strategy for Consumer Protection and Market Surveillance*, as well as others regarding public health, tobacco use, alcohol consumption, prevention of iodine deficiency and health insurance (8, 10, 11, 14, 15).

Social inclusion

The *Social Inclusion Strategy* (SIS), approved on January 2008 by the Council of Ministers, is one of the most important government policy documents and an imperative strategic document in Albania's movement towards integration into the EU. This cross-cutting strategy aims toward integrated, preventive and active social policies, as well as refocusing on investment and commitment to social inclusion. The strategy is a component of the *National Strategy for Development and Integration* and modelled on the *National Action Plan for Social Inclusion of European Union Member States*, so Albania, as a prospective candidate country, will eventually need to submit such a plan. In this framework, social inclusion is considered a priority of the current government, with poverty reduction as its main focus, to be ensured not only through economic development, as it focuses on poverty and social exclusion risks that remain even with economic growth. SIS is as an umbrella document for a set of strategic texts on vulnerable groups including children, Roma, people with disabilities, women, young people in high risk groups and the elderly. As a cross-cutting strategy, it is fully consistent with the underlying sector strategies and in particular those policies and institutional arrangements for assisting vulnerable individuals, families and groups so that they are able to operate independently, be self-sustaining and have the same rights as other members of society.

Its strategic priorities are to:

- raise income generation opportunities by facilitating labour market participation and promoting lifelong learning;
- tackle disadvantages in education and training, prevent early departure from formal education and training, ensure access for all children, particularly those from marginalized groups and improve the quality of education;
- facilitate access to services including social care, education, health, justice, housing, transport, telecommunications, water and sanitation;
- modernize social protection systems, ensuring new social assistance schemes targeted to needy households and individuals; and
- assist vulnerable groups.

Modernizing social care services includes improving residential and daily support services to families as well as community-based services across the country. Health service improvements include ensuring access of the whole population to the main services and protection from excessive expenses. Broader social aims include ensuring access to accommodation and to social housing for low income families, legal assistance services to ensure equal access to legal processes for all citizens, access to water and sanitation of EU standards in urban and rural areas, access to transport services in urban and rural areas and access to inexpensive telecommunication services. There is a particular focus on integrated policies and measures aimed at vulnerable groups, including:

- children at risk – to ensure early intervention for their development and protection from all kinds of abuse, violence and exploitation;
- the Roma community –to improve their status by reducing poverty, overcoming discrimination and ensuring integration;
- the disabled – to promote their full inclusion in all areas of life and
- the elderly – to alleviating economic difficulties and social deprivation and create possibilities for a decent, long and healthy life in old age.

Other aims are in the areas of:

- gender equality – to achieve equally beneficial outcomes for women and men through a combination of mainstreaming and targeted measures, particularly increasing economic sustainability, participation in decision-making and access to justice; and
- reducing domestic violence – to recognize domestic violence as a crime perpetrated mainly against women and develop prevention measures and protection of victims.

Monitoring and evaluation

Reducing the effects of social exclusion requires concerted effort across government and partnership with wider society. SIS monitoring and evaluation is based on sector strategies that have their own accountability and mechanisms. Medium-to-long-term progress in implementing SIS will be assessed on the basis of specific monitoring indicators. To ensure accountability and continue to give an overview of developments in the areas of social inclusion, an annual bulletin will be produced, with information on progress. The Social Inclusion Advisory Group (comprised of representatives of NGOs) will provide a formal channel for feedback on social inclusion policies for the bulletin. Currently, policy evaluation is provided primarily by donor agencies and research institutions. INSTAT is also able to provide good quality information through its policy evaluation surveys. Social inclusion staff in the Ministry of Labour and Social Affairs and Equal Opportunities also monitors and evaluates the social inclusion strategy, including through the bulletin. In this way, Ministry applies social policies that will help reduce poverty and support groups in need, as well as focusing on its role as coordinator of common issues in areas covered by the other ministries.

Two sets of indicators will be used, the EU indicators (Laeken) and other indicators of national importance. The Laeken indicators were adopted by the European Council in 2001 to monitor progress towards poverty eradication by 2010 and to improve understanding of social exclusion. The decision to use these indicators allows some degree of comparison with other European countries, and draws attention to the statistical surveys that will allow their measurement. However, the Laeken indicators measure poverty by means of income comparisons, which may be appropriate in economies where the labour market is formal and income reporting is reliable, but in Albania, where the majority of people are employed informally, welfare levels are best measured using consumption indicators and it is recommended that this approach be used in the foreseeable future. Although this means that the indicators will not be directly comparable to those of EU Member States, they will nevertheless provide a more reliable picture of socioeconomic conditions. Some of the Laeken indicators have been left out either because the necessary statistical instruments are unlikely to become available in the next seven years, such as those needed to measure low income persistence, or because they are less relevant for Albania, such as those on regional cohesion. Two surveys will be the main sources of information: the Living Standards Measurement Survey (LSMS), a national household survey, conducted in 2002, 2005 and 2008, and the Labour Force Survey (LFS), a national survey first conducted in 2007. The second set of indicators captures further issues of national significance. Among them, indicators related to the MDGs, which Albania has committed to achieve by 2015, feature prominently. Other indicators are expected to be measured primarily through administrative data.

According to a Strategic Planning Committee decision, the Ministry of Labour and Social Affairs and Equal Opportunities has been appointed as the lead ministry in formulating and implementing SIS. A prime ministerial order has established the Interministerial Committee on Social Inclusion, headed by the Minister of Labour, Social Affairs and Equal Opportunities and comprising members from all the participating ministries. It specifies the roles and responsibilities of the Committee. There are two groups functioning to support the Interministerial Committee: a cross-cutting technical working group led by the Vice Minister of Labour Social Affairs and Equal Opportunities and the Social Inclusion Advisory Group, which comprises non-government and business stakeholders.

Mechanisms, tools, instruments and platforms for advancing HiAP

Article 11 of the *Public Health Act* of 11 May 2009 establishes the National Public Health Council, which will coordinate the functioning of the public health system and provide a basis for policy development. It is an advisory body, under the Minister of Health, advising the latter on the development and implementation of coordinated public health policy to preserve and protect the health of the population. Its composition, selection criteria for members, powers, duties and manner of operation are determined by the Council of Ministers. The Council will encourage cooperation among actors in the health field. The scope

of its work includes:

- analysis of public health policies
- policy proposals to improve health by integrating other sectoral policies
- coordination of development strategies in specific areas for the realization of adopted policies
- evaluating the effectiveness of existing legal provisions
- proposing amendments to existing legal provisions
- giving opinions on the public health impact of draft normative acts
- establishing working groups for specific needs
- reviewing the biennial public health report before its submission of the Health Ministry Assembly.

HiAP aims to achieve equity, so is important that the Council ensure intersectoral collaboration and lay the groundwork for initiatives undertaken for better health and health for all, which will require evidence and measurable indicators.

Information for HiAP

The health information system in Albania is fragmented, and does not allow for the disaggregation of all data on health status, health behaviour and utilization of health services by socioeconomic status, including income level. There are many efforts underway from the Ministry of Health, Albanian experts and partners (WHO, USAID, World Bank, and others) to establish a national health information system strategy. There is a unique information system in place for primary health services, but with many problems concerning sharing.

National health surveys collect data on the SDH, self-assessed health status, lifestyles, access to health services and household health expenditure. These data enable evaluation of policies and programmes in the period between surveys and identification of priority problems and implementation of activities for improvement of population health status. Such surveys include periodic LSMS, multiple indicator cluster surveys, demographic and health (DHS) surveys (5).

Capacity building for HiAP

The Faculty of Medicine prepares specialists in public health through a postgraduate course in public health, including a 5-year of undergraduate curriculum leading to the Specialist in Public Health degree. The University of Montreal, Canada, organizes training courses in Health Management. The Continuous Education Centre in the Ministry of Health has a unit which can be used very successfully for HiAP capacity building. The public health associations in Albania, such as the National Association of Public Health, the Albanian Association of Epidemiology, the National Association for Health Information and others, have experience in continuous education and can be very good resources for capacity building. At present HiAP is not incorporated into any undergraduate, graduate or continuing professional education for health professionals, nor are there any specific systematic or ad hoc HiAP capacity building programmes for policy-makers or advisors.

Challenges, opportunities and recommendations

Challenges facing HiAP implementation include gaining recognition for the approach and establishing monitoring and evaluation systems for it. There are opportunities to make better use of the existing skills of the public health staff and to ensure that current information and data are better used by policy and decision-makers. In light of these factors and the above, we recommend:

1. collating of all legal and other documents impacting health for monitoring, evaluation and showing achievements;
2. establishing a legal basis to guarantee cooperation and coordination among institutions;
3. developing the indicators for monitoring health;
4. use of HIA as a decision-support tool for policy development in and outside of health.
5. preparing HiAP capacity throughout SEE;

6. establishing a permanent secretariat with experts and organizational structures to support HiAP for the region;
7. establishing national legal frameworks for HiAP; and
8. support the development of human resources for HiAP.

References

1. *Causes of death for the year 2007*. Tirana, National Institute of Statistics, 2009.
2. *2001 Population and housing census of Albania*. Tirana, National Institute of Statistics, 2002.
3. *Women and Men in Albania*. Tirana, Institute of Statistics, 2008.
4. *Albania Millennium Development Goals report 2005*. Tirana, United Nations Development Programme, 2007.
5. *Albanian demographic and health survey (ADHS)*. Tirana, National Institute of Statistics, 2009.
6. Kakarriqi E. 2002. *Epidemiological background of infectious diseases in albania and their prevention and control in the context of natural disasters and infectious diseases..* Tirana, R&T Advertising, 2002.
7. *An overview of the health care system in Albania. Some performance indicators*. Tirana, Ministry of Health, 2009.
8. Shendeti ne Shqiperi, Raporti i ISHP mbi Indikatoret Kryesore te Shendetit dhe Faktore te Tjere qe Ndikojne mbi ta [Health in Albania, The Report of the Public Health Institute on Key Health Indicators and other factors that affect them]. Tirana, Institute of Public Health, 2004.
9. Public Health Act of 11 May 2009 (Law No. 10138). *Official Journal*, 2009, 87:3303
10. Health Care Act of 23 April 2009 (Law No. 10107). *Official Journal*, 2009, 46:2304.
11. Act on protection of health from tobacco products, of 6 November 2006 (Law No. 9636). *Official Journal*, 2006, 124:4970.
12. Act on the protection of minors from the use of alcohol, 18 April 2006 (Law No. 9518). *Official Journal*, 2006, 46:1390.
13. Act on preventing disorders of iodine insufficiency, of 26 June 2008 (Law No.9942). *Official Journal*, 2008, 114.
14. Health Insurance Act of 13 October 1994 (Law No.7870). *Official Journal*, 1994, 15.
15. *Albania: Trends in poverty 2002-2005-2008*. Tirana, National Institute of Statistics, 2009 (<http://www.instat.gov.al/graphics/doc/downloads/Living%20Standart%20Measurement%20Survey%202008.pdf>, accessed October 1 2011).

2. Bosnia and Herzegovina

Introduction

Bosnia and Herzegovina is located in the western part of the Balkan Peninsula and covers an area of 51 129 km². It shares a border with the Croatia on the north, south and west, and with Serbia and the Montenegro on the east. According to the 2009 estimates of the Statistics Agency of Bosnia and Herzegovina, the population was 3 842 566.

Bosnia and Herzegovina consists of two entities, the Federation of Bosnia and Herzegovina (FBiH) and the Republika Srpska (RS), and the Brcko District is a separate administrative unit. The FBiH is administratively divided into 10 cantons, which are divided into 79 municipalities. The RS is divided into 62 municipalities.

In Bosnia and Herzegovina the health sector is decentralized. Public health is the responsibility of the Ministry of Health of FBiH, the Ministry of Health and Social Welfare of the RS and the Department of Health and Other Services of the Brcko District, while the coordination of the health sector in Bosnia and Herzegovina is implemented through the Ministry of Civil Affairs of Bosnia and Herzegovina.

Bosnia and Herzegovina recognizes that the health of the population is more than just the responsibility of the health sector, and accordingly considers it important to ensure the application of the HiAP approach. The health authorities in Bosnia and Herzegovina together with other sectors undertake activities to identify the goals and responsibilities of HiAP and define and implement integrated responses through the official policies. HiAP requires reconsideration of the decision-making processes and putting health at the centre of public policy, which the authorities are trying to do.

Aware that HiAP involves overall policy-making in the public and private sectors, with the aim of promoting and protecting public health and based on the analysis of social and environmental impacts, Bosnia and Herzegovina is committed to adopting HiAP approaches and principles at all levels of government. The health of the population is of crucial importance for the economic success of the country and for the benefit of individuals. A healthy economy depends on the health of the population, otherwise, the economy loses the productivity of the workforce and citizens remain deprived of the potential length and quality of life. Therefore, the authorities are trying to expand the focus beyond just issues that affect the physical environment, insisting that health be incorporated in all policies and activities at all levels of government.

Crucial to understanding the health challenges facing Bosnia and Herzegovina is the acknowledgement that they can no longer be resolved within the health sector itself. HiAP points out that the main risk factors and determinants of health are successfully modified by the measures of other government and social sectors. At the moment, there is a wealth of experience on the efficiency of public health interventions to show the success of health education about lifestyle and diseases. This needs to be supplemented by work on the social factors that shape the daily life of people and work environment. Considering that the disparity in health in Bosnia and Herzegovina is growing, the health authorities deem it necessary to respond to the new policies in order to support and extend the quality of human life and reduce the number of years that people live with sickness or disability.

The population of Bosnia and Herzegovina is relatively healthy. The 75-year average life expectancy is slightly above that of south-eastern European countries and has increased since the mid-1990s, concealing the fact that the age at which people get sick is beginning to decline (currently at 63 years old), as a result of an increasing number of people with poorer health. Although infectious diseases in Bosnia and Herzegovina represent a significant issue, the basic concern is noncommunicable diseases that reflect trends in lifestyle and risk factors in Bosnia and Herzegovina, such as the use of tobacco and alcohol, lack

of physical activity, stressful lifestyle, social and working conditions and unhealthy diets that result in massive increases in overweight and obesity. The four main factors that contribute to the growth of the disease burden are high blood pressure and heart disease, neuropsychiatric disorders, malignant neoplasms and unintentional injuries, which together constitute 68% of the disease burden. The high rate of smoking contributes 21% to the disease burden, alcohol consumption 4%, obesity 10% and lack of physical activity 5%. It is also believed that the road safety and the prevention of traffic accidents will have an increased role in the near future.

The health authorities in Bosnia and Herzegovina have accepted the HiAP principles, which require the attention of governments to policies and law making processes, capacity building in public health and development of special instruments such as HIAs. Leading health authorities agree that the key factors for a successful HiAP approach are:

- strong leadership at all levels of government
- strong support of the health system
- a clear vision for health and welfare
- well-defined policies with clear objectives
- identification of the highest HiAP management body
- new, permanent organizational structures to support HiAP
- new responsibilities for HiAP within existing structures
- legal support for HiAP, reflected in revision of legislation at all levels
- simultaneous activities at different institutional levels.

Bearing in mind the above factors, a successful HiAP approach in the country would be demonstrated through:

- establishing HiAP working groups
- an open process in order to encourage broad participation
- considering the impact of policy on the health of the population (particularly vulnerable groups)
- clarification of recommendations or their impact on health
- sustainable development to meet the needs of present and future generations
- evaluating the best evidence of different perspectives and experiences
- considering the determinants of physical, mental and social health.

In light of the WHO appeal to Member States to “ensure dialogue and cooperation between relevant sectors with the aim of integrating health into relevant public policies and strengthening the intersectoral cooperation”, the leading health authorities in Bosnia and Herzegovina believe that HiAP working groups should be established, taking into account the balance of, or representing all sectors of government, including education, traffic, environmental protection, urban planning, social welfare services, public health and health care, as well as the business community. In taking this strategic step toward HiAP, Bosnia and Herzegovina is acting in accord with WHO and the principles designed to help governments at all levels to assess the impact of development on health.

In light of the European Commission’s call to strengthen the integration of health concerns into all policies and to use HIA and evaluation instruments, Bosnia and Herzegovina, by the adoption of the foregoing approach, takes action in accord with the European Commission policies, the White Paper and *Together for Health: A Strategic Approach for EU 2008–2013*, which makes HiAP a basic principle.

Experience and examples from the rest of Europe show that Bosnia and Herzegovina can hope to deliver results in implementing HiAP that would ultimately improve the quality of life and increase life expectancy, taking into account the increasing of years of healthy life. Thus, Bosnia and Herzegovina believes that HiAP is more than a slogan: it is a new way of thinking about public policy and a worthy goal that will guide the country in improving the quality of life and health for all.

This introduction was prepared jointly by the Ministry of Civil Affairs of Bosnia and Herzegovina, the Ministry of Health of the Federation of Bosnia and Herzegovina, the Ministry of Health and Social Welfare of the Republika Srpska and the Department of Health and Other Services of the Brcko District.

HiAP in the Federation of Bosnia and Herzegovina

The Federation of Bosnia and Herzegovina is currently going through a significant transition, which has obvious implications for the health of the population. The main determinants of health are demographic changes, an increase of noncommunicable diseases and a high prevalence of unhealthy lifestyles. Health indicators of last ten years show demographic changes from a decreasing birth rate, a slight increase of the mortality rate and a decrease in the fertility rate. Recent population surveys show a high prevalence of noncommunicable diseases, as well as unhealthy lifestyles (smoking, alcohol consumption, unhealthy diet), which are the key causes of mortality.

Taking into account the social definition of health and socioeconomic determinants of health such as social background, working and living conditions, educational level, the impact of community and society and the general socioeconomic, cultural and environmental conditions, it is imperative to carry out comparative research to measure the degree of change in health and identify a basis for joint debates and actions at regional level. There are currently extensive mechanisms for cooperation with the education, social protection, environmental conservation and law enforcement sectors, aimed at developing strategic documents through intersectoral working groups or surveys to obtain relevant evidence for the development of sector-wide policies.

The health care system is also in transition. The commitment in the *Health Sector Development Plan, 2008–2018* is to improve access to health care and its quality and efficiency, with increasing solidarity and decreasing inequality. The latter implies ensuring appropriate health care delivered to those who need it. One of its strategic goals is to strengthen the role of public health which will require harmonizing legislation with the EU, harmonizing reporting to comply with international standards and EUROSTAT and strengthening promotion and prevention programmes and interventions in order to raise awareness of public health issues. Health policy and its harmonization with EU regulations are significant activities in the transitional period during which Bosnia and Herzegovina wants to develop as a modern democratic state integrated into the European Union.

This report was prepared by experts from the Federal Ministry of Health and Federal Public Health Institute. The Sector for Public Health, Monitoring and Evaluation from the Federal Ministry of Health was responsible for collecting literature and other references and data analysis. There was a continuous collection of reports, publications and research in electronic form and/or hard copy. During the initial phase of preparation, a questionnaire based on the WHO methodological framework was distributed to all ministries in the FBiH government and the ten cantonal ministries of health, in order to directly obtain information about intersectoral programmes, projects and initiatives. The report was prepared in two language versions, local and English.

Entity of the state of Bosnia and Herzegovina context

Political background

The Federation of Bosnia and Herzegovina is a decentralized entity, as is its health care system. The Government of the FBiH consists of the Prime Minister, two Deputy Prime Ministers and ministers for 16 ministries: Agriculture, Water-Management and Forestry; Physical Planning; Interior; Justice; Finance; Energy, Mining and Industry; Transport and Communications; Labour and Social Policy; Displaced Persons and Refugees; Veterans and Disabled Veterans of the Defensive-Liberation War; Health; Education and Science; Culture and Sport; Trade; Development, Entrepreneurship and Crafts; Environment and Tourism.

Administratively, the FBIH is divided into 10 cantons, each of which has its own legislative and executive power. The cantonal administrations have a considerable degree of autonomy in making health care decisions in their respective territories, while the Federation level is responsible for strategic guidelines and has a coordination role. A decentralized health care system is established in the FBIH, pursuant to its Constitution, which implies that competence in the health care field is split between the FBIH and the cantons. In the decentralized health care system, the Federation is given the role of the designer of the relevant FBIH policy and laws, with the consensus of the cantons, and the cantons are given the role of implementing institutions, as well as the role of principal financiers. At various administrative and political levels (municipality, canton, Federation) through working groups, ministries coordinate the drafting of laws, Bylaws and policy documents, and there are some horizontal connections. There is cooperation and coordination between different levels of administrative policy, but regarding public health issues, channels for the flow of information are not clearly defined and are in need of strengthening.

Socioeconomic conditions

Socioeconomic development is one of the primary determinants of the health status and needs of individuals and the overall population. In that regard, poverty, defined as the inability to achieve minimum living standards in given circumstances, represents a very important determinant of health. According to the official statistics of the FBIH Statistics Office, the GDP increased slightly over the past few years by €2805 (5487 marka in local currency) in 2009 per capita. Living standards measurements show that around 15% of the population lives below the general poverty threshold. The official unemployment rate in 2009 was extremely high at 44%. Annual employment rates have continually fallen in past few years. Social exclusion is still a considerable issue, as every citizen is socially excluded in some way. Being excluded effectively means being deprived of access to socioeconomic and political rights that are available to other people. The primary reasons for social exclusion are high unemployment rates, the enormous percentage of people with a low level of education, ethnic exclusions and discrimination against minorities and returnees, as well as an inadequate social security system, which inevitably results in poor access to resources and services.

According to Ministry of Labour and Social Affairs statistics, in 2009 the FBIH had a total of 9853 civil victims of war and 48 308 disabled people or 2.5% of its overall population. According to the statistics of the FBIH Pension and Disability Insurance Institute, by the end of 2009 the percentage of retirees in the population was 15.3 and rising. In both 2008 and 2009, the dependency ratio was at 47.3%. This is a significant demographic indicator and so are measures of population ageing and share of dependant population in the overall population. The increased rate of the dependant population represents a very serious problem for financing the health care system. The most recent available value of Human Development Index (HDI) for the Bosnia and Herzegovina, from 2004, reported it at 0.816. This puts the FBIH in the group of countries with high human development (high HDI is > 0.800). The 2004 gender development index (GDI) was reported at 0.801, so the difference between the HDI and the GDI effectively indicated considerable gender inequality, as confirmed by the Gender Empowerment Measure (GEM) which was reported at 0.496, indicating gender inequalities in politics and economic participation measured through earned incomes.

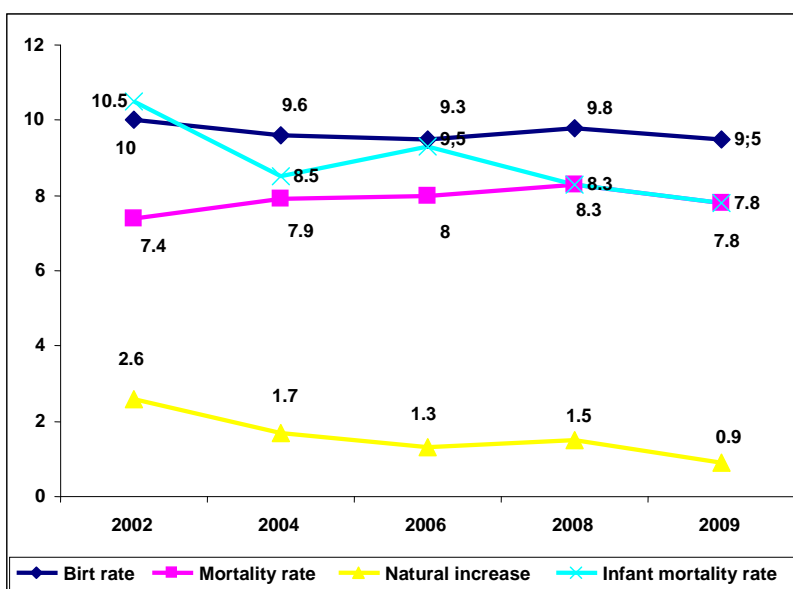
Demographics

According to the official statistics of the FBIH Statistics Office, the population in 2009 reached 2 327 318, with an average population density of 89 people per km². The population of the FBIH falls under the category of a stationary or reducing population, with 14% of people over 65 years of age. The female population accounts for 51% of the overall total (1).

The birth rate in the FBIH in 2009 was 9.5 per 1000 and has been maintained since. The median general mortality rate was at 8.6 per 1000 and has recorded a slight but continued increase in recent years, which altogether indicates the ageing of the population. As a result of decreased birth and fertility rates and a slight increase of the mortality rate in recent years, the natural increase dropped to 0.9 per 1000 in 2009.

The 2009 infant mortality rate was 7.8 1000, with a declining trend in recent years. According to WHO estimates, life expectancy at birth is 73 for males and 78 for females.

Fig. 4. Natural change in the population of FBIH 2002–2009



Burden of disease

The general mortality rate is affected by a number of socioeconomic and biological factors, with population ageing the most important. The leading causes of death in 2009, as in previous years, were diseases or conditions of the circulatory system (53.4%) and malignant neoplasm (20%), so that these two groups accounted for almost three quarters of all causes of death. They are followed by endocrine and metabolic diseases with dietary disorders (5.4%). The leading diseases in the overall population reported for 2009 were identical to those in previous years, i.e. chronic diseases (hypertension diseases, dorsopathies, diabetes, among others) associated with a high prevalence of risk factors such as smoking, obesity, lack of physical activity, stress and others. Mental disorders also saw a slight but steady increase. The leading diseases reported in adult primary care are neurotic, stress-related and somatic disorders (42%) followed by mood disorders, thenschizophrenia, schizotypal and delusional disorders and other mental disorders. Fifth on the list of reported disorders are alcohol abuse disorders which account for 3.6% of all mental disorders. Mental health care should be a priority due to poor socioeconomic status of the population, constant increase of unemployment rates and unhealthy behaviour (alcohol and controlled substances abuse). The leading communicable diseases in 2009 included respiratory diseases (influenza) while tuberculosis is still one of the leading communicable diseases (2).

A population survey in the FBIH conducted in 2002 showed a rather high rate of hypertension among the adult population (41%) and a high prevalence of obesity (17% among men and 25% among women). Accumulation of other risk factors of noncommunicable diseases in the middle and older age groups is likely to increase the future burden of cardiovascular disease and diabetes in the near future. Smoking prevalence in the FBIH is rather high. Almost 50% of males and 30% of females are daily smokers. The finding that smoking is most prevalent in younger age groups, especially among women, might reflect the continuous increase in smoking in the FBIH. A high prevalence and accumulation of risk factors in older age groups can be considered a serious risk for a rapid increase of noncommunicable diseases in the adult population (3). Hence, there is an urgent need for preventive action. The model of integrated management of risk factors of noncommunicable diseases as a comprehensive population-based, well planned and well

coordinated programme should be established and directed primarily to general lifestyle modification, which implies the involvement of all government departments.

The health system

Health care in the FBIH is provided on the principles of comprehensiveness, continuity, availability and an integrated approach, irrespective of age, gender, religious or ethnic background, and emphasizes the importance of joint decision-making by patients and providers. One of the fundamental determinants of the health care system reforms is the focus on PHC, with significant attention to strengthening health promotion and disease prevention (4). Health care is organized at the primary, specialist-consultative and hospital levels. The *Strategic Plan for Primary Health Care* continued the process of introducing family medicine in health centres. There are three key components of the reform: primary health care, capacity building for health management and policy dialogue and monitoring and evaluation (5).

In 2009 the health care sector employed 24 865 workers (1068 per 100 000 population). Over two thirds of all employees were health workers (69.9%). Per 100 000 inhabitants in 2009 there were 183 physicians, 21 dentists, 12 pharmacists and 530 health technicians, and 25 hospitals (general and cantonal hospitals, clinical hospitals, clinical centres, specialty hospitals, medical centres, institutes for addiction), which employed 46% of physicians and 44% of health technicians (2).

The major source of health care financing is mandatory health insurance (paid by employees, employers, farmers, unemployment funds and other contributions), organized on the principles of non-competitive, regionally-based social health care insurance. The mandatory health insurance scheme is based on principles of equality and solidarity. Cantonal health insurance institutes and the FBIH Health Insurance and Reinsurance Institute are responsible for implementation and oversight of the mandatory health insurance scheme. In the system that is characterized by the division between users and providers, the health insurance institutes consolidate the insurance contributions and use those funds to finance services provided by registrees in the health care provider network, the vast majority of whom are public care providers. The private sector is mainly represented by privately-owned pharmacies which sell prescription drugs and a number of privately-owned polyclinics (4,6). In addition to the mandatory health insurance, funding also comes from cantonal budgets, the Federation budget, loans, donations, participation, revenues earned by care providers, etc. Voluntary and extended health insurance, although stipulated by law, has not yet been implemented.

Inequities in health status, health behaviour and health system access

The Federation of BIH *Health Care Act of 2010* stipulates that every citizen shall have the right to receive health care respecting the highest possible standard of human rights and values, namely to have physical and psychological integrity and safety of his/her personality, as well as respect of his/her moral, cultural, religious and philosophical convictions. Every child from birth until 18 years of age shall have the right to the highest possible standard of health care (Article 26) (7). The Act stipulates that health care shall be provided under equal terms for the population of the Federation, as well as for groups of citizens exposed to increased morbidity risk, and includes prevention, early detection and treatment of diseases of high socio-medical significance, as well as health care for socially disadvantaged citizens (Article 12).

In 2002, the FBIH formed the Solidarity Fund, financed with 9% of the cantonal mandatory contributions and 9% of the Federation budget which, however, has not been fully met. These funds are used to finance a number of prioritized vertical health care programmes and prioritized cases that involve the most complex forms of health care in specific areas of specialty medicine. Also funded are prevention programmes such as secondary prevention in malignant diseases (breast and rectal cancers), and prevention of oral ill health in children.

In order to increase equity in health, the FBIH adopted a basic package of health rights in 2009, to be provided under the same conditions for all insured people according to health legislation (8). Health care rights include the right to health services according to measures, actions and procedures classified into six

groups: health improvement and promotion, prevention and control of diseases, early diagnosis of disease, diagnosis of disease, treatment of disease and rehabilitation. The basic package will ensure the implementation of public health and preventive-promotional activities by community health centres and public health institutes in the FBiH, and it is stipulated that basic package be provided to uninsured citizens of Bosnia and Herzegovina residing in the FBiH territory. The rights referred to will be financed from the budget of the canton or the municipality of the uninsured person's last place of residence. The cantonal governments, based on the proposals of the cantonal ministers of health, establish public health programmes and preventive-promotional activities of interest for the cantons. The government of the FBiH, based on the proposal of the Federal Minister of Health, does the same on the Federation level.

One of the important goals of the reform of the health care system is putting health care as close as possible to the population. Research has shown that distance from the place of residence to the nearest PHC clinic for 54% of the population is less than 1.5 km, while for 22% the distance is over 5 km. This indicates inequality in PHC access. The capacities of different cantons vary significantly in their ability to provide an adequate number of family medicine (FM) teams, ranging from 91 to only 24 FM physicians per 100 000 population. Differences in the health status of the population and accessibility of health care across geographical regions and vulnerable groups must be reduced; many improvements have been made but more are needed.

Policy frameworks for health in all policies

Through sustainable economic development, the Federation of Bosnia and Herzegovina should enhance the quality of life of its citizens and there are several strategies and projects that aiming to do so.

The Development Strategy of the FBiH 2010–2020 aims to support economic development and reforms to be implemented as part of the EU accession process. This strategy is designed to stimulate economic activities, develop physical infrastructure and improve the quality of the social, educational and cultural environment, environmental conservation and promotion of high environmental values. Under this long-term sustainable development programme, the FBiH will focus particularly on education and development of R&D and technological infrastructure, sustainable development and environmental conservation (farming and rural development) and creation of a healthy community with special focus on young people and their interests (9).

The *Strategic Plan for Health Care Development, 2008–2018* defined goals for the development of a modern, high-quality, rational and cost-effective health system designed to lead to the overall psychological and physical well-being of the population and to create the conditions improving the social status of individuals and in turn the economic development of society. Its general strategic objective is to improve access, quality and efficiency of health care of the population, by increasing solidarity and decreasing inequality. The latter implies ensuring appropriate health care delivered to those who need it. Relative wealth and other external factors should therefore not influence access to health care. The Plan does not have a significant dimension for intersectoral cooperation. It was approved by the Federation Parliament and it represents a basis for health policy formulation as the sector policy of the Federation government. One of its strategic goals is to strengthen the role of public health, for which it will be necessary to harmonize local legislation with EU legislation and reporting with international standards, as well as to improve promotion and prevention programmes and interventions in order to raise awareness of the importance of health, the identification, prevention and control of environmental risk factors. A medical waste management system will be put in place, environmental awareness will be strengthened, public health capacities will be institutionally strengthened at all levels, biosafety in the Federation laboratory will be increased and the health care system will be improved for rapid response to global health threats (4).

In 2008 the government formally approved the *Youth Health Policy (10)*, which was used as basis for the *Strategy for Youth and Health*, which was also approved by the government in 2009. It primarily focused on health promotion and disease prevention but it also covered organization and change management by

developing youth-friendly services to be provided by both health and non-health sectors and continuous quality improvement and monitoring and evaluation of outcomes of those activities, as a number of social factors had put many young people at a disadvantage with respect to health care (11).

The *Strategy for Improvement of Sexual and Reproductive Health and Rights, 2010–2019* is based on the priorities of sexual and reproductive health and rights: prepartum deliveries and postpartum care, family planning including infertility services, abortion, STI (including HIV) transmission prevention, malignant diseases of the reproductive organs, promoting sexual health and rights, promoting reproductive rights, continuing education and the role of NGOs. Sexual and reproductive health and rights must be treated as a multidisciplinary and multisectoral problem at all levels requiring the active participation of both governmental and nongovernmental sectors. The strategy was adopted by the government of the FBiH in September 2010. One of its priorities is promoting sexual health and reproductive rights including improving access to information on sexual and reproductive health using various communication channels. It establishes youth centres and/or informative centres as a part of a friendly approach to young people, as a vulnerable population, providing information on available health services and of diagnosis and intervention. It has a multisectoral approach involving the NGO sector. Information centres support educational programmes on sexual health and reproductive rights. Local communities work in collaboration with the youth centres to promote healthy lifestyles. The role of municipalities or local communities is of great importance for implementing such programmes (12).

Box 4. Early childhood development policy in the Federation of Bosnia and Herzegovina
(13)

According to the Convention on the Rights of the Child, children should be a priority in every society and their rights promoted. Every society should ensure a healthy start in life for each child in order to attain positive social and health values. Until now, planning and developing projects devoted to child care and development in the FBiH was sector-based, and there was an evident lack of intersectoral coordination of these activities. To move from the current sector-based approach to the new forms of intersectoral integration and coordination requires developing new forms of planning and designing and implementing integrated programmes for early childhood growth and development, which is the main focus in the document *Policy for early childhood development in the Federation of Bosnia and Herzegovina*, adopted by the government in May 2011.

Integrated Centres for Early Childhood Growth and Development for Parents and Children aim to bridge the gaps in the existing health, education and social welfare systems, and establish links between the services of the existing system and the parents who can be strengthened through the centres, and trained in responsible and stimulating parenting skills. They promote integrated services and even an integrated approach to service delivery based on a holistic view of child development. This means that the sectors must be well connected and offer a comprehensive package of services that will enable children to have optimal conditions for growth and development. This creates a space of action for innovative forms of service delivery for children and families, which do not aim to replace existing system facilities, but to make them more accessible to citizens and fill perceived gaps in the system. This implies standardization of preventive, educational, curative and compensation programmes targeted at vulnerable and minority children and parents. Intersectoral activities will be focused on youth, future parents, pregnant women and mothers with young children, families with children and children of ages 0–3, 3–6 and 6–10, because each of these population groups requires specific attention, measures and activities.

The *Equal Opportunity for the Disabled Strategy, 2010–2014* was developed by the FBiH Ministry of Labour and Social Affairs. It is an intersectoral strategy whose primary goal is to improve the quality of life of people with disabilities. The document was based on the Council of Europe's 2006–2015 *Action Plan for Promotion of Rights and Full Social Inclusion of People with Disabilities*. The part of the strategy that deals with health care includes a series of activities and measures aimed at reducing inequalities of access to health care and health services for people with disabilities (14).

The *Federal Environmental Conservation Strategy 2008–2018* was developed by the FBIH Ministry of Environmental Conservation and Tourism and was formally approved by the FBIH government in 2009. It is an intersectoral strategy, one goal of which is to minimize or remove environmental health risks. It aims to strengthen central government institutions responsible for environmental conservation and development of relevant policies in order to improve sustainable environmental management across FBIH and consequently improve the health status of the population. It is necessary to ensure stronger integration of environmental conservation policy into other sectors' policies (including energy, transportation, farming, industry, tourism and health). Funding for implementation of this strategy should be provided by the budgets of municipalities, cantons and the Federation, as well as the developmental projects such as IPA projects, EU funds, and donations (15).

The *Water Resources Management Strategy* (law pending approval) represents an integral part of the Environmental Conservation Strategy. One of its major goals is to reduce the level of risks to the general health status of the population by improving coverage of public water supply, coverage of waste water management and improvement of both surface and underground water quality. The Intersectoral Water Resources Management Coordination Board developed the strategy (16).

The *Medium Term Agricultural Sector Development Strategy* is geared towards activities that will, under international standards, increase produced food safety and quality in order to ensure protection of the health status of the population (17).

There is extensive cooperation with the education, social protection, environmental conservation and law enforcement sectors aimed at developing strategic documents through intersectoral work groups or through surveys designed to obtain relevant evidence for further creation of sector-wide policies.

