Gaining Health

Analysis of policy development in European countries for tackling noncommunicable diseases

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WORLD HEALTH ORGANIZATION
EUROPE

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Abstract

There is no greater threat to the health of people in the WHO European Region than that of noncommunicable diseases, yet this is an area where the greatest health gains are available at relatively modest cost. This book gives a detailed insight into the policy development in eight European countries over several decades to address the challenge of noncommunicable diseases, and draws out the main themes to assist policy-makers in formulating their own response. While originally developed to support countries in the implementation of the WHO European Strategy for the Prevention and Control of Noncommunicable Diseases, the insights are likely to be of benefit to a much wider audience.

Keywords

CHRONIC DISEASE - prevention and control
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Abbreviations

The abbreviations shown below are those of a general nature that are used in the book. Others pertaining to individual countries are explained under the relevant case studies.

AGE	European Older People's Platform
BSE	bovine spongiform encephalopathy
CDC	Centers for Disease Control and Prevention
CHD	coronary heart disease
CINDI	countrywide integrated noncommunicable diseases intervention (programme)
CSR	corporate social responsibility
CVD	cardiovascular diseases
DALYs	disability-adjusted life-years
DFID	United Kingdom Department for International Development
ECHO	European Commission's Humanitarian Aid Office
ECHI	European Community Health Indicators
EFTA	European Free Trade Association
ENHPS	European Network of Health Promoting Schools
ENWHP	European Network for Workplace Health Promotion
EPIC	European Prospective Investigation into Cancer and Nutrition
EU	European Union
EU15	the 15 countries belonging to the EU before May 2004
FCTC	WHO Framework Convention on Tobacco Control
G8	Group of Eight
GDP	gross domestic product
GHPS	Global Health Professional Survey
GNP	gross national product
GP	general practitioner
GYTS	Global Youth Tobacco Survey
HIA	health impact assessment
IAEA	International Atomic Energy Agency
IARC	International Agency for Research on Cancer
IUHPE	International Union for Health Promotion and Education
KRIS	Kaunas-Rotterdam Intervention Study
MDGS	Millennium Development Goals
MONICA	Multinational Monitoring of Trends and Determinants in Cardiovascular Disease
NAP	national action plan for social inclusion
NCD	noncommunicable diseases
NGO	nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
OMC	EU's open method of coordination
PHARE	Assistance for Economic Restructuring in the Countries of Central and Eastern Europe
PHC	primary health care
PPP	purchasing power parity
SDR	standardized death rate
USAID	United States Agency for International Development

Foreword

There is no greater threat to the health of people in the WHO European Region than that of noncommunicable diseases (NCD), yet this is an area where the greatest health gains are available at relatively modest cost. An upstream focus on the social determinants of health and prevention of risk factors common to several NCD, as well as more widespread implementation of effective interventions for managing disease, is likely to bring considerable benefit to the health and well-being of society.

At the fifty-sixth session of the WHO Regional Committee for Europe, Member States unanimously endorsed the WHO European Strategy for the Prevention and Control of Noncommunicable Diseases. This book derives from their request to the WHO Regional Office for Europe to support Member States in the implementation of the Strategy through, among other things, facilitating the exchange of information on evidence and best practice with a focus on policy development and implementation.

Through a set of case studies, this book analyses policy development in eight countries over several decades to address the challenge of NCD, and then develops the main themes from these and elsewhere in order to broaden understanding of the policy-making process and conditions that influence it. I welcome this approach and am convinced that this book will provide an invaluable resource for policy-makers in formulating their own response. Although Europe is diverse, and capacities differ, it is possible for all countries across the Region to effectively combat NCD.

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Preface

The WHO European Strategy for the Prevention and Control of Noncommunicable Diseases, endorsed by WHO European Member States in 2006, was a landmark strategy in a number of ways. First, it was prepared over a period of almost two years in what was described as "a unique participatory and transparent manner".[1] Fifty-one countries appointed national counterparts specifically to work with WHO on its development, drawing on expertise from the fields of health policy, public health, health promotion, disease prevention and clinical medicine. A drafting group with participants from eight countries was appointed, meeting nine times and developing three drafts for consultation.

Second, the Strategy took an integrated approach to prevention, focusing on social determinants of health and risk factors common to several noncommunicable diseases (NCD). Prior to this, WHO strategies and action plans had largely focused on individual risk factors. Third, it was one of the most comprehensive strategies that the WHO Regional Office for Europe had produced. During the consultation process, countries said that they wanted a strategy that was comprehensive and balanced and that covered health promotion, disease prevention and health care in one strategic framework, pushing the action upstream and making the reduction of inequalities in health an integral part of all policy measures.

By 2006, European countries already had a number of policies and programmes in place of direct relevance to the prevention and control of NCD. While the Strategy did not intend to repeat or replace what already existed, the challenge was to pull these together towards a common goal, within a coherent and mutually reinforcing framework.

The present piece of work was born out of this challenge, and sought to find answers to the questions so often posed by countries. What is an NCD policy in reality? Is an overall, integrated NCD policy necessary? Are there certain basic prerequisites for the successful development of NCD policy? Furthermore, this work set out to explore the evolution of policies in countries over time. How does a country develop a comprehensive approach to tackling NCD? While we had information from surveys of countries on the range of policies and programmes in place, these were just snapshots and the richness of the picture was missing. How and why had this present collection come about? How did these different instruments work together? Where should a country start? And what experience was available from other countries to assist them? We are grateful to the authors in taking up this challenge and for their hard work and enthusiasm in working to find answers to these questions.

We also gratefully acknowledge the contributions of those who participated in meetings of an ad hoc Advisory Group held in Copenhagen in August 2006 and February 2007 and in London in December 2007 to discuss the approach, direction and content of individual draft chapters of the book. These were, in addition to WHO staff and the chapter authors, Fiona Adshead, Maggie Davies, John Devlin, Robert Geneau, Vilius Grabauskas, Jeroen Hulleman, Paul Lincoln, Owen Metcalfe, Larissa Mylnikova, Richard Parish, Bosse Pettersson, Mike Rayner, Sheela Reddy, Graham Robertson, Sylvie Stachenko, Alban Ylli and Jozica Maucec Zakotnik.

The generous support of the Department of Health for England is gratefully acknowledged. Particular thanks go to Fiona Adshead, then Deputy Chief Medical Officer in the Department, for hosting the London meetings and to Maggie Davies and Chris Brookes for assisting in their organization.

[1] Statement of the European Union to the fifty-sixth session of the WHO Regional Committee for Europe, September 2006.

This work would not have been possible without a grant from the Public Health Agency of Canada, funded under the Population Health Fund. Technical support from the WHO collaborating centre on noncommunicable disease policy at the Public Health Agency of Canada is also thankfully acknowledged.

We should especially like to thank the respondents in the eight case-study countries who so generously gave of their time and expertise and shared their experiences openly and frankly. In the interests of confidentiality, these respondents have not been named but it is their knowledge and experience that has provided the foundation for this piece of work. Here, we would also acknowledge the contributions of the WHO country offices, ministries of health and NCD counterparts in facilitating the collection of material for the case studies.

We also gratefully acknowledge the time taken by Bosse Petersson and Robert Geneau to review the penultimate draft of this book, which has benefited greatly from their very helpful comments and suggestions.

Efforts were made during the development of this book to link with other relevant work under way in WHO and to share understanding as it developed. In this context we are please to thank Mathilde de Bruin, Gauden Galea and Ruitai Shao at WHO headquarters; Maria Haralanova, Mike Sedgley, Aushra Shatchkute and Ursula Truebswasser at the Regional Office; and Dévora Kestel at the WHO Country Office, Albania.

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Jill L. Farrington
Editor

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Chapter 1
Introduction

Péter Makara

The greatest disease burden in Europe comes from noncommunicable diseases (NCD). In 2005 *(1)*, an estimated 86% of deaths and 77% of the disease burden[1] were caused by NCD, a broad group of conditions linked by common risk factors, underlying determinants and opportunities for intervention.

At its fifty-forth session in 2004, the WHO Regional Committee for Europe acknowledged the importance of the problem *(2)*. It charged the WHO Regional Office for Europe with developing a comprehensive, action-oriented strategy for the prevention and control of NCD in the WHO European Region, to be presented at its fifty-sixth session in 2006.

The resulting document, entitled *Gaining health: the European Strategy for the Prevention and Control of Noncommunicable Diseases (3)*[2] was endorsed by the Member States in 2006 *(4)*. It is integral to the updated Health for All framework *(5)* and takes account of existing Member States' commitments through WHO ministerial conferences, relevant strategies and resolutions,[3] as well as the experience gained through the countrywide integrated noncommunicable diseases intervention (CINDI) programme.

The European NCD Strategy promotes a comprehensive and integrated approach to tackling NCD. Its objectives are to combine integrated action on risk factors and their underlying determinants across sectors with efforts to strengthen health systems with a view to improving prevention and control. The Strategy puts forward a framework for action to assist countries in formulating their response to NCD, building on strategies and actions already in place and encouraging them to assess and refine existing approaches. It is guided by six key messages: the importance of prevention throughout life, the value of health-supporting environments, the need for health services to be fit for their purpose, the empowerment of people as active partners in promoting health and managing disease, and the crucial role of government in building intersectoral policy and facilitating access. While recognizing the diversity of European countries and the variety of resource/capacity levels and challenges faced, it nevertheless sees an effective response to be within the reach of all.

To support Member States in implementing the Strategy, the Regional Office was requested, through the accompanying resolution, to facilitate an exchange of information on evidence and best practice, and to establish a monitoring mechanism to measure progress in policy development and implementation and their related impact on health development *(4)*. A network of national counterparts was to be established as an international resource and advisory mechanism to support this work.

Within this framework, the then Coordinator, Noncommunicable Diseases at the Regional Office, Jill Farrington, initiated a qualitative review of NCD policies in selected European countries. The aim was to broaden understanding on NCD policy development and implementation within

[1] As measured by disability-adjusted life-years (DALYs).
[2] Hereinafter referred to in short as the European NCD Strategy.
[3] For a list of the relevant WHO strategies, action plans and ministerial conference declarations, see Annex 2 of the European NCD Strategy *(3)*.

the European Region, sharing experience and lessons learnt between countries and establishing a baseline for measuring progress over time. Initiated in the summer of 2006 and taking over 18 months to complete, the review was to include a number of interrelated components:

- a qualitative analysis of NCD policies and their development in a sample of countries (case studies);
- an overall analysis of the patterns and characteristics of NCD policy development in Europe according to the policy cycle;
- an overview of challenges and opportunities facing NCD policy development in the future; and
- development of advice to countries, tailored to context, with pointers for the future in NCD policy development.

The intention was to provide evidence-based practical guidance for decision-makers and civil servants in the field of NCD policy development and their interested partners. In the event, while leaving many questions open, the study uncovered a wealth of material that will support continued development of the implementation of the European NCD Strategy as a flexible policy framework, and provides a valuable learning experience for the further refinement of policy analysis skills.

The structure of the book is as follows.

Chapter 1. Introduction
This chapter gives the rationale for the study and an overview of the book.

Chapter 2. History and context of policies to tackle NCD
This chapter describes the key features of NCD policy development in the last two decades, the broader context and related policy initiatives.

Chapter 3. Methodology, underlying concepts and values
This chapter sets out why and how the original study was carried out, with an explanation of underlying concepts and values.

Chapter 4. Country case studies
The case studies describe NCD policy development in Albania, Finland, France, Greece, Hungary, Ireland, Kyrgyzstan and Lithuania. These eight countries were selected to provide reasonable geographical coverage and to include countries at different levels of economic development and with a range of political, administrative and health care systems and length of NCD policy experience.

Chapter 5. Reflections on experiences
Drawing on cross-analysis of the case studies and other sources, this chapter reflects on country experience throughout the policy cycle, presents the lessons learnt, and illustrates how different stakeholders and NCD issues influence the development of policies.

Chapter 6. Pointers for the future
Leading on from the conclusions of the analysis, this chapter offers countries valuable pointers on moving forward within the framework of the European NCD Strategy and also alerts them to emerging challenges and opportunities for NCD policy development in the future.

This book should be of use to those in health administration interested and/or in a position to influence NCD policy development, their colleagues in other sectors and departments whose work may impinge on health, and decision-makers at national, regional and local levels who must take action for health and development. While not primarily written for an academic audience, the book is also likely to be of interest in academic and research circles and prove useful for teaching purposes.

It is hoped that much of the material presented will be part of a European dialogue and debate about the way forward in substantially reducing the threats posed by NCD and related inequalities in health.

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Chapter 2

History and context of policies to tackle NCD

Péter Makara & Jill L. Farrington

The historical origins and the period of pilot projects

Before analysing policies for tackling NCD that exist in Europe today, we would do well to look to the past for guidance and a better understanding of their origins. The historical development of the NCD policy process was initiated by basic changes in health status in Europe and the new prevailing role of NCD in morbidity and mortality statistics. A new epidemiological era started, bringing with it challenging new public health approaches.

After the identification in the 1950s of tobacco smoking as the principal cause of lung cancer, other major risk factors for NCD became known, mainly in the 1960s and the early 1970s. The evidence that epidemiologists generated on the role of risk factors influencing health problems and their magnitude was impressive. The results of experimental and observational studies in the 1970s, guided partly by WHO, led to evidence-based preventive interventions and increased the direct impact of epidemiology on policy decisions. The first pilot projects, such as that in North Karelia *(1)* and Heartbeat Wales are still pioneering examples of good practice and are referenced in most policy documents on NCD prevention.

The combination of developments in epidemiology, the American approach to setting national health objectives (1980) *(2)* and the Lalonde "health field" concept (1974) *(3)*, which emphasized the interaction between lifestyle and environment, human biology and the health services, contributed to new approaches in health policy thinking.

This shift began to occur around an important WHO global meeting at Almaty (then Alma-Ata) in 1978. The Declaration of Alma-Ata *(4)* formally promoted primary health care (PHC) as the most important mechanism for health care delivery. The Declaration recognized that health improvement should not occur just by developing more health services or by imposing public health solutions in a top-down way. It called for a shift in power from the providers of health services to the consumers of those services and the wider community. This way of thinking stimulated WHO in 1981 to prepare a Global Strategy for Health for All with a series of clear objectives. The Regional Office produced 38 targets for the European Region to complement the Global Strategy *(5)*. These targets were endorsed in 1984 and motivated policy-makers to think rationally about health policy development. The strategy was broadly used as a tool to improve health policy and the methods and structures required to bring about significant improvements in population health. By the early 1990s, most of the governments in Europe had adopted broad policies of the Health for All type.

With the use of targets, efforts to monitor and evaluate consistent activities also increased. More specific epidemiological data on various problems and population groups

were collected. This monitoring of health gains initiated country-specific and international cooperative activities in epidemiological research and surveillance, such as the WHO MONICA (Multinational MONItoring of Trends and Determinants in CArdiovascular Disease) Project *(6)*. The development of the European Health for All database has to be mentioned among the most important initiatives taken in this framework. This is also the context for launching the CINDI programme.

The CINDI programme

Under the leadership of WHO, existing databases on coronary heart disease prevention were used to demonstrate the commonality of lifestyle-related risk factors to a number of NCD. At a WHO meeting in 1981, the concept of an integrated approach to the prevention and control of NCD was formulated, based on growing evidence that major NCD, such as heart disease, stroke, cancer, chronic respiratory disease and diabetes, shared common risk factors such as tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol. This pioneering idea was followed up and in 1982/1983, together with a group of European Member States (later joined by Canada), the Regional Office established the CINDI programme *(7)*. CINDI addresses NCD through integrated action on common risk factors and draws together actors from health and other sectors in health promotion, disease prevention and health care. Every CINDI participating country tests preventive efforts at the local level through demonstration areas that are later scaled up for implementation at national level. For effective monitoring and evaluation of community-based interventions within and between participating areas and countries, CINDI developed innovative tools, methodologies and mechanisms. Monitoring and programme evaluation are carried out at agreed intervals, their aim being to monitor risk factors and health trends in participating countries and allow comparative analysis *(8)*.

Today, the CINDI network comprises 29 fully participating countries (28 Member States of the WHO European Region and Canada) and 3 candidate countries.[1] While CINDI country programmes began at different points in time, making it difficult to estimate their overall success, there is no doubt that CINDI contributed to disseminating the concept of a need for policies to tackle NCD at national and community levels and increase public awareness on the issue. CINDI also offered a number of examples of good practice in project implementation through the successful and sustainable integration of the CINDI concept into the health system. Over more than two decades, a considerable body of evidence has been accumulated of what works in different countries and what requires further development in terms of NCD policies and approaches.

The new public health and health promotion

In the early 1980s, the term health promotion was becoming increasingly used by a new generation of public health experts who were dissatisfied with the traditional top-down approaches of "health education" and "disease prevention". Health promotion was conceived as a positive, creative and outcome-oriented approach.

On the initiative of the Regional Office, an important activity started to clarify the concept. The first product of this process was the publication in 1984 of a document outlining the concepts and principles of health promotion *(9)* and the most important milestone was the Ottawa Conference and Charter in 1986 *(10)*.

The key achievement of the Ottawa Charter for Health Promotion was to shape the vision of health promotion by clarifying the basic concepts, highlighting the conditions and resources required for better health and identifying key ac-

[1] Further information on the CINDI programme is available at http://www.euro.who.int/CINDI.

tions and strategies to achieve the basic aims of promoting health. The Charter also identified prerequisites for health, highlighted the role of organizations, systems and communities as well as individual capacities and types of behaviour in creating choices and opportunities for better health. Since then, WHO has organized follow-up conferences focusing on the five key areas of the Ottawa Charter.

The Ottawa Charter stimulated further development of social epidemiology and put a new focus on the basic issue of health inequalities. New experiences of intersectoral cooperation started at government and local levels in the second half of the 1980s. The decade after the Ottawa Conference was a period of gaining experience in the institutionalization and implementation of different policies tackling NCD and the important process of capacity-building – developing the financial, organizational and human resources for health promotion and disease prevention. As an implicit effect of the Ottawa Charter, a new divide emerged between the concepts and practices of health promotion and disease prevention. This often led to conflicts of ideologies and practical interests and competition for power and resources between the two ways of thinking.

Recent developments

With the new millennium, it became more and more apparent that the world is changing fundamentally and this includes our understanding of the ways of making policy and tackling the determinants of health. New opportunities and challenges have emerged that were unpredictable at the time of the Ottawa Conference.

The Sixth Global Conference on Health Promotion was organized in Bangkok in 2005. It was structured around four thematic tracks: new context, health-friendly globalization, partners and sustainability. It became clear that building capacity to promote health goes beyond community and skills development: it includes local and global policies, partnerships and alliances, finance and information systems and trade considerations. In the Bangkok Charter for Health Promotion in a Globalized World *(11)*, four new commitments were identified, making the promotion of health: (*a*) central to the global development agenda; (*b*) a core responsibility of all governments; (*c*) a key focus of communities and civil society; and (*d*) a requirement for good corporate practice.

Over the two decades since the Ottawa Conference, there have been major shifts in thinking, policy and actions for better health at local, national and international levels. Important changes can be summarized as follows.

- A new conceptual framework has been elaborated for tackling social and economic determinants of inequalities in health in a more differentiated and efficient way.
- A new emphasis has been placed on health policy approaches based on the settings of everyday life, such as the city, workplace and school.
- New concepts and practices have been developed for linking health and development and focusing on the assets of a given country or community in health policy-making.
- A large number of upstream policies, centred on the social and economic determinants of health, have been developed with success.
- New focus has been placed on the importance of health issues in early childhood.
- New technologies and ways of communication have been introduced for innovative practices in health policy-making and health communication.

By the start of the 21st century, a new comprehensive and balanced approach for improving health became generally accepted, looking at the issues of health promotion, disease prevention and health-oriented health services in a more coherent way.

During the late 1980s and the 1990s, the Regional Office placed strong emphasis on health promotion and pioneered the development of the settings approach to health promotion. During this time, the Regional Office took a more upstream approach to tackling NCD, with increased focus on the determinants and common risk factors causing, or influencing the course of, these diseases. The first European Conference on Tobacco Policy was organized by the Regional Office in 1988 and was followed by three consecutive action plans for a Tobacco-free Europe spanning the period 1987–2001, leading to the adoption of the European Strategy for Tobacco Control in 2002. Similarly, there were three phases to the European Alcohol Action Plan, beginning in 1993 and leading to the launch of the Framework for Alcohol Policy in the WHO European Region in 2005. The first food and nutrition plan for Europe was endorsed in 2000 and later renewed in 2007 as an Action Plan for Food and Nutrition Policy. In 2006, the Regional Office organized the Ministerial Conference on Counteracting Obesity together with the European Commission.

At the global level, the importance of prevention and of tackling the risk factors to which much of the disease, disability and death in the world could be attributed was underlined by *The world health report 2002*. The Global Strategy on Diet, Physical Activity and Health was adopted at the World Health Assembly in 2004. The WHO Framework Convention on Tobacco Control (FCTC), which entered into force in 2005, was the first treaty negotiated under the auspices of WHO, addressing a major public health challenge through a regulatory strategy.

During the current decade, there has been increasing consensus that stronger health systems are the key to achieving improved health outcomes and the best use of available resources. *The world health report 2000* considered how well health systems carry out four vital functions: stewardship (influencing, formulating and implementing policy); financing (raising revenues, pooling funds and purchasing services); resource generation (creating human resources, infrastructure and consumables); and service delivery (efficiently producing high-quality and accessible personal and non-personal services). Narrowing the disparities in health system performance between countries was a theme of the Ministerial Summit on Health Research, convened by WHO in 2004. In the European Region during the current decade, there has been recognition of the need to strengthen health systems, with the second phase of the Regional Office's country strategy focusing on this aspect and on the preparation of the WHO European Ministerial Conference on Health Systems held in 2008.

Review of prevention and control of NCD in Europe

In 2000, the World Health Assembly endorsed the global strategy for the prevention and control of noncommunicable diseases. To assess the capacities and policies of countries to respond to NCD and to learn how best to assist them, WHO carried out a survey of the Member States in WHO regions during 2000/2001. The survey was later repeated during 2005/2006 *(12)*.

The survey results provide a snapshot of the European situation just prior to the launch of the European NCD Strategy. Thirty-eight European countries responded to the 2005/2006 survey, while 30 responded to both surveys. Key findings of the survey for European respondents are as follows.

Of the countries responding in 2005/2006, 74% had a national health policy relevant to the prevention and control of chronic diseases.[2] Of those responding to both surveys, the proportion having such a policy rose from 57% to 83% over the five-year period.

[2] For the purposes of this survey, the term "chronic diseases" was taken to be synonymous with "noncommunicable diseases".

- Of the countries responding in 2005/2006, 71% reported that they had national targets for chronic disease prevention and control.
- There is an increasing tendency for having a national action plan for tobacco control, diabetes, heart disease and cancer. The proportion of countries responding to both surveys that had such an action plan increased by 40%, 14%, 13% and 17%, respectively, over the five-year period.
- Almost two thirds of the countries had become contracting parties to the WHO FCTC and 24% were already under way with plans for implementation.
- Of the countries responding in 2005/2006, 92% reported that they included chronic diseases in their annual health reports.
- Of the 30 countries responding to both surveys, the proportion having a routine surveillance system for chronic diseases increased 10% between 2000/2001 and 2005/2006 to 84%.
- Most countries responding in 2005/2006 reported having national or provincial studies or surveys of the risk factors tobacco use, unhealthy diet, physical activity and alcohol consumption (87%, 84%, 82% and 84%, respectively).
- Nearly two thirds of the countries responding in 2005/2006 had established a national demonstration programme for integrated chronic disease prevention and control.
- A large proportion of responding countries in 2005/2006 reported having national protocols, guidelines or standards for hypertension, diabetes, heart disease and cancer (79%, 82%, 74% and 82%, respectively).
- The proportion of countries responding to both surveys that had a specific budget for implementing a national policy or strategy for chronic disease prevention and control rose from 50% in 2000/2001 to 73% in 2005/2006.

The main characteristics of NCD policies, programmes and legislation in place in European countries, based on the replies submitted by 38 countries, are summarized in Table 1.

Thus, at the time of the development and launch of the European NCD Strategy, the NCD policy field in European countries already appears to have been rich in "vertical" issue-specific national policies and programmes as well as more "horizontal" or "umbrella" policies and programmes relevant to chronic disease prevention and control as a whole.

The results of the survey indicate clearly the opportunities but also the limits of such a quantitative approach. While the survey had measured the quantity of policies and programmes present in a country, it could not indicate their quality or their success in implementation, or explain how or why they had evolved in such a way over time and their interrelationships. The case studies presented in Chapter IV aim to provide deeper, more refined qualitative data and information on the assessment of Member States' policies and capacities to respond to NCD.

Gaining health

The WHO Regional Committee for Europe, at its fifty-fourth session in 2004, while acknowledging the extensive work and experience already existing in the European Region, pointed out the lack of and need for a strategy for NCD prevention and control in Europe. Such a strategy needed to take an integrated approach across the continuum of health promotion, disease prevention, rehabilitation and health care, and should draw on Member States' existing relevant commitments, such as the various resolutions alluded to above on risk factors and determinants. For such an ambitious strategy and complex task, there then began an extensive consultation process with countries, experts, nongovernmental organizations (NGOs) and other stakeholders for its development.

Table 1. Range of NCD-relevant policies, programmes and legislation in place in European countries

	National health policy	Specific national programme	Specific national legislation
NCD prevention and control	28	28	—
Tobacco control	28	25	37
Nutrition/diet	24	20	35
Physical activity	19	17	13
Alcohol control	19	17	28
Hypertension	15	16	—
Diabetes	20	29	—
Heart disease	20	20	—
Stroke	17	14	—
Cancer	23	23	—
Chronic respiratory disease	13	10	—
Other chronic disease	10	10	—

Source: WHO Regional Office for Europe *(13)*.

The European NCD Strategy was endorsed in September 2006 at the fifty-sixth session of the Regional Committee. The guiding principles of the document are derived from those of the HFA policy framework for the WHO European Region, which can be summarized as follows:

- achievement of full health potential;
- addressing of inequalities – closing the health gap between and within countries;
- active participation of the population;
- multisectoral strategies and intersectoral investment; and
- the health impact of different sectors.

The European NCD Strategy promotes a comprehensive and integrated approach to tackling NCD. It simultaneously promotes population-level health promotion and prevention programmes, actively targets groups and individuals at high risk, and maximizes population coverage of effective treatment and care while systematically integrating policy and action to reduce inequalities in health. The goal of the Strategy is to avoid premature death and significantly reduce the disease burden from NCD, improving quality of life and making healthy life expectancy more equitable in Europe within and between Member States. The objectives of the Strategy are to combine integrated action on risk factors and their underlying determinants across sectors with efforts to strengthen health systems to improve prevention and control *(13)*. The present NCD policy analysis is in fact an integral part of the Strategy implementation process.

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Chapter 3

Methodology, underlying concepts and values

Anna Ritsatakis

This chapter discusses why and how the present study was designed and carried out. Rather than simply providing a glossary, the basic concepts and values underlying the study are also discussed within the body of the chapter for three main reasons: to ensure a common understanding of terms used throughout the study; to offer a deeper insight into the thinking behind the study design; and to provide essential information for policy-makers intending to assess their own processes for NCD policy development.

Objectives of the study

This study was carried out in the framework of the European NCD Strategy *(1)*. It is part of a broad package of products and actions being developed to promote a comprehensive approach to tackling NCD in European countries.

Following on the WHO global survey on the progress in national chronic diseases prevention and control, referred to in Chapter 2 *(2)*, the present study was expected to explore NCD policy development in Europe in greater depth. Its main objectives were to:

- carry out a qualitative analysis of NCD policies and their development in a sample of countries;
- provide a general analysis of the patterns and characteristics of NCD policy development experience in Europe, based mainly on the sample countries; and
- draw conclusions, learn lessons and identify challenges and opportunities that could prove useful to other countries as they attempt to tackle NCD.

Setting up and designing the study

The study was conceived in mid-2006 by the then Coordinator, Noncommunicable Diseases at the Regional Office, Jill Farrington. Two principal researchers (Péter Makara and Anna Ritsatakis), both experienced in international and national health policy development, implementation and analysis, were commissioned to carry out the task. Their work was supported by policy analyst Zsófia Németh.

The work was steered by the programme of noncommunicable diseases at the Regional Office, assisted by an advisory group of experts, academics and national counterparts drawn from countries within and outside the study. This group met together with WHO staff and the researchers four times from August 2006 to December 2007 to: discuss and advise on the methodology and approach; review the draft case studies and the preliminary steps towards a synthetic analysis; and comment and advise on the draft conclusions of the synthetic analysis.

The work was supported by the WHO collaborating centre on noncommunicable disease policy in Ottawa, Canada and

co-funded by the Public Health Agency of Canada and the Department of Health in the United Kingdom (England).

The present study was to complement those quantitative surveys on NCD policy and their risks factors previously carried out by WHO at the global and European levels, using qualitative research methods to go deeper into the NCD policy development process in a small number of countries. In particular, the interviewing of key informants was expected to uncover aspects of policy development that could not be obtained in other ways.

Selecting the country case studies

The intention was to include countries from different parts of the WHO European Region, ensuring examples of countries with a long history of systematically tackling NCD and some relative beginners. The following criteria for country selection were therefore agreed:

- a reasonable geographical distribution;
- different levels of economic development across Europe;
- a range of political, administrative and health care systems; and
- different lengths of NCD policy experience.

Time and financial resources indicated that no more than eight case studies could be carried out. For practical reasons, the researchers' countries of residence influenced the choice of Greece and Hungary as central and southern European countries. This opportunistic selection was strengthened by the fact that these two countries offered examples of relatively early and late beginners and different health systems.

The following eight countries were therefore selected: Albania, Finland, France, Greece, Hungary, Ireland, Kyrgyzstan and Lithuania.

Designing the case studies – scope and dimensions

In defining the scope and dimensions of the proposed case studies, the researchers were mindful of the fact that the main aim was to use these as a source of information and experience from which countries across Europe might learn. It was necessary therefore to be clear about certain concepts.

What is meant by policy development?

For practical purposes, the term policy was defined as "an agreement or consensus on the issues, goals and objectives to be addressed, the priorities among those objectives and the main directions for achieving them" *(3)*.

Government policy, which is the main concern of this study, is manifested in many ways. It may be discerned, from the provisions of acts of parliament, local by-laws and regulations, or be seen to evolve as the result of incremental administrative decisions or regulations *(4)*. Even the lack of a discernable policy statement may be considered a policy in the sense that it indicates a lack of interest in a particular issue. Policy aims and objectives are frequently stated in published "policy documents".

In policy/planning terminology, a "strategy" or "action plan" is more specific than a policy, and defines the broad lines of action to achieve policy goals and targets. In practice, countries frequently use the terms policy, strategy and action plan interchangeably. For reasons of practicality, in this study the central focus is on published policy or strategy documents.

The intention was not to analyse the content of such policy documents in detail but to check how far they related to NCD prevention and control, and briefly to examine the range of policy instruments used, such as:

- legislation and regulatory measures
- structural, administrative and management measures
- financial instruments
- consultation and negotiation
- human resource development
- research and information
- awareness building and health education
- monitoring and evaluation.

The focus of the research was not restricted to the "formulation" of such documents but covered the whole policy development process through which issues reach the policy agenda, policies are formulated and implemented, and provisions are made for monitoring and evaluating progress and moving on.

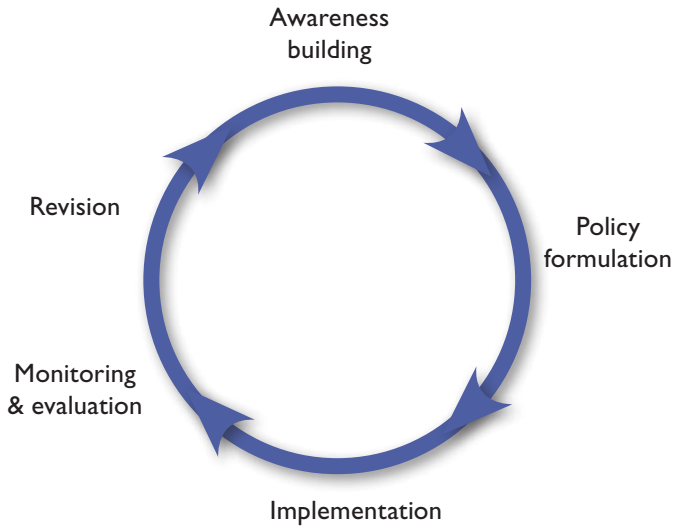
Policies are influenced by individuals and groups and the policy process is determined by the power relations between them, their converging or conflicting interests, and how these are resolved *(5)*. Policy-makers can be influenced by various factors: the available evidence; the ethos of public service; the limits of resources; the promise of innovations; the policy environment; and politics *(6)*. It was this dynamic process that the research intended to address.

Structure for the case studies

On the basis of the researchers' experience and the related literature, it was clear that health policy development can be affected positively or negatively by the general policy environment at any given time. A brief examination of the socioeconomic and political context in which NCD policy was developed was therefore to be the first step.

To emphasize the dynamic nature of policy development, the stages of the policy development cycle (awareness building, policy formulation, implementation, monitoring, evaluation and revision) were used to structure much of the information presented in the case studies (Fig. 1).

Fig. 1. Policy development cycle



At each stage of policy development, the following factors were to be examined:

- the processes, structures and institutions utilized
- the information, expertise and skills available
- the people involved.

This seemingly neat, linear form was adopted simply to analyse coherently the information collected. It was not by any means intended to give the impression that policy development is a linear or neat and tidy process. In real life, policy objectives may have already been discussed, for example, before the formal decision to formulate a policy is taken, and participation in policy formulation is said to be the first step in implementation. In fact, developing policies to tackle NCD is frequently a messy and chaotic process of checks and balances between different power bases and stakeholders. As expressed elsewhere *(7)*, "decision-making is not a rational, logical process in which information and research

determine policy outcomes, but a highly political process in which power and interest are the main driving forces".

Partly because of the non-linearity of real life, and of issues that cut across all stages of the process, some of the stages of the policy cycle were merged so as to avoid repetition when presenting the findings of the case studies.

Types of policy for tackling NCD

The European NCD Strategy *(1)* defines NCD as:

> a group of conditions that includes cardiovascular disease, cancer, mental health problems, diabetes mellitus, chronic respiratory disease and musculoskeletal conditions. This broad group is linked by common risk factors, underlying determinants and opportunities for intervention.

The focus of the European NCD Strategy, and consequently of the case studies, was therefore on how countries tackle these diseases, excluding other noncommunicable conditions such as accidents.

The results of the WHO survey *(2)* indicated that European countries tackle NCD through a wide range of policies, implemented at different levels of authority and in different settings. These include:

- broad or "umbrella" health policies
- public health and health promotion policies
- health services policies
- issue-specific policies (dealing with specific diseases or health risks)
- levels and settings of policy development
- general policies with a health component.

It was clear, therefore, that the case studies would need to examine this wide range of policies. To ensure a common understanding of terms used and the different types of policy of concern, these are briefly described below. Broad or "umbrella"-type policies could be found under different headings in different countries, including policies for health for all, public health, health promotion, health systems or health care. They were variously labelled as policies, programmes, plans, strategies or resolutions, according to the usual usage in the country (and the translation from the original language version). These "categories" are frequently overlapping or blurred. "Umbrella"-type policies may be formulated at national, regional or city levels.

Since the adoption in the mid-1980s of the WHO European Health for All targets *(8)*, many countries have developed their own Health for All policies at national, regional and/or city levels. A Health for All policy is defined as one "based on principles of equity and democratic participation in decision-making. It deals with issues of lifestyles, environment and health care" *(9)*. Thus a Health for All policy is perhaps the broadest type of health policy and, most importantly, is based on explicit values or, as expressed in the 2005 update of the WHO European Health for All policy *(10)*, is "values-based, values-driven".

In the context of the 2005 update, 52 national health policies were analysed according to four criteria *(10)*:

- the policy commits itself to the goal of Health for All in a document;
- it introduces a multisectoral perspective;
- it is explicitly values-oriented; and
- it includes health targets.

Forty policies satisfied all four criteria.

It can be difficult to distinguish between "public health" and "health promotion" policies, and in practice it is frequently a question of labelling in a particular country. Over the years, the focus of public health has expanded from what might be called issues of "hygiene" (mainly providing clean water, sewage disposal and protection from communicable diseas-

es) to health education and disease prevention and through to health promotion. This has been called "the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. An evolving concept that encompasses fostering lifestyles and other social, economic, environmental and personal factors conducive to health" *(9)*. The main definitions of health promotion proposed over the last 30 years or so *(11)* are said to differ not so much in substance as in perspective and emphasis. Two decades after the adoption of the Ottawa Charter *(12)*, however, the proposed five areas for action (building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; reorienting health services) are still considered relevant *(13)*.

In some countries, the main emphasis is still on health care policies, dealing mainly with the balance of primary, secondary and tertiary health care and their organization, management, financing, staffing and appropriate distribution. These may or may not deal with issues specifically related to tackling NCD.

According to the WHO survey *(2)*, in many countries the starting point for tackling NCD has been through policies dealing with specific diseases, most notably cardiovascular diseases (CVD) and cancer. More recently, a number of countries have developed policies to deal with diabetes and mental health.

Efforts to deal with the main NCD risk factors have an extremely long history in some countries, particularly those for controlling the use of tobacco and alcohol. Nutrition policy is also high on the agenda in most countries. Policies for social groups such as women or older people can also have strong health components and specific reference to NCD.

Finally, and particularly under the influence of the European Union (EU), the World Bank and other funding or donor agencies, countries have been preparing more general development policies, some of which have a health component or are particularly concerned with determinants of health such as poverty and social exclusion. In most EU countries, the link between development and inequalities in health has been recognized, although data limitations for measuring progress are considerable *(14)*. The poverty reduction strategy initiated by the World Bank in 1999 indicates a possibility for including health-related components *(15)*. Recognizing the increasing impact of NCD, the World Bank recently stated *(16)* that "depending on country requests, the Bank will consider increasing its support for country-led efforts to prevent and control NCDs. This will be done within the context of both health sector and multisectoral programs that affect NCD outcomes".

Particularly for EU countries, the inter- or intranational level of policy-making is increasingly important for NCD policy development.

It was clear from the outset, therefore, that the process of tackling NCD in countries was extremely complex. On the one hand, there was a need to do justice to the broad range of possible policies for tackling NCD and, on the other, to keep the work within feasible limits. It was therefore agreed that the central focus should be on national-level policy development while taking a bird's eye view of possible involvement at both supranational and subnational levels.

Given the time and resource constraints, as a "minimum set" the following policies were to be examined, where they existed, in each of the eight countries:

- a national "umbrella" health policy, as the main focus of attention;
- policies for heart health and cancer;
- tobacco use and nutrition as risk factors, the first in view of the WHO FCTC and the second as a typically intersectoral issue involving many partners;

- policies for older people, as an example of policies for social groups;
- the "settings" approach, to be referred to briefly and expanded where it appeared to be of particular interest in a country; and
- health components of general development policies, to be referred to briefly.

In addition, other NCD-related policies were to be included if time allowed and they appeared to be of particular interest. Finland and Greece requested that mental health be included, and this was accepted.

Values and principles underlying the process

Even when policy-making is backed by sound scientific evidence, an element of "value judgement" is involved, implicitly or explicitly. This is clear even in relation to choosing what evidence to use and present. Indeed, it has been suggested that evidence for policy-making is usually considered through an "evidence triangle" of good evidence, good theory and value judgement *(17)*.

What is important is that the values and principles governing NCD policy development are explicit and transparent, so that the personal values of those engaged in policy processes have less chance of covertly taking over. Explicit values and principles guide the policy-making process as to which choices may or may not be acceptable. Without this guide, the policy-making and planning possibilities and options would be too wide to handle technically *(18)*.

The WHO Health for All policy has influenced policy-making throughout Europe, and the European NCD Strategy *(1)* reaffirms its core values, stating that five key principles should guide policy development at all levels.

- The ultimate goal of health policy is to achieve the full health potential of everyone.
- Closing the health gap between and within countries (i.e. solidarity) is essential for public health.
- People's participation is crucial for health development.
- Health development can be achieved only through multisectoral strategies and intersectoral investments that address health determinants.
- Every sector of society is accountable for the health impact of its own activities.

It was therefore necessary to assess attempts to tackle NCD in the case-study countries through a specific set of values and principles. Although difficult to disentangle, it might be helpful to group the values on which NCD policies should be based and the principles guiding the approach to NCD policy development.

- *Equality in health, solidarity and participation* are the non-negotiable values relating to the rights of individuals and groups to reach their full health potential, to benefit from the solidarity of their fellow citizens, and to be involved in decision-making concerning issues that affect their health and well-being.
- *Accountability for the health impact of policies in all sectors,* together with *sustainability* and *effectiveness* of policy proposals, are principles relating to the obligation of society to be accountable for the impact of policies on health and to ensure sustainability, effectiveness and efficiency in the use of resources.
- *Intersectoral action, investing in health* across all sectors, including the health sector, and taking a *life course* and *gender* perspective, are principles to be followed in taking action to tackle NCD. To this group could be added *subsidiarity.*

Certain implications of basing NCD policy development on these values and principles are discussed briefly here, and readers are referred to WHO documentation for further details. With the creation of WHO, health was defined as a human right through the WHO Constitution *(19)*. The importance

of explicitly stating equality in health as an underlying value, and understanding its implications for policy development, was forcefully iterated through the WHO Health for All policy, for two main reasons: health is an end in itself, contributing directly to human well-being; and good health is an important factor enabling people to function fully in society. In the WHO European Region, the first of its 38 Health for All targets called on countries to reduce inequalities in health *(8)*. Drawing on WHO's subsequent publications *(20–22)* to elaborate the concept,[1] the following working definitions are used.

- Equality in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided.
- Equality in access to health care implies equal access to available care for equal need, equal utilization for equal need, and equal quality of care for all.

Although the available literature offers no general agreement on the way to conceptualize socioeconomic position *(26)*, socioeconomic differences are usually measured in terms of levels of education, income or occupation.

The WHO Commission on Social Determinants of Health, launched in 2005, defined equality in health as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically" *(27)*. Of particular interest for NCD policy development is the suggestion that both the range of differences in health within a population and the position of the most vulnerable should be tackled, and that priority should be given to those socioeconomic determinants that contribute significantly to the health gap.

[1] The WHO Healthy Cities programme has issued a guide for policy-makers at local level entitled *The solid facts (23)*, summarizing research around the main determinants of inequalities in health in a language accessible to policy-makers. Other documents *(24, 25)* present some of the latest thinking on incorporating the value of equity in health into policy-making.

Solidarity is usually interpreted as a society's sense of collective responsibility *(10)*. It implies that the vulnerable should be protected and no one should be deprived of the basic prerequisites to health owing to their inability to pay, including access to health care. The principle of solidarity remains strong in Europe and is behind many EU programmes. The results of Eurobarometer surveys of attitudes to population ageing in Europe indicate "a remarkably high level of consensus across the Member States that those in employment have a duty to ensure, through the contributions and taxes they pay, that older people have a decent standard of living" *(28)*.

The European Health for All policy states that "health for all will be achieved by the people themselves. A well informed, well motivated and actively participating community is a key element for the attainment of the common goal" *(8)*. This assumes that people have a right to participate in decisions that affect not only their personal health but that of the society in which they live. In the context of intersectoral action to combat NCD, this implies that multiple stakeholders should be involved in NCD policy development. Nevertheless, even when the political will is evident, wide participation in decision-making is easier said than done *(3)*. The most obvious challenges in partnership working include: ensuring a common language; understanding and respecting respective culture, values and objectives; facilitating participation; ensuring access to information; and building capacity, skills and opportunity for participation *(3)*.

Whether referring to the main risk factors for NCD – such as smoking and alcohol consumption, eating patterns and physical activity – or tackling the "causes of the causes", the factors influencing the way people live and the barriers to adopting a healthier lifestyle, there is no escaping the need for action across sectors. From recognizing this need, there has been a shift to stating more boldly that other sectors are themselves responsible for their possible impact on health, and must be held accountable. Countries are

developing methodologies for carrying out health impact assessment (HIA) *(29)*.

Article 152 of the Treaty of Amsterdam states that "a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities" *(30)*. This was reflected in the ensuing public health strategies and programmes for the European Community, which aim to tackle the underlying causes of ill health. Health in all policies *(31)* was given high visibility in 2006, when Finland made it the main theme of its EU presidency.

The principle of subsidiarity, defined in Article 5 of the Treaty establishing the European Community, is intended to ensure that decisions are taken as closely as possible to the citizen *(32)*. In tackling NCD, action should be taken at the lowest possible level, close to the citizen, counterbalancing what is frequently a top-down approach.

Socioeconomic status in childhood, as indicated by the parents' occupational class, frequently determines socioeconomic status in adulthood. Lifelong exposure to low socioeconomic status carries higher risks of ill-health than does such exposure for only one stage of life *(23)*. Many health-related types of behaviour, such as eating habits and smoking, are formed in childhood or adolescence. Specific life events, such as unemployment or the loss of a spouse, also have significant effects on health. Furthermore, the exposure of men and women and of people in different age groups to health determinants such as low income and unemployment differ considerably. Consequently, it is considered essential that NCD policies take a life course and gender perspective.

For these reasons, therefore, it was considered essential to examine the experience of NCD policy development in countries through the prism of such values and principles.

Carrying out the case studies

For countries for which information was available, the initial assessment was made on the basis of existing policy documents, related bibliographies and material available on the Internet. The first draft was submitted to key informants in the country for comments. In countries where such information is not yet well developed, interviews took place at a preliminary stage in order to provide the basic information for the first draft.

In all eight countries, information from written material was complemented by semi-structured interviews with key informants. A revised draft was then sent back to the countries to check for possible inaccuracies.

The key informants interviewed or providing comments on the drafts were mainly civil servants and experts in ministries of health and other organizations, academics and researchers (see Appendix 1). Members of NGOs were interviewed in an attempt to reach people outside the government system. Many of those interviewed had been directly involved in the development of the policies examined. Given the different phases and patterns of NCD policy development in the eight countries, the common outline for the semi-structured interviews was intended as a checklist of the main issues to be covered rather than a restrictive structure.

Data collection

Information from WHO

This included:

- responses by European countries to surveys carried out by WHO headquarters and the Regional Office on NCD policy and their risk factors;
- country profiles prepared by WHO, such as the Highlights on Health *(33)* and HiTs *(34)*;

- progress reports from countries involved in WHO networks, including those from the CINDI programme;
- the WHO European Health for All database *(35)*; and
- examples of national policy documents and unpublished reports from countries available in the Regional Office.

Information from countries
This included:

- published policy and strategy documents, mainly from ministries of health but also from NGOs;
- other published materials, such as scientific articles and reports, obtained from the countries and from Internet searches;
- unpublished materials, including mainly background material on the policy process provided by ministries of health; and
- results of the interviews with key informants.

Other sources
Country reports to the EU on various related issues were available for Finland, France, Greece, Hungary and Lithuania. Although the eight case-study countries were intended to provide the main source of information for the general analysis, given that the study is intended to aid policy-makers it was considered inappropriate to exclude relevant information from other countries. Policy documents from other countries were therefore also referred to and the source of such information is clearly referenced. No formal literature search was made, but extensive use was made of the Internet in searching for material on specific issues. The web sites of ministries of health and related bodies and NGOs were also extensively used.

Advantages and limitations of the process

As participants in a WHO project, the researchers had access to top-level policy-makers (see Appendix 1 for categories of key informant) and to unpublished background information that otherwise might not have been made available.

Much of the information on the process of policy development is in the heads of policy-makers and not otherwise recorded. The interviews with key informants proved vital in filling gaps, rectifying possible misunderstandings and providing further information on the why and how of events observed. Time and other resources for interviews, however, were limited in some cases.

Given the very different experiences in NCD policy development, it was not possible to follow a common outline in all case studies. Countries just embarking on the process had not yet reached the stages of implementation, monitoring and evaluation. In countries such as Finland, on the other hand, the information was overwhelming. This naturally created an imbalance in the length of the case studies. Nevertheless, it was felt that excluding parts of the longer cases, in the interests of achieving a better balance, would give only a partial picture of the reality and defeat the main purpose of informing policy-makers.

Although e-mail has totally changed opportunities for communication, the possibilities provided for discussion with the advisory group, and for face-to-face collaboration of the main researchers, greatly strengthened the team approach and enabled feedback from recognized experts in the field.

Adequate triangulation was ensured by drawing on multiple sources of written material and by interviewing or requesting comments from key people in different institutions.

This critical analysis is based on scientific principles, adhering to the commonly agreed WHO values, and the experience of the principal researchers. Its results do not purport to represent an official position of WHO or the opinion of the eight case-study countries.

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Appendix 1

Key informants interviewed between September 2006 and December 2007

To ensure the confidentiality of those interviewed, total numbers for all eight case-study countries are given.

Category of key informant	Total number interviewed
Prime minister	1
Minister of health	2
Former minister of health	4
Secretary of state/director-general, ministry of health	5
Deputy minister of health/under-secretary of state, ministry of health	6
Head of parliamentary health committee	1
Chairperson, chief executive, intersectoral committee for health	6[a]
Chief medical officer, chief public health officer and deputies	11
Former director-general for health	2
Director of health promotion or disease prevention agency	7
Executive Director of international organization for health promotion	1
Director/deputy director of topic-based agency	5
Civil servant in the ministry of health (apart from director-general)	21
Staff of research centre	4
Technical officer in public health and health promotion agency	25
Professor/lecturer at university or school of public health	24
Leading person in public health association	3
Activist and staff of NGO	14
WHO liaison officer and WHO staff	8
Representative of other international and donor agency	6
Representative of other ministry	8

[a] Includes one former chairperson.

Chapter 4

Case studies: policy development in countries for tackling noncommunicable diseases

Albania

Péter Makara & Zsófia Németh

1. Country profile

Albania is located in south-eastern Europe. It is bordered by Greece, Montenegro, Serbia and the former Yugoslav Republic of Macedonia. Unlike most of the inhabitants of neighbouring countries, Albanians are mainly Muslims and the official language, Albanian, belongs to the Latin family of languages.

Albania has an area of 28 750 km^2 and a population of 3.1 million. More than half of the population live in rural areas. Around a third of the inhabitants are under the age of 15 and 40% are under 18. The population grew by 1.2% per year in the period 1980–1999, and the fertility rate in 1999 was 2.4 children per woman of childbearing age. The fact that, according to the latest census, the population of Albania fell slightly in the period 1989–2001 can only be explained by extensive emigration.

Albania is divided into twelve administrative areas known as prefectures, which are subdivided into several districts.

1.1. Socioeconomic development

Together with the Republic of Moldova, Albania is one of the poorest countries in Europe. It enjoys impressive economic growth but the proportion of the population living in poverty, the unemployment rate and school enrolment are nevertheless among the worst in Europe. Following severe economic and social crises and emergencies in the 1990s and substantial emigration to neighbouring countries, the political and economic situation stabilized somewhat. The rate of unemployment fell from 10% to about 7% in 2005 and the proportion of those living in poverty fell from 25.4% in 2002 to 18.5% in 2005. Despite the great strides taking place in development, the rural population is generally still very poor, electrical supplies are insufficient and, owing to regular power cuts, water supplies to households suffer shortages. Nevertheless, government action has resulted in a massive reduction in poverty, especially since 2002. This has been accompanied by significant regional convergence, and poverty rates across broadly defined regions have narrowed substantially. The Gini index had risen to 30% by 2006, indicating an inequality level in the distribution of income similar to other European countries *(1)*.

1.2. The people and their health

Albania's health outcomes lag behind those of other countries in the WHO European Region. Life expectancy for Albanians is lower than the European average, while infant and maternal mortality rates (particularly in rural areas) remain higher than the European average.

Poor living conditions, including overcrowding, polluted environments and poor nutrition, result in low health status, to which the health care services are unable to respond effectively. Tuberculosis, eradicated during the communist era, has reappeared as a result of poverty and overcrowding in major cities. Albania is facing an increasing incidence of NCD as the population ages. The greatest burden of disease for men comprises the effects of tobacco and alcohol use and high blood pressure, while that for women comprises high blood pressure and obesity *(2)*.

1.3. The main features of the health system

A basic PHC system was established prior to 1990 but in 1991 and 1992, and again in 1997, many PHC facilities were closed. According to the Statistics Unit of the Ministry of Health, the number of health centres fell from 702 in 1994 to 564 in 2000, while the number of health posts decreased from 1973 to 1582 during the same period.

In rural areas, a typical health centre is staffed by up to three PHC doctors plus some nursing staff. Most of the

doctors are not trained in general practice. A typical health post is staffed by a nurse or midwife and provides maternity care, child health care services and immunizations. Rural health services have ceased to function in some areas owing to a shortage of equipment and staff resignations.

In urban areas, large polyclinics provide specialized outpatient care, but are now also used by people as their first point of contact with the health care system. Previously, patients had to be referred for specialist care by their general practitioner (GP), even though GPs were not highly respected as health professionals. This referral system is no longer used. The Ministry of Health has introduced fees for those who bypass their GPs but, so far, this disincentive has had little effect.

Local authorities now own PHC facilities in rural areas, whereas in urban areas health care facilities are still owned by the Ministry of Health. This division in the country's decentralization of health services has led to underfunded rural health services and better funded urban health services.

Reform of the PHC system began in 1992, guided by the EU's PHARE programme (Assistance for Economic Restructuring in the Countries of Central and Eastern Europe), the World Bank and WHO. PHC facilities remain publicly owned, with the exception of licensed private pharmacies and dental clinics. The PHC policy, which was developed in 1997 with EU support, states that there should be at least one health care centre in each commune and one health post in each village. Health centres are supposed to be physically separate from polyclinics, medical centres and hospitals. Many health centres were renovated and re-equipped during 1999/2000, and the Ministry of Health is rebuilding others with financial assistance from the European Commission's Humanitarian Aid Office (ECHO), the World Bank and the German Government. The policy proposes that primary care teams have to be led by GPs. The planning guideline is one GP per 2000 inhabitants in urban areas and one per 1700 inhabitants in rural areas.

The Ministry of Health, with assistance from donors, has started integrating separate health services into PHC teams. As part of this process, tuberculosis prevention services, which are part of a national programme administered through the districts, will also become part of the PHC system. Public health and preventive services such as school health and health education will also be included, along with maternal and child health and family planning services. Recently, mental health services have been tested at the level of primary care, with the support of the Swedish Government and WHO. A pilot integration project has been set up in the Tirana Prefecture in connection with the development of its regional health authority. The World Bank is supporting this effort. At present, PHC teams have very limited actual involvement in NCD prevention *(3)*.

2. Albania's approach to developing policies to tackle NCD

2.1. How things started

In 2003, Albania developed a document on health promotion and disease prevention. In fact the process was initiated by the World Bank as a condition for a loan. The relevant Albanian authorities were quite open to the idea but were not very motivated or convinced of the rationale of such a policy measure. Consultants from the London Development Agency drafted the text in cooperation with a small group of internationally trained Albanian experts.

The first draft was considered by the Albanian partners to be too theoretical and not specific enough for Albania. The drafting team was requested to prepare a more balanced and action-oriented document with specific priorities reflecting the Albanian situation.

The strategy was finally endorsed at the level of the Ministry of Health as a decree, without the commitment of the Government. The document is a technical paper and as such meets international standards, but without indicating funding, implementation mechanisms and capacities. Thus, the strategy has a limited reference value and there has been no follow-up at government level.

2.2. Is there a broad national policy for tackling NCD?

The main problem is related to the fact that such strategies or policies in Albania are often not backed up by operational planning and earmarked budgets. It seems that the process of developing long-term policies lacks the crucial components that could ensure the implementation of the strategy. Strategies are often launched with the financial support of donors such as the World Bank. After the first steps, however, implementation collapses owing to a lack of financial (and general) sustainability.

Long-term policy documents with important impacts are not always based on building and getting consensus from the opposition parties, thus jeopardizing successful future implementation. Political consensus building was totally neglected in the preparatory process for the Strategy on Health Promotion and Disease Prevention, and there was no involvement of key stakeholders at the various stages of policy development.

In planning strategies that explicitly require interinstitutional or/and interministerial cooperation, experts from different institutions are among the members of the working groups. Representatives of civil society can be members of these groups as well. A good example was the involvement of a large spectrum of actors in the development of the Drug Demand Reduction Strategy in Albania.

The Second Albanian Conference on Public Health in late 2006 *(4)* probably offered a new opportunity to raise awareness of the need for a more strategic modus operandi in NCD prevention. The Prime Minister, in his opening speech, gave at least rhetorical support for such a development. Nevertheless, commitment at governmental level is likely to remain weak, and none of the key stakeholders seems to have a clear idea of how to develop (using the existing document) more broad, consistent and sustainable action. Without such a development, however, NCD prevention and health promotion in Albania may remain fragmented and basically inefficient. Because of the situation described above, the existing mechanisms and capacities cannot be considered as sufficient for implementing a strategy framework.

2.3. Values, principles and main policies

The Albanian Constitution declares that equality in health care is a basic human right for all citizens. This normative type of declaration does not seem to reflect entirely the real situation of the Albanian transition.

At parliamentary level, the Health Commission has an influence on legislation covering such issues as health protection and health care financing. At present, the Commission plays a very limited role in health promotion and disease prevention. Because of the low prestige of the Albanian Parliament (related to the sharp political divides) its potential to build consensus for policy development to tackle NCD remains limited in the medium term.

Apart from the Ministry of Health, there are a number of ministries whose activities influence health. These include the Ministry of Social Welfare, the Ministry of Education, the Ministry of Culture and Youth and the Ministry of Transport, all of which are entitled to make decisions that may influence the health of Albanians. A special adviser in health issues assists the Prime Minister to assess the impacts of his decisions on the health of the population. (The present Prime Minister has a medical background, including WHO experience.)

In the last seven years, Albania has developed two main macro-level strategies with a direct focus on health:

- the Strategy on the Development of the Health System; and
- the Strategy on Health Promotion and Disease Prevention.

Other strategies and policy documents with a direct impact on health include:

- the Drug Demand Reduction Strategy;
- the Mental Health Reform Policy Paper;
- policy documents related to alcohol and tobacco control; and
- the Infectious Diseases Control Strategy.

During 2006/2007, at the request of the Ministry of Health, WHO, the International Agency for Research on Cancer (IAEA) and other international agencies supported Albania in developing a National Cancer Control Programme, but this did not appear to progress to concrete action and implementation.

Other comprehensive strategies have been developed with a clear link to tackling the social and economic determinants of health inequalities. These strategies are not focused directly on health but include components that reflect the health of the population and health interventions. Such examples are the Strategy for Social Inclusion and the Strategy for Economic Development *(5)*.

These latter two strategies are good examples of comprehensive development policies fully incorporating the broader determinants of health. The principles of equality in health are embodied and explicitly expressed in both. The frequent political crises of the 1990s and rapid changes in the social structure were the greatest challenges to closing the health equality gap and to achieving a coherent policy for health and development in Albania. These conditions pushed the political decision-making system towards crisis management and unfavourable practices. The prerequisites for long-term strategic thinking were often missing. Sometimes long-term policies were clearly urged by foreign partners, as in the case of World Bank projects. The example of Albania clearly represents the dilemma of tackling crises and emergency situations while introducing developmental strategic elements into decision-making. In such conditions, the process of policy development lacks the necessary dynamism and commitment from Albanian stakeholders, thus jeopardizing the sustainability of the process and successful implementation.

There seems to be a high level of awareness among experts and lower ranking civil servants of the need for comprehensive approaches to health, involving various institutions and tackling not only disease but the broader determinants as well. This might be a good base for building stronger coordinative mechanisms in the near future.

Taking all the above-mentioned factors into consideration, in reality Albania is far from having a strategy-driven, coherent process at government level for initiating a policy to tackle NCD.

2.4. Structures and processes for implementation

2.4.1. The Ministry of Health: agent of change?

The Ministry of Health remains the major sponsor and provider of health care services in Albania. The Ministry has been reorganized, and it continues to assume the leading role in most areas of health care. It "owns" most health services, with the partial exception of primary care.

The Ministry of Health devotes most of its efforts to health care administration rather than to policy and planning. Many health care institutions (especially in tertiary care) are under the direct administrative control of the Ministry of Health and its small and overloaded staff, which makes it difficult

for these organizations, and for the administrative districts, to make quick decisions.

After the fall of communism, the Ministry of Health went through a process of reform. It is now supposed to transfer most of its managerial powers to the lower levels of the health system, focusing instead on the macro-level regulation of services and engaging in policy formulation and long-term health development. In practice, it is still engaged in many small administrative problems and conflict management, which diverts attention away from long-term policy development.

Interministerial and interinstitutional bodies improve the coordination of policy implementation. These structures are organized in committees covering such areas as nutrition, water, drug prevention and third age issues. Most of these structures operate under the leadership of the Ministry of Health, but in some cases another ministries take the lead. This happened, for instance, in the case of the Drug Demand Reduction Strategy: after five years of failure, political coordination was taken over by the Ministry of Public Order. Nevertheless, interministerial bodies can be very fragile structures with limited efficiency in decision-making. They cut across the power hierarchy and lack a clear structure.

In the Albanian context, the development of strategies on HIV/AIDS prevention *(6)* and reducing the demand for drugs can be considered success stories in terms of involving many stakeholders and incorporation of a broader vision on health determinants.

The Mental Health Policy and Action Plan *(7)* will use existing health and other social sector resources, including local government, to provide access to mental health services compatible with international standards. Activities include the deinstitutionalization of psychiatric hospitals by expanding mental health services to provide multidisciplinary care in the community. Six mental health services are operating on the basis of a community mental health approach supported by donors.

The Government has pledged a high-quality and honest health service with guaranteed access for all, and this will be the aim of the new Health Sector Strategy.

2.4.2. Planning, regulation and management in the Ministry of Health

The formulation and development of policies and plans in the Albanian health sector have been affected by two important factors.

1. Several consecutive crises (financial, social, political and regional) have had a significant impact, forcing the Ministry of Health to adopt a more reactive approach in order to cope with the dramatic events of recent years.
2. The weak technical capacities of the staff in the Ministry of Health have made it extremely difficult to formulate policies, strategies and plans for the health sector.

Despite these difficulties, the policy-making and planning process has slowly advanced, strengthened by a substantial amount of external assistance and driven mainly by bilateral and multilateral agencies.

The establishment of the Department of Policy and Planning in 2000 was an important step in strengthening the planning capacities of the Ministry of Health. The main considerations in establishing this new department were as follows.

- As part of the decentralization process that has begun in the country, the role of the Ministry of Health should shift in the direction of policy-making, planning, regulation and coordination.
- By developing a national policy and a comprehensive strategic plan for the health sector, the Ministry of Health will be more able to justify increased spending on health care. The resulting policy and plan will also

enable the Ministry of Health to invest its budget and donor funds more effectively.

- The Department of Policy and Planning should help to establish a participatory consultation process, as well as to promote greater transparency in setting priorities and allocating resources among different health subsectors and geographical areas.
- Little continuity can be observed within the Ministry of Health. Its institutional memory and much documentation have disappeared with changes in staff. Every new government replaces its senior and even middle-level managers. The Ministry has not been able to set up a system for preserving its "technical memory".
- The planning capacities of the Ministry of Health are weak, since day-to-day administration takes priority.

The Department of Policy and Planning has begun to carry out some of its scheduled activities, but it lacks management tools and experience to undertake major planning activities. This lack of capacity and experience is especially characteristic in the field of policy development to tackle NCD. However, a new structure does not necessarily mean new functions. Planning is a complex and highly political process, and it will take time for a new department to take over the tasks and perform successfully in the difficult environment and bureaucratic culture of the Ministry of Health.

An important new development from this perspective is the establishment of a new focal point for health promotion within the Ministry of Health in 2006. Despite all the weaknesses of this position, it creates a clear institutional identity for health promotion and NCD prevention at the level of the Ministry.

2.4.3. Public health services: facing the new task of NCD prevention with obsolete practices

Under the Ministry of Health, the Institute of Public Health (IPH) is responsible for health protection (particularly the prevention and control of infectious diseases and the national vaccination programme), environmental health and the monitoring of drinking-water and air quality. It works mainly through the district public health services. Monitoring of food quality is a responsibility shared by the Ministry of Agriculture and the Ministry of Health.

In this context, policy development to tackle NCD can hardly be considered as a priority area among the activities of the IPH. The appropriate financial and human resources are missing.

The IPH, reorganized in 1995 from the previous Research Institute for Hygiene and Epidemiology, is directly accountable to the Minister of Health. It has a staff of about 150 and is larger than the head office of the Ministry of Health. IPH collects public health statistics, organizes and participates in health surveys, runs immunization programmes, monitors the environment and collects data on health status. It also offers advice on public health policy, provides technical support and acts as a national research and training centre.

In early 2001, the National Directorate of Health Education and Promotion was integrated into the IPH. Another change occurred in 2006 when, owing to restructuring, a Health Promotion Centre was created within the framework of the IPH, which received greater autonomy. However, this small organizational unit lacks a clear strategy, efficient management, appropriate funding and tools for action.

Recent changes in the leadership of the IPH may offer an important new opportunity to modernize the functioning of the system and to give higher priority to policy development to tackle NCD and modern pubic health thinking in general.

2.4.4. District directorates and the Tirana Regional Health Authority (TRHA)

Much of the responsibility for public health lies with the district public health directorates and PHC directorates, which have two distinctive structures and sets of responsibilities.

The directorates are accountable to both the IPH and the Ministry of Health.

Health directorates used to be organized around separate, vertically integrated services, such as maternal and child health, but they have been replaced with a hospital directorate and a PHC directorate. The directorates are administered primarily through the Ministry of Health district bureaucracy.

Following a government decree of July 2000, a new model was introduced in the Tirana Prefecture (which includes two districts) with the assistance of the United Kingdom Department for International Development and the World Bank. PHC services and public health programmes have been integrated under the TRHA, a single organization that is responsible for their planning and management. A Regional Health Board has been set up to endorse the proposed regional policies, plans and budgets. It is hoped that this model will pave the way for the Ministry of Health to delegate more authority and power to regional bodies.

2.4.5. Local government

The local authorities of all 315 rural communes now own their PHC facilities and are thus partly responsible for PHC. The Ministry of Finance gives them grants earmarked for equipping, maintaining, operating and upgrading PHC centres and posts, as well as for paying some staff salaries. In urban areas, district offices of the Ministry of Health still own and administer such services.

According to the report of the Second Albanian Conference on Public Heath in 2006 *(4)*, in some 9 months, 131 health promotion teams in 16 Albanian districts conducted 1834 health promotion activities reaching thousands of villagers in need of information. Nevertheless, these actions were fragmented, in most cases simply distributing poor-quality leaflets.

3. Smoking: a potential success story in specific NCD policies?

Efforts to draft a law on tobacco and health began in 1999. Since then it has been reviewed several times, but owing to the lack of appropriate political commitment it was not approved until 6 November 2006, when the Albanian Parliament finally gave its blessing. This law, entitled "For the protection of health from tobacco products", was drafted in the light of the WHO FCTC, which was ratified by the Albanian Parliament on 26 April 2006.

In essence, this law represents a powerful effort by the Ministry of Health to protect the health of citizens from the harm caused by smoking and involuntary exposure to tobacco smoke. It also aims to protect consumers from more harmful tobacco products and to involve as many stakeholders as possible. The key actors in attaining this progress were a few committed and skilled prime movers on behalf of government and NGOs, using the momentum of the WHO FCTC and the beginning of Albania's process of accession to the EU.

The forthcoming challenge, perhaps even larger than the approval itself, will be implementing the law, which will require the serious commitment of all governmental structures. The situation is still far from satisfactory: the prevalence and public acceptance of smoking remains very high, advertising is omnipresent, and cheap cigarettes are on sale everywhere on the streets. The tobacco industry and trade in tobacco products, including illegal trafficking, are backed by very powerful vested interests.

Three surveys have already been carried out in the country in collaboration with WHO and the Centers for Disease Control and Prevention (CDC): a nationally representative survey on smoking *(8)*, GYTS (Global Youth Tobacco Survey) and GHPS (Global Health Professional Survey) *(9)*. Thus a comprehensive information base for further policy planning is available.

The NGO "For a tobacco-free Albania" *(10)* has played a prominent role in bringing the need for tobacco control into the public domain. The NGO will play a continuing role in reporting on the implementation of the tobacco control law.

4. Infrastructure and resources for policies to tackle NCD

4.1. Human, technical and financial resources for health promotion and for policies to combat NCD: a fragile basis

Human resources in health promotion and NCD prevention are partly inherited from the previous health system. The rest has been recently recruited through a "negative selection" process from people trained in traditional medicine.

Before the 1990s, GPs in PHC were directly involved in health promotion activities. Now, despite formal contracts with the Institute of Health Insurance or the local health authority, they focus only on curing patients because of their basic interest in out-of-pocket payments.

The current Albanian education and training mechanisms for preparing professionals in this field lag far behind European standards. Despite an acute need for formal (advanced postgraduate) and continuous (supervised development of practical skills) training, little was done before 2005.

Before 2000, the traditional specialization after qualifying for a diploma in medicine was a two-year course in hygiene and another in epidemiology. There were only weak attempts to broaden the vision and to develop skills consistent with a modern understanding of health promotion and disease prevention.

Health care staff do not receive adequate in-service training to perform their job, while continuous professional development is spontaneous or nonexistent for most. There is also a lack of skilled health care managers, leading to inefficient allocation and management of resources, both human and financial. Another problem is the emigration of specialists. There is a clear need for more systematic training for a larger number of participants and for improving the working conditions of those who stay in Albania.

A five-month course in health planning and management by the Institute of Public Health and the University of Montreal, organized in 2003, provided just a partial answer to these needs.

A significant change is expected to be brought about by the introduction in Albania of Master of Public Health training to ASPHER[1] standards. This academic course is open not only to medical graduates but also to professionals in other fields. The long process required to set up such a project requires a lot of coordination to overcome barriers imposed by the traditional academic system and the rigid nature of various institutions (i.e. the Ministry of Education and the Ministry of Health). Within this framework a new bachelor training course started in 2007.

As a consequence of the decentralization process in Albania, the financing of public health services was temporarily transferred to local authorities, which proved to be unprepared and to lack sufficient awareness of the importance of these services. Now the reform has excluded public health services from the decentralization process, thus lowering the risk of draining public resources in programmes other than health promotion.

Nevertheless, it seems that this centralized model will not be able to make use of local resources for some time to come. On the other hand, the necessary involvement of local professionals in decision-making, strategy formulation,

[1] ASPHER: the Association of Schools of Public Health in the European Region.

etc. will continue to be almost nonexistent. Thus the existing model of providing public health services only tries to preserve some reasonably good levels reached in the past; it seriously hinders the supposedly growing local contributions to creating the conditions for health and enabling local populations to increase control over the determinants of their health.

4.2. Supporting the development of civil society: a hope for real action

Civil society is officially considered in Albania an important contributor to democracy because its organizations may fill gaps in services (especially for the most vulnerable groups), produce information and ideas, and absorb projects. NGOs are generally perceived as a neutral alternative to the bipolarity of the two main political forces in the country. NGOs are able to make a more credible critique of policies, including those on health. Clearly, NGOs have a great potential in promoting and protecting the standards of services, and improving health ethics and the legal rights of citizens.

Nevertheless, the role of civil society is not always seen in a positive light. There are often frictions between state institutions and NGOs for reasons that include competition for funds and unclear division of responsibilities. Despite the lack of formal structures that are supposed to support civil society development, several state institutions are open to cooperating with civil society in their long-term strategies.

The majority of NGOs are still weak and lack continuous support for providing a more sound contribution to social cohesion and community participation. Balancing their flexibility and community links with public control and sustainability remains a big challenge for civil society organizations in Albania.

At least 100 NGOs operate in the country, often organized in civil society forums and other coordinative bodies. State institutions such as the IPH try to play a coordinative role, gathering evidence on the activities that NGOs carry out. Thus there are some possibilities – even if not systematic – for monitoring, evaluating and registering the contribution of their work, including health outcomes. Final project reports published by NGOs could be an important source of evidence in future NCD prevention activities.

4.3. Management of information systems in policy development to tackle NCD

In Albania, there are considerable problems in accessing the necessary health information. Even existing information is not easily accessible by people who need it. Data are collected from different institutions, often without consistency or compatibility.

Data on health status, mortality and morbidity are collected and reported monthly to the IPH and the Ministry of Health by public health directorates in each region. In some cases, in order to avoid taxes, the new private clinics do not properly report their epidemiological data. The collection of data on mental health, suicides or sexual health is even more complicated: owing to prejudice and ignorance, people with these kinds of problems tend to avoid clinics.

In recent years, some surveys have been carried out to evaluate health behaviour, such as assessing the health behaviour of adolescents. Mechanisms for regularly monitoring the health behaviour of adults do not exist. Interventions for health promotion and NCD prevention are sporadic and are not carried out at national level. For this reason, there is no systematic countrywide evaluation of health promotion and NCD prevention activities. A limited number of interventions are evaluated, mainly according to the requirements of donor agencies.

The results of monitoring and evaluation are collated, analysed and interpreted by the Department of Statistics at the IPH and at the Ministry of Health. Not all the results

are published or even accessible for public discussion and debate.

Attempts to reform the health information system have begun. The leadership was provided mostly by foreign donor agencies such as USAID (United States Agency for International Development). A comprehensive information system is far from being set up, and there is a lack of appropriate coordination between competing actors in the field.

4.4. Development of research and expertise

The Ministry of Education and Science is responsible for funding and coordinating research. Public health has not been a priority area until recently.

In 2002, the Government decided to significantly increase research funding in the health field. Following this decision, the Ministry of Health and IPH prepared the first National Research Strategy. A committee of professionals was set up to lead this process. The Strategy includes a number of priorities, serving as a basis for providing funding to various projects. In this process, indicators such as mortality, trends in the burden of diseases and the efficacy of interventions were taken into consideration.

Nevertheless, the majority of research in health is carried out outside the National Research Strategy. This is due to the fact that, for almost a decade, most of the research has been financed by different donors and very often carried out by civil society organizations. Even if formally most of the donors try to coordinate their research-type activities with government-based health agencies, donor-driven research is not always in line with the priorities expressed in long-term policies and strategies, including the National Research Strategy.

Research in Albania has been going through a process of transformation. Traditionally, research in the health field has focused mainly on infectious diseases, occupational medicine and child health. Recently, the range of issues has broadened substantially to include a focus on such aspects as risk factors for chronic diseases, healthy ageing, reproductive health, adolescent health, mental health, and new dangers in environment health. Nevertheless, evidence for NCD prevention is still weak and inconsistent with the development of a comprehensive, long-term NCD prevention strategy. The biggest barrier to the development of multidisciplinary research on NCD prevention is the lack of coordination of existing resources and the lack of adequate funds.

There is an increasing general awareness in health policy-making, at least in theory, that strategies and interventions should be based on evidence supported by valid research results. In the health sector, the outcomes of long-term policies are not monitored and evaluated by sound scientific research.

The Second Albanian Conference on Public Health in December 2006 *(4)* clearly demonstrated an increasing interest by the whole public health community in research results and the further development of a research base in NCD morbidity, mortality and risk factors. This reflects a general acceptance that steps have been taken to develop health policy analysis in the field of health promotion and disease prevention.

5. Conclusions and lessons learnt

- Considering the double disease burden in the country, it is a real challenge for Albania to initiate policies to tackle NCD. In the present situation, despite the existence of the Strategy on Health Promotion and Disease Prevention, the characteristic political feature is an opportunistic day-to-day management of NCD prevention that is fragmented and inefficient.
- The status of policy development to tackle NCD in Albania is one of the lowest in Europe. Public health

thinking is still dominated by health protection and prevention of communicable diseases.

- The challenge of shaping a future policy for NCD prevention in Albania includes the dilemma of how to move away from crisis management to development and how to bring innovation to traditional public health activities.
- At the moment, the level of coordination of policies to tackle NCD is very low. There are some success areas, however, such as Health Promoting Schools and the recent results in tobacco control policy development.
- In Albania there are broad equality-oriented strategies for social inclusion and poverty reduction. Because of the social situation in the country, concerns on equality issues are rather strong. This is partly reflected also in health promotion and prevention activities. HIV/AIDS prevention *(6)* and reducing the demand for drugs may offer good examples of practice in this field.
- A clear process of policy development in the field of NCD is still missing in Albania. Existing strategies are largely not implemented, mainly owing to a lack of strong political commitment, appropriate organizational structures and skilled and motivated management staff. This relates also to the overall weakness of health policy-making and of capacities at government level.
- There is a lack of a critical mass in health promotion and disease prevention capacities. Human resources are lacking and the health sector is exclusively dominated by clinical and medical ways of thinking. Also, the financial interests of PHC staff lie generally in curative medicine. The organizations dealing with health promotion and disease prevention are small and fragile, with very limited funding opportunities. Most NCD prevention staff lack appropriate technical backgrounds and skills, since the positions are not attractive to skilled and well-trained applicants.
- International organizations play an outstanding role in stimulating and initiating policy development activities to tackle NCD in Albania. They are certainly important in shaping a public health mentality, and also offer a learning process for the best of the Albanian experts. The impact of international donor activities is controversial, however. Prevention activities often seem to be externally driven without a real commitment. Sometimes international agencies, instead of boosting capacities for strategic thinking, instead demoralize and alienate Albanian experts from real long-term involvement and participation.
- There are some positive elements that give hope of a better future for health promotion and disease prevention in Albania. These include the number of very proactive prime movers with international experience, the increasing NGO activity and commitment in the field of NCD prevention, and the establishment of a new focal point in the Ministry of Health offering new opportunities for better leadership in strategy development.
- The following are the main dilemmas encountered in developing a policy to tackle NCD in Albania:

  - how to raise political interest and how to build consensus on the need for a strategy focusing on NCD;
  - how to strengthen managerial and coordinative capacities in health promotion and disease prevention;
  - how to facilitate the review and real implementation of the existing strategy;
  - how to improve capacities for implementation, with special regard to PHC and public health staff;
  - how to modernize ways of thinking in the field of public health and how to demedicalize public health practices;
  - how to provide more efficient international support to health policy development while avoiding the contradictory effects of the past; and
  - how to put health higher on the Albanian developmental agenda, linking health promotion and disease prevention to the long-term perspective of the EU accession process.

