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The Verona initiative : Investing for health in the context of economic, social and human development (1998-2000) - WHO

## Sujet

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## **The Verona Initiative**

In October, 1988 the WHO/E launched the verona Initiative, which aims to provide a framework for government, corporate and individual decision maker throughout Europe to assess the impact on the promotion of health of current policies and approaches, advocate for and take action to ensure the use of population health as a way of guiding and measuring the success of all developmental actions. The Verona initiative will provide a European arena for analysing fundamental determinants of people's health and increase the ability and confidence of policy-makers, managers, professionals , consumer organizations and lay communities within each country and region to shift to a wider approach towards investment for health.

The three symposia, - "European macrotrends and implications for investing for health" in 1988, "Investment for health: decision-making guidelines" 1999, and "Positioning health promotion for the 21st century: the investment for health strategy", in the year 2000 - , will progressively build on modern thinking about health in economic, social and human development. The products of each symposium will be high impact publications. The intent is to attract the attention and to motivate action of policymakers, planners and health-related interest groups in both public and private sectors in all European countries to position and support health promotion for the new millenium.

The attendance is by invitation only. The WHO has selected 120 experts from a wide range of disciplines. The CP has been selected to participate.

It is an excellent opportunity for the CP to contact decision makers in Europe and to spread its opinion on future health policy.

More detailed information will become availbale just before the September 1999 meeting in Brussels.

# **Integrating Health Sector Action on the Social & Economic Determinants of Health**

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## **Summary**

This paper argues that the investments of health-care system resources in Europe are less efficient, effective, sustainable and ethical than they might be because they are focussed on the consequences of illness in individuals rather than determinants of health in populations. Much greater health outcomes could be achieved from existing health sector investment if the evidence that is already abundantly available was acted upon. Health services across Europe need to transform themselves if they are to meet the new challenges outlined in Health 21.

The paper reviews some key issues of relevance to this claim and examines :

- **Why healthcare systems have not produced health as much as they could.**
- **The determinants of population health and the contribution of social capital.**
- **Emerging evidence for effective and integrated health sector action on health determinants**

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# **Why healthcare systems have not produced health as much as they could**

The Verona initiative addresses the central and most challenging issue for health system reform in the 21 century - how might health systems be refocused to make the most productive investment for population health improvement? In order to answer the questions raised, it is necessary to review the state of knowledge about where health is created and to consider whether current health investment strategies are properly aligned with what is now known to improve health. This in turn will lead to debates about what new social systems, relationships and structures might be needed to improve the efficiency and effectiveness of whole system health sector investment.

Recent reviews of both European and international health care reform agree on at least four areas of challenge that will drive health policy and management towards the next millennium. WHO (1997) , Seedhouse D (1995) , Williams R. (1995)

- The challenge to contain health sector costs.
- The challenge to increase the population health outcomes from health sector investment.
- The challenge to ensure that access to health is based on values of solidarity, inclusion and equity.
- The challenge to involve increasingly empowered health consumers.

The wealthier western nations get - it seems - the less they feel they can afford universal health and social welfare services. Whilst this probably demonstrates a crisis of political commitment rather than available resources, the paradox is that despite the talk of cost containment over the past 20 years or so, healthcare budgets have been rising inexorably throughout the industrialized world .....and yet there is little evidence of any corresponding population health improvement.

In fact there is considerable evidence demonstrating that contemporary paradigms of health care resource investment are allocatively inefficient, financially unsustainable and, in many respects , unethical. The central problem is that health care systems in industrialized societies have not been designed to produce health.



Most people are kept healthy or made ill where they live, work and play – long before they have contact with the health care system. A review of UK experience illustrates the problem.

**Source: UK Department of Health (1991) Health Of The Nation. Greenpaper.**

The graph above shows the standardised Mortality Ratio (S.M.R) for preventable mortality (deaths of people under 65 years) from all causes in England and Wales from 1841 to 1985.