Table 13. Cooperation between the health and other sectors

Sectors with greatest intensity of cooperation	Sectors with greatest needs for intensifying cooperation
Education	Transport
Social protection	Labour/employment
Environment	Urban planning
Agriculture	Housing
Police	Culture
Finance	Economic development
Media	Rural development
	Migration
	Tourism

Mechanisms, tools, instruments and platforms for advancing HiAP

The health system of the Federation of BIH is decentralized, with the Federation Ministry of Health and 10 cantonal ministries of health. The cantons have a considerable degree of autonomy in health care decision-making, while the Federation is responsible for strategic guidelines and coordinating activities. Decision-makers at all levels of government are aware of the requirements that should be complied with pursuant to the *EU Stabilization and Accession Agreement* (18).

Intersectoral work groups and bodies are formed in designing strategic documents, primary and secondary legislation and developmental projects. However, intersectoral work is not fully featured in project implementations. A major problem in this regard is the lack of a single methodology for assessing and measuring the impact of joint activities on population health. The Health Committee of the House of Representatives in the Federation Parliament is considering the development and improvement of health care and health insurance, the health care financing, prevention and control of infectious diseases and other issues. The Committee consists of 11 members and favours medicalized approaches.

The *Health Care Act* is fully compliant with the standards and norms of the European Union and WHO recommendations, focusing on functions required for EU accession, including patient benefits, the quality, safety and efficiency of health care, a market economy, free movement of patients, health professionals and goods, public health and coordination of EU policies (7). Article 17 of the law stipulates the social responsibility for public health. Public health is therein defined as achievement of public interest by creating conditions for the population health through organized and comprehensive activities of society aimed at conserving physical and mental health, environmental conservation and prevention of disease and injury that can be achieved by using health technologies and measures for promotion of health, prevention of diseases and improvement of life quality. The Essential public health functions, as defined under the Act include:

- monitoring, evaluation and analysis of the population health status
- public health supervision, surveys and risk and threat controls
- health promotion
- increased community involvement in health care
- development of health policies and institutional capacities for planning and management
- strengthening institutional capacities for regulation, implementation, planning and management
- evaluation and promotion of equal access to basic health care
- development and training of human resources
- monitoring and supporting improvements of service quality at individual and population levels
- public health surveys
- mitigating the effects of emergency situations and disasters on population health.

Public health functions are exercised at all levels of government and the health care system, and functions should be financed from the budgets of the municipalities, cantons and Federation, presenting a good opportunity to promote public health at all levels. Article 14 of the Act assigns the social responsibility for health to the municipal level. The Health Care Council evaluates needs and oversees services, including evaluating institutions and the quality of services. It also gives opinions on plans and programmes and proposes measures for improvements in quality, accessibility and patients' rights. In general, representatives of local self-government, patients, patients' rights organizations, youth, health care associations, professional associations, trade unions, health care institutions, private practices, and the Red Cross participate in the work of the Council. Instruments used to promote quality of life, health, welfare and equal access to health care in all policies are in fact secondary legislation mainly enacted by the Federation Ministry of Health and enforced across different sectors.

Public health activities are undertaken at the municipal level through hygiene and epidemiological units with the community health care centres and at the canton and federal levels through respective public health institutes, whose responsibilities include monitoring, assessments, and analysis of the health status of the population, as well as organization of health care and implementation of prevention and promotion activities. The FBIH has one Federation Public Health Institute and 10 cantonal public health institutes (3,19,20).

Strengthening of promotion and prevention programmes and interventions to raise awareness on the importance of health is a continuous activity carried out by experts from the Federation and cantonal PHIs. Based on the availability of funds in the cantons and public health priorities, intersectoral prevention and promotion programmes are expected to be implemented at the canton and municipal levels. Cantons will develop short-term public investment programmes.

The municipalities also develop Local Development Programmes with respective operational plans. The Municipality Council is the decision-making body of the municipality and is a representative body. The Municipal Council is responsible for adopting the budget, which includes financing public health projects in conjunction with NGOs, thus making this an area of intersectoral collaboration. There are commissions for protection of human rights, gender equality and youth issues. Quality of life, health and equality in health and welfare as envisioned in these strategic documents are not separately designed goals, but are

integrated in a number of programmes and projects including transportation, environmental conservation, waste water management, air pollution control, youth violence prevention, and others. An example of good practice in developing HiAP methodologies is the Sarajevo Healthy City project (see the box below).

Box 5. The Sarajevo Healthy City project

In 2000, the Sarajevo Canton Ministry of Health supported the initiation of the project, which was developed by the Sarajevo City Administration (Office of the Mayor), and financially supported by the Sarajevo Canton budget.

Between 2000 and 2002 representatives of the project actively participated in the work of the Environmental Council formed as an intersectoral working group of the Sarajevo Canton Ministry of Spatial Planning and Environmental Conservation. The purpose of their involvement was to make sure that the environmental conservation policy and spatial planning was based on experience of intersectoral cooperation and responsibility for health.

In 2004, Sarajevo City Council formally approved the *Health Plan for Citizens of the City of Sarajevo*. This document outlines the political commitment of the City to a multisectoral and interdisciplinary approach to activities aimed at improving the health of the Sarajevo Canton population. The Plan was developed by the experts with the Sarajevo Canton Public Health Institute, preceded by two studies – the *Health Profile of the Population of Sarajevo Canton* and the *Overview of Health Status of the Population of Sarajevo Canton*, financed by the Sarajevo Canton Ministry of Health. They represent a significant contribution to a holistic understanding of health and improvement of multisectoral responsibility for health and development of a healthy city concept for the city.

Activities are now conducted on a smaller scale in Sarajevo City, through its City Council.

The *Act on Restricted Use of Tobacco Products* stipulates requirements for the producers, and ban on advertisement and sale of tobacco products with purpose of protecting and promoting health of the population from harmful effects of tobacco products. This law is a good example of intersectoral collaboration, as enforcement is carried out by the sanitary inspectorate, the labour inspectorate and the market inspectorate; part of the oversight is also performed by the Federation Ministry of Finance and the Customs Authority. Unfortunately, monitoring of the Act's implementation is not done (21).

The *BIH Food Act* defines general principles and requirements concerning food safety including the responsibilities of natural and legal entities concerning food safety, general requirements for marketing of new food, emergency management, health requirements for food, etc. This law is very important from a public health perspective as its purpose is to improve the health status of the population by improving food production and marketing. Notably, the Act also defines the chain of obligations and responsibilities. The Food Safety Agency of FBIH was formed under this law and the law provides (Article 19) that the Agency, working together with relevant institutions, is responsible for authorizing limitations on the marketing of food and order withdrawal of food from the market if there are reasons to suspect that the food is of unsatisfactory quality. This law has shown a very clear formal and public commitment for harmonization with the EU legislation (22).

The laws in other sectors of government also cover the issue of health but not to significant extent. In the Federation, thus far there has not been any major multisectoral project that was either designed or implemented to involve significant multisectoral engagement or pooling of budget funds. The multisectoral projects implemented so far have been financed by international institutions. The public health institutes also serve as implementing agencies for a number of research projects mostly financed by international organizations, including WHO, UNICEF, UNDP, UNFPA and CIDA. These projects are primarily geared towards supporting reform commitments in the development of the health sector. Through various projects, public health experts have received continuous training in this area which considerably strengthens the capacities of the public health institutes. In recent years the public health institutes of Bosnia and Herzegovina have increasingly collaborated on different levels. In FBIH, the

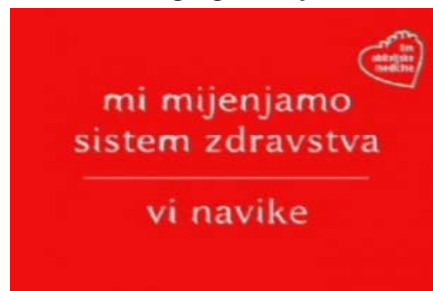
collaboration is performed through the Association of Public Health Institutes. Cooperation with public health agencies in the region has been performed through the SEE Health Network. Several studies and projects were implemented in order to assess actual health needs of the population and define directions for prevention and promotion programmes and intersectoral collaboration in this area. Some of the most significant activities have been included under implementation of the *European Action Plan for Food and Nutrition Policy, 2007–2012*, while cooperation with the industry sector has been implemented through a series of workshops on food safety improvements.

The applicability and relevance of a policy analysis questionnaire and communal questionnaire concerning food and nutrition were tested in FBIH under the EURO-PREVOB Consortium for the Prevention of Obesity through Effective Nutrition and Physical Activity Actions. International networking and capacity strengthening for effective nutrition and food safety has continued through the initiative of the Stability Pact and the Enhancement of Nutrition and Food Safety Agencies project and through a food and nutrition capacity building network in central and south-eastern. A MICS was carried out in 2006–2007, including indicators of the health needs of mothers, and its results should have implications for the social and education sectors. A good example of obtaining information required for intersectoral collaboration is the series of projects in monitoring radioactive materials of natural origin. Monitoring air pollution in the Mediterranean region is another activity of the Federation Public Health Institute and its results should be used for intersectoral cooperation between the health and environmental conservation sectors. Benefit-incidence analyses as such have not been performed. The health status of the population depends on the interaction of factors associated with individual behaviour and lifestyles, the socioeconomics and cultural, biological factors and environmental status. This is why promotion of health and prevention of disease has become increasingly important, as has public health, which needs to be better integrated into the community. Thus in the near future it will be necessary to start to work on designing a public health strategy. The Federation is responsible for financing promotion and prevention programmes but, as in other countries, the budget funds allocated were insufficient for such activities. In the near future it will be necessary to ensure adequate financing.

Other significant activities of the public health institutes include intersectoral cooperation and informing the general public and politicians of the most pressing health issues and priorities, including recommendations for effective solutions. In order to improve HiAP, the health sector should learn to work together with other sectors as partners. Joint research activities aimed at bringing about the innovations in policies, new mechanisms and instruments and improved regulatory framework will be crucial. This process will require the health sector to be open and outward looking, equipped with necessary knowledge, skills and mandate. This also means that it will be necessary to improve coordination and provide effective support to health sector leaders. Use of techniques of social marketing should be geared toward raising awareness on the significance of health and its advancement. Such campaigns should be initiated by the health sector and the method should be applied in other sectors as well, but through a number of multidisciplinary and intersectoral teams.

Box 6. Federation Ministry of Health campaign

We are Changing the System – You Are Changing Your Habits



A good example of social marketing campaign is the activity of the Federation Ministry of Health implemented under the Health Sector Enhancement Project. The campaign *We are Changing the System – You Are Changing Your Habits* was implemented in 2009/2010. Its primary goals included continuous information for the general public on the PHC system reform processes and education of the general public on opportunities for disease prevention and healthy lifestyles and habits.

Information for health in all policies

The health system of the FBIH is experiencing the same challenges faced by health systems globally and limited health sector funding which must also cover the cost of quality health care, development of human resources, training and medical technology according to international standards. Since health and health care do not depend solely on the health system and cannot be viewed outside the context of social, economic, political and cultural factors, there is a need for efficient implementation of health policies and strategic commitments for health and other sectors. This depends on reliable data including assessment and evaluation of the population health status. Close cooperation among relevant agencies and stakeholders from various sectors is needed in order to monitor and control all environmental risk factors that may have a health impact. Trend analyses of indicators for leading diseases and causes of death and surveys evaluating lifestyles represent vital public health functions as the key monitoring and evaluation landmarks. The evidence collected on the population's health status is invaluable. It can be used by experts to argue for changes necessary for effective use of health services and strengthening individual responsibility for health and role of the community in strategic planning and coordination among all sectors relevant for health issues. The health information system in the FBIH has no capability of disaggregating data by socioeconomic variables, but it is sometimes possible to obtain data through research studies. Inclusion of monitoring of disaggregated health statistics in the statistical forms is planned for the near future. A set of indicators in line with international recommendations will be necessary for measuring improvement in population health.

Taking into account the SDH, it is imperative to carry out comparative research in this period of demographic, epidemiological and socioeconomic transition in order to measure any health changes. Research has identified the main social factors affecting health: poverty, lack of education, unhealthy lifestyles, unemployment, poor housing conditions, environmental risks, inadequate integration into the community and society and lack of opportunities for active participation, especially among young people. Comparative research is needed in order to identify critical starting points for joint debates and partnerships actions, through the framework of a new approach to public health. In the Bosnia and Herzegovina, it is estimated that about 25% of people live below the poverty line. The dimensions of poverty are manifested in different ways: lack of income and productive resources for ensuring sustainable living, malnutrition, lack of education and other basic services, increased mortality and morbidity, inadequate housing, an unsafe environment, social discrimination and exclusion. Each of these can be a major theme or topic for research and the subsequent creation of collaborative projects and activities.

Capacity building for health in all policies

A primary deficiency faced by the Federation of BIH is poor knowledge by national agencies of HiAP methodology. Public health is taught at medical schools, the nursing school and in post-graduate programmes in the medical schools. In the FBIH there are still separate medical specialties in public health including social medicine, health organization and economics, epidemiology and hygiene and medical ecology. There is no public health specialty as such. None of the programmes cover HiAP methodology, but now there is a good opportunity to include it and we should work to support the design of collaborative and comparative research studies in the region in order to make sure that this methodology is practiced and explored. This is the right moment to introduce the HiAP methodology as a mandatory instrument for research in education in public health, in particular for postgraduate and continuing education programmes. The HiAP methodology should be detailed in the activities of the ministries of health and it should also become a mandatory part of reporting on the health status of a country's population.

In addition to adoption of the HiAP methodology as a model of work within the ministries of health, it will be necessary to promote development of a public health strategy that will call for the formation of the a public health committee within the Ministry of Health to serve as an intersectoral body for the development of HiAP studies and biannual progress reporting.

Challenges, opportunities and recommendations

The challenges facing the FBIH are poor knowledge, skills and human resources for designing HiAP studies and action plans and the lack of a single methodology for doing so, in the governmental and nongovernmental sectors alike.

The opportunities at hand stem from the potential of the SEE Health Network and cooperation of SEE health ministers and the WHO *Health 2020* strategy as a platform for continued HiAP improvement and implementation.

In light of the above, we recommend:

1. forming public health committees in Member Countries to serve as focal points for implementing HiAP methodology;
2. biennial progress reporting and biennial regional conferences on HiAP achievements and good practice;
3. technical training (for example through the WHO) for improved knowledge and skills in using HiAP methodology;
4. setting up mechanisms for intersectoral coordination;
5. promoting skills at all levels in both the government and nongovernmental sectors;
6. creating a network among the countries for implementation of HiAP methodology; and
7. developing regional collaborative and comparative studies in order to adopt and use the methodology.

References

1. *Statistical Yearbook 2010*. Sarajevo, Federal Office for Statistics, 2010.
2. *Health Status of Population of the FBIH in 2009*. Sarajevo, Federal Public Health Institute, 2009.
3. *Noncommunicable Disease Risk Factor Survey, Federation of Bosnia and Herzegovina 2002*. Sarajevo, Federal Public Health Institute, 2002.
4. *Strategic Plan for Health Care Development in the FBIH, 2008–2018*. Sarajevo, Federal Ministry of Health.
5. *Strategic Plan for Primary Health Care in the FBIH*. Sarajevo, Federal Ministry of Health, 2006.
6. Health Insurance Act of the FBIH. *Official Gazette of the Federation of Bosnia and Herzegovina*, 30/97, 7/02, 70/08.
7. Health Care Act of the FBIH. *Official Gazette of the Federation of Bosnia and Herzegovina*, 2010, 46/10.
8. Decision on establishing the basic package of health right. *Official Gazette of Federation of Bosnia and Herzegovina*, 2009, 21/09.
9. *Development Strategy of the FBIH, 2010–2020*. Sarajevo, Federal Institute for Development Programming, 2009.
10. *Youth Health Policy*. Sarajevo, Federal Ministry of Health, 2008.
11. *Strategy for Youth and Health*. Sarajevo, Federal Ministry of Health, 2009.
12. *Strategy for Improvement of Sexual and Reproductive Health and Rights in the Federation of Bosnia and Herzegovina, 2010-2019*. Sarajevo, Government of the Federation of Bosnia and Herzegovina, 2010.
13. *Federal Environmental Conservation Strategy, 2008–2018*. Sarajevo, Federal Ministry of Environment and Tourism (http://www.okolis.ba/download/Federalna_strategija_zastite_okolisa-finalni_nacrt.pdf, accessed 8 May 2011).
14. *Policy for Early Childhood Development in the Federation of Bosnia and Herzegovina*. Sarajevo, Government of the Federation of Bosnia and Herzegovina, 2011.
15. *Strategy for Equalizing Opportunities for Persons with Disabilities, 2010–2014*. Sarajevo, Federal Ministry of Labour and Social Policy, 2010.
16. *Strategy for Water Management Strategy*. Sarajevo, Federal Ministry of Environment and Tourism (pending adoption).

17. *The Medium Term Agricultural Sector Development Strategy of the FBiH*. Sarajevo, Federal Ministry of Agriculture, 2010.
18. Decision on procedures for the harmonization of legislation of Bosnia and Herzegovina with the Acquis Communautaire. *Official Gazette of Bosnia and Herzegovina*, 2003, 44/03.
19. Multiple Indicator Cluster Survey. Sarajevo, Federal Public Health Institute, 2001, 2007.
20. *Act on Protection of Population from Communicable Diseases*. Sarajevo, *Official Gazette of the Federation of Bosnia and Herzegovina*, 2005, 29/05.
21. *Act on Restricted Use of Tobacco Products*. Sarajevo, *Official Gazette of the Federation of Bosnia and Herzegovina*, 1998, 1999, 6/98, 35/98, 11/99.
22. *Food Act of Bosnia and Herzegovina*. *Official Gazette of the Federation of Bosnia and Herzegovina*, 2004, 50/04.

HiAP in Republika Srpska

Summary

The Republika Srpska is experiencing a falling population, with noncommunicable diseases the main cause of death. The Republika Srpska has recognized the importance of investments in health through its development programme, as well as through the strategies and policies of other sectors. Data published by the Public Health Institute and the Agency for Statistics of the Republika Srpska are available as a basis for designing strategic plans. The HiAP approach is partly incorporated into undergraduate, graduate and postgraduate education for health professionals in different areas of public health as well as through other programmes. Health is not just a concern of the health care sector, but of all sectors, and investment in health should not be considered an expenditure, but an investment in the overall development of the country.

This document has been prepared by a group of professionals working in the health sector, Ministry of Health and Social Welfare. The Committee of Health, Labour and Social Protection (National Assembly of the Republika Srpska), all government ministries and the Public Health Institute were consulted during the preparation of the document.

Entity of the state of Bosnia and Herzegovina context

Political background

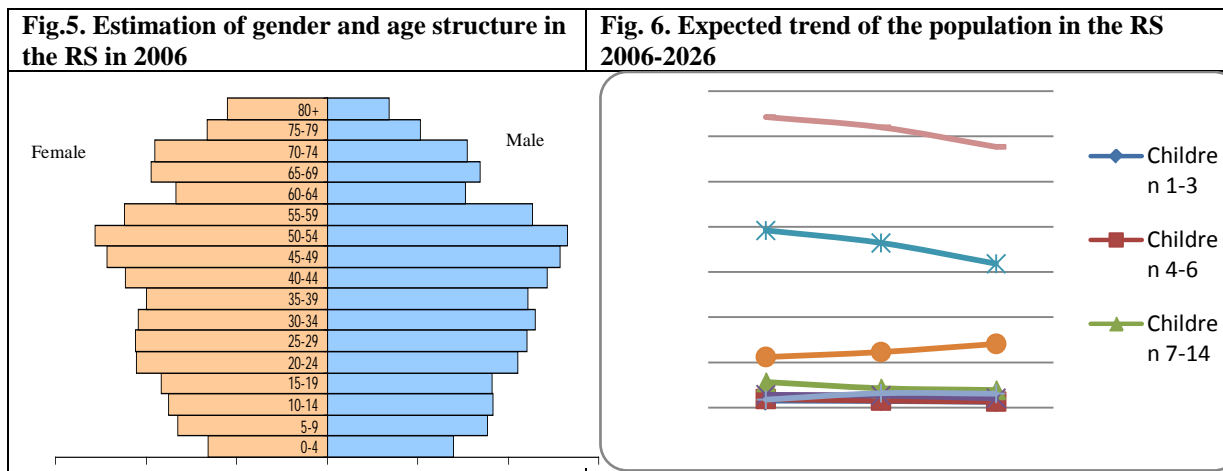
The Republika Srpska was verified as an entity of the state of Bosnia and Herzegovina on 14 December 1995 by the Dayton Peace Agreement and ratification in Paris. It is a territorially unified, indivisible and inalienable constitutional and legal entity that independently performs its constitutional, legislative, executive and judicial functions. The National Assembly is a single legislative chamber, comprised of 83 members, which decides on amending the Constitution; passes laws and other regulations and general legal acts; adopts development plans, urban plans, budgets and annual financial reports; determines the territorial organization of the Republic, announces referenda; announces public loans and decides on the state debt; calls elections of National Assembly deputies and the President of the Republika Srpska; elects, appoints and dismisses officials, supervises the functioning of the government and its bodies, grants amnesty and performs other functions in accordance with the Constitution and the law.

Socioeconomic conditions

Per capita GDP in 2009 was €2930 and GDP growth was 3%. The employment rate in 2006 was 30.9%, and in 2008 had reached 37.3%. The global financial crisis had an impact and in March 2010 employment was 36.6%. Between 2005 and 2010, average wages increased by 67.5% (1). During the period 2001–2006 the poverty rate decreased by 4%, with 16.1% of the population living in poverty, and no recorded extreme poverty (2).

Demographics

The estimated population in 2009 Republika Srpska was approximately 1.43 million. The gender and age structure of the population are presented in Fig. 2 and the expected population trend is presented in Fig. 3. (3) In the 2005, the natality rate was 7.9 while the natality rate in 2009 was 7.4. The mortality rate for the same period was 9.7 or 9.6 which resulted in decline in natural increase from -1.8 to -2.2. The highest population densities are in the City of Banja Luka and the City of East Sarajevo.



The health system

The health system functions through coordination with the RS government, Ministry of Health and Social Welfare, Health Insurance Fund, Public Health Institute, and Agency for Certification, Accreditation and Health Care Quality Improvement, and the Bosnia and Herzegovina Agency for Medicines and Medical Device, health chambers and professionals associations, medical faculties, hospitals, health centres, municipalities and the public. The RS has achieved significant progress in health care stewardship thanks to the efforts that have been invested in producing and implementing policies, health care development strategies and normative and legal regulations.

Through many governmental projects and other investments, the RS has made significant progress in improving access to health care, efficiency, effectiveness and responsiveness of the health system to the needs of citizens. Currently, the RS is working to raise health system capacity to provide adequate health care to satisfy population needs. The high susceptibility of the population to noncommunicable diseases requires continuing efforts for health service improvements, and further strengthening of health promotion and disease prevention activities (4).

Burden of disease

The leading causes of death for men and women of ages 20–64 are myocardial infarction and cerebral vascular diseases. The life expectancy for males is 71 years and for female 73 years. The disease burden attributable to unhealthy lifestyles is suspected to be increasing due to the worsening post-war socioeconomic conditions. The current prevalence of youth smoking is 13.9% (5). The mean BMI is 26.5. The prevalence of overweight (grade I, BMI 25–29.9) is 37.6% and obesity (grade II, >30) is at 17.8% (6).

Inequities of health status, health behaviour and health system access

The key national targets for public health services development are disease prevention and health promotion, as well as monitoring and evaluation services. The broader determinants of health are actively incorporated into decision-making in public health through the *Strategy for Reducing Differences in Health Status, and Access to Health Care* and the *Strategy for Reorganization of Health Care and Health Services and Increasing Efficiency and Quality of Health Centres*. Health is everybody's responsibility: individuals, communities and state bodies. It is an obligation of the state to secure equality of accessibility to health care for everyone, based on the principle of solidarity, law and stable financial conditions. Existing differences in the population health status and accessibility of health care across geographical regions and socioeconomic groups must be reduced, first of all through efficient measures of health protection of vulnerable groups of the population and equal development of PHC (7).

Policy frameworks for HiAP

The Development Plan of the Republika Srpska, 2010–2012 is a basic development document that aims to achieve strong public financing for public services and improved social and economic infrastructure in for health, pensions and education. As one of its strategic commitments, the plan emphasizes better protection of certain social categories. To reduce inequities among the population, the plan aims to improve the well-being of demobilized soldiers, through specific employment programmes, employment of family members of fallen soldiers, and ensuring well-being of returnees. *The Social Economic Programme for 2011*, as a component of the development plan, envisages the construction of basic health care infrastructure for vulnerable groups, with the aim of reducing differences in health status and access to health care, as well as increasing the efficiency and quality of health care institutions. It supports activities for development of education for children and adults, with the focus on primary education and illiteracy. It also supports activities for strengthening small and medium enterprises, industry and agriculture to promote employment, and communities and municipalities burdened with natural disasters, unemployment and difficult living conditions. One of the components of the development plan is the housing project for specific vulnerable groups and special interest groups, including youth and highly educated people, too.

The *Social Economic Programme* represents the core policy of the government regarding quality of life, health, health equity and well-being for the next four years. Some of the priorities for investments are: health care reform and reform of pension and disability insurance, investments in agriculture, food production and rural development, investments in infrastructure with particular attention to the system of flood protection and investments related to the conservation of the environment. The programme includes the actions focused on protection of people and properties from natural disasters, social stability and the protection and preservation of employment. The *Budget Framework of the Republika Srpska, 2011–2013* stipulates that the macroeconomic policy should support an increased rate of GDP growth (which slowed down in 2009 due to adverse effects of the global economic crisis), maintaining existing and creating new jobs, continuing current investment in infrastructure and beginning new projects, enhancing social security and further strengthening of economic, fiscal and social stability of the RS.

Several sectors have responsibility for some areas of health and this is the basis for intersectoral cooperation. For example, road safety is overseen by the ministries of Transport and Internal Affairs; violence prevention includes policy areas of internal affairs, media and social protection; food and water safety are overseen by the Ministry of Agriculture, Forestry and Water Management. Other sectors are indirectly connected to the health sector and this is where better cooperation is needed. The sectors that have the greatest intensity or greatest need for intensifying cooperation are presented in the Table 14.

Intersectoral actions within different policies are reflected in many legal frameworks or strategies. Better quality of life, health, health equity and well-being are generally mentioned in the Constitution of the Republika Srpska, and are reflected in many policies.

Table 14. Cooperation between the health and other sectors

Sectors with greatest intensity of cooperation	Sectors with greatest need for intensifying cooperation
Education	Labour/employment
Agriculture	Urban planning
Transport	Housing
Finance	Environment
Social protection	Culture
Media	Economic development
	Rural development
	Migration
	Tourism

The *Framework Plan for Water Resources Development* in the RS includes the provision of safe drinking-water. Also it contains measures for preventing waterborne outbreaks, which have very significant impact on the social and ecological environment. It is expected that proposed actions will improve health, living conditions and stabilize economic conditions. Besides the Ministry of Agriculture, Forestry and Water Management, the water management planning process must include all stakeholders including health care and the public.

The *Energy Development Strategy to 2030* aims to ensure sustainable energy sector development with limited emissions of greenhouse gases, and promotes renewable energy sources. According to the strategy, all major energy facilities must have an environmental allowance and are obliged to inform the authorities about the environmental impact of all their products. The *Forestry Development Strategy to 2020* supports the development of health tourism, environmental protection and biodiversity conservation through the development of healthy forests. The strategy is implemented through various laws: the *Air Protection Act*, *Water Act*, *Waste Management Act*, *Spatial Planning and Building Act*, *Environmental Protection Act*, *Non-Ionizing Radiation Protection Act*, *Chemicals Act*, *Act on the Transport of Dangerous Goods*, *Act on the Transfer of Explosives and Flammable Liquids and Gases*, *Act on the Protection of the Population from Communicable Diseases* and *Public Ski Resorts Act*, which all provide intersectoral legal frameworks. Although the sectors other than health are leaders for the implementation of the mentioned strategies, the health care section of the Ministry of Health and Social Welfare is responsible for ensuring the health dimension of all the strategies, which is of particular importance given the lack of capacity in the health sector.

The *Agricultural Development Strategy, 2009–2015* aims to improve the quality of rural life, in cooperation and coordination with other relevant ministries. This strategy includes activities to protect human health from foodborne diseases, animals or harmful effects of pesticides, veterinary drugs and feed additives. It emphasizes integral production, with all sectors included, through protocols complying with international conventions linked to environmental and human health, plants and animals, to produce enough food in the RS. The *Strategy for Export Promotion, 2009–2012* covers the development of programmes that include the selection of priority sectors for increasing production and competitiveness of the food industry, which is seen as an opportunity for increasing the manufacture and export of organic food and medicinal plants. It also implies continuous cooperation of ministries in providing supportive and efficient frameworks for a healthy environment to support a healthy food industry. The *Strategy for Encouragement and Development of Foreign Investment, 2009–2012* involves the creation of free trade zones for all trade activities, except activities that endanger the environment, human health, material goods or the security of the country. The *Trade Development Strategy to 2015* has a primary legislative goal of controlling and regulating of quality goods and services as well as health care of consumers and proposes that branded trademarks should be defined through the cooperation of all responsible stakeholders. The *Food Act*, *Act on Inspections in the Republika Srpska*, *Act on Matters of General Use* and *Genetically Modified Organisms Act* are connected to the provision of health and a safe environment as well.

The *Policy for Early Childhood Development, 2011–2016* promotes the creation of a safe environment in which the child is born, grows, develops, feeds, plays, learns and lives. It emphasizes strengthening existing intersectoral collaboration and coordination and proposes new forms of them. It promotes the development and implementation of integration programmes for early growth and child development to be directed to different population groups, with the aim of providing accessible and high quality services in health, education, social work, and family and child welfare. The *Family Development Strategy, 2009–2014* is directed at the development and preservation of the family and an encouraging environment for proper mental and physical development of children and promotion of parenting and intergenerational solidarity, as a part of the comprehensive socio-demographic development of the RS with a comprehensive intersectoral approach. The *Youth Health Policy, 2008–2012* is an instrument for comprehensive promotion of young people's health, solving their problems and overcoming their health challenges, and for the prevention of risk behaviour. It proposes integrated cooperative programmes

between the health sector and other sectors, including citizens' associations and organizations relevant to youth health. The Ministry of Health and Social Welfare has the lead role in the *Policy for Early Childhood Development, Mental Health Policy, Strategy for the Enhancement of Social Welfare of Children without Parental Care, and Strategy for Monitoring and Containment of Opiate Drugs*, while the Ministry of Health and Social Welfare takes the lead for *the Family Development Strategy*, the Gender Centre and the *Strategy for Family Violence Control*, all of which call attention to links with other sectors than health care. Many sectors were involved in the development of these policies and strategies, including education, internal affairs, justice, finance, media and family, youth and sport. The formal structure for cooperation in the strategies usually entails establishment of an intersectoral monitoring group. Objectives in those documents refer specific vulnerable groups, and they are focused on providing a supportive environment for implementation.

The *Strategy for Cultural Development to 2015* recognizes culture as a contributor to overall health and well-being and contributes to rapprochement in the community. The *Educational Development Strategy to 2015* aims to raise the quality of education in order to enhance the socioeconomic development of the RS. The *E-Health Strategy, 2009–2015* involves the participation of all institutions of the RS health system, local and foreign experts from various fields and their application to the health system. The implementation of many of these community strategies is supported by The *Labour Act, Safety and Health at Work Act, Adult Education Act, Criminal Code, Minor Offences Code, Law on Execution of Criminal Sanctions, Law on the Classification of Activities* and the *Register of Business Entities by Activities*.

Mechanisms, tools, instruments and platforms for advancing HiAP

The main means for advancing quality of life, health, health equity and well-being in the Republika Srpska will be the active involvement of the Ministry of Health and Social Welfare in many other policy areas. Those activities are noted in different legal instruments such as the bylaws on hygienic water, protection measures, wastewater treatment, food hygiene, medical waste management production of alcoholic and non-alcoholic beverages, the regulations on water/waterway classification and maintenance of sanitary protection zones around water sources and facilities and the prohibition on marketing, advertising and distributing breast milk substitutes.

A HiAP approach is also seen in the legislative procedure. The relevant ministry forms intersectoral working groups whose task is to prepare a draft proposal of a law, then the proposer must obtain the opinions of the:

- Republic Secretariat for Legislation, on compliance with the constitution and legal system and harmonization with EU regulations;
- RS Ministry of Economic Affairs and Regional Cooperation regarding the compliance of laws and bylaws with EU legislation, the impact on law on the introduction of new formalities;
- RS Ministry of Finance when the implementation of the act requires the provision of financial resources; and
- all other relevant authorities depending on the specific health issues and determinants.

Before presentation to the government session, the draft proposal is considered by the appropriate committees – such as Social Affairs, Finance and Economy and Internal Policy – to give their opinions and proposals. Health care proposals go to the Committee for Social Affairs. After adoption of materials in those committees, the proposer submits the material to the government through the General Secretariat. Laws that are of public interest must be published on its web sites and the deadline for submission of comments and suggestions is eight days thereafter. Furthermore, legislation which will have a significant impact on the public is usually subject to consultation, which includes submitting draft legislation to interested parties to provide written comments and suggestions and to form working groups that include representatives of interested parties. After determining the final text of the proposed legislation, the government proposes the document to the National Assembly where, after consideration by the delegates and the relevant working bodies, the document should be discussed and approved. Draft laws can be

considered by other working bodies if they are within their scope. Following the review of the draft legislation, the National Assembly may decide to put the draft to a public hearing and, if necessary, to consult with agencies, organizations or other scientific and professional institutions.

The National Assembly of the Republika Srpska has formed various committees responsible for different interests. The main committee responsible for health is the Committee on Health, Labour and Social Policy, while some of the other established committees are linked to health as well (i.e., Environmental Protection, Equal Opportunities, Protection of the Rights of Refugees, Displaced Persons and Returnees).

The implementation of adopted laws is the responsibility of the Inspectorate, which operates at different levels (republican or municipal) and covers different professions. The system of inspection includes sanitary, veterinary, agricultural and market inspection as a part of the RS's surveillance system.

In the some areas multisectoral working groups or agencies with common targets have been or are going to be formed. Some of the selected RS agencies are those for Water, Road Safety, Youth Health and Mental Health and Addiction Diseases.

To date there have been no studies regarding the benefits of health on other sectors nor has benefit incidence analysis been used. Nor have the appropriate HIA capacities been established and the structure for its implementation is not yet in place. The activities for raising awareness among different stakeholders, policy-makers and public experts that promote concepts of positive health, quality of life and well-being or the importance of multidisciplinary competences in HiAP are starting to be the focus of health authorities.

Information for HiAP

Health data are at the core of modern health systems and the basis of effective strategies and policies. The collection, processing and dissemination of statistical data in the RS is undertaken by the Republika Srpska Institute for Statistics, as the competent authority for the organization, production and dissemination of statistical data in the RS, and by other agencies and organizations authorized for the production of statistics. The Institute also publishes the newsletter *Demographic Studies*. The RS *Statistical Data Act* governs the organization, scope, authority, responsibilities and other issues relevant to the production of statistical data.

The RS Public Health Institute is responsible for monitoring, assessing and analysing the health of the population, monitoring and studying health problems and risks, keeping records, producing health statistics and conducting research in the field of public health, preparing publication of its annual population health report and reporting to the competent institution under the law and international obligations.

The RS has a complete vital registration system. Data on mortality and morbidity are regularly collected, but they are not linked, for example, to data related to exposure to environmental risk factors. To link data in such a way is important for the identification of unanticipated health problems and of risk groups. Mortality and morbidity data are disaggregated by gender but there is no disaggregation of data by income, education, occupation, household size or socioeconomic group.

Data published by the Public Health Institute and the Agency for Statistics as well as data from different surveys are usually used in creating strategic documents. Even though the link between socioeconomic data and policy is not clear and appears to be weak, there are some forms of socioeconomic data collection, such as the MICS.

MICS 2005–2006 was a national survey based on a representative sample of households, the population of women of childbearing age and children under 15 years of age, conducted in the RS by the Ministry of Health and Social Welfare. Its objectives of this survey were to:

- provide basic data for assessing the condition of women and children in the RS;
- provide data for monitoring progress in achieving MDGs and other goals of international consensus;
- contribute to the continuous improvement of data quality for information system development.

The results of this study show the overall situation of children and women in three areas: health, sanitation and social aspects, and have been used in creating a variety of strategic documents such as the *Strategy for the Development of the Family, 2009–2014*; the *Policy for Early Childhood Development, 2011–2016*; the *Strategy for the Enhancement of Social Welfare of Children without Parental Care, 2009–2014*. The study has had an important influence on improving data quality for information system development relating to the health of vulnerable population groups.

The Public Health Institute undertakes population health surveillance in areas such as noncommunicable diseases, communicable diseases, health of the environment and food and water safety. The capacity for surveillance and assessment of population health is quite well developed in the RS, but there are some weaknesses such as the collection of data on risk factors for noncommunicable diseases. This gap needs to be overcome for advancing a HiAP approach. Although the systematic use of health information to support policy and strategy in different public policies is not sufficiently prevalent in the RS, research evidence is incorporated in many areas and data from this research inform strategies and programmes for health promotion.

At the end of 2009, the RS adopted the *Strategy for e-Health Development, 2009-2014*, to provide flawless, reliable, secure and timely sharing of health information, improve access to information about population health and establish the standards for data flow and communication within the health system.

Recently in the Ministry of Health and Social Welfare Section for Monitoring and Evaluation of the Health System has been established. Its scope is performing activities to improve population health through the establishment and functioning of an effective monitoring and evaluation system based on health system results. The Section is engaged in the development of models of health policies, strategies and plans with instruments for monitoring their implementation and their impact on the health system and population health. Based on the results of the evaluation, the Section presents information and recommendations proactively to policy-makers and relevant institutions.