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Finland

Anna Ritsatakis

1. Country profile

Finland is bordered by Norway to the north-west and north, by the Russian Federation to the east, by the Baltic Sea to the south and by Sweden to the west. It is one of the largest countries in Europe, one quarter of it lying north of the Arctic Circle.

For administrative purposes, the country is divided into five provinces. In 1993, there was a general decentralization of responsibilities to the municipalities, many of which had fewer than 10 000 inhabitants. Now the municipalities are being amalgamated with the aim of creating units with about 20 000 inhabitants. There are currently 416 municipalities and about 20 mergers are currently being processed *(1)*.

Following independence from Russia in 1917 and the ensuing civil war, a rather exceptional requirement for two-thirds or five-sixths majority decisions on constitutional and other major political issues led to a culture of broad coalitions and consensus building. The multi-party governments that followed strengthened this approach of striving for consensus, which is still characteristic of Finland.

Finland has been an active member of the Nordic Council since the 1930s and joined the EU in 1995. Finnish and Swedish are the official languages, while the Saame and Roma languages have minority language status.

1.1. Socioeconomic development

Finland enjoyed robust economic growth during the 1980s. By the end of the decade, however, the economy had overheated. Combined with the changes that then took place in eastern Europe, this created a deep economic recession in 1991–1994. From around 6% in the 1980s, unemployment jumped to a peak of 19% in 1993. By 2002, this had fallen back to around 9% but was still dramatically high among young people *(2)*. Although the previous low levels were not regained, continued efforts brought the overall level below the euro area average (8%) in 2006 *(3)*.

Growth performance in recent years, at over 3%, has been among the best in the Organisation for Economic Co-operation and Development (OECD) area and is presently around 6–7% "underpinned by a strong innovation performance and high educational achievement" *(3)*. Traditional industry continues to lose ground, however, and new jobs for young people tend to be part-time or temporary so that job security has become an issue. Also, since the minimum salary refers to full-time employment, there is a growing group of the "employed poor", including single mothers working part-time and low-paid immigrants.

Until recently, Finland was considered to be a generally egalitarian society. According to the Gini index, Finland has a relatively low overall level of income inequality and a distribution of wealth that is better than the European average. More recently, partly affected by globalization, the two extremes appear to be diverging, with income of the top 5% increasing dramatically while that of the lowest 10% deteriorates.

1.2. The people and their health *(4)*

From 4.6 million in 1970, the population of Finland has now increased to 5.2 million owing to a positive rate of natural increase and net migration. With the decreasing birth rates of recent years and the large birth cohorts of the late 1940s, the population is rapidly ageing. The proportion of the population over 65 years is expected to rise from about 15.5% in 2003 to about 19.4% in 2030. Between 1970 and 2005, life expectancy at birth for men increased from 66.2 to 75.8 years, while that for women rose from 74.5 to 82.8 years. While the gender gap in life expectancy has dimin-

ished, however, differences between social groups have increased.

At 3.1 per 1000 live births in 2005, the infant mortality rate in Finland remains one of the lowest in the world. According to WHO estimates, on average, Finns can expect to be healthy for about 90% of their lives.

In 2002, NCD accounted for at least 80% of all deaths in Finland, with CVD accounting for almost 41% and cancer for almost 22%. Overall, although CVD occur less frequently than previously, CVD mortality is still slightly higher in Finland than the EU average and is a particularly problem in men aged 25–64 years. Deaths from cancer, however, are relatively lower. For example, the standardized death rate (SDR) for trachea/bronchus/lung cancer in 2004 was 26.0 in Finland compared to 36.7 in EU countries prior to May 2004. With the ageing of the population, however, there is a greater prevalence of cancer.

Efforts at tobacco control have shown results, with the level of smoking declining, as have changes in eating habits. Partly owing to binge drinking, however, particularly in men (30% of drinking occasions for men), alcohol abuse remains a growing health risk. Obesity is also increasing as a health issue.

A quarter of Finns' disease burden and sick days are due to psychiatric disorders. The number of people suffering from dementia has increased. There has been considerable success, however, in bringing down the suicide rate.

1.3. The main features of the health system

Finland has a compulsory tax-based health care system providing comprehensive coverage for the entire resident population. At the national level, the Ministry of Social Affairs and Health (MSAH) issues framework legislation on health and social care policy, norms and guidelines, and monitors their implementation. At the local level, the municipal health committee, council and executive board, as owners of the PHC centres and hospitals, plan and organize health promotion and health care.

The decentralization of the late 1980s and the abolition of the National Boards of Health and Welfare in 1991, to be replaced by the National Research and Development Centre for Welfare and Health (STAKES) and other smaller agencies, was a response to a general demand from the local level for greater independence. This does not, however, appear to have been an unqualified success. Unviable small local units were given responsibility for policy and planning for which they did not have the capacity or resources and, although they were largely freed from what they felt to be the domination of the MSAH and the National Board of Health, they lost much of the support they had previously received in the form of guidelines and the expertise of Board officials, who had spent much of their time travelling the country. Furthermore, this change coincided with the economic crisis and ensuing budget cuts. Consequently, considerable inequalities were created.

The 1972 Public Health Act aimed to shift the focus from hospital to PHC, offering strong financial incentives to attract physicians to PHC. A key feature of the system is the municipal health centre, staffed with physicians, nurses, physiotherapists and social workers and providing a full range of primary care services. In contrast to many countries, more than 20% of doctors are GPs working in health centres. To improve continuity of care, attempts were later made to develop a personal doctor system, with each GP being responsible for a certain population, but this does not appear to have been completed. According to the OECD, the ratio of nurses to physicians is the highest in the EU. Nurses traditionally make home visits, and home care is reasonably well developed for older people and children. Federations of municipalities form 21 hospital districts, responsible for arranging and coordinating specialized care.

Both the state and the municipalities levy taxes, though there is no earmarking for health care. In 2002, about 43% of total health care costs were financed by municipalities, 17% by the state and 16% by the national health insurance (NHI), while some 24% were covered by out-of-pocket fees. Private financing is increasing owing to increased user charges for municipal services, the abolition of tax reductions for medical treatment costs, and reductions in the reimbursement of pharmaceuticals by the NHI. The sickness insurance system provides modest compensation for the use of private services, and employers are partially compensated if they provide cover for curative health care over and above the obligatory preventive care in the workplace.

The Act on the Status and Rights of Patients that came into force in 1993 stressed the right of patients to good care, and provision was made for its enforcement to be monitored by research. Further legislation in 2003 attempted to address the situation whereby municipalities were trying to save money by lengthening waiting lists.

All is not well in the health care sector, however, or as one respondent put it, "the health services are in crisis". Apparently, the medical profession is losing its attraction. Many of the young doctors graduating are women, who, owing to family obligations, are unwilling to commit to general practice. Small municipalities unable to cope with their responsibilities are still trying to cut costs, and posts in PHC are not being filled. The situation in the PHC centres when they were originally established, whereby staff, together with the chief physician, had considerable control over their way of working, has long passed and the staff have lost their sense of control. This is exacerbated by the fact that empty posts are frequently filled by temporary personnel "rented out", usually on higher levels of remuneration, by large private companies. One option being discussed is the merging of PHC and hospitals, which if carried out could lead to more clinical and less health promotional thinking.

Private health care services grew by over 9% annually between 1995 and 2004. The largest private providers seem to be gearing up for additional expansion. One of the oldest private health care service providers, Mehilainen, founded in 1909, now works with 1800 physicians and has recently merged with another leading Nordic company, Carema, with operations in Finland, Norway and Sweden. The Suomen Terveystalo Group, established as recently as 2001, aimed to be the largest private health care provider by 2008.

An indication of the seriousness of the situation is that in November 2007, the relatively poorly paid nurses went on strike for the first time in their history. In fact, as a crucial care-giving group they do not have the right to strike, so about 12 000 nurses actually resigned. The Government had to rapidly pass a law that health workers can be forced to work against their will, and opinion polls showed that 70% of the population would be willing to pay higher taxes to meet the needs of higher remuneration for nurses.

2. Finland's approach to developing policies to tackle NCD

Understanding the rather special case of Finland requires looking further back in history. Following almost 700 years as part of the Kingdom of Sweden and a further 100 years as an autonomous Grand Duchy of Russia, Finland did not gain independence until 1917. The aftermath of the Second World War brought further dislocation as 400 000 people from the land that was lost had to be accommodated.

The twentieth century in Finland was characterized therefore by rapid modernization from a poor, mainly agricultural country to a rich industrialized one. So much needed to be developed all at the same time that, by the middle of the century, a culture had emerged of assessing the situation and exploring options for effective action. In this relatively small country, the seeds had also been sown of self-deter-

mination and active participation in international decision-making.

This analytical approach of defining goals and objectives and looking for politically feasible means of achieving them was already apparent in the health field by the mid-1970s and early 1980s. Simultaneous with the rapid development of health care, and partly due to the North Karelia project (see below), the need for intersectoral action for public health was clearly recognized. A rare combination of factors came together: economic growth allowed a tremendous expansion of government funds; activists from the 1960s had been co-opted to key administrative posts, and there was enthusiasm for planning. As stated by one such activist "The era was characterized by dynamic growth, rational planning and the development of egalitarian social policies" *(5)* with the Nordic-type welfare society as the clear goal.

Finnish experts were active in the development of the Ottawa Charter and the WHO Health for All policy. Finland not only joined the "world's largest study of heart disease, stroke, risk factors and population trends", the WHO MONICA Project, but gave considerable long-term support by acting as the Project's data centre from 1984 *(6)*.

Coincidently, the elected head of the WHO Regional Office for Europe was a Finn, Dr Leo Kaprio, who had been quick to recognize that Health for All held promise for countries at all levels of development *(7)*. When the WHO Director-General, Dr Halfdan Mahler, asked Finland in 1982 to act as a pilot country in adapting the Health for All policy at the national level, this was quickly accepted; this internationally agreed policy with its underlying values of equality in health and participation in decision-making; its focus on PHC; and the promotion of health through intersectoral action fitted well with the country's own aims and objectives.

Following three national seminars to discuss the concept and its implications for Finland, MSAH appointed a steering group to draft a national Health for All policy. There was no precedent in Europe for Finland to follow and the first draft was extremely long. A much shorter version *(8)* was therefore prepared and discussed by Parliament in March 1985, gaining support across political parties. Based on these agreed directions, in 1986 MSAH published a national Health for All 2000 strategy *(9)*, the first of its kind in Europe.

So began a sustained effort, surviving changing coalitions and governments. In 1993, following broad consultation, the original policy was revised and approved by the Government and was revised again in 2001. A group of highly talented, like-minded people were in influential positions in the health sector bureaucracy, which no doubt facilitated this innovative action. How far this enthusiasm trickled down to become action at the local level is less clear *(10)*.

It was not all plain sailing. Inadequate resources had been provided for implementing and monitoring progress. MSAH and National Board of Health officials were expected to handle the implementation and monitoring of progress in the Health for All policy, on top of their usual duties, and fatigue set in. Judicious use was made of WHO when energies were flagging. Twice, teams of outside experts coordinated by WHO were invited to review progress in the development of the policy *(11)* and of health promotion policies *(12)*, thus revitalizing interest.

International collaboration was ably used to support and legitimize innovative approaches to policy development promoted by key actors in Finland. At the same time, Finland pushed issues of concern to it on to the international agenda, including the explicit inclusion of mental health in the definition of health during the first Finnish EU presidency in 1999, and health in all policies *(13)* during its 2006 presidency.

2.1. Broad policy for health – Health 2015 public health programme

The current broad policy for health in Finland is the *Government resolution on the Health 2015 public health programme (14)*. This is complemented by *Strategies for social protection 2015 – towards a socially and economically sustainable society (15)*. (A policy to tackle inequalities in health is currently being prepared by the new Government.)[2]

2.1.1. How things started

This umbrella policy is a continuation of long-term efforts stemming from the 1972 law that strengthened the legal basis for health promotion, through the early 1980s when the Health for All policy shifted the focus from health care to health. *Health 2015* refers directly to the objectives set in the first 1986 Health for All strategy and progress made, or still to be made, in their achievement, and states: "The WHO's more recent global Health 21 programme and the programme for the European Region based on it provided the foundation for Finland's new Health 2015 programme" *(14)*. The revised Constitution, effective March 2000, required the Government both to ensure health services and to promote health. With this in mind, the government programme states that the promotion of the population's health and functional capacity was to be a factor guiding all public decision-making and activities. Article 152 of the EU Treaty of Amsterdam also influenced this position, and reference is made to the increasing impact of EU decisions on health and the need for a stronger international dimension in new health policy initiatives.

The main objectives defined 20 years previously, "to give people a longer and healthier life and to reduce health differentials between population groups", were seen as still being valid. There is, however, one significant shift in approach.

For the 1986 strategy, following intensive consultation, it was decided to set quantified targets only where appropriate: on scientific grounds owing to the complexity of issues such as reducing inequalities; and on political grounds since it was thought that politicians would not be comfortable setting targets in areas over which they had little influence.

In contrast, *Health 2015*, based on "research and expert opinions", sets quantified targets for improving the health of different population groups (children, young people, young adult men, people of working age and those over 75), plus targets relating to the whole population, health services, the environment and reducing inequalities.

Decentralization in the planning and management system was also said to have led to a reconsideration of the use of health targets in policy-making *(17)*. It was expected that the targets could only be reached by developing healthy public policy, action in various settings and throughout the life cycle. Much of the action was to come from the municipal level, which still tended to be in a "cutting mode" following the economic crisis of the early 1990s.

2.1.2. Awareness building and the consultation process

Before turning to the latest experience, it is helpful to consider previous consultation efforts. The Health for All process in Finland in the early 1980s was initiated by leading government officials in the health field. Although municipal and professional organizations, as well as other sectors, were involved through seminars and expert meetings, "the exercise remained to a large extent a synthesis of expert views on health policy development, which were then filtered and mangled through the political process" *(5)*. The draft policy was circulated for comments for three months. The long first draft was considered politically unmanageable, and a team in MSAH led by the Minister reformulated the report for Parliament in 60 pages. The MSAH strategy that followed was more extensive, with the explicit inten-

[2] Since the completion of this case study, a national action plan has been formulated *(16)*. This is linked to *Health 2015* and includes actions to tackle risk factors for NCD such as smoking and alcohol abuse, lack of exercise and poor nutrition.

tion of making the reasoning more meaningful to other actors involved.

The 1991 report of an external WHO review group *(11)* several times mentions inadequate participation by the public and actors in other sectors that would need to implement the strategy. This was hardly surprising, since there were no models from which to learn, Finland being the first test case in Europe. No additional resources had been designated for policy formulation, coordination or monitoring of implementation. "A lot of normal advisory boards and expert groups were used, some necessary special research was commissioned, but no extra budget or work-time allocated" *(5)*. Following the parliamentary discussion, which considerably raised awareness, the energy of heavily pressed government officials was spent in drafting the implementation strategy rather than working with stakeholders, "in paper work and not people work" *(5)*.

It was realized early in the process that some of the momentum had been lost and, in order to revitalize efforts, it was decided to attempt an internal revision of the strategy parallel with a review by external (WHO) experts. In June 1991, a broad-based and high-powered Steering Committee was set up for the implementation and follow-up of the Health for All 2000 programme *(9)*. Apart from representatives of MSAH, the Committee included representatives of the ministries responsible for education, agriculture, trade and industry, transport and the environment; of organizations with responsibilities for welfare, public health and health education; and of cities, rural communities, academia and the health professions. Their mandate was to assess progress in implementation of the Health for All 2000 strategy and to make provision for its revision and for better coordination of the activities of different sectors in achieving its objectives.

The revised strategy *(18)* took clear note of the WHO review group's criticisms and provided for closer collaboration between municipalities and NGOs, for better participation of the public on administrative bodies and for training to improve such interaction. It is interesting to note that, following a request of the external review group to interview health professionals, the nursing profession was thereafter represented on health planning bodies. Their exclusion up to then had not been intentional: in the absence of a stakeholders' analysis, they were simply overlooked.

The whole process continued to be heavily expert-led, as was the accepted way of working. Indeed, members of the WHO external review group, who came from different parts of Europe, had been impressed by the apparent public trust of and confidence placed in experts and civil servants in Finland.

In 1997, an Advisory Board for Public Health was set up by the Council of State to renew the Health for All policy. The Board was chaired by the Permanent Secretary of MSAH and included representatives from various ministries, regional health care administrations, research institutions, NGOs and health professionals' associations.

The Board published reports on inequities in health and the life-cycle approach to health promotion. A series of seminars was organized with very broad participation, leading to the drafting of a consultation document (*Health 2015*); this was sent out for comments at the end of 1999 and adopted by the Council of State in 2001.

Perhaps surprisingly, given the intention of working across sectors, only MSAH was given explicit responsibilities in the document, with little detail on what other sectors might do.

2.1.3. Values and principles

Finland's health and social policy is clearly founded on the Nordic welfare model, influenced by a sense of cohesion, a common (protestant) ethic and a very high value placed on education. The central features of this model *(19)* are:

- the principle of universality
- a strong public sector
- tax funding
- citizens' rights grounded in legislation
- equal treatment
- social benefits of a relatively high level.

With regard to income and wealth distribution, Finland is one of the most egalitarian societies in the world. Even during the severe economic crisis of the early 1990s, strenuous efforts were made for the survival of the Nordic welfare state, although the level of benefits was less generous than in the past and the universalistic nature was weakened. On the whole, however, masses of people were prevented from sliding into material poverty and multiple deprivation and income differentials were kept largely under control.

Finland has an excellent information base and strong research resources that facilitate the reflection of possible inequalities in health. The availability of epidemiological data has made it clear that, despite persistent efforts, health gaps between certain socioeconomic groups continue to grow. This has been partly exacerbated by growth in the share of the highest income decile and persistent long-term unemployment. The *Health 2015* public health programme therefore states that "another aim will be to reduce inequality and increase the welfare and relative status of those population groups in the weakest position. The objective will then be to reduce mortality differences between the genders, groups with different educational backgrounds, and different vocational groupings by a fifth" *(14)*.

All the Finnish policy documents examined for this study refer to the Nordic welfare state and the reduction of health inequalities as being central goals of Finnish policy. A 2004 report by MSAH examined how inequalities in health are tackled in England, the Netherlands and Sweden in order to "introduce experiences gained in these countries to the Finnish audience, and to assess whether lessons could be learnt" *(20)*.

Adherence to the principles of the Nordic welfare state provides a clear general framework for policy development at a national level in Finland, a situation not so easily evident in other countries. Nevertheless, although the equality principles have been so clearly stated and over a long period of time, it is more difficult to discern the policy interventions intended to narrow the gaps, particularly in relation to NCD. There is also some concern that in recent years the Nordic model has become rather shaky and that lower standards are being tolerated.

2.1.4. Setting the agenda

The long history of developing Health for All policies in Finland created a particular way of thinking, as did the North Karelia Project that gained worldwide fame. The young, talented leaders of those movements originally set the agenda. Since key bureaucrats do not change with changing governments, they have been in place for three decades and are now approaching or have just reached retirement age. It is not clear who their "heirs" might be. However, although the personal leadership qualities of such key actors might not necessarily have been replicated, it is probable that the system prevalent in Finland of facilitating on-the-job training and of moving staff between research, the academic field and the bureaucracy will ensure that experienced people emerge from among the cohorts of younger experts.

The small population of the country and easy personal contact strengthen a system that allows for open discussion of the challenges and an approach of "continuation plus change" to deal with them.

Another important condition for agenda setting was Finland's accession to the EU. Finland was acutely conscious of the possible challenges and opportunities for health in join-

ing this "club" and explored them well in advance. National research centres and individual experts have been involved in assessing some of the implications of European policies on Finnish national policies – for example the forced reduction of alcohol prices, which increased alcohol consumption. They were also prepared to influence European policies in directions of interest to Finland, such as a stronger focus on mental health and, more recently, health in all policies *(13)*.

Strong and continuous collaboration with WHO has served to help set the agenda or to further legitimize policy decisions. In this respect, the use of policy reviews by international teams has proved to be an effective way of obtaining an objective view of progress, and a particularly Finnish way of doing things.

Health 2015 continues to aim to give people a longer and healthier life and to reduce health differentials between population groups. In addition, five "targets for different age groups" and three "targets for everyone" are set *(14)*.

1. Child well-being and health will increase, and symptoms and diseases caused by insecurity will decrease appreciably.
2. Smoking by young people will decrease to less than 15% of those aged 16–18; health problems associated with alcohol and drug use among the young will be dealt with appropriately and will not exceed the level of the early 1990s.
3. Accidental and violent death among young adult men will be cut by a third of the level during the late 1990s.
4. Working and functional capacity among people of working age and workplace conditions will improve, helping people to cope longer in working life; retirement will be about three years later than in 2000.
5. Average functional capacity among people over 75 will continue to improve as it has during the last 20 years.
6. Finns can expect to remain healthy for an average of two years longer than in 2000.
7. Finnish satisfaction with health service availability and functioning, and subjective healthiness and experiences of environment impacts on personal health will remain at least at the present level.
8. In implementing these targets, another aim will be to reduce inequality and increase the welfare and relative status of those population groups in the weakest position. The objective will then be to reduce mortality differences between the genders, groups with different educational backgrounds, and different vocational groupings by a fifth.

Some targets may be difficult to reach given the crisis in the health services already referred to and the lack of success in tackling alcohol abuse, which leads to much of the violence. Nevertheless, working life has already been lengthened by two years.

Perhaps surprisingly, the need to tackle NCD is not specifically highlighted. Reference is made to related problems seen to be increasing, such as obesity, diabetes, asthma and mental health, and to dealing with risk factors such as smoking, alcohol abuse and lack of physical activity.

2.1.5. Finding solutions

The need for municipalities to act individually or in collaborative projects is seen as being crucial to implementation of the programme, and they were to be given expert assistance to accomplish this.

Within the health care sector, the emphasis is on achieving equality of access to care, although reference is made to the need for taking better account of the health promotion viewpoint.

Business and industry and NGOs are seen as playing an important role and this is to be encouraged by involving and listening to them and providing them with expert advice, but also through regulatory measures.

Broad use is made of "recommendations" and "guidelines". For example, expert committees have made recommendations regarding healthy food, high blood pressure and cholesterol, dietary guidelines, and goals for mass catering in relation to the fat, salt and sugar content of meals provided.

HIA is seen as a vital tool for avoiding negative influences on health and picking up opportunities for health promotion. MSAH and the Prime Minister's office are to produce guidelines for HIA of central government decisions and compile models for HIA at municipal level and in business and industry. In Finland, environmental impact assessment has been mandatory since 1994 and should include the impact of "health hazards". At the same time, social impact assessment has been carried out. In the Finnish language, this has a narrower meaning than "social" in other countries, referring to social protection and social services, and has been carried out mainly by Gallup-type reporting on, for example, whether people were willing to pay more for services. It is suggested *(21)* that HIA might possibly be carried out as part of a broader "human impact assessment" and in 1999, MSAH published a handbook on the assessment of social and health impacts.

2.1.6. Structures and processes for implementation

The previous method of top-down guidance through earmarked resources made the Government, in the view of a bureaucrat of the time, "almost able to dictate" to the municipalities. This system was abandoned in the early 1990s, when the municipalities demanded more freedom. Under the present system, the centre sets overall policy direction and provides expert support for local-level policy development and training. There is considerable doubt as to its success, however, owing to ensuing inequalities, and in some cases a serious lowering of standards, in services provided.

MSAH is to coordin ate and monitor the implementation of *Health 2015* at national level. In addition, the multisectoral Advisory Board for Public Health, set up in 1997, has two subgroups, one to support the municipal level and one to deal with intersectoral action at national level. The permanent standing committees of MSAH dealing with issues such as alcohol, drugs and chemical safety include important NGOs and are the locus of intersectoral action.

STAKES and five smaller agencies were founded in 1992, following the dismantling of the previous National Boards for Health and Welfare. STAKES' original mandate did not include health promotion, but over the years such tasks have gradually increased. With the reorganization of the state alcohol monopoly (ALKO) in 1996, functions related to sociological alcohol studies were transferred to STAKES. When the Finnish Centre for Health Promotion was strengthened and given the task of supporting citizens, STAKES was asked to support municipalities in developing health promotion strategies. Support to municipalities takes the form of helping prepare decisions for the allocation of health promotion funding; assistance in formulating policies; developing indicators and reporting; and training for interactive ways of working. One of STAKES' first health promotion activities relevant to NCD was contributing to the development of social impact assessment.

STAKES assists MSAH in health policy analyses, which in 1996–1997 included a review of intersectoral policies in Finland. Although it is widely accepted that STAKES has carried out valuable policy-related research, there is less consensus on how far it has been able to carry out its role of supporting the local level. The role and function of the institution is therefore presently being re-examined.

All urban and rural municipalities in Finland are members of the Association of Finnish Local and Regional Authorities, which also provides services to joint authorities. The Association not only promotes the interests of local authorities and seeks to influence related legislation, both at the national level and in the EU through its Brussels office, but provides information, guidance and training and facilitates opportunities for discussion through its networks.

2.1.7. Monitoring and evaluation

Finland has had regular surveillance systems in place for many years, providing an excellent database for the monitoring and evaluation of health policy. Considerable effort is made to provide data on the local level and give local authorities support in the use and processing of such data. The quality has been enhanced through pilot projects to improve the standardization of data and test hypotheses. Evaluation takes place on various levels from that of general policy to evaluating the effectiveness of specific methods of treatment.

Finland reports regularly to international organizations such as WHO and the EU, participates actively in Nordic monitoring exercises, and collaborates closely with the Baltic countries. Indeed, in the 1980s and 1990s, efforts expended in international monitoring and evaluation exercises perhaps detracted to some extent from similar domestic exercises, particularly from the need to discuss broadly the policy implications of the results. Undoubtedly, however, a valuable body of internationally comparable information and exchange of experience has been created.

Health 2015 goes a step further, calling for the regular monitoring and evaluation activities of the Government and individual ministries to include progress in health policy implementation. In particular, the social and health report made to Parliament every four years is expected to indicate progress across sectors and at different levels of government. *Health 2015* also continued the Finnish tradition of seeking constructive criticism and provided for an external evaluation of health promotion structures, resources and activities. This took place in collaboration with WHO in 2001 *(12)*. An external evaluation of national health policy is expected during the present decade.

Since this type of evaluation is not widespread across Europe, it is worth highlighting the Finnish attitude towards critical evaluation. For example, when in 1989 the terms of reference for the first WHO review of the Finnish Health for All policy were being agreed, the then Minister was asked what the position would be if the external review group expressed views unattractive for Finland and with which domestic experts did not agree. Her reply was, "You publish whatever you find".

2.2. Health promotion strategy

Health 2015 was considered to deal largely with health promotion and disease prevention issues and there was therefore no separately labelled "health promotion strategy". However, the new government action plan calls for a strategic plan for health promotion. An ad hoc working group set up in MSAH has almost completed its work.

2.3. Health services policies

Even though the municipalities were owners of PHC centres and hospitals, MSAH closely controlled health care development until the early 1990s by earmarking funding for investment and staffing. In 1993, the Ministry of the Interior brought in far-reaching reforms, giving greater autonomy to the municipalities by replacing earmarked subsidies with block grants. Similar changes were taking place in other Scandinavian countries such as Denmark, and with similar results. In return for greater autonomy at the local level, the central level had to compromise on the achievement of centrally defined targets. In recognition of the problem of balancing local autonomy with considerations of equality, Norway and Sweden have apparently preferred to compromise local autonomy to some extent in the interest of greater equality in relation to child care, for example *(22)*.

Since 1993, state support for statutory services in Finland has been based on a needs-criteria formula (population, age structure, morbidity, etc.). This has led to certain disparities among municipalities. Furthermore, the total cost of health care met by households has been rising steeply, reaching 19% in 2003 *(23)*, which may act as an obstacle, particularly to preventive care.

MSAH prepares for approval by the Government a programme of action for social welfare and health care for each four-year legislative period *(24)*. This includes a decision on resources, which is revised annually in line with the government budget. Since 2000, the municipalities have prepared similar four-year programmes.

It is difficult to assess the strength of health promotion in the present-day health services, although attempts have recently been made to amend the legislation "in order to emphasize preventive health care as an integral part of primary health care" *(24)*. With the shift from hospital care to PHC following the 1972 Public Health Act, health education became an important part of the work of PHC centres. All municipalities, individually or as joint organizations with a common PHC centre, were required to produce intersectoral plans for health education, in which partners from schools, sports clubs, local NGOs, etc. were expected to participate. New posts in PHC centres were established for "coordinators of health education". For the most part, these were filled by public health nurses, who became groundbreakers in the move from health education to health promotion. These public health nurses exchanged experiences at national congresses organized annually. This network has now largely disappeared, partly as municipalities took priority setting into their own hands, and partly as the economic crisis cut the flow of new resources to the health services and health promotion coordinators were returned to routine work in well-baby clinics or home nursing. However, GPs and public health nurses in PHC centres and occupational health services are said to have been central to efforts in smoking control, for example.

Until the early 1990s, Finland was able to achieve reforms and policy changes in an atmosphere of economic growth. The shift towards PHC and community-based care could be achieved by putting in new resources without necessarily cutting resources to tertiary care – although some of the perceived shift was apparently achieved by simply transferring small specialist clinics to the PHC centre umbrella *(10)*. The economic crisis brought a severe shock to this rather painless policy process. From 1991, when the Department for Social and Health Services enjoyed a budget of about 30 billion Finnish marks, funding was reduced by about one third in the following four years. PHC was hit particularly hard by the cuts *(10)*. Although the economic situation has improved, the need to reshape health and social policy in line with available resources, while ensuring equality and efficiency, is a dominant preoccupation.

Recognizing growing problems in the availability of services, the Council of State initiated a national project to ensure the future of health care *(25)*. It is clearly stated that preventive work is one of the paramount duties of PHC. The principle of access to care within a reasonable time was to be embodied in legislation by 2005. Training of health personnel was to be increased in line with a 2001 report on the demand for such professionals. The Ministry of Education was to revise decrees concerning training so that this included at least nine months of practical work in a health centre. Trade unions and employers were to discuss how "bonuses for results" might be factored into wage-related solutions in the health care sector.

National treatment recommendations have a long history, including those for alcohol control from the prohibition era of the 1930s; cervical cancer screening from the 1970s; coronary heart disease and stroke prevention from 1972; hypertension prevention and treatment from the 1980s; healthy nutrition guidelines from 1989; chronic respiratory disease prevention since the 1990s; diabetes prevention and treatment since 2002; and health enhancing physical activity from 2003. Preparation of such recommendations was to be continued.

In 2006, the Economic Council of Finland requested an expert report on curbing health care expenses *(26)*, which it discussed at its meeting on health care issues in December

2006. The report stresses the need for health promotion strategies to be included in the government programme, noting that, although national investments in preventive measures have slightly increased, at the municipal level they have actually decreased.

2.4. Policies for specific NCD

2.4.1. Heart health

Following the groundbreaking "Framingham study" *(27)* in the United States, from which the concept of risk factors for CVD was born, Finland was one of seven countries included in an international study that tried to explain the variation in death rates from coronary heart disease in different countries *(28)*. Interest was triggered by the exceptionally high rates of CVD in Finland in the early 1970s. The North Karelia Project had already started in 1972, and when WHO organized the MONICA Project in the early 1980s to measure CVD and risk factor trends in a standardized way, three areas in Finland, including North Karelia, joined the Project (see below).

In 1988, the Government appointed a multidisciplinary committee to prepare a national programme for coronary heart disease prevention, dealing with food and nutrition among other topics. In the Finnish tradition of looking for consensus and resolving conflict, negotiations ensured that losses to the state budget from cuts in one area were made up for in another, as for example in balancing price changes of dairy products and tobacco *(11)*.

Another facilitator in tackling specific diseases or their risks is the very strong role played by NGOs in Finland. This is due to their size and influence and the fact that they frequently include top national experts among their members. In 2007, for example, the Finnish Heart Association had over 85 000 individual members, 19 regional societies and 240 local societies, and its president was a world-renowned expert in health promotion and Director-General of the National Public Health Institute (KTL).

In November 1997, the Finnish Heart Association, in collaboration with MSAH, organized a consensus meeting that led to the formulation of a policy for promoting heart health. In 2003, the Finnish Heart Association began work revising this and formulating the *Action Plan for Promoting Finnish Heart Health for the Years 2005–2011 (29)*. Representatives of dozens of different interest groups participated in its preparation. Four working groups, under the supervision of a small management group, focused on health promotion at different stages of the life-cycle. They produced extensive background reports, which were crystallized into 50 action proposals for the whole population and different age groups. The main goal is that in 20 years, CVD will no longer be a health problem for working-age adults and people will enjoy healthier, active lives.

Over the years, collaboration has been achieved not only between NGOs and the state but also with the private sector. One interesting development was the 2000 launching by the Finnish Heart Association and the Finnish Diabetes Association of the "Heart Symbol". The right to use the Heart Symbol can be given in six product groups, including milk and dairy products, edible fats, meat products and bread, cereals and cereal products. Products where fat and sodium are not a problem (such as fruit and vegetables) are left out of the system. Manufacturers can apply to use the symbol subject to a charge that is used to maintain the process. By September 2006, 28 companies (277 products) had applied to use the symbol, showing consumers quickly and simply the healthier choice.

The necessary database for raising awareness and taking action on heart health has been available for many years, and experience of tackling CVD was probably a key to taking similar action on other NCD.

2.4.2. Cancer

Voluntary action for tackling cancer began in 1936 when the Cancer Society of Finland was founded, funded by a large

private donation. There are now 12 regional cancer societies and 4 patient organizations with over 140 000 individual members.

The Finnish Cancer Organizations, which includes the original society, the Finnish Cancer Registry, the Cancer Foundation, the Foundation for Cancer Research and the Foundation for the Finnish Cancer Institute, is now one of the largest public health organizations in the country.

Efforts originally concentrated primarily on helping poor cancer patients, including the running of seven hospitals, later transferred to the public sector. Attention shifted in the 1960s to patient organizations and the Finnish Foundation for Cancer Research was founded in 1969. The Cancer Society was one of the driving forces in the nationwide antismoking campaign.

By the 1970s, NGOs and public authorities were already working together in national working groups to develop cancer control programmes. The Finnish Cancer Registry provided valuable epidemiological data for this purpose. Hospice and palliative care gained ground in the 1980s. By the 1990s, health promotion campaigns had been modernized and emphasis was placed on evaluating the quality and effectiveness of various screening methods, so that only screening shown to be effective would be funded.

Cancer control is considered to be mostly well-planned and well-implemented, and developments in the reduction of cervical and breast cancer have been very good *(30)*. Of the EU countries, Finland now has the lowest death rate for all cancers in the population aged 0–64 years. There is some concern, however, that scientific results are not always taken into account quickly enough in the planning process.

2.4.3. Mental health

Finland, like most countries, has a long history of isolated mental hospitals located away from urban developments. The mental health legislation of the 1950s led to a doubling of these institutions, so that by the early 1970s Finland and Sweden were among the countries with the highest bed ratios for mental patients in the world (over 4 beds per 1000 population). About 50% of these institutions were new, built during the previous 20 years, but they were not easily accessible. The stigma associated with mental illness was still strong.

By the late 1960s and early 1970s, many industrialized countries were questioning such institutionalized care. New drugs made possible new ways of providing treatment outside institutions. The WHO Regional Office for Europe was among the early advocates for raising public health interest in mental health services in the Member States.

In late 1970s, the National Board of Health published an expert report and recommendations for the development of mental health services, including proposals for disease prevention and mental health promotion. The epidemiological analyses carried out, and the evaluation of existing mental health institutions, indicated a need for only 0.6 beds per 1000 population for institution-based psychiatric care. In fact, two thirds of the existing beds were being used for non-psychiatric patients, including chronically ill older people in need of good basic somatic care, social support and housing. This report formed the basis for mental health policies for the next few decades.

When PHC was totally reorganized through the 1972 Public Health Act, however, mental health services were not included. To compensate for the lack of a mental health component in primary care, a new role for psychologists was developed. They were given the task of promoting mental health in schools and day-care centres together with

school nurses. This approach was new in Europe and raised considerable interest in WHO Member States *(31)*.

During the 1980s, the key aims of mental health policy were the closing of mental institutions and the creation of new psychiatric wards connected to somatic hospitals, and the development of outpatient mental health services together with possibilities for sheltered housing. A special project for the early diagnosis and treatment of new schizophrenic patients raised international interest and has been a permanent and successful development in their care *(32)*.

Suicide figures in Finland have been among the highest in Europe. In the mid-1980s, therefore, a special ten-year project was initiated for the prevention of suicides. During the first year of the project, the social, psychological, somatic and mental background of each suicide was very carefully analysed. Members of victims' families and other social networks were interviewed, their latest contacts with the somatic, mental health and social services were investigated, and their use of alcohol and drugs was examined *(33)*. Based on these results, a countrywide action plan was developed. At the PHC level, the early diagnosis and effective treatment of depression and better care of alcohol problems were given priority. The results of the project were evaluated by an international review group *(34)*. Fifteen years later, suicide figures were 30% lower than in the mid-1980s.

As seen above, in the early 1990s, Finland suffered the most severe economic recession in its history and savings in all sectors were unavoidable. These cuts hit worst those not capable of defending themselves, including the mentally ill. The rapid reduction of mental institutions was an easy way to make savings in the health budget. Instead of their planned gradual closing over a period of about 20 years, 15 000 beds were reduced to less than half that figure – 6000 – over 6 years. The effect of these misguided savings has had a strong impact on the mental health of the population, with the growing burden of mental illness being the main increasing trend in compensations of social insurance costs during the last 10–15 years. The mental health services still feel the effects of these severe cuts.

To raise awareness at the European level, Finland chose mental health as its main public health topic during its first EU presidency. "There is no health without mental health" was the main message. Mental health was also the main topic of the World Health Assembly in 2001 and of *The world health report* for that year *(35)*. The WHO Regional Office for Europe held the WHO European Ministerial Conference on Mental Health in Helsinki in 2005. The Conference adopted a political declaration and an action plan to be followed until 2010, and a network of WHO collaborating centres was created to monitor and evaluate implementation of the action plan. In Finland, STAKES, KTL and the Finnish Institute of Occupational Health together comprise one such centre, with the primary task of developing mental health promotion activities for different age groups.

During the last 25–30 years, policy for mental health in Finland has seen considerable ups and downs. The structure of mental health services has undergone almost total reorganization. The stigma associated with mental health and psychiatric disease, though still prevalent, is much milder. The incidence of suicide is slowly decreasing. On the other hand, the burden of mental health problems in younger age groups is increasing and mental health constitutes a continuously growing social burden.

As in other areas of NCD policy development in Finland, recommendations for mental health policy mainly followed careful research and analysis. In the event, however, certain of these evidence-based policy recommendations were overtaken by economic considerations. One of the main future challenges for NCD policy will be in the mental health field.

2.4.4. National demonstration projects – North Karelia, CINDI, MONICA

In the 1970s, Finnish men had the highest CVD mortality in the world. This was particularly serious in eastern parts of the country, and especially in the province of North Karelia. In response to a petition for help signed by a group of provincial representatives, local and national authorities, in collaboration with WHO, launched a comprehensive effort in 1972 to tackle CVD morbidity and mortality.

The main medium-term objectives were to reduce smoking prevalence and lower cholesterol and blood pressure levels in the whole population, but particularly among middle-aged men. The existing health and social services, together with government and private authorities, were all expected to play an active role at local and national levels.

The Project included a comprehensive package of actions affecting various settings and sectors: legislation on tobacco control and the production of certain foods (such as mixing oil and butter); regulations concerning smoke-free areas and healthier school lunches; collaboration with manufacturers and retailers on the production and sale of healthier food products (less salt and fat); promotion of berry farming; broad use of the mass media to raise awareness; involvement of community organizations (local politicians and opinion leaders, the Heart Health Association, women's organizations and sports clubs) with special attention to providing healthier meals at the workplace; and far-reaching educational efforts through schools and other educational institutions.

The changes in health behaviour and their biological consequences were quite remarkable, with changes in diet playing a particularly important role *(36)*. The risk factor changes were followed by a clear fall in mortality from coronary heart disease *(37)*. In the initial pilot project period 1972–1977 only North Karelia was targeted, but given the interest of the mass media, many of the Project's messages quickly spread throughout the country. After the first ten years, the scope of the project was enlarged to cover other lifestyle-related chronic diseases and to promote general health. Over a 30-year period, the age-standardized mortality rate from coronary heart disease for men aged 35–65 years fell by 82% in North Karelia and, partly as a result of the demonstration effect of the project, by 75% in the whole country, with a similar decrease for women.

The Project continues to serve as a national demonstration project, and local agencies organize not only regional but also national campaigns such as the National Quit & Win campaign in 2005, and developmental work to create local health promotion strategies in municipalities. The surveys initially designed to evaluate the North Karelia project gradually developed into a national risk factor monitoring system (FINRISK studies).

Among the interesting characteristics of the North Karelia Project are its systematically developed evidence base; solid partnerships between national and local government, civil society and the private sector; the interaction of health services with other community activities; and the positive media interest. Within these partnerships, there has been a clear sense of government responsibility for health promotion, with civil society playing both a supporting but also a watchdog role and, over the years, the private sector gaining better understanding of a health promoting business being a more sustainable business.

Towards the end of the 1970s, intense interest in population trends in CVD encouraged WHO to bring together investigators from a number of countries to standardize their definitions and measurements and combine their findings *(6)*. This led to the WHO MONICA Project. Finland not only became a member of this project, monitoring CVD in three regions (North Karelia, Kuopio Province and Turku/Loimaa), but hosted the MONICA data centre at KTL in Helsinki.

In addition to the more traditional epidemiological work, various hypotheses were tested that could not have been done with one population alone. The Project also began to work as a national demonstration programme for chronic disease prevention and influenced action in other countries. This shows how decisive input by a relatively small country to an international project can reap considerable domestic benefit and contribute to international thinking.

Finland also became a member of the WHO Regional Office's CINDI programme established in 1984. The aim of this programme is to develop and evaluate intervention strategies and methods for chronic disease prevention. In Finland, the CINDI programme is coordinated at the Department of Health Promotion and Chronic Disease Prevention at KTL, which is a WHO collaborating centre for NCD prevention, health promotion and monitoring. Finland plays an active role in the CINDI programme, organizing international meetings and training seminars on integrated NCD strategies and prevention. There is also close collaboration with the Baltic countries through the FINBALT health monitoring system.

2.5. Policies related to risk factors

Unlike the broad policy directions defined in the umbrella-type policy documents, those concerning specific NCD and their risk factors tend to be more action-oriented or are reflected in legislation.

2.5.1. Tobacco policies

Tobacco control has been one of the success stories in Finland. The need to reduce smoking was recognized as early as the 1950s, when 76% of men smoked. In 1961, Parliament requested the Government to take strong measures to reduce smoking and to consider legislative action. The need for health education was recognized in the 1972 Public Health Law. In the same year, the Tobacco Control Act designated 0.5% of tax revenues from tobacco products to be used for anti-smoking research and education (this was raised to 0.75% in 1995).

The 1976 Tobacco Act was passed unanimously by Parliament, setting the stage for restricting sales to minors, a total ban on advertising, smoke-free public premises and smoking prohibition on most public transport. This law was amended a number of times, most notably with the Improved Tobacco Control Act that came into effect in 1995. This legislation involves many sectors in reducing the yields of certain harmful substances, reducing exposure to tobacco smoke for smokers and non-smokers alike (particularly in the workplace, where smoking was prohibited except in one-person offices or in special smoking rooms) and promoting health education, smoking cessation and related research.

According to information from interviews carried out for this study, the long-term strategy was to "give each new parliament (every four years) something new, always keeping within the limits of what was acceptable to the population, but continuously ratcheting up tobacco control". Since the prime movers in MSAH were in place over a long period of time, they successfully kept up the pressure.

In 1978, a special health education office was established at the National Board of Health and became an active focal point for national anti-smoking policy. In 1992, the office was moved to MSAH, where the work continued. Responsibilities for enforcing the regulations are divided at the local level between public health and occupational protection authorities and the police, and at the national level between MSAH and the official state prosecutor.

The original Finnish Health for All policy *(9)* stated boldly that "Refusal to use the price weapon means a conscious adoption of responsibility for several thousands of cases of cancer and unnecessary cardiac deaths". Issues related to pricing policy options, however, were regulated by the Ministry of Finance and its role and that of the Ministry of Trade and Commerce have tended towards protecting the interests of industry rather than health. This has largely

been the case at the European level, where tobacco has for many years been one of the most highly subsidized crops. The price of tobacco is estimated to be the most important single factor determining its consumption. Owing to increased prices and the simultaneous economic recession, total sales of tobacco fell by 16% in the 1990s. From a fiscal point of view, raising prices can be problematic, since tobacco products account for more than 2% of the consumer price index. The WHO Health for All strategy suggested that tobacco products should be disconnected from the consumer price index.

The role of health professionals in smoking control has gradually increased. By 1995, more than a third of smokers had been encouraged to quit in the previous year through contact with the health services. Special attention has been paid to promoting non-smoking among pregnant and lactating women and, in the home, to safeguarding children from passive smoking. An interesting outcome of the broad discussion has been the public support engendered for these actions. Regulations for smoke-free workplaces are widely accepted. Some 99% of non-smokers, but also 69% of smoking men and 83% of smoking women agree with workplace smoking restrictions *(38)*.

As in other countries, the persistent and long-term attempt to control smoking has had to contend with aggressive tactics by the tobacco companies. This has largely been a successful battle, however. The percentage of regular smokers among men has dropped from 60% in the early 1960s to 27%. For women, although there was an increase from the then very low levels to about 20% (mainly among women with low education), this increase appears to have stopped. Finland does not compare well for smoking among 15–16-year-olds, owing to an early onset of smoking. The quantified target for reducing smoking among young people, set in the overall health plan, is intended to highlight this issue, but is also expected to act as a more general indicator of progress in dealing with the problems of young people.

2.5.2. Alcohol policy

Unfortunately, alcohol control cannot be considered a success. This is despite the fact that, for historical reasons, there has been strong public support for alcohol control. Legislation in 1932 brought the production, import, export and sale of alcohol under state monopoly, a situation that lasted until 1995. In the early years, control was so tight that it even prescribed how customers should dress and behave in restaurants serving alcohol. Until 1995, it was illegal to drink in public and several municipalities still forbid this.

Investment in alcohol research has produced evidence on the effects of various alcohol control measures, supporting the rather strict control imposed. This has only gradually loosened, owing partly to free market forces enforced when Finland joined the EU. The 1994 Alcohol Act repealed the state monopoly, effective from 1995, except for retail sale through the monopoly ALKO stores. A new state agency, the National Product Control Agency for Welfare and Health (STTV), has replaced ALKO as the state alcohol administration and grants licences for the production, import and sale of alcoholic beverages. Limits on the amounts of alcohol Travellers are allowed to bring into the country had to be raised to meet EU requirements. In 1995, the retail sale of beverages produced by fermentation with less than 4.7% alcohol was allowed in grocery stores, kiosks and petrol stations that also sold foodstuffs.

In 1995, the changing situation led to the adoption of a four-year national alcohol policy, based largely on the 1992 WHO European Alcohol Action Plan. A revised programme and implementation plan was adopted in 1997. The intention was to shift the focus of preventive measures to the local level in workplaces, schools and communities, but there was apparently a lack of coordination and resources to bring the relevant actors together.

In 2000, MSAH asked the Permanent Committee on Alcohol, Drugs and Temperance Issues to update the alcohol

programme along the lines of the second WHO European Alcohol Action Plan. The Committee made ten proposals for a programme covering 2001–2003, stressing the role of more general determinants of health such as housing, income and employment in affecting alcohol-related problems.

The present programme covers the period 2004–2007 *(39)*. The main aims are to:

- reduce the harmful impact of drinking on the welfare of children and families;
- reduce risk-level drinking and its effects; and
- reduce overall alcohol consumption.

In keeping with the Finnish tradition of evaluating actions, a comprehensive package of interventions has been found to be effective, and these are to be implemented mainly through existing structures for cooperation. Funds are to be provided through the state budget for municipalities, from public appropriations for health promotion and from the Slot Machine Association for NGOs, in addition to these partners' own resources. Participation in the programme is voluntary and in its initial year over 100 partners had already signed up, including about 60 NGOs, the churches, trade unions and about 20 municipalities. Guidelines for intensifying work on substance abuse are provided for municipalities.

Particular emphasis was placed on monitoring progress, and the results of an interim survey were included in the Government's report to Parliament in 2006. The interim report indicates that EU legislation and the expanded markets have undermined the traditional alcohol policy and reduced the effectiveness of price policy. For example, the restrictions on imports of alcoholic beverages were abolished in 2004, as agreed in the Treaty of Accession to the EU, by reducing taxes levied on alcohol by 33% on average, with the result that alcohol consumption rose by 10.3 litres of pure alcohol per inhabitant *(40)*. The objectives of the government strategy are therefore far from being reached and new ways of influencing alcohol consumption must be found *(41)*.

2.5.3. Nutrition

Various factors have contributed to keeping food and nutrition issues on the agenda in Finland. Although Finland has produced and imported sufficient food for an adequate diet since the Second World War, healthy eating habits were not quickly adopted nor was the production of food surpluses avoided. The land given to those who were relocated after the War was more suitable for raising dairy cattle, and until 1987 the Centre (Agrarian) Party shared political power, creating a strong agricultural lobby.

"It is interesting that excellent data identifying the link between health status and food and nutrition were available in Finland, based on thirty years' tradition of research into coronary diseases, long before comprehensive action was taken" *(11)*. However, by the early 1980s, the public had become highly aware of the impact on health of poor diet, largely through the North Karelia Project. This made it easier to set up a National Committee on Diet and Health in 1981, which issued dietary recommendations.
Progress was not always easy, as indicated by events in 1988 "when dairy producers, reacting to decreasing butter consumption, began to fight back. Full-page advertisements were taken out to refute the claims of the nutritionists. A lively public debate followed in all the mass media. Butter consumption continued to decline, however" *(11)*.

A plan for health education for 1984–1988 included: improved public information; dietary guidelines for workplaces and institutions; the adaptation of producer food prices to favour low-fat milk; food regulations concerning sodium content and labelling; training of relevant staff; and further study of eating habits. All these were achieved, which perhaps led the food industry to increasingly seek (through surveys and symposia) the views of nutrition experts. Less was done to evaluate the effectiveness of health educational

materials or to check on the use of such materials provided by food producers.

In 1988, the Government appointed a multidisciplinary committee to prepare a national programme for coronary heart disease prevention, which dealt with food and nutrition among other topics. The National Nutrition Council prepared an action plan for the implementation of the food and nutrition aspects. What was particularly interesting in relation to creating partnerships for health was that MSAH agreed that the National Nutrition Council would be more effective if the main control came from the Ministry of Agriculture and Forestry. That Ministry chaired the Council and had the right to approve the names of its members. Fifty years later, this configuration still operates effectively, providing expert recommendations and guidelines and acting as an intersectoral body to promote collaboration among various stakeholders. Furthermore, there was an attempt through negotiation to ensure acceptable trade-offs for the various partners. For example, MHSA showed that the gain in life expectancy, which would increase the cost of pensions and other benefits, could be counterbalanced by saving lives in "productive" age groups.

New dietary recommendations were introduced in1989 and goals were set for mass catering, which plays an important role in Finland. Perhaps influenced by the cold climate for much of the year, Finland has a strong tradition of providing hot meals in institutional settings. Since the 1940s, free, hot school lunches have been provided to schoolchildren and today the great majority of 11–15-year-old schoolchildren report eating a meal in the school canteen every day. Some 40% of economically active women and 35% of men eat a hot lunch at the workplace *(42)*. Workplace canteens are supported by tax agreements and subsidies. By offering models for healthy eating, catering services have supported national dietary recommendations.

The latest action plan was launched in 2003. While the role of the Government is mainly restricted to guidance and information, the role of municipalities and NGOs is emphasized. The Finnish Nutrition Recommendations were renewed in 2005, based on the latest Nordic Nutrition Recommendations approved in 2004 by the Nordic Council of Ministers. Recommendations on physical activity are also included in the new version.

Two issues are currently high on the agenda: the prevention of type 2 diabetes and obesity, particularly among children. The Finnish Diabetes Prevention Study, started in the late 1990s, "was the first randomized study in the world to show that the onset of type 2 diabetes can be delayed and even avoided by lifestyle modifications among middle-aged individuals with impaired glucose tolerance" *(43)*. Recommendations from this study have been incorporated in the National Programme for the Prevention and Care of Diabetes (DEHKO 2000–2010). The issue of obesity is becoming so serious that one expert interviewed considered that sugar might be the next target for taxation.

One factor hindering the implementation of a strong nutrition policy is that the food industry is becoming more northern European than Finnish. As Finnish firms export more products to the Baltic countries, for example, it becomes difficult to persuade them to accept restrictions within Finland that are not necessarily required in other countries. On the other hand, Finland is also affected by what has been called the "wellness revolution" *(44)*. One third of magazines refer to health issues, and particularly to nutrition and physical exercise. At the same time, the "wellness" market is burgeoning, with functional foods to help manage specific diseases such as diabetes and arthritis or problems such as stress or low energy. There is a growing need to protect consumers from fraudulent claims and harmful products, so that knowledgeable consumers "can exercise choice in a highly unregulated health and wellness market" *(45)*.

2.6. Settings

Finland has used the settings approach for many years in schools, cities and hospitals, strengthened by involvement in international networks. More recently, certain researchers have developed standards for health-promoting sports clubs, since these play a dominant part in leisure activities, particularly for 10–18-year-olds *(46)*. Economic and legislative changes have given local communities more flexibility in allocating their state-provided resources.

2.6.1. The workplace

Health in the workplace is a top priority in Finland, and an occupational health care system has been in place since the beginning of industrialization. This was systematically developed after the Second World War, and particularly since the 1960s *(47)* through collective agreements among the labour market organizations. Legal recognition was given by the 1978 Occupational Health Care Act, at a time when consensus politics functioned well, based on collective income policy agreements. A national development plan for occupational health was introduced in 1989.

The Finnish Institute of Occupational Health supports these efforts. The Institute was originally founded with financial aid from the United States, partly to offset the fact that Finland was not included in the Marshall Plan. It has become one of the largest of its kind in Europe, operating in conjunction with six regional branches. The Institute is now funded largely by the Government, with about 30% from external sources. In addition to research on occupational health, the work environment and work organization, frequently combined with action programmes, the Institute offers advisory services and training. Two thirds of the professional staff in occupational health care have received specialized training. All five medical schools in the country have a professorship in occupational health.

According to a guide for planning occupational health services *(47)*, the goals of the occupational health services are:

- preventing health hazards and protecting employees' health;
- adapting working conditions to suit the worker;
- rehabilitation;
- health promotion; and
- PHC.

Previously, occupational health care was regarded as a series of individual actions responding to problems or risk factors related mainly to safety. Since the major occupational safety factors are now said to be largely under control, more attention has been given to health promotion, supported by important research. For over 20 years, the Institute has been concerned with the physical and mental stress encountered by people in the workplace, and by issues facing an ageing workforce. Musculoskeletal diseases are still the greatest cause of new work disability pensions in Finland and in 1994, every fifth employed person suffered from a chronic disease.

For a number of years, the issue of labour availability has been on the agenda as labour shortages in some sectors were combined with long-term unemployment, particularly among older people. There are therefore, converging interests between the health and labour sectors.

A long-term study of older workers led to the development of the concept in Finland of "maintaining work ability" *(48)*. When the collective incomes agreement was signed in 1990, and legislation on rehabilitation was completely overhauled, the major social partners also agreed on action to maintain work ability. The overhaul of the relevant legislation obliged employers to take action on the maintenance of work ability, and was followed by new reimbursement criteria. The aims can, however, be somewhat conflicting: on the one hand to protect and promote individual health at the workplace and, on the other, to reduce the numbers seeking disability pensions and retiring early.

The employer, in both the public and private sector, is responsible for health and safety at the workplace and is required to organize and pay for preventive occupational health services for all workers regardless of the size, industrial sector or form of the enterprise. The provision of curative services is voluntary but is included in 80% of the service agreements. Some 92% of wage and salary earners are now covered for such care and about one third of outpatient medical care for people in employment is provided by the occupational health services. Joining the occupational health service system is voluntary for the self-employed, such as farmers.

Occupational health services may be organized through municipal health centres or private medical centres or by the enterprise itself, alone or in collaboration with other enterprises. The aim is to assess dangers and hazards in the workplace, prevent problems through early intervention, promote health and the ability to work and develop the workplace community and environment. As increasing numbers of doctors prefer hospital or occupational health work rather than PHC, there is some danger of a two-track system, with the employed being well and conveniently served, even in terms of their transfer to hospital care, and the PHC centres dealing mainly with children and older people.

The emphasis in occupational health care is on avoiding occupational health risks, diseases and accidents and dealing with problems related to physical and mental health. Nevertheless, lifestyle issues of importance to NCD are also addressed. About one third of the workforce eat lunch in a workplace cafeteria, which has been important in improving dietary habits. By law, workplaces must have a specific programme for promoting safety and health.

As seen in the section on tobacco, when smoking was restricted in the workplace in 1994 it was well accepted by most workers, including smokers. Anti-smoking regulations in the workplace appear to have been feasible, well-accepted and implemented.

Target 4 of *Health 2015* states that "Working and functional capacity among people of working age and workplace conditions will improve, helping people to cope longer in working life; retirement will be about three years later than in 2000" *(14)*. Employers are already facing some tightening of the labour force and have an interest in keeping older workers for longer. Incentives such as a 4% increase in pension for every extra year worked, and actions to make working life more pleasant, increased the average retirement age by one year between 2000 and 2006.

2.6.2. Schools

The school has long been recognized in Finland as an important setting for health promotion. Hot school lunches have been provided in Finnish schools since the 1940s. Tobacco legislation prohibited smoking in schools in 1977 and tobacco control and other health education issues were included in the curriculum. Also, a special survey of the health habits of young people aged 12–18 was initiated in 1977 and has been carried out every two years since then. Collaboration with England and Norway, initiated in 1982, led to the WHO project on Health Behaviour in School-aged Children, which now includes 41 countries following a common research protocol. A school-based monitoring system of perceived health, health behaviour, opinions on school health services and related factors was started in 1996. The participation of a municipality is voluntary and presumes its partial financial support.

Partly based on the experience of the North Karelia Project, a Healthy Schools programme was started in 1989 and Finland joined the European Network of Health Promoting Schools (ENHPS) in 1994. There is an active national ENHPS network, but the movement for health promotion in schools is much wider than participation the WHO project.

More recently, however, the school setting does not appear to have been utilized as well as might be expected. With the devolution of greater responsibility to the municipalities, including decisions on health education in schools, considerable disparities have evolved at the local level and school health education has become disjointed and unorganized. Apparently only a very small proportion of schools now meet the national standards for health education.

Teenage pregnancies and abortions are among the lowest in the world, but smoking figures among teenagers are comparatively high. Despite the fact that obesity in children is increasing, physical education is no longer compulsory in schools.

2.6.3. Healthy Cities

A number of Finnish cities joined the WHO Healthy Cities programme from an early stage, and the Finnish National Healthy Cities Network was founded in 1996 with the aim of assisting in the implementation of the national Health for All policy. STAKES acts as the coordinator and gives secretarial support to the Network. STAKES offers developmental support and is instrumental in disseminating information to municipalities throughout the country, thus broadening the impact of the Network. Priority areas for 2005–2008 include:

- reducing inequalities in health;
- formulating municipal welfare reports;
- recommendations concerning the health promotion aspect of human impact assessment;
- healthy urban planning;
- healthy ageing; and
- physical activity.

2.7. Policies for specific population groups – older people

The 1985 Health for All policy considered population ageing the most important demographic factor affecting health policy, and tackling chronic illness and disability in the elderly one of the main challenges to public health. Some 80% of beds in PHC centres were then being used for the care of older people, in less than optimal circumstances. Although the importance of community care was mentioned, and about 90% of communes already employed home helps to support older people, the main proposals in the Health for All policy related to health care.

Finland developed its first National Ageing Policy in 1996. Its main recommendations referred to: maintaining the health and working ability of older people; maintaining a good standard of living and housing; developing a needs-led service supply system; improving care; and creating an enabling society whereby older people have similar rights to participate and live their lives as others.

The main aim of the policy was to enhance the autonomy of older people and help them manage their lives independently. It was expected to be achieved through better coordination of the public and private sectors, NGOs and households themselves. It appears, however, that during difficult economic times the community care system has not been developed as quickly as intended and services for older people are vulnerable to cuts at the municipal level.

The Government is expected to present a report on national ageing policy to Parliament every four years. Although it is not clear how far morbidity and frailty can be compressed in the later years of life, on the whole the health of older people has improved. They have fewer symptoms, chronic conditions and circulatory diseases than 20 years ago *(30)*.

Pensioners have been organizing themselves since the 1950s and now have strong NGOs, although, as in most countries, the joiners are the better educated while a large group of non-joiners remains out of the participation picture *(11)*.

2.8. Broad intersectoral policies with a health component

2.8.1. General government development programme

The programme of Prime Minister Paavo Lipponen's second Government in 1999 *(49)* stressed the "paramount importance of work". Chapter 8 dealt with health policy. The maintenance of the Nordic welfare state was stated to be an underlying principle, and the health of the population was to be taken as a prime factor affecting all public decision-making. No mention was made of NCD or health promotion in general, the focus being on the provision of health care.

The development programme is currently being revised. Conscious of the need to curb health care costs, the Economic Council of Finland requested a report on cutting costs through financing systems and disease prevention *(26)*. One of the main findings of this report is that, despite the results achieved so far, further investment in preventive action would significantly improve the level of health and thus general welfare. A call is made for including health promotion strategies in the Government programme.

2.8.2. National Action Plan against Poverty and Social Exclusion

In accordance with the decision of the European Council of Ministers in Nice in 2000, Finland developed a *National Action Plan against Poverty and Social Exclusion 2001–2003 (50)*. This was drawn up by an intersectoral working group, which held two hearings for NGOs and other interest groups. The foundations for this policy had already been included in the above government programme and the 2010 strategies for social welfare and health. Following comments by selected experts and public hearings for organizations and local authorities, the plan was revised for 2003–2005 *(51)*. Although reference is made to the 2015 strategy for health and to the alcohol programme, there is little of direct relevance for tackling NCD.

The Action Plan defines health problems as one of the risk factors leading to social exclusion. The emphasis is mainly on access to care, though mention is made of a recommendation from the Ministry of Education for "health information" to be introduced as a subject in primary and secondary schools and in vocational training, and the development of care for people with intoxicant abuse problems, including smoking and drinking. Municipalities are to offer services to improve the chances of employment for the long-term unemployed, whose limited capacity to work prevents them from benefiting from the rehabilitative job activities provided by the Labour Administration. Given the excellent data available on the increasing gaps between socioeconomic groups in relation to NCD and their risk factors, it is perhaps surprising that those suffering from NCD are not referred to in the document.

2.8.3. Strategies for social protection

Regardless of how far collaboration is achieved in practice, health and social services are seen as being connected, as evidenced by the responsibilities of MSAH. Since 1996, senior members of staff of MSAH have prepared *Strategies for social protection (52,53)* for a "socially and economically sustainable society". The vision for 2010 was for:

> Finland to be a socially and economically sustainable, efficient and dynamic society. The Finnish social protection system will be based on comprehensive collective responsibility. Finland will be actively involved in shaping European social policy. The wellbeing of our society will be rooted in the maintenance of working capacity and general functional capacity allied to individual initiative.

The strategy was summed up in four strategic lines:

- promoting health and functional capacity
- making work more attractive
- preventing and combating social exclusion
- providing efficient services and income security.

It was envisaged that people would be staying in work 2–3 years longer.

It is recognized that health will be increasingly influenced by action at a European level, and the preparation of EU decisions is seen to be an important measure. Similarly, since health must be taken into consideration across sectors, tools were to be developed for assessing the health impact of policies in other sectors.

The revised strategy in 2006 *(53)* states that employment among the ageing had improved and that the retirement age had begun to rise "as a result of legislative amendments and improved efficiency for action programmes". It defines the purpose of social protection as "to promote the health and functional capacity of the population, ensure healthy working and living environments, and secure adequate income and services" – in other words, the prerequisites of health. The need for assessing the impact of decisions at international, national and local levels was also more clearly defined, including impacts on health, social welfare and gender, so that health and welfare become part of a sustainable development strategy.

The strategic direction of the previous strategy was considered still valid, but problems of implementation had come to the fore:

> The more complex the problem at hand, the less effective the administrative action we can take. There are many issues for which legislation is an unnecessarily heavy measure, but recommendations have little effect and the provision of training produces slow change. Inefficient implementation is worst for those in the most vulnerable position, as their problems are also the most complex.

In an interesting discussion of what this means in practical terms, the introduction by the Permanent Secretary states that defining strategic lines is not enough. There is a need to "answer the questions, where are we headed, what can we do and how can we do it". The strategy for 2015 therefore outlines the main lines of action under each of the four strategic lines. Operations are to be based on the guidelines of the *Health 2015* public health programme *(14)* and the *Strategies for social protection 2015 (15)*. Action is to be based on reducing risk factors for widespread diseases and creating circumstances supportive to health. Attention is to be given particularly to groups facing the biggest health risks from smoking, alcohol and obesity, for example.

An attempt is also made to assess the potential economic impact of the strategy in terms of: attaining a 75% employment rate; reducing the age-related demand for care; unemployment; and pressure on social protection expenditure. It is estimated that the proposed measures could hold social protection expenditure at under 30% of gross domestic product (GDP) for the forecast period.

3. Infrastructure and resources for policies to tackle NCD

3.1. Infrastructure

A National Public Health Advisory Committee was set up in 1996 to coordinate approaches to public health, and began by developing a health policy for 2020. The strong research centres supporting health policy development have been referred to above.

STTV was established to prevent health and social detriments caused by alcoholic products, tobacco and chemicals. STTV is responsible for overseeing and steering the implementation of the alcohol, tobacco, chemicals and health protection acts at national level.

MSAH's National Advisory Board on Health Care Ethics (ETENE) is another valuable resource that may be called upon to provide expert opinion on issues relevant to NCD. In 2006, for example, ETENE advised on whether or not it

was medically and economically appropriate to amend PHC legislation to extend breast cancer screening to women aged 60–69 years. European Community projects also play an important role affecting national actors and efforts.

3.2. Human resources

Despite its rather small population, Finland plays an influential role in international organizations dealing with health policy. Key officials in Finland have vast experience of health policy development, particularly in Europe but, owing to their generosity as international donors, also in other parts of the world. At both the national and local levels, key officials in the public sector give their time and efforts to spreading know-how and knowledge through NGOs.

The once unparalleled force of GPs in PHC is now rather more uncertain as their conditions of service have deteriorated and new doctors gravitate towards the hospitals. Furthermore, the once strong network of health promotion coordinators at the local level has largely disappeared. Many of these came from the nursing profession, which has been underpaid for years and is now in crisis. "There is no national human resources plan for health promotion. The total numbers working in the field are not known, and whereas professional education opportunities exist, systematically organized in-service professional training appears to be lacking, and career opportunities for qualified people are unclear" *(12)*.

On the other hand, the universities, the Urho Kaleva Kekkonen (UKK) Institute, STAKES and KTL all carry out extensive training of professionals, and on-the-job additional training is the norm. The National Advisory Board on Health Care Ethics is also involved in planning and implementing joint training for nurses, physicians, hospital ethics commissions, university researchers and students, and hospital theologians.

In addition, broad use is made of "consensus meetings" to consider ways of dealing with various topics such as cholesterol reduction and smoking among young people, for example.

3.3. Financial resources

Although certain programmes and projects are funded on a time-limited basis, there appears to be an attempt to maintain long-term funding for health promotion. Finland was quick, for example, to earmark a proportion of the tax on tobacco products for financing health promotion.

Present and forecast shortages in the general labour force have focused attention on the need for a healthy workforce, which has probably encouraged the continued financing of health promotion.

A number of the policy documents examined for this study estimate the costs and benefits to the economy of investments in health.

3.4. Information and research

Routine surveys of chronic diseases and their risk factors have been carried out for the age group 25–74 years since 1972, and reports are available on the Internet *(54)*. Surveys of adolescent health and lifestyles have been carried out since 1977 *(55)*.

Despite this long history of systematically collecting statistics, it was felt that a more clear and comprehensive set of indicators was needed to define the health and well-being of the nation. A group of experts chaired by MSAH was therefore set up in 1993 to start designing and developing such indicators *(56)*. It became clear that, apart from certain gaps that could be rectified, existing data were not being effectively interpreted for policy-making purposes. This prompted regular reviews of keys areas of welfare.

This proved beneficial when, in 1995, Parliament decided to replace reports on the alcohol and drug situation by regular

reports on the state and development of health. The decision to produce a report on social affairs and health *(40)* every four years and to submit this to Parliament as an appendix to the Government's annual report has meant that a regular review is made of the state of health and welfare in Finland and the possible policy implications.

In 1996, the first such public health report was prepared and presented to Parliament for broad debate, and subsequently among health professionals, local government and the general population. It was also discussed by NGOs in their "health court session" (a type of traditional round table discussion).

What is particularly important and innovative is that, since 1996, these reports have included a systematic overview of public health aspects of policies of all ministries (except the Ministry of Foreign Affairs). The reports not only present the data but analyse the reasons for observed trends, emerging challenges, the intersectoral nature of health policies necessary to tackle them, and suggested actions. To some extent, therefore, they may be considered as pre-policy documents. The latest report *(57)* also includes international comparisons.

From the researcher's point of view, the Finnish epidemiological database has the advantage of linking information sets, not always possible in other countries. The linking of data to a personal identification number has allowed for greatly improved mapping techniques, and every attempt is made to ensure that data are accessible to and easily processed by local authorities.

Regarding research, Finland was one of the few countries to develop a research policy for Health for All *(58)*, although the necessary interdisciplinary, intersectoral and health systems research did not win much ground at the time *(11)*. Considerable attempts were later made to develop interdisciplinary research involving clinical, nursing, biomedical, epidemiological, behavioural, social and economic sciences. This approach is said to have "greatly contributed to the basic credibility of the anti-smoking work in the country" *(38)*, for example.

Both the Academy of Finland and MSAH fund research related to tackling NCD, and designate funds specifically for research related to government health policy. A number of centres of excellence are available to carry out such research. On the initiative of the National Council for Research and Technology, the Government decided that the scientific quality and performance of all government-funded research institutions should be evaluated periodically. MSAH started such a process in 1995, and all research institutions under the jurisdiction of MSAH have been evaluated by mixed teams of Finnish and international experts.

The Academy of Finland, which operates under the auspices of the Ministry of Education, has annual research funding representing about 14% of the Government's total spending on research and development, part of which relates to health. In 1997, a research programme on inequalities in health and welfare was launched and a Health Promotion Research Programme (TERVE), including four interrelated projects, was implemented for 2001–2004. TERVE was the first multidisciplinary programme in the field of health promotion research in Finland. Additional funding was given to this programme by the Finnish Work Environment Programme, the Ministry of Transport and Communications and the Finnish Cancer Foundation.

As is the general rule for the Academy, TERVE was assessed by an external evaluation team, including experts from other countries *(59)*. Their view was that, although there had been thorough preparatory work, health promotion research had not been adequately defined, with the result that the programme was more epidemiologically than socially oriented. Funding for long-standing projects with institutional support was considered sometimes more than

adequate, whereas that for new, innovative research groups was barely sufficient. One of the problems pointed out was that "There are no widely acknowledged and accepted quality standards for health promotion research, aside from the standards of the various contributing disciples. As a consequence, judges of the quality of health promotion research – researchers and funding agencies – apply the values and standards of their own disciplines, or some combination of disciplinary standards" *(59)*.

KTL was established in 1910, originally for the diagnosis of infectious diseases and production of vaccines, and continued its role as a public health laboratory until the mid-1970s. Growing public concern over increasing NCD led to its transformation to a research institute, responsible for monitoring health and research for health promotion. Research into CVD started in 1978, followed by nutrition, environmental health, mental health and genetics, while research into the prevention of infectious diseases continued.

In 1994, an international panel was invited to assess the extent to which KTL was meeting its responsibilities *(60)*. The panel members were concerned that research priorities were determined mainly by the interests of senior researchers. There were day-to-day links between MSAH and KTL, giving opportunities for the exchange of experience, but no mechanisms existed for MSAH to clarify its own needs and set research targets, nor were there mechanisms for a review of KTL's research strategy by the wider research community. The panel recommended that a national public health forum be established for the exchange of information on the research and public health strategies of public sector bodies, and to consider major policy issues for the future It also recommended that the municipalities, as users of the research, should be represented. Dissemination and implementation of research results lay with MSAH but there was concern that, owing to devolution of responsibility to the municipal level, the role of MSAH was limited.

STAKES was established after a major restructuring in Finnish central government in the early 1990s, when the National Board for Health and the National Board for Welfare were amalgamated. STAKES' mission is to produce information and know-how to promote well-being and health and help ensure equal access for all to effective, high-quality social welfare and health services. The 1997 strategy document, *STAKES at the start of the new millennium (61)*, defined the following core functions:

- statistics, registers and information systems;
- research and development;
- follow-up and evaluation;
- information clearing house function;
- promotion and implementation of education and training;
- initiatives and proposals (on policies): and
- cooperation and networking.

The report of the international evaluation group *(62)* found these functions to be appropriate for the needs of social and health policies, as indicated partly by the extensive involvement of STAKES staff in policy-making bodies. The group would, however, have liked to have seen more future orientation in the strategy.

By the time of the external evaluation, STAKES had collaborated with about one third of the municipalities in the country. It was felt that less reliance should be placed on the publication of research results and more on practical action, including answering daily enquiries from the local level. It was also felt that municipality-specific information should be provided more quickly and that, conversely, more use could be made of solutions and practices developed in municipalities, by better sharing of experience. This culture of transparent evaluation is probably crucial to making the best use of available resources, particularly human resources, in a country with a small population. At present, both STAKES and KTL are once again being assessed, partly

due to concern that the local level is not getting sufficient support.

The UKK Institute, dealing with physical activity, was founded in 1980 to commemorate the 80th birthday of the then President, who had been a life-long athlete. The mission of this independent NGO was to promote public health, especially through health-enhancing physical activity. By 1999, the UKK Institute employed 58 interdisciplinary staff and had gained international recognition for some of its research. An international evaluation of the Institute in 1999 *(63)* indicated that, although a high quality of research had been maintained and both the health and educational sectors had been satisfied with the advisory support given, more systematic analysis of clients' needs would have provided a clearer vision and strategic planning for the future. This, in turn, would ensure the application of the Institute's research results into practice.

Funding for research related to NCD comes not only from the public sector but also from private foundations.

3.5. Communication and public information/ involvement

Specific awareness building campaigns in relation to NCD and their risk factors have been broadly carried out, with strong input from the large NGOs. Many of the active members of the NGOs are either top experts in the field of interest of the organization or have influential positions in their professional life. They are consulted by the public sector as a matter of course on policy issues, or to give their advice on emerging challenges. Seminars and consensus meetings are one of the usual ways of exchanging ideas on policy issues. At least on the expert level, therefore, wide involvement is ensured.

It is not clear how much communication and involvement there is at the local level. The municipalities are quite small, which should be conducive to participation. Furthermore, in the Finnish brand of democracy, the "right to know" is strongly entrenched, so that citizens are conscious of their right to know how their taxes are spent. This probably strengthens the feeling of accountability, which is also reflected in the widespread implementation of monitoring and evaluation of health promotion activities. Wide involvement of the mass media also seems to have been achieved. However, less attention appears to be given to preparing popular versions of policy and strategy documents than in certain other countries, such as neighbouring Sweden.

4. Forces facilitating or obstructing disease prevention and health promotion

The commonly accepted values of the Nordic welfare model provide the framework for NCD policy development. A 1994 amendment to the Constitution further strengthened the rights of the individual. The assertion that "Finns are thus legally entitled to health, social security, a home and a good environment" *(30)* legitimizes intersectoral action to tackle the determinants of health. There is some concern that recent social and economic changes have slightly tarnished the Nordic model, that lower standards are being accepted and that justice begins to mean that "you get what you pay for".

The strong Finnish culture of consensus building, together with a lack of suspicion or looking for ulterior motives, facilitates intersectoral collaboration and the possibility of reaching an acceptable compromise even when there are conflicting interests. This is strengthened by the small size of the population, as people in key positions frequently know each other, informal contacts and briefing are simplified, and new developments can be discussed at an early stage.

A number of key actors have remained in place in the bureaucracy and in research institutions over a period of about three decades. They were united by common beliefs and friendship and have played a crucial role in developing a

planning philosophy and culture conducive to intersectoral action for health promotion based on principles of equality and solidarity.