What it demonstrates is that substantial population health improvement was achieved between 1875 and the early 1930s. UK Department of Health (1991)

However, the introduction of the hospital focused NHS in 1948 (the dotted line) not only failed to make a significant impact on population health improvement but actually seemed to be associated with a slowing down of the rate of reductions in preventable death already achieved.

Death rates are not a good measure of population health status, but they are an 'inverse indicator' largely immune from cultural bias. In aggregate at least, healthy people are least likely to die early.

There are a number of reasons for the apparent failure of the NHS to make any sustainable impact on population health status. Each of these has much to offer in informing the Verona debate over the coming three years, particularly with a focus on its primary goal of making sure that health determinants become centre stage for the debate on health. Consideration of these issues may also point the way to possible solutions for increasing the collective social efficacy of health investment. The issues identified include the following:

- Population based social policy changes rather than individual medical interventions brought about most of the health improvements achieved between 1841 and 1935. Improved housing, safe clean accessible water, better nutrition, better family planning and more disposable income were key factors. Improvements in medical science played a very minor role. Despite this, at the inception of the NHS, over 90% of the health care budget were dedicated to the health care of individuals.
- Health sector investment after 1948 was not made in improving environments conducive to health but was rather focused on dealing with the negative consequences of illness in individuals. At a whole system level, the NHS failed to invest resources where existing evidence showed most health improvements had been obtained.
- Such investment as has been made in health care and hospitals has been demonstrated to be less efficient, effective and scientifically rigorous than was often assumed. Studies in North America and the UK show that only about 20% of health care interventions have been proven as beneficial or useful by the standards of a double blind clinical trial. Riley et al (1995) , Brook RH and Lohr K.N. (1985) .
- Furthermore 70% of all medical and health care is for preventable conditions. National Health Service Executive, England, (1994). Of the remaining health care intervention that has both been proved useful and is dealing with non preventable disease, a considerable amount is technically but not allocatively efficient in it's application of resources. This means that, although existing intervention may bring some benefit to the patient, other interventions e.g. by less qualified staff or treatment on an out patient basis may bring equal or improved benefit for less resources Roberts (1995) . Similarly even greater benefit could be brought about by earlier intervention, associated with reduced cost and increased health gain outcomes.
- Even when specific disease groups are reviewed evidence of substantial success is hard to find. Mental health services psychiatric interventions demonstrate particular problems: ".doubts arise out of the failure of psychiatry to demonstrate that it can treat according to a set of stated objectives , and can reasonably define the likely outcome of its interventions within a predicted timescale . What we do know is that the relapse and readmission rate of around 73% appears inordinately high...."Olsen R (1992)
- Even where the most invasive clinical interventions are practised, the value of a very large percentage of very expensive healthcare service intervention remains obscure. A report published in February 1995 noted for instance that five out of the 10 most frequently performed operations in the United Kingdom had no proved benefit. Towle A (1998).

- Inappropriate amounts of healthcare system resources are spent on over medicalisation of normal human conditions. A review of the top ten causes of NHS expenditure (analysed by ICD 9 group) in 1989/90 in the UK NHS shows that normal pregnancy and delivery is number 7 in the league table , consuming 3.9% of the total NHS budget. (A large portion of this money is spent on the provision of services by medical and nursing staff whose expertise is in abnormal pregnancy)! Smee (1995)

The World Bank, reviewing the relationship between national health expenditures and population health outcomes in 1993 stated: " At any level of (population) income and education, higher health spending should yield better health, all else being equal, But there is no evidence of such a relation" World Bank (1993).

The fact that international health sector investment is unrelated to population health outcomes is not perhaps surprising. The US Surgeon General, May A. (1996) addressing this issue, has listed the general causes of premature death and disability (and thus avoidable health sector cost) as:

- 10 per cent due to inadequate access to medical care.
- 20 per cent genetic.
- 20 per cent due to environmental factors.
- 50 per cent due to 'behavioral and lifestyle' factors .