HiAP capacity building

In the RS there are no specific, systematic programmes dedicated to building the capacity of policy-makers and health professionals for using HiAP. But there are some ad hoc programmes organized from time to time within different international projects whose aim is to train health professionals in decision-making, leadership and addressing the impact of key determinants of health on the goals of sectors outside the health system. For example, public health management education is carried out through short courses in areas of health management. Private universities have organized this form of education since the 2005–2006, in the form of block courses. In the postgraduate programme of the Faculty of Medicine of the University of Banja Luka, starting in 2011–2012, students will have the opportunity to study the health system from the perspective of policy-makers and health managers. The education of public health professionals is to a great extent carried out through various projects, for example, the Social Insurance Technical Assistance Project (SITAP) and its subcomponent, Planning of Human Resources Supervision, Management and Governance and the CIDA/Balkans Primary Health Care Project. Education, certification and licensing of public health workers are regulated by the *Law on Medical Chambers* and by the *Bylaw on Continuing Medical Education*.

HiAP is incorporated into undergraduate, graduate and postgraduate education for health professionals in different public health subjects. During the six-year programme of studies at faculties of medicine at the universities of Banja Luka and East Sarajevo, there are the following public health subjects: epidemiology, social medicine, hygiene and medical ecology. After graduation, medical doctors are able

to specialize in public health disciplines such as epidemiology, social medicine and organization and economics of health care, hygiene and medical ecology.

At this moment, the Ministry of Health and Social Welfare is developing the *Human Resources Plan for the Health System, 2011–2015* and the *Bylaw on Specializations and Sub-specializations of Health Workers*, which will help policy and decision-makers to decide about how best to assess and respond to future health workforce and public needs.

Since modernizing public health education and professional training is crucial to meeting the challenges of public health, it is going to be established in the Centre for Health Care Management in the RS.

Challenges, opportunities and recommendations

The greatest challenges facing the Republika Srpska are the labour market and public health implications of an ageing population, epidemiological transition and chronic disease increases. In this context, there is a need to convince other sectors that health and investment in health are their concerns. The strong political will of the government represents a great opportunity, as does the firm foundation of public health organization, affording the opportunity to involve community in decision-making.

In light of the above, we recommend the following:

- public health policy leadership to align efforts to convene national agenda-setting meetings with other governmental agencies, NGOs, private foundations and philanthropic organizations that have an interest in reducing health inequities;
- creation of an environment that will enhance partnerships from both traditional and non-traditional sources to strengthen efforts to address the SDH and to build capacity among partners in health; and
- creation of a holistic and interdisciplinary approach to research on prevention and participatory research that engages communities from beginning to end, i.e. from conceptualizing studies through to the evaluation of their impact and outcomes, followed by establishment of proper health data collection systems.

References

1. Institute for Statistics of the Republika Srpska. *Bulletin of Demography*, 2009, 13(2).
2. Lolić A, Prodanović N, Stijak M. *The Republika Srpska Multiple Indicator Cluster Survey*. Banja Luka, Ministry of Health and Social Welfare of the Republika Srpska, 2006.
3. *Human Resource Plan for Health, 2011–2015*. Banja Luka, Ministry of Health and Social Welfare of the, 2011 (unpublished document).
4. *Evaluation of public health services in south-eastern Europe*. Copenhagen, World Health Organization Regional Office for Europe, 2009 (www.euro.who.int/en/what-we-do/health-topics/Health-systems/public-health-services/publications2/2010/evaluation-of-public-health-services-in-south-eastern-europe, accessed 23 September 2011).
5. *Global Youth Tobacco Survey Republika Srpska*. Banja Luka, Ministry of Health and Social Welfare of the Republika Srpska, 2003.
6. Report on survey results and proposal for development of future surveys. Banja Luka, Ministry of Health and Social Welfare of the Republika Srpska, 2003.
7. National Parliament of the Republika Srpska. The Programme of health policy and health strategy in the Republika Srpska until 2010. *Official Gazette of the Republika Srpska*, 2002, 01-659/02.

3. Bulgaria

Summary

Demographic changes in the country and the increasing burden of chronic diseases require the health system to play a more active role in ensuring intersectoral collaboration and inclusion of HiAP in all areas of people's lives. The established role of social determinants of health, and the possibility of influencing them through the joint efforts of all sectors, contributes to improved health outcomes, in particular for the reduction and even elimination of health inequalities.

Experience in implementation of the principle shows that there are examples of cooperation, for instance, integrating the approach in the *National Health Strategy* and the provision of a legal framework for action in the area of health protection, among various ministries, NGOs and agencies and the population in general. Aside from the HiAP successes and good practices documented here, it is noteworthy that in general this approach is not implemented effectively because efforts are not sufficiently targeted to health or modern mechanisms for assessing health impacts; the effects of policies in other sectors are not applied; there are insufficient funds; and relevant information is missing, especially with regard to disaggregated data and the available capacity. These factors demonstrate the need for a HiAP approach and measures for making the leading role of the health sector more salient, for strengthening decision-makers' capacity and for the implementation of modern methods and tools for assessing the effect of the joint efforts of all sectors on public health.

The Bulgarian Working Group was created under the order of Minister of Health and included representatives from the Institute of Public Health, the Ministry of Health, the Ministry of Education, the Ministry of Labour and Social Policy, the Ministry of Agriculture and Food, and Academic Institutions. All drafts were sent to working group members for consultation and comments. The final draft was created after a final meeting of some group members. The authors of the report are Tatiana Ivanova, Professor, National Centre of Public Health Protection; Jana Golemanova, Associate Professor, National Centre of Public Health Protection; Lidia Georgieva, Associate Professor, Medical University, Sofia; Tonka Varleva, Ministry of Health; Evgenia Delcheva, Professor, University for National and World Economy, Sofia; Natashka Danova, Associate Professor, National Centre of Public Health Protection; and Tszvetana Jakimova, Ministry of Health.

Country context

Political background

Bulgaria is a parliamentary republic governed by a National Assembly consisting of 240 deputies who are elected for four-year terms. The National Assembly selects and dismisses government ministers, including the Prime Minister, exercises control over the government, and sanctions deployment of troops abroad. It is responsible for the enactment of laws, approval of the budget, scheduling of presidential elections, declaration of war and ratification of international treaties and agreements. The President of Bulgaria is elected for a five-year term with the right to one re-election. The Prime Minister is head of the Council of Ministers. In addition to the Prime Minister and deputy prime ministers, the council is composed of ministers who head the various agencies within the government and usually come from the majority ruling party or from a member party of the ruling coalition in the Assembly. The Council is responsible for carrying out state policy, managing the state budget and maintaining law and order.

Bulgaria is divided into 28 administrative regions, which are further subdivided into 262 municipalities. Sofia, the capital, is considered an administrative region. The governors of the regions are appointed directly by the government. Municipalities act as self-governing bodies. Mayors and members of municipal councils are elected at municipal elections. Since 1992, substantial responsibilities have been devolved to the municipalities for health care, education and social affairs.

Table 15. Socioeconomic figures for Bulgaria

Indicator	Dimension
Area	110 910 km ²
Population	2011 estimate 7.35 million; 2001 census 7.93 million; 51.30% Females
Density	68.9 per km ²
Ethnic distribution (%)	Bulgarians: 83.9; Turks: 9.4; Roma: 4.7; Others: 0.9
GDP (PPP) estimate (2010)	Total \$93.763 billion; Per capita \$12 052
GDP (nominal) estimate 2010	Total \$44.84 billion; Per capita \$5955
2009 Euro Health Consumer Index	448 points of potential 1000 (33 rd position)
2009 Human development index	0.840 (high)
Currency	Lev (BGL) 1BGL=€0.51
EU accession	1 January 2007
Regions of planning	6
Regions, Districts	28
Municipalities	264

Socioeconomic conditions

Per capita GDP increased from €3400 in 2006 to €4700 in 2008, but in 2009 decreased slightly to €4600 due to the global financial crisis. The unemployment rate climbed from 5.7% in 2008 to 10.3% in 2010. There has been a reduction in the total share of health expenditures, from 6.6% of GDP to 6% for the period 2003–2008 despite the increased funds in nominal terms. For the past two years the share of the health expenditures has been 4% of GDP.

Bulgaria's rating in the global quality of life index (of more than 100 countries) has since 2008 and for 2010 remained at 69, its 2006 level. The major factor is the low level of economic growth, which in 2009 was negative. The cost of living is quite high, restricting the purchasing power for health services of disadvantaged groups. Health indicators are relatively good and have higher scores than the quality of life index.

Demographics

There has been a consistent decrease and ageing of the population (1). Compared to the 10 previous years, the population has declined by half a million, with 73% living in the cities. The share of people over 65 was 17.53% (20.15% for women and 14.73% for men). From 2007–2009, the average life increased; in 2008 it was 73.01 years, 69.9 for men and 77.08 years for women. In recent years, the birth rate has registered a slight increasing trend, at 10.7 per 1000 in 2009. Over the past two decades the death rate has been increasing. In 2008 the indicator registered a slight drop (of 0.3%) and the general mortality rate reached 14.2 per 1000 in 2009 (2). The mortality rate continues to be higher for men and in rural areas. In the deaths-by-cause breakdown, the leading causes are diseases of the circulatory system (64.7%) and neoplasms (16.4%). The infant death rate has decreased over recent years and in 2008 reached 8.6 per 1000, remaining higher in rural areas than in cities (11.6 and 7.6 per 1000, respectively).

The health system

Public health services are organized by the Ministry of Health and its 28 regional health inspectorates and are financed centrally (3). Emergency care is provided from 28 emergency centres with 198 branches. General practitioners control access to specialized outpatient and hospital care. Outpatient care is provided

by 3832 individual and 223 group physician practices, 4724 individual and 241 group dental practices; medical and dental centres and independent medical diagnostic centres; 3099 individual and 124 group practices for specialized medical care; 68 practices for specialized dental care; 590 medical centres, 49 dental centres, 33 medical and dental centres, 115 consulting centres, 928 laboratories (4).

Inpatient care is provided by hospitals. The total number of beds is 50 041 situated in multiprofile hospitals for active treatment (27 779 beds), 69 specialized hospitals for active treatment (8105 beds), 12 psychiatric hospitals (2685 beds), 40 hospitals for long term care (4489 beds) and 46 health centres (4135 beds).

There are 27 998 physicians (37 per 10 000), 5210 GPs (6.5 per 10 000), 6493 physicians in dental medicine (8.6 per 10 000) and 48 099 nurses and others (63.6 per 10 000). The geographical distribution of human resources is not even across the country. According to the National Health Insurance Fund (NHIF), GP and specialists in outpatient and hospital care prevail in big towns, while a lack of GP and specialists is observed in small settlements and remote areas.

Currently, the health system is financed through mandatory health insurance contributions of 8% of income (5). Central and local budgets cover the unemployed, poor, pensioners, students, military personnel and civil servants. The social health insurance, administrated by the NHIF, does not envisage exclusion from the obligatory insurance system. However, 12.67% of the population do not have health insurance rights due to unpaid contributions. Voluntary private insurance is contracted by 1.8% of the population. Funding also comes from taxation, which is allotted to the health system as per the *Law on the State Budget of the Republic of Bulgaria* (6); other sources of funding include voluntary health insurance contributions, subscriptions by employers for specified health services, cash payments by citizens and the regulated patient copayments.

Burden of disease

One of the main problems generated by the ageing of the population is the increase in old-age related pathology. Official statistical data on hospitalized morbidity for the period 2005–2009 indicate that the number of hospitalized cases at health care establishments has increased from 1 614 313 (20 857 per 100 000) to 1 958 897 (25 825 per 100 000) (1). According to statistical data in 2009 there was increase in the prevalence and incidence of malignant neoplasms. The highest prevalence is that of female breast cancer (1163 per 100 000) and cancer of the female reproductive organs (1027.1 per 100 000), and incidence is highest for cancer of digestive organs (106.6 per 100 000), female breast cancer (94.7 per 100 000) and female reproductive organs (86.5 per 100 000). A number of communicable diseases have been eliminated or reduced to single figures: diphtheria, poliomyelitis, malaria, abdominal typhus and measles. As a result of the sustainable high immunization coverage of newborns with hepatitis B vaccine, there has been a sharp drop in the incidence of viral hepatitis B among children under 14 (4).

Inequities in health status, health behaviour and health system access

According to legislation, access to medical services is a principle of the Bulgarian health care system. The *Constitution of the Republic of Bulgaria* (article 52, paragraph 1) emphasizes that “... all Bulgarian citizens shall be entitled to access to medical service and to free medical service at public health establishments” (7). The Health Act and the Health Insurance Act also emphasize the right to accessible medical care, and features:

- compulsory participation of the citizens and employers, the most typical principle of the modern social security systems, which guarantees collection of revenues by contributions paid by all economically active people and their employers;
- accessibility to a basic package of health care services for all insured individuals equally; and
- solidarity, which presupposes the possibility of reallocation of contribution resources from the healthy to the ill, from the rich to the poor, from the employed to the unemployed (3,5).

According to the *Labour Code*, Article 275 and *Healthy and Safe Work Conditions Act*, Art.16, all resources related to the provision of healthy and safe work conditions are at the expense of the employer. (8).

The *Social Insurance Code* of 2000 regulates the state public insurance with respect to general disease, work accidents, occupational disease, maternity, unemployment, ageing and death and additional social insurance. The amount of insurance payouts for work accidents and occupational disease is determined annually for the main economic activities by the *Budget of the State Public Insurance Act*. The payments are fully at the expense of employers. There is a special fund for the treatment of uninsured individuals. In many national programmes treatment resources are assigned (for example for AIDS, tuberculosis) and subsidized by the state budget (9,10). There are also provisions for social assistance, allocation of resources for manuals and snacks for poor children, visiting school, etc.

The specific needs of ethnic minorities have been identified and they are mainly for maternal and child health care (most importantly, the reduction of pregnancy cases in early age, correct pregnancy course, genetic screening, adequate nutrition and hygiene of children, full vaccination coverage and full access to health services in general), detection and treatment of TB, malignant diseases, care for the handicapped, better prophylactic care and specific care forms, including mobile teams. The specific needs of disadvantaged populations have been studied as well, and there is a strategy showing measures for improving their health status. Measures are being developed for accessibility for the disadvantaged, including physical access to public buildings, homes, outdoor leisure facilities and workplaces.

Policy frameworks for HiAP

The HiAP approach is central to the *National Health Strategy, 2008–2013*, which includes the impact of all policies outside the health sector on population health (11). Intersectoral cooperation is to be achieved by political decision-making, strategic planning and practical implementation of actions. The ultimate goal is to facilitate the development of policies based on scientific evidence, including assessment of health determinants and outcomes of health status. These obligations are enshrined in the *Bulgarian Health Act* and each ministry monitors compliance. The action plan of the strategy defines (12) the responsible bodies, activities, deadlines and details of reporting on performance for the Minister of Health's annual report on population health and strategy implementation, which must be adopted by the Council of Ministers and the parliamentary Health Care Committee. The last report included the following observations (13).

- The strategy and the action plan are general policy documents and do not specify priorities.
- It is difficult to analyse and assess the strategy and action plan because of the general nature of objectives, tasks, activities and results.
- There is a lack of objective measurable indicators to do this and assessment is therefore subjective.

The goal is to facilitate development of evidence-based policies including on the SDH.

All national strategies and programmes are directed towards counteracting poverty and social exclusion. There are particular strategies and associated action plans concerning ethnic minorities and deprived individuals. All these strategic documents have measures concerning housing, access to employment, health and educational needs. For example, the *Health Strategy for Disadvantaged Ethnic Minorities* contains specific measures for this group, including training of health mediators, provision of access to health services – including through mobile formats – provision of prophylactic examinations, special educational campaigns and other measures.

Important cooperation has been established between the Ministry of Labour and Social Policy and the Ministry of Health in the field of psychosocial rehabilitation for people with severe mental disorders in day-care centres (14). The executive body responsible for the implementation of the *National Mental Health Policy* includes representatives of several ministries including Labour and Social Policy, Health, Justice, Education, Youth and Science, the professional organization of Bulgarian psychiatrists,

professional groups, communities and other constituencies.

Other ministries that collaborate with the Ministry of Health include the following:

- the Ministry of Finance, which supervises the financing of the health sector and contributes to defining the aims and objectives of health policy and strategy;
- the Ministry of Environment and Waters, which is responsible for all aspects of the environment and protection against chemical, physical and biological pollution, and waste disposal;
- the Ministry of Education, Youth and Science, which through the National Health Policy and Strategy, provides schools and students with knowledge and skills regarding health and safety, including the introduction of health education programmes in schools for healthy behaviour and school sports;
- the Ministry of Agriculture, which through the National Health policy is responsible for food safety, guaranteeing yields, processing and sale of milk and dairy products according to EU standards; protection against animal diseases and risk assessment of food additives;
- the Ministry of Transport, Information Technologies and Communications, which is responsible for road and transport safety and road construction projects;
- the ministries of Transport, Internal Affairs, Education and Science, which recently cooperated on a road safety campaign for children;
- the Ministry of Labour and Social Policy, which is responsible for the organization and coordination of state policy on revenues and living standards, social security, unemployment protection and promotion of employment, social assistance and social services, social support and protection of children and workplace health and safety; and
- the Ministry of Justice, which has an active role in the development of regulations, imposing sanctions and arbitration, cooperating with many other authorities including the National Health Insurance Fund, the Ministry of Finance, the Ministry of Regional Development and Public Works, the Ministry of Transport, Information Technologies and Communications, the State Agency for Child Protection, the National Statistical Institute, trade unions, employers' organizations, and Customs.

The Ministry of Health has the main responsibility for population health. All agencies and national bodies have responsibility for coordinating activities at the national level. Many health strategies and policy documents refer to the importance of cooperation with other sectors and outline some form of intersectoral or joint planning groups or committees. For all cases of intersectoral cooperation there are established mechanisms for interaction such as national councils, standing interdepartmental councils, advisory councils, standing expert groups and working groups (15). Most of them are established by legislation and regulations which designate their membership, functions and control, as well as objectives, policies, activities, timelines for implementation and reporting. They variously have coordinating and advisory roles. Their meetings are advertised publicly in advance. Typical examples include the Coordinating Council on the National Development Plan, National Committee on AIDS Prevention, National Council for the Integration of Disabled Persons, National Food Safety Council.

Case study: HIV Prevention, Diagnosis, Treatment, Care and Support Services

Bulgaria has an integrated and balanced approach to fighting HIV through prevention, diagnosis, treatment, and care and support services for all who need them, as defined by the guiding principles of the *National Programme for Prevention and Control of HIV/AIDS and STIs 2008–2015*. The programme aims to prevent an HIV/AIDS epidemic and has a multisectoral and participatory approach. Since 2001, the national action plan has been implemented through significant funds from the Ministry of Health budget, which are used to ensure: the safety of each blood unit; universal and free-of-charge HIV testing throughout the country; universal and free-of-charge antiretroviral therapy (ART) to those in need regardless of their social and health insurance status; free-of-charge antiretroviral prophylaxis to prevent mother-to-child transmission of the HIV infection (16).

There is a network of health institutions and state agencies involved in HIV/AIDS prevention and control:

the National Centre of Infectious and Parasitic Diseases, the National Centre of Public Health Protection, the National Centre of Addictions, the Regional Public Health Inspectorates in each of the 28 administrative districts, five centres for Haematology and Transfusiology (blood banks), 17 dermatology and venereology centres and medical university hospital clinics, decentralized provision of ART in five hospitals with HIV treatment sectors and 21 municipal administrations responsible for implementation and financing of local strategies and programmes for HIV prevention and sexual and reproductive health.

Since 2002, Bulgaria has had an active Country Coordinating Mechanism to Fight AIDS and Tuberculosis which was established on the basis of the existing National Committee for Prevention of AIDS and STDs at the Council of Ministers. The CCM is a forum to promote coordinated multisectoral partnership and active involvement of the nongovernmental sector. Government, civil society, organizations working with most-at-risk populations, donors, local authorities and people affected by the diseases participate in the decision-making process and monitoring and review of the progress of the national HIV/AIDS response. The Chair of the CCM is a vice prime minister and members from the government include the deputy ministers of the ministries of Labour and Social Policy; Education; Youth and Science; Finance; Culture; Defence; Interior; Foreign Affairs; Transport, Information Technologies and Communications; and Physical Education and Sports. In 2010, membership included 14 members (35%) from the government sector, and 6 (15%) from academia, 9 (23%) from NGOs, 5 (13%) from international organizations, 2 (5%) representing people living with HIV, 2 (5%) representing the private sector and two observers.

Since 2004, the Prevention and Control of HIV/AIDS programme has been implemented with a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has enabled a significant scaling up of service provision for groups most-at-risk (injecting drug users, sex workers, young Roma people with high risk behaviour, men who have sex with men, transgender people, prisoners and children at risk out of school), as well as care and support for people living with HIV. This programme complements the national response to HIV/AIDS and is an integral part and contributes to achieving the goals of the National Programme for Prevention and Control of HIV and STIs, 2008–2015.

In the framework of the HIV/AIDS programme, analyses of the epidemiological and behavioural data, utilizing both quantitative and qualitative data collection methods, have been conducted on a regular basis to identify needs and actions to address health and social inequalities of target groups. Cultural trends and sociological differences have been considered in planning interventions of the HIV/AIDS programme. Specific health and social services and public health approaches of work are tailored to the needs of the most-at-risk groups. They include the implementation of evidenced-based interventions aimed at providing information and education, increasing knowledge, reducing high-risk behaviour, harm reduction, reducing stigma and discrimination, and protection of human rights. There is equitable provision of free-of-charge services, including HIV counselling and testing, community outreach and peer counselling and case management, regardless of status or insurance.

Effectiveness and service coverage are ensured through several important steps: assessment of local needs and resources to select districts for interventions according to their potential for a rapid increase in HIV infections; selection of reliable NGOs to provide services to the most-at-risk groups; recruitment and continuous training of NGO outreach teams; development of municipal networks for partnership and referral to existing health and social services; development of professional networks for exchange of experiences; health education for young people in and out of school with a special focus on HIV and STI prevention and reproductive and sexual health; and the development of youth-friendly services.

The Ministry of Health has contracted over 54 NGOs in 23 of the 28 districts of the country, 15 regional public health inspectorates, and the National Centre of Infectious and Parasitic Diseases for provision of services to all target groups. Additional infrastructure has been established to ensure accessibility and coverage of specific services to hard-to-reach populations, including 19 voluntary HIV counselling and testing centres, 12 mobile medical units, seven low threshold centres for injecting drug users; eight community-based health and social centres for Roma people; three centres for psychosocial support for

people with HIV. Networking has been strengthened through the functioning of 10 municipal HIV/AIDS coordinating offices; seven local HIV/TB/STI committees and 10 units for integrated biological and behavioural surveillance.

A best practice of partnership between the health care and penitentiary system is the provision of HIV and TB prevention, diagnosis, treatment, care and support services in prisons and detention centres (10). Furthermore, since 2007, there is a joint order of the Minister of Health and the Minister of Justice regulating the regular provision of voluntary and anonymous HIV testing and counselling services in all 12 prisons and two pre-trial detention centres. Since 2008, the two ministries have also been successful in their joint efforts to improve early detection and quality treatment of TB cases in the prison system and to strengthen the networking between the medical centres in the prisons and the public health TB hospitals.

The HIV/AIDS programme outlines actions to respond to different needs of all target populations, considering their social, financial and health situation. In addition to the provision of specific services, a communication strategy has been developed, addressing stigma and discrimination on the basis of disease status, sex, age, marital and migration status, sexual orientation, as possible significant barriers to equal access to prevention, treatment, and care and support interventions.

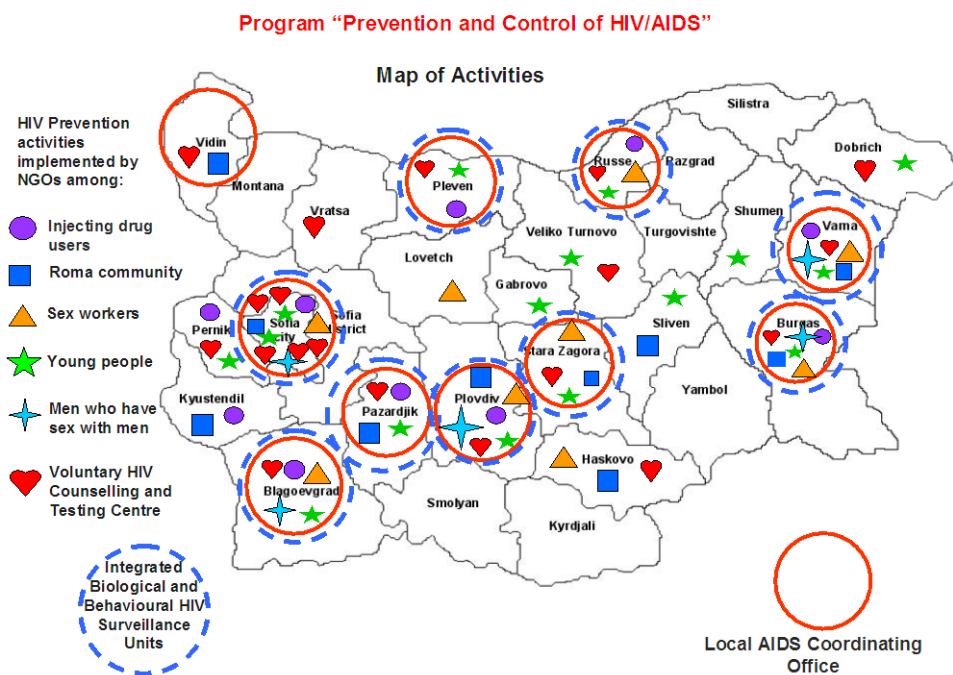
The Directorate for Management of Specialized Donor-Funded Programmes at the Ministry of Health is responsible for the development, coordination and implementation of the national policies related to the prevention and control of HIV, tuberculosis and sexually transmitted infections (STIs), data collection, processing and sustaining a national system for monitoring and evaluation of the HIV/TB/STIs response. Regular supervision, monitoring and evaluation of programmatic and financial performance are supported by the Surveillance, Monitoring and Evaluation Unit for the programmes financed by the Global Fund at the Ministry of Health.

Mechanisms, tools, instruments and platforms for advancing HiAP

Strategic planning is one of the mechanisms for advancing HiAP and involves the following actors: Council of Ministers regarding general national policy, the Ministry of Finance and Ministry of Health regarding the national health system, the National Statistical Institute regarding statistical data, the centres of public health and other scientific institutions, the National Health Insurance Fund, all other ministries related with public health and relevant to the particular policy. After the elaboration of a strategic document with planned breakdowns it is obligatorily coordinated with all stakeholders. At regional and local levels there are similar processes.

As a rule, legislative regulatory acts are elaborated at the national level and discussed with the relevant regional and local structures. For all new legislation, regulatory and other legal requirements there is training conducted in two workshops and working groups. All programmes take account of the broader determinants of health, such as poverty, housing, work and unemployment, socioeconomic exclusion of groups or individuals, access to education, nutrition, drug use and each particular strategy or programme describes the mechanisms for implementation including coordination among ministries, between departments within ministries, between ministries and other institutions, between national and international institutions, and among national, regional and local management levels. The tasks and management functions implemented depend on the respective level. However, assessment of implementation and results is difficult.

Fig.7. Map of Prevention and Control of HIV/AIDS activities financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, 2010



Case study: Overview of Bulgarian OPRD

The main reference document for the preparation of the Operational Programme on Regional Development (OPRD) was the *National Strategic Reference Framework, 2007–2013 (17)*. The Ministry of Regional Development and Public Works (MRDPW) coordinated the development of the programme and became its managing authority, overseeing its implementation, with no intermediary authorities. A working group was set up for the purpose of preparing the OPRD. About 50 relevant stakeholders took part in the elaboration of the programme (18).

Although cooperation among stakeholders was considered satisfactory and Ministry of Health involvement was ensured, a thorough review of the potential health impact of the planned investments was not carried out as part of the development process and the health considerations were only implicitly acknowledged as public health gains stemming from the implementation of other non-health investments. The consulted experts claimed that public health gains are accordingly reflected in other aspects of the programme, such as sustainable development, environment, integration of disadvantaged communities, accessibility to services by disabled people, etc. In the current OP public health impact is mostly measured through other non-health indicators (environment, social, education, sustainable development, etc.) since health indicators as such are not part of the operational programme for non-health investments.

The OPRD is meant to address social, educational and health problems of Roma minorities and measures for preserving the Roma cultural identity, to improve living conditions of citizens and make a contribution to social inclusion of disadvantaged and vulnerable urban communities. Apart from the direct benefits the interventions will also be expected to have a positive impact on public health. Additionally, the OPRD has a focus on activities ensuring better accessibility to health by improving connectivity to health centres as well as equal opportunity and access to transport, public buildings and services for disabled people.

It is not expected that the public health impact of non-health interventions will be considered in a more coordinated and systematic way under the review of the programme, which will require a review of current practices in this respect. Such a review can be ensured through straightforward and targeted guidance, or explicit obligation for the preparation of the OP. Clear requirements or instructions from the EC were instrumental in altering the approach to health gains in OPs (see Table 16).

Special HiAP mechanisms

Tobacco control, drug abuse prevention and control, alcohol control: Bulgaria has signed and ratified the Framework Convention on Tobacco Control (FCTC) and works for its implementation. It uses the simultaneous application of health education, appropriate fiscal policy and enforced legislation. There is a designated council for reducing and preventing smoking chaired by the Minister of Health, whose vice-presidents are deputy ministers of Economy and Agriculture, while members are deputy ministers of Finance, Education, Defence and Interior, and representatives from the National Statistical Institute and the National Health Fund. The Minister of Health and other competent governmental bodies together with non-government organizations are responsible for designing activities targeted at the use of tobacco, alcohol and narcotics.

These include implementing promotional and prophylactic activities and ensuring access to medical aid and social protection of the affected persons. One per cent of the resources received in the republican budget from the excise duties on tobacco products and alcohol beverages is used for financing these activities. The municipalities approve and implement regional programmes. The sale of alcohol beverages is prohibited to people under 18 years of age or in a drunken state; on the property of kindergartens, schools, hostels for students or medical establishments; at sporting events; or at public events organized for children and students. The direct advertising of spirit beverages is prohibited while the indirect advertising of spirit beverages and the advertising of wine and beer cannot be neither directed at people under 18 years of age, or transmitted in programmes or published in printed publications designated for them, nor may they participate in such advertising. Advertising may not connect the use of alcoholic beverages with sports or physical achievements or driving vehicles; nor may it contain claims about usefulness for health, social or sexual well-being or present the abstention or temperance in a negative way.

Physical activity promotion, obesity prevention and control, healthy nutrition: An important objective of the *Food and Nutrition Action Plan, 2005–2010* was to improve the national diet to reduce the risk of nutrient deficiencies and diet-related chronic diseases, with special emphasis on counteracting obesity (19). The Ministry of Health and the health sector have the leading role, but the strategy for its implementation is an intersectoral approach. In 2006 the National Coordination Council for its implementation was established, involving representatives of all ministries related to food, nutrition and physical activity, representatives of associations of food producers and professional and nongovernmental organizations such as the National Association of Municipalities. An important task is to improve the nutrition of women of fertile age and in pregnancy, including those with low income. Activities include training of medical specialists, raising awareness of women about healthy nutrition; supporting low-income households financially to improve education and qualifications. Since 2005, the government has provided free milk and breakfast for all schoolchildren in primary school, which has had the additional benefit of encouraging children from ethnic minorities to attend school. The Ministry of Health has elaborated ordinances for nutritional requirements in school canteens and cafeteria, kindergartens, social institutions and specialized schools. Training courses for medical specialists on children's and adolescents' nutrition have been conducted, and awareness of nutrition has been raised among parents.

Case study: Operational Programme for Regional Development

Table 16. MA: Ministry of Regional Development and Public Works Total EU allocation: €1,4 billion					
Priority Axis	Funds (€m)	Per cent of total OP	Content of priority/Operations	Briefing Sheet topic(s)	Health considerations in the priority
Sustainable and integrated urban development	839.07	52.40%	1.1. Social Infrastructure 1.2. Housing 1.3. Organization of economic activities 1.4. Improvement of physical environment and risk prevention 1.5. Sustainable urban transport systems	Transport, social infrastructure, energy	Contribution to quality of life, living and working environment by benefiting from improved educational infrastructure, improved health care infrastructure refurbished buildings (non-health care building); Social inclusion of disadvantaged people and equal opportunity: access to public buildings, or improved housing for vulnerable communities
Regional and local accessibility	400.32	25.00%	2.1. Regional and local road infrastructure 2.2. ICT network 2.3. Access to sustainable and efficient energy resources	Transport, energy, ICT, climate change and adaptation	Contribution to equal opportunities through improved access to health resources e.g., additional population covered by broadband and roads network and improved connectivity of disadvantaged population with urban centres
Sustainable tourism development	218.09	13.62%	3.1. Enhancement of tourism attractions and related infrastructure 3.2. Regional tourism product development and marketing of destinations 3.3. National tourism marketing	Culture and heritage	Contribution to economic development, job creation, income generation for population thus improving standards of living
Local development and cooperation	89.67	5.60%	4.1. Small-scale local investments 4.2. Inter-regional cooperation	Social infrastructure; Infrastructure: waste Institutional capacity, ICT	Enhancement of opportunities for access to educational, health care and business services for the local communities by means of improving the related infrastructure; Improvement of quality of environment and risk prevention
Technical assistance	54.12	3.38%	5.1. Management, monitoring, evaluation and control 5.2. Communication, information and publicity 5.3. Capacity building of OPRD beneficiaries	Institutional capacity	-

National Dietary Guidelines have been developed, published and widely promoted among the public and food producers and there has been training of food producers on principles of healthy nutrition. Regulations for the restriction of commercial advertising of high-energy foods and beverages, especially directed to children, are envisaged, as is implementation of fiscal measures for foods with a high content of fat, added sugar and salt. Mechanisms have been introduced to encourage companies and institutions to implement workers' health promotion by providing healthy food and conditions for physical activity and sports.

Measures have been introduced for promoting children's physical activity including enhancing sports facilities. The State Agency for Youth and Sports and the Ministry of Education and Science adopted a national Education through Sport programme in 2004. In 2006 a national Sport at School programme was implemented and there is now a national sports calendar for schoolchildren from 1st to 12th grade (20,21).

Occupational health

There has been a policy of raising public awareness about healthy and safe working conditions. The National Council for Working Conditions is the standing body coordinating occupational health and safety policy and is chaired by the Minister of Labour and Social Policy. The Council finances various information campaigns through the Working Conditions Fund.

Environmental health

Environmental health protection is implemented through constant monitoring of the quality of air, water, soil and food and the enforcement of sanctions for violations. Legislation and regulations ensure good environmental quality, for example, the *Purity of Ambient Air Act*, *Environmental Protection Act* and the *Health Act* (22). The respective structures for ambient air monitoring at the Ministry of Environment and Water and Ministry of Health have been established; rules for monitoring and communication of the results have been set. A good example is the work of Supreme Environmental Executive Council at the Ministry of Environment and Water, including representatives of the Ministry of Health, where decision-making takes eventual environmental impact into account in order to protect public health. Local authorities – municipal councils, mayors and regional governors as well as NGOs – are involved in the implementation of environmental and health policy at regional and local levels. Their competence is defined by the *Local Self-Government and Local Administration Act*, *Environmental Protection Act*, *Health Act*, *Administration Act* and others. Implementation of an integrated approach to managing environmental health involves functional interaction among leading sectors (public health and environmental protection), target sectors (industry, power production, transport, agriculture and tourism) and the general public.

Mental health

Within the frames of different projects there have been some promotion activities including a media campaign against stigma and discrimination. There is no institutionalized system for health promotion in the area of mental health. The government has adopted the *National Mental Health Policy and Action Plan*.

Child protection

The *National Policy for Children, 2008–2018* is the framework for the *Annual Programme for Child Protection*, which is submitted by the Minister of Labour and Social Policy and the President of the State Agency for Child Protection for approval by the Council of Ministers. It sets the specific obligations of all state authorities. The State Agency for Child Protection is a specialized body coordinating child policy. Its annual report summarizes activities of all institutions involved in the programme, measuring the achievement of objectives. For instance the programme for 2011 contains sections on social policy for reducing child poverty and creating the conditions for social inclusion, improving child health and ensuring equal access to good quality preschool and school education.

Information and capacity building for HiAP

The existing information system does not provide data on the relation between health and lifestyle, access to the health system, level of education, employment, gender and other socioeconomic factors. However, separate research examining these relationships has been carried out. For example, there is research on how lifestyle, risk factors, education and gender influence health.

For providing decision-makers with information on health risks, health status and health needs of the community as well as information on policies and programmes that can improve community health, a national report on the health status of the nation is elaborated and adopted by the National Assembly. Thus political decision-makers are informed on the health status of the population. Regional reports are also elaborated and presented to the regional administrations. In some cases such reports are also prepared at the local level and discussed with the municipalities. As a result of problems identified in the reports, programmes are designed for risk reduction at national, regional or local level. In certain cases the population can address directly particular institutions and request the management of a certain health issue.

For example, in the case of gas pollution in Stara Zagora, the people of the town addressed the National Assembly, which assigned the Ministry of Health to organize a working group for assessment of the health risk and health status of the community. The report of the working group was presented to the Ministry of Health, the parliamentary Health Commission and the Stara Zagora public.

In all concrete cases of cooperation, the involved bodies establish their own rules for communication and functioning. The HiAP approach is not incorporated into undergraduate, graduate and continuing professional education for health professionals.