Finland has a highly educated and motivated population, not only in the sense of formal education but in their continued search for information. A high proportion of Finns read newspapers and the nationwide network of libraries is one of the densest in the world and is well used, with 12.5 visits per resident each year *(64)*. The public is accepting of reasoned argument and expert opinion.

Investment in research and development is a defining characteristic of the Finnish economy, and is reflected in tackling NCD. The strong culture of monitoring health status and evaluating the impact of interventions for health promotion has meant that the evidence for disease prevention and health promotion has frequently been ahead of the actual action. It has also meant, however, that public opinion has been prepared. For example, public opinion supported anti-smoking measures and allowed radical anti-smoking legislation to be introduced as early as 1976. Consensus-based action has also been important in the workplace.

Over the years, this practice of evidence-based decision-making has meant that the knowledge base has been continuously built up and improved. Information is accessible and available in forms that are easy to use. Young experts involved in this type of work are trained for working outside the medical model.

The use of regular public health reports in raising awareness, following progress in policy implementation and preparing the path for policy revision, has been extremely effective. Such reports have gradually evolved so that now all sectors must account for their actions to promote health.

Work on HIA, in combination with other types of social and human impact assessment, is still at an early stage but opens the way for making actors across sectors more aware of the importance of public health for overall development.

The very long history of occupational health in Finland, and the legal responsibility of both public and private enterprises, sensitizes the private sector to health promotion to some extent. It remains for this to be further broadened to focus more strongly on tackling NCD.

NGOs related to the main NCD and their risk factors have been active in Finland for many years. Their membership includes top experts in the field of NCD. Their knowledge is valued and utilized by the public sector in formulating and implementing health policies.

Notable successes have been achieved, particularly in relation to smoking, nutrition and the reduction of CVD, showing that it can be done and encouraging further attempts at health promotion. Certain aspects of Finnish life and attitudes facilitate making the healthy choice. For example, mass catering remains a useful point of intervention, since a large proportion of children and adults eat at their place of education or work. Finland is a forerunner in producing functional foods, with some of its products in global demand. Physical activity is an important part of leisure time – approximately 40% of 10–18-year-olds participate in sports club activities, for example.

Finnish experts have for many years been closely involved in WHO and more recently EU networks. Through these international networks and national efforts such as the North Karelia Project, an attempt has been made to balance medical knowledge with social and behavioural theory. Opportunities have been taken to share experience and know-how with other countries at an early stage of innovation.

There is a clear recognition of the influence and possible threats of European and global policy on national NCD policy. An explicit attempt is made to influence European

policy by active participation on EU committees, hosting international meetings, etc. Investment in international action for health promotion is clearly seen as being of benefit to the domestic situation.

Finally, exceptional use has been made of peer review, frequently with international collaboration, to constantly assess progress and learn from experience. This process is so widespread as to have become the normal way of doing things. A culture has been created that welcomes critical assessment and is open to rethinking the status quo and learning from any mistakes.

This does not mean that tackling NCD has been or is plain sailing. Stakeholders can have conflicting interests. Excellent data identifying the link between health status and food and nutrition were available in Finland, based on 30 years of research into coronary disease, long before comprehensive action could be taken *(11)*; this was largely due to the initial opposition of the agricultural sector, which was strongly represented in Parliament. Also, the Ministry of Finance tended to put economic considerations before health issues in relation to the price of tobacco.

Decentralization of power to the municipal level has meant that more decision-making takes place where people live and work rather than in the capital. However, the instruments supporting the implementation of national policy at local level have been greatly weakened and, since central funding for health is now such a small proportion of funding in the municipalities, have perhaps less of an ethical base. This creates considerable challenges in ensuring equal access to the determinants of health across the country.

The once solid foundations of PHC are being somewhat eroded by creeping privatization and the diminished attraction of physicians to general practice.

The physical structure of this large and beautiful country of lakes and forests, covered in snow and ice for much of the year, also presents challenges in providing services for health promotion, care and rehabilitation.

5. Lessons from the Finnish experience

Overall, the 1970s and 1980s showed considerable success, with an unprecedented shift towards PHC, the development of a solid information base, and the linking of NCD to the determinants of health. Although the economic crisis of the early 1990s brought a degree of stagnation, as economic growth was restored health was more clearly linked to overall development plans.

Even though health-related behaviour is deeply rooted, Finland has shown that national diets and lifestyles can be influenced and changes effected, sometimes surprisingly quickly. Alcohol consumption, which has a very strong cultural ingredient, has been much more resilient to change

Actions to affect the determinants of health and an understanding of the policy implications take time. Not all Finland's policy efforts have been an unqualified success, but there has been a determination to learn from experience and what is perhaps an unequalled openness to external evaluation.

5.1. The policy environment

The positive economic climate of the 1970s and 1980s facilitated a shift to PHC and a period of experimentation, laying the foundations for tackling health determinants. Unfortunately, in the early 1990s, radical decentralization to the municipal level collided with a rapid and severe economic crisis, hampering a smooth transition and the necessary capacity building at the community level.

Although the most vulnerable were reasonably well protected in terms of basic services, the recession prevented

any meaningful attack on the gaps between socioeconomic groups, which continued to widen. The legislation freeing the municipalities from close central direction had been in preparation for about three years, but by the time it was implemented the recession had already hit. School education programmes were severely cut. Staff : children ratios in day care and pupil : teacher ratios in schools were enlarged. It took ten years to raise the level of hospital care for children and young people to the level planned for 1990. As the political climate for greater liberalization took hold, it became more difficult to push for positive discrimination, which has only recently reached the policy agenda. At the same time, partly owing to the opening of the borders through the Russian Federation to Afghanistan, a second wave of drug misuse started in the early 1990s and has cast a long-lasting shadow.

Recent changes in the Constitution have strengthened the right to health and not just to health care, and health and education are highly valued by the population. Finns are also reasonably satisfied with the level and quality of health care provided. Physicians and (particularly) surgeons are the most highly respected professionals. Nurses are the third most respected, although this is not reflected in their remuneration.

There is a history of assessing the impact of policies in all sectors on factors such as the environment, poverty and gender, and HIA has found a niche in that process.

On the whole, there is public confidence in the state, its civil servants and experts, partly owing to the extremely low level of corruption. The "right to know" gives the public a sense of control and policy leaders a sense of heightened responsibility. As mentioned above, however, political democracy at the municipal level has led to a lowering of certain standards and increasing inequalities in the provision of services.

Informal learning through the print media and the Internet remains high, and on the whole the public is well-informed.

Membership of the EU and the constant need for reporting and harmonizing regulations put a heavy burden on the limited number of civil servants, no doubt distracting from domestic issues. It also brought a threat to hard-won public health measures, particularly in the areas of alcohol control and nutrition. Finland made good use of this opportunity, however, to put pressure on politicians. The rotating presidency and membership of EU committees dealing with issues of particular interest were judicially used. The EU's recently introduced open method of coordination (OMC) is utilized as a means of both reviewing to some extent the Finnish situation, and flagging up critical issues for discussion with EU partners.

There are nevertheless looming concerns about the future. These include emerging changes with an uncertain impact on health, such as the pressure put on workers by the "knowledge economy"; the amalgamation of municipalities; the potential restructuring of institutions that have supplied much of the research for health policy development; and a growing private sector that may not keep health promotion issues so high on the agenda. The question will be whether the strands of policy development in tackling NCD, which have so far been quite robust, can maintain a balance of continuity with change, and whether the research and capacity building resources for health development, described as the "crown jewels" by one respondent, will be maintained.

5.2. Indications of the value system underlying policy development

The Nordic welfare model has provided a strong and clear framework of values for policy development. In the ten years following the economic crisis of the early 1990s, opinion polls indicated increasing support for the Nordic model. Although sometimes coming into conflict with economic in-

terests, on the whole these values are generally marshalled to protect hard-won health gains.

In the wake of recent political and social changes, however, these values may need some reaffirmation, and stronger attempts to provide the evidence that their implementation can be economically more effective and efficient.

5.3. From awareness building to policy action

The 1972 Public Health Act laid strong foundations, still largely valid today. Finland has a long history of both broad, Health-for-All-type policy development and strategies for tackling specific diseases and health risks.

There is heavy investment in building up, maintaining and developing a reliable knowledge base for health policy, reflecting social inequalities and including some evaluation of the effectiveness of actions.

- Regular surveys of health behaviour and health status are standard practice. Information is easily accessible to researchers and planners at the national level, although perhaps more could be done to bring this to the local level.
- Innovative public health reports, with reporting on health impacts from all sectors, play an important role in raising awareness and open the way for further intersectoral action.
- Demonstration projects such as North Karelia, MONICA and CINDI have made a significant contribution to the evidence-based approach to policy development, both in the pilot areas and throughout the country. This experience was not restricted to epidemiological surveillance but included testing hypotheses and evaluating interventions. They have also provided a training ground for young experts.

Dedicated opinion leaders, mainly sympathetic to the political left or centre, remained in place in the bureaucracy despite changing governments and were able to implement long-term strategies that kept public health issues on the agenda.

Finnish experts and bureaucrats are active players on the international scene, aware of and contributing to innovations in approach and practice. International policies such as the WHO Health for All policy and issue-specific policies such as those for smoking and alcohol control brought further legitimization to ongoing domestic efforts.

The use of policy training seminars and consensus-building conferences help keep professionals in touch with policy development issues. NGOs, including the medical and nursing associations, work regularly with those in the scientific field to prepare recommendations and carry out training. The trade unions have participated actively in considering health policy options, particularly in the area of occupational health. Although the media have played an influential role, particularly in relation to lifestyle issues, more could probably be done to reach the general public.

Published and widely distributed policy documents and strategies provide the argumentation for action and indicate the potential role of stakeholders, at least at the national level. There is some concern that municipalities are not sufficiently supported.

Intersectoral mechanisms with broad participation have been established. These are advisory bodies and have apparently been helpful as a forum wherein other sectors could bring up issues of concern to them, and in providing a consensus view when regulatory decisions or legislation were being prepared. They have not yet been evaluated, and there is some concern that their full potential has not been realized.

Regionally, the health gaps are gradually being closed, with differences in infant mortality rates practically disappearing.

In the overall improvement of health, however, the better-off improved more. In tackling lung cancer, for example, no strong measures were taken to deal with the fact that only 5% of those with university education smoked compared to 50% in the lowest educational group. The need also to target high-risk groups has now been recognized.

Certain health issues were brought forcefully onto the table in the preparations for entry to the EU, for example in relation to the Common Agricultural Policy and EU policy on alcohol, which undermined efforts made in Finland on alcohol control.

Finland has shown that with perseverance, health issues can be brought to the EU agenda, for example mental health and health in all policies, although this can take time, especially when health issues appear to come into conflict with economic objectives

5.4. Sustaining policy implementation, monitoring and revision

The strong culture of consensus building reaches also to Parliament, where a degree of cross-party agreement has helped sustain the general direction of health policy development over the long term. Dedicated and strong leadership has been crucial in maintaining the underlying values of the Nordic welfare state, the promotion of health, and efforts to reduce gaps. Whether such constant political focus from a small group of key players has perhaps also led to certain inflexibility in considering policy options is difficult to say.

Although there have been some conflicting objectives, certain converging interests across sectors have been exploited. For example, the long-term need for an expanding labour force has brought issues such as maintaining work capability strongly onto the agenda.

It seems probable that, as a result of this long effort, Finland has reached a state of sustainability, or what one respondent called the "Finlandization" of health policy. A focus on the determinants of health and concomitant proposals for an intersectoral approach have become the "usual" way of working for MSAH. Nevertheless, continuing calls for increased health promotion in recent development programmes indicate that investing in health is not yet the norm in the overall development scene. Stronger economic arguments may be necessary to make this happen.

There has also been a move from medium- to longer-term planning for public health and social protection. Strategies for health care and specific risks for NCD, however, continue on a medium-term basis.

Finland has been a pioneer in providing solid evidence of the determinants of inequalities in health and in developing broad intersectoral policies to tackle these challenges, and a new health promotion policy is expected in 2008.

Committed key actors and the Finnish culture of consensus building have maintained a certain level of sustainability over three decades. New ways of reporting on progress have shifted to some extent the focus from MSAH, indicating the responsibilities of all ministries for health.

As is its nature, however, the future holds some uncertainty.

- Despite long-term efforts to tackle them, NCD health gaps continue to widen, indicating the complexity of tackling the problem and perhaps the need for rebalancing the universality and targeted approaches.
- There is growing polarization in this once egalitarian society as the rich get richer and display conspicuous consumption and the long-term unemployed are excluded.
- It is unclear how the decentralization/recentralization trends will play out. The securing of a larger population base at the local level will not affect the centre/local

steering vacuum, and the capacity and inclination of the newly amalgamated local authorities to tackle NCD remains to be seen.

- As the "old guard" of public health experts, with their shared values and histories, all retire within a short time of each other, it is unclear what impact this will have on health policy.
- A certain levelling down of public health care seems to have been quietly accepted; out-of-pocket expenses are increasing; and one or two large private firms are taking the field, providing privately paid health professionals who may or may not have health promotion on their agenda.
- How far the EU will actually implement Health in All Policies also remains to be seen.

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France

Zsófia Németh

1. Country profile

France is located in western Europe and also comprises various overseas islands and territories in other continents. France is the largest country in the EU but, with 63 million inhabitants, ranks only fourth in population. France is subdivided into 26 regions and these again into 100 departments. The smallest administrative unit is the commune. Of the regions, 22 are in continental Europe and four (which are also departments) are the French oversee territories of French Guyana, Guadeloupe, Martinique and Réunion.

The executive branch of the French Republic has two leaders, the President and the Prime Minister. The President, who is Head of State, is elected by universal adult suffrage for a five-year term and has extensive legislative and executive powers. The Prime Minister is head of the Government and is appointed by the President.

France is one of the founding members of the EU and the United Nations. It is also a member of the Group of Eight (G8).

1.1. Socioeconomic development

In the late 1990s, France's economy grew faster than the European average, allowing the socialist Government to introduce a 35-hour working week, which has recently been the subject of passionate debate. The country's social model is an important feature of the economic–political system and has considerable impact on French health policy.

In recent years, the French economy has enjoyed some growth and the GDP was €30 093 per capita in 2004, slightly above the EU average. Nevertheless, the performance of the economy stayed below expectations in terms of growth and job creation. Unemployment is constantly around 10%, and the pension system and rising health care costs are straining the public finances.

Despite the considerable social policy traditions, the Gini index indicates that France has a higher level of overall income inequality than the Nordic countries. The level of inequality is also slightly higher than in Germany and the Netherlands *(1)*.

1.2. The people and their health

French demographic development is more favourable than that in its neighbouring countries. The birth rate in France is traditionally high and has even slightly increased in the last few years *(2)*. France leads Europe in birth rates and has reached replacement level. In addition, infant mortality is extremely low. As a consequence, France's positive rate of natural increase and, to a lesser extent, of net migration has led to a growth in the population.

The overall picture of the health of the French population is complex and contradictory. With a life expectancy of 78 years at birth, French people (men and women together) are the fourth longest-lived in Europe. Another important positive element is the low cardiovascular mortality, which is far below the European average. On the other hand, certain negative trends highlight some weaknesses of the epidemiological situation. While life expectancy at the age of 65 years is the highest in Europe, France is also the country in which life expectancy at birth is reduced to the greatest degree by death before 65 years. Simply put, if no French men died before the age of 65, life expectancy at birth would be increased by 7 years. Considerable differences in premature death are detected between geographical areas linked to the level of socioeconomic development. The life expectancy of boys born in some areas of Brittany and Normandy differs by 7 years from that of boys born in more affluent regions *(3)*.

The low cardiovascular mortality and morbidity have been studied by a number of researchers. The so-called "French paradox", first described by Samuel Black in 1819, refers to the fact that people in France have a low incidence of coronary heart disease, despite their diet being rich in saturated fats. It is believed that France's relatively high red wine consumption is a primary reason for this paradox but also that nutrition, the moderate consumption of beer and distilled spirits, the regularity and quality of physical activity, the climate and many other factors may play a role *(4)*.

1.3. The main features of the health system

The French health system has a good reputation. In fact, *The world health report 2000* ranked France as having the best health care system in the world *(5)*. The positive characteristics are the high level of access to health care and service utilization, an abundant availability of choice without any significant waiting lists and the high level of life expectancy.

The French health system is based on a national social insurance system complemented by elements of tax-based financing and complementary voluntary health insurance.[3] The health system is regulated by the state and the statutory health insurance funds. The state sets the ceiling for health insurance spending, approves a report on health and social security trends, and amends benefits and regulation.

There are three main schemes within the statutory health insurance system: the general scheme covering about 84% of the population (employees in commerce and industry and their families); the agricultural scheme covering farmers and their families (7.2% of the population); and the scheme for self-employed people covering 5% of the population.

In 2004, an insurance fund was established specifically for dependent elderly people.

In January 2000, universal health coverage was introduced, introducing the right to statutory health insurance coverage on the basis of residence in France. Furthermore, those whose income is below a certain level (currently 1.8% of the population) are entitled to free health care.

In 2002, total expenditure on health care was estimated at 9.7% of GDP, of which 7.4% was public and 2.3% private expenditure *(6)*. Expenditure on prevention is estimated at 2.4% of all health costs *(4)*.

There are around 10 physicians and nurses per 1000 inhabitants, which is above the EU average. The number of nurses is double the number of doctors, though this favourable proportion has slightly changed recently *(4)*.

2. France's approach to developing policies to tackle NCD

A special historical characteristic of the French public health system is that the all-embracing term noncommunicable diseases is not widely used. Public health experts, policy-makers, administrators and practitioners prefer to refer to the individual conditions rather than refer to them as a category. This is mainly because of the strong traditions and identity of each field and the existence of separate, well-established public health working groups with different interests.

The major instrument of strategy is the Public Health Act of 2004. Although the primary role of the Act was to reorganize and restructure the decision-making and administrative system related to public health, the Act can be considered as a broad, complementary general framework for the

[3] The general principle is that health care costs are reimbursed by the statutory health insurance system. However, there is usually a discrepancy between the actual amount paid by patients and the amount they are reimbursed by their health insurance fund. A complementary health insurance scheme can be subscribed to on a voluntary basis to cover this discrepancy.

existing French NCD programmes.[4] In fact, the law fulfils the typical tasks and functions of a broad national strategy: it sets 100 fields of action in the national public health policy with clear objectives, baseline data and specific indicators. The objectives are comprehensive, lean on the already existing public health programmes, and cover key NCD prevention areas. The law aims to improve the health of the population by establishing a more effective administrative system in public health and by reinforcing the implementation of national and regional programmes. The achievement of the 100 objectives will be reviewed in 2009, five years after it entered into force, based on the indicators outlined in the Act.

French experts and policy-makers consulted for the research agreed that the Public Health Act of 2004 can not be considered an umbrella strategy for NCD policy development because it sets targets but does not have a real overall concept or policy guidance or framework for realizing these goals. In fact, the Act provides only a legal framework for public health policy in terms of institutions and public health objectives. Although the Act builds on previous programmes, it is not really embodied and incorporated into the diverse field of specific sub-policies. A special characteristic of the French public health policy is the strong presence of specific sub-policies. After the Act was passed, these sub-policies continued to coexist with the Act and did not constitute part of it.

The Act makes reference to specific public health national programmes and strategies but it does not replace them. There are currently around 35 national public health programmes containing more detailed and developed descriptions of targets and programme implementation. Some programmes are oriented towards certain diseases or risk factors while others aim at specific target groups. The most important programmes with respect to NCD policy are those on cancer, nutrition and physical activity, tobacco, alcohol and healthy ageing.

France has long traditions in many NCD policy fields, especially cancer prevention and nutrition. Cancer research is extensively institutionalized in France, not only at national but also at international level, and the strong French advocacy led to the foundation of IARC (the International Agency for Research on Cancer) in Lyon.

The role of NGOs and private organizations in NCD prevention is crucial in raising public awareness, in influencing public health policy-making and in the implementation of national programmes. This is particularly important in CVD and cancer prevention, in which wealthy and influential NGOs carry out a considerable part of the work.

2.1. How things started

The reasons for the existence of numerous interconnected national strategies and the creation of the Public Health Act go back a long way. Health policy development and processes in France are complex and difficult to describe, owing to the numerous actors involved in health policy and practice and because of the dispersal of competences between various levels. First, it is related to the historical separation between health care and public health. Health care and, to some extent, preventive activities are the responsibilities of the health insurance funds, while public health belongs clearly to the state. Second, public health tasks are allocated to regional and local levels. To make the picture more complex, some preventive services are provided by local or departmental bodies (such as monitoring children's health), though they are reimbursed by health insurance funds. For example, breast cancer screening programmes are coordinated by the state and financed partly by the health insurance funds and partly by the departments.

[4] In France, it is specific feature of the administrative–political system that many key policy documents and strategies exist in the form of legislation passed by Parliament.

A characteristic feature of the fragmented public health policy is that there are currently 35 national programmes in force in France, setting different priorities for improving the health of the population. According to the principle of subsidiarity, the construction of the programmes is mainly top-down and the regions are expected to represent national priorities in their regional action plans and to organize projects in accordance with them. However, the necessary facilities and financial resources are often not provided and national programmes cannot be adapted to the regional level.

In 2004, after many reforms and attempts at improving the system, the Public Health Act was passed in order to ensure a general framework with clear priorities and directions for a national and regional public health policy over a five-year term.

2.2. Awareness building and consultation process

The first important attempt at starting a consultation process and building a coherent public health policy was linked to the establishment of the High Committee on Public Health (HCSP), an advisory body founded in December 1991 by the Ministry of Health. A significant impact of establishing the HCSP was the differentiation between health care and public health and, more importantly, the strong advocacy for public health. The mission of the HCSP was to define a multisectoral public health policy strategy, to identify the needs, weaknesses and strengths of the French public health system, and to improve transparency between the actors and activities. Every four years, the HCSP publishes a report providing a critical, global and intersectoral perspective of the members in various working groups on issues such as the health status of the population, health inequalities and disparities, and resource allocation in the health system.

The first report of HCSP, published in 1992, was a milestone in French public health policy. It called attention to the two major challenges of the public health system: the high premature mortality and the issue of health inequalities. The report argued for the continuation of decentralization to enable greater autonomy in setting priorities, based on specific regional needs. The Committee issued three further reports in 1994, 1998 and 2002, but no report was published in 2006 because the Act foresaw changes in the structure of the Committee.

An important change in public health policy followed intervention by the new French President in 2002, which set new priorities in the dispersed prevention programmes. The new President declared a "presidential initiative" in five areas of prevention:

- cancer
- road safety
- disabled people
- environmental health
- rare diseases.

This was the first time that the President of the Republic had become involved in public health programmes, and it raised awareness of the issue of prevention. The initiative led to new programmes and reinforced the implementation of relevant national programmes as well.

The initiative for the Public Health Act came from leading government officials in the health field and leaned on the five priorities announced by the President. The fundamental idea of the Act is the need for more synergy and coherence between programmes and structures. In the consultation process, government officials were appointed in 2003 to design, plan, implement and give feedback. The views of the public, service users, service providers and policy experts were gathered about the governance of public health services. Although municipal and professional organizations were also keen to have a transparent, clear strategy and distribution of tasks, the law was developed and compiled by

the Government and Parliament. The consultation process built on the recommendations of the HCSP and on previous programmes. Regional and departmental governments and associations also took part in the consultation, but their interests were not fully served as the Act involved a slight shift from decentralization to centralization.[5]

In the summer of 2006 the Minister of Health announced a general consultation of stakeholders aimed at debating a new strategy on disease prevention. A Commission on Prevention was set up and asked to make a thorough analysis of the strengths and weaknesses of the French disease prevention system and make recommendations. A report was published at the end of 2006 providing a general, multisectoral overview and constructive criticism *(7)*. A regional consultation process then began and regions were asked to comment on the report.

2.3. Values and principles

The first report of the HCSP defined a basic set of values, including equality in health, solidarity with disabled people and freedom of choice in the lifestyle of individuals and communities. These values reflect the three core values of the Republic: *liberté, égalité, fraternité*. Tackling health inequalities is a key aim of a number of government documents and often appears as a horizontal aspect, though health promotion experts often lack real action and commitment.

The Public Health Act of 2004 *(8)* incorporates the same values as the first HCSP report and declares a clear system of principles. It defines public health policy as a driver for promoting the health of the population, with special respect to social and health inequalities. It stresses the point that public health policy must tackle the physical, social, economic and cultural determinants of health. The principles of the Act are explicitly stated in nine points:

- knowledge and information
- reducing inequalities in health
- specificity
- protecting young people
- priorities and urgency
- economic effectiveness
- intersectorality
- conciliation
- evaluation.

2.4. Setting the agenda

From the beginning, it was proposed that the Act should be based on solid research and evaluation of epidemiological studies and routine surveys. For this reason, each of the 100 objectives is linked to expected results and indicators. To prevent overlap and avoid increasing the already dense spectrum of various national programmes, the Act refers to the existing strategies. The Act slightly modified structures and systems but the principle of decentralization has not fundamentally changed.

In the field of NCD prevention and health promotion, the Act deals with the following themes:

- alcohol
- tobacco
- nutrition and physical activity
- health promotion at the workplace
- environmental health
- health inequalities
- disabled people
- child and maternal health
- reproductive health
- mental health

[5] The Bill established the Regional Working Groups for Public Health (GRSP) (see Fig. 1), comprising key actors from governmental and non-governmental bodies at regional level that aim to define a regional public health programme. Compared to the earlier practice, whereby regions were expected to set their own public health agenda, state representation in the GRSP is 51%. Thus the state has the strongest voice in the establishment of regional public health plans.

- cancer
- CVD
- respiratory diseases
- musculoskeletal diseases
- rare diseases
- dental health
- healthy ageing.

2.5. Structures and processes for implementation

The Public Health Act introduced some major changes to decision-making in public health policy and programme implementation, with a stronger profile for the HCSP. Thus the HCSP was modified in March 2007, renamed the High Council of Public Health (HCSP) and integrated into the Ministry of Health. Some French public health experts identify the reasons for this step as the decreasing authority of the Ministry in recent years owing to the establishment of various institutions.

The HCSP consisted originally of 20 public health experts led by the Minister of Health. It has now been enlarged to 105 members, elected for 3 years with a renewable mandate. Since the Minister can no longer lead the HCSP, following its integration into the Ministry, its President will be elected by the members. The President ensures the coherence and coordinative function in the work of the Council. The permanent secretariat and its tasks of providing support to the Council remain unchanged. Four specialized commissions have been created, covering respectively health security; chronic diseases and incapacity; disease prevention and health determinants; and monitoring and evaluation.

From March 2007, the Specialized Commission on Disease Prevention and Health Determinants will take over and continue the work begun by the Commission on Prevention. In fact, when the Commission on Prevention was created, its mandate was similar to that of the HCSP but restricted to the field of disease prevention. Both bodies are asked to formulate strategic advice and recommenda HCSP and it is feared that this will shift the focus of its work away from the field of health determinants.

The Public Health Act brought some structural changes at regional level as well. The GRSP were established to provide a policy-making platform for representatives of the state (directorates of health and social affairs at regional and at local level), the health insurance funds, the National Institute for Health Promotion and Education (INPES) and various NGOs. In contrast to the Regional Health Conference (see Box 1), the GRSP includes a narrower circle of actors and has more decision-making power. The GRSP defines, in dialogue and in agreement with the Regional Health Conference, the Regional Public Health Programmes (PRSP). The new structure may create more transparency and synergy and reduce overlaps. So far, half of the regions have developed and approved a PRSP.

In the implementation of NCD prevention and health promotion activities, the role of NGOs is particularly important. They carry out important activities in certain sub-policies, such as those on cancer and CVD, bringing a sophisticated and differentiated representation of these policies to the PRSP. The role of public health institutes is also determined by ensuring trained and experienced expertise in specific fields.

The relationships among the various bodies and their functions are illustrated in Fig. 2.

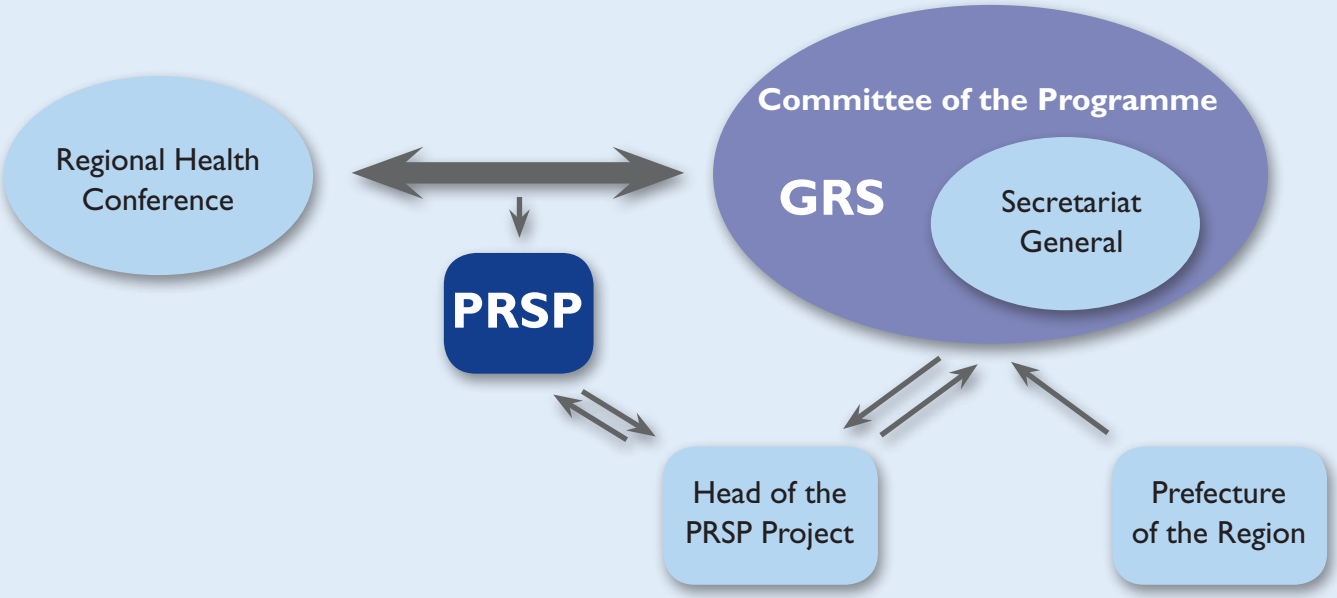
2.6. Monitoring and evaluation

The availability of health data and information has considerably improved in the last ten years. Now, comprehensive and reliable information is provided by different institutions on various health issues and many high-quality studies have been conducted. Public health institutes such as the National Institute for Public Health and Medical Research (INSERM), the Sanitary Surveillance Institute (InVS) and

Box 1. The role of regions and departments in the French public health system

Regionalization of public health and health promotion has a long past in France. A particularly important element in the regionalization was the creation of the Regional and Departmental Health Education Committees in the 1970s. The process started with the first national campaign against smoking on the initiative of Simone Veil, the Minister of Health at the time, which was coordinated by the French Committee for Health Education (CFES). The reason for the creation of the regional and departmental committees was to implement the campaign at community level and to work in different settings. The regionalization of public health tasks and services was continued by establishing the Regional Health Observatories in the 1980s. Furthermore, the HCSP, created in 1991, supported in its recommendations the process of regionalization. In 1996, a new body, the Regional Health Conference, was formed to analyse the needs and to discuss the priorities and programmes of each of the regions. The Regional Health Conference is still in force and serves as a consultative "mini-parliament", in which all key players working in the field of public health can debate and articulate their needs and opinions about public health problems and challenges. The Public Health Act of 2004 introduced some changes and reorganized the structures of administration and decision-making, while emphasizing the regions as the optimal level for initiating and coordinating public health programmes.

Fig. 2. The relationships among the various bodies at regional level



INPES carry out data collection and research and publish their findings on a regular basis. Three regions of France took part in the WHO MONICA Project coordinated by INSERM on behalf of France. The Project aimed at the surveillance of coronary mortality and morbidity by working towards the standardization and comparability of international data *(9)*. Every five years, INPES publishes its *Baromètre santé* (Health Barometer) with valuable data on the health behaviour and attitudes of the population *(10)*. The nongovernmental Regional Health Observatories (see Box 1) provide epidemiological data on the health of the population in the regions. In addition, InVS participates in data and information collection, although its main mandate is to carry out health checks, to inform about health alerts and to contribute to managing health crises. In terms of NCD policy, the regular reports and information of INPES and INSERM are crucial and have a considerable policy impact.

It is expected that the new HCSP Specialized Commission on Monitoring and Evaluation will bring forward and strengthen the work that was started by the HCSP in the 1990s. From its outset, the HCSP advocated for a more systematic collection of data and drew attention to numerous flaws in the French health information system. In the HCSP reports, the most striking observations and findings were identified and presented based on an analysis of the available information. The Specialized Commission will contribute to the integration of data from different sources and the monitoring and evaluation of the 100 objectives defined in the Public Health Act.

2.7. Policies for tackling NCD

The first comprehensive national public health programme, on breast cancer screening, was launched in 1992. It was developed at national, regional and community levels and coordinated by an interministerial group. This national programme was followed by many others, focusing on various areas of health promotion and disease prevention *(11)*.

On the initiative of the ministers, members of the cabinet and the administration, various national programmes were created reflecting government current priorities. Between 1995 and 2002, around 40 national health programmes were launched by the Government, with an overwhelming focus on disease prevention. The objectives and the methods of these programmes were generally well-defined, but none addressed the question of system reorganization. Concern was raised from time to time that many strategies existed in parallel, that programmes were dispersed, and that there was no coordinating mechanism to ensure a concentrated, effective distribution of resources.

In 2001, a vain effort was made to create a coordinating horizontal framework for the various existing national programmes. The Public Health Act of 2004 aimed to respond to this need to fill the gap. It proposed to reorganize the structures between the regional and national levels and to bring together the strategies under one umbrella. The national programmes did not become integrated parts of the Act and only a fraction of their aims and objectives were included in it.

The timeframes of the national programmes vary from a couple of months to a few years and are based on the principles of multidisciplinarity and intersectorality. The programmes aim to integrate different levels and reach synergy among various actors, approaches and methods. INPES has a strong profile in communication at national level and implements a number of NCD campaigns linked to the national programmes. Moreover, INPES, jointly with regional associations dealing with health education, makes a fundamental contribution to organizing health education in different settings all over France. Communication and health education are important pillars of the French NCD policy (see Box 2).

It is often said that the national programmes are not sufficiently monitored and evaluated. No systematic measure

Box 2. Communication and health education

France has a long and considerable tradition in health education, as exemplified by the foundation of the International Union for Health Promotion and Education (IUHPE) on a French initiative in 1951. Jacques Parisot and Lucien Viborel, French researchers in health education, were the main founders of IUHPE, which received strong commitment from French political leaders *(12)*. As the paradigm of health education was called increasingly into question, France shifted its approach to health promotion. Nevertheless, health education is still an incontestably dominant and determining concept. It is also reflected in the name of INPES, which was created in 2002 as a result of the Act relating to patients' rights and improving the quality of the health care system. According to this decision, the status of the former CFES was changed from a nongovernmental to a governmental body and renamed INPES. The regional offices of CFES remained nongovernmental, however, and therefore a new umbrella organization had to be found to coordinate the work of the (currently 110) regional and departmental associations. The new organization is called the National Federation of Health Education and cooperates closely with INPES.

In addition, communication is an important aspect of INPES activities. Intensive use of communication channels is seen as key to changing norms, beliefs and attitudes. Even if some criticize the expensive and only moderately effective use of the mass media in health communication, INPES spends a considerable part of its €100 million budget on influencing public thinking. It is argued that this is one of the most important and effective ways of counteracting the massive influence of companies promoting unhealthy products and lifestyles.

for either quantitative or qualitative research exists and thus only a few examples of good practices have been developed. The interpretation of research is not strong enough, although some improvement has been observed (the nutrition and diabetes programmes are based on solid scientific evidence). Nevertheless, the coordination of scientific research in NCD prevention should be more extensive and interrelated at various levels *(13)*.

2.7.1. Cancer

Cancer research and prevention have enjoyed a high priority in the French health policy since the beginning of the last century. The first association in the field of cancer prevention, the National League Against Cancer, was founded in 1918 and was among the first such association in Europe. From its outset, diversified international collaboration was developed and the League paved the way for establishing the International Union Against Cancer in 1921. At national level, the activities of the League have greatly influenced public thinking and have always been a driving force for health policy in France. After the Second World War, Charles de Gaulle made strong commitments for strengthening national programmes against cancer and funded the Centre for the Fight Against Cancer in the mid 1950s. In a short time, the Centre developed a powerful network and significant level of advocacy. In 1964, the Centre changed its name and became the National Federation of Cancer Centres, a non-profit-making umbrella organization that unites a number of hospitals and regional centres. Both the League and the National Federation are among the largest public health organizations in the country.

As a result of the presidential initiative in 2003, an interministerial committee was established to create a national cancer strategy. The Cancer Plan 2003–2006 aims to reduce cancer mortality by 20% by 2007 through improving

the fight against cancer in five fields: prevention, screening, treatment, training and research. Unlike those in other countries, the strategy does not focus on health care; considerable proportion of the 70 measures address preventive activities such as reducing smoking and excessive alcohol consumption, promoting healthy nutrition, raising awareness about the risks of sunbathing, and controlling harmful environmental factors.

These objectives have strong linkages with other national programmes, such as those on alcohol use, environmental health, nutrition and physical activity and smoking. The overlaps in these fields of prevention resulted in the different sources of initiatives. While the Cancer Plan grew out of the presidential initiative against cancer (with the approval of Parliament), the other NCD strategies were initiated by the Ministry of Health. Potential overlaps were partly reduced by intensive interdisciplinary cooperation and communication. Nevertheless, the cancer programme was well-planned and well-implemented, emphasized the need for scientific research and interdisciplinary work, and received a positive evaluation. The final report on the programme stresses the success in reducing the risk factors of cancer, allowing equal access to good quality treatment and fostering dynamic research.

The Public Health Act of 2004 referred to cancer as a key area of the public health programme and decreed the foundation of the National Cancer Institute (INCa) in 2005. INCa is now a government agency based in the health Ministry. INCa is a leading actor in the so-called *cancerpôles* that integrate various institutes, universities, associations and government offices dealing with cancer. Experts considered the foundation of INCa a guarantee of the sustainability of the national cancer programme, and the continuation of the government strategy will be incorporated in the work plan of the Institute. Its tasks and administrative structures are in line with the key objectives of the former Cancer Plan.

Cancer is a particularly important field of NCD policy that enjoys a high priority in French health politics. The commitment of French presidents and the high level of popular awareness on this issue are keeping cancer on the agenda. Experts pointed out that cancer is a popular topic in France owing to increasing mortality and morbidity rates, the availability of prevention methods, and the links with many other public health problems.

2.7.2. Heart health

France has the lowest CVD mortality in Europe and has a favourable record among the industrialized countries of the world *(14)*. Paradoxically, the favourable epidemiological situation has been an obstacle to launching a national cardiovascular strategy; because of the optimistic figures, no CVD programmes were begun until 2002. A study of the HCSP reports revealed the significantly increasing direct costs of CVD. While in 1994 direct expenditure on CVD was €6.5 billion, in 1998 this had increased to €11.8 billion *(15)*. Moreover, the WHO MONICA Project and some other research found striking inequalities in CVD in terms of gender, age and geographical area. In the light of these results, experts expressed concerns about the lack of government action.

Finally, in 2002 the Government launched the National Programme to Reduce Cardiovascular Risks 2002–2005, which set six objectives:

- strengthening of epidemiological research and surveillance;
- strengthening preventive activities contributing to lower levels of smoking, obesity and salt consumption;
- promoting patient education and improved access to and quality of treatment;
- widespread first aid training;
- better organization of care and treatment of victims of cerebrovascular accidents; and

- dissemination of examples of good practice and experience in clinical therapy.

The Programme ended in 2005 and no other heart health programme has taken its place, although certain measures and objectives on heart health were replaced by the National Nutrition Health Programme (PNNS) launched in 2001 and 2006 and the Public Health Act of 2004. PNNS tackles a significant number of the objectives of heart health (see section 2.8.2). Furthermore, of the 100 objectives of the Act, some items cover the major aims of CVD prevention (such as reducing arterial pressure by 5 mmHg among people suffering from hypertension and by 3 mmHg among those with normal blood pressure, and reducing mortality linked to ischemic cardiopathology by 13% among men and 10% among women).

The Public Health Act intended to compile and collate the objectives under one framework and to reduce overlap with other strategies. Overlaps among different strategies are justified by the presence of common risk factors and the view that joint actions could strengthen NCD policy. In reality, these strategies do not have many links with each other, and at the implementation level actions are often not the same. The reason for this fragmented approach is the strong advocacy of influential NGOs in the fields of heart health, cancer and diabetes, which act separately with little coordination. The contribution of these organizations is essential for continuous, well-established projects, but these bottom-up initiatives should be coupled with strong government coordination to reduce these overlaps.

The most important, renowned and long-standing organization is the French Federation of Cardiology (FFC). To reach a wide population and to reduce overlaps, FFC coordinates its activities with those of INPES, the national agency on health promotion. INPES takes care of population-based, mass media campaigns on healthy nutrition and physical activities, while FFC focuses on community-based programmes and specific, targeted campaigns.

FFC organizes a "heart club" in regions and communities under the leadership of local cardiologists. Within the framework of the annual campaign of the FFC, "Never the first cigarette", some 100 000 young people are reached annually in schools. For more than 30 years, an annual two-day "Heart Competition" has been organized country-wide with various events and programmes to promote and advocate the fight against CVD.

FFC also coordinates its work with the French Society of Cardiology (SCF), another prestigious organization known for its scientific research and secondary and tertiary prevention. Both organizations are financed exclusively by donations from private sources and companies. A common project of FCC and SCF, "Heart without tobacco", includes a number of information events about the harm caused by smoking and the wide distribution of a brochure to GPs' waiting rooms on the prevention of CVD.

2.8. Policies related to risk factors

2.8.1. Tobacco

France shows a serious commitment towards a tobacco-free society and has undertaken significant steps to reduce smoking. Cigarette advertising is prohibited, the price of cigarettes is relatively high and continuously increasing, and the selling of tobacco products has been made difficult by the appointment of special tobacco points of sale. Smoking in public places has been banned since February 2007 and smoking in bars and restaurants since January 2008. A number of other anti-smoking interventions are taking place but, despite of the ambitious activities and regulations, the epidemiological situation is still not satisfactory. The last comprehensive health survey, the Health Barometer in 2005, identified a decreasing prevalence of smoking among the general population aged 15–75 years but a slight increase among those aged 18–25 years. In a ministerial document

published in early 2007 *(16)*, these critical population groups were targeted for smoking prevention activities.

Anti-smoking campaigns in France began a long time ago and changes were made in the legislation to facilitate a reduction of the number of smokers and to protect non-smokers. The first campaign took place in the 1970s on the initiative of the former Minister of Health, Simone Veil, and organized by CFES (see Box 1). During the 1980s and 1990s, a number of programmes and awareness campaigns were implemented countrywide by the Ministry of Health, CFES and NGOs such as FFC, SCF and the National League Against Cancer. Nevertheless, an intensification of government efforts took place in 2001–2002 owing to the presidential initiative and the establishment of INPES. Both developments were significant in tobacco prevention because the presidential programme, focusing greatly on cancer, stressed that smoking is the primary risk factor in lung cancer and action must be taken to achieve a significant reduction. INPES received an important mandate and resources for reducing the prevalence of smoking by conducting national campaigns. Additionally, a government report was published on the negative consequences of passive smoking, stressing that more needed to be done to protect non-smokers.

In 2003–2006, an intensive campaign to raise awareness took place, cigarette packages were labelled with warning messages, counselling points for smoking cessation were established in hospitals, an interministerial website for the public (www.tabac.gouv.fr) was launched and a telephone hotline service was set up. In 2003, the price of cigarettes was raised by more than 30%; in that year, sales of cigarettes dropped by 13% and in 2004 by 25% *(17)*.

The introduction in 2007 of the law banning smoking in public places was preceded by a media campaign with 900 television and 1000 radio spots and a wide distribution of brochures and information kits. Moreover, the Minister of Health announced his plans to double the number of hospitals with consultation centres for smoking cessation, and the health insurance funds offered a reward of €50 to every patient who participated in the anti-smoking programme.

In addition to government activities, various associations carry out important programmes in smoking prevention. A network known as "Alliance against Tobacco" aims to bring together NGOs working in this field in order to coordinate and strengthen action against smoking and to provide a platform for efficient advocacy towards the Government. This umbrella organization greatly contributed to the introduction of the law prohibiting smoking in public places.

2.8.2. Nutrition

Nutrition policy did not receive much attention in France until 1998. Epidemiological data on overweight were rather positive and policy-makers were delighted to refer to the favourable situation known as the French paradox in public health (see section 1.2). Experts in scientific laboratories and clinical centres carried out some research related to nutrition, but this remained outside the horizon of politicians.

At the end of the 1990s, two notable events brought a change in this trend. Bovine spongiform encephalopathy (BSE), commonly known as mad cow disease, shifted attention to the issue of food safety and nutrition. A Green Paper was launched on food safety and healthy nutrition, calling for a debate at general and at professional level on the improvement of nutrition. Another remarkable change was initiated in 1998 by the new Director for Public Health in the Ministry of Health, who decided to pick up the issue of nutrition policy in France. Despite the positive epidemiological data, he expressed concerns about nutrition-related problems and pointed out the negative trends in energy balance and the lack of physical activity of the French population. An expert group composed of public health and nutrition experts was set up within the framework

of the HCSP. A thorough situation analysis was made and concrete, quantifiable targets were set in the report of the expert group. In the mean time, INSERM issued a scientific report on child obesity with key findings about the challenges related to nutrition in French society *(18,19)*.

Thanks to the reports of the HCSP and INSERM and the Green Paper on food safety, all published nearly at the same time, nutrition-related themes were took centre stage. In addition, in 2000, France took over the EU presidency and the Ministry of Health singled out nutrition as a key priority in the French working programme. During the presidency, national and international working groups were established and on 13 December 2000, at the European Summit of Health Ministers, nutrition was the key item on the agenda. The next day, the French Prime Minister announced a broad debate on nutrition and asked the Minister of Health to launch a nutrition strategy and set up an Interministerial Committee on Nutrition. A scientific Pilot Committee was also established, whose members were middle-level administrators, practitioners and researchers. The coexistence of both committees is considered to have been fruitful. The Interministerial Committee is a rather administrative, high-level body while the Pilot Committee carries out scientific studies, coordinates activities, facilitates the exchange of information and experience, and initiates further actions.

The report of the Interministerial Committee was issued in early 2001 as the first PNNS. In 2005, after overwhelming success and a positive evaluation, it was extended until 2008; its continuity is also ensured by the Public Health Act of 2004.

The name of PNNS reflects its general aim of incorporating and linking nutrition into the various fields of health promotion. The guiding principles include a multisectoral approach with quantifiable objectives, focusing on promotion and primary prevention while embracing a food culture of gastronomy and eating together, and based on independent scientific analysis. PNNS includes nine specific objectives on physical activity and nutrition. Strategies tackle the improvement of both supply and demand for healthy food and physical activity and partnership with the stakeholders from the private sector such as producers, manufacturers, retailers and caterers (in schools and places of work). To achieve this, a multisectoral committee chaired by the Ministry of Health was established in 2001, including representatives of eight ministries, the food industry, consumer associations and local authorities.

In 2004, a document was issued dealing specifically with cycling *(20)*. A general sports programme entitled "Move for health" was adopted in 2004 to fight sedentary lifestyles and promote physical activity and sport. The programme aims at distributing information and evaluating the physical condition of the population *(21)*.

In 2002, national food guidelines were produced and later a complementary brochure was published on physical activity by the Pilot Committee and INPES. Separate guidelines for adolescents were produced in 2004, addressing both nutrition and physical activity. In 2005, three large media campaigns were launched by INPES on fruit and vegetables, physical activity and reducing the consumption of sugary foods. Within the economic sector, bakers were encouraged to reduce the salt content of bread. Leaflets on healthy lifestyles for different population groups were developed, as well as educational materials for teachers. In September 2005, vending machines in school campuses were banned and the quality of school meals was improved, based on specific guidelines. Furthermore, a new policy on food and drink advertising was introduced, requiring that all carry health-related information provided by the Ministry of Health. If a company does not want to include such information in its advertisements, it has to donate 1.5% of the advertising costs to be used for health promotion. An attempt to amend the national public health law so that food advertising on television would include this health-related

information was not successful, however, owing to a lack of consensus on the link between television food advertising and obesity.

Each region was asked to establish a committee on nutrition to coordinate the implementation of the national nutrition policy, and to ensure the presence of healthy nutrition in the PRSP (see section 2.5). Resources for the work of the committee are ensured by the Regional Authority on Health and Social Affairs (DRASS). Moreover, the Government strongly supports cooperation among cities, to reinforce local initiatives and actions on healthy nutrition. In February 2007, the Minister of Health, together with the association of mayors in France, announced a charter of cities active in the nutrition programme. The charter aims to foster the mutual responsibility of communes and the state for giving high priority to nutrition in the programmes of the communes. Typically, communes are involved in improving the quality of food in school canteens and hospitals and creating greater opportunities for physical activity. In return, they are allowed to use the logo of the national programme.

PNNS is often considered the most effective and successful public health programme In France, and among international experts to be an exceptionally well-designed and well-implemented strategy. The reasons for success are various: there is strong political will for PNNS and committed leadership in the Ministry, in INSERM and in other research institutes; it works at interministerial level and has clear, coherent objectives that agree with those of current and former programmes (such as the Cancer Plan); it is based on scientific evidence and supervision; and it involves various partners and stakeholders by creating a broad forum, a strong voice and a focus on the issue. Cooperation with the private sector is a key element of the programme, as the regulation of market supply is one of its main aims. In general, businesses are interested in participating in the nutrition programme and thereby creating a positive public image. In addition, the Ministry sets out a clear framework and ethical guidelines for cooperation and for allowing use of the well-known PNNS logo.

A challenge for PNNS is to create and maintain good cooperation with other programmes. PNNS cannot and should not deal with all the nutritional problems of the French population. Experts express concerns about the sustainability of the programme because of limited financial resources and recent cut-backs that it has had to face.

2.8.3. Alcohol

France is world famous for its wine production and is one of the world's leading wine exporters, as well as the third largest exporter of spirits in Europe. In terms of alcohol consumption, France is characterized as having a "wet" culture, whereby daily light drinking is the norm, alcohol is linked to meals and wine has always been a part of everyday life.

After the Second World War, alcohol consumption rose significantly and reached its peak in the 1950s. In the last 50 years, per capita alcohol consumption has fallen by about 40% (from 19 litres of pure alcohol per capita per year in 1950 to 10.5 litres in 2000) *(22)* because of the decline in wine consumption, the change in consumption patterns and the rural-to-urban shift in the population. Nevertheless, per capita alcohol consumption in France is higher than the EU average and alcohol-related harm gives cause for serious concern. A government alcohol strategy from 2001 *(23)* stressed that alcohol consumption is responsible for 14% of total mortality among males and 3% among females, with strong regional and socioeconomic differences. Recognizing the relevance of alcohol-related problems in France for the first time, in 1954 the Government established the High Committee for the Study of and Information on Alcoholism, charged with making recommendations for policy-makers; it was incorporated into the HCSP in 1991. A major result of the work of Committee was the

passing in 1991 of strict alcohol legislation, the so-called *Loi Évin*. The Law aimed to ban the sale of alcohol to minors below 16 years of age and in sports facilities and to restrict the advertising on alcohol beverages, off-licence sales and drink–driving. However, the stringency of the Law evoked the opposition of wine makers and the alcohol industry in general and its implementation was not entirely successful. In the past 15 years, the *Loi Évin* has been amended many times, for example to provide a more precise definition of places where alcohol consumption is legal.

Ten years later, in 2001, the Government's alcohol strategy *(23)* set precise, quantifiable objectives over five-year terms, supported by baseline measures, for:

- the consumption of wine, beer and distilled spirits;
- attitudes toward the consumption of alcohol on a daily basis;
- drinking during pregnancy;
- the prevalence of "binge drinking"; and
- drink–driving.

The strategy paid special attention to reducing inequalities regarding alcohol-related harm and to improving the capacity for treatment.

These objectives were underpinned by the Public Health Act of 2004, which ordered a report on alcohol policy for the year 2005. Of the Act's 100 objectives, two focus on alcohol policy. These objectives foresee a 20% fall in alcohol consumption and a reduction of alcohol-related harm (binge drinking and drinking during pregnancy) by 2009. The special focus on pregnant women is a strong characteristic of the French alcohol policy and is also included in a number of health campaigns. This special focus stems from 2004, when three mothers publicly accused the Government of not informing them about the hazards of drinking during pregnancy.

A consultation of stakeholders on alcohol policy was subsequently held in 2005, and the stakeholders suggested creating a new alcohol policy-making mechanism. At national level, the new mechanism should be based on three strands: a National Orientation Committee (an intersectoral body for guiding the implementation of the alcohol policy), an expert group for advising on work based on scientific evidence, and a working group between the Ministry of Health and INPES. At regional level, DRASS creates a forum for open debate among the stakeholders. A budget has been allocated for DRASS to enhance its activity in the alcohol policy field. According to the decision of the stakeholders in 2005, alcohol was not part of the PRSP owing to the predominantly social character of the problem. For this reason, DRASS is necessary to represent alcohol policy at regional level.

Evaluation of the consultation was carried out by an interministerial committee in 2007 *(24)*. The report does not make a systematic evaluation of the objectives of the Alcohol Strategy and the Public Health Act, but it makes clear points about French alcohol policy. The report claims that the main challenges remain insufficient knowledge among the population about the hazards of alcohol consumption, the positive popular image of alcohol and the limited resources for alcohol research. The report recommends strengthening the role of DRASS in alcohol policy-making and disseminating information on alcohol-related harm. In respect of the latter, INPES should be supported in its campaigns, such as those promoting moderate drinking and warning of the dangers of alcohol consumption during pregnancy.

NGOs make a significant contribution to promoting responsible and moderate drinking. The National Association for Prevention of Alcoholism and Addiction is the oldest and most important civil society organization in this field, established in the late nineteenth century. It raises public awareness on all problems related to acute and chronic

intoxication, improves services for people at risk and organizes training at local and national levels for health promotion practitioners. The Association employs about 1200 physicians, social workers and training agents in specialized teams within its 100 local committees, located throughout France and the overseas territories.

2.9. Settings

2.9.1. Schools

Health promotion in schools is carried out by two types of stakeholder. First, school physicians are responsible for health checks on pupils, and an obligatory health check takes place at the ages of 6, 12 and 15 years. School physicians are employed by the Ministry of Education but the service is managed jointly by the Ministry of Education and the health ministry since data on health examinations is forwarded directly to institutes of the latter. .

Second, teachers are requested to address health aspects in all school subjects. In France, no course is specifically devoted to health promotion and, in the absence of a clear framework, teachers introduce aspects of health promotion on an ad hoc basis. Nevertheless, in 2003 the Ministry of Health and the Ministry of Education signed an agreement on strengthening the methodological assistance for teachers in this field. To this end, INPES issued methodological guidelines for teachers and published brochures on healthy nutrition and tobacco use in clear, understandable language for children. In addition, INPES developed jointly with the University Institute for Teacher Training specific training modules on health promotion for trainee teachers. France faces a lack of coordination and consistent practice of health promotion in educational institutions. In response to the need for improvement, a committee has been established in every school to coordinate the presentation of health promotion and to provide assistance and expertise to the teachers. School physicians and teachers are volunteer members of this committee.

The Public Health Act of 2004 ordered some changes to the structures of health promotion in schools. The new public health decision-making mechanism, the GRSP (see section 2.5), established by the Act, must have a so-called "rector" as a permanent member, who is charged with ensuring an appropriate representation of health promotion at schools in the PRSP. The rector is appointed by the Ministry of Education and represents all schools of the region in the GRSP. The work of the rector is supported by a permanent team.

The report of the Commission on Prevention (see section 2.2), launched in 2006, devoted a chapter to health promotion in schools and suggested introducing a regulated, continuous presentation of health promotion in the school curriculum. It was recommended that the School Committee on Health organize suitable training for teachers. In addition, it was proposed to take advantage of the current system of "school projects". Within the framework of this system, schools are asked to highlight a certain issue or topic every year and organize events and activities around it. The Commission recommended adapting this project annually to focus specifically on health under the leadership of the School Committee on Heath *(25)*.

2.9.2. The workplace

Occupational health care was systematically developed after the Second World War, initiated and supported by NGOs. Until recently, health policy at the workplace remained restricted to health inspections and health examinations by physicians and on safety at high-risk sites.

Government competence for workplaces and occupational health lies with the Ministry of Employment, Social Cohesion and Housing and the National Institute for the Prevention of Accidents at Work and Professional Diseases (INRS). INRS is the oldest institution in occupational health (a governmental body since 1968) and works under the supervision of the Ministry. Through its activities, INRS aims

to reduce work accidents and profession-related risks and diseases.

However, a lack of focus on public health in the work of INRS led the Ministry of Health to create a special department for occupational health in InVS in 1999 *(26)*. This decision indicated a willingness to integrate "health at the workplace" into public health policy and symbolized a shift of approach from occupational health care to health promotion at the workplace. This trend continued during the following years and the report of the Commission on Prevention, published in 2006 *(7)*, also clearly reflected this change by dedicating one of eight action priorities to health promotion at work. Referring to the Bangkok Charter, the report argues for more attention to health promotion and primary prevention as well as occupational health and workplace safety.

The report was made in the spirit of some public health experts at INPES who reported in 2003 on needs for controlling alcohol consumption and smoking at places of work. Moreover, one of the key areas of action of the National Nutrition Health Programme is the improvement of healthy nutrition at workplaces. Businesses were encouraged to participate in screening and awareness-raising measures, including within the framework of the Cancer Plan. Based on the positive results of these efforts, the Commission on Prevention suggests implementing more programmes at workplaces and it stresses the need for both individual and community-based approaches to prevention and recommends the following actions:

- developing an epidemiological database specifically for this setting;
- building an information system on the main occupational risks as a contribution to regional health policy;
- establishing a network of health issues at the workplace; and
- improving collaboration among enterprises on occupational health issues.

2.10. Policies for specific population groups – older people

Healthy ageing is a highly relevant issue in France and first received attention in the Laroque report of 1962. Over the following decades, however, policy and debate on the challenges of an ageing society were linked exclusively to questions of reforming the retirement system, the labour market, housing and the increasing health care costs. Public health aspects were marginalized and ageing brought under the aegis of the Ministry of Labour and Solidarity.

This trend changed in 2003 following the record-breaking heatwave that caused over 14 800 deaths during August of that year and affecting mainly old people *(27)*. As a result, the Prime Minister at the time, Jean-Pièrre Raffarin, launched a four-year National Programme on Ageing and Solidarity to improve the living conditions and care of the elderly. Genuine efforts were made to create greater independence for elderly people in society. Between 2003 and 2007, 25 000 new places were created in homes for elderly people. The Programme aimed mainly at reducing the dependence of elderly people; public health aspects appeared as a horizontal perspective but were not the main focus.

In 2006, a follow-up to the programme was prepared by the Ministry of Social Security, Elderly and Disabled People entitled "Solidarity for the Elderly", setting 17 objectives in 5 groupings. The overall objectives of the new programme were to improve the socioeconomic models of ageing and to enable a healthier life. This five-year programme has a budget of €2.3 billion, which is foreseen to be spent on creating more long-term care facilities and improving care for elderly people who wish to stay at home. The programme aims to develop a modern financing system based on the value of solidarity and to reinforce geriatrics research. Similar to the model of *cancerpôles* in the field of cancer

research (see section 2.7.1), *gérontopôles* were created in 2007 in Toulouse to foster new multidisciplinary research for improving the health of the elderly. The *gérontopôles* project expressed a growing governmental interest in the health-related problems and needs of the ageing society, albeit in a rather traditional, medicalized way.

A real breakthrough in policy-making that stresses health promotion and prevention was the national programme "Healthy Ageing 2007–2009", launched in 2006 by the Ministry of Health. With a modest budget of €3 million, the programme sets various objectives to promote good health in people between 55 and 75 years of age. One part of the programme focuses on healthy nutrition and physical activity by disseminating brochures and booklets, launching various campaigns and events, supporting sport clubs for the elderly, and organizing training for professionals specializing in the physical condition of the elderly. Another strand of the programme aims at sharing information on diverse activities and initiating local projects to strengthen an "active lifestyle". Further objectives aim at reducing accidents, promoting CVD screening and dental health, and addressing osteoporosis and other health-related problems. The programme includes specific, targeted projects to tackle inequities in the health of elderly homeless people and migrants.

3. Infrastructure and resources for policies to tackle NCD

3.1. Human resources

Public health expertise is represented at all policy levels in France. Apart from the wide range of specialized governmental institutes such as INSERM, InVS, INPES and INCa, a number of influential NGOs and regional bodies make important contributions to policy formulation through their expertise. The increasing number of public health institutes, the escalating number of government strategy papers on various public health issues, and the continual activities of NGOs give the impression that France has well-established human resources to tackle public health challenges.

Nevertheless, experts consulted stated that there was a lack of strong leadership in health promotion and disease prevention needed to create an integrated NCD policy and to provide the image of a modern, non-medicalized approach to public health in France. Others consulted, referring to the launch of various national programmes, stressed that it was not so much strong leadership and political will that was lacking but rather a broad, well-trained and experienced team approach. The reason for this was identified as a lack of appropriate high-level university training and the lack of inspiration derived from international exchange and collaboration in health promotion. As one of the experts pointed out, new approaches in health promotion reached France relatively late and the first book on health promotion was not published before 1994.

French "best practice" in NCD prevention and health promotion is rather underrepresented and less known at international level. International partnerships are limited to some exchange of expertise and projects with Canada and francophone African countries. Experts often explain France's limited international activities as a problem of language.

A distinctive characteristic of human resources in NCD prevention and health promotion in France is expertise in the field of health communication. Both in public institutes and NGOs, individual and mass health communication plays an outstanding role. Experienced staff assist in the design and implementation of programmes using modern communication tools.

3.2. Financial resources

NCD prevention and health promotion programmes are financed either directly by the health ministry or by public institutes. The budget of some programmes is fixed for the

period of the programme, while others are budgeted on an annual basis. The HCSP stresses the need for long-term budgeting. In its latest report (3), it argues that the changing pattern of disease from infectious to noncommunicable and chronic diseases makes new financial mechanisms necessary. While short-lived infectious diseases require short-term measures, nowadays long-term strategies are needed for NCD policy based on long-term budgeting.

3.3. Information and research

Information on health status and programme evaluation is traditionally provided by public institutes. INPES, INSERM, INCa, InVS and regional bodies collect information regularly, linked either to specific projects (such as the WHO MONICA Project or to general surveys on the health behaviour and status of the population (such as the Health Barometer of INPES published every five year). The regularly published reports of HCSP are an excellent source of information, containing collated key data not only on the overall public health situation in France but on health status and behaviour as well.

The Public Health Act of 2004 took a step towards systematic data collection by setting comprehensive and clear indicators that are measured regularly. Two years after the Act entered into force, a thorough report was published, with contributions from a number of institutes, government bodies and insurance funds, to explore the possibilities of achieving the 100 objectives by 2008 *(28)*.

Scientific research in the field is partly the realm of public health institutes such as INSERM and partly that of the universities. It is felt that epidemiological research is excessively dominant in France and that the social sciences are not well represented in public health research. Nevertheless, excellent report was published in 2007 by the Institute for Research and Documentation in Health Economics on the results of a general population survey on psychosocial resources and health inequalities in France *(29)*.

To step up research and make it more multidisciplinary, the Government has suggested the creation of a new institute aimed at coordinating scientific public health research in France. However, experts doubted the real need for such an institute and feared that it would lead to greater fragmentation of capacities and resources. It was pointed out that INSERM, for example, with its strong team of experts in the social sciences, would be in the position to cover a broad perspective of public health research. On the other hand, some argued that a new institute would be justified if it focused specifically on health promotion research, which is chronically underrepresented in France.

3.4. Training

Public health and health promotion training in France reflects the typical characteristics of the French higher education system and public health structures. Training focuses on the education of professional public health administrators in the field of public health and fosters the medicalized focus of public health.

In principle, there are three types of educational centre for studies in public health. First, faculties of medicine at all universities offer public health courses within the framework of the basic, obligatory training at graduate level to all students. In addition, some departments of law and of social and economic sciences integrate public health courses into their curricula as well.

Second, specialized studies in public health are organized at some faculties of medicine for students who have accomplished their basic courses. Students who completed the specialized studies obtain a final diploma of "Medical Expert in public Health". Some 15 universities in France offer specialized public health studies at faculties of medical sciences. Third, the National School of Public Health (ENSP) was founded in 1945 in Rennes in northwest France to provide a masters degree in public health. ENSP is not research-based but rather a public administration school where courses

on public health represent around 20% of the curriculum. Basically, ENSP aims at tutoring specialized bureaucrats to ensure expertise in public health in national or regional government bodies. There are other universities in "specialized public administration" (such as the National Education Centre for Field Workers) that train public administrators of regional and local authorities and include public health courses.

From the very beginning, ENSP was devoted to education in public health and management. Students of the school are heads of administrations, state employees and doctors employed in health and social work. This has not changed in the last five decades, but the Public Health Act of 2004 expressed a need for some modernization by giving the school more status in the education system. In 2004, the school became a postgraduate university-style institution. Nevertheless, the dominant approach in the curriculum did not change and it continues to be designed for hospital directors, health inspectors, and school doctors and nurses. The programme is a one-year sandwich course with both theoretical and practical aspects.

Experts consulted stated unanimously that schools that were not purely administrative in approach were needed in the field of public health. Nevertheless, there is no consensus as to whether ENSP could fill this role. As a striking indicator of the dearth of public health training in France, it is often mentioned that Belgium (one fifth the size of France) has more public health schools and health promotion research.

4. Forces facilitating or obstructing disease prevention

France has many national NCD-related programmes but they exist in parallel, lacking a comprehensive, coordinative umbrella strategy. Owing to the strong advocacy of specific interest groups, reforms and new programmes and strategies have been tacked onto existing ones without replacing them. This has led to an extraordinary complexity and compartmentalization within the system. To reduce this element of redundancy and parallelism, an attempt was made in the Public Health Act of 2004 to provide a framework for different public health policy areas. The Act being basically "only" a legal framework, however, it was unable to replace existing programmes and after 2004 even more new programmes were launched.

The distribution of power is complex and lacks full transparency. The process of decentralization failed to abolish the deeply rooted vertical hierarchy; in fact, it added horizontal structures and brought in external players. While the Government provides guidance through national strategies that should be implemented at regional and local levels, the regions are also expected to develop their own regional health plans. This distribution of competencies has led to increased overlaps and complexity. On the other hand, bodies at regional and local levels apply the concept of subsidiarity, enabling an adequate response to specific local needs and contributing to reducing health inequalities among regions.

The strong advocacy and long-term experience of NGOs substantially facilitate NCD policy development in France. NGOs not only supplement the activities of government but, owing to their having top experts among their members, help formulate and implement health policies in the public sector. There are NCD policy areas such as cancer and nutrition that are historically "lobbied" by influential associations representing powerful views in French public health policy. For instance, cancer research and prevention are widely institutionalized and multisectorally represented. Objectives of the cancer plan cover a wide range of risk factors and determinants of health such as smoking, alcohol use and nutrition. PNNS also includes a broad range of risk factors and health determinants.

Despite substantial improvements and huge efforts among public health experts in the last two decades, French policy for tackling NCD still has to face the dominance of a medicalized way of thinking and the strong heritage of health education and social medicine. Experts agree that there is a lack of leadership through a new public health approach that could mobilize and concentrate efforts to act on health determinants. Even if the HCSP does excellent work in outlining the most important strategic directions in public health, and many other bodies contribute greatly to high-quality NCD programmes, France has not so far developed well-coordinated policies to tackle NCD. The key threats and challenges in the medium term can be summarized as follows.

- Is there a need to create a strong overall strategy for NCD policy and to reduce the fragmentation caused by sub-policies?
- How can we establish a real commitment to "health in all policies" so as to represent health aspects in other sectors?
- How can we influence the development of policies to tackle NCD based on an evaluation of the Public Health Act's objectives in 2009? What will be the consequence of the evaluation?
- How can we incorporate the ideas and recommendation of the recently established Commission on Prevention into the new HCSP and reduce parallel structures?
- How can we increase political commitment to tackle health inequalities and ensure its representation in the decision-making system?
- How can we increase resources for research and training in health promotion?
- How can we improve the evaluation of policies and programmes?

5. Lessons from the French experience

The French approach to NCD policy development is unique in Europe. In France, NCD policy development was not driven by an Health-for-All-type policy, as in some other countries covered by the case studies, but is rather characterized by a large number of sub-policies. A number of good practices can be identified in various areas such as cancer prevention and nutrition, but these are not well-known internationally. Even though France has in several instances promoted NCD policies and action at international level, its level of cooperation with international agencies has been much lower than in any of the other case-study countries.

5.1. The policy environment

Topic-based sub-policies are the driving force of NCD policy development in France. It is quite illuminating that in France the all-embracing term NCD is not widely used. Public health experts, policy-makers, administrators and practitioners prefer to refer to the individual conditions rather than refer to them as a category. This characteristic feature is inherited from the past, when some NCD areas became progressive and dominant in France. The French development of cancer research and prevention was a pioneering activity in Europe. In the case of cancer policy, there was a successful, continuous development based on the innovative work of researchers and NGOs. The further support of the Government and a presidential initiative underpinned this initiative. Of late, this has been backed up with a National Plan on Cancer. Other fields such as CVD prevention lack this kind of continuity and, except for a short-lived national strategy, it remained a field of activity of NGOs.

There are 35 national programmes in force in France setting different priorities for improving the health of the population. These programmes were established mainly following pressure from different stakeholders within the health sector (insurance companies, strong associations and lobby

groups and the health Ministry). An interesting feature of French NCD policy development is that some policies were initiated by the President (within the framework of the so-called presidential initiative) while others were set up by Parliament or the Ministry, and these programmes have different legal status. The Public Health Act of 2004 was intended to facilitate a broad common policy, but it lacked a policy concept and its main purpose was only to provide a legal instrument for the implementation of already existing public health policies, thus leaving the fragmented structure of them untouched. Moreover, a clear objective of the Act was to assist the decentralization of public health programmes in the country.

5.2. Indications of the value system underlying policy development

Values and visions are less pronounced and rather more implicit in NCD-related programmes and documents than in other countries. Inequality is often emphasized as a basic problem, but there is a sharp conflict between France's Gini index, regional and social inequalities, and the declaration of values in strategies. Tackling socioeconomic determinants of inequalities in health does not appear often in policy language and this is certainly not a strength of French NCD policy development.

5.3. From awareness building to policy action

The creation of the HCSP was a milestone in NCD policy development. This advisory body provided a strong voice and powerful advocacy for public health. The regularly published reports of the HCSP contributed to better priority-setting by focusing on objectives and calling attention to the major challenges of the French public health system.

This complicated policy development, based on a balance of different forces, has been sustainable in the last decade. However, significant changes can be expected in the role of the regions and in the financing of public services in the near future.

French health communication is undoubtedly among the best in Europe.

5.4. Sustaining policy implementation, monitoring and revision

Comprehensive and reliable health information is provided by different public institutions on various health issues and many high-quality studies have been conducted. Public health institutes carry out data collection and research and publish their findings on a regular basis. France participated in the MONICA Project but not in the CINDI programme.

Every five years, INPES issues its Health Barometer with valuable information on the health behaviour and attitudes of the population. The Regional Health Observatories provide epidemiological data about the health of the population in the regions. In addition, InVS participates in data and information collection. In terms of NCD policy, the regular reports and information of INPES and INSERM are crucial and have a considerable policy implication.

Despite the broad nature and high quality of available health information, in the light of the lack of a coherent overall policy implementation mechanism all this data can hardly be considered as a general monitoring and evaluation system in NCD policy development.

5.5. Key conclusions

- The integration of French NCD policy is controversial and difficult to describe in terms of being top-down or bottom-up.
- There is a government-level umbrella strategy that can be considered rather as an eclectic framework of existing activities than as a centrally driven strategic process.
- The French policy includes nearly all the thematic areas of NCD policy at a high technical level.
- The decision-making system is only theoretically centralized, the process and financing mechanism being provided by the interplay of different key actors.

- This situation creates fragmentation and unequal development of various subject-based policies.
- Explicit international influences on NCD policy development are more limited than in most of other European countries.

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Greece

Anna Ritsatakis

1. Country profile

Greece is bordered to the north by Albania, Bulgaria and the former Yugoslav Republic of Macedonia and to the east by Turkey, and is surrounded in the west by the Ionian Sea and in the east by the Aegean Sea. Much of the mainland is mountainous and there are numerous inhabited small islands.

Greece is a presidential republic and the official language is Greek.

There are 13 geographical and administrative regions and 52 prefectures or counties (*nomos*, pl. *nomoi*). The prefects, who until 1994 were appointed by the Government, are now elected officials but the *nomos* is not hierarchically superior to the communes and municipalities.

Greece is a member of the EU and maintains close relations with the Balkan countries.

1.1. Socioeconomic development

When Greece joined the European Community in 1981, it did so with a dominant public sector and little preparation for membership *(1)*. Although the economy is now more balanced, the public sector remains comparatively large with the Government retaining a large stake in major public utilities. A place in the civil service is still a main aim of young people entering the labour market.

Unemployment has been high over the past decade, particularly for young people. In 2001, it was 21.0% for men aged 15–24 years and a huge 35.7% for women in the same age group. It is now slowly falling and reached 9.6% in 2005, which is still higher than the average for EU countries prior to 2004. A severe problem is the number of "educated unemployed": young people with university education who are jobless, or in jobs with low skill requirements, unrelated to their field of study.

GNP per capita rose rapidly from US$ 4299 in 1980 to US$ 16 610 in 2004, a rise in real GDP (PPP) per capita of from US$ 5277 to US$ 22 205. There is a relatively high level of income inequality and a more imbalanced distribution of wealth than the average for the EU15 countries.[6] The first survey on poverty, carried out on behalf of the Ministry of the Economy in 2007, indicated that poverty has begun to threaten social cohesion and that 60% of the population feared that they might fall beneath the poverty line.

1.2. The people and their health

The birth rate in Greece is one of the lowest in Europe, with a resulting natural population growth of zero *(2)*. Reversing the trends of the mid-20th century, when thousands of Greeks left to find work abroad and migrants' remittances were one of the mainstays of the economy, the recent positive net migration has slightly increased the population to just over 11 million.

The aging of the population is one of its main characteristics. As the large birth cohorts of the first half of the 20th century reach retirement age, the proportion of people 65 years and over is estimated to grow from about 17.5% in 2003 to 25.9% in 2030 *(3)*.

Overall life expectancy at birth reached 79.3 years in 2005 (76.9 for men and 81.8 for women). For many years, Greece enjoyed one of the longest life expectancies in the world, which may have led to some complacency. In

[6] EU15: the EU prior to the accession of 10 candidate countries on 1 May 2004. It comprised the following 15 countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom.

recent years, Greece has slipped from its former position in the international ranking, reflecting the results of strong public health policies in other countries, an increasingly high prevalence of risk factors in Greece such as smoking, and divergence from the traditional healthy pattern of nutrition, particularly among younger people. Life expectancy for those aged 45 years increased between 1970 and 1995 by two years in Greece compared to four years elsewhere *(4)*.

CVD are the number one cause of death, the single largest cause being diseases of the pulmonary circulation and other heart diseases, followed by cerebrovascular diseases.

Although overall mortality from cancer is about 12% lower than the average for the EU15, death rates from lung cancer are especially high and above average. This reflects the fact that Greeks consume more cigarettes per person than the average EU15 (56% more in 2000, not including cigarettes illegally obtained through smuggling). The smoking prevalence is 47% for men and 29% for women and both are increasing: almost 60% of those aged 25–34 years are smokers.

Consumption of alcohol, on the other hand, is lower than the EU15 average (15% less in 2001). Standardized death rates for chronic liver disease and cirrhosis, at all ages and for both sexes, are also correspondingly lower.

Some 28% of men and 30% of women are obese, a much higher level than the average for the EU15 countries *(5)*. Only a small proportion of the population takes regular exercise, and this decreases with increasing age. Greece made the transition from an agricultural economy comparatively recently; 60% of the population now live in urban areas compared to an average of almost 80% for the EU15 countries. The changes in nutritional habits and physical activity associated with urbanization and more sedentary lifestyles are now being felt.

1.3. The main features of the health system *(2)*

Expenditure on health care amounted to 9.8% of GDP in 2004, slightly over the average (9.3%) for the EU15 countries. Unusually for much of Europe, however, the public–private split was just about even, with public funding accounting for only 51.7%. This is far below the 76% average for public funding in the EU15 countries, and does not take into account "under-the-counter" private payments made to doctors, still considered to be a considerable scourge despite attempts to stamp them out. About 25% of beds are in private hospitals and maternity clinics.