It should be noted here that the separation of environmental and 'behavioral and lifestyle' factors is largely a social construction arising from the North American culture of individualism. Clearly, environmental, social and economic influences shape the behavior and lifestyle patterns of both individuals and populations and vice versa. It may be more accurate to simply say that 70% of the determinants of premature death and disability are due to the interactions of the social, physical and economic environment, lifestyle and related behaviors.

Despite such evidence of the poor outcomes of health sector spending, and the new data on the determinants of population health from around the world, resource investment for health is overwhelmingly dedicated to treatment and care of prevalent disease in individuals, within the health sector itself. Resources are focussed only on the small percentage of the population who are ill at any one time, to the exclusion of those who certainly will be ill if preventive action is not taken.

This is not just a UK problem but is also a cultural problem for all industrialized nations .

This is a cultural and political problem for all countries in Europe. The irrational privilege accorded to clinical definitions of health need in industrial societies has the effect of allowing a potentially preventable incidence of ill health to arise in the whole population as a result of unmet need for preventative and health promoting interventions.

A recent review of health sector investment in the UK concluded that less than 1% of the UK NHS budget is spent on formal health promotion. Limb M (1996) Furthermore, much of this resource is spent on clinical prevention – aimed at influencing high risk behavior in individuals, Rose (1993) – rather than population based prevention and health promotion, targeted at modifying the determinants of population health.

## **The determinants of population health and the contribution of social capital**

As Blane et al (1996) argue, "There is a growing recognition that the most powerful determinants of health in contemporary populations are to be found in social, economic and cultural circumstances." Their analysis is rooted in well documented and relatively recent research findings on population health. The issues identified have a very powerful explanatory value in that they go beyond theoretical treatise to link observable and measurable clinical indicators of health in individuals and populations to social and environmental determinants. This has important implications for health investment.

### **Population Health Determinants**

For many years traditional public health approaches, have focused analysis and prescription for effective action to improve health on disease orientated risk factor epidemiology. This sought to know about the social, behavioural and biomedical causes of disease. Recent work over the past ten years (Evans R ,1994, Marmot ,1993, 1996 Syme, 1996 Hertzman ,1996, Wilkinson, 1996, Brunner, 1993, 1996) has been highlighting the inadequacy of this foundation for policy and action in the promotion of health. Syme (1996) asks, "How is it possible that after 50 years of massive effort, all of the risk factors we know about, combined, account for less than half of the disease that occurs? Is it possible that we have somehow missed one or two crucial risk factors?" (p21) He suggests that about 60% of preventable morbidity and mortality are located neither within individual sovereignty nor the domains of individual behaviour, lifestyle or 'risk' but within social organisation. Marmot (1996) has shown how control and autonomy are crucial determinants of health often more powerful in explanatory value than smoking and Wilkinson (1996) has shown how inequality itself rather than poverty *per se* may be a major cause of preventable morbidity and mortality in most industrialised societies.

Antonovsky (1996) has reminded us that disease oriented risk factor epidemiology is only half the story. We know the biomedical causes of why 40 % of people smoking 20 cigarettes a day may die early - we do not know the bio/ psycho/ social reasons why 60% do not - we have no real epidemiology of health (salutogenesis).

Even within a narrowly defined biomedical model there is now convincing evidence to discredit the received wisdom on which most individual, behaviour change focussed, health promotion / education has been undertaken. This is not to say it was not effective, just that it was largely irrelevant and certainly an inefficient use of very scarce specialist resources.

Syme(1996) and others suggest there is an urgent need for a paradigm shift in the conceptual framework and problem solving strategies for public health. This must recognise that most health risk and most determinants of health are systemic located within complex, dynamic and interactive social relationships which themselves are determined by social institutions and organisations including families, communities, workplaces - indeed the healthcare system itself. Such a change of paradigm requires population health to be seen not as the 'additive' outcome of the application of health care resources but as an integrative social product arising from the impact of social systems on individuals, communities and societies. Determinants of population health are mediated *through* social systems but are determined *by* social relationships within those systems. This understanding has enormous implications for the efficacy effectiveness and efficiency of health investment and the search for an evidence based health promotion within social systems.