Challenges, opportunities and recommendations

Challenges

1. There are many intersectoral strategies and they are reflected in legislation, but in most cases they do not progress because of the lack of funds, capacity or both.
2. No systematic monitoring or evaluation is in place.
3. Decision-makers are not provided with sufficient evidence about the benefits of the intersectoral actions for the health of the population.

Opportunities

1. Traditions have been developed for cooperation and good practices can be identified, failures studied or lessons analysed.
2. There is enough international experience, particularly in the area of assessment, that can be used.
3. Work should continue for capacity building to further implement the policies.
4. Information systems have to be improved to obtain relevant data for planning and evaluation of HiAP and research should be used to justify these actions.

Recommendations

1. The HiAP approach is the basis of effective policy responses. Developing a HiAP approach and building capacity for implementation will allow HiAP to be applied more widely and with greater success.
2. The importance of social determinants of health has to be the main principle for proactive the role of the health system.
3. Joint actions linked to common results, with clear roles and responsibilities, should be developed.
4. There should be a shift from cooperation and coordination towards integrated policies.
5. More tools should be developed to implement this policy with increased institutional capacity and support of regular monitoring and evaluation.
6. The leading role of the health sector should be consolidated.

References

1. *National Programme for Prevention and Control of HIV and STIs, 2008–2015*. Sofia, Ministry of Health, 2008.
2. *National Health Strategy and Action Plan, 2008–2013*. Sofia, Ministry of Health, 2008.
3. Health Act. *Bulgaria State Gazette of Bulgaria*, 2004, 70.
4. *State Budget Act of the Republic of Bulgaria*. Sofia, Ministry of Finance, 2011.
5. Health Insurance Act. *State Gazette of Bulgaria*, 1998, 70.
6. *Health For All Database*. Copenhagen, World Health Organization Regional Office for Europe, 2011.
7. Constitution of the Republic of Bulgaria. *Bulgaria State Gazette*, 1991, 56.
8. Act on Healthy and Safe Working Conditions. *Bulgaria State Gazette*, 2007, 124.
9. *Programme for Prevention and Control of Tuberculosis in Bulgaria, 2007–2011*. Sofia, Ministry of Health, 2007.
10. Public health statistics. Sofia, National Center of Health Informatics, 2009 (<http://www.nchi.government.bg/Eng/Engli6.html>, accessed 3 October 2011).
11. *National Health Strategy 2007–2013*. Draft. Sofia, Ministry of Health, 2007 [in Bulgarian].
12. Republic of Bulgaria. *National Strategic Reference Framework, 2007–2013*. Sofia, European Union European Regional Development Fund, 2007 (<http://www.eufunds.bg/document/435>, accessed 3 October 2011).
13. Minister of Health of Bulgaria. Annual Report of the Minister of Health. In: *Health of the Nation in 2008*. Sofia, Ministry of Health, 2009.
14. *Actualized National Action Plan of the Policy for Mental Health of Bulgaria, 2006-2012*. Sofia, Ministry of Health, 2007.
15. *Evaluation of public health services in south-eastern Europe*. Copenhagen, World Health Organization Regional Office for Europe, 2009, p. 144.
16. *UNGASS country progress report on monitoring the Declaration of Commitment on HIV/AIDS*. Sofia, National Committee for Prevention of AIDS and STIs at the Council of Ministers, 2010 (http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/bulgaria_2010_country_progress_report_en.pdf, accessed 3 October 2011).
17. *National Regional Development Strategy for the period 2005 –2015*. Sofia, Ministry of Regional Development and Public Works, 2005.
18. *Operational Programme “Regional Development” (OPRD), 2007–2013*. Sofia, Ministry of Regional Development and Public Works, 2007.
19. *Food and Nutrition National Action Plan, 2005–2010*. Sofia, Ministry of Health, 2005.
20. *National Programme for Sport at School*. Sofia, Ministry of Youth and Sports, 2006.
21. *National Programme for Education through Sport*. Sofia, Ministry of Youth and Sports, 2004.
22. Environmental Protection Act. *Bulgaria State Gazette*, 2002, 91.

4. Croatia

Summary

Croatia's overall population trends have been affected by a long-term decline in the birth rate, increase in the mortality at a younger age and the population ageing. Global recession has led to increased unemployment, a reduced credit rating and a standstill in investment and production. Neoplasms, cardiovascular diseases, mental health problems and traffic accidents are recognized as the most important public health problems and lifestyles and behaviour such as lack of physical activity and alcohol and tobacco use are therefore important as contributory factors.

The health system incorporates the primary, secondary and tertiary levels of health care at the level of state health institutes. In the last two decades Croatia has enacted numerous policy, strategic and action plans where health and health gains were recognized as a high priority. Different policy documents from the area of health, social welfare, science, education and sport, environmental protection, traffic safety, agriculture and other areas form the framework that supports quality of life, health, well-being and health equity.

There are various initiatives to deal with health inequalities, with measures both vertical – such as the national preventive programmes – and horizontal, some originating from the local level. A case study on inequalities in health by the Croatian National Institute of Public Health showed that GDP per capita at the county level was negatively correlated to the SDR for cardiovascular diseases.

Recognized challenges are the need for strengthening intersectoral collaboration and building a healthy environment, and strengthening PHC and its involvement in the specialized programmes on health promotion and disease prevention taking into account a balanced collaboration with compulsory and private insurance and the need for sustainable funding.

Country context

Political background

The Croatian government consists of the prime minister, one or more deputy prime ministers and ministers. There are deputy prime ministers for Agriculture, Fisheries and Rural Development, Health and Social Welfare, Foreign Affairs and European Integration, Regional Development, Forestry and Water Management, Social Issues and Human Rights. There are 16 ministries: Environmental Protection; Physical Planning and Development; Justice; Finance; Family; Veterans' Affairs and Intergenerational Solidarity; Interior; Tourism; Economy; Labour and Entrepreneurship; Defence; Science, Education and Sports; Sea; Transport and Infrastructure; Culture; and Public Administration. Croatia is divided administratively into 21 counties. Local governments take care of the implementation of all activities concerning environment and housing, urban planning, child care, social welfare, health care, compulsory education, culture and physical culture, sport and environmental and civil protection.

Aiming at better intersectoral collaboration, county health councils were established under the *Health Care Act of 2008*. Since then, the councils have strongly supported the implementation of the health development strategy at the local level.

Socioeconomic conditions

Croatian GDP was estimated at €12 892 per capita in 2010. Global recession has led to increased unemployment, reduced credit rating and a standstill in investment and production. The share of health care consumption in the GDP is approximately 9% (1).

Demographics

In the census from 31 March 2001, Croatia had a population of 4 437 460 (1). Population trends have been affected by a long term decline in the birth rate, increase in the mortality of younger age groups during the war and negative migration trends in the last decade. In 1991, Croatia entered a depopulation phase. In 2009, there were 44 577 births and 52 414 deaths registered. The birth rate was recorded at 10.1 per 1000, mortality at 11.8 (2). The general fertility rate was 42.6, and the population growth rate was -1.8. Further population ageing may be expected with all its burdens on the health care system, pension planning and society as a whole.

Like most European countries, the Croatia has an ageing population. The share of the total population over 65 has grown from 13.1% in 1991, to 15.6% in 2001. Estimates suggest that by 2030 the same age group will constitute 25% of the population. The percentage of the young population (0–14), which was relatively stable during the 1980s, dropped from 20% in 1990 to 17% (2001 census). Life expectancy at birth in 2009, according to the Central Bureau of Statistics, was 76.3 years for both sexes: 79.6 for women and 72.9 for men. The mortality rate is relatively stable at around 11 per 1000 (3). The infant mortality rate in 2009 was 5.3 per 1000 live births (4). The most common risk factors for infant mortality concern complications in the perinatal period and certain genetic and environmental predispositions for developing congenital diseases and anomalies incompatible with life. Over 60% of infant deaths take place in the first seven days of life, which is related to a short gestation period and immaturity, the leading perinatal causes of infant mortality.

The health system

The Croatian health system incorporates the primary, secondary and tertiary levels of health care at the level of state health institutes (5). The primary level includes medical practices of family medicine, paediatrics, dentistry, gynaecology, school medicine, occupational medicine, epidemiology, public health, mental health and addiction prevention. Primary health care also administers emergency medical care, community nursing, home care, palliative care, biochemical diagnostics and pharmacy. Some medical practices still operate under health centres, but most have individual contracts with the Croatian Institute for Health Insurance (CHIH). Secondary health care consists of medical specialist and polyclinical practices and facilities, regardless of ownership, as well as general and special local or regional hospitals. The tertiary level is based on clinics, clinical hospitals, clinical hospital centres and state health institutes. Institutes of public health cover all three levels of health care.

The *Health Care Act of 1993* consolidated the system of financing the health sector under one public institution, the CHIH, which laid the groundwork for a modern system of financing, based on social security and the principles of solidarity and comprehensiveness. The same act also introduced the principles of patients' rights and choice, and allowed the participation of the private sector in providing health services and health insurance. Though most health care providers remained publicly owned, the number of private providers grew, especially in PHC, dental medicine, specialized clinics and pharmacy. A new but growing private insurance market has developed to offer supplementary insurance for services not covered by the mandatory insurance. Mandatory health insurance covers over 95% of the population. There is also supplementary insurance, which provides additional services or exemption from patient participation fees.

Burden of disease

Cardiovascular diseases remain one of the main public health problems. They are the leading cause of death with a share just under 50%, most commonly ischaemic heart and cerebrovascular diseases. According to the number of years of life lost (YLL), an indicator of premature mortality, cardiovascular diseases run second, behind neoplasms, with 76 215 YLLs. Since 2000, the standardized mortality rates of CVDs for all ages and to the age of 65 have decreased (6). Cancer incidence and mortality are rising. Neoplasms are the second most common cause of death, accounting for 25%. The most common cancer in

men is bronchial and lung cancer, the third cause of death among Croatian men in 2008, after acute myocardial infarction and chronic ischemic heart disease. In women, breast cancer is the leading cause of cancer death, and is the fifth cause of death in women overall. Injuries are the third leading cause of death generally, and the first cause of death in children and youth. Children and youth most frequently lose their lives in car accidents, middle-aged persons in suicides, and the elderly (65+) in falls. According to the YLL indicator (1-75), injuries are also third.

Mental health and disorders are a public health priority. For several years, there has been an increase in mental disorder morbidity, with some fluctuations. Hospitalization due to mental disorders has accounted for 6–7% of overall hospital morbidity. The highest number of admissions were recorded for ages 20–59, a leading cause of hospital morbidity for this occupationally active age group. Addiction diseases are significant, including disorders caused by excessive use of alcohol and psychoactive drug abuse.

A comprehensive control of infectious diseases is another public health priority. Although the epidemiological situation regarding infectious diseases in Croatia is relatively favourable, there is continual implementation of preventive and counter-epidemic measures. A programme of compulsory vaccination covers “classic” infectious diseases, while additional programmes are tailored to the needs of vulnerable population groups.

Overweight and obesity, as well as related chronic diseases, are a significant public health concern, as in other European countries. There is an excessive consumption of fats as a source of energy, and relatively low consumption of fish, milk and dairy products, fruits and vegetables. Of special concern is the irregular and poor diet of children (low intake of fruits and vegetables, excessive consumption of soft drinks and fast food of low biologic value). Efforts are being made to standardize meals in kindergartens and schools, as well as to educate all population groups. The amount of daily physical activity in the population has shown great variability in terms of sex, age, level of education, genetic and cultural inheritance, as well as socioeconomic factors. Efforts are, therefore, being made to promote an active lifestyle, primarily among the young, but not disregarding older groups.

According to the WHO estimates, smoking is the leading cause of the burden of disease, expressed in DALYs, in Croatia, with a rate of 15.8%. According to the Croatian Health Survey conducted in 2003, 27.4% of Croatians age 18 and older smoked (33.8% of men and 21.7% of women), which was lower than the smoking prevalence in the EU-15 (28.1%), or EU-10 Member States (28.3%), according to the WHO database. It is estimated that in Croatia over 9000 people (or every fifth to sixth person) annually die due to smoking-related diseases.

STIs are important not only due to their wide prevalence, but also due to prospective later sequelae, such as female disorders, extra-uterine pregnancies, infant diseases and mortality, malignant neoplasms of the cervix, infertility and increased vulnerability to HIV. Attention today has shifted towards the modern diseases such as non-gonococcal cervicitis and urethritis, hepatitis B and C, HIV infection and AIDS, genital herpes and HPV infection.

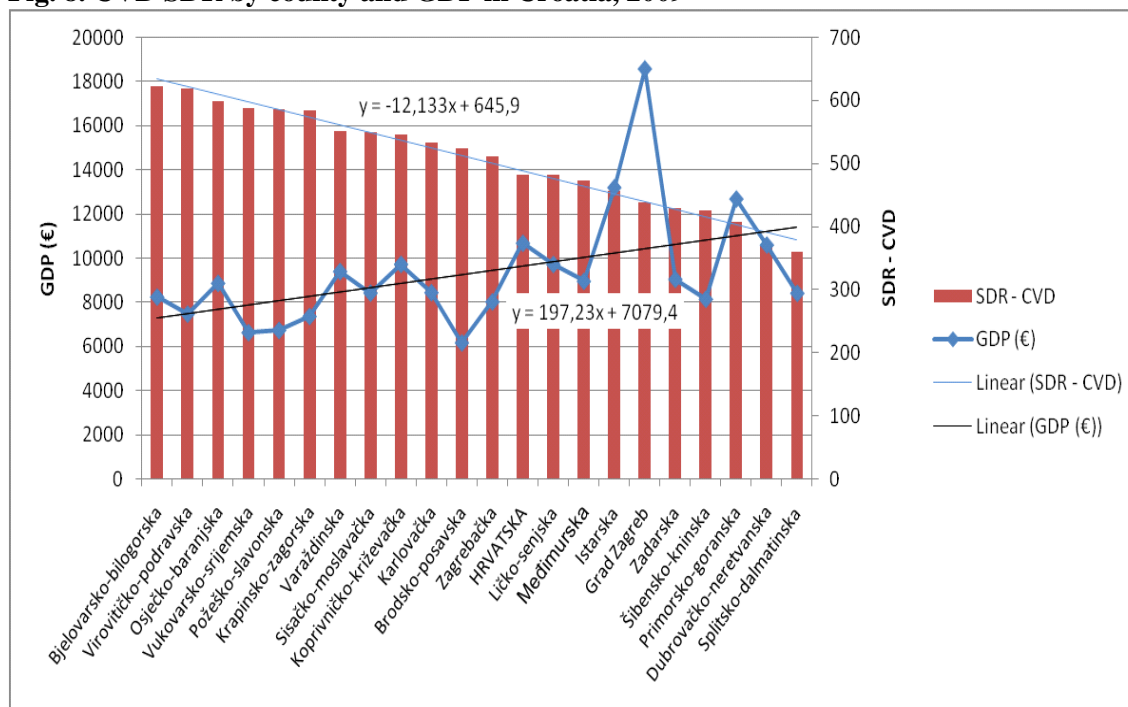
Inequities in health status, health behaviour and health system access

The economic progress of the country does not necessarily imply an improvement in health or health care for all inhabitants. As health indicators for the general population improve, inequalities may increase or the same indicators may worsen for certain groups. Various factors have an effect of health inequities, including socioeconomic status (education, income, employment, wealth), nationality, sex, age, residence (region, county, urban or rural, isolated areas, mountains, islands), special groups (immigrants, Roma, HIV-positive, prisoners, etc.). Such factors are often intertwined and affect health through interactions such as social networks, physical environment, access to health care, personal behaviour and biological factors.

A study on the connection between cardiovascular mortality and GDP at the county level has shown that it is higher in counties of lower income. After the *Tackling Health Inequalities* summit organized by the EU in London in October 2005, a case study for Croatia on inequalities of health was prepared by the Croatian National Institute of Public Health. The analysis showed that GDP per capita at the county level was negatively correlated to the SDR for cardiovascular diseases, meaning that SDR for cardiovascular diseases was higher in counties where GDP was lower (the analysis was done for 2002). The counties having lower SDR for cardiovascular disease than the national average, except Zagreb, were from the coastal region.

The results of the study were presented to the representatives of county public health institutes, calling on them to strengthen health promotion and CVD prevention programmes, especially in counties with higher CVD SDR. The results also formed the basis of a CVD prevention programme in Međimurje County. In 2002 they had higher CVD SDR (566 per 100 000) than the Croatian average (487) ranking eighth. They mobilized local government and resources, created, implemented and fostered the comprehensive prevention programmes. The programmes included the counselling unit for CVD prevention in the County Institute of Public Health. In 2009 the county had a CVD SRD of 472 per 100 000, lower than Croatian average of 483, ranking it fifteenth (Fig. 8).

Fig. 8. CVD SDR by county and GDP in Croatia, 2009



Inequities in health are among the top priorities of the Ministry of Health and Social Welfare. The Project “Changes and perceptions of equity in health and the health system”, supported by the Ministry and carried out by the Croatian Society for Pharmacoeconomics and Croatian Chamber of Nurses is in the final phase. The Project goal is to determine the perception of the possible changes in the specific population, to determine possible reasons and to analyse the economic and health outcomes. The first phase of the project reflected a relatively high general satisfaction with primary and hospital health care. There was a somewhat lower subjective perception of the quality of care by citizens living in villages and remote areas in comparison to the urban and suburban population. The results were presented to the Ministry of Health and Social Welfare, published in the professional journal and made available on the public web site.

In the last two decades Croatia has enacted numerous policies, strategies and action plans where health and health gains were recognized as a high priority.

Policy frameworks for HiAP

Croatia's Constitution guarantees every person health care, based on the principles of comprehensiveness, continuity and availability. There are many strategies, plans and programmes in Croatia that impinge on health.

The *Strategic Development Framework, 2006–2013* has established actions and priorities for stable economic growth, employment and a better living standard. It requires reform of the health system in a way that would ensure all parties transparent and efficient access to basic health services.

The overall objective of the *Strategy for Sustainable Development of the Republic of Croatia* (in the chapter "Public health"), is preservation and improvement of the health of the entire population by ensuring timely access to health services by means of scientifically based programmes for disease prevention and control and health promotion. The strategy does not define the specific goals for reducing inequalities, but the activities aim to achieve equities in health care by:

- improving public health literacy and enabling public involvement and participation by ensuring favourable and secure conditions for child development, health promotion at schools and workplaces, efficient prevention of and care for communicable diseases, healthier nutrition and lifestyles, including physical activity and reducing tobacco and alcohol use;
- strengthening intersectoral collaboration in health promotion; and
- strengthening the public health system and empowering it to carry out the comprehensive preventive activities and systematic implementation of the national preventive programmes.

As competent bodies, the ministries of Health and Social Welfare; Agriculture, Fisheries and Rural Development; Environmental Protection, Physical Planning and Construction; Finance; and Science, Education and Sports as well as local and regional self-government are named.

The *Health Development Strategy, 2002* focused on collaboration between social organizations and individuals to maintain the health of the population. It asserts that lowering preventable (smoking, alcoholism, psychoactive substances), occupational and traffic risks, as well as risks resulting from poor nutrition and unhealthy lifestyle, cannot be achieved solely by health care measures, without the participation of the wider community. Establishing social responsibilities for given health risks should be extended to those who contribute to the risk itself. For example, manufacturers and users of products with adverse health effects should take proportional responsibility by ensuring funds for disease control. Higher taxes for tobacco products or alcoholic beverages, for example, could help reduce the consumption of these products, and should be used for the comprehensive prevention programmes.

As a strategic measure, it is proposed that by law a certain share of profits from products harmful to human health be contributed toward treatment of any consequent diseases, by means of taxes or similar mechanisms. The strategy goes on to state that an integrated IT and communication infrastructure is an indispensable element of the health system, ensuring all participants of the health care process have access to relevant information. The plan has been followed by the *National Health Development Strategy 2006–2011*.

The new document *Strategic Plan of Public Health Development, 2011–2015* has recently been adopted, with the specific goal of reducing social inequalities in health, citing the need to implement comprehensive primary prevention programmes tackling health determinants. One chapter in the document is devoted to the establishment and development of partnership and intersectoral collaboration among agriculture, education, construction and environment, financing, etc., specifically stressing that this

collaboration could contribute to a reduction in inequalities. The health system could be the main actor in the initiatives and activities, but other sectors might also act independently.

Health and well-being and the intersectoral approach

The *Croatian Food and Nutrition Policy, 1999* is multisectoral and appoints as responsible bodies the Ministry of Health and Social Welfare; the Ministry of Agriculture, Fisheries and Rural Development; the Ministry of Science, Education and Sport; the Croatian Chamber of Economy and the public media, food industry and various other organizations.

The *Overweight Prevention and Reduction Action Plan 2010–2012* has as responsible bodies the Ministry of Health and Social Welfare; the Ministry of Science, Education and Sport; the Ministry of Agriculture, Fisheries and Rural Development; and local and regional self-government and civil society organizations.

The *National Road Traffic Safety Programme 2001–2010* aims to upgrade road traffic safety, with quantitative objectives echo EU objectives. The fundamental aim is to reduce the number of fatalities in road traffic accidents.

The *National Plan of Activities for the Rights and Interests of Children, 2006–2012* has served as the foundation for drafting the National Child Accident Prevention Programme and Suicide Prevention in Children and Youth Programme. Implementing bodies, depending on the specific measures and activities, are the Ministry of Health and Social Welfare; Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity; the Ministry of Science, Education and Sport; Ministry of the Interior; the Ministry of Foreign Affairs and European Integration; and the Croatian National Institute of Public Health in cooperation with county institutes of public health, health facilities, family centres, professional chambers, institutions, societies, NGOs, as well as local and regional governments.

The *National Strategy of Protection Against Family Violence, 2011–2016* provides a framework and mechanisms for tackling family violence. Implementing bodies, depending on the specific measures are: the ministries of Family, Veterans' Affairs and Intergenerational Solidarity; Health and Social Welfare; Justice; the Interior and Science, Education and Sport, along with the governmental offices for Gender Equality, Human Rights, Cooperation with NGOs and the Chamber of Economy, coordinators at county offices of the state administration, county commissions for gender equality, competent state attorney offices, local and regional governments, civil society organizations, public institutions and the media.

The *National Programme for Occupational Health and Safety, 2009–2013* lists the areas where it is necessary to define health and safety at work and strategic principles (partnership and cooperation of all participants, prevention of hazards, sustainable development and common sense, as a way of reducing risk to a minimum).

The *National Mental Health Strategy, 2011–2016* focuses on the priority areas of advancing mental health in the general population, and age-specific and vulnerable groups and in the workplace with respect to prevention, treatment and rehabilitation, community mental health care. It includes a special chapter on intersectoral cooperation with NGOs and the ministries of Science, Education and Sport; Justice; Family; and Veterans' Affairs and Intergenerational Solidarity.

The *National Strategy against Disorders caused by Excessive Consumption of Alcohol, 2011–2016* targets alcohol abuse prevention, treatment and rehabilitation of persons with alcohol-related problems, as well as a socially engaged approach to problems of excessive alcohol consumption. Measures include intersectoral cooperation with the NGOs and the ministries of Science, Education and Sport; Justice; the Interior; and Veterans' Affairs and Intergenerational Solidarity.

The *National Strategy and Action Plan against Narcotic Drug Abuse* include a series of measures of primary, secondary and tertiary prevention based on a broad, socially engaged approach to drug-related problems. Intersectoral cooperation is also recommended with NGOs and the ministries of Science, Education and Sport; Justice; and the Interior.

The *National Decade of Roma Inclusion* programme and action plan focuses primarily on the education of Roma and their inclusion on the labour market. Special attention was paid to equal distribution of health care services to Roma, with a focus on children and compulsory vaccinations.

The *Development of the integral information system in primary health care* project was implemented since 2008 and is now in its final phase. The offices in PHC (GP, paediatricians, gynaecologists, dentists, school of medicine and biochemical labs) are integrated in the system. The implementation of the e-prescriptions and e-referrals is fully developed, and e-appointments and e-health files are under development. The system aims not only at rationalization of health expenditures, but at diminishing health inequalities.

National preventive programmes

The *National Programme for the Early Detection of Breast Cancer* (2006) was started by an official decision of the government in 2006 as the first national programme of early detection of malignant diseases in Croatia. The programme encompasses a mammography examination every two years for all women from 50–69 years old. It is, additionally recommended to undergo a clinical breast examination every three years from 20 to 40 years of age and annually afterwards. A special algorithm is applied for women running a high risk of developing breast cancer (case history of parents, diagnosed non-tumorous breast disease and other risks).

The *National Programme for the Early Detection of Colorectal Cancer* (2007) includes an occult blood test for everyone over the age of 50.

Given the public health significance of diabetes in Croatia, the *National Diabetic Health Care Programme* was passed in 2007 aiming at early detection in primary care by reducing complications by 20% within 5 years after programme implementation and approximating pregnancy results in diabetic women to those of healthy women. The programme focuses on prevention and aims to achieve early diabetes detection in people over 50, as part of preventive examinations, including for all pregnant women at least once during pregnancy, while in higher risk pregnancies immediately after diagnosing pregnancy. The programme also foresees patient education aiming at prevention of developing chronic diabetes-related complications. Education should start in childhood so as to prevent the risk of developing diabetes. A comprehensive organization is based on the Croatian model of a tri-dimensional network of functionally connected organizations. Activities include programme evaluation through a diabetes registry.

The *Early Cervical Cancer Detection Programme* is expected to start in September 2011, and will include a pap smear every three years for women aged 25–64. A later phase of the programme foresees an introduction of new technologies, such as liquid-based cytology and HPV testing.

There is a mixture of the vertical and horizontal programmes for reducing health inequities. The bottom-up initiatives originate from the local level, as described above in the Medimurje County example. The vertical programmes are implemented as the above mentioned national preventive programmes.

The *Plan for Public Health Development, 2011–2015* stresses that stable and sufficient financial resources are needed for the implementation of the programmes and activities. The financing, according to the health policy and legislative framework will come from the state budget, the Health Insurance Institute, local governments, donations or other funds. Additional sources are international projects, scientific and research projects, educational activities, etc.

Strategies, plans and programmes

- National Health Development Strategy, 2006–2011
- Plan and programme of mandatory health insurance health care measures (OG 126/06)
- Plan of Public Health Development, 2011–2015
- Strategic Development Framework, 2006–2013
- National Strategy against Disorders Caused by Excessive Consumption of Alcohol, 2011–2016
- Croatian Action Plan on Alcohol (2010)
- National Plan of Activities for the Rights and Interests of Children, 2006–2012
- National Road Traffic Safety Programme, 2001–2010
- Proposed National Plan for Prevention of Accidents in Children, 2010–2014
- Proposed National Plan for Prevention of Suicides in Children and Youth
- Overweight Prevention and Reduction Action Plan, 2010–2012
- National Strategy for the Establishment of Equal Opportunities for Disabled People, 2007–2015 (OG 63/07)
- Croatian National Plan for Health and Environment (1999)
- Croatian National Programme for Occupational Health and Safety, 2009–2013
- Strategy for Sustainable Development of the Republic of Croatia (OG 30/09)
- Strategy of National Security Republic of Croatia (2010)
- Croatian Nutritional Policy
- National Generic Integrated Plan of Coordinated Actions in Public Health Crisis (2010)
- National Strategy and Action Plan Against Narcotic Drug Abuse
- National Strategy of Protection Against Family Violence, 2011–2016
- National Diabetic Health Care Programme (2007)
- National Programme for the Early Detection of Breast Cancer (2006)
- National Programme for the Early Detection of Colorectal Cancer (2007)
- National Decade of Roma Inclusion
- National Mental Health Strategy, 2011–2016
- Croatian Food and Nutrition Policy (1999)
- Health Development Strategy (2002)
- National Implementation Plan for Social Inclusion, 2011–2012

Mechanisms, tools, instruments and platforms for advancing HiAP

Different policy documents from the area of health, social welfare, science, education and sport, environmental protection, traffic safety, agriculture and others form the framework that supports the promotion of quality of life, health, well-being and health equity in Croatia.

In Parliament several committees dealing with health protection and promotion exist: the Parliamentary Committee for Health and Social Welfare, the Parliamentary Committee for Environmental Protection, the Parliamentary Committee for Education, Science and Culture and the Parliamentary Committee for Environmental Protection, Physical Planning and Construction. During the process of development of policy and strategic documents, multisectoral working groups are usually formed and work together on the documents' creation and harmonization.

No continuous or systematic health inequities impact assessment exists. However, in a specific situation, on request of any of the above-mentioned bodies, analysis of the health status and assessment of possible influencing factors, such as environmental risk factors, are provided and the results used for the necessary interventions. The process is overseen predominantly by the state institutes of health and/or the Ministry of Health and Social Welfare. The possible sanctions and consequences depend on the results of the assessment, and incentives depend on the specific situation.

Current activities

In line with documents and relevant reports mentioned here, some sectors have already been actively included in health promotion and healthy lifestyle. The education sector, for example, is a part of health programmes on all levels of training programmes, while the public media are getting more and more involved in these activities. It has penetrated the primary level of the Croatian health care, including diagnostic labs. An important element thereof is the institution of e-prescriptions throughout Croatia. Enforcement of strategic documents clearly shows that health and well-being are high on the priority list of state policy. However, inconsistent and incomplete implementation, as well as insufficient funds, has been thwarting full strategy realization.

An example of multidisciplinary competence is the evaluation of the National Strategy for Drug Abuse Prevention and the beginning of creation of a new document. An external evaluation of the existing document planning process and implementation assessment was asked for; an online questionnaire for different stakeholders is envisaged; and the results of the evaluation are to be presented to the multidisciplinary working group and based on the results, drafting of the new document will be planned.

Information for HiAP

Morbidity and mortality data for Croatia have been routinely collected in line with the statistical research programme re-adopted annually by Parliament. The main institution responsible for collection and analysis of the data on health status, health behaviour and functioning of the health care system is the Network of the Public Health Institutes, coordinated by the Croatian National Institute of Public Health.

Morbidity analyses are based on hospital morbidity, diseases registered in PHC and data from the Cancer Registry, Psychoses Registry, HIV/AIDS Registry, Registry of Treated Psychoactive Drug Addicts, Diabetes Registry, etc. Mortality analyses are based on state mortality statistics sent also to large international WHO and EUROSTAT databases.

All the above data can be analysed by WHO ICD diagnoses, sex, age, county of residence, and partly by marital status, employment status or education. However, data on lifestyle, health self-assessment, family size, migration, socioeconomic status and their connection to the level of health or given diseases can only be obtained by means of special research. Data on lifestyle and behaviour are also extracted from international studies such as the European School Survey Project on Alcohol and Other Drugs (ESPAD), Health Behaviour in School-Aged Children (HBSC), Global Youth Tobacco Survey (GYTS) or the Croatian Health Survey. After implementation of a pilot project, the National Health Interview Survey is planned for 2014.

Certain environmental pollution parameters are also routinely monitored, but specific data on the impact of exposure to given environmental risk factors can only be obtained from special targeted research.

Though the monitoring of intersectoral intervention has not yet been set up, it is planned as part of the surveillance of the implementation of the Overweight Prevention and Reduction Action Plan.

Capacity building for HiAP

Medical specialization in public health is not new in Croatia. The specialization is available for medical school graduates (medical doctors), and the conferred degree Specialist in Public Health. A postgraduate training course in public health is a compulsory part of the medical specialization in public health, but attendance is open for other medical and non-medical professionals as well (lawyers, psychologists, economists, etc). The course is organized by the medical schools in Croatia. Special training in public health, as a specialized education at the Faculty of Applied Medical Science is available for nurses after three years of the basic training. A course in health management for medical and non-medical professionals is organized by the Zagreb Medical School. The Andrija Stampar School of Public Health

has for decades been an active member of ASPHER and involved in the annual organization of the summer postgraduate training in health promotion Strategies for Health in Europe, supported by the European Training Consortium in Public Health and Health Promotion (ETC-PHHP).

In addition, the specialization of the school and university medicine for medical doctors has existed in Croatia for more than 50 years. The meetings, workshops and lectures of the health care programme are not only for students, but for the school staff members and parents, embracing the most important issues regarding children and youth health and development.

Being aware of the forthcoming shortage of medical staff, especially medical doctors, with the aim of preventing recently graduated doctors of medicine and dental medicine from leaving the profession, the Ministry of Health and Social Welfare initiated a model of paid internship. By providing financial resources in the state budget, the internship of college and university educated health professionals is fully covered.

The same rules apply for medical professionals working in public health as for other medical professionals: at the beginning of their career they are issued a license, which has to be renewed every five years, in which period they have to collect a specified number of points through different activities such as attending continuous training courses, publishing articles, writing professional texts, defending a masters or doctoral thesis, participating at national or international congresses.

Challenges, opportunities and recommendations

Croatia strongly supports the initiative to strengthen public health capacities and services in Europe. This especially refers to the imperative of reducing inequalities in health and focusing on social and environmental factors influencing health as well as behavioural determinants such as smoking, diet and exercise. Among other things priorities should be to harmonize the academic approach to training of public health professionals across countries, strengthen intersectoral collaboration and the capacities to deal with emerging public health challenges and strengthening of existing public health institutions through regional cooperation and networking with similar institutions in other countries.

Challenges facing the country include:

1. strengthening intersectoral collaboration in health, social welfare, environment, education, agriculture, labour sectors;
2. building a healthy environment by monitoring and eliminating environmental health hazards;
3. strengthening PHC as the fundamental part of the health care system and its involvement in the specialized programmes on health promotion and disease prevention in close cooperation with public health services; and
4. strengthening balanced collaboration with the private sector (compulsory and supplementary health insurance plus sustainable funding of national and other prevention programmes).

Opportunities exist, as reflected in the following.

1. The existing organization of public health structure enables a comprehensive approach to the most important public health issues.
2. Long standing and successful experience in public health capacity building is a prerequisite for reducing health inequalities.
3. Developing programmes of health promotion including the reduction of health inequalities can be done using available international funds and cooperation.
4. Fully implementing the e-health project, embracing primary, outpatient and hospital health care is possible.

Based on the above, we recommend:

- advocating for public health impact assessment in decision-making;
- strengthening evidence-based public health research, which should enable analysis of health data in terms of socioeconomic factors;
- ensuring sustainable public health system financing for activities aiming at health and well-being as well as quality of life in all policies;
- strengthening partnership-building with relevant stakeholders including civil society organizations; and
- strengthening collaboration with media in advocating public health challenges.

References

1. *Statistical yearbook of the Republic of Croatia for 2009*. Zagreb, Central Bureau of Statistics, 2010.
2. *Croatian Health Service yearbook, 2009*. Zagreb, Croatian National Institute of Public Health, 2010.
3. *Report on deceased persons in Croatia, 2009*. Zagreb, Croatian National Institute of Public Health, 2009.
4. *Infant deaths in Croatia, 2009*. Zagreb, Croatian National Institute of Public Health, 2009.
5. *Global burden of disease, 2004 update*. Geneva, World Health Organization, 2004 (http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html, accessed 1 October 2011).
6. *Health Care Act of 2008 (OG 150/2008)*. Zagreb, Ministry of Health and Social Welfare, 2008.

5. Montenegro

Summary

The development of the health system in Montenegro is being implemented with citizens at the centre of the process. It is therefore essential to raise awareness of the responsibility of all citizens, to emphasize the importance of their own health and lifestyle decisions. The long term development of the health system is based on its present values and strategies, alongside the strategies and basic acts of the EU. Preventive and health promotion programmes should be a priority of all state sectors.

The government of Montenegro has placed health as its number one priority in strategic documents, including those for sustainable development and poverty reduction, which apply to all state sectors. The main strategic goals are to ensure the highest level of health for an ageing population; diminish differences in health across regions or population groups; improve self-awareness concerning health issues to prevent early morbidity; protect all citizens against health threats; improve the availability, safety and quality of health services; invest in human resources and modernization of all health facilities; and support the development of new technologies. These are recognized in documents of all state sectors. It is essential to improve intersectoral cooperation so that the implementation of a HiAP approach is more successful.

This report is the result of a consultation process among stakeholders from the health sector of Montenegro. The group of experts who worked on the report were nominated by the Minister of Health at the beginning of the process. They prepared the first draft of the study, which was presented at the second technical preparatory meeting organized by WHO, the SEE Health Network and the Ministry of Health of Slovenia. They held numerous meetings, organized meetings with representatives of different institutions of the health system and maintained communication with experts from related sectors. All gathered suggestions and recommendations were included in this document.

Country context

Political background

The government of Montenegro is headed by the prime minister, deputy prime ministers and ministers. The General Secretariat of the government consists of the Prime Minister's Office; the Office of the Deputy Prime Minister for the Political System, Internal and Foreign Policy; the Office of the Deputy Prime Minister for Economic Policy and Finance; the Department for Government Affairs; the Department for Planning, Coordinating and Monitoring Government Policy; the Public Relations Bureau; the Office for Sustainable Development; the Office of National Coordinator for the Fight Against Trafficking of Human Beings; the Office for Cooperation with NGOs; and the Office of the State Agent of Montenegro at the European Court of Human Rights. There are 16 ministries: Justice; Interior; Defence; Finance; Foreign Affairs and European Integration; Education and Sports; Culture; Economy; Transport and Maritime Affairs; Agriculture and Rural Development; Sustainable Development and Tourism; Health; Human and Minority Rights; Information Society and Telecommunications; Labour and Social Welfare; and Science.