The Greek health care system is characterized by the coexistence of the National Health System (ESY) established in 1983, compulsory social insurance and voluntary private health insurance. About 97% of the population is covered by compulsory social insurance through over 35 different funds, the largest being those for urban workers (IKA), the rural population (OGA) and civil servants. This fragmentation of insurance cover, offering different levels and conditions of services, leads to inequalities in access. Until recently, funds covering categories such as bank employees and employees of public corporations were considered to be "privileged", but rising costs have slowly eroded some of their advantages. Ongoing discussions indicate that the Government will attempt to unify certain funds, but this proposal has caused strong reactions from the trade and professional unions, including general strikes.

Inequality in access to care is exacerbated by the physical structure of the country, which offers endless attractions for tourists but means that small communities, frequently with a large proportion of older people, are to be found in inaccessible mountainous or island areas.

The still entrenched system of informal payments to health professionals for health care ("little envelopes" or *fakelakia*), even within the ESY, further affects equality of access. The prevalence of this system was apparently not affected by

substantial increases to hospital physicians' salaries in the early 1980s *(6)* and is exacerbated by the fact that, at the present time, remuneration in the ESY is relatively low. The Code of Medical Deontology, updated in 2005, strengthens the severity of action to be taken against medical staff accepting (or even soliciting) such payments.

The Ministry of Health and Social Solidarity (MHSS), renamed from the Ministry of Health and Welfare following the 2004 elections, decides on overall health policy issues. Until 2007, 17 regional health authorities had responsibility for implementing national priorities at the regional level, coordinating regional activities and organizing and managing the delivery of health and welfare services. Legislation passed in 2007 provided for a reduction in the number of health regions, to cut down on expense but also to bring them more in line with the general administrative regions of the country. The MHSS validates all financial transaction in the health regions.

The annual budget of the ESY is set by the Ministry of Economy and Finance, based on historical data. Taxes provide about 70% of all hospital funding, the remainder being covered by social security and out-of-pocket payments. Fixed per diem or per-case fees are set by the state but tax revenue is often used to fill the gap between these levels and the actual costs of services provided.

PHC centres were originally financed through the budget of the public hospital to which they belonged administratively, although from 2004 they gradually achieved financial and administrative autonomy. Historically, the rural population was provided with PHC in rural surgeries and health centres. Later, health centres were developed for urban workers insured under IKA. A draft Law for PHC *(7)* is available on the Internet for comments. Through this proposed legislation, all public PHC units, and those of the private sector that wish to join, are to be brought under one system following common guidelines and levels of payment.

Apart from a few exceptions, the concept of health promotion is not yet strongly on the agenda. The Code of Medical Deontology mentioned above states that medical action includes prevention, diagnosis, therapy and rehabilitation and that physicians are responsible for the maintenance and improvement of health, rehabilitation and tackling pain.

In 2004, there was a high concentration of physicians (4.9 per 1000 population, compared to an average of 3.4 per 1000 in EU15 countries), whereas the supply of nurses was only about half that in Europe as a whole (3.5 per 1000 population compared to 7.5 per 1000 for the EU15 average).

2. Greece's approach to developing policies to tackle NCD

2.1. History

Some years ago, when Greece regularly formulated five-year socioeconomic development plans, these plans included health and social welfare. They were based on evidence and on proposals set out in reports made by working groups with a broad participation. They were published by the Centre of Planning and Economic Research (KEPE), which acted as the secretariat for the planning process under the supervision of the then Ministry of Coordination. In the framework of the 1976–1980 development plan, for example, the extensive report on health *(8)* examined the health status of the population, highlighting inequalities in mortality between geographical regions and the urban and rural populations, and proposing policy measures dealing with health risks for NCD, preventive measures, improvements in environmental health, and the health care system.

Also during this period, Professor Spiros Doxiades, the then Minister for Health in the Conservative Government, gathered a team of young scientists to further explore available health data with the aim of proposing the establishment of a national health system. This initially created considerable opposition, mainly from the medical profession, and in

the wake of political changes the Socialist party eventually established the ESY in 1983. Since then, there have been numerous proposals for reorganizing the health services and unifying the health insurance funds. Few of these have been fully implemented, since "Governments continue to postpone costly political decisions either by replacing the real problems with formalistic conflicts or by offering short-term remedies" *(9)*.

The issue of a broad policy for health has been largely absent from the political agenda for the past 20 years and, apart from the work of individual researchers, there has been little official recognition of the problem of inequality in health status, observed in all countries across Europe. As in other countries, the National Statistical Service publishes regular statistical yearbooks containing data related to health (mainly mortality and hospital discharge data), though these do not usually reflect socioeconomic inequalities.

At the beginning of the 1990s, the Ministry of Health and Welfare (with the support of WHO) established an ad hoc committee, with experts from the University of Athens, the School of Public Health and others, to prepare a public health report. The report was prepared in Greek and, with WHO funding, translated into English. Neither version appears to have been published or distributed after submission to the Ministry. Experts from the University of Athens voluntarily prepared analyses of the health status of the population for the period 1986–1996 and again for 1997–2006 *(10)*, which they presented to the Ministry. We were unable, however, to locate any official national report on the health status of the population.[7] It is difficult to understand therefore the evidence basis on which NCD policy is discussed and developed.

Similarly, apart from mental health, there do not yet appear to be published policies relating to NCD, or their risks, although there are related health education campaigns. On the whole, Greece seems to have missed much of the vast mobilization for health promotion that has taken place in Europe since the Ottawa Charter and the WHO Health for All policy. There are signs that this may be about to change however, as the Law on Public Health *(11)*, passed in June 2005, calls inter alia for reports on health status to be prepared at national and regional levels and for the national report to be presented annually to Parliament.

2.2. How things started

The WHO Health for All policy seems to have had little impact at the national level in Greece, despite a number of attempts by WHO Regional Office for Europe in the early 1990s to initiate such a policy development process. At the start of the 21st century, Costas Stefanis, a professor of psychiatry who enjoyed intensive international collaboration, was Minister for Health and Welfare. Since Greece held the EU presidency in 2003, Stefanis, together with Commissioner Byrne, signed the WHO Framework Convention for Tobacco Control on behalf of the EU. Under his leadership, public health, including the need to bring care for mental health from institutions into the community, gained some prominence.

The Supreme Council for Health (KESY) was reorganized to advise on public health issues. KESY is, however, composed of physicians and professors from the medical schools and takes a medicalized view of health. It is responsible, inter alia, for recognizing medical specialities and awarding educational leave and research grants. There does not, however, appear to have been a clear strategic plan for the disbursement of research grants. KESY did play an important role in putting in place the means to secure the 2004 Olympic Games against threats to health. It had hardly started in its enhanced public health role, however, when general elections brought in a change of government.

[7] Since this case study was completed in October 2007, a National Action Plan for Public Health 2008–2012 (in Greek only) has been formulated by the Ministry of Health and Social Solidarity. The first chapter of the Action Plan includes a detailed analysis of the health of the population.

On taking office in 2004, the new Conservative Government passed two health laws in quick succession: the Law relating to the National Health System and Social Solidarity, and other matters *(12)* and the 2005 Law on Public Health referred to above. As its name suggests, the first of these deals with the organization and operation of the ESY. Certain measures taken by the previous Socialist Government were reversed, such as the definition of the health regions mentioned above. This extensive 27-page law deals in detail with the organization, staffing and operation of the health regions, the establishment of a Central Council of Health Regions to coordinate their activities, and the establishment of Regional Health Councils. Unlike similar authorities in a number of other countries, however, membership of these councils is to be drawn exclusively from the health sector and there is no provision for public participation. The remaining articles of the Law deal with the administration of ESY hospitals and other services.

The Law on Public Health, which followed three months later, offered greater potential for NCD strategic planning, introducing some of the necessary concepts and structures to allow this in the future. For example, Article 1 of the Law defines public health as an investment in the maintenance and improvement of human capital. It states that public health encompasses all evidence-based action for preventing disease, protecting and promoting health, lengthening life expectancy and improving quality of life, and that this requires intersectoral action. Article 2 also clarifies, for the first time, the fact that action to support vulnerable groups and to reduce socioeconomic inequalities in health is an essential part of public health.

Article 6 of the Law refers specifically to policies for public health, which it states should be based on effectiveness, efficiency and equality, be intersectoral and multidisciplinary in nature, and be carried out at central, regional and local levels. Such policies should deal with the determinants of health and specific health risks and lifestyles, with particular attention to vulnerable groups.

The Centre for the Control of Special Communicable Diseases, set up in 1992 mainly to deal with AIDS and sexually transmitted diseases, was renamed the Centre for the Control and Prevention of Disease (KE.EL.P.NO) and its mission broadened to include NCD, accidents, environmental health, a Central Public Health Laboratory and the evaluation of health services. The Centre is to be operated according to European standards but, at the time of writing, it is not fully operational so it is not possible to assess how this might contribute to tackling NCD. The Cancer Registry was also moved from the MHSS to KE.EL.P.NO (see below). KE.EL.P.NO is responsible directly to the Minister and funded by ministerial decision.

Since much of the 2005 Law on Public Health still has to be implemented, the provision of health services still dominates the health policy agenda. In Greece, the public sector is perhaps more on the defensive in this area, owing partly to what can be rather aggressive attacks in the mass media (mainly television) in the event of any perceived failure in the provision of care.

2.3. Health policy development in the framework of EU structural and cohesion plans

Parallel to this important legislation, health policy development in Greece appears to be largely linked to the preparation of investment plans within the framework of the overall development plan, EU development financing and regulations, and agreements made within the framework of the Lisbon Strategy.

The European structural and cohesion funds are the main instruments for supporting social and economic restructuring across Europe. They account for over one third of the EU budget and are used to tackle disparities and support regional development, mainly in terms of infrastructure,

telecommunications, human resources, and research and development.

The European Commission's proposal to establish a programme of action in the field of health and consumer protection for 2007–2013 *(13)* states that the main aims are to: protect citizens against health threats; promote policies that lead to a healthier way of life; contribute to reducing the incidence of major diseases; and improve the efficiency and effectiveness of health systems. Among the common actions proposed are improved communication with the general public, improved participation in policy-making, and the development of HIA and enhanced risk assessment. The need to tackle the determinants of health, address inequalities, improve information and involve stakeholders in policy-making is stressed, as is the need for more resources. Changes in healthy life years are to be closely monitored. The proposal makes clear reference to the need to tackle lifestyle issues (tobacco, alcohol and drug use and nutrition) and proposes that the health determinants strand of the programme be reinforced and complemented by a new strand on disease prevention. Socioeconomic factors such as poverty and working conditions are to be addressed and health inequality issues are to be integrated into other policies.

It was within this framework, therefore, that early in 2005, the MHSS published its proposal for formulating a national development plan for 2007–2013 *(14)* and placed it on the Internet. This refers, in its opening section, to the WHO definition of health and to the need to deal with socioeconomic inequalities in health.

As will be seen below, Greece is also to develop, by early 2008, a strategy for public health. Since it is still in the early stages of development, it was not possible to do it justice in this section. To present as complete a picture as possible, therefore, we focus mainly on the available strategy documents developed in relation to EU programmes, with reference to other strategies being initiated.

The above-mentioned development strategy document does not offer background information on the health status of the Greek population. With reference to international experience, it refers to the need for intersectoral action, defined mainly in terms of dealing with poverty and social exclusion, adequate funding of health care, improvements in the quality of care, particularly for mental health, and improving human resources for the health and social services. Cooperation with sectors such as education, tourism and labour are mentioned briefly, from the point of view of delivering health and social services.

Later in 2005, a private company was commissioned by the MHSS to expand on the investment programme for development in the field of health and social cohesion *(15)*, within the framework of the national development plan for 2007–2013.

2.3.1. Awareness building and the consultation process

The document containing proposals on health for the 2007–2013 development strategy *(14)* appears to have been formulated by staff of the strategic planning unit of the MHSS. As mentioned above, an expansion of this, with specific investment proposals, was carried out by a private consulting firm. The consulting firm sent questionnaires to or interviewed more than 50 people in the MHSS, the ESY, the health professions and NGOs, collaborating with staff of the School of Public Health and the Special Service for the Administration of the EU Operational Programme. A conference was organized in Athens in November 2005 to discuss the first draft. The second draft was discussed at a National Development Conference organized by the MHSS in Salonica in January 2006.

The background report for the strategy makes brief mention of life expectancy and infant mortality but does not

refer to disease-specific mortality or the main health risks (apart from obesity) and has therefore little relevance for tackling NCD.

The consulting firm refers in its report to the lack of adequate information on which to base health policy development in Greece. It is not clear why a private firm was selected for this task, though this appears to be a usual practice. Experience from other countries has shown that when national academic and research centres are given the responsibility for preparing the information background for health strategies, their involvement gives a greater sense of ownership and frequently lays the foundations for improvement of the information base and the future implementation of the policy.

A number of respondents consulted for this case study, from both inside and outside the system, referred to the challenges presented by the intense party political nature of the public administration system that has existed for many years in Greece. The usual practice is for each new minister to bring in his or her own small group of advisers. Top-level civil servants frequently change with a change of government. Policy proposals seem to be developed mainly by the small group of advisers supporting the minister. High-level ministry staff may or may not be included in the process, their role depending very much on their relationship with their minister. Although they may be consulted on issues for which they are responsible, it is apparently not unusual for the regular staff in the ministry to learn about policy proposals from press releases. When a political decision has been taken, if there are regulatory or legislative implications or a question of harmonization with EU regulations, the issue would then need to be referred to the responsible staff in the ministry for further elaboration. This situation, however, makes it difficult for the interest and commitment of staff in public administration to be enhanced and developed.

The problem of improving public administration in Greece is a long-standing issue for which there does not yet appear to be an effective solution. It is of considerable public concern and always high on the agenda of political parties during general elections.

Given the process outlined above, it is unclear how ownership of national-level policy decisions by the public services at the local level is to be achieved. The health regions are not yet fully operational, some having only administrative personnel. At the prefecture/county level there are County Doctors and Directors of Public Health. In practice, their main tasks relate to the implementation of specific legislation and regulations issued from the centre, with emphasis on the vaccination programme.

2.3.2. Values and principles

As an EU Member State, Greece shares the EU values but WHO's Health for All values and principles do not seem to have effectively influenced health policy development. The special attention given to the agricultural population, and social groups such as the disabled and large families, indicates a broadly accepted sense of solidarity. There is not, however, a clearly implemented framework of commonly agreed values such as is found in the Nordic welfare state model. In fact, as an expert on social exclusion recently put it, "It is the family that works today as an informal welfare state and absorbs social shocks".

Equality in health is mentioned in a number of recent documents, usually in terms of access to care. Even in this case, however, it is described in the narrow sense of geographical distribution of services and financial obstacles, with little mention of other factors affecting access to services. Some years ago, the National School of Public Health translated into Greek the WHO discussion papers on the concepts, principles and strategies for tackling inequalities in health *(16,17)* but these do not appear to have been widely disseminated.

2.3.3. Setting the agenda

Unlike in many European countries, there is no tradition in Greece of preparing public health reports. The universities and large NGOs make fragmented attempts to analyse aspects of the situation, focusing on issues of interest to them, but there is no official published report giving a comprehensive picture of the health challenges and their determinants and the ways in which these might be tackled. By default, the focus remains on the organization and reorganization of health care, with passing interest in other issues when these are raised by interested researchers or NGOs, or when a "world day" on a particular theme is celebrated. The "Health Map" *(18)* (see below) is to bring together a considerable amount of data in an organized way and could perhaps shift the future agenda.

Given the lack of focus on relevant data concerning inequalities in health in the policy proposals available to us, the link between socioeconomic inequalities in health and the need to address the determinants of health is almost nonexistent

2.3.4. Finding solutions

Since the health challenges have yet to be openly discussed outside academic circles, solutions remain focused mainly on the provision of health care or are linked to the potential for EU funding. As observed in certain other countries, attention is paid to high-visibility action such as providing intensive care units and reducing waiting lists rather than the long-term and less visible action needed to tackle NCD. Disease prevention relies on health education rather than health promotion. Issues related to the use of new communications technology seem to be high on the agenda, again partly due to the availability of EU funding.

Implementation of the 2005 Law on Public Health should offer hope for change in the future, as should the plan of action for public health currently being formulated. The growing attention given by the EU to tackling health risks could, in the long run, open up the discussion in Greece.

2.3.5. Structures and processes for implementation

Article 8 of the 2005 Law on Public Health provides that the MHSS, together with the National Council for Public Health, will decide on the priorities for public health and formulate four-year action plans, which are to be compulsory for the regional level of government.

2.3.6. Monitoring and evaluation

Provisions are made in the 2005 Law on Public Health for annual reports to Parliament on the health status of the population. Similar reports are to be prepared at the regional level. This provision has not yet been implemented but, if well founded with structures and processes in place for the collection and processing of essential data, the evidence base for monitoring and evaluating health policy in the future could gradually be built up.

Apart from regular administrative monitoring, for example of budgets, it appears that the monitoring of EU structural funding (for which regular reports are prepared by the Planning and Evaluation Unit of the MHSS and can be found on the Internet) dominates the process.

2.4. Public health and health promotion

Recently, the Minister for Health and Social Solidarity announced, during a public presentation, a strategy for health up to 2020. The text of the speech focused in its introduction on the need to deal with a situation in which the old welfare state had reached its financial limits and there had been rapid developments in information and communication technologies, administration and the management of human resources. It referred to the heavily bureaucratic ESY and the need for greater flexibility, control and evaluation to ensure equal access to health and welfare services. The Minister presented the following ten strategic points:

- financial improvement of the ESY and ensuring its sustainability;

- establishment of a modern PHC network;
- dynamic promotion of disease prevention policy;
- introduction of new information technology at all levels of administration;
- new policy for human resources;
- reorganization of mental health and public health
- development of voluntary action and communal responsibility;
- promotion of education, research and innovation;
- political joint action with the private sector; and
- promotion of Greece in the global market and the health community.

Apart from an overall attempt to cut costs, particular attention is to be given to the development of PHC. It appears that the main focus of preventive action is to be on health education, though other unspecified measures for public health are to be introduced.

The Minister's speech is available on the MHSS web site. It appears that the ten points outline the political framework for guiding the work of the Ministry in the next few years. It is not clear whether a long-term policy document is to be formulated.

Preparations are already under way, however, for the formulation of a National Action Plan for Public Health. The Unit for Health Policy and Strategy of the MHSS, which has the main responsibility for organizing this process, has outlined the scope of the proposed Action Plan, due to be completed in the spring of 2008. The preparatory work for the Action Plan outlines a list of important challenges, including: shifting the focus from hospital care; the risks for communicable diseases, particularly in view of the country's geographical position; the serious lack of essential statistical data; the lack of health professionals trained in health promotion; the present restricted action for public health at the level of the *nomos* and the "total lack of coordinated programmes for health promotion" at that level; the lack of collaboration between the public health services of the *nomoi* and the health centres; the lack of financial resources for health promotion and of evaluation of such services provided by other organizations; the failure to provide health promotion services in schools; the lack of a strategy for dental care; the need for interdisciplinary collaboration; the staffing of the regional level public health departments, many of which have no or only administrative staff; and finally the need to set the necessary standards for epidemiological research and its evaluation, and to set priorities in this field.

Given these very serious challenges, the main vision and values for the Action Plan include:

- a national policy for public health that will secure equal rights and the creation of a community based on solidarity;
- the development of resources to promote and protect health;
- public health services focused on quality of life; and
- public health close to the citizen.

The framework is composed of three sections: a study of the challenges; an analysis of the existing situation, including services provided, personnel and needs; and sub-strategies for tackling the various issues. Following a review of related services (see below) and of public health services in other countries, separate action plans are to be drawn up for the main causes of death and their risk factors (17 action plans). These will be further refined for implementation in the family, community, educational institutions, health services, workplace and the environment, and for various population groups. Finally, attention will be given to the necessary legislative changes and the need for epidemiological monitoring.

In setting up the process for policy formulation, a survey was made of possible agencies/institutions either providing relevant services or with scientific expertise in the field.

They were asked to send their comments and proposals on the basis of a common format. The draft policy based on these contributions will then be sent to all stakeholders for consultation. It is expected that at least three meetings will be organized between the drafting group in the Ministry and the stakeholders, for the revision of the draft. Finally, the economic feasibility and sustainability of the proposals will be assessed.

One important part of this process is the development of a "Health Map", which in effect is a huge database presenting data (as its name suggests) by geographical area in an easy-to-use way. This ambitious project was initiated in the early 2000s with 75% funding from the EU *(18)*. Considerable work has been accomplished towards developing the Health Map, which will include:

- demographic data (socioeconomic characteristics such as family situation, income, education, occupation and education);
- epidemiological data (including such aspects as mortality, morbidity, life expectancy, lifestyle, smoking, nutrition and physical activity);
- resources for health and welfare, services provided and personnel in the public and private sectors;
- utilization of services, costs, effectiveness, efficiency, etc.; and
- environmental data such as of air and water pollution.

The Health Map will be available on the Internet, and is intended to serve the public with information on services available in the area in which they live; the public services for informed policy-making and planning; and the research community, for whom raw data will be available. Different parts of the Map will be accessible to different groups on the appropriate terms.

A communication strategy *(19)* developed for 2006–2007 included television spots and pamphlets dealing with cholesterol, obesity, diabetes, blood pressure and skin cancer. A similar social awareness campaign *(20)* was launched at the end of 2007, aimed mainly at young people and dealing with risks such as smoking, drugs, nutrition and exercise. Well-known personalities are to act as "ambassadors" for health. The development of modern methods of health promotion is hampered by the lack of a critical mass of health promotion experts and a recognized research centre for health promotion, although the School of Public Health plays this role to some extent.

2.5. Policies for specific NCD

2.5.1. Heart health

Although CVD are the main cause of death in Greece, regular surveys to monitor heart health and its causes are not yet in place. Some years ago, Greece applied to join the WHO MONICA Project but unfortunately was unable to fulfil the requirements for data collection. No doubt it is partly due to this dearth of information that there appears to be no clearly defined policy for tackling CVD.[8] However, the MHSS makes available information materials concerning the risks for heart health, and the use of television spots for health education is being intensified.

The impact of such health education material does not yet appear to have been evaluated. Furthermore, the "family physician" system is not yet widespread in Greece, nor is it clear how much support or training is given to first-contact health professionals to carry out health promotion activities related to tackling CVD.

The Greek Institute of Cardiology, established in 1991, has been working for more than a decade with the Ministry of National Education and Religious Affairs and its more than 300 cardiologists visit schools to inform children about the

[8] Since the completion of this case study, a National Action Plan for Heart Disease 2008–2012 has been formulated (in Greek only) by the Ministry of Health and Social Solidarity and is available at http://www.mohaw.gr.

prevention of CVD. The association plans to establish a research centre to focus on disease prevention.

2.5.2. Cancer

The first National Strategic Plan for Cancer Control is currently being formulated and is expected to be ready for consultation early in 2008.[9] This is expected to cover the range of cancer-related services, from prevention and health promotion to screening, detection, treatment, rehabilitation and research.

Until quite recently, one of the obstacles to the development of such policies and strategies was the lack of accessible data. Serious attempts are now being made by the MHSS to rectify this situation. Since the 1960s, information on cancer mortality has been collected from death certificates, with the well-known weaknesses of such data. An attempt was made from about 1980 onwards to systematize this but, in contrast to communicable diseases, there was no legal obligation to report and the stage of the disease was not reported. Furthermore, the information collected was not electronically processed. The National Statistical Service was responsible for operating the mechanism for registering cancer cases at the national level from 1967 to 1982; it then seems to have fallen out of use, to be taken up again by the Department of Public Health in the MHSS between 1990 and 2005. The last data published were for 1990/1991, but the notification system run by oncological hospitals and laboratories remained in operation.

Universities and relevant NGOs, including the Hellenic Cancer Society, are frequently funded by the MHSS to collect information on cancer, its screening and its treatment, but are not obliged to report back to the Ministry with the data collected. There is thus no channel for linking such information to policy formulation. In his recent report on the activities of the Hellenic Cancer Society, its President refers to the "unacceptable" lack of a tumour registry in Greece and the unsuccessful continuous attempts of the Society to convince the public authorities of the need for such information. The Society has managed, through EU funding, to computerize its own activities.

The 2005 Law on Public Health stresses the need for policies and strategies for public health to be evidence-based. In the framework of this law, responsibility for the cancer registry has been moved to the newly reorganized Centre for the Control and Prevention of Disease, where the necessary personnel are available. All notifications of cancer since 1991 are to be entered retrospectively into the registry. A pilot study involving three large cancer hospitals (covering about 70% of cancer patients treated) will commence in the spring of 2008. Together, these two main efforts are expected to provide a much improved understanding of the magnitude of the problem, to identify populations at greatest risk, to indicate where further resources and efforts should be focused in order to improve cancer survival, and to further improve cancer registration.

There are as yet no strong support services from the public sector for cancer patients and their families, apart from those (including home care) provided by a number of large hospitals, mainly in the Athens area. Voluntary support groups, however, are very active, particularly for breast cancer.

The Hellenic Cancer Society, established in 1958, is the largest NGO active in this field. Other, smaller organizations are also active, particularly in the care of children suffering from cancer. The Hellenic Cancer Society has 80 branches throughout the country and provides a wide variety of services, including health education, screening and early diagnosis, rehabilitation, and training for health professionals. Owing to its history and size, since 1960 the Society has

[9] Since the completion of this case study, a National Action Plan for Cancer 2008–2012 has been formulated (in Greek only) by the Ministry of Health and Social Solidarity and is available at http://www.mohaw.gr.

been responsible for carrying out the annual pan-Hellenic fundraising campaign for cancer on behalf of the MHSS. The costs of the campaign were very high, largely because those collecting donations were paid. The costs were returned to the Society, which then applied to the Oncology Committee of the Central Health Council for funding. Since the President of the Society is a member of the Oncology Committee, his proposal for a proportion of the funds raised to be automatically designated to the Society was recently accepted by the Committee, thus ensuring regular funding.

Over the past two years, the MHSS, in collaboration with voluntary groups and NGOs, has made intensive efforts in educating women with respect to cancer. For example, national education campaigns on breast and cervical cancer through television spots were financially supported by MHSS.

Given the underdevelopment of PHC, it is not possible to assess the role of the PHC services in health promotion and the early detection of cancer. The strenuous efforts currently being made to improve the evidence base should shed further light on the challenge of cancer control at all levels of care.

2.5.3. Mental health

As mentioned above, with a well-known psychiatrist as Minister for Health, mental health was brought firmly onto the policy agenda in the late 1990s. A ten-year action plan was prepared for 2001–2010. This was approved for partial funding under the third EU support framework and progress in its implementation is regularly evaluated.

This long-term plan is now being revised to further promote community-based mental health care. The main aims are to restructure and reorganize mental health services on a regional basis, giving priority to rehabilitation, PHC and outpatient care, and the reintroduction of mental health patients into the community.

The MHSS has already completed the establishment of Mental Health Sections in all health regions in the country, and special committees are now in operation dealing with mental health and the mental health of children and adolescents. The main purpose of these committees is to systematically monitor and evaluate the Mental Health Units in their area. This includes dealing with any operational problems and generally coordinating medical and hospital care for mental health and related administrative, scientific and educational activities, and supporting the work of the Committee for the Protection of Persons with Mental Disorders. In addition, they are to gather epidemiological data on the mental health of the population in their region. There are currently 46 Mental Health Sections supervising over 400 Mental Health Units throughout the country.

The strategy for mental health emphasizes the development of PHC with the creation of psychiatric day-care centres, health centres with the capacity to carry out pilot programmes for the provision of mental health care, and mobile care units. Regarding secondary care, psychiatric departments for children, adolescents and adults are already being established in the general hospitals.

The intention is to gradually reduce and finally completely abolish the old psychiatric hospitals. Already, between 2005 and the end of 2007, five such hospitals have been abolished. Correspondingly, over the past two decades, 23 mental health departments for adults and 4 for children have been established in general hospitals. Care in the community has been considerably increased with the establishment of mental health centres, day-care centres, mobile units and family-sized living accommodation.

A "mental health epidemiological map" is to be prepared in order to provide the information base for the revision

of the present ten-year strategy. Representative sample surveys of 4000 children and adolescents and 8000 adults aged 18–65 years throughout the country are to be carried out by academic centres in collaboration with the Ministry and the Health Regions. For the children and youth survey, the Achenbach questionnaire is to be used, while the survey of the adult sample will be carried out by household visits. In addition, there is to be a study of the existing utilization of mental health services. Consequently, it is expected to obtain a greatly improved picture of the real prevalence of mental illness and of mental health care and other services available, such as sheltered housing. By securing this much-needed information, it is hoped to secure the evidence base necessary for defining emerging challenges and promoting mental health.

2.6. Policies related to risk factors

2.6.1. Tobacco control

Tobacco is still an important crop in some parts of the country and Greece is the world's seventh largest tobacco producer. The tobacco lobby is therefore quite strong.

The rate of smoking in Greece is above the European average. Disregard for the comfort of non-smokers is not uncommon, particularly in bars and restaurants (where, according to existing legislation, space for non-smokers should be provided), in the work environment and in many public services. Smoking is still socially quite acceptable, reinforced by a culture where free will and tolerance play an important role and where many consider that restrictions on smoking are invasive *(21)*. This may be slowly changing as the rights of non-smokers begin to be recognized.

There are apparently considerable differences in the rates of smoking in different parts of the country *(22)*. Rates are higher in Athens (where 51% of men and 39% of women smoke) compared to rural areas, where cultural traditions that frown on women smoking tend to keep rates down. Contrary to many countries, however, it appears that "those of higher socioeconomic position are more likely to smoke than the less educated or those of lower income" *(23)*. The most serious challenge is the high rate of smoking among young people.

Greece complied with the 2001 EU Directive 2001/37/EC introducing large warning labels on packages of tobacco products. A decision of the Ministry of Health and Welfare in 2002 prohibited smoking in all buildings housing public services, private workplaces, and places where the public is obliged to wait for long periods of time (such as airports and railway stations), all health services and educational institutions, where smoking rooms were to be provided. A supplementary decision in 2003 indicated that, by agreement between employers and employees, smoking and non-smoking zones were to be provided. Implementation of these decisions was left to those "in charge" of the said institutions with the result that, even where smoking restrictions are in place, there is a tendency to break the rules, particularly in leisure-oriented places in general and in railway stations and taxis *(24)*.

Although the MHSS has intermittently organized committees to discuss the problem of tobacco and health, and laws regarding the sale of tobacco products have been passed, this has not yet led to a comprehensive smoking control policy.[10] There is no related training for health professionals and, equally importantly, as yet almost no effective restrictions on the sale of tobacco to minors.

The WHO FCTC was signed in 2003 and ratified in Greece in 2005. A joint ministerial decision *(25)* was taken to bring Greek legislation in line with an EU Directive of 2003 regarding the banning of tobacco advertising in the mass media and the sponsorship of cultural events by tobacco

[10] Since the completion of this case study, a National Action Plan for Smoking 2008–2012 has been formulated (in Greek only) by the Ministry of Health and Social Solidarity and is available at http://www.mohaw.gr. As from 1 July 2009, smoking is prohibited in all public places.

companies. Nevertheless, large hoardings advertising tobacco products still feature prominently on Greek roads.

A number of NGOs, including the Hellenic Cancer Society and the Hellenic Anti-smoking Society, provide information on the risks of smoking and support for smoking cessation. Television spots provided by the EU have recently become much more intensive.

A move towards stronger tobacco control was apparent early in 2006, when at a public discussion organized by the Hellenic Anti-Smoking Society for the WHO anti-tobacco day, the Minister for Health and Social Solidarity, Dimitris Avramopoulos, stressed the severity of the problem in Greece and stated his intention of developing a comprehensive anti-smoking policy. At a similar event on 31 May 2007, the Minister announced that a draft law developed in collaboration with related ministries was being formulated, aimed mainly at dissuading young people from smoking. According to the press release, the main provisions of the draft law will include the following provisions.

- The direct and indirect advertising of tobacco products, including the sale of toys in the form of tobacco products, will be banned.
- Packages containing fewer than 20 cigarettes will be banned.
- Tobacco products must include a label stating that they are not to be sold to people less than 18 years of age.
- A special Tobacco Control Agency (EFEK) is to be established with responsibility for related research, monitoring of the implementation of the law and the development of antismoking policies and action strategies;
- Those selling tobacco must be licensed and part of the cost of the licence will go to EFEK to be used for anti-smoking measures.
- The Health and Welfare Inspectors of the MHSS will be responsible for checking on implementation of the law, as will specially formed groups plus the newly established social volunteers, who will check on places of entertainment, offices etc. to see that they implement the law.
- Internet cafes and other places where young people meet will be smoke-free.

2.6.2. Nutrition policy

In the early part of the twentieth century, a chair of nutrition was established in the newly founded School of Hygiene, and by 1938 a report on the problems of nutrition in Greece had already been prepared *(26)*. Within a few years, however, the nutrition chair remained empty and the Second World War brought a tragic situation whereby, particularly in Athens, people were dying of hunger. Following the War, the Ministry of Agriculture concentrated on dealing with nutrient deficiency, deploying home economists in rural areas to help improve eating habits. This concentration on ensuring enough food continued for many years.

In the early 1960s, WHO embarked on a study that was to last for 30 years, investigating the dietary habits of people aged 40–59 years in 7 countries, including Greece. The results showed that people living in Mediterranean countries, and especially Greece, had the lowest mortality rates from cancer and coronary heart disease and had the longest life expectancy. The causes were thought to include working outdoors and physical activity combined with a sparse and simple diet whereof most of the fat came from olive oil and fish (what became known globally as the "Mediterranean diet").

By 1980, however, the (renamed) School of Public Health had been examining changes in eating habits and disease patterns in Greece, on the basis of which Professor Polychronopoulou-Trichopoulou wrote to the Ministry of Agriculture and the Ministry of Social Services suggesting the need for a nutrition policy. Despite intermittent interest from the public sector and the establishment of the Greek

Society of Nutrition and Foods, which brought together top academics with an interest in the issue, there was little practical policy action. It is suggested *(26)* that this was partly because the lobby group did not have a clearly defined strategy and did not employ available epidemiological material to convince policy-makers, but also that there was a dearth of people with training in nutrition. In addition, mortality from nutrition-related causes was comparatively low at that time and Greeks were obviously still benefiting from their Mediterranean diet. Greek experts were actively involved in raising the issue of the Mediterranean diet in international research circles.

Surveys carried out in the late 1990s indicated that the pattern of nutrition in Greece was moving away somewhat from the traditional Mediterranean diet, although a very high intake of fruit and vegetables was still reported. Data on cause of death were also being improved in the sense that the categories "old age" and "unknown causes", which had covered 20% of all deaths, were practically eliminated *(27)*. Gradually, a convincing body of evidence was being collected indicating that Greeks were increasingly burdened by nutrition-related diseases.

In 1994, Greece joined the joint WHO/EU study entitled European Prospective Investigation into Cancer and Nutrition (EPIC), in which 22 research centres from 9 countries take part. In Greece, about 28 000 adult volunteers have been recruited, representing a broad range of socioeconomic groups. Apart from self-administered questionnaires or telephone interviews regarding 24-hour dietary recall, this includes the use of blood samples and medical files in a longitudinal study.

In 1999, a core group of nutrition experts moved from the School of Public Health to the new Public Health Nutrition and Nutritional Epidemiology Unit, created in the Department of Hygiene and Epidemiology of the University of Athens Medical School. This unit became a WHO collaborating centre for nutrition and, with the prestige of the university behind them, a small band of dedicated nutritionists under the leadership of Antonia Trichopoulou continued to push for action to deal with the observed changing eating and morbidity patterns.

In 1999, partly as a result of their pressure, the Hellenic Food Authority was established and became operational in May 2001. This is a governmental organization, supervised by the Ministry of Development and based in Athens. A number of regional branches were foreseen but have not yet been developed. The principal aim of the Food Authority is to ensure that food produced, distributed and marketed in Greece meets high standards of food safety and hygiene and that the relevant legislation is enforced. It also has a division for nutrition policy, and is advised by a Committee for Nutrition Policy and other relevant experts.

The fortuitous appointment of the Professor of Epidemiology and Hygiene at Athens University as President of the Supreme Scientific Health Council meant that the University was asked to prepare food-based dietary guidelines for adults in Greece. Through collaborative action by the Ministry of Health and Social Welfare, the Ministry of Agriculture, the Ministry of National Education and Religious Affairs and the Ministry of Development, with input from a number of related NGOs, these guidelines, based on the Mediterranean diet with its high use of olive oil, fruit and vegetables, were quickly developed and accepted by the Supreme Scientific Health Council *(28)*.

In 2003, the Committee for Nutrition Policy proposed a draft nutrition policy to the then Minister for Health and Welfare. This was well-received by the Minister, who defined the field of nutrition as being one of the significant factors that contribute not only to longer life expectancy but simultaneously to avoidance of illness and a better quality of life. However, before this could be finalized, general elections brought in a new government. According to the

comparative analysis of nutrition policies *(29)* carried out by WHO in preparation for the 2006 European Ministerial Conference on Counteracting Obesity, the Committee for Nutrition Policy has now approached the new Minister regarding the adoption of a national nutrition policy.

The draft policy has five main aims: reducing childhood obesity, increasing the consumption of vegetables and pulses, reducing the consumption of meat and increasing that of fish, improving nutrition in mass catering, and broader information of the public regarding nutrition and food safety. It is hoped that this draft policy, submitted to the Ministry in November 2006, will be adopted and followed by a national action plan for its implementation.[11] It is not yet clear what the structure for its implementation might be, although a committee coordinated by the MHSS, with participation by the ministries responsible for education, agriculture, development and transportation, is being discussed.

Recent surveys *(30)* have indicated that, although compared to other developed countries risk factors such as hypertension are still relatively low in Greece, their levels are already becoming a serious public health problem. Those who are conscious of their hypertension, although on the whole not achieving their preferred body weight, seem to be trying to improve their eating habits, for example by consuming low-fat products, thus perhaps indicating areas where nutrition policy could be strengthened.

Few Greek schools provide school meals, but most have kiosks selling snacks and drinks. In an attempt to influence eating habits from a young age, in July 2006, regulations proposed some years before were finally introduced, listing in detail what may be sold in such kiosks *(31)*. These regulations define the accepted content of sandwiches, for example (cheese or turkey, tomato, no mayonnaise) and the type of cheese to be used, etc. and permit natural fruit juice (without added sugar) and water but no other soft drinks. It is said to be one of the strictest regulations in Europe. However, there appears to have been little support effort, such as raising awareness among teachers, pupils and parents of the need for such regulations.

The Mediterranean diet gives an important role to olive oil, which is produced and consumed throughout the country. Many urban dwellers have their supply of olive oil for family use from their own trees or those of relatives. A number of food producers have recently joined the nutritionists in promoting the main components of the Mediterranean diet and providing recipes. Ongoing research by the University of Athens and others, partly funded by the EU, is investigating traditional foods, how they are made and their nutritional value.

2.6.3. Alcohol policy (32)

Wine has been produced in Greece since ancient times and alcohol consumption is very much a part of social and family life, particularly in rural areas, where it is usual to drink wine with meals every day. About one third of the wine produced in Greece is made on small farms and in households. While they contribute to the consumption of alcohol, family and social networks are nevertheless considered to play an important part in restricting excessive drinking. There appears to be a strong belief among the general public that there are no serious alcohol-related problems in the country, and drunken and disorderly behaviour tends to be associated with certain groups of tourists.

Although there is no published preventive alcohol control policy,[12] various ministries have developed related policy

[11] Since the completion of this case study, a National Action Plan for Nutrition and Nutritional Disturbances 2008–2012 has been formulated (in Greek only) by the Ministry of Health and Social Solidarity and is available at http://www.mohaw.gr.

[12] Since the completion of this case study, a National Action Plan for the Control of the Damaging Consequences of Alcohol on Health 2008–2012 has been formulated (in Greek only) by the Ministry of Health and Social Solidarity and is available at http://www.mohaw.gr.

measures. For example, the Department of Mental Health of the MHSS has a section dealing with preventive activities in the field of alcohol and drug control, the Ministry of National Education and Religious Affairs organizes health education campaigns in selected schools, and the Traffic Police are responsible for administering the drink–driving test, which was introduced in the late 1990s partly as a result of the WHO Alcohol Action Plan.

Alcohol producers require a licence, but to ensure the high quality of their products rather than to control consumption. Since 1989, the legal lower age limit for purchasing alcohol in bars, discotheques and restaurants is 18 years. However, there have only recently been attempts to enforce the law and such places of entertainment are open long hours, or even all night in seaside areas. Alcoholic beverages are freely available in supermarkets, kiosks and specialized stores.

There are no legal restrictions concerning alcohol advertising and sponsorship, though recently the three public television channels initiated a policy of reducing the amount of alcohol advertising.

Fines for drink–driving have not until recently been severe unless the driver has been involved in an accident (when there may also be a temporary suspension of the driving licence) and many drivers seem to think there is little chance of their being tested. According to a Eurobarometer report *(33)*, 49% of respondents in Greece do not know what level of blood alcohol is allowed when driving. However, 92% consider that effective police controls would reduce alcohol consumption before driving. The new driving code and points system introduced in 2007 imposes much heavier penalties for drinking and driving.

There is no central coordinating body responsible for alcohol control, although the National Council on Alcohol, which consists of experts and representatives of several ministries, is working towards this end.

2.7. Settings

The settings approach has been introduced in Greece to some extent and the public health strategy presently being developed intends to expand this approach.

2.7.1. Healthy Cities

Athens has been a member of the WHO Healthy Cities programme since 1995 and continues to be part of the WHO network. The Athens Healthy Cities office is based in the municipality's urban planning division and is expected to study the quality of life not only in the city but in the whole of Attica. Within this framework, a city health profile has been formulated and an intersectoral strategy for health developed. There appears to be cross-party support in the Athens municipal council for action to deal with the determinants of health.

Some years ago 52 cities from all parts of the country were members of the National Network of Healthy Cities, but this network no longer appears to be in operation.

Meanwhile, two related NGOs, the National Network of Health Promoting Municipalities and the Transmunicipal Health Network, have developed similar networks. These aim to support cities in organizing and evaluating health promotion, exchanging information and training, and linking with similar international networks.

2.7.2. Schools

There is no school health system in Greece. Schools are inspected regarding their hygiene standards, and children are, examined at the start of the school year. A joint decision of the Ministries of Education and Religious Affairs and the MHSS in 2005 standardized this process, clarifying the form and content of a personal health card for pupils. The introduction of the card is already considered to have had

an important effect on the early diagnosis of disease and the avoidance of possible problems among pupils, particularly in relation to participation in physical activity. Medical associations and research teams from the medical schools carry out health education activities on an ad hoc basis.

Greece joined the ENHPS at an early stage, largely owing to the initiative of interested national experts in the Institute of Child Health. From 1 school in 1992, when the project started, the network quickly grew to 26 in 1994 and to around 40 schools by 1997.

A conference of the ENHPS was organized in Salonica in 1997, at which the Greek Ministers for Health and for Education played an active role. Partly owing to the prominence of this international event, the concept of health promotion in the school setting gained in political stature in Greece, with many more actors interested in joining the movement. As a result, the original idea of gradually increasing the network of "health-promoting schools" lost importance while that of introducing the health promotion concept into all schools took its place.

The Ministry of National Education and Religious Affairs, together with the National Youth Foundation (established in 1947 under the supervision of the Ministry) and a number of NGOs have implemented health promotion programmes in selected schools, including health education, counselling, and campaigns to reduce accidents and to improve nutrition *(34)*. The original ENHPS team has collaborated closely with the Ministry of National Education and Religious Affairs in providing training for teachers and other interested people. Other institutions with an interest in health promotion, such as teacher training academies, the National School of Public Health, the medical schools and a number of NGOs, have also provided training to the educational sector.

In 1996, the position of Regional Health Education Officer was established to support health promotion in secondary schools, and in 2000 was extended to the primary school level. By 2000, there were about 160 officers in place, their main aims being to organize seminars and workshops to train teachers, to encourage and motivate them to introduce health education programmes and to support them in applying for funding. The National Youth Foundation has funded the development of training guides for health promotion, while the Paedagogical Institute has added chapters on specific health issues in school books.

Health education is not, however, part of the regular school curriculum, either in primary or in secondary education. It was introduced as an elective subject to be taught after normal school hours, or in the case of primary schools in the 2–3 hours per week designated for elective subjects. Only in the higher technical schools is it included in the curriculum, but those teaching it do not have regular posts.

The availability of EU funding has perhaps been conducive to increasing interest. For example, in the EU framework for the academic year 2006/2007, the National Foundation for Youth announced the funding of 182 programmes on health education in schools.

The MHSS has recently been active in the school setting, limiting the type of food to be supplied in school canteens. Although the guidelines are clear and rather strict, it is not sure how far they can be implemented if the privately run canteens have difficulty in making a profit from the restricted list of products. Already, minor adjustments have been made in recognition of children's preferences for certain products that are not considered harmful in small quantities, and an attempt is being made to explain the measures to food producers, parents and pupils' associations *(35)*. The working group that prepared the guidelines is to assess how they have been accepted by children and canteen owners. Obesity and healthy nutrition will therefore remain on the school health agenda for the immediate future.

Despite these developments, "Greece still lacks a whole school approach and implements pilot projects that are not integrated into the ... school curriculum" *(36)*. There is very little continuity, with only a few educators and small groups of students participating in the programmes for short periods of time. For example, although a school smoking prevention policy was introduced in 1997, a study of three randomly chosen public lyceums in Athens in 2004 showed that more than 80% of the students had seen at least one classmate smoking in the previous two weeks, and fewer than 10% of the regularly smoking pupils could recall having attended a school class on the hazards of smoking *(36)*.

The intended intersectoral action has not developed, apart from certain exceptions around the area of Patras (where there is long-standing collaboration between a number of municipalities and local NGOs to promote training programmes for teachers, parents and volunteers) and in certain other places in, for example, Attiki, Larissa, Crete and Salonica. The Ministry of National Education and Religious Affairs maintains a list of agencies and institutions allowed access to schools, and NGOs dealing with NCD-related issues may have considerable difficulty in collaborating with schools if they are not on this list.

As the role of the Ministry of National Education and Religious Affairs has grown, there appears to be diminishing interest in working with the MHSS. Schools are not generally linked to the expertise and resources of local health centres or hospitals, or this takes the form of the classic health examination, except where interested individuals bring a health promotion approach. A certain rivalry may perhaps be discerned from the parallel development of a network of prevention centres by the MHSS and a network of youth counselling centres by the Ministry of Education.

From international experience, the school has proven to be an effective setting for health promotion. A clear policy and strategy at the national level for tackling NCD could indicate the role of the school setting.

2.7.3. The workplace

The Centre for Occupational Health and Safety (KYAE), established in 1978, is a directorate of the Ministry of Employment and Social Protection. Its main focus relates to health risks at the workplace, but since 1996 it has also been the national focal point for the European Network for Workplace Health Promotion (ENWHP).

In the context of this network, the Ministry finances the Hellenic Workplace Health Promotion Forum and secretariat. A number of mainly large and middle-level firms are members of this network and their health promotional activities range from the more general (such as facilitating the balancing of family and working hours, ensuring workers' participation in decision-making, providing healthy food in workplace canteens, and provisions for physical activity) to the more medically oriented such as preventive health checks. The participating firms exchange experiences of good practice through the network web site, and indicate that their activities have not only been good for health but have had economic benefits such as a reduction in absenteeism.

An NGO known as the National Network for Health Promotion in the Workplace has recently been established. It has a number of large companies among its members and is also linked to the ENWHP.

2.7.4. Health promoting hospitals

Greece has been a member of the WHO health promoting hospitals network since 1998. There are now 22 member hospitals, 18 of which are in the greater Athens area. In relation to NCD control, the network is part of the smoke-free hospitals movement.

2.8. Policies for specific population groups – older people

Interest in self-help groups has been growing in Greece and there are now active NGOs addressing, for example, breast cancer, diabetes and the need for dialysis. In some cases, their pressure has been extremely effective: for example, the Association of People with Cooley's Anaemia managed not only to secure proper medical care but also social and economic provisions that are now law. Although there is no national council or committee for older people, there are a number of quite vociferous pensioners' organizations and an NGO for healthy ageing, Ellas50plus, which represents Greece on the European Older People's Platform (AGE).

We were unable to locate published policy documents for specific population groups, including older people. However, as seen above, the necessity of reporting to the EU provides a valuable source of policy information in Greece. The *Annual report on health, health care and care for the elderly (37)* is one such source. The report does not refer to the health challenges faced by older people but outlines efforts made to improve the quality of and access to hospital care, including the improved computerization of information and proposals to expand PHC.

The success of the community centres for the elderly (KAPI) introduced during the 1980s, and particularly of the home-help services they provide, is highlighted in the report. In view of their success, the Government intends to further expand these services, which can be expected to support older people suffering from NCD.

In relation to older people and nutrition, in the context of the WHO/EU research project (EPIC) referred to above, nine countries, including Greece, are examining the role of diet on the etiology of cancer and other chronic diseases among older people.

2.9. Broad intersectoral policies with a health component

In the framework of the EU agreements, Greece develops national action plans for social inclusion (NAPs). The 2003–2005 NAP *(38)* included, as its tenth target, "Promoting better health. Increase of two years in average life expectancy at birth". The NAP did not relate this to tackling NCD. The main issues presented were ensuring access to health care in geographical and financial terms and expanding community services for mental health. Disease prevention was seen in terms of advice on quitting smoking, diet, etc. offered by the hospital services.

An intersectoral Commission for Social Protection was set up in 2003, chaired by the Minister for Labour and including among others the Deputy Minister for Health, the general secretaries of a number of ministries, and representatives of local authorities, trade unions, entrepreneurs, the church and voluntary organizations.

The 2006–2008 NAP *(39)* is aimed at three policy areas: social inclusion, the social security system, and health and long-term care. Employment is seen as the key to lifting people out of poverty. Health is seen, however, in terms of access to health services and the document states that "although health care expenditure has risen importantly, there has been no improvement as to the basic indicators on life expectancy, morbidity or potential morbidity of the population" *(39)*. There is no reference to the concept of dealing with the determinants of health and the main causes of death and morbidity.

3. Infrastructure and resources for policies to tackle NCD

3.1. Human resources

"In Greece, only the University of Crete has recognized family medicine as an academic discipline; only one chair is available in this country, and GPs are seeking recogni-

tion from sister medical specialities. There are no other career pathways or training opportunities, and one Masters Degree in Public Health is available at this medical faculty" *(40)*. The health system in Greece is extremely medicalized, with physicians dominating decision-making bodies related to public health. As one respondent for this case study put it, "the Greek population still see physicians as gods".

In accordance with the 2005 Law on Public Health, a General Secretariat and General Directorate for Public Health was established in the MHSS. One of the main responsibilities of the new Directorate is to propose policies and strategies for public health in close collaboration with the National Council for Public Health. The National Council has been reorganized over the years with changing governments, seemingly suffering from the general party politicization that dominates the public sector in Greece. Intended as an independent organization, when fully operational it is to be guided by a 15-member scientific committee, appointed by the Minister and including staff of the MHSS.

One of the problems faced for many years by the National School of Public Health, which provides postgraduate training in public health, is that its graduates have not found positions in the public sector demanding their level of training. There is a small financial incentive for those who undergo this postgraduate training, in the form of a scientific supplement to their salary in the public sector. Public health does not have a high status, and as yet a critical core of public health experts has not been created in the country. According to Article 5 of the 2005 Law on Public Health, "public health services are provided by specialized scientists who belong to the Body of Public Health Specialists and the necessary training and experience". This includes "scientists from the wider field of health sciences, the environment, communication, education, and social and economic sciences". This body has not yet been established, so it is not possible to assess where they might be employed and what might be their impact.

3.2. Financial resources

Without clearly defined policies for tackling NCD, it is not possible to assess resources designated for that purpose. On the whole, funding for NCD prevention seems to be on a project basis.

3.3. Research

There is a great deal of scattered research related to NCD, but this is not collected to give a comprehensive picture. Regular surveys of lifestyles and behaviour have not yet been instituted on a national basis in Greece. This appears to form part of a vicious circle, whereby the limited and discretionary Greek welfare state has not required extensive assessments of its citizens and the lack of such information keeps potential health challenges out of the public eye. Where limited surveys are carried out, they depend on the interests of individual researchers and the institutions in which they work, as seen in relation to nutrition, or they are carried out in relation to EU-funded programmes.

The need for such surveys to uncover the health challenges in Greece is evident. In 2006, under the leadership of Jiannis Tountas, Associate Professor of Social Medicine at Athens University, the first national survey of inequalities in health was carried out *(41)*. The ESOMAR social grades were used, based on the age at which formal education terminates and the occupation of the main income earner. Initial results indicate patterns similar to those found in other European countries, with chronic diseases being more frequent among the lowest compared to the highest socioeconomic class. Use of health services, according to the organization under which people are insured, also indicates the severe inequalities of access inherent in the Greek system.

The reorganized National Council for Public Health is to be an independent organization with its own budget, under the aegis of the MHSS but without its administrative control. It is to be responsible for overseeing the scientific work of the

public health services, for preparing an annual public health report to be presented to Parliament and, in collaboration with the MHSS, for formulating the National Action Plan for Public Health. When the Council is fully operational it will decide, together with the National School of Public Health, on the data and indicators to be included in the new Health Map.

The MHSS appears to have little impact on the direction or content of research in the health field. The focus of research in the academic field depends largely on the personal interests of individual experts, frequently influenced by their participation in international studies and the availability of international funding. National funding through KE.ELP.NO appears to be affected by agreements between its medical members.

Although, compared with other EU Member States, Greece spends a small proportion of GDP on research and development, the annual growth in this amount has been rapid in recent years, as has the annual increase in scientific publications. The country is said to be in a "catching up phase" as a result of decisions of the European Council of Ministers in Lisbon and Barcelona *(42)*. The demands of EU research programmes could be conducive to gradually improving the situation in Greece.

In 1998, the Greek Social Data Bank was created by the National Centre for Social Research to support and promote social empirical research and to disseminate the results. There is as yet, however, no strong health focus.

3.4. Training

Except where medical schools have developed the concept of community medicine, as in Crete, health professionals are not considered to be adequately prepared for health promotion and disease prevention. Most health promotion programmes so far have been staffed by physicians and untrained support personnel, with the result that they focused mainly on hygiene and medicine.[13]

More recently, new programmes offered by the medical schools, the National School of Public Health and the Technical Educational Institutes have allowed people from various disciplines to study health-related issues, facilitating a move away from the previous strictly medical viewpoint of health. The commitment of the MHSS and other government agencies for the effective utilization of such personnel will be crucial to the development of a multisectoral approach to health.

There is still an uneasy relationship in the public sector towards professional evaluation. The administrative and scientific committees and councils responsible for the operation of the National Centre for Public Administration and Self-Government of the Ministry for Internal Affairs are heavily dominated by union representatives. In the past two years, even members of the academic community – including students – have been vociferously against various evaluation proposals.

A law is currently being drawn up for the mandatory training of directors and unit heads of public services, and experience from France and the United Kingdom has been requested.

Insufficient knowledge of foreign languages certainly restricts access to developments on the international level, and an improvement in such skills would go some way towards remedying this.

3.5. Communication and public information/ involvement

Awareness-building campaigns in relation to NCD and their risk factors take the form of health education pamphlets and television spots rather than interventions (combining,

[13] A. Christoforidou, unpublished data, 2005.

for example, information, advice and support) that international research has shown to be more effective.

We do not have information on how effective health education campaigns, such as the MHSS communication campaign for public health described above, have been in terms of monitoring people's retention rates and their knowledge concerning NCD risk factors, etc.

Generally in the health sector (and perhaps more broadly in the public sector), there does not yet seem to be a tradition of actively involving stakeholders in policy formulation and evaluation, although a broad range of stakeholders were said to be involved in the ongoing preparation of the National Action Plan for Public Health.

3.6. Local community and social support system

The family and social support system in Greece is still comparatively strong, partly owing to and partly reinforcing the fact that the state steps in only when the family fails *(43)*. A complex network of family and kin, including *koumbaroi* (godparents, marriage witnesses, etc.) offer and receive economic and practical support, information and personal contacts. There is as yet little development of community services, although some local authorities are slowly moving into this area and the community centres for older people (KAPI) are popular where they have been established.

4. Forces facilitating or obstructing disease prevention and health promotion

Greece's rapid economic development over the last half century may have outstripped the corresponding social development and change in attitudes. No tradition of a strong "welfare state" has developed, although solidarity was expressed quite practically for many years through, for example, third-party taxes levied on the urban working population to support health care and insurance for the agricultural population.

The WHO Health for All movement, with its focus on tackling inequities in health through intersectoral action, has had little impact in Greece, even on a rhetorical level. Although individual Greek researchers are involved in multicountry studies, engagement from the public sector with the international level and therefore the influence of that level do not appear to have been significant.

In this respect, there is a clear differentiation in relation to the EU, where the development of certain strategies is essential for political or funding reasons. The recent shift in thinking in the EU in relation to the determinants of health has not yet penetrated Greece to any significant degree, however, although there are indications of the health determinants terminology entering the policy vocabulary. Only in areas where individual national experts have managed to maintain and utilize international links, supporting their research findings over a long period of time, and where they were in a position to influence policy (as in the case of nutrition) or where politicians had a particular focus of interest (as in the case of mental health) has the health promotion message come through more strongly.

Although there are indications of change, the reasons for this slow start are not easy to define. One of the main obstacles to action must certainly be the lack of regular and reliable information on health and its determinants. One respondent to the case study interviews suggested that Greece's specific history, with a civil war and a military dictatorship within living memory, has created considerable suspicion and reluctance to collect information related to the population.

The failure to prepare a formal public health report outlining the main causes of death and morbidity, and their related health risks and determinants, has meant that there has been no focus for informed public debate. Consequently, the mass media contribute to keeping health services in the limelight. Similarly, although individual experts are involved

in defining inequalities in health, apart from certain regional differences, there has as yet been no concerted attempt to reflect possible inequalities in health in regularly collected data, so the equality issue is simply not yet on the political agenda in relation to NCD and their risk factors.

Although important health-related laws have been passed in recent years, parliamentarians do not appear to play a strong role in the health discussion. Effective cross-party discussion is a rare event. The position generally taken appears to be that whatever another party proposes is de facto to be opposed, frequently "from the streets". Since the 2005 Law on Public Health calls for an annual report to Parliament, when this is implemented it could help refocus the political discussion.

There are a large number of NGOs related to the main NCD and their risk factors. Many of these count well-known experts among their members, and they can be and are asked for their advice on committees and consultations regarding policy development. On the whole, however, participation in Greece is more at the level of consultation, requesting comments and opinions, rather than through closer involvement in defining the issues, policy formulation or evaluation.

There is as yet no culture of trying to engage the public in informed debate. Policy related to NCD is expressed in legislation or administrative documents. The language is therefore legalistic and not as easily readable text outlining the issues and challenges, the needs for action and the proposed interventions. The structures and mechanisms are not yet in place for developing simplified policy discussion papers, not only to inform lay people but to elicit their participation in the policy development process. One step on the way was the recent pamphlet, widely distributed to all households, explaining the new and much more severe "points system" of the driving code, which aims at reducing death and injury on the roads.

The challenge for Greek participation in decision-making may, however, be deeper, as a number of respondents felt that young people were not taught to collaborate and work together, to share information or to look for effective means of joint action. Consequently it was felt that the types of regular meeting in institutions/authorities responsible for health policy, whereby staff plan and report on progress together, are not common in Greece. This hesitancy to share information is perhaps borne out by the fact that a search of the Greek Social Data Bank, housed in the National Centre for Social Research, reveals no current working papers for comment and only one out of 2000 on children with disabilities. This lack of dynamically evolving channels for participation naturally affects ownership and commitment and is not conducive to strong follow-through in terms of implementation or evaluation. There appears to be an urgent need for training in this field.

The medical profession, rightly or wrongly, is considered by the public to lead to bright careers and financial success, as indicated by the tremendous competition for entrance to the medical schools. This is despite the fact that, given the very high numbers of physicians compared to other European countries, many young doctors have difficulty finding work. Public health, however, does not have the same financial allure. The lack of financial incentive, plus the strong politicization of the civil service, are said to be negative factors impeding the attraction and retention of strong leaders in the MHSS.

On the whole, disease prevention and health promotion take a back seat to curative services. Vaccinations are perhaps the exception where, although still below European levels, the experience has been reasonably good, even among vulnerable groups such as immigrants. But even here, 70% of vaccinations are in the private sector. Article 8 of the 2005 Law on Public Health provides that services and actions to be defined in national public health programmes are to be provided free of charge by the health in-

surance organizations or other designated services. On the whole, health professionals are not considered to be well prepared for health promotion, and in the public sector it is doubtful whether they have the time or facilities. Following years of rhetoric regarding the need to develop PHC, a draft law has now been formulated.

The situation may change dramatically in the next few months, partly as a result of a proposal *(44)* presented to the WHO Regional Committee for Europe in September 2007 for the establishment in Greece of a WHO centre dealing with NCD. The practical implications of this are currently being discussed.

5. Lessons from the Greek experience

The situation in Greece is characterized by a severe lack of regularly collected data on NCD and their risks and determinants. This has clearly hindered the development of a comprehensive approach to tackling NCD. Persistent efforts by key players have kept certain issue-specific policies, such as those on mental health and nutrition, more firmly on the agenda. The development of the necessary legislative framework in 2005, and the process already under way for a focus on public health, should facilitate attempts to tackle NCD in the future.

5.1. The policy environment

Greece has been a member of the EU for many years and enjoys a reasonably high standard of living, although income inequalities are considerable and large numbers of the population live close to the poverty line. The total amount spent on health care is slightly above the EU15 average, so the issue is probably one of effective rather than increased spending.

Family support is still extremely strong, cushioning the effects of unemployment and the lack of community and other support services.

Greek society is characterized by a high degree of party politicization, hindering any attempt at cross-party consensus building. This also affects public administration, generally considered to be in need of modernization. In the public health field, even internationally recognized national experts may not be fully utilized when they are not of the right "political colour".

There is as yet no well-developed culture of negotiation and consensus building. The use of private consulting firms in the policy development process (particularly when this is EU funded), rather than attempting what admittedly might be a more time-consuming process of involving a broad spectrum of players from public administration, academia and civil society, exacerbates the lack of broad ownership in the policy-making process.

Involvement of the public services in international networks has been rather limited, restricting their awareness of developing public health issues and ways of tackling them. Greater involvement in EU-funded projects could open new windows and develop a culture for improved policy development, including regular monitoring and evaluation.

5.2. The value system underlying policy development

As a member of the EU, Greece shares the EU values. Partly owing to the lack of an adequate knowledge base to focus discussion, equality in health is not clearly evident as an underlying value of health policy, except in the sense of access to health care and other services.

Given that, according to WHO and EU research networks, "all European countries are faced with substantial socio-economic inequalities in health" *(45)*, it would be surprising if Greece were the exception. Initial results from a recent first national survey referred to above have already brought certain inequalities to light.

5.3. From awareness building to policy action

The lack of an adequate and accessible evidence base through which to focus the public health debate restricts awareness of NCD issues among politicians, health professionals and the public. Greece's comparatively high ranking in relation to life expectancy, although now slipping, has probably led to a degree of complacency. Regular analysis of long-term trends in NCD and their risk factors among different socioeconomic groups could help disperse such complacency.

Of particular importance is the lack of a national public health report analysing the health challenges and possible ways of tackling them. The formulation of such reports is foreseen in the 2005 Law on Public Health. Individual researchers and voluntary associations are concerned on an ad hoc and intermittent basis with aspects of the problems that interest them, and increasingly with issues for which there are international study groups and funding. Clear priorities need to be set for the compilation of data and for NCD-related research.

The situation is exacerbated by the lack of a critical mass of public health experts to instigate discussion and action. The medical model of thinking is heavily dominant and health promotion is not a term generally understood and used. Public health issues come to the fore in a fragmented and short-lived way. Without health promotion leadership at the national level – apart from bright exceptions whereby like-minded local authorities, volunteers and experts collaborate to promote health – there is little support for a focus on the determinants of health at the local level.

Related to this is the lack of information and discussion of the concept of inequality in health. Apart from limited reference to regional differences and certain narrowly focused studies, the issue is simply not on the table. Without the relevant data and broad understanding of the determinants of inequalities in health, there will be little opportunity to prevent potential growing inequalities, or to enhance conditions promoting equality in health. The issue is urgent, given that countries committed for 40–50 years to closing the gaps still find the reduction of health inequalities elusive.

The 2005 legislation has for the first time given legitimacy to health promotion and introduced, at least briefly, the concept of equality in health. It makes provision for structures and processes to develop policies for health. Few of the provisions of this legislation have been implemented, however, and without a critical mass of public health advocates it will take time to bring about much-needed change in the health promotion field. On the positive side, the formulation of a broad-reaching public health policy is currently under way.

The recent EU focus on intersectoral action for health, strongly promoted by a number of Member States *(46)* and reflected in policies for social cohesion and poverty reduction, could be one of the ways of bringing health promotion higher on the Greek political agenda. Methods for HIA in other sectors are being developed in a number of countries *(47,48)*. The 2005 Law on Public Health makes reference to the need for assessing the impact of policies in other sectors. Considerable effort will be required to train people to do this.

5.4. Sustaining policy implementation, monitoring and revision

The urgent development of an adequate information base is essential to all stages of the policy development process. This will need to be accompanied by the training at national and local levels of experts to effectively utilize this knowledge.

The mandatory monitoring and evaluation of EU-funded projects could help develop the necessary culture for this way of working. However, this is presently limited mainly to whether or not capital investment or training projects were

carried out and how funds were spent. If the planned public health policy includes targets for reducing NCD, their monitoring and evaluation might establish a new approach.

Fortunately, there are many interesting examples of NCD policy development in Europe for Greece to borrow and adapt, and numerous related European networks. A rapid catching-up process could be successfully achieved when the following pressing concerns are met:

- regular surveys of health status and behaviour, taking into account socioeconomic and gender differences;
- the publication and open discussion of regular public health reports in order to raise awareness of the challenges and opportunities for action, including the specific challenges of inequalities in NCD;
- capacity building for health promotion in the health care system, and for intersectoral action to tackle the determinants of NCD; and
- closer involvement in the policy process of the rich source of expertise available in the research and academic fields and the voluntary sector throughout the country.

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Hungary

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1. Country profile

The Hungarian Republic is located in central Europe. It has a territory of 93 000 km^2 and a population of approximately 10 million. One fifth of the population lives in the capital, Budapest, and almost 65% lives in urban areas. The birth rate is lower than the death rate and the population has fallen steadily since the 1980s. The proportion of the population aged 0–14 years old fell from about 20% of the total in 1990 to 16% in 2003. The percentage of the population over the age of 65 years has increased since 1980; it is currently 15% and by 2030 is estimated to have risen to 22% *(1)*.

Hungary has 23 large cities and 19 counties. Since 1996, the counties have been grouped in 7 regions.

1.1. Socioeconomic development

As a result of the shift to a market economy, Hungary had to face the collapse of the former economic system in the 1980s and a transformation crisis at the beginning of the 1990s after changing the political system. The GDP fell by more than 15% over the first three years. This period had a fundamental impact on the social structure, redistributing social positions, strengthening some old and creating some new inequities, and deeply influencing the health perspectives of the population. The Hungarian economy has seen constant growth since 1993, with an average of 3.5% per year. The high level of national debt was a legacy of the former regime and its repayment placed a heavy burden on the national economy. Nevertheless, the debt reached a manageable level by 2000, although in the last five years it had tended to increase. Balancing the national budget is one of the most significant risks for the national economy; one of the criteria for the introduction of the Euro in 2010 is that the budget deficit be stabilized below 3% by 2008.

The unemployment rate decreased between 1993 and 2001 but has risen somewhat since. The difference between the unemployment rates of men and women has decreased. At the same time, the percentage of people actively employed in the working-age population in Hungary is one of the lowest in Europe. Eurostat reports that in 2002, 10% of the Hungarian population lived in relative poverty. The GINI index has fallen since the beginning of the early 1990s and is now comparable to that of western European countries.

1.2. The people and their health

In the mid-1960s, life expectancy in Hungary was comparable with that of the more developed western European countries. Public health programmes, coupled with improvements in the socioeconomic situation, successfully brought communicable diseases under control. On the other hand, NCD prevalence increased, leading to rising adult mortality while life expectancy continuously improved in western European countries.

An increasing gap opened up between the heath status of the Hungarian population and that of people in western Europe. In the late 1980s, mortality rates among 45–64-year-old men in Hungary rose to levels higher than those of the 1930s. Cardiovascular mortality accounted for the majority of this excess, and led to a dramatically high level of premature mortality in middle-aged men. The reasons for this are complex and not fully understood. The phenomenon, known as the central–eastern European health paradox, describes this remarkable gender difference, despite the fact that men and women share the same socioeconomic and political circumstances *(2)*.

Risk factors such as tobacco use, alcohol consumption, low fruit and vegetable intake and low level of physical activ-

ity cause the greatest burden of disease on the Hungarian population. In terms of the main causes of illness and death, Hungarians have the highest death rates in the WHO European Region for lip, colorectal, laryngeal, tracheal, bronchial and lung cancers and the country has the second highest total cancer mortality rate in women, after Denmark.

1.3. The main features of the health system

The current Hungarian health care system was created at the end of the 1980s when the Social Insurance Fund was separated from the government budget and the financing of recurrent costs of health services were transferred to this Fund. Restrictions on the private provision of health care were abolished at that time. Since 1989, the system has become more pluralist, with responsibilities divided among various players. Nevertheless, the basic structure and the character of a highly centralized system have not changed.

The health service is primarily funded by social health insurance from the Health Insurance Fund for recurrent costs, administered by the National Health Insurance Fund Administration. Services are delivered predominantly by public providers owned by local government, who contract with the Administration.

The present Hungarian situation reflects a health system in rapid and radical transition, focusing on health care and health financing. A comprehensive health care reform is on the way in Hungary, characterized by prioritizing the reorganization of the hospital system and the insurance-based health care financing. The reform has created sharp conflicts with different interest groups in the health care system and emotionally heated political debates. Health promotion and NCD prevention are on the periphery of this policy development process and the debates relate to it. However, government mechanisms for health promotion and NCD prevention are formally well established and articulated, but with the overwhelming dominance of the central state apparatus. In the current political discussions about reform, a decisive question for the future of NCD prevention and health promotion is what type of preventive activities and services will be included in different insurance levels and packages. The question of a new, partly insurance-based financing system for preventive activities is proposed for debate.

2. Hungary's approach to developing policies to tackle NCD

2.1. Values and principles

Health as a basic value is included and emphasized in the Hungarian Constitution. The Constitution recognizes the right to a healthy environment, to an optimal level of physical and mental health and to income maintenance through social security.

The values set out in Hungary's National Public Health Programme (NPHP) are in full accordance with WHO documents and are based on the Health21 strategy. Generally speaking, in Hungarian legislation health is systematically considered as a human right and the principle of equality is present in all relevant documents. Recent planning in the context of Hungarian policy development to tackle NCD is largely influenced by the EU's programme on public health. Hungarian political documents are not specific on this point.

2.2. Structures and processes for implementation

Parliament has an important role in policy development to tackle NCD, although, its influence should not be overestimated. Questions about the health impact of different policy measures are often raised in parliamentary debates and the Health Commission of the Hungarian Parliament assesses the impact of most legislation from a health perspective. Nevertheless, health considerations do not often explicitly and significantly influence parliamentary decisions. Individual members may play the role of prime mover in different health actions, thus bestowing on them popularity and political weight.

The main functions of health policy formulation, coordination and regulation are carried out by a number of institutions under the direct control of the Minister of Health.[14] Beside these administrative functions, some of these institutions provide health services themselves, including public health services.

The National Public Health and Medical Officer Service (NPHMOS) is one of the most important agencies of the Ministry of Health. NPHMOS, headed by the Chief Public Health Officer, is considered as the government-based implementing agency for the NPHP. Its central organ is the National Public Health Centre, which consists of national health institutes. The Chief Public Health Officer is the Director-General of the National Public Health Centre, which controlled the local organs of NPHMOS through county and city public health officers until a shift to regional and district levels in 2006. NPHMOS institutes operate in the counties and the capital on the basis of the former sanitary-epidemiology stations. This means a homogeneous, regimented, government-based authority with national institutes and also county and city public health offices. In fact, most prevention activities are developed in different settings with outsourcing to NGOs.

Since the establishment of the two-tier local government system[15] in 1990 (which replaced the former "council" system), local authorities have become key actors in the health sector. Although national policy determines the broad framework for local policy, the Constitution guarantees the discretion of local government on local affairs, and this cannot be overruled by the national authorities. The local authorities are key partners in the different prevention programmes.

Nevertheless, a lack of consensus can be seen about the decentralization of the overall administrative system, including the regional and district levels. A number of governmental organizations, including NPHMOS, were reorganized in 2007 at regional and district level, replacing the old county- and city-level system. However, because of the wider political debate, the constitutional basis for such an important change is still missing. In future we can expect a shift from central decision-making bodies towards regions and districts in the development and implementation of policies to tackle NCD. The planned EU structural funds will be mainly distributed according to a bidding system at regional and district levels.

2.3. How things started

2.3.1. The first Health for All policy

Hungary has long experience in developing strategies aimed at improving the health of the population. The first CVD prevention programmes in cooperation with WHO, pioneered by the National Institute of Cardiology, began in the mid-1970s in the 17th district of Budapest and the city of Pécs.

In December 1987, the Government announced by decree a long-term programme on health promotion, a unique experiment under socialist conditions in Europe. The programme was to be implemented at the time that basic political reforms were taking place. Changes that culminated in the collapse of the regime marginalized this initiative, which disappeared along with the old system by 1990. Hence this programme cannot be evaluated properly.

The planning and initiation of the long-term health promotion programme in Hungary was made possible by a num-

[14] Act CLIV of 1997 on Health (1997/16) assigns responsibility for health services to the National Assembly, the national Government, the Ministry of Health, the National Public Health and Medical Officer Service and in general the owners of health facilities, who since 1990 are mainly local administrations.

[15] Act LXV of 1990 defined the basic structure, rights and duties, sources of funds and properties of local government. Municipal and county authorities share responsibilities on the basis of the principle of subsidiarity. This means that county authorities take over only those public services that municipal authorities cannot undertake and are willing to transfer to the county level.

ber of unique circumstances within a regime that was considered "soft" among the other socialist countries. Although Hungary's epidemiological data were poor, even by eastern European standards, the Ministry of Health developed a good and active relationship with the WHO Regional Office for Europe. The European Health for All targets and the Ottawa Charter inspired health policy in Hungary. A team of interdisciplinary experts, including social scientists, was on hand to plan and implement the programme, and the personal interests of the Deputy Prime Minister at that time were closely tied to the health promotion programme.

Hungary's long-term Health for All strategy was based on a well-meant but sometimes limited adaptation of the WHO targets. The Prime Minister issued a decree creating the National Council for Health Promotion and the National Health Promotion Fund, which was in charge of securing financing for health promotion. The Council set eight priorities:

- AIDS
- tobacco or health
- drug abuse
- alcohol abuse
- hypertension
- mental health
- the mass media
- accidents.

Action programmes addressed these priorities in 1988–1990.

As a next step, institutional frameworks were installed: the National Institute for Health Development was established and a number of local programmes were developed. The activities of the AIDS and hypertension programmes had positive, quantifiable results.

There were, however, signs of difficulty, and only some were linked to the political system. The programme lacked legitimacy. The National Assembly did not debate the population's health and the Health for All policy. The medical profession and most other health personnel were indifferent to health promotion. The programme failed to implement action that would serve the population's interests directly and obviously, offering services that could have made it popular with and well-known to the public. In the absence of a comprehensive system of objectives and means for tackling social and economic determinants of health, the programme also lacked public support. Both its supporters and its opponents blamed it for problems (ranging from the insensitivity of the taxation system to the issue of commercial supply) that could only be regulated in the framework of a really comprehensive, multisectoral policy.

Even the Ministry of Social Affairs and Health seemed to make only limited effort to harmonize prevention and welfare policy. In apparently taking responsibility for problems that the programme could not influence, ease or overcome, the ensuing criticism aroused a sense of failure among the programme's supporters. Trapped in the contradiction between the targets set and the real possibilities, the programme was increasingly pushed back within the boundaries of the health care sector.

Despite several positive examples at the local level, no countrywide awareness to promote health emerged. Movements and public institutions for health promotion and disease prevention did not cooperate. The National Council for Health Promotion did not lay the groundwork for a long-term relationship with important NGOs based on common interests. The programme did not take the opportunity to identify and build on the economic interests related to healthy products, goods and services. In addition, the programme did not have sufficient resources to reduce inequalities in health. During the three years following its formulation, there was no real programme planning or

management at an appropriate level to determine targets, methods, organizational requirements, financing, evaluation and adjustment mechanisms in a coherent system.

In the absence of appropriate annual and medium-term programme formulation, priority-setting could not proceed well. Since financial, personnel and organizational resources were scarce, plans were over-ambitious and subjective. In the lack of appropriate programme planning, the National Council for Health Promotion was not accountable for its work, stating that needs were so great that any action taken would have some benefits somewhere. The lack of conditions for fair evaluation made feedback and professionally sound adjustment impossible. Further, there was no sufficient research infrastructure to assist the policy in a comprehensive way.

The continuance into this period of some major strategies and guidelines for policy development to tackle NCD permitted substantial elements of continuity in health policy.

2.3.2. Umbrella policies in the period of transition

After the basic political changes in 1990, a more conservative, medicalized approach to public health emerged. The long-term strategy from 1987 rebounded and there was a nostalgia for the public health system of the 1930s. This, together with a more centralizing and bureaucratic approach, led to the formation of NPHMOS in April 1991. It was to guide and supervise epidemiology and health protection activities and supervise health care under the direct guidance of the Minister for Public Welfare.