## **Social Capital**

Particularly important to the future health and social welfare of the whole local population (not just those who are ill today) is the development of 'Social and Organisational Capital for health'

'Social Capital' has been formally defined as " those features of social organisation, such as networks, norms, and trust, that facilitate co-ordination and co-operation for mutual benefit' (Putnam 1993). Institutional (or organisational) performance (or development) has been defined as " how responsive representative government is to its constituents and its efficiency in conducting the public's business. In practice this is composed of measures of the policy process and internal operations , the content of policy decisions, and the capacity to carry out policy" Hertzman (1996)

This concept is linked to that of 'civic society'. Civic societies are those "which value solidarity, civic participation, and integrity; and where social and political networks are organised horizontally, not hierarchically " Putnam et al (1993).

Collectively social and organisational capital and the construction of civic society is seen as an area of social development widely neglected by monetarist approaches to economic and social development in the west and by state capitalist systems in the east.

The consequence for both has been a rapid reduction in the quality of life, a decimation of the 'co-operative economy' (what we do for each other without the exchange of money such as child-rearing, self help, organising community events etc.) , and these factors in turn are major sources of loss of social cohesion, 'public life in public space', crime and health status in communities. Most importantly, Putnam et al (1993) in a study of the impact of Italian Regional Government (introduced in 1970) has established a number of measurable constructs for institutional performance and civic society which show close correlations between infant and child mortality and social capital - the higher the indicators of social capital the lower the mortality. The relationship is striking but does seem to disappear by mid-life for reasons that are not fully as yet understood.

Addressing this emerging area of social policy in The Guardian 1997, Geoff Mulligan , a Director of the think-tank Demos said in an article "On The Brink Of A Real Society" said , ...some of the structures that would make sense for a more community orientated government....will require a greater use of commitments. This may mean asking parents to commit to helping with homework; it may mean encouraging households to separate waste for recycling; it may mean following the Dutch model of agreeing a covenant of environmental targets between business and government, whereby business is left to determine how each target is met. Add these together and it is possible to see a radically new way of governing, one that puts the emphasis on prevention (and health promotion) not cure, looking at problems in the round rather than slicing them up, and seeing society as a web of commitments rather than contracts. Such a programme would draw on the radical shift from the "me" to the "we" and turn it into new architectures and tools for government"

## **Implications**

The implications of this analysis are just beginning to be addressed in health policy at international levels. Governments are discovering that developing a community infrastructure for health can have a significant impact on environmental, behavioral and lifestyle factors.

The creation of new 'social systems for health' within the community has been identified by Grossmann and Scala (1994) at Vienna University as a major new area for health promotion development within 'settings', with a vast potential for population health status improvement.

This wealth and health creating power of community is well illustrated in Lima's largest squatter settlement Villa El Salvador. Such projects demonstrate the links between social, health and environmental action to improve the wellbeing of the community. A large area of state owned desert land has, over a period of 15 years , been transformed into a thriving, self-governing community of 300,000 people. At the heart of the development has been CUAVES (the Self - Management Urban Community of Villa El Salvador) , Villa's own community organisation.

The organisations democratic structure gives representation to each block and a vast network of women's groups, through which citizens have planted 500,000 trees and built 26 schools, 150 day centres and 300 community kitchens. Training and education has reduced illiteracy to 3% and infant mortality to 40% below the national average. This is despite the fact that one third of the residents live on lower-than subsistence incomes, compared with only 10% in Lima as a whole. Ekins P (1994)

Studies in the UK Campbell C et al. (1998) have also identified links between levels of health and aspects of social capital , and organisations such as the Health Education Authority England are now looking closely at how the development of social capital in low income communities might contribute to population health improvement and a reduction in inequalities in health status.

Despite this widespread interest in the new evidence as to where investment may be refocussed to improve population health change at the whole system level is slow.