The Ministry of Health is responsible for health policy in Montenegro, and it performs the tasks relating to development and management of health care policies; health insurance and the provision of health care from public funds; establishment and organization of health care institutions and defining the requirements for space, personnel and equipment of health care institutions; professional training and specialization of health workers and associates; and public health functions including food and consumer goods safety, protection against infectious diseases, commerce of drugs and medical devices, tobacco control, transportation of hazards, production and trade of poisons, production and trade of narcotics and precursors, coordination and monitoring of intersectoral activities and policy implementation in the field

of drugs and management of medical waste and hazardous biological material, among others. In a number of these activities, the Ministry cooperates with other government departments, NGOs and international partners.

Measures and activities that contribute to the improvement of population health, as well as working conditions and development of health care services can be organized at the national and municipal levels. Health care institutions are also administered on the state and local levels. Only the state can establish institutions at the tertiary level of health care, public health institutions, institutions dealing with blood transfusion and taking, typing and transplantation of human body organs and emergencies. This restriction does not apply to institutions that also provide some services at tertiary level within their basic services, or to services provided within public-private partnerships.

Labour issues and social policy are the responsibility of the Ministry of Labour and Social Welfare, whose tasks include the development and management of employment policies; workplace safety; wages; development and management of labour market policy, employment and adult education; employment of foreigners in Montenegro; employment of persons with disabilities; protection of Montenegrin citizens working abroad; international agreements and conventions; international cooperation and European integration; pension and disability insurance policy development for veterans and disability insurance; policy in the field of social protection, child protection, family protection and protection of persons with disabilities; protection of the elderly and of displaced persons and refugees; cooperation with international organizations and other assigned tasks.

Socioeconomic conditions

In 2002 the annual per capita gross income was €208, and it rose to €5893 by 2009. The average salary increased by 3.5% from 2009 to 2010. The unemployment rate was 30.4% in 2002, falling to 12.8% in 2009. The poverty rate increased from 4.8% in 2008 to 6.8% in 2009 (1,2,3).

The indicators of wider determinants of health (socioeconomic conditions, wealth index, nutrition, household consumption, housing and education) are collected through occasional national surveys such as the *Household Consumption Survey*, *National Health Survey LSMA*, Multiindicators by MICS, the *Living Conditions and Poverty Survey*, and others. Health determinants included in the *National Health Survey* include health-related behaviour determinants, social determinants, economic determinants and measuring health outcomes to assess population health status. According to the latest *National Health Survey* in 2008, 12.3% of households considered their current living conditions as bad, whereas 41.7% claimed they had just enough money for all basic costs and 34.2% of households said their income covered all costs in a month.

Demographics

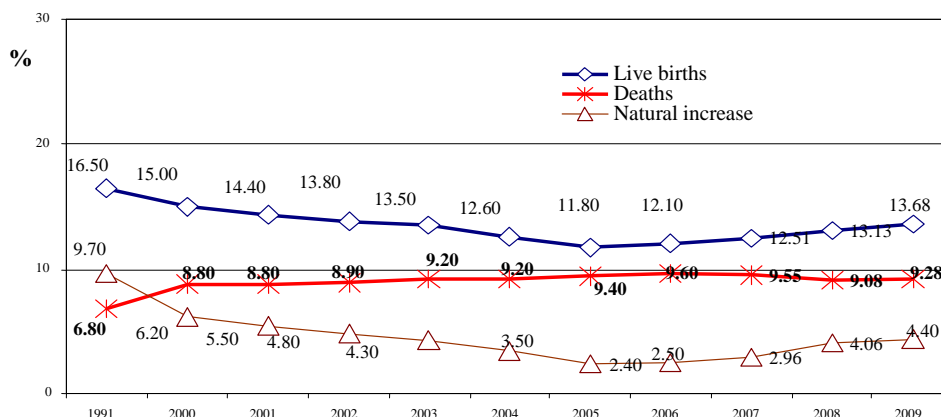
It is estimated that there were 631 536 people living in Montenegro in 2009. The previous census in 2003 recorded 620 145 people; 19.4% are 0–14 years old and 13% are 65 and older. The number of refugees and other displaced people is approximately 25 000, according to the Office for Refugees and Displaced Persons. The average mortality rate increased from 6.80 in 1991 to 9.28 in 2009. Changes in the birth and death rates have had a significant influence on the population growth rate, which fell steadily from 1991 to 2005 (see Fig. 9) (4).

The health system

Public health care facilities include: 18 primary health centres, 3 health stations, 7 general hospitals, 3 special hospitals, the Clinical Centre of Montenegro, the Institute of Public Health and the Pharmacy Association of Montenegro (5). Following the PHC reforms, other activities have been introduced by support centres for health promotion and disease prevention and rehabilitation. The system of health protection that is organized on three levels is based on the health insurance principle, financed from taxes

and fees paid by both employers and employees. The health protection of the whole population – including the unemployed, refugees, displaced persons and other categories – is financed from restricted funds, i.e. the obligatory fees and taxes paid for health insurance.

Fig. 9. Natural changes in the population structure of Montenegro, 1991–2009



Burden of disease

More than half of all deaths were caused by CVDs (54.9%), followed by neoplasms (15.2%) (6). Life expectancy at birth for both sexes was 74.1 years of age in 2009 (71.6 for men and 76.5 for women). One in three people are smokers and among secondary school pupils 20% smoke; 15.1% of adults are overweight, and 21.2% of children and adolescents have weight problems, mostly in northern parts of the country and among people with a lower level of education. According to the same research, 33% of adults have hypertension or are potentially threatened by it. This is also common for northern regions and among people of lower education or socioeconomic status (7). In the 2008 *National Health Survey*, 42.8% of adults said they suffered from 27 of the listed chronic diseases, and blood exam results showed that 10% of those tested had elevated glucose levels, and 30% had elevated triglyceride levels.

Inequities of health status, health behaviour and health system access

In Montenegro, all residents, regardless their status, have the right to services provided within the basic health care package. Basic care for the uninsured is provided through a special budget of the government. The social welfare system, through short-term aid, provides basic living conditions to all those without any income. The implementation of all activities at the level of social and health support is coordinated by the government, with the competent ministry (Health or Labour and Social Welfare) implementing decisions. Much of the responsibility is transferred to local administrations, but budget limitations sometimes necessitate centralization. All indicators of fund-sharing among different levels of health protection are monitored within population groups, especially among vulnerable groups, and within territories. The poverty and sustainable development strategies as well as the MDGs also deal with aspects of inequalities in health status (8,9,10).

Policy frameworks for HiAP

The *National Strategy of Sustainable Development*(9)of 2007 set out clear goals of improving the quality of life and maintaining and improving the health of the population with emphasis on vulnerable categories of people. The health policy to 2020 has set out general goals that include obtaining longer life expectancy, improving the quality of life, preventing worsening living standards due to health problems, reducing health inequalities and protecting against financial risks (11). The Ministry of Health is responsible for monitoring progress towards the policy aims.

Intersectoral cooperation has been recognized as an essential condition for achieving the goals of health policy outlined by the document *Health Policy in Montenegro to 2020*, but establishment of a coordinating body to monitor the impact of intersectoral cooperation for achieving these goals has not been initiated. All laws and strategies include a financial estimation of implementation costs and the funds are included in the national budget. The strategy and health policy recognize health as an important factor in the policy and activities of other sectors, including labour and social policy, agricultural and rural development, education and sports and road traffic. The policy has become the basis for many programmes and strategic activities in order to achieve a more efficient and effective health system, which will eventually lift health status toward European and world levels. Montenegro is firmly on its way to achieving the MDGs in all areas and is committed to accomplishing all previously planned development goals.

Intersectoral policies have been introduced by the following documents, with their lead ministry:²

- *Strategy for Poverty Reduction with an Action Plan* (2003, Labour and Social Welfare)
- *Decade of Roma Inclusion*;
- *National Strategy for Sustainable Development* (2007, Tourism and Sustainable Development)
- *Strategy for Prevention of Chronic, Noncommunicable Diseases* (2009, Health)
- *Strategy for Controlling Smoking* (Health)
- *Strategy for Mental Health* (Health)
- *Strategy for HIV/AIDS* (Health)
- *Action Plan for Drug Abuse* (Health)
- *Action Plan for Children* (Education and Sports)
- *Action Plan for Youth*, (Education and Sports)
- *Action Plan for Prevention of Violence* (Health)
- *Strategy for Food Safety* (Agriculture and Rural Development)

Health equity is addressed in several of these strategies, which include specific goals for overcoming health inequalities. The *Strategy for Mental Health* emphasizes the destigmatization of people with mental disorders in order to overcome discrimination, as well as to receive adequate treatment. The needs of vulnerable groups especially mothers and children are recognized in the *National Strategy for Reproductive Health*, which is also important in the achievement of the MDGs. One of the aims of the *Strategy for HIV/AIDS* is to secure human rights and respect for all people with HIV/AIDS and those affected and their full integration into everyday social and work activities.

For all strategies there are working groups and coordinators, nominated by the minister responsible for leading the implementation, and for some strategies additional intersectoral bodies have been formed, e.g., the *Strategy for HIV/AIDS*, *National Strategy of Sustainable Development* and *Action Plan for Children*.

The documents give details of the people involved, activities, deadlines and monitoring information to be collected. Planned activities are recorded as completed, ongoing or cancelled. Realization of actions often depends on the allocation of funds. All the strategies imply an intersectoral approach and there is intensive cooperation among the ministries of Labour and Social Welfare, Finance, Tourism and Sustainable Development and Agriculture and Rural Development. For example, before the introduction of the *Strategy for Prevention and Control of Noncommunicable Diseases*, public debates were organized in three regions, where the results of the *National Health Survey* were presented. Members of the public, journalists and non-government representatives took part. The action plan of this strategy outlined many of the activities to be undertaken in sectors outside of health, such as the construction of recreational facilities, healthy meals for children in schools and introduction of the optional subject “Healthy

²Strategic documents and action plans are available from the website www.gov.me.

lifestyles” in schools. For the tobacco strategy, the Ministry of Health cooperates with the Ministry of Economy on pricing of cigarettes, taxes and excises, with the Ministry of Tourism on use of tobacco products in restaurants, and with Ministry of Education and Sports about tobacco control in schools.

All government sectors must accept the national policies, strategies and action plans before they are adopted and experts from different sectors take part in their monitoring and evaluation. In this process there is significant cooperation between the ministries of Health and Agriculture and Rural Development in projects on healthy food and tobacco control, and with the Ministry of Environment on noise control. In nursing homes, which are primarily social institutions, health care sector is included, in order to provide complete and adequate care for the elderly. Child protection is achieved through the education system with the inclusion of the health sector, which carries out monitoring of growth and development, while secondary prevention measures are implemented by the educational institutions. UNICEF, WHO and many NGOs are included in the protection of this population. The protection of the Roma, Ashkali and Egyptian (RAE) population comes under social welfare, health care, education, the environment, UNHACER, WHO, UNICEF, the World Bank and many NGOs. The Red Cross, in cooperation with government departments including health care, social welfare and education implements the education programme for Roma children, health education for Roma women, prevention of violence among young Roma and others.

Refugees and displaced persons living in Montenegro have the highest level of protection by law (see *the Official Gazette of Montenegro*, 2010, no. 45). They have the same rights to health insurance and health protection and welfare. Difficulties of people with no identification documents or status are being addressed within the health system. Strategies aimed at the Roma population include the *Strategy for Reducing Poverty*, *Strategy for Social Inclusion* and the *Decade of the Roma Population*, which is primarily focused on health. The *Strategy for Reducing Poverty* is a national plan aiming to diminish poverty, combining social, economic and structural elements, and to identify the means of evaluating progress towards these goals.

The *Strategy of Poverty Reduction in the Health Sector*(8) takes account of WHO goals and MDGs. The health policy strategy is primarily based on providing equal rights to health protection for everybody. The main goals of the poverty reduction strategy include: maintaining and improving population health, diminishing service provision inequalities among different population groups and providing quality health protection for vulnerable groups. This strategy comes as a result of intersectoral cooperation, including agriculture and rural development, tourism, environment, woods and water resources, social welfare, education and health. The strategy includes many social factors in its assessment of poverty, including housing conditions, environmental conditions, access to high quality drinking-water, sanitation, education and economic factors including employment and income. The health sector is one of the sectors that create policy for poverty reduction. The government coordinates activities of all sectors. The basic budget for poverty reduction is oriented towards to the provision social and child protection, to vulnerable population groups (financial benefits for families, children in social protection institutions, etc.). Cooperation between the education and health sectors is required for health education and monitoring of the children’s health, and for the elderly care, child care and care of the RAE population. Cooperation with the environmental protection sector is achieved through joint efforts to preserve and improve the environment, defining strategies, action plans and legislation. There is cooperation with the economic sector in overcoming economic barriers, achieving the best possible results in order to create conditions for employment of marginalized groups. Cooperation with the European integration sector is also very important.

The *Health Development Strategy* (2003) implies equal availability of health services in the basic benefit package. This is the domain of the Health Insurance Fund for socially insured people and by state budget funds for other population groups regardless their social or economic status.

Mechanisms, tools, instruments and platforms for advancing HiAP

Formal mechanisms to promote social inclusion and quality of life, health, welfare and health equity are developed in the main laws of the health sector and other sectors. The basic laws that define the health care system and health insurance are the *Health Care Act* and *Health Insurance Act* (12,13). The *Patients' Rights Act* establishes the rights of every person, sick or healthy, who seeks health services in a medical institution, in order to maintain and improve health, prevent illness or undertake rehabilitation (14).

The *Social and Child Protection Act* sets out the rights and services for social and child protection. The *Act on the Restriction on the Use of Tobacco Products in order to Protect Life and Health* prescribes measures to reduce and restrict the use of tobacco products and prevent the harmful consequences of using them. The *Act on Protection and Rights of the Mentally Ill* ensures the rights of the mentally ill, the organization and implementation of services, as well as creation of the conditions for measures to protect against discrimination. The *Act on Protection of Population from Infectious Diseases* defines the infectious diseases that threaten the health of the population, as well as infections that occur as a consequence of carrying out health care and establishes measures for their prevention and control and the competent authorities for their implementation and supervision. The *Act on Control of the Production and Transport Of Substances That Can Be Used in the Production of Narcotic Drugs and Psychotropic Substances* defines the monitoring and regulation of relevant activities to prevent their misuse, as well as for the protection from harmful consequences and environmental protection. The *Act on Protection against Noise in the Environment* regulates the protection of the environmental noise and determines measures to combat the harmful effects of noise on human health. The *Medicines Act* determines conditions for production and trade of drugs for human and veterinary use; measures to ensure the quality, safety and efficacy of medicines; as well as the jurisdiction of the administration bodies of the medical and medical devices sector and other state authorities in this field. The *Medical Devices Act* prescribes the manner of carrying out production and sale of medical devices for human use and use in veterinary medicine.³

Implementation of the adopted laws is controlled by the relevant inspection services, such as health and sanitary inspections, veterinary inspections, ecological, commercial inspection, etc. The regulatory bodies that exist to promote inclusion and quality of life, health, welfare and health equity are: the Environmental Protection Agency, the Medicines and Medical Devices Agency, the Tobacco Agency, the Centre for Ecotoxicological Research and the Centre for Environmental Health at the Institute of Public Health. Within the working bodies of the Assembly of Montenegro there is a Board of Health, Labour and Social Welfare, which discusses issues of importance in this area.

A report on MDG achievement has been made through intersectoral cooperation of all departments of the government and was presented at the annual United Nations General Assembly in September 2010.

There are numerous ad hoc multisectoral working groups and advisory bodies with specific tasks in carrying out laws and regulations, conducting administrative proceedings, adopting and enforcing rulings and other individual acts, giving explanations, issuing professional guidelines and operating instructions and giving technical assistance, such as: the Intersectoral Body for Sustainable Development, the Intersectoral Body for European Integration, the Youth Council and others. During 2008, a team of WHO experts made an assessment of environmental impacts on health, highlighting the key challenges for Montenegro in this area. The report noted that:

The environment is a key focus of the new country of Montenegro, as the country is promoting itself as an environmental/ecological state. Investment into the environmental sector is evident but the field of environment and health has not gained full attention. Many aspects of the health and environment sector fall under many departments within the Ministry of Health, whose main focus until more recently has been on

³ The laws are available from the website www.gov.me.

health care, rather than prevention of ill health. Through improving the understanding of environment and health at institutional level, improvements in the population's health and quality of life can be achieved. A positive development is the obligation of the Ministry of Health to comment and review all legislation prepared by other sectors in order to increase the intersectoral approach. Nevertheless this task is considered to be difficult to implement due to a lack of human resources. In addition it has been suggested that there is the need to make better use of the existing institutions with well developed experience and to define the responsibilities of each sector and institution. (15)

There are workshops for capacity building in various sectors, for improving knowledge and skills, such as capacity building in public health, tobacco control, and monitoring and evaluation activities under the *Strategy for Sustainable Development*, and implementation of activities under the strategies for HIV/AIDS poverty reduction and others. In addition, a large number of NGOs are involved in organizing and participating in many workshops. Activities related to training among NGOs usually involve peer education, but in the public sector this method is rarely used.

The MICS 1.2 and 3 that were conducted in Montenegro in cooperation with the national statistical agency, Monstat, and UNICEF in 2000 and 2007 included monitoring children and women for the following indicators: nutrition, child health, environment, reproductive health, child development, education and sexual behaviour. During 2008, a national survey was conducted as a LSMS study that dealt with health surveys and the factors that are associated with the health of the population. The Global Youth Tobacco Survey (GYTS) and Global Health Professional Students Survey (GHPSS) are research on tobacco consumption among young people that show results from factors within other sectors (education, social settings and others) that have an impact on smoking while similar research, the European School Survey Project on Alcohol and Other Drugs (ESPAD), is being conducted for drug abuse among young people, including the influence of different sectors on youth behaviour. However, there are neither specific studies dealing with health benefits and impact of other sectors, nor benefit-incidence analyses in this regard.

Processes for using impact assessment methodologies that account for health and health equity impact, such as HIAs and Social or Environmental Impact Assessments, are carried out periodically, mainly on Environmental Health impacts. Within ordinary activities the Institute for Public Health and Centre for Ecotoxicological Research conduct analyses of water, air, soil and food quality. Analysis of environmental factors includes the identification of risk factors to health from infectious and chronic diseases and undertaking measures to reduce their impact and achieve their removal; analysis of food safety, articles of general use, drinking-water and solid waste, noise and air pollution, monitoring and control of environmental parameters relevant to population health and other parameters for which procedures have been accredited.

The Centre for Health Promotion of the Institute for Public Health's principal activity is monitoring and studying the socioeconomic, cultural, environmental, political and other community characteristics, as well as attitudes, beliefs and behaviour that directly or indirectly affect the health of the population. The Centre is also responsible for professional and methodological guidance, coordination and preparation of appropriate plans and programmes as well as monitoring their implementation, evaluating performance, proposing modifications to existing and new programmes. Activities are specifically aimed at vulnerable population groups. Within the framework of the activities of the centre and other centres of the Institute of Public Health, a campaign with the aim of informing the public about the harmful effects of tobacco, healthy lifestyles, prevention and early detection of cancer, prevention of HIV/AIDS, pandemic influenza, the promotion of breastfeeding and other activities is being conducted. The Centre for Disease Control and Prevention conducts and recommends preventive measures in case of infectious and chronic diseases and health threats in all environments.

Promotion programmes are associated with a range of sectors because a number of programmes are

implemented in schools. The Healthy Lifestyle programme is incorporated into the regular curriculum in elementary and secondary schools and includes teachers and children directly and their parents indirectly. A health promotion programme for Roma women and young Roma is implemented with the Red Cross. Programmes for the elderly are implemented with the Gerontology Institute; programmes for sustainable development and safe waste disposal are implemented with the sector for environmental protection; the programme for prevention of infectious disease (HIV, TB) and noncommunicable diseases (in particular the determinants of behaviour) with the education sector and NGO; tobacco control with the sectors for tourism, economics and education. Implementation mechanisms and instruments include questionnaires that identify actual health and educational needs, workshops using interactive methods to influence behaviour, use of various health and educational resources in order to fully implement specific health education strategies. At the primary care level the counselling centres for young people are designated for reproductive health and reproductive advice. The counselling centres implement preventive and promotional programmes, according to the standard methodology created by the Institute of Public Health.

Although the health sector recognizes the importance of HiAP, particularly in the regular promotion and prevention programmes and monitoring of social determinants of health, no dedicated programmes or activities exist for raising awareness of various stakeholders, policy-makers and public health experts about the importance of this multidisciplinary approach and competences in HiAP work.

Information for HiAP

The established system of health monitoring is of great importance for monitoring and analysing the health of the population, the functioning of the health protection system, and implementation of statistical and scientific research. In the statistical system of Montenegro, which is under responsibility of the Statistical Office, health statistics are produced by the Institute for Public Health, which submits an annual statistical research programme.

Data on health status and health care protection are collected and processed by the Institute for Public Health at the national level (16), and are still mainly kept and published in an aggregated form. At the primary level disaggregated data on established morbidity and use of health services exists for age and gender categories (pre-school and school age, adults, women), and at secondary and tertiary levels in for age and gender of patients treated in hospitals. Data on the health of citizens and health care in Montenegro are prepared and published by the Institute for Public Health in the Statistical Yearbook, its regular publication since 1999.

Since the development of an integral health information system in 2009, as part of the Strategy of Health System Development and the IT strategy of the health care system 2006–2010, there are the conditions for better implementation of new legal regulations in the field of record keeping in the health care system (17,18). The work on the primary level of the health care has been supported through an electronic health record of each patient, which contains basic data including educational and employment status, insurance status, etc. Implementation of a hospital information system is currently under way, and activities for development of health-statistical information system are under preparation which will enable the Institute for Public Health to collect and analyse different types of data from all levels of health care. The Institute of Public Health does not collect regularly disaggregated data. However, the latest population health status survey, requested by Ministry of Health and coordinated by IPH, allows disaggregation and analysis of data by all indicated categories.

Data on behaviour related to health, quality of life and welfare are accessible from health research of representative samples of population (NHS- LSMS type, the last from 2008) and MICS research (2000, 2004 and 2007). The methodology of surveys has enabled disaggregation by more categories: gender, age group, welfare index, education, environment, urban/rural, size of household, etc. Some examples related to population health status have been disaggregated by several categories:

- In-house running water was available to 96.2% of Montenegrin household members, with a significantly higher percentage southern Montenegro (98.3%) and in urban areas (99.9%), and a significantly lower percentage in rural areas (89.9%) and in the poorest households (82.8%). Sanitation facilities were available to 92.5% of households in 2008.
- Northern Montenegrins (47.4%), adult females (47.5%), those older than 45 and those with elementary education or less (62.9%) had a significantly higher prevalence of all reported chronic diseases. On the other hand, a significantly lower prevalence was observed among men (37.7%), people less than 44 years old, the wealthiest quintile (36.1%) and among those with secondary education (37%) or college or university education (35.9%).
- Hypertension was more common among the rural population (37.3%) than the urban population (30.2%), those over 45 years old, northern Montenegrins (40.1%), in the poorest quintile (42.3%) and was especially pronounced among the population with primary education or less (53.2%) and those above 55 years old. Hypertension prevalence was significantly below average among southern Montenegrins (27.1%), the urban population (30.2%), those under 44 years old, those with secondary, college or university education, and the wealthiest quintile (21.1%).
- The highest prevalence of obesity was found in the 55–64 age group (25.3%), followed by those 65–74 (22.8%) and 45–54 (20.4%). Significantly above average obesity is also found in the north (18.6%), as well as among those with primary education or less (21.8%). The prevalence is lowest in the youngest age group (20–3), at 5%.
- Of all adult Montenegrins who smoked, one in five smoked daily (26.4% of the population), more often men (30%) than women (23%). The regular smokers were more frequent in the north and less frequent among those with college or university education. There was no significant difference in the proportion of regular smokers in urban and rural environments, nor within the different wealth index quintiles.

Within the jurisdiction of the Institute for Public Health there is supervision in the fields of infectious and chronic illnesses, environment, safe water and food. Through regular reporting, the Institute informs relevant professionals in the health sector about health status, state of infectious illnesses and executed immunizations and the regularity of drinking-water and food. Ad hoc information is given in case of natural disasters, for example the floods of 2010, when updated information from the institute was provided on a daily basis on the health condition of the population and sanitary-health regularity in flooded areas.

The MDGs provide an example of continuous monitoring of data relevant to HiAP, for example economical, social, educational, employment-related indicators as well as those of health and state policy. They are also monitored in relation to the objectives of the poverty reduction and sustainable development strategies. However there are insufficient recent data and studies of environmental impacts on health, SDH, risk factors for the occurrence of particular chronic illnesses or completion of Health for All activities in sectors outside of the health, where more could be done to advance a HiAP approach. There is no national action plan for implementation of coordinated activities for health in all sectors.

The only monitoring or evaluation mechanism for intersectoral interventions is the MDGs and monitoring of implementation of previously stated strategies, but there are no established mechanisms for joint monitoring and evaluation of such interventions.

Capacity building for HiAP

There are no special programmes focused on capacity building in political representation and development of health professionals for HiAP implementation. There are seminars and other types of education to create and develop HiAP capacities, including in management in health care and the like, and experts attend training abroad, such as in capacity building in the health sector, staff development in public health for tobacco control, among others.

Undergraduate studies in the health sector do not yet offer HiAP programmes, but universities that provide education and confer academic degrees in health care also include health policies in the public health curriculum. In addition, public health experts in Montenegro organize global and international programmes with the aim of strengthening capacities in public health (organized by WHO, the Stability Pact for SEE, the World Bank and others). Continuing education for health professionals in HiAP has not yet been organized. The Public Health Institute is the umbrella institution for educating health and other professionals in public health. The Institute conducts education on health promotion and prevention in line with defined needs in the field of preventive health care and promotion of healthy lifestyles.

Primary health care is the priority of health system development, including promotion of healthy lifestyles and preventive health care. With the aim of developing special mechanisms for capacity building in health care, Montenegro was recently host to several expert and scientific conferences related to capacity building in public health.

Challenges, opportunities and recommendations

Challenges facing Montenegro include:

1. raising awareness among decision-makers about the significance of health for the general development of society;
2. creating intersectoral networks with the aim of implementing HiAP activities, including technical support;
3. defining and providing sustainable funding for implementation of HiAP activities by all sectors, building on concerns about the need to use scarce resources more efficiently;
4. supporting regional and international cooperation in public health sector;
5. acknowledging the limitations of previous approaches, especially those that involved sectors working alone;
6. taking advantage of political transition to reassess roles and begin to work better together; and
7. building consensus across networks, such as through conferences or community meetings.

Opportunities at hand include those to:

1. create new organizational structures to support HiAP or introduce new obligations related to HiAP implementation;
2. define a national action plan for all sectors, to implement health in all policies;
3. ensure strong evidence for the impact of determinants on health and introducing health criteria into sectors where policies have not considered health aspects so far, including the use of existing data to more directly support a HiAP approach, such as health equity data from HIS, to inform policy;
4. support health policy in areas including tobacco and alcohol control, traffic injuries reduction, as well as prevention of NCD; and
5. benefit from the knowledge and experience of foreign professionals and adjust to EU standards in all sectors.

Based on the above, we recommend the following:

1. recognizing health as a priority at the highest level of governmental, for all sectors;
2. strengthening public health capacities for advocacy in order to define and realize a HiAP approach at the national level;
3. educating relevant professionals for implementation of planned HiAP activities;
4. exchanging information, knowledge, and experiences at regional and international levels;
5. regularly evaluating implemented activities, with the support of international bodies;
6. strengthening preventive activities and health care promotion, as essential for the general well-being of all populations;
7. setting the HiAP approach as a priority goal and task of all sectors, and preparing mechanisms for realization of planned goals;

8. defining precise goals of intersectoral activities for health; defining the broader context of health issues as social; and facilitating the engagement of other sectors toward shared goals and responsibilities; and
9. exchanging experience in HiAP implementation among the countries of the region, the SEE Health Network, and other countries.

References

1. *Statistical Yearbook 2010*. Podgorica, Statistical Office of Montenegro, 2010.
2. *Survey on Household Consumption*. Podgorica, Statistical Office of Montenegro, 2010.
3. *Analysis of Poverty in Montenegro, 2009*. Podgorica, Statistical Office of Montenegro, 2010.
4. *Natural Movement of Population and Internal Migration Trends in Montenegro in 2009*. Podgorica, Statistical Office of Montenegro, 2010.
5. *Evaluation of Health Care Programme in Montenegro in 2008*. Podgorica, Institute of Public Health of Montenegro, 2008).
6. *Health Statistical Yearbook of Montenegro 2009*. Podgorica, Institute of Public Health of Montenegro, 2010.
7. *National Health Survey, Montenegro*. Podgorica, Ministry of Health of Montenegro, 2009.
8. *Strategy of Development and Poverty Reduction in Montenegro*. Podgorica, Government of Montenegro, 2003.
9. *National Strategy of Sustainable Development of Montenegro*. Podgorica, Government of Montenegro, 2007.
10. *Mid-term Report on Millennium Development Goals*. New York, United Nations Development Programme, 2010.
11. *Health Policy Goals in the Republic of Montenegro up to 2020*. Podgorica, Ministry of Health of Montenegro, 2004.
12. Health Care Act. *Official Gazette of the Republic of Montenegro*, 2004, 39/04.
13. Health Care Insurance Act. *Official Gazette of the Republic of Montenegro*, 2004, 39/04, 2004.
14. Patients' Rights Act. *Official Gazette of the Republic of Montenegro*, 2010, 40/10.
15. *Second Environmental Performance Review: Republic of Montenegro*. Geneva, United Nations Economic Commission for Europe, 2007.
16. Health Records Act. *Official Gazette of the Republic of Montenegro*, 2008, 80/08.
17. *Strategy of Development of the Health Care System in Montenegro*. Podgorica, Ministry of Health of Montenegro, 2003.
18. *Strategy for ICT in the Health Sector in Montenegro*. Podgorica, Ministry of Health of Montenegro, 2004.

6. Republic of Moldova

Summary

As a country in transition, the Republic of Moldova has the double epidemiological burden of communicable and noncommunicable diseases. Current health concerns are mainly related to low life expectancy and to diseases associated with an ageing population and other demographic trends. There have been many health sector and public health reforms in the country in recent years, and several policies and programmes that involve different sectors for their implementation. Health sector reforms continue with full political support, but with significant financial constraints.

Analysing the existing framework and implementation of policies and programmes at the national level in for relevance to the HiAP approach is the aim this report, which is based on the perspective of a wide range of stakeholders in a working group at the National Centre of Public Health. A variety of policy documents and national health reports were assessed and the main results were included this evaluation. The main priorities, challenges and opportunities were identified. The report finds that public health is actively promoting issues in sectoral policy documents, but there are also some gaps in and barriers to interministerial collaboration.

The results show a generally positive perception of the existing framework that needs further advocacy, commitment and capacity building and an integrated health policy response across sectors, incorporating public health principles in all policies.

Country context

Political background

The Republic of Moldova is a parliamentary republic consisting of 32 districts, two municipalities and two autonomous territories. The parliament is made up of 101 members who are elected every four years. The cabinet of the government consists of 21 members, including the prime minister who is the head of the government, four deputies and 16 ministers (Economy; Finance; Justice; Foreign Affairs and European Integration; Health; Education; Environment; Transport and Road Infrastructure; Agriculture and Food Industry; Labour, Social Protection and Family; Culture; Youth and Sport; Information Technologies and Communications; Defence; and Regional Development and Reconstruction). Administrative issues in the government are conducted by the State Chancellery. The new government formed on 14 January 2011 has declared European Union membership a priority.

The Republic of Moldova is not a highly decentralized country. Financial mechanisms at the local level are lacking and the majority of government activities are implemented with central budget support. Health and social policies are developed by the Ministries of Health and of Labour, Social Protection and Family, approved by Parliament and the government and implemented by central and regional institutions. All institutions of the public health service (national and regional centres of public health) are financed mainly from the state public budget (70%) and partially from paid services (30%), including services supported by the Health Insurance Fund. These institutions do not receive any contribution from local budgets. Primary care institutions and hospitals are financed mainly by the Health Insurance Fund; local public authorities are responsible for co-funding the maintenance of infrastructure and they are fully responsible for the functioning of social institutions, including schools, kindergartens, social centres and hospices.

Socioeconomic conditions

The Republic of Republic of Moldova has been labelled the “poorest country in Europe”, but during recent years its socioeconomic situation has improved. According to data from the National Bureau of

Statistics, nominal GDP in 2010 was 71.8 billion lei (around US\$ 5.8 billion), and has increased in real terms by 6.9% since 2009 and 64.8% since 2000 (1,2). Per capita GDP in 2010, according to the IMF, was US\$ 2959 (2). Both public finance and external trade indicators have improved in recent years, but inflation persists and is highly influenced by external factors such as food, gas and energy price increases. The indicators related to industrial goods and agricultural production, volume of investments in fixed capital, retail sales volume, services volume etc., have registered continuous growth since 2000.

Average monthly wages in the Republic of Moldova increased from 1318 lei (US\$ 110) in 2005 to 2972 lei (US\$ 247) in 2010. Most income is used to fund basic household consumption, consumer durables, purchases of housing and debt repayment.

Table 17. Moldovan unemployment and employment rates, 2000–2010

Year	Unemployment rate (%)	Employment rate (%)
2000	8.5	54.8
2001	7.3	53.7
2002	7.3	53.3
2003	7.9	47.5
2004	8.1	45.7
2005	7.3	45.4
2006	7.4	42.9
2007	5.1	42.5
2008	4.0	42.5
2009	6.4	40.0
2010	7.4	38.5-

Source: National Bureau of Statistics (3)

Even though the labour market is improving, unattractive working conditions and low wages are still the main factors encouraging people to migrate for work.

According to data from the National Bureau of Statistics (3) (see Table 17) the rate of both unemployment and employment are decreasing, which can be explained by an increasing number of people who are looking for work abroad or working informally.

Income is unequally distributed among different social groups and regions. Inequality of consumption expenditures, which can be measured by the Gini coefficient, declined slightly from 0.380 in 2000 to 0.375 in 2005, but is still high (4).

Fig. 10. Moldovan population structure, 2010



Source: National Bureau of Statistics

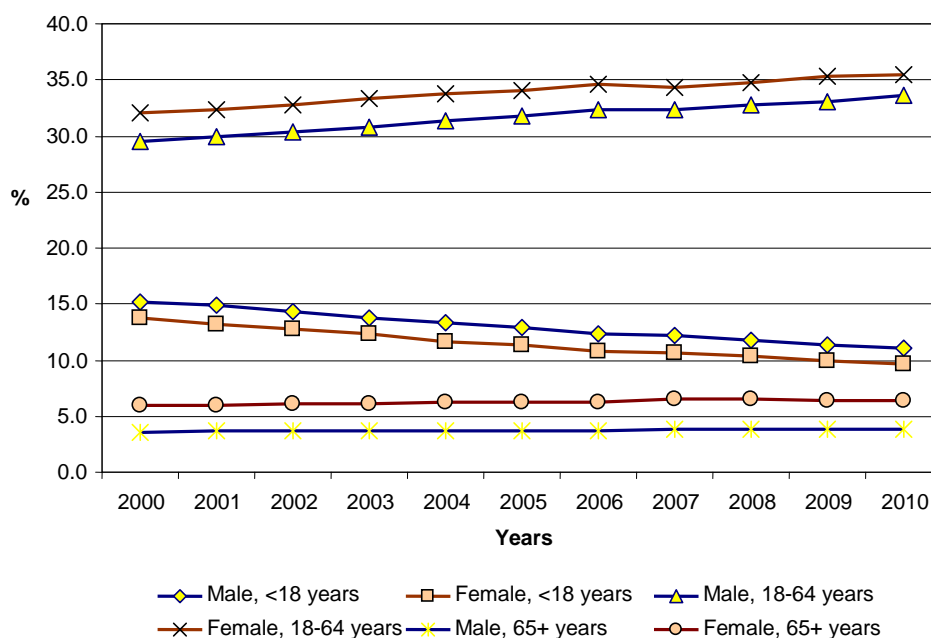
Demographics

Data of the National Bureau of Statistics show that the population of the Republic of Moldova in 2010 was 3 563 695, comprising 51.9% men and 48.1% women. The population has declined since 1989 due to

high emigration and a low birth rate. The population age structure shows the characteristic demographic ageing (see Fig. 10), which is the predominant trend in most countries in Europe, especially eastern Europe. It is mainly due to a decreasing birth rate and, to a lesser extent, by increases in average life expectancy.

Compared to 2000, the share of young population (0-18 years) has fallen from 28.9% to 20.8% and the proportion of the elderly (65 years and over) has increased from 9.4% to 10.1% (see Fig. 2). If the trends continue, the proportion of elderly will increase and eventually exceed the proportion of young population; the migration process of people in the working age will enhance the ageing process.

Fig. 11. Age and gender distribution, Republic of Moldova, 2000–2010



Source: National Bureau of Statistics

The average life expectancy at birth in 2009 was 65.3 years for males and 73.4 years for females. Life expectancy increased by 1.7 years from 2000–2009. There is a significant disparity in life expectancy in urban and rural areas, for both men and women. Life expectancy was 3.5 years higher for men and 3.2 years for women in urban areas in 2010. Urbanization is lower than in Europe generally. Data of the National Bureau of Statistics show that in 2010 58.6% of the population was rural and 41.4% urban. This proportion has not changed over the past 10 years.