In the second half of 1992, the Government became interested in quickly producing a strategic document for disease prevention and improving the health of the population. At first, the Secretary of State in the Ministry of Public Welfare wanted to set a two-month deadline, but after internal discussions, the Chief Public Health Officer secured the right to formulate a health policy document and made it his personal creation.

The Government accepted the document one month before the election and its subsequent Resolution 1030/1994 (IV.29) on the principles of a long-term public health policy set the following five national targets.

1. Health should be seen as one of the major values by an increasing proportion of the population. At the same time, efforts will have to be made to ensure that decision-makers attach primary importance to improving the population's health in both legislation and budgeting.
2. The years of life lived free from disease shall be extended to at least 55.
3. Life expectancy at birth shall be increased to at least 67 years for males and 75 years for females.
4. The difference in life expectancy at birth of population groups in extremely good and extremely poor social situations shall not exceed three years.
5. The difference between the number of deaths and live births shall be reduced considerably, to the advantage of live births.

These rather simple targets formed the basis for a structured system of prevention programmes. The way of thinking of the document can be illustrated by the following basic considerations *(3)*.

> a. Healthy lifestyles that influence the population's health status shall be shaped by means of education, mass media and health education, in the frameworks of which people must be made aware of the harmful effects of unhealthy dietary habits, tobacco and alcohol abuse and sedentary lifestyles. Further, the methods that enhance the adoption of healthy lifestyles shall be disseminated widely. To implement the above, the national core curriculum shall highlight activities related to health education, and

> the delivery of health care shall include, in addition to medical treatment, counselling tailored to the needs of the individual.
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> . . . . . .
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> d. Taking into account the most prevalent disease groups and most frequent causes of death, efforts shall be made to develop the methods of preventing, first of all, diseases of the circulatory system and malignant neoplasms, as well as to establishing an appropriate scheme of screening to ensure their early diagnosis.

This resolution offered a plan until the year 2000 with 20 prevention programmes, but was not discussed or approved by the National Assembly and offered a strategy mainly for NPHMOS. Intersectorality was not sufficiently developed, while community action and, generally speaking, partnerships were missing from the plan of implementation. The prerequisites for health were not considered and there was no clear concern for equality. In fact, the programme was never really implemented and the change of government in the summer of 1994 swept away the early plans *(3)*.

In the autumn of 1994, the new centre-left Government decided to restructure the health promotion and disease prevention programme and to broaden its focus on the determinants of health, with more emphasis on community-based elements. The financial crisis and the subsequent economic restrictions in 1995/1996 led to the deferment of that initiative.

During the next six years, various communiqués on public health were issued by the governments of the day but little was done. Nevertheless, some important legislative steps were taken in 1997 (a law on health, including public health) and in 1999 and 2000 (laws on protection of non-smokers and amending regulations on tobacco and alcohol advertising) but these did not become part of a larger framework.

Two important programmes were launched in 2000 and 2001.

- The National Strategy on Combating Drug Problems had more resources and attention to implementation, and in some aspects important results were achieved (local forms of coordination were established, school-based prevention programmes supported, and harm reduction services established and maintained). From the NCD prevention perspective the Strategy offered a fairly good example of the feasibility of a sustainable health strategy.
- The Public Health Programme for a Healthy Nation started late in the parliamentary cycle (2001) and thus faced the problem of limited resources. A national-level breast-screening programme was launched, and several administrative measures were taken to ensure effective intersectoral cooperation within the government. The Interministerial Public Health Committee was established and its legal basis was established by the Government.

2.4. The NPHP

A few weeks after the elections in 2002, a new Parliament with a socialist and liberal majority opened before the establishment of the Government. In this period, its agenda seemed relatively open and flexible. One of the members, a former staff member of the National Institute for Health Development, used the opportunity to propose a resolution requesting the Government to elaborate a new comprehensive public health strategy and to present it to Parliament by the end of 2002.

This (partly improvised) initiative was rather successful, Parliament adopting it without any difficulty. At the same time, the short deadline for drafting the document of no more than six months limited opportunities for consensus-building, the development of realistic alternatives and the appropriate integration of different interests as well as a priority-setting procedure.

The Public Health Programme for a Healthy Nation elaborated by the Conservative Government in 2001 served as a kind of template for the further development of the NPHP. A situation analysis was more or less available, based on detailed epidemiological data including geographical and social differences in mortality, morbidity and risk factors. There was little discussion of the basic values inspired by key WHO and EU documents. The insufficiencies and conflicts in the strategic planning were related to the lack of a clear planning system, process and practical coordination. In fact, a formal priority-setting mechanism was missing, with the result that the process was unduly influenced by lobby groups.

The NPHP therefore became a sort of melting pot with 19 priority directions, very much based on the 17 activity areas of the previous programme of the Conservative Government. In the climate of sharp political debate in Parliament, the NPHP offered a unique opportunity for consensus building. This was a decisive factor in government policy-makers emphasizing the continuity and similarities with the former document.

The 19 priority areas included some traditional public health activities linked to the EU accession process and created a delicate balance among the different interest groups, trying to avoid conflict and please everyone. Working groups were established to develop the details of each priority area based on a common template and to produce a two-year work plan of implementation. The working groups were given around three months for the drafting process. This short time precluded opportunity for substantial consultation and, the involvement of important stakeholders, and resulted in limited coordination and harmonization among the 19 areas.

The general introductory part of the NPHP – including the visions, goals, basic values and approaches – was drafted after the 19 working groups had finished their work. This contributed to the lack of full consistency between the basic principles and the real work plans. The general introductory part was inspired by basic international documents but the proposals of most of the working groups were more traditional, with a medicalized and individual risk approach. In technical terms, the strategy document offered great freedom in terms of implementation, without demanding annual priority-setting, but also making the whole process fragile and dependent on the changing political commitments of the various actors.

The text of the NPHP did not include a description of the way in which it should be implemented. In fact, the NPHP was basically characterized by a top-down approach to implementation. Because of the uncertainty related to the rapid changes in health care reform, the central managerial and coordinating structure is fluid and unclear.

The NPHP was provided with considerable resources compared to previous programmes. The work began in many areas at once, creating capacity problems at local level and coordination difficulties at central (governmental) level. The NPHP did not focus on key development areas, too many fields of activity were incorporated into the implementation plan and priorities were not set, mainly due to political decisions and lobbying independent of the technical and feasibility considerations.

The initial budget was subsequently halved because of general budgetary restrictions, and the administrative and institutional capacity for implementation deteriorated. The financial support at the beginning of the programme was quite robust, but in later years it was insufficient to complete newly begun elements of the programme. The lack of adequate research and human capacities has been a permanent problem in programme implementation. Capacity building needs systematic development. Financial cutbacks affected these areas immediately, leading to further deterio-

ration in the long- and medium-term viability and sustainability of different programme components.

Most professional organizations expressed their support at the beginning, but later criticized the implementation when they realized that their own objectives were not among the few and decreasing number of well-resourced areas. Other initiatives also suffered financial cutbacks.

In 2006, a Socialist–Liberal Government was re-elected and introduced radical steps in health care reform. The focus of the new Liberal leadership of the Ministry of Health centred on reducing hospital capacities, introducing fees for co-payment, reforming the pharmaceutical market and reshaping the health insurance system. In this very rapid process, public health issues, including policy development to tackle NCD, were marginalized. Policy implementation in the field of NCD depends to a large degree on public spending, and it suffered gravely as a consequence of the overall economic situation in the country. The agencies dealing with NCD prevention had to face severe staff reductions and diminishing funding.

Currently, health policy-makers appear to be paying increased attention to policy issues to tackle NCD. The policy planning and coordinating capacity of the Ministry of Health have been strengthened through the appointment of a special Commissioner of Public Health. The Parliamentary Health Committee often acts as watchdog for the implementation of the NPHP, and a mid-term review is on its agenda in 2008. In November 2007, a national conference on CVD prevention was organized with the participation of clinical institutions, PHC, civic and public health organizations. The expected outstanding support of the EU structural funds in the forthcoming years might be a stimulus for new policy developments in this field.

2.5. Monitoring and evaluation

Annual progress in the NPHP has to be reported to Parliament, which scrutinizes the activities and programmes in detail. Compared to the previous situation, this represents significant progress, stimulating not only the development of a comprehensive monitoring and evaluation system on NCD prevention but also calling, at least once a year, the attention of policy-makers to health promotion and disease prevention issues within the framework of parliamentary debate. However, the report does not make a critical analysis concerning implementation, the lack of resources or the effectiveness of the programmes. In 2005/2006, a lack of funding made impossible the preparation and publication of a full printed public health report.

Each separate activity of the yearly public health action plan is monitored in technical and financial terms, with special consideration given to some horizontal elements, including impact on equality. This monitoring system is insufficient to evaluate the quality and effectiveness of the programmes. Some specific monitoring and evaluation activities of the National Institute for Health Development offer deeper and more detailed evaluation results in some specific target groups.

2.6. Policies to tackle NCD

In the Hungarian health policy, the status and the relationship between different strategies related to the prevention of NCD is not clearly systematized and consistent. From a public health perspective, the broadest policy framework is the NPHP. The different sub-policies tackling the issue of risk factors are not always and explicitly integrated in the overall public health strategy framework and independent development of this type of policy can be observed mainly in the case of tobacco and nutrition.

The most important sub-policies with clear identities are:

- tobacco control
- food and nutrition
- alcohol control
- physical activity.

At the same time as a new government initiative in 2006, three broad strategy documents were launched and partially adopted on important elements of policies to tackle NCD:

- the National Cancer Control Programme;
- the National Heart Health Programme; and
- the National Infant and Child Health Programme.

Currently the interrelationship between these topic-based programmes, the public health strategy and other sub-policies is not explicitly regulated and the coordination mechanisms are also unclear.

2.6.1. Cancer

In 2006, the Government initiated the development of a long-term National Cancer Control Programme, requesting the professional associations working in the field to draft a programme document. The main reason was the extremely unfavourable epidemiological situation in Hungary compared to other countries. At present, there are about 300 000 cancer patients; 33 530 people died of malignant neoplastic diseases in 2003. Cancer is the second most frequent cause of death following CVD. Hungary declares in the document to be determined to permanently reduce malignant neoplastic diseases through complex, coordinated national action that includes all affected disciplines and addresses all involved groups of people.

The programme document includes an analysis of the epidemiological situation. Established by the World Bank, the National Cancer Registry began operating in line with international guidelines in 2000. The National Cancer Registry receives regular data on cancer from 198 medical facilities.

The Programme is based on the assumption that one of the most important of the many reasons behind the unfavourable epidemiological situation is the insufficiency of primary prevention, and that the educational system must play a crucial role in imparting relevant information. The role of health policy, as the drafting group understands it, is to initiate the dissemination of information on prevention through the schools, and to promote media coverage through articles and programmes, of knowledge on risk factors and on ways of controlling them. It also needs to support anti-tobacco groups and other NGOs and social organizations in their educational and information dissemination efforts. This way of thinking clearly reflects a more naïve and medicalized approach than that reflected in the spirit of the NPHP.

The document indicates as key areas of primary prevention:

- tobacco and alcohol consumption
- obesity
- viral and bacterial infections and parasitic infestations.

The draft programme gives high priority to secondary prevention for recognizing cancer and precancerous states with no signs or symptoms, in order to prevent serious consequences later. The method to be used is screening, including:

- mass screenings (organized, coordinated and controlled for quality by NPHMOS):
  - breast screening
  - cervical screening
  - colorectal screening
- ad hoc screenings:
  - oral cavity screening
  - prostate gland screening
  - skin screening
  - fluorography.

According to the document, in the field of cancer patient care, effective and up-to-date cancer therapy and diagnos-

tics are based on close cooperation between specialists (a cancer care team) and on organized consultations – in other words, on multidisciplinary communication.

To ensure that standardized principles of treatment are applied, treatment and financing protocols were defined as early as December 2005. A decision was also taken that certain types of cancer were to be treated not in oncology centres but in separate units in specialist facilities, partly because of their specific nature and partly because of Hungarian practice. A multidisciplinary programme is needed for the modern treatment of malignancy. Concerning the rehabilitation of cancer patients, physical and emotional rehabilitation is available at county oncology centres and a mobile team offers palliative care.

There are currently 1700 beds for cancer patients undergoing chemotherapy and radiotherapy and for the care of those with chronic disease, an insufficient number for the proper management of the tasks in hand. Cancer care facilities are organized and operated hierarchically, managed by a network of GPs, the oncology departments of the municipal and county hospitals, the clinical oncology departments of universities and, at the top, the National Institute of Oncology.

In recent years, the transfer of research results to oncology practice has accelerated, which is a huge challenge to the profession. It is essential that this research be included as a key component of the National Cancer Control Programme, in conformity with international practice. A sufficient number of appropriately trained specialist physicians are fundamental to cancer treatment. The schools of medicine and the National Institute of Oncology play the defining role in training specialist physicians.

The cancer programme includes 16 objectives covering the three pillars of primary prevention, secondary prevention and treatment. The list of objectives includes neither baseline measures nor clear, measurable indicators. It is noteworthy that the planning group expects substantial support from the EU structural funds in the forthcoming years, but there is great uncertainty as to the prospects of implementation. It is too early to forecast the chances of its success.

2.6.2. Heart health

In spring 2006, the Prime Minister requested the Hungarian Alliance of Associations in Medicine and Natural Sciences (having among its members various cardiological associations) to draft a National Heart Health Programme. Hungarian CVD mortality and morbidity are very high compared to the EU average, especially in middle-aged men. Despite some favourable trends in the last few years (the decline in mortality from acute myocardial infarction), Hungary still faces great challenges in reducing CVD mortality and morbidity. In addition, the social and regional inequalities in CVD are striking. The draft Heart Health Programme was discussed at different national conferences and technical meetings and the document was published on the Internet with a call for comments.

According to the Programme, the main aim is to improve significantly the health status of the population, and in particular life expectancy at birth should approach the average of the 27 EU Member States by the year 2013. To achieve this and to develop an efficient level of health promotion it is crucial to develop health communication and ensure the quality and effectiveness of care while reducing inequalities and joining the "information society". As far as we can see, this list of key components is rather eclectic.

Instead of clear objectives, the document uses the terminology of expected results. Only one objective is quantified, which is the increase in life expectancy at birth by three additional years by 2013 for both males and females. Among the expected results, the following are explicitly mentioned:

- declining cardiovascular morbidity and mortality;
- decreasing inequality;

- positive changes in lifestyle (in terms of smoking, alcohol use, overweight and physical activity);
- declining avoidable mortality;
- a lower incidence of acute myocardial infarction and stroke;
- a declining number of disabled people and improved quality of life;
- an increase in well-diagnosed and treated cardiovascular patients, a reduction in the high-risk population and an increase in successful rehabilitation; and
- a reduction in cardiovascular morbidity and mortality in younger and middle-aged people.

The conceptual framework of the Programme puts special emphasis on health promotion, on the lists of indicators according to the European Community Health Indicators (ECHI) system and the creation of a coherent database. The document underlines the importance of PHC in the community.

The document makes clear reference to other existing policies and programmes, including the NPHP, the National Cancer Control Programme and others, without making clear its own added value. The key people in the planning group may have an important lobbying function for securing financing from the EU structural funds in the period of implementation up to 2013. At the moment, the Programme has no clear legal status or managerial structure.

2.7. Policies related to risk factors

There are clear-cut sub-policies for tobacco control and nutrition. The alcohol policy is in a preparatory phase. A strategy on leisure time physical activity is included in the document outlining the National Sport Strategy.

2.7.1. Tobacco

Physicians in Hungary – reflecting international trends – started to call attention to the devastating results of smoking in the early 1980s *(4)*.

Studies on the social and economic costs of smoking show that from 1995 on, direct and indirect costs increased continuously, exceeding by about three times state revenues from the tobacco sector. Direct smoking-related costs, including hospital care, disability pensions and subsidies on pharmaceutical products, accounted for around 10% of the total costs to the national Health Insurance Fund in all three years for which calculations were made.

The NPHP lists tobacco control among its most important programme elements. Within this framework, the 10-year National Antismoking Action Plan states as its overall priority to reduce smoking in Hungary by 8% every year.

With the ratification of the WHO FCTC in 2003, the Hungarian Government assumed responsibility for creating the institutional framework for developing and implementing programme elements. The implementation of the FCTC is in progress and a ban on cigarette advertising has been introduced. Steps have been taken to provide smoke-free environment for the public, such as a ban on smoking in public buildings. The media pay increasing attention to the issue and public acceptance of smoking has declined significantly in the last few years.

Several anti-tobacco campaigns have been developed and run in the last 20 years, aiming to draw the population's attention to the negative effects of smoking on their health and quality of life. Campaigns are designed and carried out by the Ministry of Health and the National Institute for Health Development. Different programmes are designed for smokers, to make them aware of the dangers of smoking and encourage them to quit, while others are designed to prevent young people taking up smoking *(5)*.
One of the most widespread cessation campaigns is the "Quit and Win" programme, which is part of the CINDI framework activity in Hungary. The programme was launched in 1998, and events were organized in every two years *(6)*. A number of active NGOs, including the National

Smoke-Free Association, have developed high-visibility activities in the last two decades. Their advocacy role is important and is widely reflected in the media.

In the first decade of the 21st century, tobacco policy development is undoubtedly a success story in the area of policies tackling NCD.

2.7.2. Nutrition

Nutrition policy and physical activity are among the 19 goals of the NPHP. The main objective of the programme on nutrition is to reduce the prevalence of nutrition-related disorders and to improve the general state of health through healthy nutrition. The programme on physical activity aims to promote an active lifestyle in as wide a section of the population as possible, to increase personal motivation to lead an active life, and to see participation in sports become generally accepted as a community and social activity. However, the implementation of the NPHP is currently facing financial difficulties. Owing to structural changes, the Ministry of Agriculture and Rural Development is now in charge of food safety, while nutrition still belongs under the Ministry of Health.

Nevertheless, nutrition and physical activity remain still a priority on the public health policy agenda. A framework for a National Nutrition Policy *(7)* and the National Food Safety Programme were developed in Hungary in 2004. The National Nutrition Policy was developed by the National Institute for Food Safety and Nutrition and is based on recommendations from the WHO Regional Office for Europe *(8)*. The Hungarian document provides a detailed analysis of the main trends in the nutrition habits of the population and makes clear recommendations for further action. The document underlines the role of education in healthy nutrition, with special emphasis on schoolchildren in. A successful programme within the framework of the National Nutrition Policy was carried out among 125 000 primary school children throughout the country, teaching them the principles of healthy nutrition. Regular distribution of newsletters was one of the ways of introducing children to the elements of healthy nutrition.

In addition, the National Institute for Food Safety and Nutrition developed its *Food-based dietary guidelines (9)*, first published in 2001 and updated in 2004. The publication provides information on the principles of healthy nutrition and food safety, contains advice for home food preparation and storage, and offers incentives and ideas for health-enhancing physical activity.

In addition, the National Institute for Health Development, together with the National Institute for Food Safety and Nutrition, launched a booklet entitled *Should I eat it or not? (10)*, a practical tool with key information on nutrition, energy balance and physical activity written in easily understandable language. Another publication of the National Institute for Health Development is a *Heart-friendly cookery book (11)*, which aims at promoting healthy eating habits.

A major joint effort by the Ministry of Health and the Ministry of Education was the launch of the National Healthy School Canteen Programme in 2005 *(12)*. The key objective of the Programme is to provide healthy choices for children in school canteens. The related legislation was proposed by the Ministry of Education, while recommendations together with educational materials were provided by the National Institute for Food Safety and Nutrition for teachers, parents, students and school medical staff. Before the launch of the Programme, conferences were organized for mass catering experts, school doctors and teachers. An information campaign was organized in a major supermarket chain with the involvement of NPHMOS. Attention was drawn to healthy food, drinks and sports equipment in the information brochure of the supermarket, and customers could ask for personal lifestyle advice as well as have their blood pressure, blood-sugar level and body weight measured.

Finally, a Platform for Nutrition, Lifestyle and Physical Activity was established involving key experts from the civil, public, private and academic sectors. The Platform addresses the issues of labelling food products, developing rules for food advertising and physical activity programmes at workplaces.

2.8. Settings

Promoting health and preventing diseases in settings are undoubtedly success stories of the last decade. The three major strands in combating NCD are health promotion in cities and communities, at the workplace and in schools. There is also a weak network of health-promoting hospitals and a very proactive alliance of health-promoting kindergartens using, among other things, a "heart health toolkit".

2.8.1. Healthy Cities

The establishment of the Hungarian Healthy Cities Network in 1986 was the result of WHO's efforts to involve the leadership of cities and communities in health-promoting activities. In 2006, the Network had 23 member cities that developed a wide range of programmes and products for strengthening intersectoral health strategies based on community participation. Members were asked to draft a health development strategy for each city with the aim of promoting healthy lifestyles and a healthy environment, with special regard to vulnerable groups.

The Network has launched a series of publications about basic documents such as the Ottawa Charter, the Athens Declaration of the International Healthy Cities Conference, and case studies. Practical guidelines have also been published on how to develop a healthy city plan, how to introduce a health focus into urban planning, and how to link sustainable development and health in communities. The Network maintains a web site (http://www.hahc.hu) with more-or-less up-to-date information. The President of the Network subsequently became a member of the European Parliament, since when the activities of the Network have abated somewhat.

Since 2005, a foundation entitled the Association for Healthy Settlements, chaired by the wife of the Prime Minister, has developed important activities in this area. The various local government associations also pay attention to NCD policy issues, with special regard to developing local health plans at community level.

2.8.2. Health-promoting workplaces

The Hungarian Association of Health Promoting Workplaces is quite successful and has continued to develop since its establishment in 1997. This development is stimulated and supported by participation in EU projects. A key element of the success of the Association is that it implements the majority of its programmes jointly with the National Institute for Health Development: This arrangement allows the Institute to focus on national campaigns while the Association, which is less bureaucratic, has greater direct access to companies.

The Association organizes events for its members for the exchange of experiences and consultations, provides methodological assistance for the implementation of programmes, reports on best practices and disseminates helpful materials in Hungarian. Programmes tackle a wide range of health promotion issues from classical occupational safety to mental health promotion of employees. NCD prevention activities (mental health, nutrition, smoking, alcohol) are covered by the programmes. A number of publications are available on the regularly updated web site of the Association (http://www.emegy.hu/index.php).

Recently, the Association has carried out, within a project financed by the European Commission, a campaign for companies that aimed at easier access of employees to physical activity at the workplace. Another successful programme is that supported by the Ministry of Health for enhancing

healthy nutrition and physical activity at work. The Association and the Faculty of Health Psychology of Eötvös Loránd University jointly organize "train the trainer" seminars in smoking cessation.

2.8.3. Health Promoting Schools

The Health Promoting Schools network in Hungary is less active now, when it made an important contribution to the institutionalization of health promotion in schools. Hungary was among the first countries to join the ENHPS in 1990, with 10 schools involved at that time.

According to a decree by the Ministry of Education, health promotion has to be included in the "class master class", which usually takes place once a week. This has managed to create a mandatory countrywide system of health education in the regular school curriculum. Nevertheless, the content and type of health education have not been specified and teachers are generally not suitably trained.

The Health Promoting Schools network clearly plays an important role in providing expertise to assist its more than 300 member institutions in the implementation of successful complex health promotion programmes in schools. It is reported that only a handful schools (generally members of the network) take real advantage of the decree of the Ministry. Some schools carry out programmes in specific health-related fields such as smoking or HIV prevention on either an ad-hoc or a regular basis. It is more typical that schools launch a "healthy day" or a "healthy week" to raise awareness of health promotion. A number of schools organize a "lifestyle camp" to address some key health-related issues.

In summary, there are positive efforts to foster health promotion in schools but access is better for those who are well-informed and trained and have sufficient basic resources to take advantage of the opportunities.

2.9. Policies for specific population groups

2.9.1. Deprived groups

The health of marginalized and other vulnerable groups is an explicit component of the NPHP and a number of activities have been undertaken in the last few years, for example to improve the health of the Roma population. Most of the risk-related programmes have some special components for poor and socially excluded people. Screening programmes pay special attention to reducing inequality of accessibility. The Government has launched a new strategy against child poverty, in which health plays an integral part. In the last few years, Hungary has given priority to specific gender-related health issues among both women and men. In some socially excluded groups, such as the unemployed and migrants, public health action is fragmentary or missing.

Tackling the social and economic determinants of health inequalities has become a generally recognized principle among decision-makers and practitioners in Hungary in recent years. There are examples of good practice at local level, but all this is largely insufficient in the face of still increasing health inequities in Hungary.

2.9.2. Healthy ageing

One of the critical weaknesses in health promotion and disease prevention relates to the target group of elderly people. In 1996, a Committee for Elderly People was established within the Ministry of Health. The Committee meets regularly, with members delegated from the civil sector and experts from the health care system. In 2001, the Committee assigned a Commissioner of Health Care for Elderly People, responsible for preparing a health care programme for the elderly. The programme follows the main areas set out in the Elderly People's Charter prepared by the Committee. These areas are:

- participation in social activity
- social and economic security

- health care and general care
- advocacy.

The provisions of the Charter and the recommendations of the Committee are intended to be included in future legislation on the care of elderly people.

The National Institute for Health Development has developed a National Implementation Plan for Healthy Ageing. An information day was held in September 2007 to raise awareness about the programme, and the Institute launched a pilot project in Budapest for retired people to walk together. Seven regional conferences have been organized in seven large cities, together with a walking festival in the capital involving the leaders of 50 walking clubs from all parts of Hungary. A booklet has been published with detailed information on walking clubs. Other information booklets have been launched on healthy nutrition, physical activity and mental health, together with advice for organizers of activities specifically for the elderly. The publication *Community-based actions for healthy ageing (13)* also provides useful information and contacts for elderly people.

The Scientific Association for Healthy Ageing is an NGO whose activities include supporting scientific research on ageing and age-related diseases and health care for elderly people.

3. Infrastructure and resources for policies to tackle NCD

3.1. Human resources

The existing human resources available to the Government may be sufficient in quantitative terms. In each region, there is a health promotion department in the Regional Public Health Office with a staff of 10, and in each district there is at least one health coordinator. At the same time, the public health culture of the staff is often outdated The skills needed for flexible, broad, multilateral cooperation and for negotiating with policy-makers are generally lacking, as are an up-to date technical knowledge and proficiency in English. In the coming years, the National Development Framework (based on the EU structural funds) will place strong emphasis on human resource development in this field. In the next two or three years we can expect a radical change in the public health culture of both governmental and nongovernmental practitioners in the field of health promotion and disease prevention.

The human capacity of universities, colleges and other educational institutions has a growing importance and influence. Public health/health education training at the bachelor level is provided by three colleges in Budapest, Szeged and Szombathely, supported by government funding. Master-level training in health education is available at the Semmelweis University in Budapest. Postgraduate training in public health, environmental health, epidemiology and health promotion (separate courses) is provided by the School of Public Health of the University of Debrecen, which is unique as such in central and eastern Europe. The School of Public Health carries out broad research and training activities in the field of health promotion and disease prevention, and has produced a new generation of public health experts with contemporary knowledge and skills.

The development of human resources at local, subregional and regional levels is a great challenge for the future of health promotion and disease prevention in Hungary. The planned measures of human resource development and capacity building in this field may offer an important step forward in the forthcoming 3–5 years.

3.2. Financial resources

Concerning financial and technical resources, the basic conditions of work are provided by core funding from different public health institutions. Nonetheless, resources for cooperation between different actors in the field are limited.

In 2008, the target funding from the central budget (within the framework of the NPHP) for health promotion and NCD prevention is less than US$ 1 per year per inhabitant. The level of overall per capita expenses related to health promotion and disease prevention is roughly US$ 10 per year.

The process has begun of releasing local resources for health promotion, but the current situation is still far from satisfactory.

In relation to political, economic and social change, a slow but clear move towards decentralization might be expected. The EU integration process might accelerate this tendency. The main developmental trend will be towards subsidiarity, with increasing importance of local, subregional and regional levels, also concerning resources and capacities for health promotion and disease prevention. Between 2008 and 2010, Hungary can expect an important investment of US$ 25 million from the EU structural funds for developmental activities in health promotion and disease prevention. This is a unique opportunity for developing capacities and actions in the field of NCD prevention, which is a declared priority of the programme. In the longer term, questions of sustainability have to be addressed, hopefully in the context of a healthier national budget.

3.3. Information and research

Since health promotion and disease prevention are not institutionally included either in medical or in social research, they lie in general at the periphery of Hungarian research activities. Nevertheless, some exceptions exist, such as the Ányos Jedlik Programme, which is financed by the National Research and Technological Development Agency and includes preventive programmes and health policy research.

Some research activities, mainly in the epidemiological field, are carried out by different teams and published in national scientific reviews, as well as being presented at the annual conferences of the Hungarian Scientific Society of Public Health. Research activities related to health promotion and NCD prevention are based at the various university departments of public health, medicine and social sciences, the leading role being taken by the Debrecen School of Public Health.

Hungary has relatively detailed information on the lifestyles of the population and on health determinants, including inequality issues. Lifestyle issues such as nutrition, tobacco, mental health and coping, together with their process of change, have been the focus of research activities for many years. There is no research activity, however, on health promotion capacity or on infrastructural analysis.

Hungarian participation in international research and networking is satisfactory. Hungarian researchers are involved in research financed by the European Commission under the Research Framework Programmes and the Public Health Action Programme. Hungary participates in other international research projects on quality of life, social status, poverty and deprivation.

There is hope that from 2008, owing to the availability of EU structural funds, NCD prevention research will gain greater financial support and the results will be used by health policy decision-makers. It is planned to establish a countrywide, health observatory system at regional level with the participation of the medical universities and the public health services. This will be a very important step forward in NCD information and research.

4. Forces facilitating or obstructing disease prevention

4.1. Strengths and weaknesses within the health system

In shaping policies to tackle NCD, the conflict of interest between curative and preventive activities does not seem

to be sharp. The proportion of the health budget spent on preventive measures is extremely modest: less than 0.001% of the health budget is estimated to be allocated to NCD prevention and health promotion. Thus it would be ridiculous to speak about competition for resources between curative and preventive medicine. Neither does prevention exercise any political power among the leadership of the health sector, having only long-term rather than immediate impact on the political situation. Unlike the closing of hospitals or medical malpractice, health promotion issues are hardly likely to be involved in scandal.

Most of the elite in curative medicine, especially top cardiologists and oncologists, take a mildly supportive attitude towards NCD prevention and health promotion, though without too strong a commitment and interest. Nevertheless, their role is significant because some of them are prime movers in secondary prevention.

The picture is slightly different regarding the attitude of physicians in PHC. By the nature of their position they are part of everyday life and have a direct relationship with their patients. Hungarian doctors, especially in smaller cities and communities, enjoy high social status and are often leading figures in the local community. Therefore their potential impact on disease prevention is very important. They play an important role in lifestyle advice and local preventive measures. Many PHC physicians set up and run NGOs, mainly dealing with secondary prevention, and patient clubs. Despite this positive aspect, however, most of them are overworked and have neither the time nor the interest for with preventive issues. In the present situation, family physicians prefer out-of-pocket payments, which do not encourage preventive activities. The same is true for the tariffs of the health insurance system. Thus, if PHC physicians are active in health promotion and disease prevention, their interest is driven mainly by personal, moral commitment or social awareness, often to the detriment of their income.

The roots of the Hungarian public health system are in the sanepid tradition and in fighting communicable disease. Although the system is in transition, the "hygienic" way of thinking can still prevail at the various levels of power and decision-making. This can limit capacity to adapt to horizontal working methods based on multiple partnerships, participation and democracy.

In addition, there is competition for a given budget allocation between NCD prevention, health promotion and the rest of the activities. In conclusion, it can be difficult for the Hungarian public health system to adequately facilitate and promote NCD prevention. Rethinking the public health system is on the political agenda, but budgetary hardships make the way forward even more complicated.

4.2. Opportunities and threats at the macroeconomic and social levels

Hungary faces the challenge of linking health and development at national, regional and local levels. At local level, there are existing results and traditions and some examples of good practice.

The process of implementation of the NPHP is hindered by sharp and deepening inequalities. The social differences are higher than those in the EU15 countries. The ratio between the highest and lowest deciles of income is around 10, higher than in any EU15 country.

The third of the population with the lowest income has neither financial possibilities nor health literacy to develop healthy choices, and key elements are missing from the prerequisites for health. The victim-blaming attitude of traditional public health approaches worsens the vicious circle of poverty and illness. The impact of population-level actions is socially selective: the majority of actions are implicitly targeted at the upper middle class, thus opening up the inequality gap.

One of the key opportunities for tackling social determinants of health would be a problem-centred approach combining social and health policies. There has been no harmonization at the level of government of actions in social and health areas, not even when social and health affairs belonged in the same ministry. The traditional medical approach is socially insensitive while the social sector is unprepared to tackle questions of health.

Taking into consideration the present characteristics of policy development for tackling NCD, the key threats and challenges in the medium term are as follows.

1. How can health and development be linked at national level in the National Development Framework (EU structural funds)?
2. How can social and economic determinants of health be tackled from a health promotion and disease prevention perspective to achieve better equality?
3. How can health be put higher on the political agenda in a period of health care reform?
4. How can commitment be increased and strategic sustainability of policies ensured to tackle NCD beyond the government cycle?
5. How can economic models be found for NCD prevention?
6. How can one cooperate with the private sector in a strategic and ethical way?
7. How can an integrated approach for the whole communication system be developed from a health prospective?
8. How can the fragmentation of strategy implementation be avoided?
9. How can an increase in human and financial resources for NCD prevention and health promotion be maintained in the light of current developments?

5. Lessons from the Hungarian experience

The epidemiological situation related to NCD is quite unfavourable by European standards, especially in the middle-aged population. Considering the economic indicators of national development, the health status of the Hungarian population gives a much more negative picture than expected.

In the last three decades, rich and increasing experience and know-how have been created in Hungary in developing policies to tackle NCD. Broad Health-for-All-type policies were developed from the late 1980s, supported later by a number of issue-specific sub-policies. This strategy, based on umbrella policies while developing more and more vertical programmes, does not offer an appropriate level of co-ordination. In 2008, Parliament was to use the opportunity of the fifth anniversary of the NPHP to look at the situation and suggest ways for further development.

5.1. The policy environment

After beginning with some CVD prevention programmes in the mid-1970s, Hungary developed a long-term Health-for All-type policy for health promotion in 1987. This unique experience of the communist era was very largely influenced by the WHO Regional Office for Europe. After the fundamental political, economic and social changes in 1990, more conservative, medicalized approaches in public health became dominant, leading to a government resolution on the principles of a long-term public health policy in 1994. This programme has never been really implemented, however.

At present, the key elements of the macro-policy environment influencing the chances of developing policies to tackle NCD can be summarized as follows.

- The present Government undertook important new steps in health care reform. For politically understand-

able reasons, the Ministry of Health pays more attention to the key elements of the reform (co-payments, restructuring of the care system, new systems of insurance, etc.) and less on long-term issues of policy development to tackle NCD.
- The complicated economic situation of the country restricts possibilities for public funding. This rather difficult financial situation requires innovative ways of thinking in using the assets of the country and creating a closer link between health and development.
- In the medium term, the EU structural funds offer a unique opportunity for investment in building new capacities for NCD prevention and health promotion.
- Inequalities in health are much larger than the EU average and are still increasing. The present situation challenges policy development to use new techniques for an efficient way of tackling social and economic determinants of health in Hungary.
- Globalization greatly affects the Hungarian economy and society, including the health sector. It is a huge challenge for capacity building, learning processes and innovative thinking to use the opportunities and to limit the potential for harm of ongoing change. This stresses the responsibility of policy development to tackle NCD.

5.2. Indications of the value system underlying policy development

The NPHP and other key policy documents define the values and visions for health policy according to the major programmes of WHO and the EU. These values are based on a broad national consensus and clearly linked to those of the WHO Health for All policy. They are, however, sometimes poorly translated into action. Thus, although the Constitution guarantees health as a human right, the prerequisites for health are largely missing in society and inequalities are still increasing.

5.3. From awareness building to policy action

The Hungarian Parliament adopted a resolution on the NPHP in 2003. Using existing experience and working papers from the previous programme, the NPHP was developed in only six months. A small number of international experts in health promotion and disease prevention played an influential role in guiding the policy development process. The role of prime movers has been decisive in the case of Hungary for any important policies to tackle NCD.

The NPHP includes 19 priority areas based more on a sophisticated balance among the different interest groups than on clear priority-setting mechanisms, combining different approaches focusing on risk factors, settings and lifestyle.

The NPHP lacked a policy analysis of the experience of former Hungarian strategies and information on existing capacities was only partly available. Nevertheless, appropriate basic information for shaping the policy document was available, including data on morbidity, mortality, lifestyles, risk factors, and geographical and social inequalities in health. However, the text of the NPHP did not include any proposals for its implementation and the central managerial coordinating structure is still fluid and unclear.

The status of and relationship between different strategies for the prevention of NCD are not clear or consistent. The various sub-policies are not always and explicitly integrated into the overall NPHP framework, and one can discern that some sub-policies have been developed independently. The most important, clearly identified sub-policies are those on tobacco control, food and nutrition, alcohol control and physical activity. Recently, a National Cardiovascular Diseases Prevention Programme and a National Cancer Control Programme have been drawn up by the Government. Promoting health and preventing disease in settings are the success areas of the last decade. Three major strands are dominant in combating NCD: in cities and communities, at the workplace and in schools.

The health of excluded and vulnerable groups is an explicit component of the NPHP. The most important initiative is a target health programme for the Roma population. Despite some examples of good practice, health inequalities are still a huge challenge for Hungarian policy development to tackle NCD.

5.4. Sustaining policy implementation, monitoring and revision

Annual progress in the NPHP has to be reported to Parliament, which scrutinizes the activities and programmes in detail. Compared to the previous situation, this represents significant progress, stimulating not only the development of a comprehensive monitoring and evaluation system on NCD prevention but also calling, at least once a year, the attention of policy-makers to health promotion and disease prevention issues within the framework of parliamentary debate. However, the report does not make a critical analysis concerning implementation, the lack of resources or the effectiveness of the programmes. In 2005/2006, a lack of funding made impossible the preparation and publication of a full printed public health report.

Each separate activity of the yearly public health action plan is monitored in technical and financial terms, with special consideration given to some horizontal elements, including impact on equality. This monitoring system is insufficient to evaluate the quality and effectiveness of the programmes. Some specific monitoring and evaluation activities of the National Institute for Health Development offer deeper and more detailed evaluation results in some specific target groups.

5.5. Key conclusions

Hungarian policies to tackle NCD have existed for three decades, with some degree elements of continuity. The system is in place but is not necessarily sustainable owing to uncertainty in the availability of resources. There are some better developed sub-policies, such as those on tobacco and nutrition, partly related to the EU integration process. There are links between the public health strategy (as the main umbrella policy), the risk-related sub-policies and the topic-oriented larger programmes on, for example, CVD, cancer and child health, but there is little consistency or a clear coordination mechanism.

The NPHP has an uncertain sustainability owing to marginalization of health policy, limited political commitment and declining public funding. At the same time, however, there is relative stability in institutional human resources and a number of action areas. The investment of the EU structural funds in the field of public health may create a new situation in the medium term, with long-term challenges for sustainability.

Equality is a key horizontal dimension of any programme planning and evaluation in public health. There are specific programmes matched to the needs of different marginalized groups, such the Roma population and children from poor families. However, inequality in health is still increasing in Hungary and the equality aspect of the NPHP, despite expressed concern, is not a success.

Examples of good practice appear mainly in communities and settings at regional and local levels. There is a large number of outstanding programmes, successful initiatives and prime movers in the different settings, such as workplaces and schools and at community level. There is also a limited number of recent successful experiences in cooperation with the private sector.

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Ireland

Anna Ritsatakis

1. Country profile

Ireland lies in the Atlantic Ocean, separated from Great Britain by the Irish Sea. The President is head of state, with a largely consultative role. Local government is composed of 29 county councils, 5 county borough corporations, 5 borough corporations and some smaller entities.

In 1973, Ireland joined the EU. Irish is the first official language and English the second.

1.1. Socioeconomic development

Entering the 1980s with high inflation, substantial external debt and deteriorating public finances *(1)*, this small open economy achieved a remarkable turnaround in the following decade. Unemployment dropped from around 18% in the late 1980s to 4.4% in 2005, half the average rate for the EU countries prior to 2004. GNP per capita rose from US$ 18 230 in 1980 to US$ 26 960 in 2003.

Ireland's economy is now one of the world's most globalized and has experienced annual growth rates above the averages for developed countries. Growth rates averaging 10% were experienced in the period 1997–2000, while current rates are of the order of 4–5%.

1.2. The people and their health

The population of Ireland has increased from 2.9 million in 1970 to 4.2 million. Some sources forecast an increase to over 5 million in the next 10 years. With decreasing fertility rates, the proportion of children aged 0–14 years in the population fell from 31.3% in 1970 to 20.7% in 2005. The proportion of people aged 65 years or more has remained stable at around 11%, but the numbers of people living to a very old age is expected to increase rapidly and, given the widening gender gap in life expectancy, these will be mainly women.

Life expectancy at birth increased between 1970 and 2005 from 68.5 to 77.3 for men and from 73.2 to 81.8 for women. Until about 2000, this was the result of a rather mixed picture. While the SDR for cerebrovascular disease dropped rapidly, by 2000 it was still above the EU average. Mortality from all cancers and particularly from lung cancer in males aged 0–64 years dropped substantially between 1980 and 1990, but remained above the EU average in 2000. Since then, death rates from these diseases have fallen below the average in pre-2004 EU countries.

Improvements in death rates for diseases affecting women have been less evident. The SDR for cancer of the cervix remains double the pre-2004 EU average (4.6 compared to 2.3 in 2004) and the mortality rate for breast cancer in women also remains above the pre-2004 EU average (30.8 compared to 25.7 in 2004).

Deaths from selected alcohol- and smoking-related causes dropped very significantly from 1980, though the latter remained well above the EU average in 2004 (252.6 compared to 205.4 per 100 000 population).

The All-Ireland Study on Mortality 1989–1998 *(2)* showed that there was a three-fold difference in SDRs between men in the lowest and highest socioeconomic groups during this period. The strong impact of occupational class was evident for nearly all the major causes of death. While occupation is recorded on death certificates, mortality data are not routinely available by socioeconomic group and there are inadequacies in the available data. More recent data for 2002, although not strictly comparable with the 1989–1998 data, indicate persistence in health inequalities, particularly in areas such as heart disease, cancer, accidents and injuries, and low birth weight.

1.3. The main features of the health system *(3)*
Public funding accounts for approximately 78% of money spent on health care in Ireland. Access to the National Health Service is based on a means-tested system of eligibility comprising two categories. People whose income is below a certain level fall into category I (currently 36% of the population) and are entitled to a wide range of free services. Those not entitled to a medical card (category II) have limited eligibility. There is a well-developed private sector, accessed through insurance cover and/or direct payment.

Those in category I are entitled to: GP services; all inpatient care in public wards; treatment at specialist outpatient clinics; dental, ophthalmic and aural services and supply of appliances; prescription drugs and appliances; maternity care; and infant welfare services. Attempts are being made to enable more people to become eligible for the medical card and free GP services. The income limit for medical cards is progressively being lifted, and an estimated 230 000 more people were able to access their GP free of charge in 2005 *(4)*.

Category II people are entitled to all inpatient services in public hospitals, subject to certain charges; specialist services in outpatient clinics (excluding dental and routine ophthalmological and aural services, unless referred from child health or school health clinics); maternity care and infant welfare services, including the services of a family doctor during pregnancy and for up to six weeks after birth; drugs for certain illnesses; and a refund on drugs over a certain limit per month. People in category II tend to have recourse to voluntary health insurance. The Voluntary Health Insurance Board covers around 35% of the population. It pays the contribution for care in public hospitals for category II people and for other care not available to them such as GP services and private care.

The Department of Health and Children (DoHC) has a policy and coordinating role but is not directly involved in the provision of services, which is the responsibility of the newly established Health Service Executive (HSE). The HSE took over full operational responsibility for running the country's health and personal services on 1 January 2005. Previously, this was delivered through ten regional health boards composed of elected local representatives, health professionals and ministerial nominees and serving populations of between 200 000 and 1 million The HSE is now the single body responsible for primary care and community, hospital and acute services, and is the largest state employer with approximately 100 000 employees.

The HSE is broadly organized through four administrative areas. Each area is supported by a regional health forum made up of representatives from the relevant city and county councils. These forums make representations to the HSE on the range and operation of health and personal health services within the region. Below the administrative regions are 32 local health offices, which are the public's first point of access to community services. The hospital system is administered through the HSE's National Hospitals Office, which manages the acute hospital services in 51 hospitals nationally. There are 8 hospital networks providing local administration of the hospital system.

Prior to the changes, the development of certain services was felt to be influenced more by local political pressures than evidence-based needs. One of the main aims of this radical centralizing of operations was to reduce some of the inequalities in the delivery and quality of services across regions. Two years on, however, interviews carried out for this study indicated a great deal of frustration with the new system, mainly since lines of responsibility and accountability were not yet considered clear.

2. Ireland's approach to developing policies to tackle NCD

Ireland has considerable experience in developing the full range of policies for tackling NCD referred to in Chapter III.

This includes: broad umbrella-type health system and health promotion policies; specific policies dealing with diseases such as cancer, with heart health and diabetes, and with risk factors and behavioural issues such as food and nutrition, obesity, alcohol consumption, physical activity and smoking; health components in policies for population groups such as children and older people; and health components in the National Development Plan 2007–2013 *(5)*, *Towards 2016 (6)* and the National Action Plan for Social Inclusion 2007–2016 *(7)*.

This plethora of policies has been interlinked in various ways, ranging from referencing, to the provisions of a particular policy appearing in the text of other policies, to the setting of common targets, to utilizing funding opportunities in one policy area to implement related objectives under another policy heading. Strands of continuity and a willingness to build on previous efforts are reflected in references to earlier policy documents. It was not possible, however, to discern readily recognizable structures and channels for the overall coordination of policies relevant to tackling NCD and their risks. Partly owing to this, a *Policy framework for the management of chronic diseases (8)* was approved early in 2008.

2.1. Broad policy for health – "quality and fairness"

The current broad policy for health in Ireland is *Quality and fairness: a health system for you (9)*, covering a 7–10-year period.

2.1.1. How things started

The pattern of health policy development in health in Ireland has been that of formulating broad strategies and complementing these by more detailed policies and strategies for health promotion and for specific diseases and their risk factors.

The 1994 strategy for effective health care, *Shaping a healthier future (10)*, provided the foundations for the current policy. This document concentrated mainly on health care, but was an integral part of the overall development planning process for economic and social progress. It tried to shift from the traditional focus of providing a particular level of health service to achieving outcomes in terms of health and social gains. CVD, cancer and accidents were listed as the three main causes of premature death. The four-year action plan accompanying the strategy set quantified targets for their reduction and anticipated additional strategies for health promotion and individual risk factors.

Quality and fairness (9) appears to have been triggered partly by the fact that an unprecedented increase in the funding of health services at the end of the 1990s (investment in health care was doubled between 1997 and 2001), although bringing improvements, was clearly not enough. This conviction was strengthened by research results, including the first survey of lifestyles and attitudes, completed in 1998, and surveys in the health behaviour of schoolchildren. This concrete evidence underlined past convictions that, unless trends in smoking, alcohol consumption and diet were reversed, this would lead to avoidable deaths in the future.

As the 1994 policy did, *Quality and fairness* indicated concern that Ireland was not keeping pace with health improvements achieved in other EU countries. All of this led to the understanding that it was time not only to improve the level and quality of health and social services but "to ensure that health is given priority across all the sectors with a role to play in improving health status" *(9)*.

2.1.2. Awareness building and the consultation process

Effective action was seen to require a stronger multisectoral approach. To this end, in addition to a 17-member Steering Group to oversee the process and a 15-member Project Team comprising officials of the DoHC and of the health boards, a high-level Inter-Departmental Group was set up. Nine of the nineteen members of this group came

from outside the DoHC. A small international panel gave additional support. Links were made to those working on health aspects of the National Anti-Poverty Strategy.

At the beginning of 2001, consultants were asked to design, plan and report on a consultation process to gather the views of members of the public, service users, service providers, staff, management and governance of the health services. This process fed directly into the preparation of *Quality and fairness*.

The planned organization of local consultation meetings for the general public had to be cancelled owing to travel restrictions to halt the spread of foot and mouth disease at that time. Background information on *Quality and fairness* and existing health services was therefore provided in a special pack entitled *Your views about health (11)*. Individuals and organizations were asked to respond in writing to questions, to describe their own experiences of the health services, and to give their ideas about future change. A full report of the results was published and reference is made throughout the final strategy document to comments on the draft.

The Minister established a National Health Strategy Consultative Forum representative of key stakeholders to provide advice on the main themes and direction of *Quality and fairness* and on the process for its preparation. In addition to the plenary sessions, working groups dealt with specific issues, which mirrored similar groups established within the DoHC. The Forum played a key role in the consultation process and continues to meet annually to advise on implementation of the strategy.

The Working Group on the National Anti-Poverty Strategy (NAPS) and Health was established in the autumn of 2000 to set targets for reducing health inequalities among the poor or socially excluded, as part of the overall strategy to address poverty. These health targets were closely linked to the objectives of Ireland's first National Action Plan Against Poverty and Social Exclusion (NAPinclusion), published in 2001, and the framework for achieving them became an important strand in *Quality and fairness*. The NAPS Working Group also undertook a major consultation process to feed into the preparation of the strategy, and this consultation process was later evaluated.

A strong commitment to tackling inequalities was reiterated in the revised NAPS, *Building an inclusive society*, published in 2002 and in the second NAPinclusion published in 2003. A new National Action Plan for Social Inclusion (NAPinclusion) 2007–2016 has recently been launched *(7)*, closely linked to the new National Development Plan 2007–2013 *(5)* and the new national partnership agreement, *Towards 2016 (6)*. Both the NAPinclusion and *Towards 2016* adopt the lifecycle approach, placing the individual at the centre of policy-making and delivery and providing the framework for a more coordinated and multidisciplinary approach to policy-making.

2.1.3. Values and principles

Quality and fairness – a health system for you (9) describes its vision for the future as:

- a health system that supports and empowers you, your family and community to achieve your full health potential;
- a health system that is there when you need it, that is fair, and that you can trust;
- a health system that encourages you to have your say, listens to you, and ensures that your views are taken into account.

The principles of the strategy are explicitly stated as being equality, people-centeredness, quality and accountability.

2.1.4. Setting the agenda

From the outset, it was intended that *Quality and fairness* should be based on solid research and evaluation. To this end, a first ever audit of value for money within the health system was carried out, and projections of likely future needs for health services were made. The first ever surveys of lifestyles also provided essential evidence.

It was stated that the strategy was to be centred on "a whole system approach to tackling health in Ireland", going "beyond the traditional concept of 'health services'. At its widest limits this system does not just include the services provided under the auspices of the Minister for Health and Children. …It includes every person and institution with an influence on or a role to play in the health of individuals, groups, communities and society at large" *(9)*.

Quality and fairness has four goals with their related objectives:

1. better health for everyone:
   - the health of the population is at the centre of public policy;
   - the promotion of health and well-being is intensified;
   - health inequalities are reduced;
   - specific quality of life issues are targeted;
2. fair access:
   - eligibility for health and social services is clearly defined;
   - the scope of the eligibility framework is broadened;
   - equitable access is assured for all categories of patient in the health system;
3. responsive and appropriate care delivery:
   - the patient is at the centre of planning care delivery;
   - appropriate care is delivered in the appropriate setting;
   - the system has the capacity to deliver timely and appropriate services;
4. high performance:
   - standardized quality systems support best patient care and safety;
   - evidence and strategic objectives underpin all planning/decision-making.

The first goal refers specifically to NCD such as CVD and cancer and the reduction of injuries, and to risk factors such as smoking, alcohol consumption, diet and lifestyle.

The focus is both on the total population and on targeting high-risk groups in order to reduce the observed health gaps. Particular attention is paid to Travellers (an indigenous minority) and homeless people.

2.1.5. Finding solutions

Implementation of a National Health Promotion Strategy is seen as an important means of reaching those at risk. Implementation of the National Cancer and Cardiovascular Strategies was also to be intensified. To this end, new implementation plans were to be developed at national and regional levels and, equally importantly, their implementation was to be evaluated by the National Cancer Forum and the Heart Health Task Force.

In implementing these strategies, priority is given to tackling smoking, alcohol consumption, diet and exercise. New legislation restricting smoking was introduced and agreement sought for disregarding tobacco products as a component of figures to calculate inflation. The Alcohol Policy was reviewed.

HIA or, as more frequently called in Ireland "health proofing", is seen as a vital tool for influencing the determinants of health. The DoHC is to support other departments and agencies in carrying out HIA. The Institute for Public Health in Ireland offers training in HIA. Furthermore, health proofing was embedded in the Strategic Management Initiative for all government departments, in that they are required

to incorporate an explicit commitment to sustaining and improving health status in their statements of strategy and in their business plans. Judging from party political platforms, HIA appears to have wide political support.

Since the publication of NAPS in 1997, government policy is "poverty proofed" to test whether it reduces poverty or has an adverse impact on poorer people.

2.1.6. Structures and processes for implementation

Recognizing the intersectoral nature of the strategy, a Cabinet Sub-Committee was established for its implementation, with ministers participating as relevant issues arose. The Cabinet Sub-Committee was expected to review overall progress and that of selected initiatives as it saw fit. In the event, however, this committee does not appear to have been active. An Inter-Departmental Group of senior officials reviews, on a continuing basis, progress in implementing the strategy.

The Sub-Committee and Inter-Departmental Group were to be serviced by a National Implementation Team established within the DoHC, which was to report annually, making the report available to Parliament.

In addition, a National Steering Group, reporting to the Minister for Health and Children and including people from outside the health sector, was to oversee the process and provide practical experience of managing change. The DoHC was reviewed regarding its potential for supporting this wide-reaching strategy, and a new Population Health Division was to be established with responsibilities for integrating DoHC policies in the areas of public health and environmental health, health promotion, NAPinclusion, preventive/screening programmes, food safety, medicines and HIA. Following the huge upheaval of establishing the Health Service Executive, the proposed Population Health Division was not established. It remains to be seen, therefore, how far the DoHC will be able to meet the challenges for policy integration with its present capacity.

An Interim Health Information and Quality Authority was also established. In addition to developing health information systems, the Authority has a wide mandate in terms of setting and monitoring standards and overseeing accreditation.

Finally, a broadly based National Consultative Forum of stakeholders is convened annually to consider progress and comment on priorities. The Forum may review any of the various reports produced and has so far met three times. Respondents from one of the NGOs, interviewed for this study, questioned the real participatory character of the Forum, however, since the agenda and the approximately 350 attendants at its one-day annual meeting are selected by the DoHC.

2.1.7. Monitoring and evaluation

The strategy provides for the establishment of a monitoring and evaluation function at both national and regional levels. The large number of quantified targets set in this and related strategies provide one of the means against which to measure progress. In addition, a national set of key performance indicators was established.

Since 2001, the 121-point Action Plan for implementing the strategy has been reported on annually. From 2006, the DoHC, the newly established Health Service Executive and the then Interim Health Information and Quality Authority were each responsible for reporting on the actions for which they were accountable *(4,12)*. These reports are available in printed form and on the Internet.

The three key health status targets defined in *Building an inclusive society* state that, by 2007, the gap in premature mortality between the lowest and highest socioeconomic groups for circulatory diseases, cancers and injuries should

be reduced by 10%, and that similar reductions should be made in low birth weight and in the gap in life expectancy between the Traveller community and the whole population. The experience of the past few years and the lack of timely data for NCD disaggregated by socioeconomic group suggest, however, that the social inclusion targets related to reducing inequalities in premature mortality and in low birth weight now need to be viewed as longer-term outcomes. It is expected that progress can be achieved through shorter-term actions and targets as set out in the new NAPinclusion 2007–2016 *(7)*, the National Development Plan 2007–2013 *(5)* and Towards 2016 *(6)*.

2.2. Health promotion strategy

Since the 1980s in Ireland, broad umbrella policies and health promotion policies have run simultaneously. Key reports on the wider dimensions of health and promoting health through public policy had already set the stage by the mid-1980s.

The formulation of the 1995 health promotion strategy, *Making the healthier choice the easier choice (13)*, was led by experts who had been actively involved in the development of the health promotion concept at the international level. Outlining the rationale for health promotion, clear reference was made to the Ottawa Charter *(14)*. Also, during discussions in the EU on the Maastricht Treaty, it was apparently on Ireland's initiative that, under Article 129, health protection was to form an explicit part of the EU's other policies.

A Health Promotion Unit replaced the old Health Education Bureau, and a Cabinet Sub-Committee on Health Promotion was already in place, chaired by the Minister for Health and Children and including the ministers of Agriculture and Food, Education, Transport, Energy and Communications, Environment, and Enterprise and Employment. However, as expressed by one respondent, "People are very busy on their own patch. The compulsion wasn't there to work as a group." Consequently, this intersectoral committee met only once, though ministers would meet bilaterally.

The 1995 strategy, defined the main health problems as CVD, cancer and accidents. In keeping with the targets set by the 1990s health care strategy, there was an attempt to move from a risk factors focus to that of settings: schools, community, workplace and the health services. Goals and targets were set for developing health promoting schools and health promoting hospitals and for working with employers and trade unions to promote health in the workplace. Quantified targets were set for reducing CVD and premature mortality from cancer over the following ten years.

The *National Health Promotion Strategy 2000–2005 (15)* is seen as building on the first health promotion strategy. The principles of the Ottawa Charter are reaffirmed and an outline of the main determinants of health, together with an analysis of lifestyles and behaviour, sets the scene. Again, the strategy follows an interlinked focus on population groups, settings and topics. Settings include schools and colleges, the youth sector, communities, workplaces and the health services, whereas topics include mental health, smoking, drinking, nutrition, oral health, drugs, physical activity, injury prevention and sexual health. The objectives outlined are of a rather general nature, for example "To develop programmes which address the needs of children at risk" *(15)*. Many of the objectives refer to the development of other policies and strategies, the production of reports and research, and generally to working in partnership. The way in which many of these general objectives were to be achieved is not always clear, although it is stated that specific, measurable, achievable, realistic and time-bound (SMART) targets will be set (the term "objectives" rather than "targets" is used).

In 2004, there was an interim review of progress *(16)*. The review group concluded that there had been substantial developments at both national and regional levels. Surveys of lifestyles and behaviour had created a reliable database and the health promotion workforce had grown considerably. Interestingly, the CVD strategy *Building healthier hearts (17)* had provided core funding for dedicated health promotion posts and activities, thus prioritizing action to combat CVD. There was found to be a high level of activity in settings such as schools, communities, workplaces and hospitals (ten hospitals had joined the health promoting hospitals movement).

The planned forum to coordinate intersectoral health promotion approaches had not been established, however, and it was felt that there was need for a stronger focus on guidelines for partnership building.

Work has started on a new health promotion strategy, with a particular focus on the health of children and the determinants of inequalities in children's health.

2.3. Health service policies

The umbrella policies referred to above, *Shaping a healthier future (10)* and *Quality and fairness (9)*, focus on the health care system within the wider context of promoting and protecting health. Recently, however, the health services in Ireland underwent radical upheaval. This "transformation" was considered necessary owing partly to the fact that the previous Regional Health Boards were felt to be going their own way, as local politicians developed local services regardless of national needs and policies, thus making it impossible to rationalize health care. The transformation was also linked to a more general management reform in the public sector.

An external consulting firm was brought in to audit the structures and functions of the health system. The main aim was to determine whether structures in the health system were appropriate and responsive in integrating services across the system, meeting consumers' needs and focusing sufficiently on the principles of the national Health Strategy *(18)*. Proposals were to ensure:

- clear lines of accountability and communication between each part of the system;
- no overlap or duplication between organizations; and
- a proper alignment of the structure as a whole to the vision and objectives outlined in the Health Strategy.

As a result, the role of the DoHC was to focus on health policy. The 2004 Health Act proposed the creation of the HSE, established in 2005, as the single body responsible for meeting Ireland's health and social care needs. This replaced a range of about 40 different agencies, each of which was independently answerable to the DoHC. It was hoped that this transformation would facilitate more equal access to quality care across the country. The new authority's stated priority was to give "increasing emphasis on Primary and Community care and Health Promotion, by increasing preventive intervention to keep people healthy" *(19)*.

The HSE has three main divisions: population health; primary, community and continuing care; and the National Hospitals Office. From the organizational chart, it is not clear how certain responsibilities are shared between the DoHC and the HSE. For example, although the DoHC is responsible for policy development, the Population Health section of the HSE includes "develop public health policies" among its tasks *(12)*. Furthermore, although the DoHC has an oversight role to "hold the system to account", it is not clear how this can be achieved when the HSE receives funding directly from Parliament and is accountable for its spending through that line of auditing. The DoHC does, however, have to sign off on HSE business plans.

Consequently, in this centralizing move, the old Regional Health Boards were abolished and four new regions have

taken their place. These new regions, however, do not seem to reflect any recognizable, natural, physical or cultural regional identity. One of them stretches practically the length of the western side of the country from Donegal to Limerick, and Dublin is split between two regions, with the River Liffey as the boundary. The new system is intended to facilitate vertical reporting from the local level to Dublin. It might be expected that collaboration and integration of action will be facilitated at the top; it is less clear how improved collaboration is to be achieved at the local level when all are reporting separately to Dublin. Along with the weaknesses of the old system, it is possible that strengths such as local people meeting on a regular basis, making the horizontal links and working for the improvement of "their" region could be lost.

The way that these radical changes were implemented, with the creation of certain functions and jobs, has led to the view, some three years later, that management structures have not yet been sorted out. There is a perception that it is impossible to clarify who is responsible for what and consequently simple transactions with the HSE can become stressful and time-consuming: one of the NGOs interviewed stated that it can no longer reach decision-makers, which would not previously have been the case.

Despite this difficult atmosphere, the HSE identified six programmes of work. One of these was the development of a framework for the management of NCD, approved towards the end of 2008 *(8)*. A support programme for patients with chronic disease is already being implemented. Written protocols and guidelines for treatment and evaluation are being prepared. At the same time, an attempt is being made to change the concept of performance evaluation in the health services to focus more on outcomes. Concern was expressed by one person interviewed that, for small countries where resources are limited, organizations such as WHO could offer more in terms of guidelines on what does and does not work in disease management.

As a result of the Health Act 2007 *(20)*, the Health Information and Quality Authority was established on a statutory basis, integrating the Social Service Inspectorate and the Irish Health Services Accreditation Board. The main aims of the new Authority are to develop safety and quality standards and monitor their implementation; evaluate the clinical and economic effectiveness of pharmaceuticals, medical devices, diagnostics techniques and health promotion activities; and provide information on the outcomes of these activities.

2.4. Policies for specific NCD

2.4.1. Heart health

CVD is the largest single cause of death in Ireland, accounting for 43% of all deaths. There appears to have been an intensive and comprehensive attempt to deal with heart disease over the last decade.

The 1994 umbrella strategy included specific targets related to heart health. Given Ireland's disadvantaged position compared to other EU countries and the fact that lower socioeconomic groups were more heavily burdened by coronary heart disease (CHD), this was not felt to be enough. In the south of Ireland, death rates from CVD were almost three times higher in the semiskilled and unskilled working classes than in the professional classes. In March 1998, the Minister established a Cardiovascular Health Strategy Group to advise on initiatives to improve cardiovascular health. All but one of its members came from the health sector but they consulted more widely, inviting written submissions and meeting with representatives from other organizations.

The basic principles guiding the Strategy Group refer to the achievement of health and social gain, including an environment to support healthy choices. Equality was seen mainly in terms of access to health services. To this end, a pilot exercise commenced in 2005 to test standards for reflect-

ing socioeconomic variables in the National Cardiovascular Information System.

The Group's report, *Building healthier hearts (17),* was endorsed by the Government and launched by the Prime Minister in 1999. The main aims of the strategy were:

- to reduce the risk factor profile in the general population;
- to detect those at high risk;
- to deal effectively with those with clinical disease, and
- to ensure the best survival and quality of life for those who recover from CHD.

The targets set were to bring premature death from CHD at least in line with the EU average, and over the longer term to reach the best performers in the EU. The 211 recommendations, 58 of which relate to health promotion, were presented to a national stakeholders' conference in November of the same year. The weight of the report focused on health services and health personnel. In the case of GPs, this also referred to an increased role in supporting smoking cessation, improved nutrition and physical activity.

Considerable financial resources were designated for implementing the strategy (€59 million in the first three years). Infrastructure was put in place for its implementation over the longer term, at national regional and local levels, including:

- a Ministerial Group, chaired by the Minister for Health and Children;
- a joint parliamentary Committee on Health and Children;
- a Heart Health Task Force to ensure that intersectoral recommendations were implemented, by reviewing the objectives of government departments charged with implementing detailed aspects of the strategy;
- an Advisory Forum, with subgroups relating to primary care, hospital care, rehabilitation and health promotion for heart health, to advise the Task Force and the DoHC, including advice on priority-setting;
- a National Cardiovascular Information Systems Steering Committee;
- a human resource group on consultant cardiology;
- a steering committee related to the secondary prevention of CVD through the GP service;
- regional CVD committees (prior to 2005); and
- an interdivisional working group within the DoHC.

Together with the National Heart Health Alliance, which represents about 40 NGOs, the CVD Advisory Forum held a one-day workshop to identify the lead agency for each recommendation of the strategy, and the tasks required for its implementation. The report of the workshop indicated priorities for action that were missing from the original document. Later conferences organized by the Irish Heart Foundation to consider the implications of the strategy for hospitals and for PHC reiterated the need for prioritization and for rolling out such a comprehensive strategy in a "logical fashion" *(21)*.

A national media campaign entitled "Ireland needs a change of heart" was developed, with an accompanying information pack and a handbook distributed to all households *(22)*. The Irish Heart Foundation, an NGO with 40 years' experience, played an active role throughout the process. Similar campaigns were developed for other risk factors.

Legislation on tobacco control was tightened and Ireland became the first country to ban smoking in the workplace and all public buildings. In the second phase of implementation, handbooks on specific risk factors such as physical activity were designed for the general public, particular attention being paid to walking as a form of exercise. A 2002 survey of people's recall of the campaign and pamphlets indicated that they had had a significant impact on people's knowledge *(23)*.

Two detailed progress reports have already been published, and special committees have made recommendations on some of the implications regarding cardiology consultants and action by GPs. Links were made to policies and interventions related to risk factors such as smoking, nutrition and physical activity. Ireland also made cardiovascular health the focus of its EU presidency in 2004.

Members of the Irish Heart Foundation felt that stroke has been the "Cinderella" of CVD, with care of its victims being difficult and time-consuming and not claimed by any of the medical professionals. They were of the opinion that there had been considerable neglect in stroke management, leading to morbidity and disability, which the right team, including speech and physiotherapists, might have avoided. In association with the DoHC, therefore, the Foundation commissioned a National Audit of Stroke Care, providing half the necessary funding. The Audit examines the level of clinical and support care provided to stroke patients and their families in hospitals, and by GPs and community services. The findings will set the scene for a National Stroke Strategy. This initiative was met warmly by the Minister for Health and Children, who happened to have a family history of stroke. The HSE has asked for written comments in the areas of stroke prevention; emergency care; acute hospital care; rehabilitation; ongoing care and prevention of further strokes; and support for patients and their families and carers *(24)*.

It is not part of the GPs' contract to provide disease prevention services, although some are said to do so. One way in which health professionals have been kept on board in tackling heart disease was by screening for risk factors and informing GPs of the results. In addition, in 2002, a secondary prevention programme (later called Heartwatch) *(25)* was established with the collaboration of the then Health Boards, the Irish College of General Practitioners, the Irish Heart Foundation and the DoHC, the aim of which was to reduce mortality and morbidity due to CVD. The first stage of the programme ran until 2004, during which time GPs monitored the progress of patients who had experienced a cardiovascular event (mainly through nurses attached to their practices) in terms of their lifestyles (smoking, physical activity and nutrition). This experience highlighted the potential benefits and challenges to be faced if health promotion to tackle NCD is to become an integral part of PHC.

Other events have brought heart health to public attention through the media. One such was sudden cardiac death, which became a media issue when high-profile athletes died. A task force was quickly convened to report on ways of tackling this.

2.4.2. Cancer

Serious attention has been paid to improving the evidence base for developing cancer policies. The Irish National Cancer Registry was set up in 1991, wholly funded by the Ministry for Health, and began registering cancers nationwide in 1994. The information produced was considered essential for the development of a comprehensive cancer policy. The Registry's report on cancer treatment and survival 1994–2001 *(26)*, for example, indicated that "the likelihood of cancer patients receiving a given treatment still varies substantially between different parts of the country" and that such differences were accounted for more by local policies and ease of access to care than by the seriousness of the patient's cancer and suitability for treatment.

The first cancer strategy was formulated in 1996. The current one, *A strategy for cancer control in Ireland (27)*, was published in 2006. The members of the National Cancer Forum set up to develop this strategy were nominated by the Ministry, a number of NGOs including the Irish Cancer Society, and representatives of medical and nursing associations. There were no members from outside the health sector. The vision for the strategy is to "reduce cancer incidence, morbidity and mortality rates relative to other EU15 countries by 2015".

The strategy is seen as a further refinement of proposals for cancer control set out in the Health Strategy and was developed in accordance with recommendation 12 of that Strategy. Although it is stated that more than 30% of all cancers are preventable, and that prevention must remain a central focus of cancer policy, the aims set out in the introduction relate almost exclusively to health care. One of the central proposals is for the reorganization of health services around four cancer control networks, each serving about one million people and with about eight cancer centres each serving a minimum of 500 000 people.

This health care focus appears to be in tune with prevailing public sentiment. An evaluation of the 1996 National Cancer Strategy, including a broadly based consultation process, found that the target to reduce mortality from cancer in the under-65 age group by 15% in the ten-year period from 1994 had been reached by 2001. Those consulted commonly stated the main achievement of the 1996 strategy as being that of providing a framework for the development and funding of cancer services. The relatively poor survival rates for common cancers in Ireland, together with the expected increase in the incidence of cancer due to population ageing, led the 2006 strategy to conclude that there "needs to be significant expansion in all aspects of cancer service capacity". As part of this effort, screening for breast and cervical cancer has been expanded and funds made available to offer this programme by 2007. Approval has also been given for a national network for radiation oncology services to be put in place between 2008 and 2011 *(4)*. The strategy refers to the national health promotion policy and to policies relating to risk factors such as smoking, alcohol abuse, nutrition and physical activity, endorsing their full implementation. Specific recommendations are made to deal with the danger from ultraviolet radiation and radon, and for population-based screening where there is evidence that this is effective.

Proposals are made for better monitoring of inequalities in cancer risks, occurrence, uptake and access to services, and of outcomes of care. The need for further human resources planning and research is also covered.

2.5 Policies related to risk factors

2.5.1. Towards a tobacco-free society

Ireland is now one of the leading countries in tobacco control. Broad consensus on the need for this has been achieved through sustained effort and the fortuitous appearance of a strongly anti-smoking Minister committed to seeing the battle through.

The change in public attitudes to smoking built up slowly. Towards the end of 1999, the Parliamentary Joint Committee on Health and Children published a report on health and smoking, recommending that a national anti-tobacco strategy be adopted. A Tobacco Free Policy Review Group was set up to carry out a review of health and tobacco and make appropriate recommendations. The report of the Review Group, *Towards a tobacco free society (28)*, was published in 2000 and adopted as government policy. The strategic objectives are:

- to change attitudes
- to help people give up smoking
- to protect people from passive smoking
- to focus on children.

One recommendation was the setting up of an independent statutory body, the Office of Tobacco Control (OTC), formally established in 2002 through the Public Health (Tobacco) Act. The OTC was responsible for national implementation of the smoke-free law.

The means of implementing the strategy are far-reaching, including gaining support from key figures and local communities, providing adequate information and support for research in collaboration with the main NGO (ASH

Ireland), and requiring the tobacco industry to make public all information about the effects of its products. All forms of tobacco advertising have been banned and regulations put in place to exclude indirect advertising. Training is to be provided for health care professionals and teachers.

Particularly aimed at reaching children, taxes were to be continuously increased on tobacco products, the legal age for buying tobacco was raised to 18, and tobacco was to be sold only through registered premises. Health education programmes were to be improved and specific remedial programmes for child smokers developed.

At the local level, the then regional health boards were to set up subcommittees for tobacco control and the legal provisions were to be enforced by designated environmental health officers and inspectors. These officers have the authority to issue a warning or initiate proceedings against those who contravene the law, sending the matter to the relevant district court. The maximum fine is a hefty €3000 at the discretion of the judge. Despite the dismantling of the old regional health board system, environmental health officers and community services at the county level continue much of this public health work.

The OTC commissioned an independent scientific working group to investigate the health risks of passive smoking. It concluded that second-hand smoke in the workplace increased the risk of heart disease, cancer and respiratory diseases and that pregnant women, bar staff and waiters were at increased risk. In January 2003, the Minister announced his intention to ban smoking in all enclosed public places.

A national debate occurred over the 15 months following this announcement, with national and local media taking up the issue on a weekly basis *(29)*. One of the main concerns was the possible loss of bar business and associated jobs, and the process was nearly derailed a number of times. Public support for the proposed measure was high, however (59% of the population one month after the announcement), support coming from health professionals, NGOs and a wide range of trade unions.

The OTC and its collaborators concentrated on raising public awareness of the adverse effects of smoke, counteracting misleading claims by opponents and building confidence in the enforceability of the legislation. Several key steps were taken during the year prior to the workplace provisions becoming law, including: consultations with representatives of the hospitality industry, trade unions and enforcement agencies to develop guidance for implementation; the production and dissemination of information and guidance materials; media advertising on the health effects of smoking; the setting up of telephone lines to investigate complaints of non-compliance; proactive visits to workplaces by environmental health officers before and after the introduction of the law; the establishment of fines for non-compliance; and the prominent display of no-smoking signs plus the name of the person to whom complaints could be made. The strong focus on the plight of those working in bars and clubs struck a cord with the public, as they related to the problem of passive smoking in the workplace.

Smoking in the workplace was banned in 2004. With clear messages, close collaboration with key stakeholders (particularly the trade unions) and provisions for enforcement, compliance has remained at over 90% and public support is almost universal. Some 98% of people think that workplaces are healthier as a result, including 94% of smokers.

In the first 12 months of the workplace smoking ban there was a drop in national smoking levels, representing a 6% decrease in the number of people smoking. An evaluation carried out on the National Smokers Quitline in March 2005, showed that the workplace smoking ban was a very important factor in helping them quit the habit of smoking.

2.5.2. Nutrition

Some 39% of adults are overweight and 18% are obese. About 2000 premature deaths per year are estimated as being due to obesity, with an annual cost to the state of €4 billion *(30)*. The Survey of Lifestyle, Attitudes and Nutrition carried out in 1998 and 2002 gave ample evidence of the emerging problems, as did the survey of Health Behaviour in School-aged Children, and obesity is considered to be one of the fastest developing health problems in Ireland *(31)*.

Ireland administers a Food Frequency Questionnaire supplemented by a dietary record for schoolchildren. This shows rather mixed results, with an increase in fat intake since 1998 but a decline in carbohydrate intake. A recent survey indicated that just over half of schoolchildren eat sweets at least once a day and one third have fizzy drinks and potato crisps. Although the majority of children are involved in some exercise outside school, boys exercise more than girls and exercise decreases with increasing age, particularly for girls. The growing number of overweight and obese children is of particular concern.

There has been no lack of interest from the public health sector. Health promotion interventions dealing with nutrition have been ongoing in Ireland since 1991 *(15)*. One of the key components has been the establishment of community nutrition services at regional level. A strategy for the then health boards to promote physical activity was also developed in 1997 *(32)*. Reviewing action in health promotion for nutrition in 1997, the National Nutrition Surveillance Centre pointed to the need for greater focus on socially disadvantaged groups.

The *National Health Promotion Strategy 2000–2005 (15)* deals with both nutrition and physical activity. The objectives of the Strategy are linked to policies for heart health, cancer, children and young people, as well as the specific policy recommendations for food and nutrition for older people *(33)*.

One problem so far has been the lack of essential collaboration with other sectors. Facilities in schools for physical exercise are said to be woefully inadequate, many schools not even having a playground, so that by the time children are 10–12 years old they are not used to exercising. Walking to school and playing on housing estates are said to be a thing of the past, a change that has taken place in the last few years owing to parents' real or imagined fears of letting children out alone. Few of the rather narrow country roads are safe for walking and cycling. There are very few public indoor facilities for physical activity, despite the inclement weather in Ireland. Private and voluntary facilities tend to be used by middle-class children whose parents take them to participate.

To promote intersectoral action, the Government launched a national obesity campaign covering the period 2003–2006. In addition to the health sector, stakeholders included physical activity coordinators, NGOs, supermarket chains, caterers, cafes, restaurants and hotels, schools, workplaces and the media.

As part of the campaign, in March 2004 a National Taskforce on Obesity was set up with representation of civil society, the food and drinks industry, sports associations and the Irish Heart Foundation. Following considerable consultation, the Taskforce reported early in 2005 in *Obesity: the policy challenges (34)*. The Taskforce felt that to date nutrition policy had concentrated mostly on actions within the remit of the DoHC, such as implementing dietary guidelines. Although important, it was felt that in the face of changes in the availability of food and patterns of eating and more sedentary life and work styles, the time had come to look at the totality of policies that influence what people eat and their opportunities for engaging in physical activity.