It has been suggested for instance that only about 1% of the evidence already available on effective *healthcare* interventions themselves has ever been used as a basis for routinised healthcare practice or the purchasing of health services . (ECHHO ,1997). Given this disappointing figure , it is unlikely that evidence relating to reinvesting on determinants will impact quickly on practice . Indeed Weiss C H (1991) convincingly demonstrates that there is evidence to show that research has 'very little' impact at all on *any* public policy. (Caplan ,1977; Bulmer 1978;Weiss with Bucuvalas, 1980; Alkin et al 1979; Deitchman, 1976; Dockrell 1982; Knorr ,1977; Rich, 1977; Leff 1985). She argues that research rarely determines policy, rather it tends to be used to illuminate the consequences or support the advocacy of decisions already made on the basis of custom and practice , values or interests.

With this in mind it may be useful to reflect on whose interests are and are not served by a refocusing of health system resources on the determinants of health. The principal tools for change may not just be information and evidence. What may be needed is more effective leverage to challenge the cultural and political domination of health system investment strategy currently enjoyed by medicine and the other clinical professions.

# **Emerging evidence for effective action on health determinants**

There are a number of valuable insights into effective action on health determinants emerging from new management science and public health perspectives. This section reviews some of these and draws some conclusions.

## **Re defining the 'theory of purpose' of healthcare systems - particularly hospitals.**

In the UK, the NHS has recognized its unifying goal is to improve the health for all of the population, National Health Service Executive England, (1996) , but its constituent parts are not yet orientated to this 'theory of purpose'.

The international movement for Health Promoting Hospitals (HPH) has been developing practical change strategies for increasing the allocative efficiency of hospitals and health care organisations within a number of pilot hospitals, NHS Trusts and Ambulance service providers in Europe within a systems approach.

A key principle of the organisational development strategy for HPH is to involve all stakeholders in incremental practice based learning for health promotion and a refocusing towards the determinants of health.

The overall vision for the health care system is to move practice north or west on the diagram below. Most health sector investment is currently within the quadrant focussing on treatment of the individual. The overall strategic vision is to move health system investment towards prevention within the whole population. For health care staff , this inevitably implies earlier more cost effective interventions (associated with increased health outcomes and reduced cost). It also necessarily involves increased focus on health determinants including action on community participation and integration of the health care system within the community.

## Population

Future health sector investment.  
(Increased allocative efficiency.)

o

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**Prevention**  
(& promotion of  
population health)

**Treatment**

o Current health sector  
investment(Least allocative  
efficiency)

**Individual**

Adapted from HEA (1996).

## **Transforming management and leadership styles in health systems.**

Increasingly , within the European public sector , traditional assumptions about the nature of leadership and management are shifting to take account of new demands. European social systems and organisations are largely rooted in 19<sup>th</sup> century approaches to problems . They were established to deal with the issues of their time. These were vertical social systems amenable to management through command and control systems. However, most contemporary problems are horizontal , requiring action across many social systems. This requires the development of virtual organisations developed collaboratively within and between traditional social systems. It requires innovative problem solving and management styles that allow ascendancy to networking and trust rather than command and control.

An illustrative example of this issue in practice is road traffic accidents a Europe-wide principal cause of early death amongst people under 30 . Most European countries control the determinants of accidents through vertical social systems . These can be defined as : Transport policy (Department of . Transport) , Community driving standards (community), traffic control measures such as speed bumps (Local Authorities) ), road safety education (Department of Education) , accident and emergency services (Department of Health). Resolving the problem of road traffic accidents to children requires action across all these agencies through the creation of a new problem solving structure.

**Accidents To Children - A horizontal problem whose determinants are controlled by vertical social systems.**

The skills to manage such changes in social problem solving require a clear paradigm shift in understandings of authority. New paradigm management is largely sapiential (to do with wisdom ) and is knowledge based . Clearly some management functions will remain as positional in nature but this is not going to be the major skill for future management effectiveness in European healthcare systems. The model below, Douglas (1996), outlines the key dimensions of authority in management and leadership. Action on health determinants within the healthcare system requires the development of skills in sapiential and knowledge -based authority.