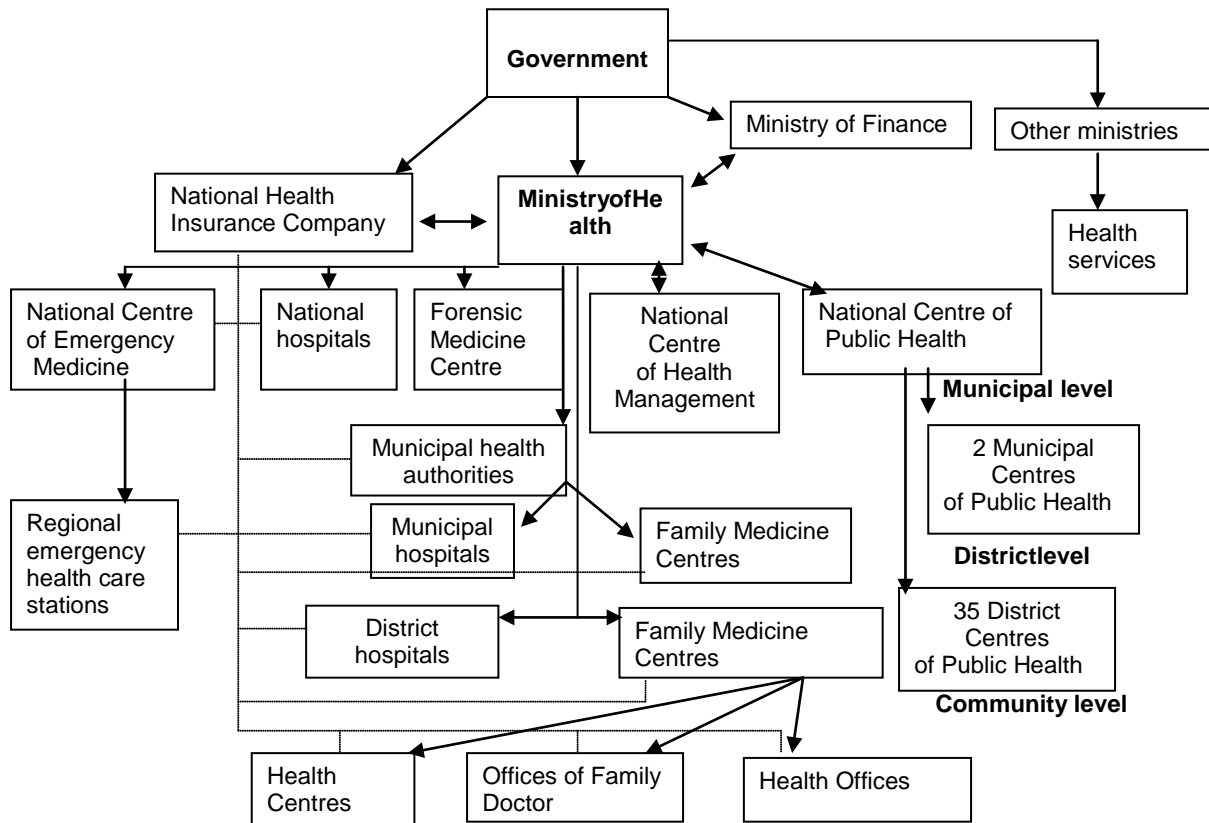
The latest census data (5), in 2004, showed a majority Moldovan/Romanian population (78%), followed by 8% Ukrainian, 6% Russian, 4% Gagauz, 2% Bulgarian and 1% others. The overwhelming majority of Moldovans are affiliated with the Orthodox religion.

The health system

Before independence in 1991, the country had a Semashko health care system. Since then there has been an ongoing reform of the health system. Mandatory social health insurance was introduced nationwide and has operated since 1 January 2004, funded through the National Health Insurance Company (NHIC). All service providers for emergency, primary, secondary and tertiary levels contract directly with the NHIC for funding, whereas the State Public Health Service, which includes the National Centre of Public Health

and district/municipal public health centres, is subordinate to and directly financed through the Ministry of Health. Fig. 12 presents an overview of the health system.

Fig. 12. Health system organizational chart



Primary and secondary health care as well as the State Public Health Service have been reorganized and consolidated. At present, PHC is based on the general practice model with family doctors. At district and municipal levels there are 49 family doctor centres (35 in districts, one in Balti and 13 in Chisinau municipality). Depending on the population at the community level there are health centres with three to four family doctors, single family doctor offices and health offices without physicians. The coverage of family doctors is insufficient in some rural areas. There are 82 hospitals, almost half of them in Chisinau municipality (56% of all beds). The distribution of beds by type of hospital is: national hospitals, 8283 beds (36.4%); municipal hospitals, 3550 beds (16%, including 12% in Chisinau municipality); district hospitals, 8005 beds (37.6%); departmental hospitals, 1979 beds (9.0%); private hospitals, 204 beds. There is duplication and overlapping of services and insufficient exploitation of existing beds, resulting in increased maintenance costs. For these reasons there is an ongoing reorganization of the hospital service.

The Public Health Service is coordinated by the Ministry of Health through the Department of Public Health Policies and the National Centre of Public Health. Each of 35 districts and two municipalities has a regional public health centre that provides services across all subordinated territory. In the past year the structures of national as well as district/municipal public health centres have been reorganized. New divisions have been established at the National Centre of Public Health for NCD control, nutrition and physical activity, health promotion and disease prevention, public health emergencies monitoring,

surveillance and control of addictions, control of health determinants, control of chemical hazards and toxicology, continuous training. The reorganization in the public health system will continue.

Table 18. Selected indicators, 2001–2008

	2001	2002	2003	2004	2005	2006	2007	2008
Life expectancy at birth, years	68.3	68.1	68.1	68.6	67.8	68.5	69.0	69.4
Noncommunicable conditions, SDR per 100000, all ages								
Diseases of circulatory system	815.5	855.7	857.5	805.2	858.4	786.4	849.3	716.5
Malignant neoplasms	149.2	153.3	155.5	158.4	161.24	166.2	161.9	164.7
Diseases of respiratory system	79.7	91.7	96.7	81.2	92.6	83.6	78.8	74.3
Diseases of the digestive system	128.2	126.7	129.4	130.9	143.1	134.2	127.4	118.5
Chronic liver diseases and cirrhosis	105.2	100.9	103.8	104.7	114.25	107.1	103.0	96.7
External causes, SDR per 100000, all ages								
Transport accidents	15.8	14.8	15.2	15.5	14.4	13.6	15.9	15.2
Injury and poison	106.2	106.1	110.6	107.6	113.8	109.0	103.7	100.2
Selected alcohol related causes	219.7	217.2	223.0	221.6	239.0	227.1	219.2	207.4
Selected smoking related causes	874.4	922.3	930.8	862.4	917.2	838.7	791.9	755.1
Communicable diseases, incidence per 100000, all ages								
Infectious and parasitic diseases	18.9	20.0	20.3	21.5	22.9	21.1	20.9	20.1
Tuberculosis	84.8	88.9	100.1	133.3	143.0	139.1	135.7	124.4
HIV	5.5	4.9	7.1	9.9	14.8	17.3	20.4	22.2

Source: European Health for All Database, WHO (6)

Burden of disease

The Republic of Moldova has the double epidemiological burden of communicable and noncommunicable diseases. During the two decades since becoming an independent country, there has been a constant reduction of communicable diseases due to implementation of disease control and health promotion measures. The main causes of death are CVD (56%), neoplasms (14%), chronic gastrointestinal diseases (10%), chronic respiratory diseases (5.5%), injuries and poisoning (8.5%), diabetes (1%) and others (5%). Low incomes, alcohol and tobacco are the main health determinants and mortality and morbidity from these factors account for a sizeable burden.

Current health concerns are mainly related to low life expectancy, diseases associated with ageing and demographic trends. Future changes in the population structure will lead to an increase in the elderly population for therapy, rehabilitation and nursing care. It is also expected that there will be an additional need for health services responding to cardiovascular and chronic gastrointestinal diseases and cancer diagnosis and therapy. A large preventive capacity for cardiovascular, respiratory diseases and accidents is also foreseen.

Inequities in health status, health behaviour and health system access

Life expectancy in the Republic of Moldova is one of the lowest in Europe. During recent years a small improvement has been registered for both men and women. There are significant gender and regional disparities. In 2008, life expectancy at birth was 65.6 for men and 73.2 for women, and the average life expectancy in urban areas was 71.2, compared to 68.2 in rural areas.

The health insurance system is based on the solidarity principle. The economically active resident population is obliged to contribute a proportion of wages through a payroll tax, or pay a flat rate lump sum if self-employed. Contributions for the rest of the population are paid by the government from the state budget. Coverage is incomplete, however, particularly for the self-employed, who are often rural poor engaged in subsistence farming. According to the recent study “Access of population to health services”, 74% of the population has health insurance, including 26.4% of monthly contributions, 46.2% are insured by the state, and 1.4% have purchased medical insurance policy separately. Seventy-three per cent of all uninsured people are in rural areas. This can be explained by their limited financial options to purchase mandatory medical insurance and lack of formal employment, since a large number work on their own agricultural activities. The main costs of medical services are partly by National Medical Insurance Company, and partly from fees-for-service. There is a special budget line for prevention purposes, at 1%, down from 2% until 2010.

Policy frameworks for HiAP

The State Public Health Surveillance Act of 2009 (7) established a legal basis for actions in public health reform, setting out new approaches in public health: to protect, to prevent, to promote. The approach will a) protect the population from health threats, led by central government, with a modern public health service and strong frontline services; b) empower local leadership and encourage wide responsibility across society to improve everyone’s health and well-being, and tackle the wider factors that influence it; c) positively promote healthy behaviour and lifestyles, including adapting the environment to make healthy choices easier.

Quality of life, health, health equity and well-being are explicitly identified as priorities, goals and objectives in the *Governmental Action Plan for 2011–2014 (8)*. The public health section states the aim of maintaining and improving the health of the entire population by ensuring affordable access to health services by means of health insurance and programmes for disease control, health promotion and disease prevention. The main objectives are to improve the infrastructure of health institutions and the quality of health care and the efficiency of the public health system and the performance of the health care system. The main actions focus on improved access to health services; implementation of national health programmes based on prevention; increasing capacities for rapid response to public health threats; reducing the impact of major diseases on the public health system; integrating preventive and basic care services provision for the population at high risk; assuring the minimal basic package of medical services for vulnerable groups; promoting interventions to address the determinants of health; shifting care towards preventive health services; reducing the impact of major diseases on the public health system.

The National Health Policy 2007–2021 (NHP) (9) recognizes health as a major priority of the state and society. It serves as a tool for a systemic approach to health problems and as a base for intersectoral cooperation, robust national, local, sectoral action plans and programmes for public authorities promoting and improving health. The NHP has four general objectives: 1) to increase life expectancy at birth and healthy life years; 2) to support a higher quality of life and to reduce health inequality among all social groups; 3) to consolidate intersectoral partnerships for health; and 4) to increase personal responsibility for health. The means by which the objectives are to be achieved include: a) engaging the state in monitoring of NHP implementation and sectoral strategies and programmes; b) creating a legal framework, through the transposition of EU directives as a condition of implementing the NHP, together with other relevant national strategies; c) cooperating in intersectoral activities with potential health impact; d) ensuring equitable and affordable access to health services for all citizens; e) ensuring sustainable financing and resource generation; f) deconcentrating and decentralizing responsibilities; and g) ensuring community involvement.

The sectors with which there is currently the most cooperation on health matters are education, the environment, youth and sport, territorial development and urban planning. For example, the *National Environmental Health Action Plan* addressed many issues regarding improvement in the quality of the environment as major health determinant by:

- developing policy documents for environmental health issues
- implementing environmental protection measures
- defining policy-makers and obligations concerning the environment and health
- planning environmental health interventions intersectorally
- introducing measures to ensure safe drinking-water and food
- supporting joint research on climate adaptation
- promoting sustainable waste disposal, air and housing
- ensuring protection against ionizing and non-ionizing radiation.

Another example of effective intersectoral cooperation is The *National Programme on Healthy Lifestyle Promotion, 2007–2015*. The ministries of Health; Finance; Education; the Environment; Youth and Sport; Social Protection, Labour and Family; and Regional Development and Construction; the Academy of Science; and NHIC as well as local public authorities are nominated as competent bodies. Relevant examples of good intersectoral cooperation are the joint development with the Ministry of Education of a school curricula in 2010 that introduced the discipline of civic education, which contains a module on health promotion; the joint development and implementation with the Ministry of Interior of a training curricula on road safety; the approval by the Sectoral Council on Water and Sanitation of a health promotion component for each project in water and sanitation.

Because of the public health significance of diabetes, the *National Programme of Diabetes Control (MoldDiab), 2011–2015* is totally different from the previous two programmes. Where previous programmes were focused mainly on treatment, the new one is focused on prevention and early diabetes detection, of both types I and II, with concrete actions on primary and secondary prevention through communication campaigns, free screening and establishing a diabetes registry.

Another important policy document has recently been approved, the *State Programme of Public Health Institutions Technical Development, 2012–2016*, with the overall goal of increasing the effectiveness of public health services through sustainable development of public health institutions. The main objectives of the programme are:

- improving management of public health institutions
- establishing an efficient system of continuous professional training of public health specialists
- strengthening the integrated information system
- implementing quality management for public health services
- implementing a communication strategy and programmes
- building capacities for intervention in public health emergencies
- strengthening capacities for research in public health.

Implementation of the programme is the responsibility of the Ministry of Health, but should also be supported by the ministries of Finance, the Economy, Education, and Social Protection, Labour and Family.

Those sectors where there is the greatest need and/or opportunity for intensifying cooperation are agriculture, labour and employment, economic development and finance. For example, the Ministry of Agriculture and the Food Industry has developed regulations on food safety and epidemiological surveys of infectious diseases without consultation with the Ministry of Health.

Policy Frameworks in Public Health in the Republic of Moldova, 2011

- *State Public Health Surveillance Act*
- *Regulation on State Public Health Surveillance*
- *National Health Policy*
- *Strategy of Health System Development, 2007–2017*
- *State Programme of Public Health Institutions Technical Development, 2012–2016*
- *National Immunization Programme, 2011–2015*
- *Prevention of HIV/AIDS, sexually transmitted diseases and infections*
- *National Programme on Healthy Lifestyle Promotion, 2007–2015*
- *National Environmental Health Action Plan*
- *National Programme of Hepatitis Prevention, 2006–2011*
- *National Programme of IDD Prevention to 2015*
- *Action Plan for IHR Implementation*
- *National Programme of Tuberculosis and Bronchial Asthma Prevention*
- *National Programme of Blood Transfusion Services Regulation*
- *National Programme of Mental Health Control, 2007–2011.*
- *Unique Programme of Mandatory Medical Insurance*
- *National Programme of Diabetes Control (MoldDiab), 2011–2015*
- *National Governmental Action Plan, 2011–2014*
- *National Programme on Reducing Diseases Caused by Iron and Folic Acid Deficiencies, 2012–2017*
-

Policy frameworks under development at the time of publication include:

- *Strategy and Action Plan of NCD Control*
- *National Programme of Tobacco Control*
- *National Programme of Alcohol Control*
- *National Programme of Cardiovascular Disease Prevention.*
- *National Strategy on Road Safety, 2011–2020.*

Across policy documents, the term “health equity” may not explicitly be used but may be referred to with various terms such as “solidarity in health”, “equal opportunities for health”, “equity in access”, or the “right to health”.

Mechanisms, tools, instruments and platforms for advancing HiAP

The main formal mechanism to promote inclusion of quality of life, health, well-being and health equity considerations in all policies and advocate for effective implementation across sectors is the *State Public Health Surveillance Act of 2009*, which regulates the areas of activity of the Public Health Service and the domains of common responsibilities with other governmental bodies such as Labour Protection and Health and Safety in the Workplace, the Environmental Protection Agency, and others. An important role is played by the Parliamentary Committee on Health and Social Protection. Joint planning mechanisms are also used in establishing intersectoral committees or working groups for implementation of national programmes in many areas, for example, in tobacco control, health promotion, eradication of iodine deficiency diseases, road safety. The health sector has a leading role in these committees and groups. They work on a voluntary basis, without additional budget support.

Another option for promoting the HiAP approach is application of Regulatory Impact Assessment (RIA) managed by the Ministry of Economy for promoting health policies and influencing the policies of other sectors. A special intersectoral working group, including public health representatives and chaired by the Deputy Minister of the Economy, examines all draft policy documents before they are presented to the

government and decides whether to support to them. The decision depends on expert conclusions and recommendations issued by an independent core expert group, consisting of legal professionals and financed by the World Bank. This instrument can be considered effective, even if it is applied mainly for new or modified documents and cannot influence existing policies. Another possibility to minimize any negative impact on health of other policies is Ministry of Health examination and coordination of new or revised legal documents proposed by other authorities to be approved by the government. Without the positive conclusion of the Ministry of Health, they are usually not accepted by the government.

Information for HiAP

Necessary information for operational information systems is provided by the National Centre of Public Health, the Centre for Health Management and the National Bureau of Statistics. The Republic of Moldova has put in place a new modernized Information System on communicable disease control, considered by the World Bank as one of the most efficient in Europe. The system is comprehensive, well organized and functional and it is largely in line with EU legislation. Technical tasks for the Information System for Noncommunicable Disease Control are under development.

The National Centre of Public Health produces annual reports about Public Health Service activities, based on indicators. These reports cover all domains of activity of public health institutions: economic and financial indicators, human resource management, surveillance of communicable disease, professional morbidity and morbidity related to the workplace, immunization, safety of goods with a direct or indirect impact on health and data on food and water safety. Every two years a report on environmental health is published, including information on the quality of the living environment, access to services, air and water quality, quality of the occupational environment, chemical hazards, injuries and poisons, child health related to the environment. A copy of this report is distributed to all government bodies for information and action.

The National Centre for Health Management produces annual health reports based on health statistics, using disaggregated data on health status by age, gender and rural-urban location. Such data as health status related to household size, health behaviour, quality of life and well-being, health system access by income, education and occupation are produced based on special surveys. There are no health data related to ethnicity.

Capacity building for health in all policies

Public Health specialists usually obtain their license after graduating from State Medical University, Public Health Faculty and a residency in public health. Postgraduate training courses in public health – including hygiene and epidemiology – and health management are available for medical professionals at the same university. From 2011, at the National Centre of Public Health there are short training courses on specific items, according to a continuous training programme mainly for specialists from territorial public health centres. The School of Public Health was created in 2003 at the Medical University, which is an active member of ASPHER and has already produced more than 100 Masters of Public Health, mainly for health professionals, but from 2007 it became open to non-medical professionals as well. For the moment, there is no specific training in HiAP.

Because of the forthcoming shortage of medical specialists in general and especially in public health, in 2011 the *Development Strategy of Medical University, 2011–2020* was approved, the main goal of which is to increase the quality of education and the development of a qualified medical workforce for the next decade, with special attention paid to public health. A special government programme has been established from 2011 to increase the attractiveness of rural regions for medical professionals. They will be paid double the salary earned in urban zones. The main beneficiaries of this programme will be in primary care.

In line with ongoing reforms, the number of non-health professionals such as sociologists, biologists, statisticians, psychologists, journalists and lawyers working in public health centres will increase; training courses at the National Centre of Public Health will be organized for this purpose.

Challenges, opportunities and recommendations

Public Health authorities of the Republic of Moldova are determined to continue the conceptual and structural reforms in the public health sector that were initiated in 2009. At the moment there is full political support but less financial support for strengthening public health capacities and services in the country. Special attention is being paid to new structures for health promotion and noncommunicable disease prevention, focusing on reducing major risk factors, such as alcohol consumption, tobacco smoking, unhealthy diet, physical inactivity and other lifestyle factors. At the same time existing capacities in communicable disease control and environmental health need to be strengthened. At the present time it is crucial to increase and motivate the workforce in public health. Among other things, an important priority should be the establishment of a regional health development centre for human resources in health in Chisinau, in order to harmonize the academic approach to training of public health professionals in the Republic of Moldova and in the other SEE countries.

The challenges facing the Republic of Moldova include:

1. long term political instability, given the three parliamentary elections without the election of a president in the past two years;
2. a lack of financial resources from the state budget;
3. a lack of trained public health professionals;
4. a need to reduce inequalities in health;
5. giving examples to the public of positive benefits and the health impact of other policies;
6. preventing or minimizing any unintended negative impact of other policies; and
7. a need for specific and convincing arguments for other sectors that the HiAP approach can produce dividends for them as well as for the health sector.

Current opportunities for the country can be seen in:

1. strong political will for public health reforms
2. a favourable policy framework for promoting health in all policies
3. WHO and EU support, including financial and technical expertise on the main public health issues
4. Ongoing reorganization of the health sector, with a focus on public health.

Based on the above we recommend:

1. creating mechanisms for promoting health policies in relevant national documents developed by other sectors;
2. developing and optimizing sublegislative acts to assure the implementation of the Public Health Service Act;
3. developing a continuous training system for public health professionals and policy-makers, including specific training on HIAP; and
4. creating a sustainable financial mechanism for public health institutions.

References

1. Gross Domestic Product in the Republic of Moldova in 2010. Chisinau, National Bureau of Statistics, 2011 (<http://www.statistica.md/newsview.php?l=en&id=3287&idc=168>, accessed 30 June 2011).
2. Country Report No. 11/200. Washington, International Monetary Fund, 2011 (<http://www.imf.org/external/pubs/ft/scr/2011/cr11200.pdf>, accessed 30 June 2011).
3. Labour force in the Republic of Moldova, employment and unemployment 2011. Chisinau, National Bureau of Statistics, 2011 (http://www.statistica.md/public/files/publicatii_electronice/ocupare_somaj/Fora_Munca_eng_2011.pdf, accessed 5 July 2011).
4. *Moldova: Poverty Update* (World Bank Report No. 35618-MD). Washington, World Bank, 2011 (<http://siteresources.worldbank.org/INTMOLDOVA/Resources/MDPovertyUpdateEng.pdf>, accessed 5 July 2011).
5. *Population Census results, 2004*. Chisinau, National Bureau of Statistics, 2004 (<http://www.statistica.md/pageview.php?l=en&idc=295>, accessed 30 June 2011).
6. European Health for All database (HFO-DB) [online database]. Copenhagen, WHO Regional Office for Europe, 2011 (<http://data.euro.who.int/hfad/>, accessed 30 June 2011).
7. *State Public Health Surveillance Act No. 10-XVI/2009. Official Monitor of the Republic of Moldova*, 2009, No. 67, art. 183.
8. *Governmental Action Plan for 2011–2014, Official Monitor of the Republic of Moldova*, 01.04.2011, No. 46-52, art 212. (<http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=337937>, accessed 6 November 2011)(in Romanian).
9. *National Health Policy, Republic of Moldova 2007-2021*. Chisinau, Government of the Republic of Moldova, 2007.

7. Romania

Summary

Romania presents some of the poorest health indicators in the European Union and has major rural-urban disparities in access to health services and health indicators. Many reforms have taken place in recent years and there is a long-term development plan focused on health and the health sector, aiming to improve equity, access and quality. There are a series of strategies and action plans focused on different areas of health that are defined and implemented through intersectoral cooperation. Analysing the existing framework and the implementation at national level of the broad concept of HiAP is the aim this report.

A working group including both ministerial representatives and technical representatives was established to produce a report based on broad expert opinion, integrating a wide range of stakeholder perspectives. The study team designed and carried out a Delphi survey relying on four groups of panel respondents: coordinating health professionals, operational health professionals, academics and collaborating ministries. The three-round survey results allowed the selection of priority policies to be included in the report and provided an assessment of implementation and examples of existing best practices and specific experiences. The main priorities, challenges and opportunities were also identified. The results reveal a generally positive perception of the existing framework that needs further advocacy, commitment and capacity building and an integrated health policy response across sectors, incorporating concern for health and health equity impact in all policies.

Country context

Political background

Romania started the move toward a free market economy in 1989. After a difficult transition period that took longer than in other former communist countries, in 2007 Romania joined the European Union together with Bulgaria.

The government of Romania has the following structure consists of: the prime minister, one vice prime minister, 15 ministries, the General Secretariat of the Government, the Department for Parliamentary Relations, the Department for Inter-ethnic Relations, the Department of European Affairs, the Department of Inspections and 42 prefectures (local governments).

In 2010, health system decentralization started, with the following main aims:

- transferring the competences for hospital administration and health care management to local or district public administrations;
- creating specific structures for local/district health unit administration;
- reducing the number of hospital beds; and
- creating new administration boards at the hospital level.

The general secretariat is directly subordinated to the prime minister and cabinet. Since 2006 it has been designated as the responsible body for coordinating the elaboration of public policy and framework and instruments for regulatory impact assessment and analysis (*1*).

As institutional support for the public policy process, there are public policy units in each ministry, directly under the highest ministerial management level. Based on multidisciplinary teams of doctors, economists and lawyers with expertise in project management and policy-making, they ensure technical support for the elaboration, adoption and monitoring of public policy. They collaborate closely with the general secretariat and the partner ministries for the adoption of all national public policies. They are responsible

for impact assessment procedures and guidelines to be performed, a position that makes them an excellent vector for exerting influences over other sectors.

Socioeconomic conditions

Despite robust economic growth during the years before the global financial crisis and the constant decline of inflation, poverty persists in Romania, with over 15% of the population living below the poverty line and a high level of unemployment. There has also been significant emigration from Romania, especially to other parts of the EU, which has kept unemployment rates below what they would otherwise have been. Using the World Bank's recommended benchmarks to measure absolute poverty in Europe, a 1989 survey found that 5.4% of Romania's population lived on US\$ 4.30 per day or less. A 1994 survey found that the rate had jumped to 80.0%. By 2000, it had dropped to 67.5%, and in the last survey, in 2002, 14% of the population reported living on US\$ 2.15 or less per day.

Demographic characteristics

The Romanian population is the eighth largest among EU countries, currently at 21.46 million inhabitants, following 19 years of negative natural growth. According to the 2002 census by the National Institute of Statistics, the ethnic structure of the population is 89.5% Romanian, 7.1% Hungarian, 1.8% Roma and 1.7% other nationalities. The capital, Bucharest, has about 10% of the population (2).

Burden of disease

Life expectancy in 2002 was 71 years on average (67 years for men and 75 years for women). The main causes of death are the principal noncommunicable diseases, which accounted for about 90% of deaths, external causes accounting for about 6% and communicable diseases for about 1%. In total, just over 60% of all deaths are caused by diseases of the circulatory system, neoplasms account for 16.3%, digestive system diseases 5.8%, accidents 5.3% and respiratory diseases 5.3% (2002 figures).

Table 19: Facts about Romania, 2009

Capital	Bucharest
Population	21.5 million
- 0–14 years old (%)	15.1
- 15–64 (%)	70
- 65+ (%)	14.9
Area (km ²)	237 500
Urban population (%)	55.1
Births per 1000 population	10.4
Deaths per 1000 population	12.0
Natural growth rate per 1000 population	-1.6
Life expectancy at birth	
- Males	69.68
- Females	77.09
Infant mortality rate (%)	10.1
GDP per capita in Purchasing Power Standards (PPS) (EU-27 = 100)	46
<i>Source: Ministry of Health – Health Statistical Yearbook 2011; EUROSTAT</i>	

The health system

In 1998 Romania adopted a mandatory social health insurance system. The Ministry of Health is responsible for health policy-making, setting organizational and functional standards and developing national public health programmes. There are 42 district public health authorities which serve as decentralized units of the Ministry. The National Health Insurance fund is the main funding source of the health system.

Inequities of health status, health behaviour and health system access

There are major disparities in both health service access and health indicators. Rural areas continue to be the most disadvantaged from this point of view (3). Morbidity and mortality data show a mix of specific indicators for developed countries, including high mortality from CVD, increasing incidence of cancer, as well as specific indicators for developing countries, including the re-emergence of communicable diseases such as TB and STIs.

Policy framework for HiAP

The principles stated by the new *Public Health Act*, part of the broader *Health Reform Act of 2006*, set up the principle of a multidisciplinary and intersectoral approach to public health issues. The integration of health priorities within public policy dedicated to sustainable development is included among the main functions of public health (4).

The main policy frameworks at national level are the *National Development Plan, 2007–2013* and the *National Sustainable Development Strategy, 2013–2020* (long-term target year 2030), as agreed by the main public health specialists through a Delphi style study.

The *National Development Plan, 2007–2013* is the key policy document for strategic planning and multiannual financial programming designed to guide national economic and social development in line with EU cohesion policy. It indirectly addresses the most influential health determinants through economic and developmental measures. It includes six priorities with related actions: increasing competitiveness, upgrading basic infrastructure to EU standards, improving the quality of the environment, improving living standards, developing and effectively using human capital by promoting social inclusion and developing the rural economy. These priorities are intended to make a decisive contribution to improving the quality of life and reducing disparities among and within regions (5).

The National Sustainable Development Strategy, 2013–2020 (long-term target year 2030) was elaborated with broad stakeholder participation and adopted in 2008. It is the main national policy specifically on health and health equity, setting public health priorities for the short, mid-and long term (6). The short-term objective is to improve the structure of the health sector and the quality of health care and the public health system and the performance of the health care system. The main actions focus on improved access to health services; implementation of national programmes responsive to priority concerns and to the needs of vulnerable groups; rapid response to public health threats; reducing the impact of major diseases on the public health system; integrating preventive and basic care services for the high risk population; assuring the minimal basic package of medical services for vulnerable groups; promoting interventions to address the determinants of health; and shifting care towards preventive health services. These priorities will be supported by actions to upgrade infrastructure, develop human resources and improve the quality of care to assure continuity, accessibility and compatibility with EU health care standards. At the same time, the chapter on social inclusion, demography and migration defines the interventions for reaching the overall goal of creating a socially inclusive society by taking into account solidarity between and within generations and to secure and increase the quality of life of citizens as a precondition for lasting individual well-being.

The National Commission for Social Inclusion, a consultative body, working within the Inter-ministerial Committee for Social Affairs, coordinates the activities of the social inclusion units in all national institutions with relevant responsibilities, including in the Ministry of Health and National Insurance House, which monitor and evaluate the implementation plans. At the local level, each prefect institution is in charge of implementing the social inclusion activities.

Sectoral strategies and action plans relevant for addressing health directly or indirectly include *The National Anti-Drug Strategy, 2005–2012*, *The National Programme for Health Promotion in Schools*, *The National Strategy for Climate Change* (2004), and national action plans for atmosphere protection, chemical substances management, and waste management (7–8).

Several existing mechanisms, including structural funds, are available for local implementation of objectives set at the national level. According to the Delphi survey results, the most important mechanisms for implementation of those policies at the local level are local development plans and the national public health programmes of the Ministry of Health. Local development plans are completely separate programmes. The public health programmes are approved by the government and they set up national priority activities that are implemented by the district public health directorate specialists. The convergence of activities is realized by collaboration among local structures.

According to specialist opinions, the main fully-implemented policy addressing health inequalities at the national level is the *National Institutional Framework for the Implementation and Evaluation of Social Protection*, coordinated by the Ministry of Work, Family and Social Protection. There are specific strategic documents for institutionalized youth, the Roma population and people in prison. The national public health programmes and the Roma Health Mediators Programme were considered important contributions to improved health equity.

Effective intersectoral collaboration and communication in integrating and addressing health in other sectors includes the Ministry of Education, Research, Youth and Sports; the Ministry of the Environment and Forestry; the Ministry of Labour, Family and Social Protection; and to a lesser extent media and local authorities. The transport, agriculture, economic development, finance and cultural sectors were considered the fields where further improvements in collaboration are needed. Among the main common factors affecting inter-institutional collaboration is a lack of continuity, due to the high turnover rate of staff within ministries, which makes it difficult to set up collaborative networks and functional mechanisms; a lack of time; the large volume of work versus the worsening shortage of personnel; and complicated, bureaucratic procedures for collaboration.

In the context of the EU agenda for better governance, a national framework for integrating public policies coordinated by the General Secretariat was set up in the form of the 2006 *National Strategy for Improving the Elaboration, Coordination and Planning of Public Policies in the Central Public (1)*, which contributes to increased coordination, transparency, collaboration and substantiation of public policies within the whole government. For this purpose, public policy units were established in each ministry, the template for policies and regulation was established and impact assessment requirements and inter-institutional mechanisms of consultation in the process of elaboration of national policies were clearly defined.

Nevertheless, health policy priorities are dependent on broader priorities and aims of government. Ministers and ministries of health are not necessarily the strongest players within the government. The aims of enhancing competitiveness of the economy or priorities of trade and industry are often substantially higher priorities in national policy-making. This has led to a situation where, rather than articulating how economic, industrial and trade policies could contribute to the health and well-being of European citizens, health policies and especially the organization and financing of health services provision are themselves scrutinized for compliance with and contribution to industrial, trade and economic policies.

Case study:

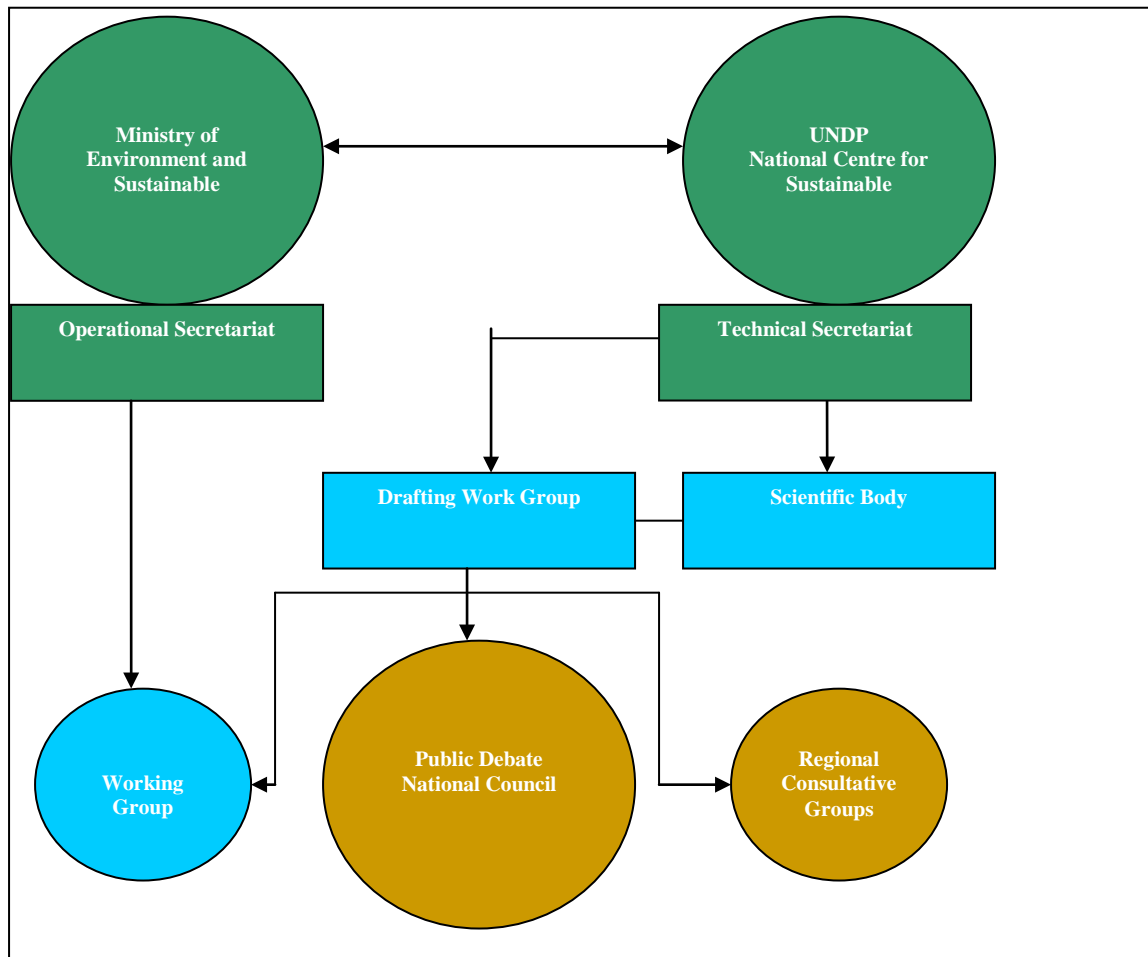
The National Sustainable Development Strategy, 2013–2020 (up to 2030)

The strategy is the result of a joint effort of the Romanian government, through the Ministry of Environment and Sustainable Development, and the United Nations Development Programme, through its

National Centre for Sustainable Development in Bucharest, approved in 2007 (8). For its elaboration, the functional and support structures presented in Fig. 13 were created.

One of the specific objectives under the public health priority area is to improve access to health services. It was intended to achieve this objective through implementation of national health care programmes responsive to priority public health concerns and to the needs of vulnerable groups. The strategy also proposed to concentrate prevention and provision of basic care services for those segments of the population that are exposed to higher health risks as well as to establish minimal packages of services especially for vulnerable groups. The main mechanism proposed by the strategy for addressing health equity is to approach the vulnerable groups.

Fig. 13. Drafting structures of the *National Sustainable Development Strategy of Romania*



Source: *National Sustainable Development Strategy (6)*

To monitor the implementation of the strategy, the Interagency Committee for Sustainable Development under the direct authority of the prime minister was created, bringing together the ministries and national agencies involved in the strategy implementation. The Interagency Committee has the obligation to present an annual report to Parliament, based on the monitoring of the sustainable development indicators that were agreed at EU level and of the specific indicators as adapted to Romanian conditions. The Interagency Committee has responsibility for coordinating the activities for elaboration and permanent updating of the monitoring indicators and implementation of sustainable development objectives at

national, regional and sector levels, in compliance with guidelines to be developed by the National Institute for Statistics according to EU rules, in order to ensure the accuracy of reported data and comparability with the data provided by the other EU Member States.

The Interagency Committee must submit a complete biennial report to the European Commission on the implementation of the *National Sustainable Development Strategy*, starting in June 2011, accompanied by proposals and recommendations regarding possible changes to the general orientation, policies and priorities of the relevant EU strategy. The Ministry of Health is a partner in the implementation of the strategy. A multiannual national budget was prepared, annually revisable estimates spanning seven year, (thus mirroring EU financial programming), are to be conceived on a sliding scale, in order to ensure the continuous, uninterrupted funding of sustainable development objectives.