The proposed actions take a population approach for adults and children, together with weight reduction management for the severely overweight. While recognizing that people

have a right to choose what they want to eat and how active they want to be, the strategy proposed by the Taskforce is to tackle the forces that impede people's ability to make the healthier choice.

Implementation of the strategy will require an integrated and proactive approach across all government departments, in partnership with the private sector and NGOs. Support for this will be given at the highest level, with the Prime Minister's Department ensuring that this happens.

The 93 recommendations (available in a separate pull-out attached to the full report) relate to actions across six broad sectors:

- high-level government
- education
- social and community
- health
- food, commodities, production and supply
- the physical environment.

Particular efforts will be made to ensure that action taken reaches vulnerable groups. An implementation strategy is presently being developed, as is a National Nutrition Policy for the next five years, which will focus on children *(35)*.

As far as possible, existing agencies and strategies are to be marshalled to meet the challenge. There is already statutory provision for collaboration between the DoHC and the Department of Agriculture and Food. For example, a fruit and vegetable programme has been launched in a number of primary schools, and the departments collaborated in reviewing the EU school milk scheme. Work is carried out under a service contract with the Food and Safety Authority of Ireland (FSAI), an independent body reporting to the DoHC. A number of studies have been co-funded by the Department of Agriculture and the FSAI. Annual targets are set and monitored and the results published by the FSAI.

An example has also been set by the health services through the development of guidelines on food and nutritional care in hospitals, published in 2005.

In addition to information gained from the general surveys of adults' and children's behaviour, a food research committee has been established to share information and research. A research project to elicit young people's views about opportunities, barriers and supports to recreation and leisure was launched in 2005 and will inform the work of an intersectoral Steering Group, which also includes representation from the local authorities and the Sports Council.

Despite what appear to be widespread actions and the provision of funding, there was considerable doubt among some interviewed that the obesity policy was moving forward; indeed, it was described as having "come to a grinding halt".

2.5.3. Alcohol

Ireland endorsed the European Charter on Alcohol in 1995 and adopted a National Alcohol Policy in 1996. In 2002, the DoHC set up a Strategic Task Force on Alcohol, which was informed by international experts on effective alcohol policy measures and issued an interim report at the end of the year. In 2004, a second interim report was published. This second task force was a vastly more intersectoral group than most examined in this study, including representatives from NGOs, the drinks industry and a number of departments and councils, with staff of the DoHC in a minority. Their task was to review international research in order to identify effective evidence-based measures to control harm from alcohol; examine experience so far in Ireland, and make recommendations for further action. They were asked to do this within three months.

The Task Force found that Ireland continued to be among the highest consumers of alcohol in the world, and that the norm among men still tended to be binge drinking.

The national lifestyle survey reported an increase between 1998 and 2002 in the number of people drinking six or more drinks on one occasion. An interesting aspect of the report is that it gives economic data relating both to the amount spent on alcohol and to the cost of dealing with alcohol-related problems, estimated to reach over €2650 million in 2003.

In examining implementation of the 2002 report, the Task Force found that increasing the price does indeed reduce drinking and that legal measures had been taken to restrict drinking, particularly among the young. Workshops on responsible sale of alcohol were being organized for staff working in bars and off-licences, with particular focus on restricting the availability of drinks to young people.

In 2003, the Drinks Industry Group established a company to check advertisements. The industry also revised the Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks, and the Irish Sports Council produced a code of good practice to keep children from harm.

The issue of drink–driving got a positive response from the public. The legal provisions for testing for drink–driving were tightened, and a designated driver programme was launched. A three-year alcohol awareness programme was implemented by the Health Promotion Unit from 2001 to 2003, and the Department of Education and Science made the provision of health education mandatory on the school curriculum at primary and junior levels. The seriousness of the attempt made to prevent the sale of alcohol to minors was indicated by the number of prosecutions and the levels of convictions and closure orders in all regions *(36)*.

Information continued to be improved, particularly through the national lifestyle surveys and, following the 2002 report, the Health Promotion Unit commissioned a national survey to evaluate public attitudes to alcohol policy changes. There was strong support for protecting children and reducing drink–driving and little support for greater availability, with only 8% wanting longer opening hours.

The 2004 report reaffirmed the overall public health approach and set quantified targets for the reduction of per capita alcohol consumption. The report builds on the recommendations of the 2002 report, further refining recommendations where there is evidence of effectiveness. It also recommends continued support for NGOs, including the new Irish National Alliance for Action on Alcohol.

In July 2005, a Working Group on Alcohol was established to mobilize the various stakeholders through social partnership to achieve targeted and measurable reduction in alcohol misuse. The DoHC has negotiated a voluntary code of practice with the advertising and drinks industries and the communications sector, relating to the content and placement of alcohol advertisements. This is to be overseen by an independent monitoring body *(4)*. Finally, there are attempts to develop alcohol policies in settings such as colleges *(37)*.

Despite these positive actions, alcohol consumption, which has risen so quickly in recent years, is not back down to the levels of ten years ago. There is a feeling among public health experts that much more could be done. The close involvement of the drinks industry, on which they themselves insist, means that they are well versed in damage limitation. In the words of one respondent interviewed, "They know what's coming and are ready to mitigate its effects on the drinks industry even before it happens". Alcohol is increasingly accessible in garages and supermarkets, special offers on alcohol are still permitted, and there have been no big increases in alcohol tax to match those on tobacco. One reason offered by respondents was that politicians still hold their clinics in pubs and are beholden to the drinks industry.

2.6. Settings

Since the mid-1990s, the settings focus has been strengthened by involvement in international networks such as Health Promoting Schools, Healthy Cities and Health Promoting Hospitals, all of which continue to grow.

2.6.1. Schools

Ireland joined the ENHPS in 1992. From 1993 to 1996 there were 10 schools in the Irish network (5 primary and 5 post-primary). From 1996 to 1999 the network expanded to include 40 schools (20 primary and 20 post-primary). For schools in general, health education was an optional subject until that time, developing in different ways throughout the country.

It was decided in 1999 that specific support would discontinue for a designated network of schools and that instead all schools would be supported. Consequently, when "social, personal and health education" (SPHE) became a required part of the curriculum for all primary and post-primary schools in 2000, it was decided to subsume the experience of the Health Promoting Schools network with a substance abuse prevention programme that had been used in some schools since 1991; a relationships and sexuality education programme (first developed in 1995); and a life-skills (health education) programme that had been operating in many schools in one local region since 1979. All these were included under the new SPHE umbrella, and schools are supported to implement SPHE "in a health promoting school context". Sub-networks of schools continue to operate in three regions of the country, using the ENHPS process, but are not linked to each other or to a national network.

In 2005, the National Taskforce on Obesity identified 300 000 Irish children as being overweight or obese, a figure that was increasing by 10 000 each year, and made recommendations for supporting schools. According to a survey published by the Irish Heart Foundation in 2007 *(38)*, only one third of schools had developed healthy eating policies. Energy-dense and nutrient-poor foods are widely available in tuck shops and vending machines. Schools, many of which rely on commercial sponsorship for sports and computer equipment, reported overwhelmingly that they would be in favour of a code of practice in relation to the provision and content of vending machines (92%), and a of national code of practice in relation to industrial sponsorship (87%).

On a more general level in the education sector, goals in relation to school retention and addressing literacy difficulties are acknowledged as enhancing personal skills, affecting health in the long-term.

2.6.2. The workplace

An all-island (Ireland and Northern Ireland) network for workplace health promotion was established and all the then regional health boards had workplace coordinators. The Health Promotion Unit participates in the corresponding European network of national agencies and institutes with responsibility for health in the workplace. The policy document *Healthy bodies – healthy work (39)*, published in 1999, outlined the need for a proactive approach in the workplace. The implementation of cardiovascular strategies is one of the priorities for the workplace setting. Some 650 companies with 350 000 employees participate in the "Happy heart at work" initiative.

2.7. Policies for specific population groups – older people

There are a number of policies directed at specific population groups relevant to combating NCD, including a policy for men's health – there is a gap of 15 years between the average life expectancy of a rich woman and a poor man. In the framework of this study, we refer only to policy related to older people.

A first policy for older people was published in 1988, *The years ahead: a policy for the elderly.* Its main recommendations – to maintain or restore older people to their home environment, to encourage the care of older people in the community and to provide high-quality hospital and residential care when necessary – were later recognized in the 1994 broad health strategy and the 1995 health promotion strategy.

Although these broader health strategies of the mid-1990s identified older people as a priority population group with particular health promotion needs, their main focus was on the under-65s. Furthermore, a study of older people found that almost half of the respondents had major health problems, and one in four suffered from psychological distress provoked more by the onset of poor health than old age itself *(40)*. In 1995, therefore, the National Council on Ageing and Older People proposed the development of a healthy ageing programme to improve life expectancy and the health status of people at age 65 and beyond, and to improve the lives and autonomy of older people already affected by illness.

The programme had three strands, the first of which was a health promotion strategy for older people: *Adding years to life and life to years (41).* This strategy, formulated in association with the DoHC, marked the launching of the Council's Healthy Ageing programme. It was seen as a further refinement of the 1994 health and the 1995 health promotion policies, and a follow-up to the 1988 policy for older people. The main objectives are to improve:

- life expectancy at age 65 and beyond;
- the health status of people aged 65 and beyond; and
- the lives and autonomy of older people who are already affected by illness and impairment.

It recognizes that older people are sometimes left out of more general health education and health promotion interventions, and that owing to the broad diversification of older people in terms of health status and dependency levels, different approaches may be needed than those for younger age groups.

CVD accounts for 48% of deaths among those aged 65 years and over, and cancer is the second most common cause of death in this age group. The strategy sets quantified targets to reduce the death rates from these causes among older people and to deal with risks such as smoking and hypertension. It also deals with broader determinants of health, including tackling ageism and supporting participatory structures such as the Irish Senior Citizens National Parliament.

The second strand involved the development of an information and support network, including a database on health promotion practice and a fact file series, *Ageing in Ireland.* The third strand aimed to evaluate new or existing initiatives, starting with a home accident prevention programme, a health education programme in the north-east and an intersectoral programme, involving the Irish Sports Council ("Go for life"), encouraging physical activity.
As is the usual practice, the strategy takes fully into account similar international developments. It also makes provision for evaluation of interventions.

2.8. Broad intersectoral policies with a health component

A number of important developments with implications for social inclusion issues, including efforts to reduce health inequalities, took place in Ireland in 2006 and early 2007.

- A new 10-year Framework Social Partnership Agreement for 2006–2015, *Towards 2016*, was published in June 2006.
- The National Report on Strategies for Social Protection and Social Inclusion was forwarded to the European Commission in September 2006, outlining key objec-

tives and targets over the period 2006–2008 in relation to social inclusion, pensions, health and long-term care.
- A National Development Plan (NDP) 2007–2013, *Transforming Ireland – a better quality of life for all*, was published in January 2007 and contains a specific chapter on health and on social inclusion, unlike the previous NDP where social inclusion was dealt with mainly as a "horizontal principle".
- Ireland's National Action Plan for Social Inclusion 2006–2016 (NAPinclusion) was published in February 2007, expanding from an implementation and delivery point of view on aspects of *Towards 2016*.

Health issues are addressed in all the above documents. For example, *Towards 2016* includes the following commitments of specific relevance to NCD:

- developing a new strategic health promotion policy addressing factors undermining the health of young people;
- launching a national nutrition policy to address children's food poverty and obesity;
- developing a national database to monitor prevalence trends in growth, overweight and obesity; and
- monitoring prevalence trends in smoking and substance use through the National Health and Lifestyle Surveys and the European School Survey Project on Alcohol and other Drugs.

In common with *Towards 2016 (6)* and the National Development Plan 2007–2013 *(5)*, the *National Action Plan for Social Inclusion 2006–2016 (7)* adopts the lifecycle framework, placing the individual at the centre of policy development by assessing the risks facing him/her and the support available to address those risks at key stages in his or her life.

Of the 12 goals set out in the *National Action Plan for Social Inclusion 2006–2016 (7)*, two relate specifically to health, one being particularly relevant to NCD.

- Develop 500 primary care teams by 2011, which will improve access to services in the community with particular emphasis on meeting the needs of holders of medical cards (i.e. those on low incomes and those over 70 years of age)

Other significant health commitments in the National Action Plan that are relevant to NCD include:

- development of specific community and sectoral initiatives to encourage healthy eating and access to healthy food, with a focus on people living in areas of disadvantage;
- monitoring of inequalities in cancer risks, cancer occurrence, cancer services and cancer outcomes to maintain a policy focus on cancer inequalities; and
- an ethnic identifier, to facilitate more evidence-based planning through identification of needs, measurement of uptake of services and evaluation of outcomes, to be initiated from 2007.

An attempt was also made to learn from the NAPS consultation process *(42)*. A team of people with experience in organizing participatory and consultation processes, coordinated by the Institute of Public Health, was asked to plan and oversee the consultation process. A National Checkback Seminar was held in June 2001 so that those who had participated in the consultation process could be brought up to date on progress and influence the final decision-making process. This proved successful in highlighting gaps and issues not yet identified. Interestingly, participants identified a problem of consultation fatigue/overload yet at the same time wanted to participate. Feedback indicated that people are not comfortable talking to a comment line and prefer to have a person at the other end of the telephone, and that web pages are not currently an effective mechanism for seeking participation in consultation.

In addition, many of the social determinants of health, which lie outside the health sector, are addressed under the broad framework of the National Social Partnership Agreement, including income support, education, employment and activation, and housing. The Social Partnership, initiated in 1987 and renewed every three years, has been credited with playing a vital role in Ireland's impressive social and economic development *(43)*. Negotiated agreements between the state, employers' organizations and the trade unions to keep wage demands and strike action in check, thus encouraging economic growth, are offset by government benefits in terms of health and social welfare provisions. Progress in implementing the agreement is reviewed every six months through the Prime Minister's Department. The adoption of a "problem solving approach", with shared analysis of economic and social problems and policies, is said to have led to an important outcome in terms of consensus building and shared understanding.

3. Infrastructure and resources for policies to tackle NCD

3.1. Structures and processes

Ireland has a long history of promoting intersectoral action for health. There have been notable successes in policy formulation, monitoring and evaluation, but policy implementation has proved more problematic.

Although bilateral collaboration on the whole continues to work well, even cabinet-level intersectoral committees for health have not been very effective. It has been difficult to break down the "silo" mentality and there has been insufficient incentive for teamwork. Where top-level structures have been established, ministers or senior officials may attend in the beginning but are gradually represented by increasingly lower-level officials. The exception appears to have been where committees are led by the Prime Minister's Department. Attempts are being made to understand better what makes partnerships work or fail *(44)*.

Some of the large health-related NGOs are well-endowed financially and include top experts among their members. These NGOs have considerable influence in instigating research and lobbying for action and are active participants in the formulation and evaluation of public health policies.

Significant efforts have also been made to develop the methodology and techniques for HIA *(45)* and to offer training for understanding and carrying it out. Much of this work has been carried out in collaboration with Northern Ireland, where the possibility of developing "integrated" impact assessment has been considered. The implementation of HIA does not appear to have progressed as quickly as might have been hoped for *(46)*, but respondents felt that there is at least a tendency for policy-makers in other sectors now to "think health" and to stop and consider whether their planned actions might have an impact on health.

Ireland has a long experience of setting quantified targets related to combating NCD, their risks and determinants. The first health promotion strategy outlined the key components of target setting as follows: "Targets are specific ... Targets assume the availability of reliable basic data, effective strategies to achieve change and means of measuring that change. Setting targets makes it possible to identify and quantify progress towards the achievement of goals. Targets need not be numerous nor elaborate to begin with but need to reflect key national priorities for a stated time period whose attainment is as measurable as available indicators permit" *(13)*.

The broad health policies in Ireland and specific policies to tackle diseases and risks such as smoking, and to promote the health of population groups such as older people, all set quantified targets. Setting, implementing and monitoring targets and revising them as necessary are considered to be among the most important elements of the NAPS *(47)*.

3.2. Human resources

The usual way of formulating policy in Ireland is through task forces and committees, with members from the health sector, NGOs and academia. Their invariable reference to international developments suggests no shortage of people who are up to date on innovations in the field.

The policies examined indicate quite a strong focus on training, particularly when new interventions or ways of working are to be introduced. In addition, specific provision seems to have been made for the establishment of positions for "coordinators" at local level for the various interventions proposed. For example, through the cardiovascular health strategy, funds were provided for additional smoking cessation officers, community dieticians, physical activity posts and health promotion officers. We are not in a position to assess whether or not these additional posts were adequate to meet the new needs. In 2005, the first skills monitoring report for the health sector was published *(48)*.

3.3. Financial resources

Certain programmes and projects are necessarily funded on a time-limited basis. Nevertheless, there are attempts to maintain long-term funding for health promotion, as indicated, for example, by structural changes creating specific health promotion units.

The linking of health to socioeconomic development and anti-poverty programmes indicates that health is seen as an investment. This could perhaps have been influenced by Ireland's relatively rapid economic growth in recent years and the need for a healthy workforce.

3.4. Research

The DoHC has overall responsibility for health policy, including health research policy. The Health Research Board, an executive agency of the Department, promotes, commissions and conducts health research. It is also the main funder of health research, although additional funding is provided through a number of government agencies and NGOs such as the Irish Heart Foundation and the Irish Cancer Society.

The Centre for Health Promotion Studies was established in 1990 at Galway University, the first of its kind in Ireland. The DoHC Health Promotion Unit had therefore an important resource from which to commission a number of research projects. These included, from the late 1990s, regular national surveys of lifestyles and behaviour in the general population and among schoolchildren. This provided a solid information base for assessing priority action to tackle NCD. In the future, these surveys are to be carried out more frequently and to be more focused.

In 2000, the Health Research Board put out a draft strategy for consultation, which was a first attempt to define the role of research for health in Ireland and was discussed at a conference of over 300 representatives of interested organizations.
On the basis of the feedback provided, in 2001 the DoHC formulated a strategy for health research, *Making knowledge work for health (49)*. The strategy clarifies the need for complementary strands to:

- increase the economic benefits from health technology;
- fund research leading to combating disease and improving health and health services; and
- develop research and teaching skills and capacity.

Better coordination of research efforts was also to be achieved, and the value of an all-island approach was recognized. Regarding the latter, the co-development of cancer research, for example, was inserted into the Belfast Agreement of 10 April 1998. The EU was seen not only as an important source of research funding but a means of valuable networking and training for Irish scientists.

The strategy calls for a twin approach: contributing to global knowledge of health and disease and the effective application of such knowledge. It also recognized criticism of the consultation document's lack of attention to models for scientific research for health based on biology, psychology and sociology, which respondents thought better reflect the complex nature of human health. It was felt that a research and development function needed to be put in place in the health services at national and regional levels.

The Advisory Council for Science, Technology and Innovation has a remit to contribute to the development of an effective national strategy for science, technology and innovation, advising the Government on these issues and acting as the primary interface between stakeholders and policy-makers. In 2006, the Council established a task force to examine the current performance and future potential of health research in Ireland. The consultation paper prepared by the task force considered that the 2001 strategy had not been fully implemented and that the diffusion of responsibility over a number of government departments led to a lack of coordination *(50)*. It was therefore proposed that a permanent forum be established to formulate and implement a comprehensive health research policy, ensuring interdepartmental coherence.

Perhaps surprisingly, given the consultation and comments surrounding the formulation of *Making knowledge work for health,* the above-mentioned report seems to focus on linking hospitals and academia, ensuring clinical researchers and clinical trials; no mention is made of the need for research on the determinants of health.

The Institute of Public Health, established in 1998, has a special position in that it was designed to promote cooperation across the island. It was also designed to look at areas not being dealt with elsewhere, which is one reason it started with a strong equality focus. One of its main functions is as a population health observatory, acting almost as a clearing-house collecting available data and linking up to other data sets to create a "first point of call" for users. Equally importantly, an attempt is made to facilitate users in processing and manipulating the data graphically to meet their own needs.

3.5. Training

Most of the policy documents examined make provision for training, frequently linked to establishing and funding relevant posts. The Institute of Public Health has also been active in meeting new needs for capacity building. This includes a "Leadership for public health" training programme, running for five years. Although demanding in terms of commitment (a full year's programme with three weeks' residential training during the year), the programme has attracted top-level officials.

Training courses of various lengths are offered for HIA, starting from a half-day introduction. Such courses are usually oversubscribed.

3.6. Communication and public information/involvement

Specific awareness-building campaigns in relation to NCD and their risk factors are regularly carried out. From the documents available to us, considerable effort seems to be made to prepare material directed at the general public and at groups in various settings such as colleges and the workplace. Certain pamphlets are sent to all households. Wide use is also made of the Internet, although of course this only reaches those who have access to it.

The monitoring of people's retention rates of such campaigns and their knowledge concerning NCD risk factors indicate that they have been reasonably successful, with the anti-smoking campaign being particularly successful.

The assessment of the consultation process for the NAPS and health consultation process referred to above sets out the following guidelines for consultation *(47)*.

- Have a team of key stakeholders, with a designated co-ordinating role, dedicated to the development, support and reporting of the consultation.
- Be clear from the outset of the objectives, constraints and desired outcomes.
- Base the consultation process on explicit principles.
- Be aware of barriers to participation and pre-empt them as much as possible, e.g. by building the participative capacity of people and organizations or providing access to events for people with disabilities.
- Develop a range of approaches to elicit information in different ways from different groups, such as the multi-strand approach of the NAPS and health process. Prompt questions are a means of guiding those who are making submissions and of assisting the analysis of submissions.
- Allow at least three months for people and groups to participate and be aware of the timing of other consultation exercises.
- Utilize creative methods of participation, such as art, drama, photography, story-telling, role-playing and sharing of personal experiences.
- Utilize local and regional structures, as appropriate.
- Provide resources for participation, particularly for those who are the subject of the action and policy.
- Host a check-back seminar before deciding on the final results and priorities.
- Use qualitative as well as quantitative methods to analyse the information gathered. Utilize the quotations of respondents when producing documentation.
- Circulate widely the outcomes of the consultation.

Over the last ten years, health has been among the top three issues of interest to the Irish population and gets good coverage in the media. Recently, issues concerning Travellers and older people have been on the agenda.

4. Forces facilitating or obstructing disease prevention and health promotion

Ireland has a considerable history of developing umbrella and issue-specific policies, facilitating a continuous step-wise process to improve methods and techniques. At the national level, there is a strong body of public health experts able and committed to taking the NCD agenda forward. Irish professionals, services and organizations are heavily involved in international health promotion activities, including the main international and EU networks, ensuring acute awareness of developments in tackling NCD. Health promotion has been successfully included in efforts for closer collaboration across the island, facilitating the sharing of resources.

In recent years, considerable progress has been made in developing the knowledge base for NCD policy development. The extensive use of quantified targets in health policy development has highlighted the need for improved data and indicators of progress.

The rapid growth of the economy has focused attention on the need for a healthy workforce, facilitating increased funding for health promotion.

Despite a highly trained health sector workforce, the provision of health services was not considered as good as it might be, owing partly to their uneven geographical distribution. Together with more general administrative reforms in the country, this brought a far-reaching transformation of the health care system, including the establishment of the new HSE. These changes have radical implications for national/local collaboration in health policy implementation and, during the necessary transitional period, might possibly delay to some extent the implementation of health promo-

tional policies. At the moment, it would be premature to try to assess the possible implications for NCD policy.

The Parliamentary Joint Committee on Health and Children does not simply react to reports put before it but has instigated action, calling for example for an anti-smoking strategy. Furthermore, judging from the reference made by ministers to policy documents of their predecessors, there is some level of political consensus on certain health issues.

There are excellent examples of progress in certain regions of the country, but more could be done to share the good practice and experience of progressive regions.

NGOs related to the main NCD and their risk factors have been active in Ireland for many years. Their vast experience informs the work of task forces formulating or monitoring policy, and they play an active role in evaluating progress.

5. Lessons from the Irish experience

Ireland employs a complex array of broad health and health promotion policies to combat NCD, complemented by a range of policies and strategies to tackle specific NCD and their risk factors. Most of these are then picked up or reflected in policies for settings such as schools, the workplace and hospitals and, as appropriate, in separate policies for specific groups of the population.

5.1. The policy environment

Ireland has enjoyed rapid economic growth in recent years, shifting from an exporter of human resources to a country with net immigration. The need for a healthy and growing workforce has contributed to a receptive environment for health promotion arguments, put forward by national public health experts closely involved in the WHO Health for All and health promotion movements. From the late 1980s, health and development have been linked, with health components included in efforts for economic growth and a change in the pattern of economic development.

The national social partnership agreements initiated in 1987 brought health on to the negotiating table between the state and the trade unions at a level not seen in most countries. These agreements were possibly conducive to strengthening the culture, already evident, for searching for a degree of consensus.

Health does not appear to be an issue for intense party political polarization.

5.2. Indications of the value system underlying policy development

Practically all the policy documents examined refer in detail to the WHO Health for All policy and its values. There is a clear focus on equality issues. Supporting this, a new unit for primary care and social inclusion has been established in the DoHC. The equality focus is strengthened by links to the anti-poverty strategy and the attention paid to vulnerable groups such as Travellers.

Tackling the determinants of health has been less obvious. Certain policies examined introduce the right argumentation but their proposed interventions are sometimes rather disappointingly focused on equality in access to care or health education interventions, with less attention paid to the determinants of inequalities.

5.3. From awareness building to policy action

There is now a comparatively good research and information base. Some respondents felt, however, that research does not necessarily trigger policy development and that excellent information had been available without being acted on. Ireland's ranking among other EU countries in relation to health status was a clear motivator for action in a number of policy documents examined.

From interviews conducted, it was felt that the historical pattern of developing both umbrella and issue-specific policies was largely ad hoc, but had been influenced to some extent by international developments such as the Ottawa Charter and the WHO Health for All policy. This is borne out by specific references to these international movements in the policy documents examined. Partly in response to international developments, earlier policies were more settings-focused, with the determinants of health being introduced rather later. The availability of funding has also influenced the direction of policy development.

The focus on particular diseases or risks appears to have been largely led by the interests of political leaders, public health experts and lobby groups, backed by improved information. The main NGOs are extremely influential and include the top specialists among their members. The Irish Heart Foundation, for example, successfully promoted the development of a national strategy for stroke prevention. Interest in issues where the stakeholders, the means of disease prevention and management, and indicators of progress are more easily defined has proved easier to maintain than for broader policies that can become "everyone's and no one's baby", as is apparently the danger in the case of obesity.

There is clear cross-referencing between policies dealing with the same issue. For example, targets set for heart health in an umbrella policy are adopted in the separate heart health policy and related risk factor policies. An integrated or coordinated approach cutting across policies dealing with different issues is less easy to define. The new *Policy framework for the management of chronic diseases (8)* is intended to bridge that gap, mainly in the health care field, improving the identification and registration of all NCD patients and ensuring planned approaches for patients with long-term conditions.

Following the transformation of the health services, there has been some discussion of money for health care being attached to specific strategies. This could mean that the health services will be prepared to tackle only one issue at a time. It could also mean a stronger focus on issues that are more clearly defined and concrete, and where results can be monitored, for example in patient support programmes.

5.4. Sustaining policy implementation, monitoring and revision

Given that population health surveys have been established on a regular basis, and posts for policy implementation have been established and funded at national and regional levels, NCD can be expected to remain on the policy agenda, supported by an adequate number of professional proponents. Some umbrella and issue-specific policies and strategies are already on their second or third revision.

Expert task forces and committees monitor implementation of the various policies at interim periods and at the end of the planning period. This is a transparent process with regular public reporting of their findings, most of which are easily found on the Internet. The policy dialogue between the stakeholders is therefore continuously fuelled by a serious knowledge base.

Continuous reference is made to intersectoral action, although the composition of many of the policy formulation groups is frequently still rather oriented towards the health sector. High-level intersectoral structures for the implementation of health policy have been tried, with limited success. Some respondents felt that "joined-up thinking" would be best achieved with "joined-up funding". It was also felt that strong leadership has been lacking, and that this might best be provided outside the health sector, particularly from the Prime Minister's Department. Consequently, in 2007, it was decided to latch on to an existing, successfully operating mechanism for intersectoral action: the cabinet subcommittee dealing with social inclusion, operating and chaired by

the office of the Prime Minister. It was deliberately decided not to set up a new structure but to introduce the health inequalities issues through the successfully operating social inclusion mechanisms. Together with the HSE, the DoHC will define a short-term health agenda for this cabinet group and senior officials. It is hoped that this will lead to "full government buy-in to addressing the determinants of health". A cross-divisional group in the DoHC will support the work, and the Department also intends to offer support to other ministries for HIA.

The tobacco control strategy, which is perhaps easier for lay people to understand, has successfully achieved broad intersectoral collaboration, eliciting encouraging reaction from international experts and organizations. The obesity strategy, which also defines a broad range of cross-sectoral action, does not yet appear to have rallied the necessary cross-sectoral proponents.

A serious attempt is made to ensure the involvement of NGOs in policy formulation and monitoring, through systematic public consultation on draft policies. Following the publication of a white paper, a Voluntary Activity Unit was established in the DoHC in 2005. The HSE also works with a range of NGOs and provides financial support through service-level agreements. It is not clear how far the average citizen is informed and involved. The experience of consensus-building through joint analysis of problems and solutions in the framework of the social partnership, at both national and local levels, might hold valuable lessons.

Briefly, the main characteristics of the Irish experience include:

- a complex pattern of umbrella, disease-specific and risk-specific policies;
- an increasingly close link between health and development policy;
- a greatly improved knowledge base, transparent monitoring, evaluation and reporting system, and institutions in place to further develop research and training for NCD policy development;
- an influential body of public health experts in the public and voluntary sectors;
- partial success in securing intersectoral collaboration to tackle the determinants of health, but a promising new approach to achieving this;
- a new attempt to rethink the management of care for chronic diseases; and
- attempts to improve consultation and participatory processes.

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Kyrgyzstan

Péter Makara

1. Country profile

Kyrgyzstan lies in central Asia at the eastern border of the WHO European Region. It became independent following the dissolution of the USSR in 1991. Over 80% of the country is mountainous, the highest point being 7439 metres above sea level. The capital is Bishkek, situated close to the northern border with Kazakhstan. In mid-2003, the population was approximately 5 million, the majority of whom (65%) live in rural areas. Kyrgyzstan has a young and multiethnic society, over 30% being of non-Kyrgyz origin and 30% being under 14 years of age. The main religion is Sunni Islam, although the society is secular.

Kyrgyzstan is a republic with a presidential style of government whereby the President is elected for five years. Executive power lies with the Government headed by the Prime Minister, who is inaugurated by the President. Heads of the local state administrations are also appointed by the President.

1.1. Socioeconomic development

Kyrgyzstan, like many other countries emerging from the former USSR, was heavily subsidized during the Soviet era and contributed to the economy of the USSR mainly through the supply of raw materials. After the collapse of the USSR, Kyrgyzstan saw a decline into poverty followed by a rapid and real recovery of its GDP after 1995, when the economic depression in these countries was at its worst. The vulnerability of the Kyrgyz economy was revealed, however, when it slowed down during the Russian economic crisis in 1998. While economic performance has recently grown considerably, difficulties remain in securing adequate fiscal revenues and providing an adequate social safety net.

In 1999, according to a national index, 64.1% of the population was living in poverty. In 2001, the Gini index was 29.0. This is consistent with the pervasiveness of poverty in the country and with other countries emerging from the former USSR, albeit representing a greater level of equality than the Russian Federation using the same index. *(1)* In Kyrgyzstan, per capita GDP, adjusted for PPP was US$ 1935 in 2004, being the lowest among the CIS countries. About half of the population works in agriculture, the largest sector of the economy, while industry and construction contribute only 23% of GDP.

Kyrgyzstan is the only central Asian country to have joined the World Trade Organization so far. There is also a long history of cooperation with the World Bank and the International Monetary Fund.

1.2. The people and their health

Despite the enormous emigration in the early 1990s and the slowly decreasing birth rate, the population of Kyrgyzstan has been growing overall owing to the increasing life expectancy. Average life expectancy at birth in 2005 was 68 years with a significant gender gap: 72 for females and 64 for males. Health indicators have changed considerably over the last 15 years, replicating the U-shape curve of economic slump and rebound, albeit with some delay.

CVD are the main cause of death, followed by cancer and respiratory disease. CVD also account for the highest burden of disease among both males and females, followed by unintentional injuries among males and neuropsychiatric disorders among females.

Infant mortality fell over the past decade and reached 59 per 1000 live births in 2005, which is nevertheless higher than in some neighbouring countries such as Kazakh-

stan and Uzbekistan. Serious concerns have been raised, however, about the quality and reliability of the data from all central Asian countries, especially infant and maternal mortality rates.

The remarkably high rate of excess mortality caused by chronic lower respiratory disease is explained by a number of unfavourable environmental and behavioural factors, particularly the use of solid fuels and smoking.

As for many other countries in the WHO European Region, NCD are the main cause of death. Morbidity from infectious diseases is relatively high, however, especially with respect to tuberculosis, malaria and, increasingly, sexually transmitted infections.

As to risk factors, tobacco and alcohol use place the greatest burden on males and high blood pressure and overweight on females. Between 2000 and 2005, alcohol consumption increased by 28% and deaths caused by excessive drinking rose by 130%.

1.3. The main features of the health system

In Kyrgyzstan, as in all countries emerging from the former USSR, the health care system was developed based on the strongly centralized Semaško model. The rights and responsibilities of the population in the field of health protection are secured in the Constitution of the Kyrgyz Republic and the Law on health protection of citizens of the Kyrgyz Republic.

The Government adopts health policy following its approval by Parliament. The Ministry of Health implements health policy and other national and specific programmes. Local state administrations are owners of health care facilities, including polyclinics and regional and district hospitals. Through their coordination commission, local administrations exercise considerable influence on national health policies.

In 2004, 5.4% of GDP was spent on health, a figure comparable with that of other CIS countries. Financial planning and budgetary management for health are the responsibility of the Ministry of Health, though the Ministry of Finance and local administrations also play an important role in the budgetary process. As a result of a major reform in 2000, fragmentation of the health care budget was halted and the regional level identified as the ideal distribution and budget management point. A complementary reform allowed health facilities more autonomy and greater flexibility in managing their budgets. Out-of-pocket payments are significant and represent a major source of revenue for the health system. The private health sector has developed since the 1990s but remains small, comprising mainly outpatient care and pharmacies.

2. Kyrgyzstan's approach to developing policies to tackle NCD

2.1. How things started

A unique feature of Kyrgyz health policy is the almost total lack of background or developed sub-policies in the field of NCD policy development. The situation is characterized by the legacy of the Semaško system, traditions of health propaganda and a few isolated and fragmented actions. Kyrgyz participation in WHO projects such as MONICA and experience with loans from the World Bank have contributed to a raised awareness of the need to develop a strategy on NCD. Thus, policy development to tackle NCD starts with constructing a broad new umbrella policy framework within the so-called *Manas Taalimi* overall health policy strategy *(2)*. This includes a strong public health element while emphasizing aspects of health promotion and CVD prevention. The public health components were proposed by the World Bank as a loan condition and were accepted by the Kyrgyz Government. The WHO Regional Office for Europe and representatives of the international community provided significant technical support in planning the strategy.

In the case of Kyrgyzstan, description of the basic policy umbrella document is necessarily limited to the infrastructure of implementation. There are no sub-policies to be analysed in classical terms, such as tobacco or nutrition policy. In most countries, the key question is the integration of different sub-policies. In Kyrgyzstan, the challenge is just the opposite: how will starting with a broad umbrella policy document ensure appropriate differentiation in the activities of NCD policy?

The main dilemma in assessing the present situation is to foresee the future of implementation in a country with economic hardship, striking social inequities and political uncertainty. Experience from some other central Asian countries indicates that progress from rhetoric and cliché to real action is far from guaranteed. In such a highly uncertain situation, even a medium-term forecast is rather risky.

2.2. Manas Taalimi, the broad health policy strategy

The Kyrgyz National Health Care Programme, *Manas Taalimi* 2006–2120, was approved in February 2006 by means of Government Decree No. 100. This is in fact a broad health policy strategy, including a strong public health component and with emphasis also on health promotion and some key issues of NCD prevention. The situation analysis of the strategy draws some important conclusions related to the further policy development to tackle NCD.

According to *Manas Taalimi*, community involvement in health protection and promotion is one of the key elements in the success of the public health approach *(2)*. In the context of reforming the mechanism of governance, certain functions or responsibility for health promotion can be delegated to NGO. The capacity and resources of NGOs, which are able to make decisions more flexibly and more quickly, are gaining importance in supplementing the activities of public health organizations. This is certainly a new and important change in health policy as compared to Soviet times. There are already examples of good practice for community involvement at regional and local levels.

Some new approaches are emphasized in the strategy, such as a shift to more active, intersectoral cooperation by various stakeholders in order to identify clear priorities and common ground. As important stakeholders, a number of NGOs are working in close collaboration with the health sector. Donor organizations provide training to new members on self-help and mutual help and on disease prevention and control. According to the strategy document *(2)*, these are in fact the most promising resources for the future implementation process. Good examples are community-based patient organizations such as those concerned with hypertension, asthma, diabetes and other NGOs in the field of social protection.

The major goal of the strategy is "to improve the health status of the population through the creation of a responsive, efficient, comprehensive and integrated system of individual and public health service delivery; increased responsibility of every citizen, family and public authority; and health administration for each person and society in general" *(2)*. Compared to other national documents, this goal is rather unusual. Despite The text expresses a clear commitment of the Kyrgyz Government to NCD prevention and a high level of openness to new ways of thinking in this respect.

1. From the NCD policy perspective, two general objectives are explicitly expressed in the document Improvement of mechanisms enabling and promoting the involvement of the population in physical and mental health promotion and disease prevention.
2. Involvement of the mass media in working more actively with the public in relation to health protection and health promotion, thus increasing public awareness of the health reform process.

2.2.1. General objective 1

An important element in the planned implementation of the strategy is the mobilization of the local community to react to problems of health promotion and protection, and to strengthen village health committees on the basis of the Jumgal Model developed under the Kyrgyz–Swiss Health Reform Support Project. This will allow communities to identify priorities in the health sector, as well as to undertake certain measures to minimize risks and influence key health determinants. Nevertheless, there is still a high level of uncertainty about the sustainability and appropriate financing of village health committees and other positive local initiatives.

Objective 1 includes some key actions in this area:

- the development of a population interaction strategy on issues related to health promotion and disease prevention;
- rendering assistance in the development of different models of community mobilization on issues of physical and mental health protection and promotion; and
- improving the interaction of the Ministry of Health with the population.

The proposed key actions can be interpreted as a step away from the patronizing political way of thinking, with special emphasis on public participation and community mobilization.

2.2.2. General objective 2

A special emphasis on the media is a characteristic feature of health policy-making in the country. The authors of *Manas Taalimi* stress that "broad coverage of issues on disease prevention, health promotion, development of sanitary–hygienic skills and other health issues, together with coverage of important health care problems by the mass media, will contribute to the development of a health culture and a more active participation by the population and communities in activities promoting health" *(2)*. Special emphasis will be paced on strengthening the press office of the Ministry of Health and its interaction with all types of media organizations and NGOs.

It is important for the implementation of the strategy, however, that this strong emphasis on the media should not distract from the need for substantive action.

2.2.3. CVD policy in Manas Taalimi

One field of policy development in the strategy is that of tackling NCD. CVD prevention is an innovative component of the strategy and is given high priority. According to the strategy *(2)*:

> With a view to the early detection of the most widespread and socially significant CVD and adequate timely correction of them, as well as an effective reduction in the prevalence of risk factors for the emergence of these diseases, it is planned to expand preventive work through population screening and provision of training in the basic principles and skills in preventing CVD and their complications.

Capacity building is a crucial strand of CVD prevention in Kyrgyzstan and according to the strategy *(2)*:

> To improve health services, it is essential to ensure that health workers are given adequate knowledge and practical skills related to CVD. This will require ongoing development and the introduction of continuing education programmes with a view to training and retraining doctors and nurses on the primary and secondary prevention of socially significant CVD, methods of early detection and strategies for evidence-based preventive and curative interventions at the family level. Efficient of distance learning methods should be introduced for health workers. The use of telecommunications technologies will contribute to the delivery of high-quality health care to populations in remote regions.

The active involvement of the public, communities, local governments and NGOs is a guiding principle of the CVD prevention component of *Manas Taalimi (2):*

> A significant role will be assigned to local health committees, arterial hypertension societies and coronary-lipid societies established with the aim of training patients and family members to be aware of CVD preventive measures and training programmes aimed at risk reduction (overweight, imbalanced nutrition, lack of physical exercise, stress, arterial hypertension and hyperlipidaemia). Likewise, it is necessary to use the media on a broader basis, as well as to disseminate booklets and brochures, on measures of controlling and preventing CVD.

These measures reflect to some extent surviving traditional ideas of health education in Kyrgyzstan.

The strategy includes a rather brief mention of the need to develop legislation in the field of CVD risk factors, such as smoking and excessive alcohol consumption, to support public policy dealing with healthy nutrition and food safety, and to incorporate training on healthy lifestyles into the secondary and higher education curricula. These ideas also appear in the health promotion strategy (see below) but in a broader context.

One of the explicit and very ambitious targets of *Manas Taalimi* is to reduce the CVD mortality rate to EU levels by 2015. In this context the following activities are to be carried out:

- promotion of healthy lifestyles and preventing CVD through the reduction of risk factors;
- publication of brochures for the whole population on measures to control and prevent of CVD;
- assistance in the creation of outpatient "arterial hypertension clubs" and "coronary-lipid societies" and others at local level with the aim of providing training for patients and their families; and
- developing and introducing modern and efficient prevention technologies and diagnostics.

All this is based on an optimistic vision and the chances of its implementation greatly depend on overall economic and social development and success in tackling the broader socioeconomic determinants of health. It is difficult to understand why these ideas are not integrated into a more explicit and broader framework of NCD prevention, and why cancer prevention does not appear in the strategy. The influence of the Institute of Cardiology and the cardiological background of some top-level decision-makers is one explanation. The public health components of the strategy are coordinated at deputy minister level, indicating the high policy priority given to the issue.

2.3. The national health promotion strategy for 2007–2015

Within the framework of *Manas Taalimi*, the National Centre for Health Promotion was requested to develop a long-term health promotion and NCD prevention strategy to serve as a basis for medium-term and annual action plans in this field. The strategy planning process started in autumn 2006. Representatives of all ministries were involved in the preparatory activities in most cases with a rather limited technical input. The WHO Regional Office for Europe provided genuine technical support while stimulating progress and emphasizing the focus on equality, social and economic determinants of health, and regional and local participation.

The draft strategy was circulated among the various key actors (ministries, health experts, international organizations and donors) in order to build a consensus. Following a national workshop in July 2007, the process of implementation began and the first annual plan was developed. The first experience of multisectoral coordination in October 2007 was rather promising. The representatives of the different ministries carefully studied the draft strategy and contributed constructively to the discussion. The next phase of

the planning process will confront the difficult questions of financing, partnerships and coordinating responsibilities, including the harmonization of donor activities on the basis of the national strategy.

2.3.1. Structure of the strategy

While planning the structure of the strategy, four vertical and three horizontal approaches were taken into consideration.

Vertical approaches include:

- health in all policies: government policy supporting health and intersectoral cooperation in health promotion and disease prevention issues, including:
  - legislation;
  - coordination and management of the strategy; and
  - mechanisms of financing;
- healthy lifestyles and risk factor reduction: boosting personal involvement of the population to support healthy lifestyles, reduce risk factors and develop personal skills for healthier choices, including:
  - development of individual/personal skills and abilities to live a healthy lifestyle;
  - fighting harmful habits; and
  - creating the conditions that enable people to make healthy choices in everyday life;
- partnerships: supporting health in everyday life at different levels and settings of the community, including:
  - broadening health promotion activities in everyday settings;
  - creating partnerships in support of health at all levels; and
  - strengthening the strategic character of international cooperation;
- health services: to strengthen the preventive work of medical organizations and institutions, including:
  - strengthening and developing health promotion and NCD prevention in public health institutions;
  - increasing the role of PHC in NCD prevention and health promotion; and
  - developing cooperation with the clinical sector.

Horizontal approaches comprise:

- reducing inequities and having a positive effect on the socioeconomic determinants of health:
  - a positive effect on socioeconomic determinants and an improvement in the health of the overall population;
  - a reduction in health inequities as an integral part of the planning, implementation and evaluation of any action within the framework of the strategy; and
  - the development of special actions aimed at vulnerable groups;
- health communication, targeting:
  - various groups of the population;
  - medical workers; and
  - other sectors and partners;
- monitoring, evaluation and effectiveness of ongoing measures:
  - monitoring and evaluation of strategy implementation as a whole, taking into consideration processes and results, and
  - separate monitoring and evaluation of each step.

Concrete measures are integrated into this planning framework and are essentially interrelated. The adoption of the document in July 2007 at a national workshop also served as a basis for elaborating the concrete steps in its implementation.

2.4. Key institutions in the field of public health and health promotion

Kyrgyzstan faces the challenge of new ways of governance. The whole public administration system is changing. Intersectoral managerial structures for health promotion and

disease prevention at government level are at the planning stage.

Currently, as in other central Asian countries, the role of the Kyrgyz Ministry of Health is mostly administrative, managerial and regulatory. It directly administers government health facilities such as the scientific research institutes and national centres of excellence and manages the Kyrgyz State Medical Academy. Until recently, the Medical Academy was unable to control the number of admissions. It appoints the heads of government-based health care organizations and its prior agreement has to be obtained to appoint heads of municipal health organizations. The overwhelming role of academic bodies is a rather conservative and an obstruction to health policy development.

Since donors play an important role in Kyrgyzstan, the Ministry of Health is also responsible for coordinating relevant donor activities and distributing of humanitarian aid. This very complicated and sensitive task is not carried out in a satisfactory way at the moment. At least in the field of public health and health promotion, most activities are driven by external donors and the Ministry of Health has rather limited influence on the support of the international community.

The Ministry of Health develops a health budget according to national health policy priorities, taking into account donors and health revenue estimates. The budget planning process is a sensitive issue in Kyrgyzstan, in which the Ministry of Finance also plays a crucial role. The basic problem is the poor economic development of the country, and the budgetary possibilities of financing health care are rather limited and inflexible. In the face of serious underfinancing, one of the specific dilemmas of the Kyrgyz situation is how to integrate strategic considerations of health promotion and NCD prevention to a policy basically under crisis management. If successfully implemented, *Manas Taalimi* may serve as a good example of moving from incremental, emergency-type action to long-term, sustainable policy development in the field of health.

Local state administrations are responsible for health planning, regulation, coordination and implementation at subnational level. Prior to major local reforms in 2000, these functions were performed by *oblast* health departments. As the result of the reforms, these departments were abolished and their functions transferred to regional hospitals and then to the supervisory councils for health management, which became the coordination commissions on health management in 2003.

According to Kyrgyz law, NGOs (at least theoretically) "take part in ensuring health security and promotion and provide scientific and health information" *(3)*. A large number of NGOs are active, including initiative groups and health committees and international agencies such as the Soros Foundation–Kyrgyzstan and Counterpart Consortium, along with projects funded by international organizations to support the development of civil society initiatives.

2.4.1. Primary health care

The PHC system includes various levels and entry points for patients:

- feldsher-obstetrical posts
- family group practices
- rural outpatient centres
- family medicine centres
- polyclinics.

In rural areas, the feldsher-obstetrical posts are the most important points of entry to health care, including NCD prevention. In cities, health providers include general and specialized polyclinics, as well as city hospitals and maternity homes.

The reorganization of PHC is still in progress. Family group practices are taking on more and more responsibilities in the health care system. In particular, they are now responsible for carrying out screening, immunization and counselling. Small family group practices face a shortage of capacity and have begun to merge in order to create economies of scale. As a result, between 2000 and 2003, the number of family group practices fell from 800 to 668. Further decisions on the status of family group practices still have to be made in the context of the ongoing restructuring of the health care delivery system.

There are very sharp geographical differences in accessibility of PHC, with particular difficulties in mountainous areas with small populations.

2.4.2. The public health system

The public health system operates at national, *oblast*, city and *rayon* levels. At national level, the Department of State Sanitary–Epidemiological Surveillance is the main actor of the public health service. It is staffed by doctors, epidemiologists and assistants. The public health service has two departments: a health department dealing with the health of children and adolescents, occupational health, nutrition and hygiene and an epidemiological department dealing with infectious, parasitic, immunological and epidemiological matters. Bacteriological and sanitary laboratories serve both departments. The Department of State Sanitary–Epidemiological Surveillance is in charge of implementing nationwide public health programmes in such areas as tuberculosis and the prevention of HIV/AIDS and sexually transmitted infections. In addition to its national office, there are 7 *oblast* centres and 50 *rayon* and city centres.

The entire public health system is based on Semaško principles. It is more or less oriented towards health protection but is inappropriate for modern approaches to NCD prevention and health promotion. In general, the infrastructure of the public health system is weak and the administration has a strongly vertical structure. Many laboratories and their equipment are outdated. National epidemiological data are collected at different administrative levels and, through a vertical information flow, aggregated by the Department of State Sanitary–Epidemiological Surveillance. Some reorganization has taken place in the Department since 1990, especially significant being the reform of public health services within the framework of the Second Health Reform Project funded by the World Bank. Nevertheless, experts claim that no overall comprehensive reform process has been implemented as yet and the public health service is urging change in terms of restructuring, financial reform and staff training.

One of the weaknesses of the Kyrgyz health system is a lack of clear coordination and cooperation between the PHC services and the public health system.

2.4.3. Health promotion

The newly established Republican Centre for Health Promotion represents a change of approach in health promotion and public health in Kyrgyzstan. The Centre aims at liberating the health promotion service from the traditionally dominating "hygiene" approach and introducing a modern concept of health promotion. Besides the Republican Centre, located in Bishkek, health promotion units are to be found at *oblast* and at *rayon* level. They interact with PHC and other health facilities, village projects and local administrations, etc. Nevertheless, health promotion units do not have enough human resources. In addition, the available staff are not sufficiently trained and the mechanisms of funding health promotion units are practically nonexistent.

The Swiss Red Cross has piloted health promotion units in Naryn *oblast*. Following a positive evaluation and supportive feedback these regional units were established throughout the country from 2005. Owing to limited financial resources, various programmes and activities are carried out by international donors, particularly by the Swiss Red Cross.

The existing, often fragmented actions support the dissemination of modern health promotion concepts and try to adapt international guidelines and best practices to the specific needs of rural areas.

The purpose of the health promotion units in *rayons* is to support community action for the health strategy and to act as a link between the health system and community organizations working on health issues. Since 2003, WHO has provided assistance in developing a National Population Health and Development Programme, which envisages the development of the actual intersectoral strategy of health promotion.

3. Infrastructure and resources for policies to tackle NCD

3.1. Human resources

Public health programmes for the general public or the local community face a lack of skilled personnel. There are very few (20–30) experts in health promotion and NCD policy that meet international criteria, and these mainly concentrated in Bishkek. The broad partnerships in village health committees and other local initiatives may have a great potential for human resource development in the future.

The Institute for Public Health of the State Medical Academy provides training for specialists in public health and health administration. Within the framework of a rural sanitation and hygiene project, held in 2004 under the aegis of the United Kingdom Department for International Development (DFID), a course in training in health promotion took place at the State Medical Academy. The course aimed to demonstrate the introduction of an education curriculum into a medical school, the outputs of which are to be a base for further work on preparing public health personnel. Despite this positive initiative, however, there is generally a lack of appropriate training schemes in NCD prevention for graduate, postgraduate and in-service training. In contrary to initial expectations, the School of Public Health in Almaty (Kazakhstan) has no practical influence on Kyrgyz human resource development in health promotion and disease prevention.

3.2. Financial resources

The funding of NCD prevention and health promotion programmes basically depends on external assistance. The Government co-finances a number of investment projects, but at present NCD prevention programmes have a low priority.

At village level, initiative groups (within the DFID project) and health committees (Kyrgyz–Swiss Health Reform Support Project) are working along with other groups. At the moment, they are mainly funded by international projects. Their activities are recognized to be quite effective, but the issue of sustainability and harmonization of their activities remains unsolved. Efforts have been made to ensure mechanisms of self-reimbursement after projects have been carried out.

Village organizations mobilize funds and human resources as a contribution to health promotion and disease prevention projects. This approach is considered the most effective, especially for rural populations with of scarce social and economic resources. Recently, some projects have focused on the social capital of communities, which is a considerable asset of rural populations.

3.3. Information and research

Kyrgyzstan has limited experience and practice in health promotion and disease prevention research. With the *Manas Taalimi* planning process, there is doubtless an increased need for and interest in research and information. This also relates to the establishing of the monitoring and evaluation system of strategy implementation.

There are some examples of good practice. With the assistance of DFID, the National Statistical Committee carried out research at household level that highlighted some health issues linked to poverty and other social phenomena. Another research project for health care policy analysis focuses on economic features in health in Kyrgyzstan.

The general conceptual framework and implementation mechanisms for monitoring health promotion and disease prevention are at the stage of preliminary discussions. After the adoption of the strategy, steps can be expected to be taken towards reorganizing the existing fragmented system of information flow and developing new information gathering tools for areas that are not as yet covered by the system.

4. Forces facilitating or obstructing NCD policy development

Despite the negative trends in life expectancy and the lack of resources in health promotion and NCD prevention, some improvement has recently been observed over a relatively short time. The ambitious targets of *Manas Taalimi* and the establishment of the Centre for Health Promotion aim at better conditions for developing NCD policy in the country, although the Government still faces some difficulties in terms of poverty and the significant regional differences in the socioeconomic determinants of NCD. Because of limited financial and human resources, little research has been undertaken to validate and verify the basis for the new public health strategy.

Involvement and empowerment of communities in health promotion and NCD prevention is an essential strategy for developing capacities but can be difficult in countries with a short history of democracy such as Kyrgyzstan. The greatest challenge is to translate the real *Manas Taalimi* policy agenda into a clear and pragmatic intersectoral implementation plan for how policies are to be carried out at local or national level.

The main difficulties and obstacles anticipated by the authors of the health promotion strategy are:

- the weak influence and marginal position of health promotion and NCD prevention in the overall decision-making system;
- inadequate financing;
- the nature of the democratic process in the country;
- the striking social inequities in terms of poverty, social problems and exclusion;
- the controversial effects of globalization and the market economy;
- the dominance of curative medicine; and
- old-fashioned views and approaches to public health.

To this list can be added the lack of a clear division of competences and coordination between the public health and PHC systems and the weakness of their relationship to clinical institutions such as the Institute of Cardiology. This assessment seems to be based on a correct evaluation of the present situation. Nevertheless, there are some encouraging elements that may facilitate NCD policy development in the future:

- a broad, modern strategy framework;
- a strong focus in the strategy on equality, partnerships and tackling the socioeconomic determinants of health;
- a new national centre and a critical mass of NCD prevention experts, at least in the capital;
- the interest and support of some international organizations and donors, and
- the already existing village health committees as an example of good practice.

5. Conclusions and lessons learnt

- In the context of striking poverty and underdevelopment, the Kyrgyz policy to tackle NCD has practically no roots and is in a very preliminary stage of develop-

ment. One part of the dilemma is related to the low level and uncertainty of social and economic development in Kyrgyzstan.

- *Manas Taalimi* is probably one of the most integrated policies for tackling NCD, at least at the stage of strategy planning. At the moment, only the umbrella policy document exists and potential development depends on real action.
- At this early stage of policy development, it is difficult to reach a conclusion about sustainability. Despite the unfavourable conditions, the Government seems to be committed to long-term action, although there is also a high level of uncertainty in politics.
- In terms of the strategy, the focus on equality and the socioeconomic determinants of health is strong.
- A number of good practices can be identified in Kyrgyzstan, such as the village health committees based on historical roots, multiple partnerships and intersectoral cooperation at local level.
- At the moment, there is poor information on the real tools of implementation, and a solid and sustainable means of financing is missing. Actions are mainly externally driven by donors, showing the high level of responsibility of the international community for Kyrgyz health policy development.
- The public health services are outdated and dominated by top-down approaches. There is a lack of coordination between PHC and the public health services.
- Constructing a broad umbrella policy framework in policies to tackle NCD without deep historical roots and existing sub-policies is a unique experience in Kyrgyzstan. The future will judge its success.

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Lithuania

Anna Ritsatakis

1. Country profile

Lithuania is situated on the eastern Baltic coast. It is bordered by Belarus to the east, Latvia to the north and Poland to the south. In March 1990, Lithuania declared its independence from the USSR.

Lithuania is divided into 10 regions and 56 municipalities. There are 56 local self-governing councils elected every two years, and 10 district advisory councils comprising the mayors of the local councils. In 2005, the population was 3.4 million, about 67% of whom lived in urban areas.

The national language is Lithuanian. Lithuania joined the EU in May 2004.

1.1. Socioeconomic development

At the beginning of the 21st century Lithuania had an unemployment rate of over 12%, but by 2004 this had fallen to around 6%. During the same period, per capita gross national income doubled from US$ 3170 in 2000 to US$ 7210 in 2005. Indeed, this period may be considered as one of solid economic growth, stable currency, healthy public finances, low budget deficit and successful structural reforms.

Despite these significant improvements, however, inequalities remain. Although the proportion of those living in absolute poverty decreased considerably during the 1990s, income inequalities are greater in Lithuania than in EU15 countries. Eurostat reports that, in 2002, 17% of Lithuanians had incomes below 60% of the national median disposable income (after social transfers), compared to an average of 14% in the EU countries in 2001 *(1)*.

1.2. The people and their health

Between 1970 and 1990, the population of Lithuania increased from 3.1 million to around 3.7 million. Since the political changes in eastern Europe, there has been a gradual but continuous decrease to around 3.4 million. Natural growth of the population has been negative since 1994. World Bank forecasts *(2)* indicate a continuing decrease over the coming years, reaching 3.2 million by 2020.

As the birth rate has continued to fall (around 15 live births per 1000 population in 1980 to just below 9 in 2005) and young people seek jobs abroad, there has been a rapid ageing of the population. The proportion of people aged 65 years and over rose from around 11% in 1980 to 15% in 2005, and this is estimated to reach 22% by 2030 *(1)*.

Overall life expectancy at birth increased from 70.3 years in 1996 to 72.3 years in 2000, falling again to 71.3 years in 2005. This hides a large and increasing gender gap. In 2005, life expectancy for males was 65.4 years while that for females reached 77.4 years. According to WHO estimates *(1)*, Lithuanians spend on average about 11.9% of their life with illness.

The overall rates also hide considerable regional differences, there being a twofold difference between the regions with the highest and lowest mortality rates. Life expectancy between these regions differs by almost seven years *(3)*.

The number of infant deaths per 1000 live births has been gradually falling, reaching 6.8 in 2005. This is still higher than in western European countries and its further reduction is one of the aims of the current health programme.

More than half of all deaths in Lithuania are caused by CVD. They are also the cause of 30% of disabilities and 15–20% of all referrals for health care. Within total cardiovascular mortality, ischaemic heart disease and stroke constitute the greatest proportions. Although mortality from CVD

fell rapidly from 1994 to 2000, since then it has risen again and, at 528.5 deaths per 100 000 population in 2004 (562.8 in 2005), was more than double the average for the EU15 countries (226.7 in 2004).

The SDR for cancer, on the other hand, has continued to decrease but at 194.7 deaths per 100 000 population in 2004 it was still above the 176.1 reached by the EU15 countries in that year. Lung cancer is the most common cancer for men, and breast cancer for women. The death rate for cervical cancer is particularly high, the second highest in the WHO European Region.

Regarding health risks, from a sharp increase in the late 1990s, smoking among men declined rapidly after 2000 only to rise again in 2005. The proportion of women smokers was very low in the mid-1990s then rose extremely rapidly to 2000, when an equally rapid decrease was observed. Although alcohol consumption is still slightly below the average for the EU15 countries, in contrast to smoking there has been a continuous, rapid increase in alcohol consumption since the late 1990s, and alcohol is the main risk factor for younger men. Around 70% of suicides are related to alcohol abuse and it is estimated that 30–40% of crime is committed by people under the influence of alcohol.

1.3. The main features of the health system

Health care in Lithuania still suffers from the legacy of a highly centralized system *(4)*, with its inefficient management and use of resources and strong emphasis on specialists rather than family doctors. Although the number of hospital beds has dropped since 1990, there is still an oversupply, though hospital services are reasonably well distributed throughout the country. Owing to the high levels of emigration among medical personnel and the lack of evidence-based planning for health care, what appeared to be an oversupply of physicians in the early 1980s has now become a shortage.

Health care institutions were administered either by the Ministry of Health or local administrations (municipalities). By the late 1990s, the majority had become non-profit-making enterprises *(5)*.

At the county or district level, a District Governor is appointed by the Government with responsibility for implementing national policies, including health policy. The post of District Physician has been created to assist in this task. The 1994 Law on the Health System *(6)* made the local authorities responsible for the delivery of PHC and the position of Municipality Physician was established.

PHC as a separately organized part of the health services was introduced only after 1991 through the National Health Concept (see below). The delivery of PHC takes place at medical posts (mainly in rural areas and run by paramedical personnel and/or midwives), ambulatories (group practices, usually in small towns and including a physician, midwife, dentist and paediatrician), polyclinics (employing 10–20 specialist physicians and equipped with diagnostic technology), and the outpatient departments of hospitals. In the mid-1990s, a PHC strategy was developed tackling the definition of operational standards, the role of health professionals in PHC and the training and retraining of the necessary personnel.

A major change is currently under way, with the health promotion and NCD prevention functions being assigned to the municipal level. This change has been planned for some time, but there was originally some resistance from municipal leaders. According to the web site of the Ministry of Health, local authorities are to be encouraged to establish public health offices, the main functions of which will be to coordinate and implement municipal public health programmes, monitor trends in health status, support and coordinate health education and encourage community involvement in solving public health problems. The Ministry of Health will cover 70% of the costs, but it is not clear how

the poorer municipalities in particular will be able to cover the other 30%. There appears to be some lack of clarity regarding the expected staffing and work to be carried out, and how this work will be supported and evaluated. Four Public Health Bureaux are presently operating on a pilot basis. There appear to be differing opinions on whether decentralization at an earlier stage would have facilitated more effective implementation of the health programme, or whether the present time and situation are indeed ripe for such a shift to the local level. Although too soon to consider how effective these changes will prove to be, developments of public health at the local level will clearly be key to overall progress in implementing NCD policy.

Although it was intended during the transition to a market economy that health care expenditure should not fall below 5% of GDP, this target was not achieved. By 1997, household surveys indicated that up to 20% of the total cost of health care was being met by direct private financing. Covering the cost of pharmaceuticals was a particular problem. Physicians and other health professionals are comparatively poorly paid and improvement of their remuneration is considered a high priority *(7)*. According to a report by the Open Society in 2003, 27% of physicians were considering leaving for other EU countries.

Since January 1997, a compulsory health insurance system has been in place, funded mainly through income and payroll taxes. There is a State Sickness Fund and ten Area Funds to which funds are distributed according to the proportion of the population living in each area. For a wide range of vulnerable groups, including pensioners and those receiving social assistance, the unemployed, pregnant women on maternity leave, mothers of young children, students, the disabled and others, the health insurance contribution is paid by the state. These groups account for about half the total population.

Overall, the approach taken in Lithuania to move with caution in the area of health care reform is said to have kept the system working on a reasonably stable basis throughout the transition period of social and economic upheaval. An improved economic situation should offer further opportunity for change.

2. Lithuania's approach to developing policies to tackle NCD

Even before independence, Lithuania managed to retain its links to the outside world, and to WHO *(8)*. This included active involvement in epidemiological studies and health policy development activities through projects such as the CINDI programme (which seems to have been particularly influential) and WHO networks such as Healthy Cities, Health Promoting Schools, Health Promoting Hospitals and Regions for Health. In many of these networks, Lithuania was a founding and leading member. These links created an atmosphere receptive to the concepts and principles of the WHO Health for All policy among researchers, public health administrators and even politicians.

As early as 1982, an integrated programme was initiated for NCD prevention and control. This later became part of the CINDI programme. An intersectoral committee was established, on which vice-ministers from a number of ministries, the mass media and representatives of the Catholic Church were to sit. This initiative, radical for its time, was apparently not successful, mainly since those participating were not given a sufficiently clear understanding of the origins of health problems and ways in which resources in other sectors could be brought to help tackle them. At that time therefore, the CINDI programme was forced to rely on collaboration almost solely with the health sector. Although never formally abolished, this committee is not active.

Towards the end of the 1980s, as the possibility of regaining independence became apparent, developments in

the health field were influenced by the push for political freedom. Following a considerable preparatory period, the Lithuanian Medical Association (LMA) was re-established at a national congress in 1989. Taking a role possibly unique in Europe, delegates to the congress called on health professionals to develop a new "National Health Concept" based on the WHO Health for All principles. Following broad consultation, this was to be presented to the LMA Congress planned for September of the following year, and a task force was established to carry this through.

In the mean time, in March 1990, the country declared its independence and was internationally recognized in September 1991. A Parliamentary Health Commission was created and a new Department of Health Policy and Strategy was established within the Ministry of Health for the first time.

Following intensive national debate, the LMA enthusiastically approved the draft National Health Concept at its seventh congress. The Concept laid out basic principles that are still valid and are constantly referred to and implemented today. They included:

- the promotion of equality in health;
- intersectoral action for health promotion and disease prevention; and
- strengthening PHC.

There then followed a process unique to Lithuania, and doubtless influenced by the political situation of the time. It was decided to achieve the highest possible commitment to health at the national level by submitting the National Health Concept for parliamentary approval. This process was facilitated by the fact that one of the LMA task force members, Dr J. Olekas, had become the first Minister of Health and another member, elected to the new Parliament, Dr V. Andriukaitis, was Chair of the Parliamentary Health Subcommittee. Through their good offices, procedures were established for presenting the National Health Concept to Parliament in October 1991. On giving its approval, Parliament requested the Ministry of Health to coordinate action on the preparation of a national health policy and programme.

WHO and Finland, where the first national Health for All policy in Europe had recently been formulated, were asked for assistance. Coincidently, the new Minister of Health had attended a WHO meeting on health policy development at the subnational level *(9)*. There he was exposed to top-level decision-makers from across Europe, presenting a broad range of experience in targeting health gain, and apparently asked his advisers why Lithuania had not yet taken this path.

At that point, the EU's PHARE programme came into the picture, requesting that in relation to proposed funding, Lithuania should prepare a health policy framework. Lithuania insisted this be in accordance with the WHO Health for All approach. Acting as a PHARE consultant, WHO supported the mobilization of over 40 Lithuanian experts to prepare Lithuania's first public health report, thereby providing the evidence base for policy formulation *(10)*.

The public health report was presented at the first National Health Policy Conference in 1993. The Conference was opened by the Prime Minister and attended by several members of the Cabinet as well as members of Parliament representing the Parliamentary Committees of Health, Social Security and Labour, Economy and Finance, Education, and Science and Culture. All major political parties, administrators of national, regional and local health services, academic and research institutions and NGOs having even a marginal interest in health were represented. The then Regional Director of the WHO Regional Office for Europe, Dr Jo Asvall, spoke at a parliamentary session and presented the conclusions of the Conference to the President of the Republic. The strong political commitment was obvious, as was the determination that this time there should be

as wide an understanding as possible of the determinants of health and potential for intersectoral action. The Conference recommended that comprehensive public health reports be prepared regularly.

2.1. Broad public health programme

The Lithuanian Health Programme 1998–2010 *(11)* is the current "umbrella" policy for health. It is clearly based on the principle of equality in health, although at the time when it was written this was still understood mainly in terms of equality in access to care. The programme covered the prerequisites for health, lifestyles conducive to health, appropriate health care, the environment, and the structures, training and monitoring system necessary for implementation and evaluation of outcomes. It was seen as a continuation of the National Health Concept and as a national adaptation of the WHO Health for All Policy.

Its main objectives are:

- a reduction in mortality rates and an increase in average life expectancy;
- equality in health and health care; and
- improvement in the quality of life.

Quantified targets were set to reduce, by 2010, mortality rates from accidents (30%), CVD and cancer in those under 65 years of age (15%) and infant mortality (30%), and to increase life expectancy to 75 years. Explicit targets were set for reducing health risks such as smoking and alcohol and fat consumption and for increasing physical activity.

In relation to tackling inequalities in health, reference was also made to addressing the determinants of health, such as reducing income differences, improving living and working conditions, promoting healthy lifestyles (with specific attention to high-risk groups) and to improving access to health care.

2.1.1. How things started

At the time when Lithuania gained its independence, there was already a firm evidence base and a critical core of highly skilled experts intent on utilizing their skills to improve health. These experts provided clear leadership, notably the Rector of Kaunas University of Medicine, Professor Vilius Grabauskas, who was also President of the National Board of Health and team leader for the CINDI programme. They were widely respected and their guidance sought by politicians across political parties. With the evidence they provided, consensus was reached on the priority areas needing urgent attention, which included tackling CVD, cancer and diabetes and their related health risks. The overwhelming nature of the transition period, however, when every sector was bringing up urgent legislation, meant that health joined a long waiting list of issues coming to Parliament.

A Health Reform Management Group was established in 1993, providing leadership not only for health system reform but also for the development of policies for disease prevention and health promotion. The 1994 Lithuanian Health Law provided the necessary legislative background, and the following year a task force was charged with preparing a situation analysis and action plan to address the major problems. To continue the building of intersectoral understanding and support, the challenges outlined in the analysis were discussed in a full-day parliamentary session, broadcast on national radio, with four ministers and a large number of members taking part.

The ensuing Lithuanian Health Programme was approved by the Collegium of the Ministry of Health in July 1996 and by the Government in October of that year. The following spring, it received wide publicity when it was discussed at the Second National Conference on Health Policy. Experts from other countries and from WHO were asked to comment on the draft, which was reviewed by Parliament in July 1998.

An attempt was made to streamline related activities of various WHO projects such as CINDI, Healthy Cities, Health Promoting Schools and Health Promoting Hospitals, by "networking the networks", with the intention of creating a better balance in terms of health promotion, disease prevention and health care actions.

2.1.2. Awareness building and the consultation process

The process of health policy development in Lithuania is led mainly by experts from academia and research. What is perhaps notable is that, although there are prominent, undisputed leaders of this influential group, it is not an exclusive club. As far as we can discern, attempts have been made to involve groups in different parts of the country in the background research, policy formulation and monitoring processes. As seen in relation to the development of the National Health Concept, the Medical Association also plays a strong role.

One aspect that perhaps differs from other countries is the heavy involvement of Parliament. This is not simply a question of Parliament passing legislation or approving a document at the end of a policy formulation process. Very soon after gaining independence, Parliament devoted a whole day to discussing the health challenges facing the country. Those broad discussions were clearly a part of the more general political process set in train by a country redefining its own national identity.

Since then, an annual public health report (around 100 pages) is prepared by the National Board of Health (see below). In late spring each year, a summary of this report is presented to Parliament, which allocates 2.5 half hours to its presentation and discussion. In November each year, Parliament holds its one-day "Dialogue for health", which has become a Lithuanian tradition. The public gallery is packed and the whole discussion broadcast on radio. Twice a year, therefore, on a regular basis, Parliament discusses public health. All reports are published and widely available, creating pressure on the Ministry of Health regarding the issues they cover.

There has been continued good collaboration between the Parliamentary Health Committee, the Ministry of Health and the academic community. Academics are respected by all political parties and asked to provide information on health issues. Their cross-party acceptance is said to be due partly to the fact that many academics were active in the liberation movement leading to reforms in the health sector, thus gaining and retaining the respect of politicians.

The National Board of Health, set up in 1998, plays a strong role in awareness building and its sessions are open to the public. One third of its 15 members are experts in public health, one third are nominated by the Association of Municipalities and one third represent NGOs, although there is apparently some concern among the NGOs as to the weight given to their opinion. The President is not appointed by the Government but elected by secret vote among the members of the Board. Employees of the Board's secretariat are civil servants.

The Board is independent of the Ministry of Health and reports each year directly to Parliament. Under the guidance of its first President, Professor Vilius Grabauskas, this report has taken a two-part form, the first part being a standard general report including international comparisons and the second part dealing with different topical issues. In the first three years, for example, special issues included the social determinants of health, the health of children and young people, and harmonizing the health system with EU requirements.

Partly through the work of this independent Board, strong public pressure can be brought on the Ministry of Health. For example, owing to such pressure the Ministry agreed to examine the possibility of funding health promotion services, such as certain screening processes, through the

health insurance system. Overall, it appears that a good working relationship has been achieved between the Ministry and the Board. The alignment of the opinion of these two bodies with that of the Parliamentary Health Committee has been one of the factors in putting and keeping public health on the map. An additional player is the President's Health Adviser, who can also be influential.

Involvement of the general public is less evident, although attempts are being made to address this and, as seen above, parliamentary discussions on health are broadcast on national radio. A report from the Open Society Fund states that "the citizens of Lithuania are rather hesitant to participate in the formation of national policy" *(12)* and that public policy regarding joining the EU, for example, was consigned exclusively to government institutions. The same report argues that the dominant attitude is still that only a strong state can satisfy the needs of ordinary citizens.

2.1.3. Values and principles

Policies formulated following independence have been explicitly based on the promotion of equality and solidarity in health. This appears to have been influenced by strong and continued links to activities related to the WHO Health for All policy and by largely successful attempts to improve the reflection of possible inequalities in the information base.

Participation in multicountry programmes, particularly CINDI, ensured the continuous improvement of the epidemiological information base. The *Lithuanian health report – 1990s (10)*, presented to the First National Conference on Health Policy in 1993, presented regional inequalities in infant and overall mortality and pointed to the falsity of the traditional belief that in a relatively small country like Lithuania the distribution of problems would be more or less homogeneous. This report apparently became a best-seller and was repeatedly reprinted.

As part of a WHO programme, Lithuania began in 1997 to identify all potential sources collecting equality-related information (either routinely or through surveys) and, on this basis, to make detailed, extensive analyses of existing data. The resulting report on inequalities in health and health care *(13)* was presented to Parliament and caused considerable discussion among researchers, politicians and the media.

The National Board of Health keeps the issue of equality on the agenda through its annual reports to Parliament. Health and inequalities in health are a constant focus of the mass media, particularly the local press. Public awareness can be said to be high, therefore, and political commitment to reducing the gaps is constantly iterated in policy documents.

Some of the changes in the health sector have hit the economically weaker groups of the population hard. The plethora of health-related legislation, however (including, for example, the funding of the new health insurance system), indicate a high concern for solidarity and the protection of vulnerable groups. It is less easy to discern a broad, systematic attempt to deal with this challenge by tackling the social and economic determinants of health.

Work is currently under way on formulating a policy specifically to tackle inequalities in health.

2.1.4. Setting the agenda

There is a very strong tradition of epidemiological research in Lithuania. Constant attempts are made to improve the quality and accessibility of epidemiological data for policy development, particularly through active participation in international research projects, thus further motivating and legitimizing local activities.

Routine surveys of population health have been carried out over a number of years, linked to the CINDI programme, and more recently there have been surveys of the behav-

iour of schoolchildren. The "CINDI team" was active in the development of the overall health policy and numerous related health policy development activities.

As a new member of the EU, Lithuania is also examining some of the implications and potential influence of EU membership on health policy.

2.1.5. Finding solutions

The National Plan for Health is approved by Parliament. The executive function is assigned to the Ministry of Health, while monitoring and evaluation is the task of the National Board of Health. The National Board of Health provides strategic direction. A system of accreditation is in place for public health services, as are "norms" for services and activities. Such norms are agreed through collaboration among the Ministry of Health, the Lithuanian Public Health Association and professional organizations.

There is a combination of policies directed both at the whole population and specifically at high-risk groups.

Business and industry, but particularly NGOs, are seen as having an important role. Since the regaining of independence, the voluntary sector has considerably expanded. There are now over 400 registered NGOs that are concerned in some way with health issues. Links have been made to the EU-funded project organized by the European Public Health Alliance for capacity building and the networking of public health NGOs across Europe. Since there is some concern among NGOs that their views are not given sufficient visibility, many are coming together in umbrella coalitions to strengthen their influence.

Lithuania also participates in the EU's HIA project, within whose framework a case study on the impact of transport policy and air pollution on health has been developed. Apart from this, the development of HIA is still rather primitive. There is no legal or regulatory framework for HIA yet, although the Ministry of Justice has decreed that legislation should be checked for its possible health impact. Since this is carried out by legal rather than health professionals, however, it is said to lead to a simple recording of "no negative impact foreseen."

Although EU links may still be at an embryonic stage, it appears that, as in the past, the door is wide open to sharing experiences on an international level.

On a domestic and local level, the Health Economics Centre, which is a private company, has initiated a project funded by the Open Society, on "Public debates as a tool to achieve sustainable health care development in Lithuania". Through this project, health-policy-related issues are discussed, such as who wins and who loses through health care reform, how family doctors should be paid, and whether "unofficial payment" in the health care system should be considered corruption. These discussions, involving health care managers and providers, patients and politicians, are intended to come up with suggestions that reflect more fully the interests of the population.

2.1.6. Structures and processes for implementation

The National Board of Health is responsible for monitoring the implementation of the Lithuanian Health Programme and policies for disease prevention and alcohol and tobacco control. The Parliamentary Health Committee also plays an active part in scrutinizing progress.