**Positional Authority.**

**Sapiential Authority**

Based on role and position.  
Based on the belief and organisational trust of others.

***Given Earned***

**Knowledge Based Authority.**

Based on personal capacity, experience and understanding.

***Acquired***

Dimensions of Authority. Douglas (1996)

**Moving healthcare from markets to networks : Changing the social system of healthcare relations to improve effectiveness and efficiency.**

Ferlie E. and Pettigrew A. (1996) of the Warwick University Business School Centre for Corporate Strategy and Change recently undertook a survey of the organizational responses of the NHS to its emergent performance challenges.

Defining the three archetypal forms of organization as hierarchies, markets and networks, they gave a powerful analysis of the need for the NHS to complete the existing transition into a network-based organization. They argue " the network perspective re directs our attention away from formal structure and policy to the importance of patterns of social relationships within organizations, including (perhaps especially) informal ties. It conceptualizes market processes in highly relational and socially embedded terms. Concepts of trust, reciprocity and reputation move centre stage. They argue that the challenge to improve health rather than simply provide better, or more, health services will require increased interagency co-operation which can only be achieved by agents competent in networking skills.

This will require a move to win-win negotiation and abandonment of coercive and manipulative relationships enforced by externally determined performance indicators. Networking competencies need to rest within the organizational and clinical domains of hospitals and health care systems as a whole , as well as at managerial levels.

Furthermore, networks are polycentric and diffuse rather than centralized in their character . It may be that this process will allow for the effective development of a Stakeholder culture for performance measurement to emerge, with subjective patient defined health status outcomes commanding as much attention as technically determined clinical measures.

The debate about organisational structures and culture is still only just emerging despite relevant data existing for some time. These issues have profound implications for hospital performance management and the achievement of health outcomes focussed on determinants of health. Aiken, Smith and Lake (1994) found that *magnet hospitals* (characterised by attributes deemed desirable to nurses and which were conducive to better patient care) had lower mortality than matched hospitals. This confirms earlier work by Zimmerman, Shortell and Rousseau et. al. (1993) in intensive care units, that a patient centred culture, strong medical and nursing leadership with good communication between these groups, and an open approach to conflict resolution and problem solving are associated with positive patient outcome.

### **Re -defining stakeholders in the "whole system" for transformation of healthcare systems**

Viewed as a whole system, the health sector has a range of stakeholders available as allies for change. All of these will need to be engaged if a refocusing towards health determinants and health promotion is to be achieved. Change management for health within the healthcare system has to come from every strategic level - it will not be successful either top down or bottom up - *all* levers need to be activated.

The intervention levels, strategic tools and strategic activity for change within the UK NHS, for instance can be defined as:

<b>Intervention level</b>	<b>Strategic Tools</b>	<b>Strategic Activity</b>
Commissioner / Purchaser	Specifying (Contracting)	Commissioners can contract for health promoting change.
Provider.	Managing (Organisational Development)	Providers (Trusts) can manage for health promoting change.
Practitioner.	Intervention (individual or population based)	Practitioners can intervene for health promoting change.
Voluntary Sector	Lobbying / advocacy/Mediation	The voluntary sector can lobby for health promoting change.
Consumer./Public	Consumerism / Rights / Public participation (Patients Charter rights)	The consumer can demand health promoting change. The public also pay for (and may pay for the absence of) health promoting change.

Too often change management for health has been seen as either a senior management function to do with 'systems' only or an educational process delivered at the practitioner level of intervention. These are only some of the levers a truly effective strategy for change could pull.

### **The development of the 'Population Health Gain' concept.**

A key tool for change has been the development of technical analytical tools that can expose the problems of, and needs for, health care reform from an economic perspective . Thus, focussing action on the concept of 'population health gain' has proved a useful mediation strategy, challenging the vested interests of clinical medicine from whom resources must be diverted if increased allocative efficiency is to be achieved.