Mechanisms, tools, instruments and platforms for advancing HiAP

The main national mechanisms for addressing and integrating health across national policies are legal requirements for impact assessment, interministerial working groups and expert collaboration in elaborating and implementing regulations.

Several instruments for impact assessment are in place: IIAs, for public policies and normative acts; HIAs, mainly for industrial compliance with public health requirements; and EIAs, mainly for strategic, transnational or integrated pollution control objectives (9–12).

The **interministerial working groups** involved in preparing the normative intersectoral acts for government approval and the expert working groups collaborate on a regular basis for elaborating and monitoring the implementation of existing regulations. They are also important for health integration across policy processes. For instance, working groups for the design and implementation of the National Plan for Environment and the National Plan for Climate Change are operational.

According to the national legal framework the coherence of public policy elaboration and implementation is supported by the **interministerial councils**, made up from minister-level representatives. They are functional entities, representing the highest levels of coordination and communication among ministers in multisectoral policies, ensuring the coherence multisectoral policies. Presently there are 13 permanent interministerial councils, including one for Health, Consumer Protection and Social Affairs. Through the **interministerial committees**, and working groups set up for specific issues by the councils, government, specialists from relevant institutions, representatives of academia, and civil society sectors collaborate in finding solutions for public policy coordination and convergence.

The **IIA** process and methodology (either prospective or retrospective), institutionalized at national level with dedicated units in all ministries, includes two types of impact assessment (13,14). *Policy impact assessment* is used for public policies that include tools and methods for the policy planning phase, and was perceived by the respondents of the Delphi study as one of the main mechanisms to support decision-makers in selecting the optimal solution from several alternatives. *Regulation impact assessment* is used for normative acts with a financial, economic, social or legislative impact, and assesses the future consequences of implementing different regulatory options. The process itself and the methodology for impact assessment could provide a good opportunity for addressing health in other policies.

HIA of policies and programmes from other sectors, according to Article 8 of the Public Health Law (3) represents, together with regulation of activities and products that might have an impact on public health, one of the main instruments for the implementation of public health principles and functions. The HIA is presently carried out by a small team at the Centre for Environmental Health Risks at the National Institute of Public Health (NIPH). The process is used for a relatively small number of individual objectives and it is based mainly on a qualitative approach. Impact calculation tools are not systematically

used. Several small studies on existing or new industrial sites were performed in Iasi, Satu Mare, Bucharest and Cluj.

Several studies have been performed using **EIAs**. The main fields under study where health aspects were considered were Territory Lay-out Plans, as well as development of the national networks of electricity, gas and roads. However, due to several constraints such as shortage of resources, both human and financial, and the time-consuming process, there have not been relevant, in-depth HIAs.

Depending on the type and stage of impact assessment, a broad range of quantitative and qualitative evidence is used. However, most of the impact assessment performed in the process of regulation elaboration is desk impact assessment, rather than “deep” impact assessment, and health impact is not systematically addressed.

When asked to assess the implementation of these mechanisms, the participants at the Delphi study identified the EIA and the general IA as the main mechanisms for addressing health; HIA was the last mentioned. The existing mechanisms and instruments are not very well established and relevant, from the HIA perspective; much more could be done for their further development and enforcement (15).

Information for HiAP

Existing health-related information relies on vital statistics provided by the National Institute for Statistics. There are annual local health reports by district public health directorates that analyse health status and the main health determinants. These are a useful basis for local plans prioritizing. Data related to health determinants are mainly provided by the National Institute of Public Health. Its four national centres are responsible for the management of the following information:

- health effects and resources, in health statistics yearbooks by the National Centre for Statistics and Informatics for Public Health;
- communicable diseases, in annual, monthly and operative reports by the National Centre for Surveillance and Control of Transmissible Diseases;
- environmental health determinants, in annual reports by the National Centre for Environmental Health.
- specific noncommunicable diseases data and the disease registry, managed by the National Centre for Health Status Evaluation and Health Promotion; and
- social and behavioural health determinants data, collected by the surveillance system for children and adolescent health and specific surveys by the National Centre for Health Status Evaluation and Health Promotion.

The reports are publicly available on the NIPH web site.

The overall specialist’s assessment in the Delphi study on the quality of data required for performing HIA revealed that data are generally difficult to retrieve, and only sometimes at an adequate level of aggregation. They were considered only partially or not relevant for a quantitative HIA. Most of the respondents thought that additional specific data collection was always necessary in order to conduct an HIA.

Capacity building for HiAP

Medical students and trainees in environmental health and public health receive some information on risk assessment and HIA. Nevertheless, systematic training for both a qualitative and quantitative approach to HIA is not in place at present. Even if the possibility for applying HIA methods existed in the Ministry of Health, and the general legislative framework has been in place since 2006, only a very limited number of training courses or workshops for capacity building have been organized for the Ministry of Health specialists, mainly focusing on general principles and models. Two of them can be mentioned: the 2003

TAIEX workshop “Health Impact Assessments Principles and Implementation – issues of importance to Romania” in Luxemburg and the 2007 Bucharest workshop, organized with the support of WHO European Centre for Environment and Health Rome Office, “Strengthening institutional and technical capabilities for health impact assessment”.

General training on IAs of health policies, a manual and methodology were delivered within the General Secretariat’s PHARE project for about 40 professionals from the public health network, which included IA aspects took place in September 2009 (16).

The conclusions of a 2010 scientific expert workshop “Quantifying the health impact of policies: Principles, methods, and models” in Düsseldorf were that “quantification of health impacts, especially of those resulting from policies, plans and programmes, is a scientific field which rapidly moves forward”. (17). This means that isolated initiatives should be followed by comprehensive, systematic and adequate training programmes for the HIA process and quantification in order to be effective.

Challenges, opportunities and recommendations

Given the general macro-economic context, the main challenges for HiAP implementation in Romania are:

- 1 having strong commitment and advocacy from the Ministry of Health team leading the HiAP process;
- 2 strengthening the public health system capabilities for HiAP despite the context of limited human and financial resources for the large volume of necessary activities;
- 3 building and maintaining a coordination team capable of supporting HiAP implementation at the central level; and
- 4 raising awareness in government and society of the added value of HiAP.

Opportunities currently at hand for HiAP development are as follows.

1. From the Romanian perspective the international context and support for HiAP is very important. Consequently one clear opportunity is represented by the political support for HiAP at the WHO and EU levels and the possibility of integrating and developing requirements for HIA within the IIA mechanisms.
2. Another opportunity is represented by the development of knowledge and models for quantitative HIA and by examples of in-country implementation models.

In light of the above, we recommend that interventions for HiAP implementation focus on:

- 1 achieving international agreement and commitment on institutionalizing the HiAP process;
- 2 introducing national measures for clear rules for implementation, implementing teams and knowledge transfer for HiAP processes and tools; and
- 3 introducing a continuous training system for HiAP implementation for health specialists.

References

1. Government Decision 870/2006. *Official Monitor*, 2006, 637.
2. Census Report. Bucharest, National Institute of Statistics, 2002 (www.insse.ro/cms/files/RPL2002INS/index_rpl2002.htm, accessed May 2011)(in Romanian).
3. Vladescu C et al. (2008). *Report of the Presidential Commission for Romanian Public Health Policies Analysis and Development*. Bucharest. See: www.presidency.ro/?lang=ro (accessed May 2011).
4. Health Reform Act, 95/2006. *Official Monitor*, 2006, 372.
5. *National Development Plan, 2007–2013*. Bucharest, Government of Romania, 2006 (synthesis available at: [//eufinantare.info/Documente/Sinteza_PND2007_2013.pdf](http://eufinantare.info/Documente/Sinteza_PND2007_2013.pdf), accessed 7 April 2011)(in

- Romanian).
6. *National Sustainable Development Strategy of Romania, 2013–2020, to 2030*. Bucharest, Government of Romania, 2008 (www.undp.ro/download/files/sndd/SNDD_ENG_176x235_FINAL.pdf, accessed 7 April 2011).
 7. *National Anti-Drug Strategy, 2005–2012*. Bucharest, Government of Romania, 2004.
 8. *National Strategy for Climate Change*. Bucharest, Government of Romania, 2004. (www.mmediu.ro/protectia_mediului/schimbari_climatice/1_Documentatie/SNSC_ro.pdf, accessed 7 April 2011) (in Romanian).
 9. Government Decision HG No.1216. *Official Monitor*, 2007, 737.
 10. Law 24/2000 on Legislative Technique Requirements on Elaboration of Normative Acts. *Official Monitor*, 260, 2010.
 11. Ministerial Order 66/1997. Bucharest, Ministry of Environment and Forestry, 1997 ([www.legestart.ro/Ordine-din-anul-1997-\(5132879\).htm](http://www.legestart.ro/Ordine-din-anul-1997-(5132879).htm), accessed 29 September 2011) (in Romanian).
 12. Ministerial Order 863/ 2002, for Approval of Methodological Guides for Environmental Impact Assessment. Bucharest, Ministry of Environment and Forestry, 2002.
 13. Government Decision 1076/ 2004 on Environmental Impact Assessment Procedure for Plans and Programmes. Bucharest, Government of Romania, 2004 (www.mmediu.ro/legislatie/legislatie_orizontala.htm, accessed 29 September 2011) (in Romanian).
 14. Government Decision 775/2005 on Elaboration, Monitoring and Evaluation of Public Policies. *Official Monitor*, 2005, 685.
 15. *Public Policy Framework*. Bucharest, Government of Romania (www.sgg.ro/index.php?politici_publice_documente, accessed 20 May 2011) (in Romanian).
 16. *A Manual for Impact Assessment of Health Policies*. Bucharest, Government of Romania, 2009 (www.sgg.ro/docs/File/UPP/doc/manual%20si%20metodologie%20pentru%20studii%20de%20impact%20in%20domeniul%20sanatatii.pdf, accessed 21 May 2011) (in Romanian).
 17. Fehr R, Mekel O (eds.) *Quantifying the health impacts of policies – Principles, methods, and models. Scientific Expert Workshop, Düsseldorf, Germany, 16–17 March 2010*. ISBN 978-3-88139-173-3.

8. Serbia

Summary

Serbia is a country in transition which seriously pursued social, economic and political reforms after democratic changes in 2000 in order to continue its progress towards eligibility for EU membership.

Population ageing is highly pronounced in Serbia, with a 17% share of seniors, placing it among the countries with the oldest populations in Europe. The elderly, as well as unemployed, single-parent households, people with lower educational status and those living in rural areas are at a higher risk of poverty. Despite achievement of the main objective of the *Poverty Reduction Strategy Paper*, the necessity for the government to deal systematically with the problems of the most vulnerable categories of the population, social inclusion and continuous poverty reduction persists. Effective state care is even more imperative in light of the international financial crisis and enormous budget restrictions. Funding health care for particularly vulnerable groups from the state budget is regulated by the Health Care Act and the Health Insurance Act. However, the funds earmarked in the Ministry of Health budget are not sufficient. Out-of-pocket payments for health care services and other expenses primarily for medications and diagnostic procedures still present a significant obstacle in access to health care services. The legal and strategic framework for HiAP was developed and implemented through measures and programmes financed from the national budget, and funds from bilateral donors, the EU and international financing institutions. Until now 88 strategies have been adopted, the majority of them with goals focused on health, quality of life and well-being.

Preparation of those strategic documents and programmes was usually joint activity of different ministries and other executive authorities, local governments, civil society organizations, international partners, scientific and research institutions and experts. Comprehensive consultations were conducted to achieve a national consensus on the main findings and priority areas. However, implementation is still behind the planned framework, and the monitoring and assessment process is a weak point. Progress has been made in the field of statistics, but there is still a deficiency in specific indicators for the monitoring and analysis of adopted strategies and programmes, as well as in the data for the systematic monitoring of the conditions and improvement of the health status of minorities and vulnerable social groups. Development of partnerships with health institutions, communities and NGOs is a model for new structures in training and research. Intersectoral cooperation is in place in spite of difficulties optimizing aspirations, prioritizing problems and implementing solutions.

The aim of this report was to review HiAP initiatives developed in Serbia and to identify opportunities, challenges and next steps for scaling up this approach to health improvement.

Country context

The current government of Serbia was elected on 7 July 2008 and restructured on 14 March 2011. It consists of a prime minister, 4 deputy prime ministers, 18 ministers (including three deputy prime ministers) and one minister without portfolio. Government agencies are the Business Registers Agency, the National Agency for Regional Development, Privatization Agency, the Serbian Investment and Export Promotion Agency, the Agency for Export Insurance and Financing, the Deposit Insurance Agency, the Anti-corruption Agency, the Bankruptcy Supervision Agency, the Republic Agency for Peaceful Settlement of Labour Disputes, the Energy for Electronic Communications Agency, the Energy Agency of the Republic of Serbia, the Energy Efficiency Agency, the Republic Agency for Spatial Planning, the Environmental Protection Agency, the Chemical Agency of the Republic of Serbia, the Agency for Accreditation of Health Care in Serbia, the Agency for Drugs and Medical Devices, the Anti-Doping Agency of Serbia, the Republic Agency for Postal Services and the Air Traffic Services Agency.

Socioeconomic conditions

After democratic changes in 2000, the Serbian economy recorded positive growth rates for eight years of transition. The global economic crisis affected the economy, first slowing GDP growth in the second half of 2008, and further in 2009, when there was a growth rate of -3%. With its economy disrupted by the global economic crisis, the Serbian government faces tight budget constraints for several years to come. The government has already responded by freezing wages and pension benefits and making cuts in capital works and other discretionary spending. In response to the registered deterioration of living standards, the government set up a budgetary fund with a view to addressing the adverse effects of the global economic crisis. A social security plan was also adopted in response to problems linked to the regular disbursement of earnings and the payment of contributions for pension and health care insurance, as well as to more frequent labour strikes. However, these measures, while effective in the short term, are not necessarily sustainable over time. According to international agencies, there is a need for more fundamental reforms in key public services in order to improve productivity (1).

Demographics

An estimated 7.3 million inhabitants currently reside in Serbia. The country's population is characterized by ageing, with an average age of 41.2, smaller families and declining numbers in rural and remote areas. According to the current age structure, Serbia has one of the oldest populations in Europe and the world, with 17.1% older than 65 years. The population growth rate is another critical indicator depicting demographic collapse. According to vital statistics, the rate of natural increase was -4.6 per 1000 inhabitants in 2009. Depopulation trends with negative growth rates were recorded in AP Vojvodina at the beginning of the 1980s, and in central Serbia in the early 1990s. The main feature of the projected movement of the population from 2002 to 2032 is continued ageing. According to each of five projection variants, the population of Serbia in 2032 would be lower than in 2002, thus, in thirty years, the proportion of people over 65 would increase from 17% to 22% (2).

All relevant population indicators and estimates are collected without data for Kosovo and Metohija since the Statistical Office has not provided data for this autonomous province since 1999, when Kosovo was placed under the direct administration of the United Nations in accordance with United Nations Security Council Resolution 1244.

Characteristics of the health system

The health care system and whole socioeconomic system in Serbia were highly centralized during the last decade of twentieth century. After the changes of October 2000, decentralization and strengthening local communities were on the national agenda, and preparation of the relevant legislation was initiated. The Health Care Act of 2005 envisaged decentralization of the foundation and administration of health care institutions. So, responsibility for primary health centres and appointment of their management teams are now on the municipal level. Local communities are obliged to prepare local health care plans and formulate specific programmes tailored to the needs of the local population. However, a lack of financial resources has slowed down this process. Recently, Parliament adopted a law on financing local communities with more equitable distribution of financial resources and better possibilities for local management.

Serbia and the other former Yugoslav republics historically have spent a relatively large share of GDP on health care. Public expenditure on health was 6.7% of GDP in 2008, and the share of public health expenditure in total health expenditure was 62.5% (3). Private expenditure relates to services in the private sector, out of pocket payment for medications, payment for non-standard services and bribes to health professionals. The health care system is based on compulsory social insurance. The structure of health insurance income and expenditure has been relatively constant in recent years: about 3% is spent on preventive activities, 33% on PHC and 63% on hospital care (4). The government covers health care of

uninsured vulnerable parts of the population such as the elderly, poor people, refugees, displaced persons and Roma people, though the funding available for their health care needs is insufficient.

Burden of disease

Health outcomes in Serbia have improved significantly over the last decade. In the period from 2002 to 2009 (the latest available data), average life expectancy at birth increased by 1.4 years, from 69.7 to 71.1 years for males and from 75.0 to 76.4 years for females. Infant mortality was reduced in the same period from 10.1 to 7.0 infant deaths per 1000 live births (5). However, results of a MICS showed that the infant mortality rate in Roma settlements is considerably less favourable; in 2005 it was three times higher than for the overall population (6). More than half of deaths (54.8%) in 2009 died were from CVD; the second leading cause of deaths was malignant neoplasms (20.6%); the third was symptoms, signs and ill-defined conditions (5.1%); then diseases of the respiratory system (4.0%); and injuries, poisoning and accidents (3.6%) (5). Like many SEE countries undergoing socioeconomic transition, Serbia is facing an increased burden of noncommunicable diseases related to high-risk behaviour. Smoking is the most significant individual risk factor in spite of a significant reduction in the number of smokers between 2000–2006 of 6.9% among adults, and 7.4% among youth. According to results of national health surveys, 40.3% of the population consumed alcohol (daily or occasionally) in 2006 while obesity was recorded among 18.3% of the adult population. The rates of undernourished and obese children were different between the overall population and Roma children. The share of undernourished children under 5 years old in Roma settlements was 7.7%, compared to 1.6% in the overall population. However, 15.3% of children in the overall population were obese, while this share in Roma children was 2.8% (6).

Inequities on health status, health behaviour and health system access

Twelve vulnerable population groups are defined by the Health Care Act (7), comprising an estimated 710 000 people. According to the Health Insurance Act (8) the transfer per capita for their health insurance from the central budget is 12.3% of the minimal monthly income. In the last few years the transfer has been lower than the statutory levels, which jeopardizes their access to health services. Among these groups, the risk of poverty is higher with a significant effect on their health status and quality of life.

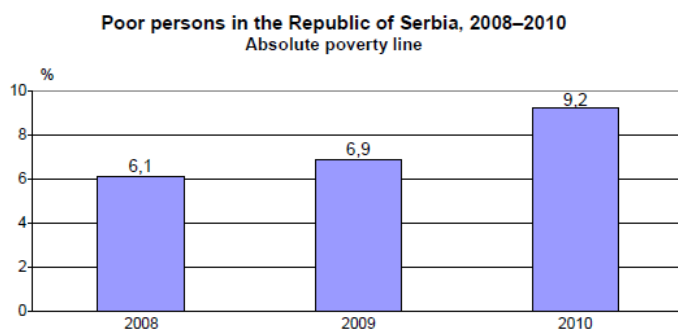
Policy frameworks

The first strategic document adopted after democratic changes in Serbia in 2000 was the 2003 Poverty Reduction Strategy Paper (PRS). The government gave the deputy prime minister responsibility for the strategy and reporting regularly on its implementation and coordination in cooperation with the PRS implementation focal point, who is tasked with supporting, coordinating and overseeing PRS implementation. Several ministries, among them Ministry of Health, are actively involved in the implementation of measures defined in the PRS document, as is Parliament, through its Committee for Poverty Reduction, reviewing draft laws and other regulations from the perspective of PRS implementation and the protection of vulnerable groups. The Standing Conference of Towns and Municipalities (a local self-government advisory committee) is actively involved in promoting the development of local plans of action and PRS implementation at the local level. At the same time, Serbian NGOs have continued to implement activities directed to improve the situation of the most disadvantaged groups in Serbia, and they promote the idea of civic activism in exercising the right to a dignified life. To date, the government has prepared and adopted 3 reports on the implementation of PRS, 17 newsletters and organized 4 national conferences (9). Poverty in Serbia has been defined as a multidimensional phenomenon which, in addition to insufficient income for securing a livelihood, implies a lack of employment, inadequate housing and access to social welfare, medical, educational and communal services. Other key aspects of poverty include the inability to exercise the right to a healthy environment and natural resources, clean water and air (9).

Despite the fact that the main objective of the PRS has been achieved, the necessity for the government to deal systematically with the problems of the most vulnerable groups, social inclusion and continuous poverty reduction, persists. The effective care of the state is even more imperative in the light of the international financial crisis and enormous budget restrictions. According to data from the *Household Budget Survey*, 9.2% of the population were considered poor (living below the absolute poverty line) in 2010 (see Fig. 14). The population living in non-urban areas, multiple member households, especially those having several children, unemployed and non-active members, and households headed by those of low education are more struck by poverty (10).

The development of the PRS would not have been possible without key and timely data. The collection of poverty-related statistics began with two annual LSMS conducted in 2002 and 2003 at the request of the government with expert assistance from the World Bank. In order to ensure comparability of data over a five-year period (2002–2007) and get clear insight into poverty trends, the Statistics Office conducted an LSMS 2007 (11). This survey together with health surveys of 2000 and 2006 provided an information database for self-perceived health status assessment across social gradients (socioeconomic quintiles) as well as assessment of accessibility and utilization of health services according to these gradients.

Fig. 14. Poverty in Serbia, 2008–2010



Source: Statistical Office of Serbia (10)

The government adopted three reports on realization of the MDGs, in 2002, 2005 and 2006, prepared by the Working Group of the Government for Monitoring the Realization of MDGs, with support from UNDP. Reports were presented at the regular yearly United Nations conferences.

The legal and strategic framework was developed and implemented through pertinent measures and programmes financed from the national budget, from bilateral donors' development funds, the funds of the EU and international financing institutions (mainly The World Bank). The most important strategic documents developed with the full participation of public health experts and the Ministry of Health stressed health status and quality of life as important aims and suggested specific measures and activities for their improvement. Those documents are listed below.

For many years, strategic documents were adopted by the government without action plans that specified financial and other resources for their implementation. Two years ago, a specific request by the government implied an obligation for ministries to specify the sources and amount of financial resources needed for the realization of all activities in strategic documents and their action plans. However, budget constraints caused by the economic crisis have had a significant impact on the implementation of measures and activities in those documents. The majority of strategic document activities still rely on the financial and technical support of international agencies and donors.

The PRS implementation process was completed in Serbia in March 2009, and then the government began defining policies of social inclusion and poverty reduction, bearing in mind the relevant effective EU policies in these areas. In order to alleviate the effects of the financial crisis, the government plans to improve measures aimed at poverty reduction and better social inclusion with an emphasis on vulnerable and marginalized groups. The transition from the poverty reduction to the social inclusion concept stems from the commitment of the government to implement measures that are part of the EU integration process as well as from the need to align national measures with EU policies leading to more effective social cohesion (12).

Intersectoral strategies and plans in health

- *National Economic Development Strategy, 2006–2012*
- *Strategy for Improvement of the Situation of Roma People in Serbia with an Action Plan for Residence, Education, Employment and Health*
- *National Strategy for Refugees and Internally Displaced Persons 2011–2014*
- *National Employment Strategy, with an action plan*
- *Better Health for the Third Millennium with a health policy document, vision of health system reform and Strategy and Action Plan for the Health Care System Reform*
- *National Action Plan for Children*
- *National Strategy for the fight Against HIV and AIDS*
- *Food Safety Strategy*
- *National Anti-Corruption Strategy*
- *National Environmental Action Plan*
- *Children's Environment and Health Action Plan*
- *Regional Development Strategy and Regional Development Action Plan.*
- *Tobacco Control Strategy*
- *Strategy for Development of Mental Health Care*
- *Strategy for Youth Development and Health*
- *Public Health Strategy*
- *Strategy for Development of Information Society until 2020*
- *Strategy of Scientific and Technological Development, 2010–2015*
- *Strategy for the fight against Drug Abuse with Action Plan, 2009–2013*
- *National Strategy for Empowering Women and Improvement of Gender Equity*
- *National Strategy for Prevention and Protection of Children Against Violence*
- *National Strategy for Youth*
- *Strategy for Stimulation of Births*
- *Strategy of Improvement in the Situation of Handicapped Persons*
- *Strategy of Social Protection Development*
- *National Ageing Strategy*
- *Republic of Serbia Health Care Development Plan.*

The *First National Report on Social Inclusion and Poverty Reduction* with social exclusion status and poverty trends in the period 2008–2010 and future priorities was adopted by the government in March 2011 (13). Seven Newsletters on social inclusion and poverty reduction have already been published as well as other relevant documents for this important process.

Cooperation in the area of health has been established with media, the social protection sector, the environmental sector, education, labour and employment. Opportunities to intensify cooperation exist within the agriculture, housing and rural development sectors; however, the greatest need for better cooperation is with the finance and economic development sectors.

Statement on Social Inclusion

It is important that the government reacts promptly so as to minimize the effects of the global financial crisis on living standards. Equally important is not to steer away from the strategic direction which our society is taking in the next few years. We have achieved the goal set in 2003 by adopting the Poverty Reduction Strategy – to halve the number of poor population. No government should resolve to the fact that a large number of its citizens lack basic living conditions, and we are obliged to utilize all available opportunities in order to continue improving living conditions in Serbia.

Mirko Cvetković,
Prime Minister of Serbia

Mechanisms, tools, instruments and platforms for advancing HiAP

Through the PRS Serbia has been successful in tackling social determinants of health, vulnerability and accessibility to health services. Preparation of the majority of strategic documents and programmes has usually been the joint activity of line ministries and other executive authorities, local governments, civil society organizations, international partners, scientific and research institutions and experts. Comprehensive consultations were conducted to achieve a national consensus on the main findings and priority areas.

The *Public Health Act* was adopted in 2009 (14). The first draft of the Public Health Act framework was initially developed under the 2005 project Support for Public Health Development in Serbia, with subsequent consensus established among public health professionals in all institutes of public health. The second draft also embraced public health financing as the responsibility of national and local authorities and improved consistency in the description of basic organizational and managerial structure of the public health institutes, as well as training and research opportunities within the system, governmental and nongovernmental sectors and collaboration with the academic environment, particularly the Centre School of Public Health and Health Management. The roles of health monitoring, health promotion and coordination are stressed in the framework in various ways. The current Public Health Act is short; it has 26 articles with seven chapters, on basic provisions, basic principles, social responsibility for public health, the public health system and division of responsibility, conditions for implementation of public health activities, control, punitive provisions and transitory and concluding provisions.

The aim of conducting the impact analysis of policies implemented from 2003–2007 under the umbrella of the PRS was to identify the government policies that improved the life of citizens, as well as the policies that are not cost-effective and that should either be made more efficient or repealed altogether. In the period from June–December 2008, the immediate impact of active employment policies was comprehensively analysed, as well as their indirect impact on poverty reduction (*Impact Analysis of Employment Policy and Active Labour Market Programmes*). The links between employment and adult education and additional training and retraining were analysed, as was the impact of introducing mandatory preschool education, the link between poverty and students' achievements, and the impact and efficiency of affirmative measures implemented in the previous four years (*Quality and Equity of Education in Serbia – Programme for International Student Assessment, 2003–2006*) (9).

In order to obtain a comprehensive insight into the efficiency of state policies targeting the poorest population, a detailed analysis of the impact of allowances was carried out. There was also an analysis of the impact of material subsidies, as well as the impact of measures implemented by the government conducive to agricultural development. Global good practices indicate that an established system and regular impact analysis of measures and policies contributes to transparency, better distribution of available funds and capacities, as well as the creation of more efficient and effective measures. Findings obtained in the policy impact assessment have been presented to relevant government institutions and civil

society. Further activities have been identified jointly by these sectors, paving the way for direct influence on improving the living standards of the poorest population. Furthermore, this will enable further capacity building, primarily of governmental institutions for conducting regular policy impact assessment and commitment to creating a democratic and accountable government.

HIAs, however, are rare in Serbia. In 2008, the impacts of health policies targeting the poorest population were analysed, focusing on the Roma population (*Impact Analysis of the Health Policies on the Health Care of the Roma Population*)(9). The *Serbia Governmental and Climate Impact Analysis* was written as a desk study at the request of the Swedish International Development Cooperation Agency's (SIDA) office in Belgrade to assess projects supported by that agency (15). More specific was a study about air quality monitoring and health impact assessment, with the aim of indicating the significance of air quality monitoring and to determine the air quality fields for assessment of pollution health effects, with special attention to risk populations (16).

Information for HiAP

Existing routine socioeconomic and health statistics provide only disaggregated data according to administrative levels, i.e., the autonomous province of Vojvodina and central Serbia, districts, municipalities and in some cases urban-rural differences. Development of gender-sensitive strategies and programmes resulted in 2004 with the first issue of the publication *Women and Men in Serbia*(15), which was prepared with financial support from the UNDP. This publication was important for monitoring MDG achievements and their promotion as well as for situation analysis and the adoption of adequate policy measures. The second issue, in 2008, was produced with financial support from the Directorate for Gender Equality of the Ministry of Labour and Social Policy and the Council for Gender Equity of the Government of the Republic of Serbia (17). These publications represent the beginning of building a sustainable programme of gender statistics in Serbia.

The information system does not permit the disaggregation of data on health status, health behaviour or utilization of health services by income level. However, this gap was partially resolved by national health surveys of 2000 and 2006. The first was realized with the financial and professional support of WHO and the Institute of Public Health, and the second was conducted by the Ministry of Health with financial and logistical support of the World Bank, WHO and the Institute of Public Health (18).

Periodic health surveys (the next national health survey is planned for the second half of 2011) provide data on socioeconomic determinants of health, self-assessed health status, lifestyles, functional abilities, utilization of health services and household health expenditure. These data enable evaluation of policies and programmes in the periods between surveys, identification of priority problems and implementation of measures for improvement of the population health status. The Serbia MICS were conducted by UNICEF, the Statistical Office and the Strategic Marketing Research Agency in 1996, 2000 and 2005. They provided information on the situation of children and women in Serbia and they were the largest single source of data for reporting on progress towards the MDGs and the World Fit for Children Plan of Action. The 2005 MICS contributed valuable data on the situation of women and children living in Roma settlements (6), the first such representative data collected in Serbia and important for the development of programmes and activities based on the *Strategy for the Integration of Roma People in Serbia*, particularly the *Action Plan for Health*.

By virtue of a strategic decision taken in 2004, poverty statistics in Serbia were based on data obtained in regular household budget surveys (HBS) until the adoption of the EU instrument for poverty measurement, the *Survey on Income and Living Conditions* (SILC). The HBS has been conducted regularly by the Statistics Office since 2003. Serbia, not yet being a member of the EU, is not required to conduct the SILC survey regularly; nevertheless, all efforts are being made for the SILC survey to be conducted in the near future, as an initial basis of objective recording of social exclusion.

Due to underregistration of Roma in the total population in previous censuses, a special programme was prepared during the preliminary census of households and population, 1–15 November 2009, called Roma in Census with the purpose of education and preparation of Roma people for the census which was planned in the second half of 2011.

Progress has been made in the field of statistics, but there is still a deficiency of specific indicators for the monitoring and analysis of adopted strategies and programmes, as well as of the data for the systematic monitoring of the conditions and improvement of health status of minorities and vulnerable social groups.

Concerning e-health development and utilization of information and communication technologies by population as an important aspect for health status improvement, according to available data for 2010, 50.4% of households possessed a computer, and 39% had internet access (19).

Capacity building for HiAP

Undergraduate education in Serbian schools of medicine incorporates lectures about health determinants, particularly socioeconomic determinants. Second-year students are encouraged to investigate inequalities in health by preparing group seminar work on physicians in the community by monitoring the health status of a patient and by determining social and environmental factors that influence health.

The School of Public Health and Health Management, which was founded in the summer of 2004 with the support of the European Union through one of the components of the project Support for Public Health Development in Serbia, was established as a functional unit of the School of Medicine, under the umbrella of the University of Belgrade, provides education and training for all professionals involved in public health activities and development of HiAP in Serbia. Students are from different fields, institutions and with different backgrounds (medicine, law, social sciences, organizational sciences and political sciences). The School was established to support postgraduate as well as continuing education in public health, health policy and the health services management.

Programmes of continuing education intended for public health workers of different professions coming from different institutions are organized on the basis of previously developed modules. During two years more than 550 public health professionals passed through three-to-five day programmes of continuing education.

The multiprofessionality and interdisciplinarity at the School of Public Health provide the institutional environment for a new generation of public health professionals in Serbia with skills, knowledge and experience for building and strengthening the health and well-being of the population. However, in practice, such professionals still need support and recognition of their role in health and socioeconomic development. Development of partnerships with health institutions, communities, NGOs and joining the network of ASPHER are significant elements of the School of Public Health's success. The Centre School of Public Health in Belgrade is a model for new training and research structures. The approach described here, together with those of other new schools in SEE can serve as a model of how to establish and promote new structures in a rigid inherited system.

In accredited doctoral studies in public health, few theses are devoted to research of health inequalities. Health survey databases, as well as LSMS databases valuable sources for investigating socioeconomic and gender differences in morbidity, risk factor distribution and health service utilization (20–22). Studies have shown that demographic, socioeconomic and health status inequalities in the utilization of health services exist in Serbia. However, projects and papers concerning HiAP are still rare, in spite of urgent needs for investigation of current determinants of health.

The Public Health Association of Serbia, an NGO established in 2003 through two projects: Strengthening Essential Public Health Functions in the Balkans (2001–2005) and Strengthening Balkan Civil Society’s Voice for Public Health by Reinforcing Public Health Associations (2006–2009), was supported financially by SIDA and technical assistance was provided through the Canadian Public Health



Association (CPHA). The Public Health Association of Serbia was also involved in capacity building for implementation of CEHAP in Serbia and raising public awareness.

Challenges, opportunities and recommendations

The main challenges facing Serbia in the context of HiAP are:

1. the public health infrastructure’s ability to meet future health challenges, both local and national;
2. understanding of public health essential functions by politicians and decision-makers and impact of their knowledge on provision of essential public health services to the population; and
3. effects on public health professionals of the global economic crisis and their strong impact on population health, particularly vulnerable population groups at high risk of poverty and with lower access to health services.

The main opportunities available in the country are as follows.

1. The workforce preparedness in new public health in Serbia has improved via establishment of the School of Public Health and Health Management, but still there is a need for better recognition of their competencies and importance of training professionals in public health, particularly among politicians and decision-makers.
2. Periodic assessment of vulnerability, poverty and health status of the population is provided by many representative surveys and has international support. However, this support is important for future assessment due to lack of funds and underestimation of their importance for establishing priorities and for development of sound and meaningful programmes and activities.
3. Although capacity to provide the essential public health services to every community has improved, there is an urgent need to focus more on poor people, old people living in remote areas, particularly old women, the unemployed and those with lower educational status.
4. There is an opportunity to build the capacity of the NGO sector and support broad partnerships, especially in local communities, for relevant public health issues and problems.

On the basis of identified challenges and opportunities, we recommend the following.

1. It is important to establish a national public health council comprised of members of line ministries, public health experts, representatives of NGOs and local authorities. The aim of such a body would be to provide a forum for communication and collaboration to achieve national health goals and to coordinate all activities and programmes in public health. Its task would be also to initiate needed public health reforms.
2. Using the framework of the PRS, a Council could be created to enhance collaboration between state and local institutions to improve the health of the people. Clearly, health is a cross-cutting issue, under the jurisdiction of different ministries and bodies (e.g. Ministry of Transportation regarding accidents; the Ministry of Interior and Police regarding registration and emergencies; the Ministry of Justice for prison health; the Ministry of Environment for environmental hazards; the Ministry of Agriculture for food safety; the Ministry of Labour for occupational health; the Ministry of Trade regarding consumer protection, etc.). As shown with the PRS work, such collaboration promotes sustainable health development tailored to specific state/municipal challenges, needs and working climate and goals. The Ministry of Health, as the holder of the health portfolio, would naturally lead and coordinate such a body, recommend policies and investment strategies and priorities to the other ministries and institutions.
3. The HiAP approach provides a platform centred on the health and well-being of all people at all stages of life. By considering health when formulating policy, public officials recognize the influence of policies related to infrastructures supporting health and well-being, public health, sustainable communities, and health outcomes. It is expected that the contribution to public health, productivity, quality of life and life expectancy will be increased, while the direct costs of the health burden under the jurisdiction of many stakeholders will be decreased.
4. An official statistical system sensitive to monitoring and assessment of the health status of disadvantaged and marginalized population groups as well as assessment of health status across the social gradient should be developed.
5. A research agenda and estimation of the funding needed to build an evidence base to guide policy-making for health status improvement should be instituted. Increasing the portion of budget allocated to population and community-based promotion and prevention research is a high priority for countries in transition such as Serbia. Also, schools and academia should increase integrated learning opportunities for public health students and other related health science professions.
6. Government and international funders of community health initiatives should focus on long-lasting change by supporting community engagement and leadership and the institutionalization of effective programmes.

7. HIA should be used to shed light on decision-making on proposed policies, programmes or projects, and on their potential effects on the health of the population.
8. It is important to promote broad intersectoral collaboration across ministries, academia and NGOs with the aim of maximizing effectiveness and efficiency of implemented programmes and activities.
9. Communication should be recognized as a critical core competency for promoting health and well-being, and an environment should be provided for public health officials and local and national media to work together in facilitating the communication of accurate information about health and medical issues.