The Board meets about once a month to discuss approved programmes, making the medical community and the public aware of implementation challenges. For example, a Board task force examined all vertical programmes, concluding that these were not as effective as expected and needed better integration. A more integrated strategy for implementation of the overall health plan was therefore agreed.

The State Public Health Service was set up in 2000 under the auspices of the Ministry of Health. Its officials play an important role at the local level. The ten regions or counties, together with the municipalities, are expected to act in accordance with the policy directions given by the parliamentary approved policy. At the county level, the Chief Medical Officer (a managerial position) is supported by the County Public Health Centre. At the municipal level, responsibility falls on the Public Health Bureau together with the Municipal (or Community) Health Council, to which NGOs may appoint representatives. These councils are composed of multi-professional interests, including health professionals, educators and employers. Although they are intersectoral, by tradition they are usually chaired by health professionals.

The municipalities apply for funding of projects from the central level on a competitive basis. At the beginning of this process, much of the funding supposedly designated for public health was in fact used for issues such as building repairs (some of which, such as leaking roofs, were understandably quite urgent). Concerted effort by the National Board of Health and others to raise awareness of the need for health promotion projects is said, in recent years, to have convinced the municipalities to be more oriented towards public health. Except in the large university cities, however, it is not clear whether the municipalities now have the required expertise, though training programmes have been initiated.

From the early 1990s, the Prime Minister appointed an intersectoral committee to deal with issues of cross-sector collaboration. Its effectiveness is diminished by the fact that membership of the committee changes, depending on the party in power, but over the years it has continued to organize discussions on public health issues and to advise the Government.

With regard to the state health programmes, once these have been approved by the Government they are mandatory at both the national and local levels. County/district institutions are responsible for organizing programme implementation within their areas. The funding system is one of the ways of ensuring that this happens.

The Lithuanian Health Information Centre plays a strong role in health information collection and, through the maintenance of established databases, contributes considerably to the task of information development.

The 200-year-old Institute of Hygiene has also partially changed its focus recently in order to inform decision-making in occupational and public health. Its newly established newsletter indicates the broadening of its interests.

2.1.7. Monitoring and evaluation

Provision was made in the 1998 health plan for an intermediate review in 2005. This was carried out in considerable detail and the results presented at a national conference organized by the Parliamentary Committee on Health Affairs, the National Board of Health and the Ministry of Health in November 2005. A number of Ministers, including those for Health, Education, Social Security, the Economy, the Environment, Transport and Communications, all made their reports. On the basis of this work and in collaboration with those ministries, a combined report was then published on implementation of the health programme and the health care reforms *(14)*.

One of the interesting characteristics of the report is that for all the quantified targets, the actual progress made is given together with projections of the progress that should have been made if the targets are to be met on time. Despite the excellent epidemiological data presented, there is less evidence of a qualitative evaluation of the process of policy implementation. Qualitative research is still a relatively new field for many Lithuanian experts.

Lithuania reports regularly to WHO (and more recently to the EU) and participates in certain Nordic monitoring exercises. Collaboration with the other Baltic countries is particularly close. The Baltic ministers of health meet on a regular basis and there are agreements in certain areas for an exchange of expertise and knowledge. A report on the health status in the Baltic countries *(15)* is produced on a regular basis (now every three years) and a healthy competition creates peer pressure for improvements in public health policy formulation and monitoring.

Research policy tends to be driven mainly by the interests of researchers and does not necessarily reflect the needs of public health policy development.

2.2. Health promotion strategy

Lithuania does not have a separate health promotion strategy, health promotion being seen as part of the overall public health policy. Health promotion and health education were included among the state health programmes approved by the Government in 1996. This programme no longer exists, however, and health promotion has apparently come under the general umbrella of the state public health office. There is some concern among public health experts that health promotion is not given sufficient visibility under this large umbrella, and that consequently the Public Health Bureaux, which are gradually to be operated at municipal level, may not receive the necessary technical support from the central level.

The 5th National Health Policy Conference held in November 2006 focused on improving health system performance and taking multisectoral action to tackle NCD. Both the CINDI vision *(16)* and the European strategy *(17)* documents were presented, and the Conference recommended that these documents be translated into Lithuanian, a task that is now under way.

In November 2006, by a joint decision of the Ministry of Health and the National Board of Health, a National Task Force for NCD policy formulation was established. Owing to changes in the top administration of the Ministry of Health and municipal elections in March 2007, submission of the draft policy document was postponed but is expected early in 2008.

2.3. Health system policy

Soon after independence, Lithuania passed a comprehensive Law on the Health System *(6)*. The opening paragraph makes clear reference to the WHO Health for All policy, the Ottawa Charter, the need to tackle the determinants of health and to the provisions of the Lithuanian National Health Concept. It is a widely embracing legal document, giving a decisive impression of a country making a new beginning.

Article 7 of Chapter 2 clearly sets out the principles of equality and social justice, the need for intersectoral action, and for the health system to contribute to the implementation of national objectives and priorities.

The structure of health care and its management at national and local levels is outlined, and the responsibilities of the national and municipal levels defined. PHC is defined for the first time as a separate activity. Public health care is given considerable prominence and is defined (in the English translation) as having a "universal character", stating that it is the duty of all natural and legal persons to take responsibility for public health and health promotion. The control of risk factors such as alcohol, tobacco and drugs, environmental health and safety at work are defined as being the responsibility of the state and the municipalities. The intention to prohibit the advertising of alcohol and tobacco products through further legislation is mentioned.

Prominence is given to the need for public health information and its monitoring and that "Information concern-

ing public health must be available to the public without restriction and it may not be considered a state secret". Long-term planning (10 years) is also provided for (Article 88), including the need to define objectives and to set "the indices of health level to be achieved".

In relation to intersectoral action for health, Article 109 sets out the joint responsibilities of the Ministry of Health and other ministries.

Provision is made for the establishment of a National Health Board with responsibility for coordinating health promotion policy, for alcohol, tobacco and drug control policy; for public health protection and the relevant policy formulation, and for setting up a State Health Commission at government level to coordinate intersectoral action for health. At the municipal level, Community Health Boards are provided for. Article 117 provides for the establishment of a State Tobacco and Alcohol Control Agency.

The 1994 law not only outlines the responsibilities of the state but also those of individuals, stating that residents of Lithuania must take care of under-aged children and of elderly parents, should refrain from violating the health-related rights of others, and should protect the environment from harmful effects. Those who do not will be held legally liable for their actions. The responsibilities of private enterprises and other institutions in relation to health are also outlined.

The training of health personnel for health promotion in PHC has begun but still has some way to go. It still has a low social status and financial benefits are being considered to motive personnel in this direction.

2.4. Policies for specific NCD

Policy documents for individual NCD have not been formulated in Lithuania, the objectives and targets for tackling these diseases being included in the umbrella policy for public health. There are, however, approved government action programmes.

2.4.1. Heart health

More than half of all deaths in Lithuania are caused by CVD, with ischaemic heart disease causing almost 28% of all deaths in 2003. There has, however, been considerable improvement in mortality rates from CVD in those aged 15–74 years, but for older people the rates began to deteriorate in the 1980s and continue to do so.

The broad health policy sets targets to reduce, by 2010, mortality rates from ischaemic heart disease and stroke for those under 65 years of age by 15% and for those aged 65–74 years by 10%. Linked to implementation of the overall strategy, the prevention of CVD is one of the programmes approved by the Government in 1996. As part of this effort, screening for high cardiovascular risk has been initiated in some regions of the country.

As in many countries, influential cardiologists tend to exert strong pressure for improved technology in their field, and there is some concern that investments in diagnostic technologies for cardiologists through the heart health programme has been to the detriment of investment in health promotion and health education. Consequently, critics of the programme feel that the heart health programme has not been as effective as it might have been.

One of the changes brought about by the regaining of independence was the establishment of numerous new NGOs. In1994, the Lithuanian Heart Association was established, and now has seven branches throughout the country. The web site of the Association (www.heart.lt) states that, owing to the level of CVD in Lithuania, heart health is "not only a medical but also a social problem" and the leading cause of incapacity to work. One of the main aims of the Association is to improve doctors' professional skills, and guidelines and protocols for tackling CVD and their main

risk factors have been developed. Seminars for physicians are organized several times a year, including teleconferences in collaboration with the Mayo Clinic in the United States, and the Association's regular periodical brings the latest information to its members. The Association also organizes television programmes and articles in popular newspapers and journals.

The Lithuanian Society of Cardiology was established much earlier in 1964 and works in collaboration with similar societies in Estonia and Latvia. It appears, however, to have a rather smaller membership.

2.4.2. Cancer

Cancer causes every fifth death in Lithuania *(1)* and is relatively high compared with other European countries, particularly in the middle-aged. Among older people, both men and women, cancer death rates (as for CVD) have increased constantly since the 1980s. The broad health plan sets quantified targets to reduce death rates from breast cancer and lung cancer, and to reduce the number of cancer cases with a late diagnosis by 20% by 2010.

Linked to implementation of the overall health strategy, the prevention of cancer was one of the programmes approved by the Government in 1996. National screening programmes for cervical and breast cancer have been initiated, and the government programme for 2006–2008 *(18)* stipulated that these should be free of charge for all women in the 30–65-year age group. There is also to be free screening for prostate cancer for men aged 60 years and over. Key to the success of efforts to get the necessary infrastructure in place for early detection/screening will be the way in which family physicians are introduced into the health system.

2.4.3. National demonstration projects – CINDI

Lithuania's collaboration with the WHO started in the early 1970s with a classical epidemiological study, the Kaunas–Rotterdam Intervention Study (KRIS). In 1981 WHO headquarters and the Regional Office for Europe convened a meeting to discuss the development of a more integrated approach to the prevention and control of NCD This meeting was held in Kaunas, and databases in North Karelia (Finland) and Kaunas were used to demonstrate the commonality of lifestyle-related risk factors to a number of NCD. An outcomes of these discussion was the establishment of WHO's CINDI programme, of which Lithuania became a founding member in 1983 *(19)*.

One of the special contributions that CINDI made to the enhancement of the national information system for health policy development was that national statistics were merged with characteristics of major health determinants derived from population surveys *(20)*. The CINDI system allows for monitoring and evaluation of changes in morbidity and its determinants at national, regional or local levels, and for monitoring the impact or effect of specific health interventions.

Participation in CINDI involves mandatory surveys of health behaviour every second year. Seven national health behaviour surveys were carried out in Lithuania between 1994 and 2006 among the population 20–64 years old. The reports were published in collaboration with the Finnish National Public Health Institute.

The CINDI programme in Lithuania was designed to cover two levels: demonstration areas and national actions. There are now six CINDI demonstration areas in the country, covering 15% of the population. The urban population is represented by Kaunas city and there are five rural areas in the project. Organized health interventions are carried out by teams of researchers and local health staff in the demonstration areas, to act as pilots. At the national level, CINDI acts as a strong advocate for intersectoral action to promote health.

Participation in this and similar international networks seems to have been an effective way of ensuring continuity in the determination to provide a strong evidence base for policy development, and of mobilizing international experience to continue the pressure at home for health promotion. Lithuania has not simply followed CINDI recommendations in developing a strong evidence base for policy development, but has been one of the most active countries involved in the continued improvement of the methodology for this evidence-based approach internationally.

2.5. Policies related to risk factors

Lithuania did not develop individual policies related to the main risk factors included in the umbrella policies for health. Strategies for tackling risks for NCD can be discerned from the relevant legislation and the mandatory state programmes approved by the Government and published.

2.5.1. Tobacco

In the WHO European Region, three consecutive regional plans for tobacco control were adopted between 1987 and 2002. The WHO FCTC, the first ever global public health treaty *(21)*, was adopted in May 2003. The FCTC was ratified by the Lithuanian Parliament in 2004, among 40 global treaties that needed its ratification. The National Programme for Tobacco Control was revised accordingly.

Lithuania increased the price of tobacco products by almost 8%, achieving an increase above inflation higher than the European average. According to the 2007 *European tobacco control report (22)*, this did not reduce domestic affordability. Lithuania has also negotiated a transition period until the end of 2009 to comply with the EU's 2002 regime for cigarette taxation. The distance that Lithuania has still to go to converge with European tax levels may be seen by comparison with the United Kingdom, where in terms of PPP the tax burden is €230 per 1000 cigarettes compared to less than €25 in Lithuania *(22)*.

The basic law on tobacco control, adopted in 1995, was amended in June 2006. The main principles are to protect people's right to a smoke-free environment; to reduce the accessibility of tobacco products, particularly for minors; to prohibit the use of public funds for growing, manufacturing or selling tobacco; to ensure the use of a portion of tobacco tax for health promotion; to ban the advertising and promotion of tobacco; to raise public awareness and assist smoking cessation; and to promote non-smoking and aim for tobacco free working, leisure and living environments.

Parliament has been active in promoting protection from passive smoking. From January 2007, smoking has been banned in all public places, including bars, discotheques, clubs and restaurants. No separate smoking rooms are permitted. Smoking is also forbidden at the workplace and in educational and sports institutions. Municipal councils have the right to prohibit smoking in public places such as squares and parks. A survey of public opinion indicated that 74.4% of the population are categorically against being exposed to passive smoking in public places where food and drink are served. Those responsible for ensuring that the law is not violated are clearly defined, as are fines imposed for non-compliance.

Tobacco has been excluded from the household basket for calculating the minimum standard of living.

Information on the dangers of smoking is given in schools. Although there is postgraduate training for doctors in tobacco control and smoking cessation, as yet there is only an introductory course available for medical students and nurses.

2.5.2. Alcohol

Alcohol control is one of the 13 programmes approved by the Government in 1996.

Far-reaching amendments were made to the law on alcohol control in 1995. The basic provisions of the law included

closer state control of the production, sale and importing of alcohol, including a reduction in alcohol content; and restrictions on where alcohol is sold (i.e. not in health care, educational, military or police establishments, sports stadiums (except beer) or shopping malls, or close to petrol filling stations). Manufacturing and importing quotas were linked to certain health indicators, with restrictions being imposed if such indicators pass a certain limit. The law introduced a restriction on the age at which alcohol can be bought (18 years and over) and a total ban on advertising alcohol products, compliance with this provision to be the responsibility of the State Tobacco and Alcohol Control Agency (STACA), the Ministry of Justice and local authorities. Related health education was to be developed by both the Ministry of Health and the Ministry of Education and Science, and Lithuanian radio and television were to devote at least twice a week no less than five minutes to this issue. Alcohol was to be excluded from the "consumer basket" when establishing minimum living standards, there were to be closer checks on drink–driving, and there was to be care for alcoholics and greater support for relevant NGOs.

The legislation was further amended in March 2004, the rationale for this being the urgent need to reduce consumption of alcohol, the damage to both health and the economy, and the need to harmonize legislation with that of the EU.

In the 2004 revisions to the law, considerable restrictions were imposed on advertising alcoholic beverages, which should not link alcohol to famous people or supposed benefits such as social success, sexual energy, etc. Municipal councils have the right to restrict or prohibit the sale of alcoholic beverages on official holidays and at mass events. Article 19 of the 2004 Law clearly links to national policy by stating that "Long-term indicators of the reduction in general consumption of alcohol must be established in the programme of the Government", and Article 20 refers to the need for further research into alcohol consumption and the damage it causes.

In order to implement the law, STACA was established under the supervision of the National Health Care Board. An intersectoral committee is to evaluate annually the way in which STACA carries out its assigned tasks. The National Board of Health is to report annually on progress to Parliament.

Institutions and enterprises violating the law are to be fined; 50% of the funds from such fines are to be transferred to the State Health Care Fund and 25% to the health funds of the municipalities in which the violations took place, part of which is to be spent on health promotion in schools. The Ministry of Education and Culture and the Ministry of Health are to introduce relevant health promotion lessons in the educational institutions under their control. Financial incentives are to be given to those helping to disclose violations of the law.

Despite these strong measures, there is some concern among public health experts that, in contrast to tobacco control, the public health messages in relation to alcohol are less clear. There is also an active and strong lobby from alcohol producers. Monitoring and evaluation of the programme will therefore be particularly important.

2.5.3. Nutrition (23)

From 1994 onwards, seven health behaviour surveys were carried out, initiated by the international FINBALT Health Monitor project *(24)* and becoming part of the CINDI Health Monitor from 2000. The results showed that, although positive trends were observed in 1994–2002, differences in nutrition habits according to level of education remained significant. People with a university education had a healthier diet than those with incomplete secondary education, and the diet of women was healthier than that of men. It was suggested, therefore, that programmes aimed

at reducing inequalities in health should pay more attention to less educated people. Given that one of the authors of the referenced article was President of the National Board of Health, it is probable that this advice was accepted.

The CINDI team was closely involved in drafting the National Food and Nutrition Strategy for 2003–2010, adopted by the Government in 2004, and the Action Plan for its implementation. These are far-reaching and broadly intersectoral, dealing not only with the production, marketing and consumption of food but also with sports and other physical activity. The specific objectives and measures proposed include:

- guaranteeing food safety and quality improvement;
- developing sustainable agriculture to ensure the ecological and sustainable production of food;
- enabling consumers to choose safe and nutritious foods through better labelling, and the regulation of advertising and marketing;
- promoting scientific research in the area of food safety and nutrition;
- focusing on the nutrition of pregnant women, breast-feeding mothers, infants, children and adolescents, the elderly, hospital patients and people in institutional care;
- organizing a better supply of food for all population groups;
- reducing the prevalence of NCD related to nutrition;
- reducing the prevalence of obesity (inter alia through implementation of a national obesity control programme and legislation concerning physical activity and sports);
- eliminating iodine deficiency disorders;
- improving the education and training of professionals;
- developing an information and educational system for the population; and
- developing systems for monitoring food safety and the nutritional status of the population.

National legislation specifies a minimum of three hours per week of physical education in schools and the Lithuanian sports sector, in collaboration with other ministries and NGOs, is trying to increase physical activity, particularly during the school summer holidays.

2.6. Settings

The settings approach is used to a considerable extent, and is strengthened by involvement in international networks such as Health Promoting Schools, Healthy Cities, Regions for Health and Health Promoting Hospitals. The national health programmes approved by the Government in 1996 provide for the implementation of healthy lifestyles in schools and kindergartens.

2.6.1. Healthy Cities

Lithuania is an active member of the WHO Healthy Cities project. Kaunas, one of the largest cities in Lithuania with 400 000 inhabitants, joined the project in 1993. This was mainly due to the efforts of the Lithuanian CINDI team, which also ensured that an evidence-based approach was taken. An intersectoral and multidisciplinary steering committee has been responsible for the development of a city-level public health strategy and action plan. Based on this experience, since 1998 a national network of healthy cities has developed.

2.6.2. The workplace

The Centre of Occupational Medicine maintains a National Register of Occupational Diseases (since 1994), carries out research into occupational risks, and develops norms and regulations for health and safety at work. The National Health Concept of 1991 states that employers must be responsible for organizing healthy working conditions, linking this to their responsibility for contributing to health insurance.

So far, only selected workplaces seem to have taken up this challenge. Their focus appears to be on the avoidance

of industrial diseases and accidents rather than on utilizing the workplace as a setting for health promotion and the prevention of NCD.

2.6.3. Schools

In 1994, Lithuania joined the long-standing (from 1983/1984) WHO project for surveying the health behaviour of schoolchildren, and since then has carried out the survey every four years. The results of the 2002 survey gave cause for concern, as eating habits were unsatisfactory, physical activity was inadequate and smoking was increasing. Lithuania has also been an active member of ENHPS since 1993, when there were 10 schools in the national network. By 2007, there were 180 certified schools in the network: primary and secondary schools and gymnasiums plus an additional 205 kindergartens. There are also five local networks, at municipal level, of schools working towards the Health Promoting Schools concept. These local networks cover 20–100% of the schools in their area and are associate members of the national network.

At the beginning of the project in Lithuania, the focus was mainly on basic hygiene issues, such as achieving a clean learning environment and topics related to personal hygiene. Since then, the scope has broadened to encompass lifestyle issues, with a focus on physical activity in recent years. Information is easily available and, in the Lithuanian tradition, strong efforts are made to monitor and evaluate activities.

Public health specialists and community nurses are being trained to work in schools.

2.6.4. Hospitals

Although there is no legislative basis for the implementation of a health promotion strategy in hospitals, a network of health promoting hospitals was established in 1996. There are now ten hospitals in the network, coordinated by Kaunas Medical University Hospital, which is also a WHO collaborating centre for CVD and other NCD. The network collaborates with other settings networks, with CINDI and with NGOs dealing with heart disease, hypertension and diabetes. The main aim of the network, which is funded by the Ministry of Health and fees from member hospitals, is to incorporate the concepts, values and standards of health promotion into the organizational structure and culture of the hospital. For example, in 2002, a focus of the network was to create smoke-free hospitals, for which a guide and training were provided. Five of the hospitals in the network are already implementing this programme.

2.7. Policies for specific population groups – older people

The period of socioeconomic transition was considered to be "especially painful for the elderly".[16] Although there is no separate policy document related to the health of older people, in recent years special attention seems to have been paid to certain of their needs. For example, the law regarding compulsory health insurance provides for insurance contributions for pensioners to be paid by the state. There is also a national strategy on ageing, covering the fields of family welfare, public health and migration.

Also, from 1998, when a three-year social services infrastructure development programme (SSID) was initiated, priority was given to funding projects at the local level that aimed to provide services for people in their homes and communities *(25)*. Some 37% of the SSID projects were aimed at older people. When SSID was renewed for 2004–2006, the community focus was further strengthened and more attention paid to rural areas where services were practically nonexistent.

Older people appear to have been particularly active in establishing NGOs to deal with their concerns. In 2001, Gabija, a nationwide network of NGOs working with and

[16] Statement by the Minister of Social Security and Labour at the 2nd World Assembly on Ageing, Madrid, 11 April 2002.

for elderly people, was established. At its outset, 17 NGOs and 2 individuals were members, and the network connected immediately to related EU and United Nations activities and to the section of HelpAge International dealing with central and eastern Europe.

Given the worsening mortality rates for CVD and cancer in the over-65 age group, it remains to be seen whether the integrated strategy for NCD (expected by early 2008) will specifically address the needs of older people.

2.8. Broad intersectoral policies with a health component

Lithuania had already developed a strategy for poverty reduction before joining the EU. On signing the memorandum of agreement with the European Commission in 2002, however, Lithuania also joined the Community Process for the Reduction of Poverty and Social Exclusion. In this framework, the *National Action Plan against Poverty and Social Exclusion in 2004–2006* (aNAP) *(26)* was developed.

The Plan includes a health component, but this relates mainly to communicable diseases and access to care. Brief mention is made of promoting healthy lifestyles.

3. Infrastructure and resources for policies to tackle NCD

3.1. Infrastructure

There is a Department for Public Health within the Ministry of Health, currently composed of about 10 people and headed by a Secretary for Health. One indication of the increasing intersectoral interest in tackling health issues is that the members of this group report being invited to take part in many more intersectoral meetings than they have the capacity to attend. Consequently, their capacity is to be increased to about 30 staff.

As seen above, a National Health Board and Lithuanian Health Information Centre have been established. On the whole, they are considered to operate on a well-established and regular basis, although there appears to be a minority dissenting view concerning the real influence of the National Health Board, which acts in an advisory capacity.

EU-funded projects have had an important effect on national actors and efforts. For example, a project to develop effective policy and practices to improve the mental health of children and teenagers following EU enlargement is being funded by the EU structural funds. Projects related to the reduction of inequalities in health have been particularly affected. A five-year project to empower communities to cope with mental health problems is being funded by the Open Society Fund in one of the CINDI demonstration areas.

3.2. Human resources

Despite its small size, Lithuania plays an active role on the international public health scene and national experts are fully aware of policy developments in other countries. Consequently, many Lithuanian experts have developed strong international networks on which they can call for an exchange of knowledge and experience. Links with countries round the Baltic Sea are particularly important.

There appears to be a sense of national pride in the best sense of the term, meaning that highly skilled people have devoted their time and talents at both national and local levels to improving the national situation. The voluntary contribution of these experts has been crucial to the success achieved in NCD policy development in Lithuania so far. National policy and planning systems cannot, however, rely endlessly on the goodwill and enthusiasm of their national experts, and academicians must balance teaching and research responsibilities with participation in policy development processes. Ways will need to be found to

ensure that in the long term such efforts are recognized and encouraged, both financially and in terms of time spent.

The gradual policy shift towards focusing on health promotion and the determinants of health has been reflected in considerable shifts in the training of health professionals. Courses have been organized to support family doctors in particular in advising on smoking cessation, diet, etc. As mentioned above, guidelines and protocols are readily available in relation to tackling NCD and their risk factors. Early in the process (1994), a Public Health Faculty was established within the Medical University at Kaunas. Work began in 2003 on a National Strategy on the Development of the Public Health Workforce and this, following revisions to the Public Health Law, was finally approved by the Ministry of Health in November 2007. While the previously recognized specialties mainly focused on issues of hygiene, among others, new specialties include public health and public health management, "health educology", epidemiology and health statistics, social work in health care, kinesiology, oral hygiene and the health of children, health law and health economics. Educational institutions have been charged with working together to develop detailed training programmes to meet the new needs of public health.

At both the national and local levels, experts and key officials in the public sector also give their time and efforts to a rapidly growing number of NGOs. The Lithuanian Public Health Association, for example, established in December 2000, aims mainly to support the improvement of policy and legislation to promote public health, participating in the evaluation of related activities and offering support at national and local levels.

3.3. Information and research

There is a strong ongoing tradition of public health research led by the academic community. Lithuania's involvement in WHO-related projects and the ensuing influence of local experts involved in those projects has been decisive in the development of a strong research and information base for NCD policy, and in the training of local experts *(27)*. As seen above, in the early 1970s, WHO was testing the possibility of multifactorial prevention of CHD. Rotterdam was selected as a western European test case and Kaunas as an example of a state-run health care system, and the KRIS project was initiated. At this time, epidemiological research in CVD in Lithuania was limited to small-scale projects, frequently involving various occupational groups. Furthermore, there were no strict standards either for the data collected or for the investigators.

With the initiation of the KRIS project, elements were introduced in epidemiological research, such as sociology, psychology, modern biostatistics and health information management. An increasing number of young health professionals underwent public health training on international courses.

Practical applications of the research data collected through KRIS and other NCD epidemiological projects were planned so that national mortality predictions could be computed from this and similar data. Kaunas University of Medicine continued the systematic collection of such data through the WHO-coordinated CINDI programme and MONICA Project.

The regular surveillance system for chronic diseases and their risk factors, initiated in 1990, includes information on NCD mortality (and to some extent morbidity), lifestyle issues such as smoking, alcohol use, diet and physical activity, and such risk factors as blood pressure, raised blood glucose, hypertension and obesity. National data on lifestyle factors are collected on a biannual basis, biological risk factors every five years and mortality data annually. The results are available on the Internet (www.lsic.lt) and in published annual reports. This information forms the permanent evidence base for policy-making to tackle NCD. In recent

years, there have been strenuous attempts to better reflect socioeconomic inequalities in this database.

With the establishment of the Lithuanian Health Information Centre (LSIC), the evidence base for policy development goes a step further. LSIC gathers and processes information on health status, the activity and resources of health care institutions and human resources, publishing this in a statistical yearbook.

What is perhaps more important is that LSIC currently provides about 1400 indicators, collected from the statistical service, various ministries, and educational and scientific institutions, relating to demography, mortality and morbidity, health behaviour, health care facilities, environmental health and health care financing. The system is designed to display statistical data in a user-friendly way to identify areas where interventions may be needed. The system can help find a problem, possible reasons of the problem or possible ways of solving the problem. In this way, the information base is opened up to researchers and local authorities and for the training of students.

The area of qualitative research is still new in Lithuania, and given the long and successful epidemiological tradition will need strong proponents if the potential in this field is to be realized and utilized for NCD policy development. The CINDI policy surveys offer one approach in this direction.

3.4. Communication and public information/involvement

The strong involvement of Parliament mentioned above has been one of the ways in which NCD policy issues are brought to the attention of the public, since parliamentary discussions on health are broadcast by national radio and broadly reported. There is also a tradition of organizing consensus-building conferences to discuss health challenges.

Laws dealing with the control of certain health risks specify that national radio and television designate a certain amount of time to health education.

According to the Open Society Fund, workers in the ministries and regional and local administrations in Lithuania are still reluctant to communicate with society by e-mail. Considerable attempts have been made to improve information on public health web sites, and some of these allow for interaction with the public.

As far as can be judged from their English translations, policy documents appear to be written in a reasonably accessible style but, as in many countries, these probably aim at the educated middle class. There do not appear to have been serious efforts as yet to provide popularized versions. The lack of financial resources for this might be a partial explanation.

4. Forces facilitating or obstructing disease prevention and health promotion

Lithuania was particularly motivated to prepare for change in the health field, in the framework of general changes in the political situation and the gaining of independence.

During the Soviet period, Lithuanian experts were closely involved in international health promotion developments relating to NCD, including the main WHO and other international networks. Throughout the transition period, a small number of highly respected leaders in public health played (and continue to play) an enormously influential role in guiding policy developments within the country and in making Lithuania's presence felt at the international level.

The medical profession, or at least its leaders acting through the Medical Association, have not been an obstacle to health promotion. On the contrary, they were quick to take on board the concept of tackling the determinants of health

in order to deal with inequalities. It is not clear how far this reaches down to health professionals working on the front line, and there are indications that not all specialists have yet accepted the health promotion concept. The role of specialists is still dominant. PHC is only now being established and family physicians, who will be crucial to the development of health promotion, are difficult to retain despite a 20–25% increase in salary in recent years. Many young doctors have left or are thinking of leaving the country.

The tradition of Parliament discussing twice a year existing and emerging health challenges, and possible ways of dealing with them, is an important and possibly unique characteristic of the Lithuanian situation. Owing to the degree of party political consensus created, the general direction of health policy development appears to be sustainable. The very short average term of office for health ministers (18 months is considered to be a long term) undoubtedly acts as an obstacle to smooth and continuous progress.

Involvement in knowledge-based networks such as CINDI has been particularly influential in developing a culture for basing policy development on sound epidemiological evidence, and has promoted the systematic surveillance of NCD and their risk factors.

Monitoring and evaluation of progress in policy development is transparent, and emphasis is given to reporting back to Parliament and through regular health conferences. Regular public health reports have kept the public health issues, including NCD, high on the political agenda. This creates a "virtuous circle", whereby public health expertise provides policy-relevant information and, as new challenges emerge or are uncovered, these respected sources are called on to provide further evidence and suggest possible solutions.

The setting of clear objectives and quantified targets has encouraged adherence to strict epidemiological monitoring and evaluation. Such quantified targets also seem to be conducive to achieving a degree of greater responsibility and accountability for health in non-health sectors. Health targets are linked, for example, to overall government development targets. In what is perhaps an unusual step, in the case of alcohol control, changes in specified health indicators are linked to the imposition of restrictions on manufacturing and import quotas for alcohol.

There has been considerable investment in sharing international experience, including regular hosting of international meetings on public health issues, involving international organizations and experts in analysing policy issues, and close collaboration with Baltic and Nordic neighbours.

As an offshoot of this activity, young public health experts have been trained and motivated, and there is a growing body of experts with international experience and links to international know-how. However, like their colleagues from other countries that have recently joined the EU, Lithuanian experts participating in some EU projects are paid according to Lithuanian standards, whereas their counterparts may be receiving much higher salaries. Their enthusiasm is maintained by interest in participating in such wider international efforts, but in the long run such differences could be disheartening.

NGOs have blossomed and their opinion is sought through formal policy-making and planning channels. However, there is some concern that even when represented on such bodies, their voices are not given enough consideration. To counteract this, NGOs are forming coalitions to create umbrella organizations and gain greater visibility. One of the most successful has been the Lithuanian National Tobacco and Alcohol Control Coalition.

There has been some shift towards a more multidisciplinary approach to NCD policy development, but there is still a strong medical focus. On the whole, the population is well educated, as are those engaged in public administration.

Vestiges of the old system still remain, however, perhaps obstructing a more free and open debate outside the circle of public health professionals regarding policy options.

The economy has improved, indicating that financial issues may be less of a constraint to health promotion in the future. A certain backlog remains, however, including the poor payment of health professionals and the need to maintain and update health facilities. The pull of attractive employment conditions elsewhere creates the threat of a brain drain from the health sector.

5. Lessons from the Lithuanian experience

In the less than two decades since independence, Lithuania has created a rich and steadily increasing experience and knowledge in developing policies to tackle NCD. Broad Health-for-All-type policies were developed in the early 1990s, supported by issue-specific government programmes. This combination of a broad umbrella policy and vertical action programmes did not bring the hoped-for coordinated action for tackling NCD. Consequently, early in 2008, an NCD policy was to be brought before Parliament.

5.1. The policy environment

Although independence in 1990 created an environment of starting afresh, the radical shift in policy thinking presented by the National Health Concept did not come about overnight or because of the new political freedom. It grew from roots put down and carefully nurtured many years previously.

A culture of effective participation in international activities is still evident, as Lithuania has been quick to join related EU networks. As a result, both experts and bureaucrats quickly become aware of new innovations, developments and emerging concerns.

Twenty years ago, Lithuania faced a difficult economic situation and an almost overwhelming need to reinvent administrative, regulatory and legislative frameworks. In this small country, without huge financial or human resources, the driving force appears to have been a determination to pull together to succeed, and the availability of individuals in all sectors willing to commit themselves to improving the situation.

There was cross-party confidence in national public health experts and the exceptional role of Parliament created a degree of cross-party consensus, ensuring sustainability in the general direction of health policy.

During the concurrent reorganization of health services towards PHC, the transition from the old system was restrained to a relatively slow pace, thus retaining a degree of consistency and avoidance of chaotic change. This allowed space for discussion of issues other than the provision of health care, but the adequate development of PHC remains a serious concern.

Despite the odds, a legal basis facilitating measures to control NCD has been gradually created and the economy has improved, indicating that financial issues may be less of a constraint to health promotion in the future.

5.2. Indications of the value system underlying policy development

The National Health Concept was clearly based on the visions and values of the WHO Health for All policy. These values have been broadly accepted and are constantly reiterated. The innovative report on inequalities in health discussed in Parliament ensured that national legislators and the public were made aware of the situation.

5.3. From awareness building to policy action

Through participation in WHO projects such as CINDI, not only were NCD monitored but the results had the

added weight of being part of an internationally recognized problem.

A small number of highly respected leaders in public health, some fulfilling multiple roles, have played an enormously influential part in guiding policy developments within the country and in making Lithuania's presence felt at the international level. The role of these key movers in this relatively small country has been decisive.

The National Board of Health retains considerable independence from the Ministry of Health and, given its regular meetings, would appear to be extremely active. The strongly expert-led policy process facilitates rather efficient policy-making but leaves much to be desired regarding the inclusion of a wider opinion base.

A valuable and accessible information base has already been created, and strong efforts are made to reflect socioeconomic inequalities in health. More specifically:

- regular surveys of health behaviour and health status have become standard practice, allowing the monitoring of long-term trends; and
- public health reports are published regularly, submitted to Parliament and discussed openly.

Parliament has played an unusually strong role in the area of public health, including the tackling of NCD. The degree of party political consensus on health issues and confidence in national experts means that Parliament is proactive in calling on its national experts to examine emerging health challenges and propose solutions. This allows for considerable conservation of energy and effort. Rather than reinventing the wheel with every change of government, policy-makers and planners have built on much of the scientific work previously carried out.

The involvement of ministers from other sectors in the health debate has been ongoing, enhancing understanding of the need for intersectoral action. It is not clear how far this translates into specific action, or if awareness of the need for cross sector collaboration trickles down within the ministries or to the agencies for which they are responsible.

Although the settings approach seems to have been used quite widely in schools and to some extent at the city level, relatively little focus seems to have been given to the workplace. Given the potential of the workplace as a setting for tackling NCD, and coupled with the fact that Lithuania is undergoing rapid economic growth, developing the concept of "socially responsible corporations" might offer considerable benefits.

The medical and nursing professions have continued to provide basic care under difficult conditions. Attempts are being made to enhance their capacity for health promotion. However, if top priority is not given to strengthening PHC, it is difficult to see how the NCD policy can be effectively implemented.

The setting of clear objectives and quantified targets related to NCD has focused the policy discussion and encouraged adherence to strict epidemiological monitoring and evaluation. More attention will need to be given to evaluating the process of NCD policy development in terms of whether or not the necessary human and financial resources were in place, whether the various partners had a clear understanding of their expected roles, and what has worked or not worked and why.

Regular health policy conferences broaden the debate, as do the mass media. More could be done to popularize information on NCD prevention and health promotion and involve the public in defining the challenges and considering the policy options.

5.4. Sustaining policy implementation, monitoring and revision

The means for monitoring and evaluating epidemiological trends are considered from the initial stages of policy-making. Less attention has been given to a more qualitative analysis, including the process of policy development, or the effectiveness of specific interventions. Interestingly, the monitoring and evaluation process is said to have caused some disillusionment, as it has become clear that certain parts of the health programme are not being implemented as planned.

The sound evidence base already achieved, the provisions for ongoing and regular surveillance of health status and behaviour, and the transparent processes in place for reporting back and making information accessible should ensure that NCD remain on the policy agenda in Lithuania, with or without the present key movers. Lithuania is in the fortunate position, therefore, of being able to further fine-tune the knowledge base for NCD policy development, including for example:

- a sharper focus on possible inequalities, including gender differences and the particular issues facing the rural population in relation to access to health promotion and NCD services;
- further development of the methodology for HIA and the creation of a legal or regulatory framework for its implementation;
- evaluation of the effectiveness of interventions to tackle NCD;
- assessment of the accessibility of information at local level and for lay people;
- methods for improved participation in policy development; and
- evaluation of the operation of structures for intersectoral action.

Numerous NGOs are being created and are attempting to strengthen their impact on NCD policy through joint action. An evaluation of the channels of communication open to NGOs and their capacities for effective action could perhaps strengthen the voice of civil society. Given the high level of education of the population, the use of modern communications technology holds considerable potential.

For NCD policy development to become a reality, three policy streams need to converge: awareness of the problem; a facilitating policy environment; and the means for policy development. In the case of Lithuania, all three are strongly evident.

In summary, five main factors seem to have dominated the process:

- political changes creating a facilitating environment;
- the decisive and persistent role of key experts and politicians;
- the unique role of Parliament and the degree of cross-party collaboration;
- long and continued participation in international networks, particularly the CINDI project, and the support when needed of WHO and other international organizations; and
- the availability of a sound evidence base at the beginning of the process and its continued improvement, with regular surveys, formal public health reports and a transparent monitoring process linked to quantified targets.

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Chapter 5

Reflections on experiences

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Introduction

This chapter reflects mainly on the material presented in the eight case studies, drawing out the main lessons to be learnt from across all of them. Taking into account the target audience, however, benchmark examples from other countries are brought in where appropriate to further inform the discussion. In this way, it is hoped to highlight issues of interest to policy-makers as they reflect on their own experience and situation.

In keeping with the structure of the case studies, this chapter refers first to aspects of the policy environment that shape NCD policy development. The types of policy developed in the eight countries are then discussed. This is followed by an analysis of country experiences through the steps of the policy cycle used as a framework for this study (see Fig. 1 in Chapter 3): awareness building, policy formulation, implementation, monitoring and evaluation, and revision. The chapter ends with general conclusions.

At each stage of policy development, consideration is given to: the processes, structures and institutions utilized; the information, expertise and skills available; and the people involved. Thus a topic may be highlighted under a number of headings (for example, information cuts across all stages of the policy cycle, with basic epidemiological data being used to raise awareness, inform policy formulation and monitor progress).

The policy environment

It is clear from the case studies that policy-makers in Europe are faced with an increasingly complex and unpredictable situation. On a broader level, the influence of globalization, EU enlargement and the shifting balance of international, national and local decision-making roles have significantly changed the policy environment. The health sector and NCD policy development are affected, for better or for worse, by the political, social, cultural and economic situation at any given time. The following brief examples from the case study countries indicate the importance of taking the overall policy environment into account when developing NCD policies.

The level of NCD policy development in Albania is closely related to the country's overall development. Following half a century of isolation and a difficult decade of transformation, and despite considerable progress, Albania is still one of the poorest countries in Europe. The main dilemma is how to shift from crisis management to planning for development aimed at social inclusion and poverty reduction. International organizations play an outstanding and sometimes dominating role in stimulating political processes. The stabilization and economic growth in recent years and the prospect of EU accession may offer new opportunities for NCD policy development.

Following the Second World War, Finland moved rapidly from a rather poor agricultural society to a wealthy industrialized country. Challenges were defined and tackled in a coherent way, helping to create a culture of planning

through consensus building. This was facilitated by the small population of the country and easy relationships between people in power, and strengthened by public confidence in experts and bureaucrats. The commonly agreed values of the Nordic welfare model provided a clear framework for policy-making. Active participation in strategically selected international networks opened up opportunities for sharing experiences.

France is one of the largest and most developed countries in the EU, where present institutions are significantly influenced by deep historical roots. The overall characteristics of French public administration are clearly reflected in the structures and processes of NCD policy development based on the balance, within defined boundaries, of interrelationships between multiple stakeholders. The relatively limited influence of international factors in French health policy development reflects the historical and cultural traditions of the country.

Greece also went through rapid economic development and political trauma in the second half of the twentieth century. Social development, including modernization of public administration, development of the education system and a culture of negotiation and collaboration, does not appear to have kept pace with economic growth. Apart from areas such as nutrition, international links are not strong but the EU environment is gradually changing the policy-making scene.

Health policy development in Hungary is influenced by the transition to a market economy and democracy. The historical changes and the EU accession process were controversial, creating a sharp political divide and increasing inequities. Slow economic growth, the alarming budget deficit and high external debt limit the Government's freedom of action and impose restrictive measures in the public services, including public health. The country is going through a radical health care reform, creating passionate debate and marginalizing other strategic health issues. Simultaneously, the EU integration process, including the use of structural funds, offers a window of opportunity for linking NCD policy and development.

Ireland has totally redefined itself within a few years, from being a small, relatively poor agricultural country to becoming one of Europe's fastest growing and globalized economies. This was facilitated by social agreements between the state and trade unions, again creating a level of consensus building. Efforts to reduce poverty and social exclusion offer intervention points for health promotion.

Opportunities for NCD policy development in the newly independent Kyrgyzstan are closely linked to the economic and political processes of transition. In the context of striking poverty and underdevelopment, in a complicated geopolitical situation, innovative approaches and strategic thinking are of outstanding importance. In these conditions, the international community has a special responsibility to support key developmental issues in the country.

In Lithuania, independence provided an opportunity for totally rethinking health policy, based on a strong consensus around WHO Health for All values. Strong international links were already in place and were put to good effect. In recent years, solid economic growth and healthy public finances have created a positive climate and enabled structural reforms.

Types of policy – patterns of policy development

As reflected in *Gaining health (1)*, WHO's European NCD Strategy, there is broad discussion throughout Europe on tackling NCD. Key questions include the appropriateness of tackling individual lifestyle factors separately or whether changes in different aspects of behaviour are so interlinked that they can only be effectively tackled together; and

whether lifestyles can be affected in a sustainable way without explicitly tackling their underlying determinants. As the present case studies and relevant WHO reviews indicate:

- there is no clear historical pattern of policy development for tackling NCD in Europe, although certain countries indicate partially similar trends;
- among the eight countries studied, there does not appear to be a common pattern or package of policies (though this relates partly to the manner in which these countries were selected and their small number); and
- no country has developed a specifically designated "NCD policy" (although Ireland has recently formulated a framework for the management of chronic disease and Lithuania is preparing a similar policy).

Over a period of 2–3 decades in Finland and Lithuania, and partly in Hungary and Ireland, an initial focus on CVD prevention was followed by a broadening of the policy framework. This introduced the concept of tackling inequalities in health and their social and economic determinants through umbrella policies, influenced largely by the WHO Health for All policy. These Health-or-All-type policies have been continually revised in these countries and issue-specific policies have been developed simultaneously. More recently, and partly influenced by the EU, there has been a stronger focus on including health components in more general development or social inclusion plans.

Even these four countries, however, have different "packages" of policies in place. From the start, Ireland developed separate health promotion policies to complement the broad umbrella policies, and is presently making a third revision of the health promotion policy. There are medium-term policies for individual NCD and their risk factors, a long-term policy for cancer (to 2015) and recently a policy for the management of chronic disease. Parallel to its long-term umbrella policy, Finland has medium-term (4–6-year) plans and strategies for heart health, alcohol control and nutrition, for example, and is currently preparing a health promotion policy. Lithuania has a strategy and action plan for nutrition up to 2010 and is developing separate policies for equity in health and for NCD, but uses "programmes" to tackle the specific NCD and their risks covered in the umbrella policy. In Hungary, after experience with CVD prevention, four different Health-for-All-type public health policy frameworks have been elaborated by successive governments over the last two decades. Topic-based and largely autonomous policies were later developed, referring to the umbrella document and influenced by international developments in, for example, tobacco and nutrition.

France offers a special case, whereby a legal instrument serves as the umbrella framework but the driving force behind implementation is based on the various topic-based policies. Greece has a strategic plan for cancer and a policy for mental health and is now embarking on a broad public health policy. Kyrgyzstan starts with the broadest framework policy document, *Manas Taalimi,* offering a strategy for all the priority areas of health policy and health care development. In Albania, the umbrella document at the moment lacks real political commitment and NCD policy development is incremental and opportunistic in different programme areas. A national cancer control programme was developed by the Ministry of Health during 2006/2007 but an action plan for implementation is still awaited

It is apparent, therefore, that one size does not fit all and that, in this small group, there are almost as many "patterns" or "packages" as there are countries. Some common traits may be discerned, however.

- All eight countries ratified the WHO FCTC between October 2004 (France) and May 2006 (Kyrgyzstan) and at least seven of them had a clear tobacco control policy and/or legislation in place by the time of the study.

- Six (all but Greece and Kyrgyzstan) have additional risk factor strategies or action plans for alcohol control and/or nutrition, in some cases dating back to 1996 (Ireland).
- Seven (all but Kyrgyzstan) have disease-specific programmes for cancer and/or CVD prevention (heart health and/or stroke).
- Two countries (Ireland and Lithuania) were developing specific NCD or chronic disease frameworks at the time of the study.

The countries where umbrella-type policies have been implemented and sustained over a long period of time are those in which three factors converge:

- a sound evidence/knowledge base
- a strong core of public health/health promotion experts
- a working level of consensus building.

Such umbrella policies entail a shift from the traditional health care/medical model to a focus on intersectoral action. Particularly in Finland and Lithuania, and to some extent in Ireland, active and continued involvement in international programmes and policy development has also played a significant role in strengthening the credibility of such national efforts, engaging local experts and improving the quality of information for policy-making.

The coordination or harmonization of issue-specific policies, either with each other or with an umbrella policy, is not entirely clear in any of the countries where such a combination of policies exists. Some concern was also expressed by experts in the field that issue-specific policies might lose the dynamism created by their proponents if they were "mushed" together.

Awareness building

Moving an issue onto or higher up the policy agenda involves a number of processes relating to problem recognition and representation, the prevailing policy environment, and key actors involved in the policy process. An opportunity may be created when a number of these issues converge.

Problem recognition

In the study countries, epidemiological data on NCD mortality and the comparison of such data within and between countries have been among the main pathways for NCD reaching the policy agenda.

For example,

- North Karelia had much higher rates of mortality from CVD than the rest of Finland.
- Ireland saw itself as lagging behind other EU countries.
- The report on inequalities in health in Lithuania caused local regions to question why they diverged from their neighbours.
- Very unfavourable trends in life expectancy and NCD mortality among the middle-aged were decisive in mobilizing Hungarian politicians to take policy action.

Conversely, comparatively good mortality rates in France and until recently in Greece may have led to a degree of complacency.

The issue is not only that of securing reliable information but of presenting it in such a way as to be meaningful to policy-makers. Analysis of mortality and morbidity data and discussion of their possible causes and implications for the economy and quality of life can be important in influencing the policy process. In some countries in Europe, public health reports are still presented in the traditional form of lengthy statistical tables and cover only a limited number of topics. In others, such as the study countries Finland, France and Lithuania, but also in other countries such as Denmark and the United Kingdom, for example, the form and content of public health reports has changed quite radically

over the years. In these countries, regular public health reporting appears to play a key role in initiating NCD policies and in keeping NCD on the policy agenda. In Lithuania, for example, the regular reports include both a basic section, updated each time, and a focus on specific issues of topical interest. In Finland, the public health report now includes reports from all ministries (except External Affairs) on what they have done to promote heath. In Hungary, the 2004 Public Health Report presented the epidemiological situation, lifestyle patterns, geographical and social inequities in health, and activities in the implementation of the National Public Health Programme in a form and language easily accessible for policy-makers. Unfortunately, in the last two years, the quality of public health reporting in that country has been affected by budget cuts.

Where such reports are produced regularly, they are frequently submitted to parliament, giving wider visibility to health issues and raising awareness among legislators and the public. In Lithuania, for example, Parliament discusses such reports twice a year and, as a result of receiving a national report on the issue, requested that a strategy for tackling inequalities in health be developed. In Hungary, discussion on the progress report on the National Public Health Programme puts health issues high on the political agenda at least once a year.

Reliable epidemiological data do not always lead to action, however. In some of the countries studied, the information was available long before action was taken. International research indicates that researchers and decision-makers often have misplaced ideas about each other's environment and little opportunity to communicate with one another, and that this is among the reasons for the slow uptake of knowledge *(2)*. In Lithuania, top researchers have continuously moved between research and policy formulation roles and have presented their research findings at regular national health policy conferences in which various ministers and parliamentarians participated, and this has invariably led to a call for policies to address the issues presented. In most countries, however, more needs to be known about how to get high-quality, relevant information into the hands of policy-makers *(3)*.

Unlike communicable diseases, NCD policy is rarely triggered by exceptional or crisis situations, although there have been examples of these (as when the death of a considerable number of older people during a heat wave in France put the issue of social isolation on the agenda, and the sudden death of well-known athletes in Ireland quickly prompted a report on the issue).

Representing the challenges

The issue is not only that of securing reliable information but of presenting it in such a way as to shake complacency and trigger action. In recent years, particularly in relation to tobacco control, victim-blaming has been replaced by an emphasis on protecting the innocent, such as protecting non-smokers in Hungary. Ireland not only used international comparison to raise awareness of the need for smoking control but appealed to a sense of public empathy with the plight of those working in bars. Public health officials collaborated closely with the main stakeholders, indicating that successfully tackling the challenges was feasible. In relation to drink–driving in Ireland, the importance of saving the lives of young drivers had a strong impact on the opinion of middle-aged and older people, that is, their parents and grandparents.

In some countries of central and eastern Europe, the challenge of shaping NCD policies is less explicit owing to the double burden of disease. In Albania and Kyrgyzstan, most central Asian and Caucasian countries and some of the Balkan countries, for example, top priority is given to fighting communicable diseases and providing basic health care. Not only are communicable diseases readily seen as a threat to health but tools for tackling them, such as immunization, are easily understood and implemented. NCD policy devel-

opment needs longer-term planning and has less tangible short-term results. Where classical public health issues still prevail, and the general economic and social situation is not propitious, the time may be not ripe for governments to give priority to NCD policy development.

The policy environment

In a number of countries, a more general change in the policy environment converged with a recognition of the problem of NCD when the state's responsibility for health (and not just for health care) was clarified. This was reinforced in some cases through constitutional changes or public health legislation and presented an opportunity for bringing NCD higher on the policy agenda.

When Lithuania regained its independence, the political mood and urge to redefine the national identity, together with the re-establishment of the Medical Association, offered an opportunity for a radical rethinking of the approach to health policy. A number of countries used their entry to the European Community and/or their presidency of the EU to bring NCD issues to the fore. For example, the French presidency of the EU was an important trigger in shaping a new policy on nutrition and physical activity in France, offering political success and recognition.

A special dilemma is the lack of an explicit NCD policy or a lack of decision-making. In the WHO European Region, the explanation of such a phenomenon is usually not policy-makers' lack of awareness of the issues. There are various reasons for a failure to promote NCD policy, including:

- the lack of short-term political gain;
- concern regarding the feasibility of changing lifestyles;
- the fear of negative public reaction;
- the lack of a "window of opportunity"; and
- the fact that many countries are fully occupied with the problems of health care financing, providing accessible and good-quality care, reducing waiting lists and meeting demands for new types of care.

Key actors in the awareness-building process

As clearly indicated by the case studies, key individuals, advocacy groups and public opinion can play an important role in awareness building.

Politicians

New presidents, prime ministers and ministers of health may be powerful agenda-setters, since the newness of their position allows them room for manoeuvre and new initiatives. In Hungary at the beginning of the 1980s, for instance, a new Deputy Prime Minister, with a medical background and inspired by the WHO Health for All policy, initiated the process for developing a long-term health promotion strategy by positioning herself politically in favour of intersectoral action. Four successive governments in Hungary developed new health policies under different labels, each attempting to create symbolic differences and a new identity compared to their predecessors. In Kyrgyzstan, the public health strategy *Manas Taalimi* can be clearly related to a change in government, a new Minister of Health and a Deputy Minister responsible for public health.

Individual advocates or prime movers

In all the study countries, certain prime movers played an outstanding role in initiating the NCD policy development process. The first generation of prime movers, a product of the late 1970s and 1980s, were deeply involved in the first national/international cardiovascular projects and the WHO Health for All movement and were pioneers in the Ottawa Charter. These people combined a number of skills: a very high level of expertise, an open mind, political and managerial ability, and a cooperative spirit. The role of such outstanding personalities is clearly demonstrated in the case of policy development in Finland, Hungary, Ireland and Lithuania.

In countries where the process has only recently started, a second generation of leading experts can be identified, initiating the NCD policy process both in technical and political terms. This is true for Albania and Kyrgyzstan.

There is no example of isolated, successful prime movers. In all countries where we have identified such people, as in Finland, Hungary, Ireland and Lithuania, they were part of a team of experts characterized by close, friendly working relationships. In some countries, professional and institutional rivalries may have hindered the process, or emerging prime movers lost their influence with a change of government.

Other key experts played an initiating role as consultants for international organizations such as WHO and the World Bank, facilitating and pushing NCD policy development in the Balkan countries and in the countries emerging from the former USSR.

Obviously, "key players" cannot be produced at will but certain factors seem to have encouraged their emergence and impact, including:

- sufficient stability within public administration when governments change, encouraging strong commitment and accumulative capacity building;
- close links between academia and the bureaucracy; and
- strong links to international networks.

The right person in the right place at the right time can make a difference. The public health expert in Hungary, who was elected member of Parliament and quickly proposed the drawing up of a new public health strategy, is such an example.

Advocacy groups

NGOs clearly play an influential role in raising awareness (and in policy formulation), particularly in the case of specific diseases or risk factors. Countries such as Finland, France and Ireland have a very long history of extremely active NGOs in the health field, with prestigious, long-standing and wealthy NGOs having a substantial influence on cancer prevention and heart health at national level. In France, the League Against Cancer founded in the 1920s has had a considerable international impact on cancer prevention policies. In Ireland, the National Heart Health Alliance, representing about 40 NGOs, has an influential role on the governmental NCD prevention policy. Many of the Finnish NGOs are headed by top experts and are regularly consulted by the public sector. Greece offers a characteristic example of the determining role of a nutritionist society and a prime mover pushing for nutrition policy in the country.

In central and eastern European countries, health-related NGOs have considerably increased in number in recent years and are making their voices heard. In Albania, the NGO "For a tobacco-free Albania" played a prominent role in bringing the need for tobacco control into the public domain, and its representatives play a leading role in reporting on the implementation of the tobacco control law and raising awareness about the issue.

Most of the NGOs referred to in the case studies focus on specific NCD or risk factors, and frequently compete to be heard and to promote "their" area of concern. Such issue-specific NGOs are less prepared to promote broad NCD policy issues. There are, however, a number of broader-based NGOs, such as associations of public health experts, who may have an important role even in the initiation of an umbrella policy, as in Finland and Hungary. In Lithuania, the Medical Association developed the first "National Health Concept " and a recently established Public Health Association offers general support to health policy development

The media

The important role of the media in the initial phase of the policy cycle is clearly demonstrated in the case of the North Karelia project in Finland. Positive media interest

was detected from the very beginning and lively public debate followed the implementation of the project, ensuring public attention at national level for CVD prevention. Ireland presents an example of public awareness building, whereby a broad national media campaign was launched for the programme "Ireland needs a change of heart" with an accompanying information pack and a handbook distributed to all households. Intensive discussion in the media over a number of months prepared the way for strong tobacco control in that country. In Hungary, round table debates on the causes of declining life expectancy preceded the formal start of the policy planning process, and some of the prime movers used the public television and daily newspapers for political advocacy and to put pressure on decision-makers. In France, advocacy through the media was an important precursor to initiating major steps in alcohol policy. In Lithuania, parliamentary discussions of emerging health challenges are regularly broadcast over the national radio.

The media appear to have influenced public opinion substantially regarding key topics such as nutrition, overweight and smoking, particularly over the last decade. A high proportion of articles in journals and newspapers deals with such issues, and all countries use television spots to reach the public. Not all media messages are in harmony with the objectives of NCD policy, however. There is a danger of the mass media oversimplifying and sensationalizing issues, with the result that complex questions may be misrepresented or that opponents such as the tobacco industry or certain food producers, for example, may use the media to present misleading information, as seen in Finland and Ireland.

Web sites have been developed very rapidly in recent years, and in some countries offer considerable information in an easily accessible form. The use of the Internet by NCD self-help and support groups is very significant but excludes those without access, possibly increasing health gaps. With increasing use comes the need to protect users from unreliable information, but this issue was not examined in the study.

International players

In the field of NCD policy development, governments are increasingly affected by international influences. The work of international organizations offers important channels for discussion of NCD policy issues, and agencies such as WHO, the EU, the World Bank and to some extent the Council of Europe act as pressure groups for particular policy choices.

The initiation of NCD policy development processes in almost all of the case studies was strongly related to contact with international organizations. The role of WHO cooperation was a determining factor in both Lithuania and Hungary, and Finland made judicious use of WHO to legitimize and at times revitalize the policy process. As compared to the other observed countries, France and Greece demonstrate a special case wherein the influence of international factors has been much more limited.

More specifically, the role of the WHO Health for All policy has been particularly important in influencing the underlying values for NCD policy development, with reference still being made in current policy documents to Health for All values. Most recently, the WHO FCTC has been particularly influential in the formulation of national tobacco control policies.

International NGOs such as IUHPE, EuroHealthNet, the European Public Health Association, the European Public Health Alliance and the different professional associations in the field of cancer and CVD have also played an outstanding role in raising awareness, mainly among professionals, and produced key guidance documents for policy-making.

Policy formulation

This section discusses the information and evidence on which policy formulation is based, the key players, the mechanisms and processes employed, and the tasks undertaken.

Information for policy formulation

In the countries studied, in addition to the so-called "hard" data on epidemiology and health resources, we were able to draw on the expertise and experience of those involved in the process, political directions from policy-makers, information from international organizations and other countries and, in some cases, other "soft" information on attitudes and opinions.

Epidemiological data

As could be expected, basic epidemiological data constituted an essential input to policy formulation in all case-study countries, although there was wide variation found in its availability. Given the short time frame frequently imposed by politicians, this was based mainly on the gathering and processing of existing knowledge and less frequently on new research.

Mortality data according to international classification are available across Europe and can frequently be disaggregated by age, gender and geographical area (even, in some countries, reaching down to postal districts or political constituencies. Much of the basic data in Finland can be linked to a personal identity number and it is even possible to link different databases, allowing for extremely sophisticated analysis. Regional differences are frequently referred to in the policies of countries where equality in health is high on the agenda, though gender differences seem to be given less attention. In other countries, such as Albania and Kyrgyzstan, concerns remain over the validity of even basic mortality data; there are considerable deficiencies in the information system, and data collected by different institutions are not always consistent or comparable.

Information on NCD morbidity is less complete. There is a degree of fragmentation and a lack of standardization, and surveys are often carried out on restricted populations, sometimes without systematic statistical sampling. The result is that clear trends in the prevalence and incidence of NCD at population level cannot be described.

Finland, Lithuania and, more recently, Ireland have carried out regular surveys on lifestyles and behaviour for many years and are able to utilize information on long-term trends for policy purposes. On the whole, however, WHO surveys indicate that such information is less widespread than mortality data, particularly in relation to socioeconomic characteristics. In all of the countries examined, there are some data on CVD risk factors and partially on those for cancer. At least smoking prevalence, cholesterol and blood pressure levels and body mass index are observed in most of the countries in a more-or-less systematic way, though not always at national level and sometimes reported rather than actually measured. Information on alcohol consumption is less satisfactory. In practically all observed countries there is a fair description of nutrition based on household statistics, food balance sheets and commercial data. Information on physical activity, which is less easy to observe, is more superficial. Much of the information collected is limited to leisure-time physical activity, failing to reflect the enormous impact on physical activity of changes in the workplace, transportation and urban planning. Albania, Greece and Kyrgyzstan are particularly short on such data. The role of the WHO was crucial in standardizing data in Finland and Lithuania, for example, in the initial stages of tackling NCD. Together with that of the EU, WHO's role is still vital, particularly in countries with less sophisticated information systems. The CINDI programme and MONICA Project have been particularly influential in the participating countries, ensuring the production of regular, systematic

surveys over long periods of time and offering comparable international data and training or nurturing national teams of experts. In Hungary, most of the outstanding prime movers behind the policy documents in the 1980s and 1990s had previously been directly involved in the MONICA Project.

In countries with a long history of NCD policy development, work carried out in relation to monitoring and revising previous policies provided a significant source of information for new policy formulation, saving time and energy. In Finland, Ireland and Lithuania in particular, extensive evaluations of previous policy implementation add to the rich source of information utilized, and are probably conducive to identifying potential difficulties in policy implementation.

Reflecting inequalities in health

The availability and use of data on socioeconomic differences in mortality, morbidity and lifestyles are well-developed in some case-study countries and sporadic or completely missing in others. In Finland, Ireland and Lithuania, epidemiological data on mortality and morbidity reflecting inequalities in health are available to a reasonable extent, not only at national but also at regional and local levels. In these countries, such information is published in regular reports and can be readily utilized in formulating health policy. Such reports can also give decision-makers a better understanding of the need for intersectoral action and for shifting the focus of attention to tackling the determinants of health.

High-quality research, if easily available, may be picked up when the time is ripe, such as in England where the famous Black Report *(4)* on inequalities in health was first published in 1980. Although frostily received by the government of the day, this and similar reports proved to be a valuable and ready-made resource to be utilized when the political mood offered a window of opportunity. The Netherlands carried out extensive research programmes involving research institutions across the country for over a decade, first to explain inequalities in health and second to generate more knowledge on the effectiveness of interventions and policies to reduce socioeconomic inequalities in health *(5)*.

The "mapping" of inequalities has also proved to be a powerful tool at the local level, such as in Finland and Lithuania where it raises awareness among politicians, who compare "their" region to their neighbours'. A number of other countries outside the study group offer excellent examples of the effective use of mapping for policy development. Pioneers such as the City of Rotterdam, for example, have developed indicators and software programs not only to signal public health problems but to try to identify determinants and offer solutions on a policy level *(6)*.

Socioeconomic determinants of health

Information on the socioeconomic determinants of health are much less prevalent in the policy formulation process, except in those few countries where equality in health is more than a rhetorical factor in policy formulation. The Swedish public health policy is a notable exception.

Owing to the activities of the WHO Commission on Social Determinants of Health, important progress has been made in strengthening the scientific knowledge base for policy development. This conceptual framework was not available for the NCD policy planning processes examined here, but may strongly influence health policy development in the future.

Availability of health care for NCD

Perhaps surprisingly, information on the availability, accessibility and effectiveness of health care for NCD does not appear to be generally available. Studies led by the EU have uncovered considerable and unacceptable inequalities in this area. An attempt in Ireland to explore this situation recently led to the development of a framework for managing care for chronic diseases.

Capacity mapping

The policy formulation process requires not only an analysis of the health status of the population but also of capacities for policy implementation and the potential for cooperation and synergy, including potential relationships with other existing policies. Little assessment of feasibility, capacities or assets is evident among the sample countries: even in those countries with the richest knowledge base for policy formulation, capacity mapping is one of the weakest areas.

This is in accordance with the findings of a WHO project to map capacities in European countries *(7)*, which concluded that "the connections between policies in other sectors and their impacts on health are not well understood and implemented. Possible assets for policy implementation outside the health sector are rarely referred to, which is perhaps to be expected given the relatively recent inclusion of the social determinants of health in the policy formulation process. However, this does seem to be slowly changing with the influence of EU membership and other international support programmes". A point worth noting in this respect is that countries requesting support from international funding agencies for policy implementation are usually required to indicate available resources.

Utilizing "softer" information

There was little evidence of the use of information on the feasibility and acceptability of taking action, including the position and opinions of stakeholders and potential partners, in most of the countries studied. Ireland is notable, however, for having made considerable efforts to elicit the views of stakeholders. In Hungary, the role of such "softer" knowledge in the policy-making process, and the need to balance "soft" knowledge and "hard" epidemiological data, has been explicitly discussed in recent years.

Information technology and organizing the database

The case studies offer numerable examples of new information technologies and communication tools being developed and utilized for policy development. This is further encouraged by the availability of considerable EU funding for such projects. Naturally, there is a huge potential for strengthening the information base for policy development through the creation of integrated databases and of clearing houses offering examples of policies, guidelines and best practice. One major restriction, however, is the frequent lack of long-term funding for the institutionalization of such databases.

The WHO Regional Office for Europe organized a technical meeting on the use of national databases in decision-making *(8)*, which concluded that most countries have some problems with date sources and that they should:

- try to ensure a legislative basis for data exchange; and
- make greater efforts to have a comprehensive database with a variety of data normally used by decision-makers.

Some of the reasons for not using evidence-based information are relevant for NCD policy-making and were reflected in some of the case studies:

- frequent changes and lack of continuity of staff at ministries of health, lack of collaboration between data producers resulting in duplication and errors, and lack of collaboration across ministries;
- inappropriate presentation, as expressed by the wrong level of disaggregation (too detailed), uninformative statistical tables, or a lack of the time, resources or motivation to issue information in a digestible format;
- data not available when needed;
- users not trained to find and use data or data not user-friendly;
- failure to actively disseminate and advertise available information;
- no agreement on priorities or how to prioritize; and
- communication difficulties between producers and users.

Experience from other countries

Policy documents from other countries are frequently taken into account during the policy formulation process. This may be as simple as briefly scanning policy documents from other countries, an effort that is necessarily restricted to documents available in a language widely understood by those involved in the policy formulation process. The influence of documents written in or translated into English tends to dominate, except perhaps in the Scandinavian countries. The quite widespread translation of national policy documents into English, as shown by our search of the Internet, is one indication of the importance given by countries to sharing policy-related information.

In some cases, there have been more systematic attempts to learn from other countries. In Hungary, for example, the Swedish and Northern Irish policy documents were very carefully studied before starting the most recent planning process. In the framework of policy formulation in Scotland, the University of Dundee was commissioned to review public health policies in other countries in order to "identify policies, evidence and interventions which could be used to help improve the health of the people of Scotland" *(9)*. International experience and international experts have been involved to some extent in the policy formulation process in most of the case-study countries. In initiating the process in Lithuania, WHO and experts from other countries were asked to present their experiences. Finland involved international experts in preparation for policy revision. Ireland used a small group of international experts to advise on the policy process. Albania, Hungary and Kyrgyzstan used outside experts, particularly through their collaboration with the World Bank.

The EU is an increasingly important player in improving the availability and quality of information for NCD policy development in the EU and certain other countries. Information is one of the main strands of the EU public health policy. EU-funded information projects are far too many to list, but surveys such as those on Health Behaviour in School-aged Children and EPIC, which looks at nutrition, have been particularly important for NCD policy development in the case-study countries. Non-EU countries could fall behind in this area unless care is taken to keep them abreast of developments. Efforts to bring together information, for example in the European Community Household Panel, which covers a range of topics simultaneously, including health, allow for an analysis of the interrelationships between specific factors in individuals' living conditions.

Key players

Stakeholders in the NCD policy development process vary according to the type of policy, but in general terms include politicians, civil servants, academia, public and private services, and the general public, including their representatives in lobby groups, trade unions and NGOs. These groups have different interests and perspectives on issues needing urgent attention and how to tackle them.

It was clear from the case studies that politicians are influenced by their party-political platforms and general government decisions such as those concerning the economy or public administration. Their personal or family experiences may also play a role, for example in the case of a minister who is vehemently anti-smoking or who has a specific NCD problem in the family.

Bureaucrats and other experts comply with policy requests from politicians, be they ministers or parliament, or react to day-to-day practical problems with incremental reflexes. In some countries, however, civil servants have managed to ably present scientific information, basically setting the policy agenda.

Specialists – the community of academics, researchers, consultants and, in the case of NCD, outstanding cardiologists and oncologists – frequently play a significant role in getting issues on to the agenda and in proposing alternative options

during policy formulation. Naturally, they tend to focus on their own area of expertise and, in some cases, have played a highly visible role in getting attention for NCD problems through collaboration with the media. The focus of those dealing with diseases rather than lifestyles and NCD risk factors can lean more towards health care and medical models of policy development rather than health promotion.

A small but eloquent elite group of NGOs, owing to their strength and influence, sometimes dominates the debate or is given a leading role by policy-makers. In Hungary, for example, the Prime Minister commissioned competent NGOs to prepare the first drafts of the heart health and cancer programmes.

The general public often has less information on the health situation and little input to the policy formulation process. However, surveys such as the EU Eurobarometer and the increasing use of opinion polls are bringing to the fore the weight given by people in Europe to various health policy issues.

Certain key players have had a decisive role throughout the policy cycle in the countries studied. Particularly in the smaller countries, they frequently play multiple roles as advocates, leaders in the policy formulation process and participants in monitoring and evaluation. Those who have been in place for a number of years became a guarantee of policy sustainability. Some have dominated the scene for the last two decades, and their successors are not clearly evident.

WHO and the EU have also played a vital role in stimulating the development of health policies and strategies. Their documents shape norms for the behaviour of national governments by creating international expectations to develop NCD policies. All international agencies in this field have a strong concern for equity, and have gradually created interest in tackling the social and economic determinants of health. The EU funding systems, including programmes to fight poverty and social exclusion, also stimulate the link of health and development in the area of NCD policies. The EU structural funds offer a unique and important funding opportunity and create special interests. This is characteristic for recent practices in Greece and Hungary, for example.

The role of international organizations can sometimes be controversial, however. In the Balkan countries and the countries emerging from the former USSR, the development of a public health policy was negotiated as a condition of a World Bank loan. In some cases, health policy documents were actually written by international experts and the resulting lack of ownership in the countries in question meant that these strategies remained on the shelf. The experience of Albania and Kyrgyzstan clearly shows both the outstanding responsibility of international agencies in low- and medium-income countries in shaping such policies and the limits and pitfalls of such action.

Mechanisms and processes

Responsibility for the process

The main focus of this study was on national policies. In the countries studied, requests for policy formulation came through a presidential decree (as in Kyrgyzstan), from parliament (as has frequently been the case in Hungary and Lithuania), as a request from the prime minister (as in the case of the Heart Health Programme in Hungary) or, more frequently, through decisions by ministers of health.

A request emanating from parliament is naturally the consequence of prior parliamentary discussion, or follows the work of a parliamentary health committee. From the countries examined, the involvement of parliament at an early stage builds broader cross-party consensus, which in turn is probably conducive to longer-term sustainability or at least prevents NCD policy slipping completely from the agenda. In Hungary and Lithuania, for example, the Parlia-

mentary Health Committee plays an active role throughout the policy making process.

The special case of Sweden must also be mentioned, since its ground-breaking national strategy for public health was formulated by a Parliamentary Commission consisting of "representatives of all seven political parties in Parliament and a number of scientific experts and advisers from national authorities, universities, trade unions and nongovernmental organizations" *(10)*. The seven politicians on the Commission were appointed by their own parties, and did not voice their personal positions but the views of those parties.

For countries such as Albania and Kyrgyzstan, when requesting World Bank funding, the formulation of an explicit policy document is an essential requirement imposed when the Ministry of Finance coordinates such requests.

The formal request for either an umbrella or issue-specific policy frequently comes from the minister of health, and the ministry of health usually takes the central role in NCD policy formulation. However, with the need for intersectoral action and an increasing focus on the social determinants of health, some countries now recognize the value of involving a higher level of authority – the president or the prime minister's office – in the policy formulation process, such as seen in Ireland and Kyrgyzstan.

Even on the ministerial level, a dominant role for the ministry of health no longer appears to be the only way. The potential for including components related to NCD policy in broader policies, such as those promoted by the EU to tackle poverty and social exclusion, offers a greater role in this area to ministries dealing with development, for example. Some years ago in Finland, in relation to nutrition policy, it was deemed politic to give the Ministry of Agriculture the lead. Similarly, in the area of tobacco control in Albania and in the face of powerful tobacco interest groups, only the very strong commitment of an anti-smoking NGO gave life to the formulation of a tobacco control policy.

Nevertheless, the ministry of health must at least play a watchdog role to ensure that policy formulation takes a sufficiently broad approach to tackling NCD, and this appears to have been the case in most of the case-study countries.

Who formulates the policy?

Although many health ministries have an administrative unit or division responsible for health policy development, in none of the countries examined does this unit take sole responsibility for formulating general or issue-specific health policies. Even if this were desirable, most of these units would be too small to take on such responsibility, being no more than one or two people in some cases. Lithuania is planning to considerably strengthen the capacity of the relevant unit. Given the complexity of NCD policy and the need for multidisciplinary skills, the usual process, whatever the size of the ministry's policy unit, is to call in additional experts and stakeholders. One of the most recent examples is the *Manas Taalimi* strategy planning process in Kyrgyzstan in 2008.

When a formal decision to shape an NCD policy has been taken, an expert planning group is usually created. In most cases, a core group of experts acting as prime movers proposes the issues and sets the initial elements of a policy agenda, often before a formal decision to start the process. This was the case in Finland, Hungary, Ireland and Lithuania.

An important issue, even in countries with some experience of NCD policy development, can be the lack of institutional memory in the health ministry as civil servants are shifted from position to position or change with changing governments. In Albania, for example, even middle-ranking civil servants can lose their positions with a change of government. Such changes occur in Greece to some extent, but usually only at the higher levels. In Hungary, although

civil servants have a degree of permanence, they are not necessarily utilized by governments of different political persuasions.

In central and eastern Europe in general, the post of minister of health has changed on average every 18 months, and together with the minister there is frequently a large turnover of experts. On the contrary, in countries where NCD policy development has been sustained over a long period of time, such as Finland, Ireland and Lithuania, a critical number of civil servants and experts have been called on in the policy formulation process regardless of changes of government, bringing with them both a strong institutional memory and a network of useful contacts. The possible danger of such long-term stability might be a tendency to consider that there is only one way of doing things and to ignore other policy options.

In some countries, the first initiative is taken by expert structures such as national health councils. Where they exist, such councils frequently play a strong role in policy formulation, one advantage being that they have the necessary expertise and facilities in place. Examples are the National Board of Health set up in 1998 in Lithuania and the High Committee on Public Health established in 1991 in France, which play a decisive role.

In countries such as Hungary, where a National Public Health and Medical Officer Service is still in place, with a Chief Public Health Officer and corresponding offices and officials at county and municipal levels, this top-down structure is extremely influential. This is characteristic of countries having a history of experience with the sanepid system.

In general, planning groups or task forces consist of a mix of administrators (civil servants), technical experts, representatives of political interests and NGOs (and, in some countries, religious leaders). Since the 1980s, in countries such as Finland and Hungary, cardiologists and oncologists have played a dominant role in NCD policy development, and to some extent this has been evident in Lithuania and other countries such as the Netherlands and the United Kingdom. More recently, there have been attempts to make such groups more interdisciplinary and to include, in addition to public health experts, sociologists, economists and others. In Hungary, this interdisciplinary approach was initiated as early as the 1980s.

The preferred format seems to be that of a rather small steering or coordinating group, sometimes with a broader group acting as a sounding board and frequently with subgroups dealing with special issues. For example, for the broad health policy formulation in Ireland there was a 17-person steering group, a 15-member project team, a 19-member high-level interdepartmental group and a small international advisory panel; a suggested Cabinet subcommittee was not active.

For the last 30 years, the WHO Health for All policy has called for intersectoral bodies involving the main stakeholders to formulate such policies, stating that "Unless those who are to carry out health and development policies and programmes also take part in their formulation and evaluation, they will feel little commitment to putting them into practice" *(11)*. For many years, this has been easier said than done and the health sector has dominated the process, with token input from other sectors. When an attempt is made to reach out to other sectors, the "easy" partners tend to be those included first.

In Hungary, it is usual to carry out a stakeholder analysis to determine the members of the groups to be established to tackle various aspects of NCD policy. Recently, in France, it was decided to carry out a general consultation of stakeholders. A commission was set up to make a thorough analysis, including the strengths and weaknesses of the disease prevention system, and the regions were asked to comment on the draft. Few countries seem to go through

a formal stakeholder analysis to ensure that important partners are not forgotten, as were the nurses in Finland in the 1980s, for example

Establishing the process

In Finland, in preparation for the policy formulation process, it is usual to organize seminars and conferences to discuss related concepts and ideas with a wide group of stakeholders, and also to organize smaller, in-depth discussions among experts. This acts not only as a means of advocacy and of boosting the process but to some extent as training for policy formulation. In the case of Kyrgyzstan, those participating in the first preparatory meeting had not been given an adequate understanding of the expected process. At the second meeting, when participants from the different ministries received a detailed draft strategy paper and were briefed on intersectoral cooperation, the activity and quality of involvement of the same people changed in a spectacular way. Preparation for participation in intersectoral policy-making bodies appears to be practically nonexistent in many countries.