The term 'health gain' was probably first used in the UK in a paper by the Welsh Health Planning Forum. Welsh Office NHS Directorate. (1989)

In 1990 the Welsh Office had begun to publish protocols for investment in health gain focusing on health strategy, cost effectiveness, evidence based intervention, contracting, rationing / disinvestment and outcome assessment.

By 1991 Professor Jan Blanpain, Director of the WHO Collaborative Centre for European Health Policy proclaimed the 1990's as the 'decade of health gain'. Felvus (1992).

The specific meaning or definition of health gain has been subject to much debate. Griffiths (1992) suggests that although there seems to be a 'broad

consensus over the value and location of the concept it is "probably best left broad because there is endless room for argument at the detailed level

By 1992 the concept of health gain began to be widely used in relation to international debate about improving health. The problem with securing consensus on its meaning is that its exposition depends on definitions of health and health is a 'contested concept' Gallie (1956).

One widely used and simple definition of health gain is " a measurable improvement in health status, in an individual or population, attributable to earlier intervention" Brambleby (1995)

A more comprehensive definition might be:

"Health gain can be defined as the cost effective, positive, planned and measurable health outcome arising from the application of health care resources upon an individual or community, or the social product of health arising from the impact of social systems on communities." Harrison et al. (1996)

More recently health gain seems to have become closely linked with concepts of 'health improvement', 'health development' and 'health investment'.

The parameters of health gain usually require a consideration of:

- Efficiency (technical and allocative).
- Effectiveness.(cost )
- Outcomes assessment.
- Evidence based intervention / decision making.
- Public participation / values.
- Health needs assessment.
- Rationing and funding debates.
- Resource allocation.
- Development of measurement and procedural tools (protocols, technical assessment, databases)
- Models of health / health development.
- Strategies for organisational change.
- Consideration of population versus individual healthcare investment.
- Population focussed health promotion.

Developing the public's role as co-producer of health - a resolution to the cost containment dilemma ?

The concept of resources for health in the late 19<sup>th</sup> century , where social action was a major contributor to population health improvement through public health measures led by social reformers, has become corrupted by neo-classical concepts of wealth to such an extent that we are now experiencing a so-called cost containment dilemma in all European healthcare systems.

Thompson (1997) makes an important contribution to this debate:

*" ..the message is that when patients judgements of care are seen to have an integral part to play in the care strategy, they will demand action from the*

*providers of care, in the same way that clinical and organisational audit are currently beginning to do. For this to happen it is necessary to accord equal status to patients as a Stakeholder group ....I would argue that the notion of treating patients as consumers or customers, far from being empowering, actually uses neo-classical discourse to place patients in a position of being able to only chose from a limited range of services over which they have no say. A more liberating model would place patients in the role of health producers, who on occasions require assistance in meeting their needs through co-operative working with health professionals, or what has been labelled a co-production model , or collaborative autonomy"*

This view has profound implications for how health system resources are conceptualised in the future.

## **Creating supportive environments for health (health promoting settings)**

In order to create a healthy society it is necessary for health care systems to act as advocates for broader change in the development of healthy institutions and organisations (or social systems). Interventions to achieve this would require health sector staff to be competent in organisational and community development intervention strategies that support planned processes to achieve:

### **1. Management commitment to improving 'health governance'**

Health governance must be promoted as a key social responsibility within the management of all social systems. Health governance refers to the co-operative integration of health promotion goals and processes into the management and day to day operation of social and organizational systems impacting on individuals and communities. The development of health is about doing differently what is already done . Health is seen as an investment, not a cost for society. It is viewed as an integrative 'value added' social product arising from equitable good citizenship in social organization - not primarily as an additive commodity to be gained only from the purchasing of health care services.

### **2. Stakeholder participation in the process and realisation of change for health**

Participation is central to a sense of control and autonomy which themselves are key determinants of health and a pre-requisite of equity and Stakeholder democratization . Social systems must enable people from all parts and all levels of an organization to get involved, to articulate their concerns and needs, to be listened to, to assess and value their capacities and to participate actively in every stage of the evolutionary process of transformation into a health promoting setting.