References

1. *Serbia: Doing More with Less— addressing the Fiscal Crisis by Increasing Public Sector Productivity*. Washington, World Bank, 2009 (Report No 48620-YF).
2. *Statistical Yearbook*. Belgrade, Statistical Office of the Republic of Serbia, 2010.
3. *National Health Accounts of Serbia*. Belgrade, Institute of Public Health of Serbia, 2009.
4. Republic Institute for Health Insurance web site (<http://www.rzzo.gov.rs>, accessed 23 May 2011) (in Serbian).
5. *Health Statistical Yearbook of Serbia 2009*. Belgrade, Institute of Public Health of Serbia, 2010.
6. *Serbia Multiple Indicator Cluster Survey 2005, Final Report*. Belgrade, UNICEF Belgrade, 2006.
7. Health Care Act. *Official Gazette of the Republic of Serbia*, 2005,107.
8. Health Insurance Act. *Official Gazette of the Republic of Serbia*, 2005,107.
9. *Poverty Reduction Strategy Paper*. Belgrade, Government of the Republic of Serbia, 2003.
10. *Poverty in the Republic of Serbia, 2008–2010*. Statistical release, Household Budget Survey, No1179, year LXI, 29/04/2011. Belgrade, Statistical Office of the Republic of Serbia.
11. *Living Standards Measurement Study, Serbia 2002–2007*. Belgrade, Statistical Office of the Republic of Serbia, 2008.
12. *Social Inclusion and Poverty Reduction Newsletters*. Belgrade, Government of the Republic of Serbia, (<http://www.inkluzija.gov.rs>, accessed 23 May 2011)(in Serbian).
13. *First National Report on Social Inclusion and Poverty Reduction in the Republic of Serbia 2008–2010*. Social Inclusion and Poverty Reduction (<http://www.inkluzija.gov.rs/?lang=eng>, accessed 29 September 2011).
14. Public Health Act. *Official Gazette of the Republic of Serbia*, 2009, 72.
15. *Serbia Environmental and Climate Impact Analysis*. Gothenburg, Gothenburg University School of Economics and Commercial Law, Department of Economics, Environmental Economic Unit, 2008.
16. Nikic D, et al. Air quality monitoring in Nis (Serbia) and health impact assessment. *Environmental Monitoring and Assessment*, 2009,158(1–4):499–506.
17. *Women and Men in Serbia*. Belgrade, Statistical Office of the Republic of Serbia, 2005.
18. *Women and Men in Serbia*. Belgrade, Statistical Office of the Republic of Serbia, 2008.
19. *National Health Survey, Serbia 2006: Key Findings*. Belgrade, Ministry of Health, Republic of Serbia, 2007.
20. Jankovic J, Simic S, Marinkovic J. Inequalities that hurt: demographic, socioeconomic and health status inequalities in the utilization of health services in Serbia. *European Journal of Public Health*, 2010, 20(4):389–396.
21. Djikanovic B et al. Gender differences in smoking experience and cessation: do wealth and education matter equally for women and men in Serbia. *Journal of Public Health (Oxf)*, 2011, 33(1):31–38.
22. Jankovic J, Marinkovic J, Simic S. Utility of data from a national health survey: Do socioeconomic inequalities in morbidity exist in Serbia? *Scandinavian Journal of Public Health*, 2011, 39(3):230–238.

9. The former Yugoslav Republic of Macedonia

Summary

The overall goal of this study is to analyse the relation of the health system to other sectors, identify the impact of their policies on health and health determinants and to search for practical policy options to maximize the positive health impact of other policies. This report describes the current HiAP situation in the former Yugoslav Republic of Macedonia and identifies challenges and opportunities and formulates country-specific recommendations for furthering a HiAP approach, which in turn inform the final political document emerging from the SEE Health Network Ministers' Forum. It was produced by a team of experts from the Institute of Public Health and the Ministry of Health. The team worked together to define the content, using methodologies such as desk reviews of policy, legal and programmatic documents as well as stakeholder interviews. The translated HiAP criteria document was sent to different sectors and the received responses are reflected in the study. The study was based on data obtained from different studies or projects since the official data systems do not permit disaggregation of data on health status and different socioeconomic indicators.

Country context

Political background

The Constitution of the former Yugoslav Republic of Macedonia guarantees the rule of law, basic freedoms and rights of the individual and the citizen, recognized in international law, and it defines the structures and processes of the state. The Assembly sets up councils, including the Health Council. Under the Constitution, the state has a responsibility to ensure that health is protected for all citizens.

The government consists of the prime minister, three deputy prime ministers who usually coordinate the work of the ministries in specific policy areas (European integration, the political system and economic reform), and ministers. At present there are 14 ministries: Foreign Affairs; Internal Affairs; Defence; Justice; Finance; Economy; Transport and Communication; Local Self-Government; Labour and Social Policy; Agriculture, Forestry and Water Resource Management; Environment and Physical Planning; Culture; Education and Science; and Health. There is currently one minister without portfolio. Other central non-ministerial state administrative bodies include: the Agency for Information, the Agency for Youth and Sports, the Agency for Immigration, the Committee for Relations with Religious and Confessional Groups, the Agency for Development and Investments and most recently the Food Safety Agency, as well as the State Statistics Office, State Archive Office and State Geodetic Bureau.

The Ministry of Health performs activities related to health policy, health care provision and health insurance of the population; health protection including protection from contagious diseases, from harmful impact of gases, ionizing radiation, chemicals, noise, as well as air, water and land pollution; monitoring the health status of the population; safety of cosmetics and toys; hygiene-epidemiological conditions; medicines; remedial medicines; medical appliances; medical equipment; sanitary devices and materials; poisons and narcotics; and other activities.

The Ministry of Health cooperates with all other sectors within the government, in particular in relevant areas with the Ministry of Labour and Social Policy, the Ministry of Local Self-Government, the Ministry of Environment and Physical Planning, the Ministry of Education, the Ministry of Justice, the Agency of Youth and Sports and the Food Safety Agency.

Socioeconomic conditions

In the period 2006–2008, per capita GDP increased from €2564 to €3283 (€7153 to €8430 in PPS). Total expenditure on health as a percentage of GDP decreased from 8.7% in 2000 to 6.9% in 2009. In the same

period general government expenditure on health as a percentage of total expenditure on health increased from 56.6% to 66.5%.

Table 20. National Expenditure on Health: Selected ratio indicators 2000-2009 (in denars)

Selected ratio indicators for expenditure on health	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total expenditure on health (THE)% of GDP	8.7	8.4	9.2	9.3	8.7	8.1	7.8	6.9	6.8	6.9
External resources on health as% of THE	2.8	0.9	1.9	1.2	1.6	0.9	1.0	1.3	1.8	1.0
General government expenditure on health (GGHE) as% of THE	56.6	57.9	57.9	58.5	59.5	61.8	65.1	64.3	68.2	66.5
Private expenditure on health (PvtHE) as% of THE	43.4	42.1	42.1	41.5	40.5	38.2	34.9	35.7	31.8	33.5
GGHE as% of general government expenditure	14.8	12.3	13.5	16.2	16.0	14.7	15.4	13.7	13.6	12.1
Social security funds as% of GGHE	97.4	97.1	97.3	97.6	97.3	95.8	92.9	94.9	94.9	92.9
Private insurance as% of PvtHE	0	0	0	0	0	0	0	0	0	0
Out of pocket expenditure as% of PvtHE	99.2	99.1	99.1	99.2	99.2	99.5	99.7	99.2	99.2	99.2

Source: World Health Organization (1)

From 1999 to 2009, employment and unemployment rates have registered minimal changes from year to year. The highest employment rate of 38.6% and the lowest unemployment rate of 30.5% were in 2001. Women's participation in the workforce was lower than men's. In 1999, the proportion of women in the workforce was 38.0% and in 2009 it was 38.2%. Unemployment among the young, 15 to 24 years old, is very high, at 62.9% in 1999, 64.8% in 2004 and 55.1% in 2009. It is mainly young and older workers, women and the low-skilled who suffer from joblessness. The poverty rate decreased from 30.2% in 2003 to 28.7% in 2008, but has since risen again to 31.1% in 2009. The most vulnerable groups are multimember households; 53.7% of poor people live in households with five or more members. The poverty rate for the unemployed is 40.5% and 42.7% of all poor people are unemployed. The old-age dependency ratio has increased from 13.4% in 1997 to 16.2% in 2008, but is still much lower the corresponding EU rates, at 22.5% and 25.2% respectively (2).

The average household spends about 64.6% of its expenditure on basic needs such as food, clothing, housing and household equipment. Health accounts for 3% of total household expenditure. The structure of incomes in 2009 was dominated by revenues from regular and non-regular work at 65.8%, pensions 17.5%, revenues from agriculture 4.6%, revenues from abroad 2.7%, and social benefits 1.6%. The data show that the average household is able to cover about 81.5% of consumption, while the rest is covered by credits or debt or by unreported and informal income.

Demographic characteristics

The total population of the Republic in 2009 was 2 052 722. As a result of the positive natural increase, the total population still maintains an upward trend, though at a slower pace. In the decade 1999–2009 population growth was 31 144 or 1.5%. During that period there was a continuous decline in the number of births, causing the birth rate to drop to 11.5 per 1000 in 2009, compared to 12.4 in 1999. The constant increase in the number of deaths caused an increase in the mortality rate to 9.3 per 1000 in 2009, compared to 8.2 in 1999. There have also been significant ageing of the population. From 1999–2009, the young population (0–14 years old) decreased from 22.8% to 17.7%, whereas the old population (over 65)

increased from 9.8% to 11.6%. Life expectancy at age 65 increased slightly in the decade, from 13.2 to 13.6 years for men and from 15.0 to 15.4 years for women (2). Life expectancy at birth in 2008 was 74 years for both sexes, 72 for men and 76 for women. Healthy life expectancy at birth is 66 years for both sexes (3).

The population is quite urban, with 57.8% living in the 34 towns and cities, with the highest concentration in the capital Skopje (20.5% of the population). There are 1728 rural settlements, many with very low populations and 141 settlements are completely depopulated and others have a very aged population. A few rural settlements, mostly located in the western and north-eastern parts of the country, have large populations.

Burden of disease

The most common causes of death are circulatory diseases, at 57.6% of the total deaths, followed by neoplasms at 19.3%, and endocrine, nutritional and metabolic diseases at 3.7%, respiratory diseases at 3.5% and injuries at 3.2% in 2009 (2). The SDR of circulatory diseases is 572.1, malignant neoplasms 171.5, respiratory diseases 36.0 and injuries 32.5 (4).

Progress in reducing poverty and social disparities, including among various vulnerable groups has been slow, and further efforts are needed to reach the planned targets. Significant progress has been made in improving mother and child health indicators during recent years, reducing infant mortality to 9.7 per 1000 live births in 2008 and under five mortality to 11.0, which has put the country on track to achieving the health-related MDGs by 2015 (5). Maternal deaths have decreased from 13.5 per 100 000 live births in 2000 to 4.4 in 2006, while in 2007 no cases were reported. The percentage of births attended by skilled medical personnel is generally high, having increased from 97.7% in 2000 to 99.7% in 2008, which is particularly important for keeping maternal mortality at a low level. Registered abortions have been decreasing steadily, from 26.5 per 100 births in 2007 to 25.7 in 2008 (6). However, there is still work to be done, particularly as some of these indicators increased in 2009, the IMR to 11.7, due to the financial crisis among other reasons. There remain inequities related to location, ethnicity and wealth. Infants and young children in certain ethnic groups were exposed to a much higher risk of malnutrition, poorer health and higher mortality rate (7).

Characteristics of the health system

The former Yugoslav Republic of Macedonia, with the independence gained in 1991, inherited a large and well-established health care system with good geographical and financial accessibility, as well as a health insurance system that covered nearly the whole population. The *Health Care Act of 1991* established the organizational structure of the system with the Ministry of Health and the government in charge of health policy formulation, stewardship and implementation, and the Health Insurance Fund responsible for the collection and allocation of funds and the supervision and contracting of providers. Based on this law, and later by means of the separate Health Insurance Act, the system of compulsory health insurance has been established. Equity, solidarity and reciprocity, as well as the provision of universal coverage for the population, have been defined as its core values.

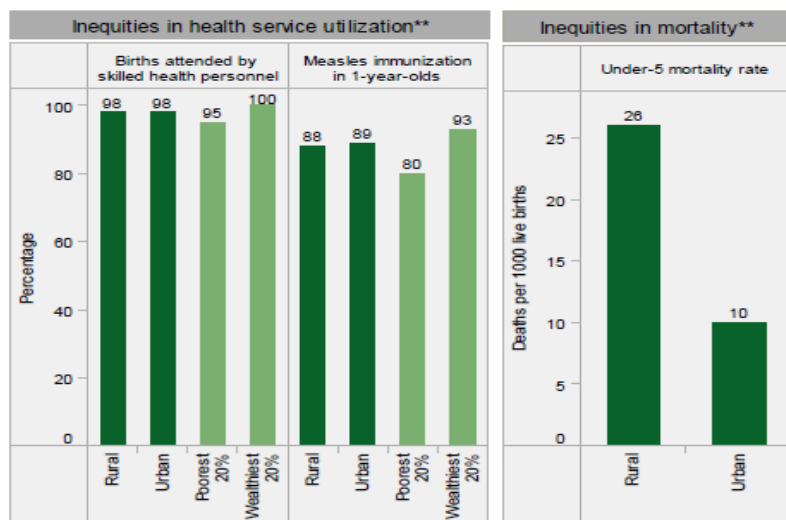
Health services are delivered through a network of public and private health care institutions. Primary care is delivered by general practitioners and other primary care doctors such as paediatricians, school medicine specialists, gynaecologists. It is contracted by the HIF and paid on a capitation basis. Privatization of PHC and dental practices was completed in 2007, while only parts of preventive PHC related to the care of infants and small children (regular check-ups, growth monitoring and immunization services) and outreach nursing services remained in the public sector. The division between public and private provision of preventive care, i.e., between the preventive teams kept on public payroll and privatized PHC physicians on capitation contracts with the HIF, has created gaps in access, coverage and quality of preventive services, especially for children and pregnant women.

Specialist outpatient care is about 70% publicly delivered, while patients pay a small copayment for services. Expansion of private specialist care services is planned. Inpatient care in hospitals is publicly provided and financed through historic budgets bound to a list of performance indicators based on which hospitals report to the HIF on a quarterly basis. Reforms envisaged in hospitals include promoting greater use of ambulatory procedures, including surgical, internal medicine and diagnostic techniques that will lower the demand for hospital beds and yield considerable savings to the system (8). A new diagnosis related group (DRG) payment mechanism for the hospital services was introduced as an integral part of the reform to improve efficiency in the utilization of available funds (material and human resources) and the quality of health care services for insured people and reduce the cost and length of hospitalization. There is a need for more integration of primary, secondary and tertiary level services (disease management). Functional division between the different health care levels remains a challenge.

Health care financing is organized around a social insurance system managed by the HIF, which pools health insurance contributions from payrolls (7.3% of gross wage), transfers from the state budget (for the unemployed and beneficiaries of social welfare), and co-payments. Average spending on health care per capita is around US\$ 200. The benefits package is quite costly. It is comprehensive, covering practically all health services for the insured. It is generous as compared to available HIF revenues contributing to the problem of implicit rationing and informal payment. Several mechanisms are in place to improve access to care. The Health Insurance Law defines exemption policies from co-payment, a stop-loss clause on the level of co-payment and reimburses some transport costs for insured individuals.

Inequities in health status, health behaviour and health system access

Health care is delivered through institutions with relatively even territorial distribution, even though there are settlements with inadequately equipped facilities (poor physical conditions, insufficient medical personnel, lack of drugs and basic medical equipment, etc.). Initial assessment of health outcomes and service utilization do not suggest significant barriers to health care access, including preventive care services. Health indicators are relatively good and comparable with indicators in the region, but there is still work to be done, particularly as some of the indicators show certain inequities, related to location, ethnicity and wealth.



Source: WHO (3)

Infants and young children in certain ethnic groups were exposed to a much higher risk of malnutrition, poorer health and higher mortality rate: Roma infant mortality, 13.1 (under 5 = 15.1), Turks, 14.2 (-5, 14.7), and Albanians 13.4 (-5, 15) in 2007, while the values of both indicators for the Vlachs were zero (5).

The Health Insurance Act was amended in 2009 with the aim of providing accessible social insurance for all citizens. Universal coverage was introduced in 2009, financed from the central budget, with an essential package for all citizens (including the unemployed and uninsured), including preventive check-ups, immunization, coverage of part of the positive list of drugs and treatment of a range of communicable diseases.

Overall however, the measures taken are insufficient to address the needs of the most disadvantaged groups. These include the working poor, the rural poor, low-educated, jobless households, women from vulnerable groups living in rural areas, the Roma, big families, people with disabilities and children living in children's homes.

Policy frameworks

The Country's Progress towards EU accession is a driver for change, as all EU policies are required by the EU treaty to follow a HiAP approach. Since the European Council granted the country candidate status in 2005, it has made progress in the implementation of the Stabilization and Association Agreement. The National Programme for Adoption of the Acquis Communautaire (NPAA) was begun in April 2007, with a focus on economic growth, the reduction of unemployment and on improving living standards including public health, health statistics and consumer protection. The NPAA was revised in 2011 to comply with the HIAP approach, considering the potential impact on health or health systems when formulating new policies in other sectors such as labour and social policy (domestic violence prevention, sexual and reproductive health), transport (promoting road safety), agriculture (food safety), environment (climate change), etc. (9, 10, 11).

Collaboration among ministries in the decision-making process is an everyday process, and includes all government sectors. The primary responsibility for ensuring proper consultation and coordination with the relevant ministries lies with the minister proposing a policy measure and is required before a proposal is submitted to the Secretary of the Government. In addition, all legislative proposals must be submitted to the secretariat for legislation. The working statute also allows for formal consultation with social organizations and interested parties, prior to a decision by the government. There is also a process at the inter-departmental level through intersectoral coordination bodies or committees as well as at local level through similar bodies.

An example of good practice is the Joint Committee against Family Violence that works at the central level to steer the actions of ministries of Health; Labour and Social Affairs; the Economy; Labour and Social Policy; the Interior; and Justice. It has developed Protocols that guide action at the local level to respond to the immediate needs of citizens. Another example is the Roma Decade framework, where all above sectors are contributing to the joint agenda on enhancing the health and social well-being of Roma (12).

During the EU accession process, the ministries of Health and Labour and Social are operating on the Joint Memorandum of Inclusion (JIM), coordinating all other sectors in implementing a HiAP approach, comprising open dialogue in consensus building, inclusion of vulnerable groups into the process and inclusion of civil society and international development partners. JIM has great potential to promote HiAP, since it gathers not just the main sectors of government, but also sectors and partners in joint activities, shaping and implementing policies toward better health and social well-being, taking account of the SDH.

Table 21. Overview of the EU integration process flagship of the HIAP approach

Chapter	Title	Public health aspects	Level of collaboration
2.2	Human rights and minority protection	Right to health, antidiscrimination, human rights (children, women, vulnerable population)	Regular formal
4.1	Free movement of goods	Health safety of food, medicines, cosmetics, chemicals	Regular formal
4.2	Free movement of workers	Human resources in health	Regular formal
4.3	Right on freedom and freedom of service provision	Conditions for health institution establishment	Regular formal
4.4	Free movement of capital	Foreign investments in health	Regular formal
4.7	Intellectual property rights	Protection of intellectual property for discoveries in medicine, medicines, generic drugs, etc.	Regular formal
4.10	Informatic society and media	Information technology in health sector, media and health	Lowest
4.11	Agriculture and rural development	Safety in food production, rural health development, access to health services in rural areas	Regular formal
4.12	Food safety, veterinary and phytosanitary policy	Food safety for human and veterinary use	Regular formal
4.14	Transport policy	Physical access to health services	Lowest
4.18	Statistics	Health statistics	Lowest
4.19	Social policy and employment	Health of vulnerable groups; open method of coordination of social sectors	Strongest
4.23	Justice and fundamental rights	Drug abuse, prison health	Regular formal
4.25	Science and research	Health research	Lowest
4.26	Education and culture	Health education, health culture	Regular formal
4.27	Environment	Environment and health	Regular formal
4.28	Consumer protection and health protection	Health care development through activities in the health sector in the context of the patient as consumer (public health)	Strongest

Source: European Commission (13)

The EU integration process involves the HiAP approach across policy areas, including economic development and consumer protection, environmental, education, statistics, free movement of goods, foreign investments, IT, food safety, research and social affairs. So far the greatest collaboration is with social policy and protection, while there is little collaboration in the area of IT and media, transport policy, statistics and science and research. There are policies in all other sectors that often do not address health explicitly. There is a big potential for establishment of solid legal framework for implementation of HiAP in the process of harmonization of national legislation with the EU (2009–2014), for which there is a need for continuous engagement and strengthened Ministry of Health capacities (13).

Local self-government and centres for social work are responsible for social inclusion at the local level as stipulated in the *Local Self-Government Act*, the legal framework for decentralizing these services (14). The project Social Inclusion and Human Rights, in collaboration with the Ludwig Boltzmann Institute, aims to support the inclusion of a human rights based approach in the planning processes of national and local authorities dealing with the issues of social inclusion, social protection and poverty reduction, in particular, strengthening the capacities of the Ministry of Labour and Social Policy's decentralized offices (centres for social work), the Employment Agency's decentralized offices and local authorities to provide efficient and effective social services to the most vulnerable groups. In keeping with the decentralization process, the project will stress the obligation to bring the authorities closer to the citizens, especially close to the most vulnerable and the poor (15).

Many health-related international strategies, such as the MDG 2015, *Decade for Roma Inclusion 2015*, NEHAP, CEHAPE, HESME, etc. have been reflected in the national policy in the *National Strategy for Sustainable Development; National Strategy for EU Integration; National Poverty Reduction Strategy; National Employment Strategy until 2010; National Action Plan on Employment, 2006–2008; National Development Plan, 2007–2009; National Strategy for Roma; National Action Plan for the Advancement of Women; Strategy for Equitable and Just Representation; Programme for Decentralization, 2008–2010* and its action plan; *Strategy for the Demographic Development of the former Yugoslav Republic of Macedonia 2008–2015(16); National Action Plan for Children, 2006–2015; National Action Plan for Youth; National Strategy for Deinstitutionalization of Social Care Services and Programme for Social Protection.*

The strategic plan is the basic development plan of the Ministry of Health for the three year period, based on the Ministry's programme and activities, the government work programme for 2008–2012, the *Health Strategy 2020* and the MDG. Its priorities are to strengthen human resources planning and training and to rationalize health care facilities to redistribute limited resources more effectively and thereby improve infrastructure and quality, especially of primary care services (17).

At the policy level a large number of strategies and public health programmes have been produced: the *Health Care Strategy until 2020; National Strategy for HIV/AIDS, 2007–2011; Strategy for TB Control, 2008–2012, Strategy for Mental Health Promotion, 2005–2012; Alcohol Control Strategy; National Tobacco Control Strategy; Strategy for Protection Against Family Violence; National Road Safety Strategy; Strategy for Noncommunicable Diseases; and National Health Strategy for Youth.*

The programmes with the most effective intersectoral cooperation are the HIV/AIDS programme and TB control programme, where national coordination mechanisms have been established and are functioning, gathering all the stakeholders, including vulnerable individuals. There are successful policies that scope two sectors, for example, the Ministry of Health and Ministry of the Economy successfully implement the national strategy on oral diseases in children from ages 0–14. There is a project for fluoridated milk in all preschool institutions including children three to five years of age, as one of the measures for endogen fluorine prophylaxis. However, many strategies function better if other sectors are not included. For example, the *Strategy for Sexual and Reproductive Health*, which mainly involved training of 50 gynaecologists and the *Strategy for Safe Motherhood*, which involved the establishment of the Centre for Human Reproduction within the Clinic for Gynaecology and Obstetrics (18).

Health in various sector policies

The determinants of health can be affected by policy decisions in a wide range of sectors, including agriculture, education, housing and transport. Most of these determinants are amenable to change, and this is where the HiAP approach is most effective. There are examples of health policies in other sectors including the environment, regarding noise and waste management; labour and social protection, regarding occupational health and safety; and the interior and justice, regarding road safety and violence. Furthermore, the Sanitary and Health Inspectorate, Food Inspectorate, Market Inspectorate and Education Inspectorate have many joint responsibilities in health protection, including food safety and tobacco control.

In HiAP implementation, emphasis on equity is of particular importance and health considerations cover both physical and mental health. The examples listed in this section of the study have among other objectives to reduce health inequities with a focus on improving the well-being of specific vulnerable groups.

The *National Plan for Gender Equality, 2007–2012* has ten strategic fields of action, including woman and health, and three strategic goals have been defined: provision of relevant and timely gender-specific health-related indicators, increasing knowledge and fostering of responsibility for sexual and reproductive

health (6) and improvement of preventive health programmes for men and women for the most common conditions resulting in morbidity and mortality.

The *National Strategy for the Elderly, 2010–2020* includes a goal of strengthening health care for the elderly.

Evidence from international comparisons suggests that countries that have consistently pursued redistributive policies generally have lower rates of poverty and better health outcomes. Although economic growth is central to reducing massive poverty, economic growth alone is insufficient to reduce poverty for marginalized groups. An institutional framework and social structure for redistributing the benefits of growth to all in society is also required. Despite arguments to the contrary, social spending has not been shown to inhibit growth. Like the rest of the world, the former Yugoslav Republic of Macedonia, has been affected by the growing integration of economies and societies around the world, especially over the last quarter century. Economic growth is affected by global economic conditions that have led to changes in the structure of the labour market, tending to benefit skilled workers and harm the unskilled. The global financial crisis has resulted in more people becoming dependent on social assistance with increased unemployment, increased informal work, reduced wages and increased living costs, especially affecting vulnerable groups (defined by ethnicity, gender, age and education) (2). Programmes that aim to address this include the *National Strategy for Reducing Poverty and Social Exclusion; 2010–2020*; the *Strategy for Integration of Refugees and Foreigners, 2008–2015*; and the *National Strategy for Roma Inclusion*.

Mechanisms, tools, instruments and platforms for advancing HiAP

There are formal structures and mechanisms that coordinate and facilitate intersectoral work, as described above. Some of them are systematic, and some are related to specific projects. For example the *Conditional Cash Transfers Project (CCT)* for poor families with children in secondary education aimed to strengthen the social safety net and to support the identification, development and implementation of possible extensions to its model. The project involves a joint body of experts of the Ministry of Health and Ministry of Labour and Social Policy for the duration of the project (19). The new *Public Health Act* of 2010 gives public health councils a more systematic coordinating role in activities, at both local and central levels (20). All policy and strategic documents include some form of intersectoral steering committee to coordinate activities. Notwithstanding all of those efforts, the most effective mechanism in place is the collaboration among ministries as part of everyday government decision-making processes. Thus, those involved should be better equipped with knowledge of the SDH and the HiAP approach.

Joint planning mechanisms across sectors – positive examples

The benefits of HiAP approaches were proven in the implementation of the integrated policies with intersectoral participation. Examples of the best practice of such policies, with clear added value for population health are the *Road Safety Policy* and the *Policy for Domestic Violence Prevention* presented below.

Case study: The National Council for Road Safety

- A public health approach was applied as a science-based framework for policy intervention. A WHO Community Injury Survey was conducted in 2008 (21).
- The *National Road Safety Strategy, 2009–2014* was adopted by the Assembly in 2008.
- Annual action plans for each sector (transport, health, justice, interior, education and science), have been made since 2009.
- The national coordinating body and an intersectoral working group were established.
- All activities have been coordinated by the National Council for Road Traffic Safety, financed by the central budget.

- A partnership was established among relevant ministries (Health, Interior, Transport and Communication, Education and Science) and the National Council for Road Traffic Safety.
- There has been participation by the Institute of Public Health, WHO Country Office, the Red Cross, the Directorate for Protection and Rescue, the National Insurance Bureau, the Auto Moto Association of Macedonia, the Association of Physically Handicapped People and the Association of Motorcyclists.
- Mortality rates among children 0–14 have significantly declined, to 0.82 per 100 000 in 2009, compared to 1.87 in 2008 and 2.88 in 2007.

The main objective of the road safety strategy is to reduce the number of road traffic injuries by 50% by 2014 and to have no fatal child injuries. The health sector is one of the partners implementing the integrated policy, through the activities defined in its annual action plan. The integrated budget is for the National Council on Road Safety, while the annual action plans are implemented from the budgets of the respective sectors; there is no additional distributed budget.

The main achievements of both the road safety initiative as well as domestic violence prevention are: development of national strategies and annual action plans, institutionalization of activities through establishment of a national coordinating body and partnerships at national and local levels among relevant stakeholders.

Case study: Domestic Violence Prevention

- A public health approach was applied as the science-based framework for policy intervention in the *Report on Violence and Health and Guide for Prevention*(22,23).
- The National Commission for Violence Prevention and Health Protection was set up.
- The *National Strategy for Protection from Domestic Violence Prevention* was produced.
- Annual action plans were drafted for each sector: health, labour and social protection, justice, interior, education and science.
- The national coordination body was set up.
- A partnership was established among relevant ministries (Health, Interior, Labour and Social Protection, Education and Science) and the Institute of Public Health and WHO Country Office.
- The *Joint Protocol for Treatment of Victims of Domestic Violence* was adopted and published.
- The Institute of Public Health prepared a methodology for data collection on violence and family violence, and a registration form and software application were also prepared for piloting in April 2011.
- The United Nations Joint Programme for Strengthening National Capacities to Prevent Domestic Violence was implemented.
- There is a protected budget of US\$ 3.5 million.

There is also a positive example of joint work in mental health involving the Ministry of Health, the Ministry of Labour and Social Affairs, the Ministry of Justice and the Ministry of Interior. The Committee for Health in Parliament has a special influence in the adoption of the health and public health regulations.

Information for HiAP

Official data systems do not permit disaggregation of data on health status by socioeconomic indicators, so HiAP studies are based on data obtained from different studies or projects. Under the *Health Data Act of 2009*, the Institute for Public Health is preparing methodological principles and statistical standards as well as standard procedures for evidence in health, data collection and record keeping, in coordination with the State Statistical Office and Directorate for Personal Data Protection, with regard to personal data protection. The defined basic data set as well as specific data will enable disaggregation by health status, health behaviour, quality of life, well-being and health system access by income, education, occupation,

gender, rural-urban location, household size, migrant status and ethnicity. There is currently a lack of data on lifestyle, socioeconomic categories, access to health and ethnicity. The Act provides a legal basis for establishing an e-health card and IT in the health sector. The Ministry of Health has purchased hardware and system software for the integrated health information system (IHIS) for the public health institutions and has provided training for health professionals related to IT system functioning. A data centre for IHIS was established and is functioning in the Ministry of Health.

The *Household Expenditure Survey, 2008(24)* shows that 68.5% of personal expenditures on health are spent on drugs and medical devices, 28.1% on outpatient services and 3.4% on hospital services. The financial situation in the country had directly affected the socioeconomic status of the population, consumer power is reduced, and many people can cover only basic living costs (25).

Currently, harmonization with EU directives under the integration process is the only existing mechanism in place for joined-up monitoring and evaluation of intersectoral interventions.

Capacity building for HiAP

There needs to be recognition at the national level of the importance of HiAP and its promotion at local and regional levels, as well as a permanent structure and horizontal management system for health promotion, to facilitate roles among sectors, including monitoring and reporting on processes and outcome indicators. Policy-makers should be aware that:

- intersectoral action is time-consuming
- results of intersectoral action take time to emerge
- tasks of the different management groups need to be defined
- the structure and system must be clear and concrete
- intersectoral action is a tool for policy coherence, not an intrinsic value in itself.

There is a clear need for capacity building for HiAP. Some of it is already happening. Capacity building for policy-makers and decision-makers has taken place through the School of Public Health's Management and Leadership in Health programme for 800 trainees, with some HiAP elements in the curriculum. HiAP is also partially incorporated into postgraduate studies of public health (the MPH programme established in 2003), but not in the continuing professional education for health professionals. In the scope of UNICEF's support for the health policy decentralization process, there is an ongoing effort for enhancing the capacities of local governments for public health and environmental health planning. The Dutch Government through the MATRA project (its social transformation programme) supports the enhancement of public health service capacity in the country.

Challenges, opportunities and recommendations

Challenges facing the former Yugoslav Republic of Macedonia from a HiAP perspective include:

1. improving health data and evidence with proper disaggregation for regular HiAP reporting and development;
2. establishing an integrated information health system to share data on the health status and determinants and to monitor HiAP-related activities;
3. improving research and preparing analytical reports on key health determinants and establishing intersectoral policies and approaches to address them;
4. addressing health determinants effectively, as mediators between policies and health outcomes, with equity as a core value;
5. developing HiAP mechanisms and instruments further (e.g., national, regional and local government public health committees) via cross sectors action teams, integrated policies and budgets;

6. strengthening the use of HIA, for example by using the online tool with a methodology and background information on key policy areas and their impact on health systems;
7. building capacity of public health expertise for HIAP through investments in human resources across ministries; and
8. strengthening the health sector to take the leading role in health in all policies, with staff with adequate skills.

Opportunities available at present include those for:

1. creation of partnerships across sectors, as emphasized in the *Public Health Act* and other strategic documents;
2. strengthening multisectoral approaches and processes at national, regional and local levels through the National Public Health Council and local public health councils to enable the impact on public health to be assessed for all policies; and
3. increased collaboration among sectors at different levels and where appropriate with WHO, the European Commission, international organizations and other relevant partners to up the implementation of health focused policies in other sectors.

We therefore recommend the following:

1. a leading role for the SEE Health Network in promoting knowledge and exchange of best practice on HiAP within SEE countries, including special conferences or training and guidance materials on basic methodologies and approaches;
2. creation of a new HiAP assessment tool, or implementation of an existing one, and to encouragement for HiAP research, including EU FP7 opportunities for research on the SDH;
3. introduction of HiAP indicators and a database specific for the SEE countries; and
4. a clearing house/coordinating role for the Regional Health and Development Centre in Skopje

References

1. National health accounts. WHO 2011. See: www.who.int/nha/country/mkd.xls (accessed 27 June 2011).
2. Macedonia in figures 2010. State Statistical Office, Skopje 2010.
3. The former Yugoslav Republic of Macedonia Country profile. WHO 2011. See: www.who.int/gho/countries/mkd/country_profiles/en/index.html (accessed 27 June 2011)
4. WHO Regional Office for Europe Health for All (HFA) database.
5. Tozija F. Millennium Development Goals 4, 5 and 6. In: Report on the progress towards the Millennium Development Goals. Republic of Macedonia. United Nations Development Programme UNDP, Skopje, 2009. pp. 45-66.
6. Tozija F. et al. *Strategic Assessment of Policy, Quality and Access to Contraception and Abortion in the Republic of Macedonia*. Republic Institute for health protection/UNFPA, Skopje, 2008.
7. Tozija F. See: [//ec.europa.eu/employment_social/progress/index_en.html](http://ec.europa.eu/employment_social/progress/index_en.html) (accessed 3 June 2011).
8. World Bank. Health Sector Management Project, Skopje, 2011.
9. WHO/EU Commission. Declaration on "Health in All Policies". WHO/EU Commission Conference on "Health in All Policies": Achievement and Challenges", Rome 2007.
10. Resolution on Priorities in EU Accession. Parliament of Republic of Macedonia, Skopje, 2009. See: www.sep.gov.mk/content/Dokumenti/MK/Rezolucija-tekst_-_1_mak_pod_%203_.pdf (accessed 27 June 2011).
11. Government of Republic of Macedonia. Review of National legislation which is harmonized with EU 2009-2014. See: www.sep.gov.mk/content/Dokumenti/MK/01_Prilog_1_Pregled_na_nacionalni_pravni_akti_koi_se_usoglasuvaat_so_EU_2009-2014.pdf (Accessed on 27 June 2011)
12. Tozija F. Social inclusion of Roma population in health: situation, challenges and opportunities. In: Journal for Social Policy, Skopje, 2008. No.1:58- 67.

13. Progress Report Macedonia, SEC 1332. European Commission, Brussels, 2010. See: www.sep.gov.mk/content/Dokumenti/MK/mk_rapport_2010_mk.pdf (accessed 27 June 2011).
14. Law for Local Self-Government. In: Official Gazette of RM 5/02. Government of Republic of Macedonia, Skopje, 2002.
15. Analysis of the social protection and social inclusion at local level. Ludwig Boltzmann Institute of Human Rights Skopje, 2011.
16. National Strategy of the Republic of Macedonia for prevention and control of noncommunicable diseases. Ministry of Health, Skopje, 2009.
17. Ministry of health (2009), Strategic programs for 2009-2011, Skopje, Ministry of health. See: [//moh.gov.mk/index.php?category=29](http://moh.gov.mk/index.php?category=29) (Accessed on May 2011).
18. Zahorka M. Stanescu A. Fota N. Improving Maternal and Infant Health – Macedonian Safe Motherhood Strategy (SMS) 2011-2015. UNICEF, Skopje 2010.
19. Macedonia – Conditional Cash Transfers Project. Project Appraisal Document. World Bank, 2011. See: www-wds.worldbank.org (accessed on June 2011).
20. Public Health Law (Official Gazette of RM 22/10). Government of Republic of Macedonia, Skopje, 2010.
21. Tozija F. Gudeva-Nikovska D. Gjorgjev D. Community Injury Survey in Macedonia. Republic Institute for Health Protection, Skopje, 2008.
22. Tozija F. Gjorgjev D. Cicevalieva S. Report on Violence and Health in Republic of Macedonia and Guide for Prevention. Institute of Public Health/WHO. Skopje, 2006.
23. Tozija F. Violence and injury prevention and safety promotion in Macedonia: evidence-based policy intervention. Archives of Public Health, 2009. 1;1:39-46.
24. Household Budget Survey. State Statistical Office, Skopje, 2010.
25. Tozija F. Gjorgjev D. Impact assessment of the global financial crisis on the socioeconomic determinants and the health of population in Macedonia. Friedrich Ebert Stiftung. Рев. за соц. пол. год. 2 Бр. 4 Стр. 319 – 338, Скопје