The way in which the work of the various steering groups and subgroups is meshed together to avoid creating a series of vertical packages is not clear. For the latest policy formulation process in Hungary, for example, all subgroups were given the same template to work from. They were aware of the common WHO values but not always aware of the overall goals, with the result that the 19 subgroups in this complex process were said to operate in isolation. Careful preparation of the NCD policy process, including a clear understanding by all participants of the concepts and values and of their own expected input, has been shown to vastly improve the effectiveness and efficiency of the policy-making process.

In countries dependent on outside funding, and with little experience of this type of policy-making, the role of external experts can sometimes dominate. This has the advantage of bringing in foreign experience and examples of good practice, and may speed up the process of policy formulation when external deadlines are to be met. Nevertheless, it does little to enhance national capacity building or ownership and may completely miss the potential of national specificities and assets, as was the concern in Albania.

For the first broad health policy after independence in Lithuania, it was only because local experts were so firmly entrenched in international networks and convinced of the right way to go that they were able to stand up to the international funding organizations and insist on following the Health for All path. They also brought in WHO and outside experts to reinforce this position. Other countries, such as Finland and Hungary, have successfully utilized foreign experts to legitimize positions that domestic experts might have had difficulty in getting accepted.

Policy formulation can be a time-consuming process. Indeed, it should be if the main stakeholders are to be identified, their views taken into consideration, and where there are differences of opinion, opportunity be given for a level of agreement to be reached. In the cases examined, the time allowed for policy drafting, consultation and redrafting varied from as little as three months to well over a year. In an external review of the first Finnish Health for All policy *(12)*, one of the criticisms made was that insufficient time and support had been given to the core group of officials, who were expected to carry out the heavy policy development tasks at the same time as their normal work.

Countries starting from scratch do not have the advantage of accumulated experience enjoyed by those with a long history of NCD policy development, and must learn everything from the beginning. Support in policy development and planning methods, with examples of good practice and potential pitfalls, could help those now embarking on the process.

It can be quite a challenge for the type of intersectoral group necessary for formulating NCD policy to reach agreement on aims, objectives and priorities, since the members frequently have different levels of understanding of the health issues and different agendas in their everyday lives. On the other hand, when the importance of the task in hand has been understood, it is clear that many planning groups have worked well and innovatively, borne along by the enthusiasm of identity with the group and their common aim. Over the long term, however, a degree of *ennui* can set in and in some countries studied, the effort and time needed was said to lead to higher-level people dropping out and their substitutes taking over.

It is worth noting that, on the whole, the way in which policy formulation (and monitoring and evaluation) bodies are constituted and function remains very much a black box. Although WHO has for many years promoted the setting up of such intersectoral bodies, there has been little analysis of their *modus operandi*. For the core policy formulation, implementation and monitoring group to work effectively, in the United Kingdom it has been suggested *(13)* that they should aim to achieve:

- a shared vision and common agenda;
- agreed objectives and priorities;
- agreed roles and policy instruments;
- openness about self-interests; and
- mutual respect, trust and ability for mutual learning, and agreed methods of dealing with disagreements.

Achieving broader participation

Beyond the core group, participation is another of those magic words easier said than done. Broad participation is still an elusive element in many policy development processes and often time is simply too short for any real consultation and negotiation. In others, although an attempt is made to distribute a draft document for comments and suggestions, the effort already invested in reaching an agreed first draft often means that there is little chance for the consultation process to affect the main aims and objectives, but only to make incremental changes on the details.

Transparency in the participatory process is essential if it is not to become a mere formality. Countries such as Ireland made clear reference in certain final policy documents to comments made on previous versions. Some years ago, Turkey published separately all comments made by institutions and individuals on a draft health policy *(14)*.

For broad participation in the planning process, one of the problems is how to reach a wide target audience. The expansion of the Internet has, of course, allowed draft policies to be made available easily and cheaply to those who have access, as was the case in the drafting of the Hungarian National Heart Health Programme, and is the case for draft legislation in most of the case-study countries. Unless a special effort is made to reach them, however, this leaves out many of those in poverty and other vulnerable groups. On the other hand, lobby groups with well-organized NGOs may have a stronger voice than is sometimes warranted, influencing priorities to the benefit of their own interest groups.

Attempts are made in a number of countries to organize subnational discussions on national policies. Wales, for example, has used a "cascade" approach involving a manageable group of people in a first briefing and discussion, the members of which undertake to carry out a similar effort in their own regions, and so on down to the local level *(15)*. Despite the fact that effective involvement of the main stakeholders is still rather a rhetorical aim in some countries, there are innovative attempts to achieve wider and more effective participation. In Ireland, there was at least one case of evaluating the effectiveness of a consultation process.

Key tasks in policy formulation

Analysing the needs and challenges

In most of the policy documents examined, though perhaps surprisingly not all, the first task was to analyse the needs and challenges. Particularly in the countries with a rich information base, the situation analysis goes beyond describing the health status to analysing the causes. On the whole, the focus appears to be on examining past trends rather than forecasts of the future, although Ireland is trying to develop forecasting methods in the policy process. This has important implications for the potential impact of the policy being formulated, and whether or not different options are examined.

In the countries with a long experience, there is usually reference to previous policies and actions already taken to tackle the issues, and to progress made. The possible reasons for successes or failures are rarely stated, however.

Defining the vision

One of the first tasks is to define the purpose of the policy. Many, though not all, of the policy documents examined outline their overall vision or goals. These may be of the type, "our goal is for less ill-health and higher levels of well-being across all population groups" or, as in Tajikistan some years ago, "a country in which the policy of health for all allows people to be in harmony with nature, in which individuals value health and realize that health is the most indispensable feature of the quality of life, and in which health providers work in adequate conditions" *(16)*.

Following the formulation of the WHO Health for All strategy, umbrella policies in countries frequently adopted its aims of adding years to life, adding health to life and adding life to years. These aims can still be found, even in recent documents. This perhaps indicates, on the one hand, the continuing relevance of these rather general goals or, on the other, the length of time necessary for policy messages be accepted and absorbed.

Selecting objectives

The formulation of objectives is frequently influenced by internationally agreed policies or the availability of internationally comparable data. For example, it is not unusual to see objectives formulated in terms of reaching or excelling an EU average, or of a country or region aiming to be among the "best in Europe".

A brief examination of objectives defined in a sample of the health policy documents from the case-study countries showed them to be what might be expected in view of their health situation. Given their rather general nature, they are frequently quite similar in different countries. The first Finnish Health for All policy stated that the criteria for selecting objectives was the need to "focus attention on health problems that cause early mortality, disability or incapacity for work and that increase the need for services" *(17)*.

General principles of planning and management are not, however, always evident. On the whole, there is a tendency for countries to define objectives but not the priorities among them. The 35 issue-specific programmes in France, for example, are each said to have different priorities.

The lack of prioritization between objects is reflected in their related targets. Consequently, those expected to take action on the ground are rarely assisted by clarification of priorities or an indication of what needs to be done first. Indeed, the lack of prioritization both among objectives and among the interventions/targets designed to achieve those objectives is given as one of the main causes of failure in implementing NCD policies in a number of countries.

According to a survey in 1999 of Health for All policies throughout Europe (18), the most common criteria in defining objectives and selecting targets were:

- the extent of the health problem as a major cause of mortality or morbidity;
- the scope for improvement through effective and acceptable intervention;
- public and professional opinion of whether the health problem is a major concern;
- whether progress towards achieving the targets can be measured through available data or data that can be easily collected, and whether reliable indicators exist to monitor progress;
- whether solving a health problem would reduce inequity in health; and
- other constraints imposed by policy or societal characteristics, including cost constraints (for example, substantial sick leave).

The following is an example from a public health policy from the Netherlands published in 2007, which refers also to possible social consequences *(19)*.

> "These main problems have been selected on the basis of the following criteria.
>
> - They present sizeable health problems, with significant (future) social consequences for the use of medical facilities and employment, for which a healthy lifestyle can (partially) affect the cause, and for which suitable (cost) effective interventions are available to prevent or reduce the health problem.
> - These interventions are not yet being implemented on a wide scale, and where the central government and local authorities can play a role in tackling the health problem."

From the information available, it appears that priorities are frequently set on a rather narrower basis than the above. Topic-based epidemiological data dominate the initial analysis, and priorities are then set according to whether action should be taken through the settings approach or according to lifestyles and the life-cycle. Those living in poverty are of concern in many countries, as are particular social groups in some countries, such as the Roma in Hungary and Travellers in Ireland. Although the EU countries in particular link health and development through policies to tackle poverty and regional development, specific objectives and targets linking health and development policies are not always clear.

Although discussion regarding the selection of objectives deals with policy options at one level, there is little evidence of consideration of policy options to achieve the selected objectives. Finland is apparently one exception: in reply to the question of how long-term civil servants interact effectively with politicians of different parties, the reply was that the usual practice when politicians outline their objectives is for civil servants to offer two or three options, indicating the possible implications of each.

Finally, even when taking an intersectoral approach, practically all the policy documents examined see this from the perspective of other sectors contributing to the achievement of health objectives. There is almost no consideration of how the health sector might contribute to meeting the objectives of other sectors.

Target setting

With the setting of 38 targets for Europe through the Health for All policy and its subsequent revisions, a number of countries basically adopted the European targets in formulating umbrella policies, including those related to tackling NCD, rather than setting their own targets as had been intended. Other countries, including Finland at first, were not comfortable with setting quantified targets.

Health21 sets out the main arguments for setting targets (11).

- The process of setting targets requires an assessment of the present situation and expected future trends, on as scientific a basis as possible.
- Monitoring the targets offers an excellent learning experience through the discussion of what had been hoped for, how far this was achieved and why.
- Targets provide a powerful communication tool.
- Targets indicate to potential partners what must happen, and what their role might be in making this happen.
- Targets can provide a rallying call for groups at the grassroots level to demand action.
- Targets can be an excellent tool for strengthening accountability for health (which is one reason why some groups would like to avoid them).
- Certain targets can provide a reference point for assessing the advisability of day-to-day actions.
- Involving people in the process of setting targets raises awareness and can be the first step in implementing health policy.

The main reasons deterring some countries from setting quantified targets in the past have been *(18)*:

- the difficulty in providing scientifically credible evidence for some important targets;
- the reluctance of politicians and health professionals to set targets for which they will be held accountable, especially in areas in which they have little or no influence; and
- the danger of appearing to give priority to issues for which targets can be easily quantified, when other issues that are less easy to quantify might be considered equally or even more important.

Also, in central and eastern European countries, there may exist an aversion created by the previous system of planning by targets.

It has been suggested that targets have been used for three main reasons: inspirational use at the political level, managerial use at the policy level and technical use at the practical level *(20)*. The review of health policies in Europe carried out in preparation for the 1994 Ministerial Health Policy Conference indicated the use of different types of target *(18)*:

- outcome (or primary) targets, such as reducing infant mortality by 15% during the planning period;
- intermediate targets that must be reached in order to achieve the primary targets, relating to:
  – health conditions or symptoms
  – exposure to risks or hazards
  – behaviour;
- input and output targets relating to resources and services that must be available to achieve primary and/or intermediate targets;
- process or action targets, such as involving other sectors in public health, establishing appropriate infrastructures for delivery or developing guidelines or standards; and
- targets relating to equity in health through socioeconomic determinants of health.

More recently, in the work carried out prior to the latest revision of the WHO European Health for All policy, an analysis of the targets in 40 national Health for All policies indicated that three appear in three quarters of the policies: "improving mental health", healthier living", and "reducing harm from alcohol, drugs and tobacco" *(21)*, all of which relate to NCD.

There is a danger in considering only those outcome targets for which epidemiological data are available for their measurement. Many outcome targets need a considerable period of time for their achievement and, although progress may appear slow, in the mean time there may have been success in achieving intermediate targets such as, for

example, improving health literacy or developing valuable guidelines.

The latest public health policy in the Netherlands referred to above, which focuses entirely on the risks to NCD, sets quantified targets related to smoking, alcohol, overweight (exercise and nutrition), diabetes and depression. Some set a specific level to be reached, for example, "in 2010 only 20 percent should be smokers" while others point to a desired trend, for example, "the percentage of overweight adults should not rise" *(19)*.

The Lithuanian Health Programme highlights quantified targets relating both to overall health and to NCD, including CVD, cancer, mental health and diabetes, and related lifestyle issues such as tobacco use, alcohol consumption, nutrition and physical activity. Finland, although originally preferring policy statements indicating the direction in which it wanted to go rather than specific, quantified targets, now sets quantified targets relating to NCD. One of the reasons given for this change of heart was that, with a decentralization of the policy development process, it became feasible to set targets for the local level. Ireland has a very strong focus on target setting.

There is clearly a need for balance in setting more-or-less quantified targets. More targets indicate the broad nature of the NCD challenges, but fewer are probably more easily manageable. While considering annual action plans for the implementation of the Hungarian Public Health Programme, it has been repeatedly stated that fewer targets would be more easily managed. A similar position was reached in New Zealand, where health targets have recently been introduced for 2007/2008, half of which relate to NCD. Their comparison of this recent attempt to utilize targets as a tool for policy development, compared to previous efforts, is interesting for our purposes. Only a small number of targets are set, "reflecting the need to focus on a manageable number of priority areas" *(22)*.

Only a few countries (including Finland and the United Kingdom) have set explicit, quantified targets for the reduction of inequalities in health. Sweden's national strategy for public health, referred to earlier, also sets targets relating to the social determinants of health, such as those related to reducing poverty and creating a satisfactory physical environment.

In recent years, there has been a general renewal of interest in setting quantified targets, partly encouraged by the EU (where targets are set and monitored, for example, for the NAPs) and by the funding agencies in countries where external financial support is requested. A number of public health experts also encourage this approach *(23)*.

Legitimization

The way in which policies are legitimized depends on the cultural, political and legal framework in a specific country. NCD policies require collaboration across sectors, and must be sustained over the long term if their aims are to be achieved. It is particularly important, therefore, that legitimization comes from as high a level as possible to ensure the necessary degree of status, stability, sustainability and harmonization of action.

Parliament constitutes the highest level of legitimization, and certain NCD policies are enshrined in legislation. In many countries, however, a formal and binding form of law is not considered appropriate, particularly for a broad, intersectoral NCD policy. Finland and Lithuania, for example, have the tradition of a less formal discussion and approval by parliament. Parliament is a naturally intersectoral body and discussion at this level should also help improve understanding of the need for collaboration across sectors.

The role of the parliamentary health committee or its equivalent is particularly strong in countries such as Hungary and Lithuania. The specific case of the Parliamentary Commission set up in Sweden has been referred to above. Whatever form it takes, the close involvement of Parliament

has been shown to be vitally important in building a degree of cross-party consensus, thereby creating more positive conditions for sustainability beyond the electoral cycle.

Particularly in recent years, in some countries, legitimization comes from or is strengthened by the president or the prime minister, which again can be important in the achievement of cross-sectoral collaboration. In France, for example, President Chirac was clearly seen to endorse the 2002 Public Health Act and he launched a presidential mobilization with five strands, one of which was cancer prevention. In the United Kingdom, the Prime Minister signed the foreword to *Saving lives: our healthier nation (24)* and the preface was signed by ministers and representatives of 12 ministries.

In some countries, such cross-sectoral legitimization is framed in the form of a government-level resolution. Even when legitimization is not formally at government level, there is a tendency to make this broader than the traditional decree or resolution of the minister of health. In recent years, there are increasingly examples whereby more than one minister signs a broad or issue-specific NCD policy. This wider legitimization has not, however, reached all countries, and this is particularly important in the countries emerging from the former USSR and in the Balkans where health ministries have a relatively low status and are weak in guiding implementation. In Albania, for example, the 2003 Strategy on Health Promotion and Disease Prevention was issued from the Ministry of Health without the formal commitment of the Government.

Recognizing the need for broader legitimization than that secured through formal approval, wider forms of consultation are gradually being developed across Europe. There is also a growing use of surveys to assess the acceptability of certain policies, particularly in the area of tobacco control or, in the case of Ireland, for example, also in the area of alcohol control. It is interesting that opinion polls and attitude surveys, such as those carried out by Eurobarometer, sometimes indicate stronger support for public health action than politicians assume.

Communicating the policy

When a policy has been formulated, the results can be lost if insufficient attention is paid to, and resources designated for, its publication and communication. Among the case-study countries, communication strategies are generally notable by their absence. On the whole, much of the work related to raising the interest of the media in NCD policy implementation appears to be rather ad hoc. Specific policies and strategies for working with the media to tackle NCD were not in evidence. For the current Swedish policy mentioned above, considerable attention was paid during the policy formulation process to producing not only scientific reports on all the sub-issues, but also thought-provoking pamphlets on controversial topics. This greatly increased the impact that the policy formulation process had through the mass media, encouraging articles in the press and television discussions.

Policy implementation

As seen from the case studies, there are examples of NCD policies, both umbrella and issue-specific, that got no further than being a book on a shelf. This may be due to political changes, as in Hungary when the Government changed before implementation could begin, indicating that the timing of policy development can be crucial. In the case of Albania, failure to implement was due to there being no strong ownership of the policy, indicating the importance of involving the main stakeholders from the very beginning.

Finland, France, Ireland and Lithuania offer examples of policies being implemented and going the full circle, reaching the end of their planning period and then being evaluated and revised.

The policy content

The content of some of the policies examined did not facilitate their implementation. In some cases, the broad objectives were so vague that the various stakeholders were said to have different perceptions of what constituted implementation. Another reason given was the defining of too many objectives and targets, and the lack of priorities between them, thereby overwhelming the implementing authorities.

On the other hand, the process of defining quantified targets appears to have inspired and motivated partners to take action in some countries, improving commitment, fostering accountability and providing guidelines for allocation of resources. This was the case, for example, in Ireland and Lithuania, where the achievement of previous targets was said to show that it could be done. Conversely, the setting of over-ambitious targets caused some frustration in the implementation process in some cases.

Plans for specific action

If NCD policy is to be implemented, it needs to be clear what is to be done, how it is to be done, and by whom, when, where and with what resources. In particular, given the essential intersectoral nature of policies for NCD, an action plan indicating where responsibility for action and for harmonization of such actions lies is imperative.

There appears to be a broad range of approaches to the preparation of action plans. In some countries, the main elements of the plan are included in the policy or strategy document itself, while in others a separate document clarifies the prerequisites, partners and tools for implementation. In Hungary, for example, of the overall health policies formulated in recent years, only one clarified the responsibilities of the necessary partners and the resources essential for implementation. In this case, 19 working groups prepared action plans for sub-issues and these were added as an annex to the policy document and approved by Parliament. The current overall health policy for Hungary does not include an action plan, neither does that for Albania. In France, proposed interventions are included in the issue-specific policies, and in Lithuania, government programmes serve this purpose. In Kyrgyzstan, there are action plans only in areas where funding is guaranteed, meaning in effect that external funders define priority interventions.

Policy instruments

The range of instruments used for health policy implementation (outlined in Chapter 3 and repeated here for ease of reference) comprises:

- legislation and regulatory measures
- structural, administrative and management measures
- financial instruments
- consultation and negotiation
- human resource development
- research and information
- awareness building and health education
- monitoring and evaluation.

The full range of policy instruments seems rarely to be used, however. Of the NCD policies examined, the tools that most frequently appear are legislation and regulation, awareness building and health education, financial instruments and, to some extent, human resource and information development. Comparatively less attention seems to be given to structural, administrative and management measures, including consultation, negotiation and coordination with other sectors. This almost gives the impression that, because intersectoral action is stated as being essential, it will happen of its own accord.

The role of legislative measures is particularly significant for issues such as nutrition and tobacco and alcohol control. The WHO FCTC had a significant impact on tobacco legislation in all the case-study countries and indeed across Europe. The strength of such measures varies, however. Countries such as Finland, Ireland and Lithuania have man-

aged to implement extremely strong legislative measures and to obtain public acceptance of them, whereas Greece, a tobacco-producing country, has not gone so far. What is also important is that those countries with strong legislation in place have also provided for the means to enforce such legislation and to call to account those who do not observe it. This includes heavy fines in some cases.

The impact of EU legislation for consumer protection is particularly important, although in some countries such as Finland this has had certain detrimental effects, examples being the EU subsidizing full-fat milk in schools and more lenient alcohol control regulations.

Certain legislative measures do not have important implications for public funding. Possibly for this reason, in lower- and medium-income countries such as Albania and Kyrgyzstan, legislation may offer feasible entry points for starting the implementation process.

Despite the development of the concept of health promotion on an international level, traditional health education measures still seem to dominate in countries such as, for example, Albania and Greece. These are not always accompanied by the necessary additional support measures that international research has proved to be more effective. On the contrary, the success of the Irish policy to prohibit smoking in bars and restaurants was due to a combination of health education on the dangers of passive smoking, consultations with trade unions and the hospitality industry, counteracting misleading claims by opponents, on-site visits to places of work, discussions with enforcement agencies, the establishment of fines for non-compliance, and the provision of a list of named people to whom complaints could be made.

Financial measures can be particularly effective, particularly in relation to the price of tobacco and alcohol. Some countries have taken the cost of tobacco out of the basket of household goods used to calculate inflation. In all the countries examined, policy implementation at the regional or local level is at least partly financed by central funds. In a number of cases, access to such funds has been linked to criteria related to NCD policy implementation. Finland offers a clear example whereby the loss of central control over designated funding has created considerable inequalities in policy implementation at the local level.

Protocols and guidelines

There is a growing development in Europe of protocols and guidelines for tackling NCD, clearly influenced by work in WHO and the EU. The scale ranges from international protocols for breast cancer screening, through standards for measuring and treating blood pressure, to the publication of nutrition guidelines for schools, workplaces or various high-risk groups. The WHO survey on national capacities and policies to respond to NCD, referred to in Chapter 2, found that it was more common for countries to have national protocols, guidelines or standards for diseases such as diabetes, heart disease and cancer than to have the corresponding policy instruments for weight control and physical activity *(25)*. Protocols for the care of NCD patients are also becoming more widely available, but are apparently not always regularly implemented.

Resources for policy implementation

Financial resources

The situation regarding designation of funding also varies considerably among the case-study countries, from those where financing is allocated for the full planning period to those, such as Hungary, where funding can be designated on a yearly basis through the annual budget. Other countries make no mention of the financial resources necessary for implementation, although the system of funding (if not the amount) may be specified. The case-study countries offer numerous examples whereby clearly designated funds, or the lack of such funds, have determined the feasibility or otherwise of policy implementation.

With the possible exception of Finland and Ireland, NCD prevention and health promotion are generally underfinanced compared to curative activities. In the case of Kyrgyzstan, the chances of implementing the first annual action plan fully depend on the very scarce resources of ad-hoc funding and partly on the flexibility of international donors.

The WHO review of NCD capacities and policies in countries indicates a more frequent use of the taxes on harmful substances, such as tobacco, for the purpose of health promotion. Finland has been implementing this approach for a number of years, and Lithuania is following suit. On a more general level, it is not clear how consistent and sustainable this approach might be compared to funding from general tax revenues, for example. A more recent phenomenon, seen in some other countries such as Austria and Switzerland, is the transfer of a certain proportion of insurance fees to health promotion or public health foundations.
One way of encouraging policy implementation is through the use of criteria related to policy values, aims and objectives when deciding on the designation of resources through state bidding systems. This is done in Hungary and Lithuania, for example.

The availability of EU funding is clearly influential in the EU countries, particularly since this entails close monitoring of how the funds are spent. The availability of World Bank funding clearly influences policy implementation in Kyrgyzstan.

Human resources
In the countries emerging from the former USSR and the Balkan countries, a limited number of trained staff in the field of public health is one of the most important restrictive factors for the implementation of NCD policies. An equally important question is whether the required combination of resources is available. During certain periods in the implementation of the Hungarian NCD prevention strategies, for example, the lack or poor quality of experts working in the field significantly limited implementation capacity, even when the funding was quite robust.

Capacity building
The element of capacity building for policy implementation, including the need for broad training programmes, is not evident in many plans of action, although Finland, Ireland and Lithuania pay particular attention to training. The proposed development of new institutions is sometimes more visible.

One optimistic sign is the development throughout Europe in the last decade of improved planning methods. Given the strict planning requirements of international funding organizations, implementing a project that they have financed can be an extremely important learning process for national experts.

Levels of governance
A complex set of arrangements is required for NCD policy implementation at national, regional and local levels and in various settings. There have recently been attempts at the national level in some of the countries studied to clarify the responsibilities of the different ministries and other organizations. One of the criticisms heard, even in those countries with a long experience of NCD policy implementation, however, is that it is frequently not clear who should be doing what and when, particularly at the local level.

The way in which national policy is implemented at lower levels of government depends very much on the prevailing general practices of the political system.

At one end of the spectrum, the centre exercises tight control over lower levels of the system through a linear, hierarchical organization led by a national agency of health promotion or public health, with subordinate units at regional and district level. This is the case in Hungary, Kyrgyzstan, Lithuania and nearly all of the countries emerging from the former USSR. Even in such a vertical system, however, the field activities are carried out in the framework of

multiple partnerships (local government, NGOs, PHC, private sector, local media, churches) coordinated by the government-based technical agencies. At the other end of the spectrum, lower-level authorities may have considerable discretion in the interpretation of the central NCD policy. This is the typical case in Finland, France and Ireland.

Owing to the complex nature of NCD policy, even when hierarchical systems are in place, additional efforts are needed to convince and motivate stakeholders and to implement new structures or procedures through negotiation and other participatory methods. Kyrgyzstan, for example, is currently facing these questions while planning the first annual action plan for implementing its umbrella policy.

Even within the health sector, the implementation process appears to be hindered by a lack of coordination between public health services and PHC. This could be a particularly serious threat to the implementation process in Kyrgyzstan, for example, and does not appear to have been handled really efficiently in any of our case-study countries.

Community involvement is clearly essential for NCD policy implementation and, generally speaking, community-based approaches are characteristic in Finland and the other Nordic countries as well as in Ireland and the United Kingdom, for example. In Kyrgyzstan, the Swiss Red Cross and the Republican Centre for Health Promotion created health promotion units at district (*rayon*) level with a strong focus on engaging the population through the traditional form of consultation in Kyrgyz society. This example also shows how NCD prevention and health promotion can contribute to the overall democratic development of a society.

Settings

The settings approach has been successfully used in a number of countries, particularly influenced by international networks such as Healthy Cities, Health Promoting Schools, and Health Promoting Hospitals, for example. In a number of cases, the international networks have been used to initiate action in a particular setting, but then much wider approaches have developed, adapted to the national situation. This is particularly noticeable in the schools setting in countries such as Ireland, where the Health Promoting Schools way of thinking has influenced activity in all schools.

The workplace has provided a very fertile setting in Finland, heavily supported by research and training facilities and strengthened by the necessary legal framework. In most of the study countries, however, it appears that the workplace is as yet a largely underutilized setting for NCD policy implementation.

Hospitals have recently focused attention on risk factors for NCD such as smoking and nutrition. The health services are one of the largest employers in many countries, yet the huge potential of this setting for tackling NCD in relation both to those working in the system and to those using the system appears to be considerably underutilized. On the whole, the health services are not yet providing a good example of tackling NCD within their own setting.

Time did not allow an exploration of the role of the Healthy Cities in tackling NCD in our case-study countries. However, one of the main aims of the Healthy Cities programme has been to encourage cities to develop their own policies for public health, and guidelines and other tools have been prepared to support this.

Pilot or demonstration projects

A number of so-called pilot projects have been developed in the countries examined, though they have not all operated as "pilots" to be tried, tested and, if successful, implemented elsewhere. In Hungary, for example, within the framework of the World Bank loan, a community-based model project to reduce CVD mortality and morbidity was launched in the city of Kalocsa in the second half of the 1990s. After three years of basically successful implemen-

tation, and an important investment, the experience and lessons learnt were never really used on a broader scale. The North Karelia project in Finland continues, however, to perform a pilot function for certain issues, even after so many years of operation. The CINDI programme, particularly as implemented in Lithuania, has also indicated the value of testing complex NCD interventions on a small scale through a demonstration site before expanding or generalizing the approach.

Monitoring and evaluation

By monitoring we mean surveillance and recording of observed changes, be they changes in epidemiological data, steps taken towards administrative or legislative action, or funds expended. Evaluation goes a step further, assessing whether changes are in the right direction and if policy proposals are being achieved in the sense of what went right or wrong, and why and how.

As might be expected from the mixed picture of implementation, the situation regarding the monitoring and evaluation of NCD policy is equally mixed and rather less vibrant than that of policy formulation. At one extreme, owing to the initial stages of the policy development process as in Greece, the newness of the policy as in Kyrgyzstan or the failure to implement as in Albania, there is little yet to monitor in policy terms. At the other extreme, in countries with well-developed databases, a long history of well-functioning surveillance systems and strong research institutions, such as Finland, Ireland and Lithuania there is a well-developed culture of monitoring and evaluating health policy. These countries have a tradition of transparency in monitoring progress in policy implementation and of reporting back, frequently to parliament.

Approach

Changes in mortality rates are those most frequently monitored, followed by changes in behaviour where this is regularly surveyed. The impact of health promotion and the uptake of screening programmes are evaluated in four of the countries examined. There is less emphasis on monitoring the functioning of the health system or the coordination of policy implementation, although Finland and to some extent Hungary try to do this.

In Finland, where there has been routine surveillance of chronic diseases and their risk factors since the early 1970s, a process has recently been instituted whereby each ministry and level of government is obliged to report back on its impact on health, thus contributing a strong intersectoral aspect to the overall report to parliament on health policy implementation. In Lithuania, the National Board of Health reports annually directly to Parliament. Significantly in this case, the Board enjoys a great deal of independence from the Ministry of Health.

There has been annual reporting of progress in policy development in Ireland since 2001. Different structures and processes for monitoring and evaluation have been tried, including a high-level Cabinet Subcommittee (which was not so successful), interdepartmental group reviews and reports, the regular reporting of the National Implementation Team; and reports of specially constituted task forces reporting on issue-specific policies.

One of the encouraging developments is that, where a system of monitoring and evaluation is in place, this is usually reflected in published documents in a transparent and accessible way. The Internet offers a new possibility for a broad accessibility of published monitoring and evaluation results. In Hungary, for instance, some public health reports and other monitoring results of the National Public Health Strategy are available on the Internet, although so far without special attention to their interest for the general public.

In Finland, France, Ireland and Lithuania, policy documents stated that an interim review should be carried out part-

way through the implementation process. Considerable efforts were made by expert groups and task forces, and the results were published in detailed interim reports. Reports on the results of the monitoring and valuation process then become a valuable resource for future policy revision.

There is a general lack of policy analysis to help inform the policy development process. One exception is Sweden, where it has been decided that there should be a regular and systemic review of the fulfilment of the objectives of its public health policy *(26)*.

Difficulties encountered

There are inherent difficulties in monitoring and evaluating the type of broad policies necessary to promote health, prevent disease and meet the needs of those suffering from NCD. As seen above, such policies attempt to bring about changes in social structures by influencing the social and economic determinants of health, changes in lifestyles and behaviour, changes in access to health care and other services, and changes in the way in which such services perform in the areas of health promotion, disease prevention, treatment and rehabilitation. It is difficult to disentangle the positive and negative impacts of such broad policies, and there is as yet no widely recognized scientific tool for distinguishing the impact of one or other programme element in an implementation process. It is also difficult to disentangle the impact of general socioeconomic changes that would have happened anyway from those targeted by NCD policies.

Particularly in the case of the intersectoral policies necessary to combat NCD, it is important that the policy document itself defines how monitoring and evaluation are to be carried out, who will do it and how they will report back, and what resources will be made available,.

As has been stated elsewhere *(27)*:

> Health promotion action requires multiple approaches, relies on interdisciplinary inputs and operates at several levels over long periods of time. Despite this complexity, health promotion programmes are often forced to be evaluated with methods and approaches that, although quite acceptable within medical care and prevention, are totally unsuitable for this field.

It is clear that in this complex field, multiple methods of evaluation are necessary, involving various partners and using both process and outcome information. It has been suggested that a minimum of 10% of the total financial resources for a health promotion initiative should be allocated for its evaluation *(27)*. Hungary tried to implement the 10% formula but this was cut as soon as there was a budget crisis.

It has been suggested *(28)* that certain areas in the evaluation of policies, such as those with which we are concerned, particularly need attention.

- A clearer definition of objectives and targets, whether related to outcomes or to processes, would avoid inappropriate expectations concerning evaluation and accountability.
- This requires more systematic use and development of reliable indicators of progress.
- An appropriate level of intensity in monitoring and evaluating should be adopted, modest attention being paid to monitoring tried and tested interventions and closer scrutiny given to newer, innovative or potentially costly interventions.
- Appropriate methods of evaluation should be designed. Certain experimental methods, including randomized controlled trials, are simply not appropriate for evaluating complex policies. The advantages of different research methodologies, both quantitative and qualitative, including a wide range of data and information, need to be combined in an approach that allows the issues to be seen from the point of view of different disciplines.

We would add that more use needs to be made of social and behavioural research to improve understanding of target populations and the range of personal, social, environmental and organizational characteristics that may be modified with a view to reducing NCD.

Participation of the public in policy monitoring and evaluation is rare, except, as might be expected, in the case of more narrowly defined issues such as the impact of smoking control policies in, for example, the workplace and restaurants or in small communities or schools.

Targets/indicators

As seen above, in a number of countries, the setting of quantified targets for reducing NCD has clearly affected the process for monitoring and evaluation. In Ireland, is said to have given greater clarity to the indicators monitored. These efforts in the health field in Ireland are also linked, however, to a more general effort to improve effectiveness and efficiency in the public sector, for which purpose a national set of key performance indicators has been adopted.

In France, for example, the 2004 Public Health Act set comprehensive and clear indicators to be measured regularly. Critical reports are to be made every four years on health status (reflecting health inequalities) and on resource allocation. A special commission of the High Committee on Public Health has responsibility for monitoring and evaluation, and the regular reporting of institutes such as INSERM and INPES are crucial to the policy process.

Reflecting inequalities in health

Finland, France, Ireland and Lithuania have vastly improved their information systems for monitoring inequalities in NCD, and to some extent try to evaluate the impact of interventions on inequalities. Apart from these bright exceptions, the evaluation of the impact of interventions and programmes for NCD on different social groups is not well-developed. An additional challenge is that it is not sufficient to simply evaluate separate interventions and to summarize them.

In general, much more remains to be done to reflect inequalities in health in the monitoring and evaluation process, including the impact of such policies on different social groups. In many countries, such monitoring goes no further than signalling geographical variations in mortality from NCD or in the use of health services. Regularly compiled data are not disaggregated according to socioeconomic variables such as income, education or occupation. However, the monitoring of regional inequalities can be a step along the way to focusing on the socioeconomic health gaps. The mandatory monitoring of progress in regions, provided in some NCD policies, can be expected to clarify the causes of inequalities in health within countries. Simple mapping techniques such as those developed in Finland, Hungary and Lithuania provide a tool for showing the relationship between socioeconomic status and ill-health.

It is possible that countries are simply not making effective use of existing databases. A review of existing data sources across sectors revealed valuable, hitherto unused information being utilized to assess the extent of socioeconomic inequalities in health. When this was published in a national report, it created a snowball effect, as researchers realized they were sitting on valuable sources of information not being used for health policy purposes.

The monitoring of the persistent and growing health gaps in Finland, despite clearly defined principles of equity in health and years of egalitarian social and economic policies, has called into question the universalistic approach hitherto taken. The need for health policies also to focus on high-risk or vulnerable groups is currently being discussed.

For countries in the EU, through programmes such as the NAPs, a gradual improvement is being made in reflecting socioeconomic inequalities.

The impact of international networks and organizations

Involvement in international networks has obviously had a strong impact in some of the countries studied. Those countries participating in the MONICA Project and CINDI programme not only have a strong history of monitoring and evaluation but, partly through their involvement in these projects, continually improve the capacity of their expert teams. Reporting back to WHO, and more recently to the EU, also improves these processes and contributes to greater comparability of international data. Finally in this respect, Finland and Lithuania are closely involved in monitoring and evaluation through the Nordic and Baltic groups of countries, providing them with interesting examples for comparison of progress being made.

In countries with a heavy dependence on external funding (EU and the World Bank), the donor or funding agencies require mandatory monitoring, particularly of financial resources used but also of progress in achieving aims and objectives. In EU countries such as Greece, for example, where NCD policy development is still at an early stage, reporting back on health components of EU regional or structural funding, which is perforce regularly carried out, could gradually improve the overall monitoring and evaluation culture.

HIA

One of the tools or approaches for strengthening the evaluation process is that of HIA (also known under other names in Finland and Ireland. HIA is, however, a tool for assessing policies outside the health sector that were not originally designed to have an impact on health. Its effect on the NCD policy process must therefore be rather indirect. The introduction of the tool, the improvement of the HIA methodology and the training of HIA practitioners can at the least encourage HIA thinking, as seen from the efforts of the Institute of Public Health in Ireland, for example *(29)*. The development of the method also holds promise from the perspective of flagging up areas of interest for future NCD policy. Recent research, for example, indicates that the modern knowledge economy may be damaging its "mental capital" as workers are pressured to be ever more productive *(30)*.

Although it is suggested that HIA should be concerned not only with the aggregate impact of a policy on health but also with the distribution of its impact on different social groups *(31)*, this was rarely seen among the countries studied or in Europe in general.

Peer review

Finally, Finland presents a special case of using reviews by external experts to evaluate progress, not only of its Health for All and health promotion policies but also of research institutions that support the policy process. These reviews were carried out with absolutely no restrictions on the material to be examined and the questions to be asked. Such openness naturally requires a particular culture, but the results of such endeavours appear to have been well worth the effort *(32)*. The regular external policy reviews carried out by OECD in the educational, environmental and economic sectors, for example, have been considered for many years to have been of considerable value, both to the countries being reviewed and to those participating in the review process.

Policy revision

In countries where there has been long-term sustainability of NCD policy development, such as Finland, Ireland and Lithuania (and France in relation to issue-specific policies for cancer and nutrition), monitoring and evaluation leads to policy revision. Such revisions can be differentiated on the basis of whether the revision is carried out by the same government or minister responsible for the previous document or whether it is carried out by newly appointed politicians who might be more critical of the work of their predecessors.

On the whole, "revised" policy documents give less weight to analysing the NCD situation, since this has probably not changed significantly. Particularly if this is a "same party" revision, there is perhaps a tendency to overemphasize the positive results in self-justification of the original policy and minimizing possible weaknesses and failures, although there are refreshing examples of a critical approach. Since the revised policy is the next step in a longer-term process, the need to clearly identify the challenges ahead can be one way of ensuring that there is some critical analysis of what might have gone wrong the first time around.

The revision process is frequently handicapped by a lack of evaluation of the effectiveness of policy measures. From the examples examined, it tends to be largely limited to changes in epidemiological data, without a serious attempt being made to disentangle the real causes of the changes.

In most cases of policy revision, there is little change in the underlying values, which are frequently reiterated. New or additional objectives may be listed and reference is usually made to related actions in the field of interest carried out in the previous planning period, such as new steps in anti-tobacco legislation or nutrition programmes in schools.

Discussion

This chapter has reviewed the findings of the eight case studies and relevant literature, drawing together the key points emerging from the cross-analysis for each stage of the policy cycle. While recognizing that this is not a statistically representative sample of European countries, nevertheless certain themes emerge that may be useful for broadening understanding of the policy-making process for the prevention and control of NCD and the conditions that influence it.

From the work carried out, it appeared that the most frequently asked questions related to the implementation of a policy process along the lines of the European NCD Strategy *(1)* are the following.

- What is an NCD policy in reality?
- Is an overall, integrated NCD policy necessary?
- Are there certain basic prerequisites for the successful development of NCD policy?

What is an NCD policy in reality?

As stated in the Introduction, NCD policy needs to address a set of conditions that includes CVD, cancer, mental heath problems, diabetes mellitus, chronic respiratory diseases and musculoskeletal conditions. This broad group is linked by common risk factors, underlying determinants and opportunities for intervention.

Although the study touched on overall approaches to tackling NCD, particular attention was paid to explicit (and thus documented) formal decisions by an executive agency to solve challenges related to NCD. These decisions were reflected in policy documents establishing of a set of goals and objectives, the priorities between them and, in many cases, quantified targets to be met within a specific time-frame, and outlined the deployment of specific resources for their achievement. For such goals, objectives and targets to be translated into operational form, countries defined various "interventions" or "policy instruments". A policy to tackle NCD is not therefore simply an "intervention", but a higher and more complex arrangement that defines and orders sets of interventions.

None of the countries studied was found to have a national-level policy specifically designed to tackle NCD in an integrated way. Although there were examples, in some cases reiterated over a number of years, of broad Health for All-type policies or other public health strategies, none of these countries with such a broad "umbrella" policy had clearly linked sub-policies for NCD originating from it. Instead, countries did have a large variety of different types

and levels of policies and strategies tackling NCD in more-or-less explicit ways, with a limited degree of coordination between the various elements. In some cases, certain NCD policy objectives were included in public health policies with a wider remit. In other cases, countries had separate policies to tackle individual diseases or various risk factors for NCD.

In practice, from the countries studied, NCD policy development is a process based on existing policy development experiences and structures and is less a question of putting the NCD label on new processes. Throughout Europe, there appears to be a rich array of approaches to tackle different elements of NCD prevention and care and health promotion. The formalized policy framework for this type of action is either linked in some way to a broader health policy document or packaged in different ways (e.g. heart health programmes).

In many ways, this fits with the findings of the WHO survey *(33)* that approximately 75% of the 38 European countries responding (which included all 8 case-study countries) said that they had an NCD strategy, even though none of them had a single document of that name. Rather, countries appeared to have policy "packages" that collectively responded to the challenge of NCD. This leads to the next question.

Is an overall, integrated NCD policy necessary?

In considering this question, it is important to distinguish between "coordination" and "integration". Coordination is concerned with bringing actions of equal rank or order of importance into harmony in order to ensure greater effectiveness. Integration is concerned with combining such actions into a unified form to meet a common objective. Generally speaking, policy integration is the process of attaining close and seamless coordination among several policy elements or systems. An integrated NCD policy should be more than the sum of separate policy elements.

Policy issues to tackle NCD are increasingly cross-cutting, and policy integration has therefore become an attractive concept. Good governance of health systems focuses on the interdependence of different policy fields, while integration contributes to identifying synergies and trade-offs.

NCD policy integration is certainly not a trivial process. It is concerned with the progressive linking and testing of policy components to merge their functional and technical characteristics into a comprehensive system. The process includes the strategic alignment of different NCD-related programme resources to increase the effectiveness and efficiency of each activity in a partnership without compromising the integrity of separate NCD programme objectives, or at least to minimize contradictions between overall NCD policy aims and different specific programme activities.

For the different actors in NCD policy development, integration also means:

- building on common interests
- finding points of linkage
- eliciting resources.

Consequently, the process of integration includes not only appropriate procedural and organizational changes in policy-making but also a wide range of practical efforts such as:

- common information systems
- NCD coalitions
- joint planning and priority-setting activities
- joint project implementation
- shared or combined funds
- joint training
- common media messages.

Thus, from the perspective of good governance of health systems and intersectoral cooperation, there are decisive

arguments for applying an integrated approach. The gains from a managerial point of view are also important.

The most decisive argument in favour of an integrated approach is the ample scientific evidence on the common social and economic determinants of NCD (including lifestyle factors). Further, in many cases these determinants have an important influence on inequalities in NCD, so that vulnerable social groups are also at risk for NCD.

This rationale related to health and inequality in health is in itself a sufficient argument for the use of coherent policy tools and an integrated approach. WHO Strategic Objective No. 7 *(34)* seeks to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate approaches that take into account poverty, gender aspects and human rights. In this respect, the European NCD Strategy *(1)* is part and parcel of overall policies to promote social justice and inclusion and to reduce health inequalities.

It is difficult to define criteria for assessing whether NCD policy integration has been achieved and to what extent. Although countries have not formally articulated all the principles of an integrated NCD policy at national level, the absence of a formal national policy statement does not necessarily mean that no attempt at integration is being made. The process and elements of at least some degree of coordination are observable in all the case-study countries. Furthermore, given the stage of NCD policy development in some countries in the sample, and the study's focus on process, it was possible to consider NCD policy integration more fully at the early stages of policy-making. Thus more focus on coordinated or integrated inputs and associated processes than on outcomes could be observed, including in a few cases examples of common objectives or targets.

It is possible that national Health for All-type policies, long-term public health strategies and even national heart health and cancer programmes could be key drivers in the integration process. In the light of our results, however, such broad umbrella policies are far from being a guarantee of a better-integrated NCD policy process.

The countries where broad health policies have been implemented and sustained, in some cases over many years, are those characterized by a high quality of information and expertise, participation in international level programmes, and a culture of consensus building. The sustainability of such efforts has apparently created long-term awareness of NCD challenges and facilitated the potential for cross-sectoral working to tackle them.

On the other hand, policies focusing on relatively simple, discrete issues seem to have had a higher potential for achieving their aims than broader policies addressing complex issues. In some countries, individual risk-factor approaches have proved highly successful, mainly in the field of smoking and nutrition and less so concerning alcohol use and physical activity.

Arguments in favour of developing issue-specific policies include:

- the issue may be more clearly defined and understood, including links between cause and effect;
- measures for tackling the issue, as in the case of smoking, may have been tried and tested;
- the number of potential stakeholders is reasonably manageable; and
- such issues are frequently supported by strong lobby groups.

The disadvantage is that there appears to be considerable overlap and wastage between some of these vertical policies. Their lobby groups compete for resources and those with the loudest voices – not necessarily those with the

most urgent needs – may get priority. This clearly represents a lost opportunity for synergistic action.

Nevertheless, some concern was expressed by experts in the field that issue-specific policies might lose the dynamism created by their proponents if they were combined with other policies.

To draw together this discussion, we can say that a policy to tackle NCD should be at least as effective as its constituent parts, but the integrated approach seems to offer added value. What is important is that the different components of the policy process are developed, planned and implemented synergistically from a solid evidence, community and theoretical base.

The path to better coordination of such policies may be not only through the development of an integrated umbrella NCD policy but through various other forms of coordination, such as shared information, expertise and settings. The case studies also indicated other means of coordination that could be expanded upon and explored further, such as shared targets, shared resources and the use of an existing cross-governmental steering group.

There is an increasing understanding across Europe of the many pathways through which social, environmental and behavioural risks interact. There are many legitimate entry points and ways of NCD policy integration/coordination that European countries can adopt to guide their actions.

There is convincing evidence and rationale for the promotion of an integrated approach to NCD policy development. An overall, formal NCD-specific policy framework may not necessarily trigger such a process. However, NCD covers such a broad area that, unless there is at least an explicit discussion of objectives and the priorities between them, it is difficult to see how the most effective use of knowledge and resources can be achieved.

Are there certain basic prerequisites for the successful development of NCD policy?

It is clear that the development of policies for tackling NCD is affected by an extremely broad range of contextual factors, many of which are outside the control of those responsible for NCD policy. Such factors, be they historical, social, economic, political or cultural in nature, may either enable or constrain the development of an NCD policy. Together, they create a certain climate in a country that affect the feasibility of such policies at any point in time. Epidemiological data clearly show that NCD are the most important health policy challenge in all European countries, but NCD policy is a long-term investment. Policy-makers can expect limited visibility or success within an electoral term, so with prospective re-election in mind the motivation for developing NCD policy may be rather low.

The many common features in the policy-making process uncovered by this study indicate that the framework of action in the European NCD Strategy *(1)* describes a number of common characteristics in an appropriate way. Certain key factors have been important in achieving success in the countries studied, such as:

- a strong resource base (information and expertise) on which the policy could draw;
- a long-term policy negotiation tradition or persistence exerted by a committed agency or group of prime movers that enabled a broad involvement of stakeholders; and
- a strong political commitment to the preferred outcome of the policy package.

There does not appear to be a linear relationship between a successful policy for tackling NCD and the level of economic and social development of the country. Low- and medium-income countries, and late starters in developing strategies, can elaborate and implement effective NCD policies. Countries have to do this by focusing on establishing

the most appropriate prerequisites for health in given situations. Nevertheless, the persistence and scale of inequalities in health status that exist within European societies and between the populations of high-, medium- and low-income countries make it necessary to identify the components of policy development that are critical to closing the health gaps in Europe. There is also a need to identify standards and indicators that can be used to improve practice.

Intersectoral action and collaboration with multiple actors is the essence of NCD policy, but the interests of potential partners do not always converge with those of NCD policy implementation. The case studies presented here offer examples of both converging and conflicting interests, but there does not appear to be any comprehensive assessment of the possible converging and conflicting interests of other sectors in relation to NCD policy development. It could be interesting to assess this, not only from the perspective of the health sector but from the perspective of the other sectors themselves.

Finally, despite the diversity of the specific national experiences, differences in health systems and different patterns of economic and social development, the study provides examples of a range of criteria for the successful development of NCD policy:

- clear values, which are particularly important in the context of NCD policy development, namely universality, solidarity, equity and participation;
- key principles of governance in public services of special relevance for an integrated NCD policy, namely transparency, participation, accountability, effectiveness, efficiency and quality;
- a long-term, consensus-oriented and inclusive strategy, responsive to emerging challenges and with special regard to political legitimacy and sustainability;
- decision-making processes that are participatory and transparent to all stakeholders and citizens;
- development of the necessary culture and capacities for policy analysis, advocacy and intersectoral action for health in public administration and in the research arena;
- NCD policy-making and planning informed by the best knowledge available, including contributions from all relevant disciplines and experience, and built-in mechanisms for monitoring and evaluation based on clear objectives;
- application of the NCD policy development principles mentioned above to both the public and the private sectors of the health system and to all levels of governance (national, regional, local) following the principle of subsidiarity, to ensure an optimal allocation of tasks among the relevant levels.

"Business as usual" is simply not good enough in this complex policy environment, particularly in view of new responsibilities being decentralized to local levels. A number of countries in this sample are making intensive efforts to modernize government and prepare their civil servants for working in a more innovative and flexible way to cope with a rapidly changing world. The need for a modern planning system is also apparent from the intersectoral approach essential for tackling NCD. To put this simply, the health sector must be able to bring about action in fields over which it has little or no control. The question is whether traditional policy-making and planning systems in the health sector are appropriate for cross-sectoral planning. On the other hand, a strong focus in some countries on addressing poverty and social exclusion could open new avenues for tackling the determinants of inequalities in NCD.

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Chapter 6

Pointers to the future

Péter Makara & Anna Ritsatakis

Introduction

In the coming years, the substantial reduction of NCD and their related health inequalities constitute one of the major public health challenges facing Europe. *Gaining health (1)*, WHO's European NCD Strategy, outlines a comprehensive, action-oriented approach to the prevention and control of NCD.

Those who plan and deliver policies and services to tackle NCD face increasing pressure to demonstrate that their actions are worthwhile, effective and efficient. They are faced with questions on: whether an NCD policy is a good investment; how the short- and long-term aims of such a policy can be harmonized; whether there are general rules of planning, coordinating, implementing and monitoring policies to tackle NCD; to what degree social and economic factors related to policies tackling NCD can be influenced; and how the resulting mutual gains can be measured. Policies and programmes to tackle NCD, if properly planned and implemented, involve complex and sophisticated activities. NCD policy action requires multiple approaches, relies on interdisciplinary inputs and operates at several levels over long periods of time. Despite this complexity, policy development must be monitored, assessed and revised.

Fortunately, over the last 2–3 decades, knowledge and understanding about how best to develop policies to tackle NCD have significantly improved. Decision-makers and practitioners, however, are not always fully aware of these developments or their implications. This study was not intended to provide a "cookery book" for NCD policy-making. Nevertheless, some of the lessons learnt may offer a source of inspiration and pointers for future policy-making.

The extreme complexity of the task requires originality and creativity, to build on existing experience while exploring new ways and solutions. In looking forward, policy-makers are faced with a wide range of issues, both long-standing such as the ageing population and newly emerging such as technological changes in health care and the communications field, globalization and an expanding EU. In this final chapter, therefore, some of the challenges and opportunities in the policy environment are briefly touched on to give an idea of the comprehensiveness and complexity of the task ahead. Some pointers for the future are then suggested.

Challenges and opportunities

Demographic and health issues

By 2050, on average in OECD countries, a quarter of the population will be aged 65 years and older *(2)*. A new, older society is emerging, with implications for families, health care, and social and economic development. In the WHO European Region, people aged 65 years can expect to live a further 17 years and, if present trends continue, those aged 65–79 years will be more active and in better health than in previous generations. They represent a valuable resource for society, so it is more important than ever that people remain healthy and independent.

As premature deaths from NCD decline, morbidity can be "compressed" to a later stage of life and degenerative diseases may have longer to develop, potentially laying a heavy burden on health and social services and on informal carers. Raising awareness of the value of health promotion and preventive measures among policy-makers and older people themselves may be needed, as many may believe they are too old to benefit by changing their lifestyle *(3)*. Problems such as alcohol abuse often go unrecognized and the benefits of taking up exercise or giving up tobacco, even late in life, may be unappreciated. NCD policy needs to be tailored to an ageing society.

The health of children and the way in which they are nurtured through adolescence into adulthood will affect the prosperity and stability of countries over the coming decades *(4)*. Although children in the European Region today benefit from better health development than ever before, and infant and child mortality rates in some countries are among the lowest in the world, there are striking health inequalities both across and within countries. The basis for good health is established even before conception. Health-related behaviour such as smoking, alcohol abuse, physical activity and eating patterns can become established from an early age. The prevalence of depressive illness among the young appears to be increasing, and this is often linked to poor educational attainment, antisocial behaviour and substance abuse.

In harmony with the European NCD Strategy *(1)*, the Regional Office's strategy for child and adolescent health *(4)* recognizes the need for taking a life-course approach in tackling chronic disease and disability, by addressing the health challenges at each stage of development. State structures for formal education are in place in all countries, and the school has been an important area for investment in health promotion *(5)*. Much greater advantage could doubtless be made of this particular setting, and the necessary links be made to other sectors. For example, EU regulations concerning the use of surplus agricultural production are being adapted to encourage children's consumption of fruit and vegetables in school *(6)*.

In many countries, immigration is vital for population size, the labour market and economic growth. While some studies suggest that chronic diseases are less prevalent in certain migrant groups, others demonstrate that some immigrants may be at higher risk for certain NCD, particularly hypertension, diabetes and certain forms of cancer *(7)*, depending on their country of origin or lack of inclusion. In many EU Member States, most of the migrants are on the periphery of the labour market with all the signs of social exclusion and the difficulties of social adaptation and integration. Among them, the prevalence of harmful habits can be extremely high. Residency status, language, literacy and cultural issues can prove further obstacles to accessing care and preventive services. Attempts are being made to improve the knowledge of migrants' health status and health determinants, to identify good practice related to access to health services, and to contribute to the definition of health policies and strategies aimed at improving migrants' integration.

"Obesity presents Europe with an unprecedented public health challenge that has been underestimated, poorly assessed and not fully accepted as a strategic governmental problem with substantial economic implications" *(8)*. Rates of obesity are rising in virtually all parts of the Region, and particularly alarming is the rise in childhood obesity. Body fat accumulates when the energy content of the food consumed exceeds energy expended. Both sides of the energy balance are of concern, but less attention has been paid to physical activity. Simultaneously, working and living environments become "obesogenic", increasingly discouraging physical activity. Tackling obesity requires a broad intersectoral approach.

Alcohol abuse is a serious and not fully recognized challenge for shaping policies tackling NCD. Alcohol is a significant contributor to major conditions such as heart disease, cancer and mental health problems, as well as injuries. Alcohol is also the leading risk factor for both disability and death among young people in Europe. Although a WHO European regional framework and an EU strategy (mainly emphasizing drinking among the young) are in place, alcohol policy development is one of the weakest elements of European health policy development. Policies to tackle alcohol abuse require a high level of complexity and must face deeply rooted historical habits, strong economic interests, mixed messages and a limited number of successful policy experiences.

The persistent challenge of inequalities in health

From ongoing research, it is clear that NCD and their risk factors reflect, and contribute to, considerable inequalities. A report from 2006 *(9)* indicates that, for 21 EU countries with relevant data, mortality from CVD is higher among those in lower socioeconomic positions, and smoking is also likely to be a key factor. The same report states that, in 18 countries, national surveys showed that self-assessed health was worse among those in the lower socioeconomic groups and that these people frequently have poorer access to necessary care.

The WHO Commission on Social Determinants of Health, reporting in 2008, has gathered a huge body of evidence on plausible causal relations; key areas in which action should take place; and effective practices and interventions for addressing socially determined health inequities *(10)*. The resulting work is accessible on the Internet (http://www.who.int/social_determinants/en), offering examples of what works.

Rethinking health care

There is now better understanding that equity in access to care refers not only to the geographical distribution of services but includes social, economic and cultural issues. The focus is on "patient-centred care," meaning that the patient must clearly be seen to be part of the health care team. NCD patients and their families are being given training in coping with their disease, and "expert" patients are sharing their experience with others, including health care professionals.

New technological developments may dramatically affect NCD. The field of genetics already provides information that can be used to determine both how diseases are diagnosed and how new treatments or more specific drug targets can be identified. Developments in pharmaceuticals have shown success in treating hypertension and diabetes, for example. Equality in access to such new developments must be ensured for vulnerable social groups.

Some developments need new skills to ensure that a high quality of care can be delivered to all. Developing capable, motivated and supported health workers is essential to achieving national health goals. WHO suggests a "working lifespan" approach *(11)* encompassing: the stage when people enter the health sector workforce, requiring investments in education and recruitment; participation in the workforce when worker performance should be enhanced through better management; and reducing wasteful loss of human resources when people leave.

Health services employ about 10% of the European workforce *(12)* and human resources account for as much as 60–80% of recurrent expenditure on health services. Nevertheless, information on human resources and their impact on NCD is inadequate in many countries. Human resources for health were the focus of a WHO European Ministerial Conference on Health Systems in 2008 *(13,14)*.

Apart from being a major employer, the health sector accounts for a considerable amount of capital investment, procurement of drugs, technical equipment and "household

goods", including food. There is huge unused potential for creating environments conducive to a healthier lifestyle for the workforce, patients, their families and the local community in the health care setting.

A radically different Europe

Of the 53 Member States in the WHO European Region, 27 are members of the EU, 3 are already candidates and a further 3 or 4 are potential members *(15)*. In addition, the four European Free Trade Association (EFTA) countries have a special relationship with the EU and participate in the Public Health Programme and the network for epidemiological surveillance. A further 16 countries are included under the European Neighbourhood Policy, and the Russian Federation is associated through a strategic partnership. In one way or another, therefore, most of the countries in the WHO European Region are linked to the EU. While this provides opportunities for intergovernmental and cross-border collaboration, it will be important to avoid a two-track Europe of EU-related members and "the rest" on health issues. Furthermore, there are more global and international players on the health scene in Europe and international cooperation for health in Europe needs a new concept with a new innovative division of tasks, rethinking the niche of each organization.

Globalization

Globalization was initially seen as a threat that might be avoided. More recently, it has been accepted as a general framework of world development with deep consequences for the world economy, consequent to changes in trade, communications technology and transportation. Cultural and physical borders are disappearing, radically increasing the movement of people, goods and ideas.

Potentially, globalization has both positive and negative effects on health, the impacts of which need to be carefully monitored and if possible controlled. The issue is one of trying to achieve socially responsible globalization *(16)*.

There is a burgeoning literature on the potential importance of globalization for health, but little consensus on the channels through which health is affected, or what should be the policy responses, although there have been a number of attempts to provide conceptual frameworks *(16–18)*.

In the globalization discussion, NCD have not always been given the high visibility of communicable diseases or problems caused by the quality (rather than the nutritional value) of food products. It has been suggested *(19)* that to have an impact on NCD, greater use could be made of "hard law" conventions such as the WHO FCTC and "soft law" resolutions such as the Millennium Development Goals (MDG).

NCD are conspicuously lacking in the MDG. This is despite the fact that, for example, a World Bank report estimates that reducing the levels of CVD, injuries and violence in the Russian Federation to those of the EU would improve life expectancy by more than ten years, as compared to a gain of less than one year for reducing infant, child and maternal mortality to EU levels *(20)*. This poses a real challenge for the next review of the MDG to include a substantial reduction in NCD, making them relevant for improving the health status in the European countries with the shortest life expectancies.

Potential partners in the global economic scene

Through activities of the Global Economic Forum and the action of certain companies, the concept of corporate social responsibility (CSR) is already quite well-developed and offers opportunities for combating NCD. Firms the world over, from car makers and petroleum companies to mobile phone makers, electronics companies and supermarkets, for example, want to boost their CSR image *(21)*. Conferences, web sites and magazines such as that of Ethical Corporation (www.ethicalcorp.com) spread the message.

Numerous multinational and local firms are actively engaged in health-related projects and closer engagement could increase their focus on NCD. This has potential impact on the health of workers (and their families), as well as the local community and its economy and further afield. In addition to the potential impact of their corporate policies and activities, these firms have significant databases, know-how and experience in problem solving, resources that could be utilized for tackling NCD more effectively in the future.

The way forward

The European NCD Strategy *(1)* offers countries valuable pointers on moving forward, grouped round the following issues:

- the role of government
- stakeholders in NCD policy development
- tackling inequalities in NCD
- transparent decision-making
- building on what is in place
- establishing a unifying framework
- monitoring and evaluation
- adopting an effective approach.

The conclusions from our analysis confirm the importance of these issues. In this section, therefore, we offer certain more explicit pointers for the future under these headings.

The role of government

The European NCD Strategy states that "the role of government is critical in responding to the challenge of NCD" and this is clearly confirmed by our analysis. In this regard, a number of points deserve further consideration in countries.

- *Linking health and development.* Effective NCD policy must deal with the integration of health promotion, NCD prevention and appropriate health care delivery, and the social and economic determinants of NCD and inequalities in NCD, closely linking health and development. It is therefore essentially a government responsibility, although not in any way excluding other actors sharing the same ambitions and values.
- *Legitimizing NCD policy.* The level at which NCD policy is legitimized can be a decisive factor. Legitimization at a level higher or broader than that of the ministry of health (parliament, government, president, prime minister, group of ministers) indicates the breadth of responsibility for tackling NCD and strengthens the potential for effective intersectoral cooperation.
- *Enhancing policy sustainability.* NCD policy development is long-term, going beyond the term of a single government. Cross-party consensus building can enhance the sustainability of the policy.
- *Understanding the goals and objectives of other sectors.* More effective partnerships for working with other sectors must certainly be developed. A precondition for this would be for the health sector to understand better the goals and objectives of other sectors, and to take into consideration the potential not only for their contribution to promoting better health but how health, mutually and simultaneously, can contribute to overall development and the achievement of goals in other sectors.
- *Supporting potential partners.* The ministry of health has important roles as an advocate for action on NCD, as a watchdog for the planning and implementation of NCD policies, and as a source of information and support to intersectoral partners.

A wide range of stakeholders needs to be involved in responding to the challenges of NCD

An integrated approach to NCD policy development demands the involvement of many sectors. The potential range of stakeholders is extremely wide, their interests may

be conflicting, and the likelihood that they will work effectively together is not exactly high.

- *Stakeholder analysis.* A formal stakeholder analysis can help ensure that important partners are not forgotten.
- *Securing appropriate leadership.* Leadership from a level above that of the ministry of health, or from a sector with outstanding knowledge and experience in a particular area, can be effective.
- *Agreeing on the terms of collaboration.* Formal agreement on the terms and process of intersectoral collaboration can ensure a common understanding of the aims and objectives, and the means of dealing with possible conflicts of interest.
- *Listening to potential partners.* A national NCD policy can be effectively implemented only through community participation and partnerships at central, regional and local levels. Much more could be done to strengthen the links between levels of governance, not only to support local levels in tackling NCD but also to listen to and learn from them, creating a two-way rather than a top-down policy process.
- *Utilizing the settings approach.* Settings where people live, work, learn and play offer a huge but underutilized potential for tackling NCD. In particular, schools and the workplace offer broad opportunities for action in tackling NCD.
- *Working with the private sector.* The emerging practices of CSR indicate important new partners in the private sector. There are exciting opportunities for further action to tackle NCD in the workplace and for the development of healthier products, but also for taking advantage of knowledge and skills available in the private sector for solving problems. Regular partnerships with the public sector may strengthen and increase capacity, provided agreements can be reached on principal social values such as equity in health.

Reducing social inequalities related to NCD

It is clear that there is rapidly growing awareness of the need to tackle socioeconomic inequalities in NCD, and opportunities for doing this are already being explored.

- *Reflecting socioeconomic inequalities.* Particularly in EU countries and through programmes such as CINDI, standardized and comparable data for measuring socioeconomic inequalities in NCD are being developed. Guidance and examples of good practice are available for all countries to ensure that regularly compiled data reflect socioeconomic inequalities.
- *Utilizing the work of the WHO Commission.* The work of the WHO Commission on Social Determinants of Health has further clarified some of the policy pathways for tackling inequalities. The results of this work could be usefully disseminated among those responsible for NCD policy at national and local levels.
- *Taking gender differentials into account.* NCD and their risks can affect males and females differently, and their needs for support may also differ. However, the gender aspects of NCD policy and programmes are not always given sufficient attention.
- *Tailor-made solutions.* Research has shown that the highly educated pick up general health education messages more quickly than their less educated counterparts. Health communication tools for health promotion and in the area of health care must be tailored to meet the specific needs and cultural situations of vulnerable groups, including, for example, those with a low level of education, the poor and unemployed, migrants, older people and ethnic minorities.
- *Considering the impact on disadvantaged groups.* The potential impact of any NCD policy on disadvantaged or high-risk groups needs to be assessed.
- *Policies for social groups.* The development of comprehensive policies to tackle NCD in specific social groups such as older people, women, adolescents, the Roma or migrants could prove effective in some countries.

- *Utilizing programmes for poverty and social exclusion.* Programmes to tackle poverty and social exclusion offer opportunities for elaborating the synergies between NCD and development, and indicating the potential benefits in both health and economic terms.
- *Making health an indicator of development.* Reporting on changes in inequalities in NCD, during annual budget discussions, could help ensure that health is included in the concept of development. Health, including the prevention and control of NCD, can contribute to poverty reduction and economic development. Given this, several countries have adapted the Millennium Development Goal 6, (on combating HIV/AIDS, malaria and other diseases) to include chronic diseases or NCD *(22)*.
- *Equity-oriented HIA.* The WHO definition of HIA *(23)* explains that, in assessing the impact of policies in sectors other than health, their "potential effects on the health of a population and the distribution of those effects within the population" need to be judged. This equity aspect is rarely implemented.
- *Improved management of care for NCD.* Not only the distribution but also the management of care for NCD must be improved if access to high-quality and appropriate care is to be ensured, at the right time and in the right place. Better understanding of the drivers of health inequalities, and modelling the specific interventions needed to reduce these, has also shown that greater access to cheap and effective treatment (such as the management of hypertension) could play a significant role in narrowing the gap between those living in the most deprived and the least deprived areas *(24)*.
- *Examples of good practice.* A compilation of well-evaluated examples of good practice would enable countries to consider innovative action and different options for tackling inequalities in NCD.

Government decision-making should take place in a transparent manner

Tackling NCD requires taking difficult decisions, some of which may be in conflict with the interests of certain groups or may be negatively received by the public. This, combined with the need to involve multiple partners, means that particular care is needed to ensure that government decision-making takes place in a transparent manner.

- *Time and resources.* Broad and open consultations can take place only if sufficient time and resources are designated for this purpose.
- *Effective participation.* There will be confidence in the process only if adequate attention is paid to feedback, making it clear that comments, suggestions and opinions offered are taken into account.
- *Strengthening civil society.* Civil society, NGOs and consumer societies have an outstanding role to play in holding government and the private sector responsible for their actions and acting as a watchdog on policy implementation. In some countries, they may need training, capacity building and support, including information and funding, in order to carry out this role adequately.
- *Transparency in spending the money.* Transparency in the allocation of funding is of outstanding importance. The criteria for funding, including the funding of research, must be clear and the priorities in line with NCD policy.

Countries can build on existing experience and move forward from whatever point they have reached

All countries have some experience in developing broad or issue-specific policies for NCD. Furthermore, comparative newcomers can learn from those with longer experience – there is no need to reinvent the wheel.

- *Evaluating actions.* To build on what a country has, it needs to know what exists already and whether it works. Evaluation of NCD policies (as opposed to monitoring) is comparatively weak, as is evaluation of the

effectiveness of interventions. A strong focus on reviewing and evaluating NCD policies, with the strengthening of intervention and implementation research, would greatly enhance knowledge on what works and what does not, particularly in building partnerships for NCD policy.

- *Funding for evaluation.* In the planning phase of policies and programmes, an appropriate level of funding should be guaranteed within public administration to fund monitoring and evaluation. In addition, the research community should be encouraged by designated funding to help fill gaps on what does and what does not work.
- *Sharing the knowledge of what works internationally.* There has been an expansion of "best practice" information in recent years but this may not be easily accessible. There is a need for new frames of reference for better understanding and more developed methodologies of adaptation to local needs.
- *Transfer of knowledge within countries.* Most countries have examples of innovative action or pilot projects at the subnational level, but this is not always widely known or used. Stronger channels for sharing positive and negative experiences and for discussing what went right or wrong could help the dissemination of existing good practices within countries. Successful practices and pilots should be better integrated into the overall policy development process.
- *Capacity building in ministries of health.* The capacity of the ministry of health to meet the needs for NCD policy development, and of public administration in general, is rather weak in some countries. It could be enhanced by training, in relation not only to tackling NCD but also to innovative and flexible policy-making and planning, modern public health approaches and the skills for intersectoral cooperation.
- *Ensuring the right care, at the right time, in the right place.* Access to prevention and health promotion services, and to high-quality care and rehabilitation for NCD, and the results of such care, present a challenge for achieving equity in health. Review of the quality, appropriateness and timeliness of care for NCD is needed to ensure that effective interventions are given priority. Evidence-based guidelines are available in some countries, and their wider adoption and implementation could be facilitated through performance monitoring, funding mechanisms and incentive schemes.
- *Addressing long-term needs.* Those who suffer from NCD, and their families, may live with the consequences of these diseases for many years. The way in which existing health and social services meet the long-term needs of patients and carers can be assessed, with a view to developing more integrated, patient-centred care closer to home. It may be worth considering testing and adapting innovations developed in certain countries.

Establishing a unifying framework

Many countries have a combination of broad policies for health (and/or policies for health promotion and health care), together with policies for specific NCD and/or their risk factors. In no case, among the countries studied, does there appear to be clear coordination or harmonization of these various efforts. Even within broad health promotion policies, individual NCD or health risks appear to be tackled in a vertical way. The European NCD Strategy provides the opportunity to establish a unifying action framework or "umbrella" that draws together the individual components towards a common goal.

- *Understanding the situation.* A comprehensive situation analysis, both of the burden of NCD and the existing policies, strategies and actions for tackling them, would give a better understanding of the challenges and existing gaps.
- *Mapping a way forward.* To support coordination among partners, it is essential to clearly state and disseminate widely:
  - the overall objectives for tackling NCD
  - the priorities between them

- possible measures for achieving the objectives.

Clear communication of the need for action, the outcomes to be achieved and the route to be taken is important for collaboration between the many partners whose involvement is necessary at all levels of governance and in many sectors.

- *Transparent discussion of issues and options.* Health policy conferences and workshops have proved to be effective in a number of countries for creating a better understanding of the challenges and possible ways of meeting them. They could also provide a forum for considering policy options.

- *Using target setting effectively.* Quantified targets are increasingly being used to focus attention on what needs to be done, and by when. The monitoring of such targets can strengthen a sense of responsibility and accountability. Care needs to be taken in setting not only outcome targets, in terms of changes in mortality, but intermediate targets relating to changes in risk factors and process targets relating to what needs to be done.

Issues related to monitoring, evaluation and surveillance

In many countries, the knowledge base for supporting the NCD policy process has been greatly expanded in recent years, but there is still room for further improvement.

- *Regular surveillance.* Routine surveillance systems for monitoring the population's health and related behaviour are still not in place in some countries. Funding needs to be provided for this and mechanisms put in place to ensure that this knowledge is fed into the policy-making process.
- *Reflecting potential inequalities.* Much more effort is needed to ensure that systems are in place to reflect, as a matter of course, potential socioeconomic differences in relation to mortality, morbidity and health risks, but also in relation to access to high-quality and effective care.
- *Widening the knowledge base.* Information systems for NCD policy need to be broadened to include key multisectoral elements reflecting the socioeconomic determinants of health.
- *Developing communication skills.* Particularly at the local level, there is a need not only for readily accessible information but for training in the use and presentation of such information.
- *Public health reports.* Regular public health reports have proved to be an effective means of keeping NCD on the agenda. When they include reporting from ministries other than health, they underline the importance of the socioeconomic determinants of health and the responsibility of other sectors for the prevention of NCD.
- *Assessing policy processes.* Greater attention needs to be paid to monitoring and evaluating the process of policy development and to health policy analysis.
- *Evaluating intersectoral bodies.* Given the vital importance to NCD policy development of councils, committees, etc. for intersectoral action, an evaluation of their operation and effectiveness could greatly improve knowledge regarding effective partnerships for NCD prevention.
- *Working with the winners.* More innovative solutions for effective intersectoral action need to be examined, including an exploration of the possibility of introducing a strong NCD component in existing successful structures for intersectoral cooperation.
- *Utilizing different types of knowledge.* Greater emphasis needs to be placed on balancing the use of quantitative and qualitative information for policy-making purposes, improving the scientific basis for using qualitative information and eliciting the opinion of the public.
- *Capacity mapping.* In most countries, the mapping of resources and skills for NCD policy development needs to be improved.

- *Examining the costs.* The economic argumentation for tackling NCD has not been made sufficiently strongly. More research is needed into the economic implications of NCD and the cost-effectiveness of NCD interventions.
- *Improving the links between policy-making and research.* Close interaction between researchers and policy-makers can be decisive in the use of scientific evidence for NCD policy-making. Channels to enhance such interaction could encourage the production and use of policy-relevant research.
- *Learning from peers.* Peer review has proved effective in Finland and Ireland and could be one way for countries to assess their existing NCD policies and the potential for improvement.

Adopting the most effective approach

The European NCD Strategy states that "It is possible for all countries across the Region with very different incomes and capacities to effectively combat NCD". The most effective approach should be adopted in a particular situation. This may require maximization of opportunity rather than increased resources.

- *Making the best of existing assets.* An assessment not only of high-priority needs but also of available assets could indicate where effective interventions could be made.
- *Borrowing and joining.* This should include a quick review of other ongoing policies (and not only in the health field) on which NCD policy could "piggy-back" or into which an NCD policy component could be added.
- *Looking for quick wins.* An initial focus on selected quick wins would encourage the long-term NCD policy process.

Being aware of the wider policy environment

Increasingly, decision-making in the health sector is influenced by decisions in the broader national policy environment or at international level. Some of the future challenges and opportunities were examined in the introduction to this chapter. Unless changes in the policy environment are adequately assessed, NCD policy could be derailed.

- Macro changes in areas such a public administration, management, and education need to be assessed for their possible impact on NCD policy-making.
- Working with the private sector offers considerable potential for tackling NCD, but should be guided by a clear code of ethical behaviour.
- In low- and medium-income countries, new forms of partnership need to be developed between international organizations, bilateral donors and national stakeholders in NCD policy.
- The potential impact of globalization on NCD needs to be more closely monitored and evaluated.
- New communication technologies offer a huge potential for access to information, consultation and networking, but also hold considerable threats. The opportunities and challenges for NCD of this information explosion need to be monitored and exploited as appropriate.
- NCD policy-makers could advocate for more openness in the EU for linking NCD policy to developmental issues through the structural and other funds.

It can and must be done

Most countries are facing what may appear to be overwhelming challenges of financial stringency, looming unemployment and the disaffection of certain social groups, and a climate in which many of the strings appear to be not in the hands of national authorities but in those of supranational and international organizations and corporations. In this difficult situation, tackling NCD could be considered not to be a priority or to require too much effort and resources when urgent economic issues must be dealt with.

In fact, the opposite is true. Action must be taken now so that the social and economic determinants of NCD do not deteriorate in this difficult climate, creating even greater problems for the future. The need to rethink economic and social policies provides opportunities for reshaping such policies (at least to be less harmful to health) and more optimistically to promote both health and development.

Much of the necessary knowledge is available, though not all countries or cities have all the pieces. A concerted attempt to put NCD issues firmly in the middle of the ongoing socioeconomic discussions at international, national and local levels should create the necessary awareness, and pave the way for a rapid exchange of information and experience.

The financial resources for creating an adequate evidence base across Europe are minimal compared to the vast amounts spent on health care (the annual cost of just one hospital bed in most countries would go a long way to covering it). In all countries, planning processes and structures are in place that can be adapted to tackle NCD. For countries with a broad experience of tackling NCD, an attempt at better coordinating and integrating these efforts should fit neatly into the overall climate of trying to improve efficiency and effectiveness. Those with less experience are fortunate in having available to them a wide array of models and experience to borrow and adapt.

Europe is fortunate in having a vast pool of highly trained public health experts. This study has shown that, when there is the will, such experts can become champions of public health. The time is ripe for such champions to make the case and take practical steps to ensure that NCD issues are part of the ongoing development discussions.

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