**3. *Creation of a healthy working and living environment***

A healthy working and living environment will promote participation, equity, concern for the earth's resources and the meeting of its peoples emotional , social and psychological needs. It will view this as a task to be undertaken by the whole organisation, but one which enjoys management support and commitment.

**4. *Integration of health promotion into the culture, values and daily activities of the setting***

A 'health promoting setting' seeks to integrate an understanding of and commitment to health within its routine activities and procedures - health must enter each system - in planning , human resources, management and other organisational functions. Consideration of health impact of all aspects of the organisation needs to be a routine and integrated part of all policy making and day to day activity. Systems will need to be developed to ensure this. A manufacturing industry may thus focus on its products and production systems asking: do the products themselves promote or damage health? Are the materials used healthy and sustainable? A hospital might ask: are there opportunities to promote health whilst we are treating disease, a school may ask: how might we organise the school to promote the students health as well as improving their education?

**5. *Collaborative partnership with other social systems in the promotion of health***

Health promoting organizations and institutions must favor networking rather than hierarchical organizational structures and relationships - they are not themselves outside of the reality that requires change. This applies internally and externally. Building health through effective inter-disciplinary, inter-departmental and inter-agency co-operation which harnesses the imagination, innovation and mutual support that can come from working across professional and organizational boundaries is a key objective.

**6. *Outreach and health advocacy for health in the wider community***

Recognizing that organizations and society as a whole are characterized by competing interests, the use and development of advocacy and mediation skills are needed along with new models of decision-making which prioritize conflict resolution and social consensus. The health promoting organization or institution will use all levels of its influence-political, social , financial and organizational to advocate for social changes that will result in improved health for the population it serves

**7. The creation of social capital and community capacities for health**

A health promoting setting will contribute to the development of informal social networks and support systems essential to build social capital, which generates community and individual health. This may involve initiatives aimed at improving knowledge, skills and competencies or providing material and technical support.

**8. Quality, audit, evaluation and accountability for health**

The development of and integration of health into routine quality, audit and evaluation procedures of the organisation will be essential. This will ensure clear outcome assessment and accountability. It will also enable the development of a system for organisational learning about the re-creation of itself as a health promoting setting.

**9. Increased understanding and collaborative development of health promotion technologies**

Just as medicine has clinical protocols and technologies for intervention in illness so the technology of health promotion and social system intervention has been developing based on systems and management theories. Contributing to the knowledge and practice basis of this emerging social technology is essential for progress in improving public health and achieving the aims of Health 21. Currently health promotion is seen as the process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion action. Health Promotion is an integrative activity and a comprehensive social and political process. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health.

The World Health Organisations Ottawa Charter identifies three basic strategies for health promotion. These are

- *advocacy* for health to create the essential conditions for health indicated above;
- *enabling* all people to achieve their full health potential; and
- *mediating* between the different interests in society in the pursuit of health.

These strategies are supported by five priority action areas as outlined in the Ottawa Charter

for health promotion:

Build *healthy public policy*

Create *supportive environments for health*

Strengthen *community action for health*

Develop *personal skills, and*

Re-orient *health services*

The WHO Jakarta Declaration on leading Health Promotion into the 21st Century confirmed that these strategies and action areas are relevant for all countries , organisations and institutions. This stresses that:

*-comprehensive approaches* to health development are the most effective. Those that use combinations of the five strategies are more effective than single-track approaches;

*-Settings for health* offer practical opportunities for the implementation of comprehensive strategies;

*-Participation is essential* to sustain efforts. People have to be at the centre of health promotion

action and decision-making processes for them to be effective;

*-Health literacy/ health learning* fosters participation. Access to education and information is

essential to achieving effective participation and the *empowerment* of people and communities.

For health promotion in the 21st century the WHO Jakarta Declaration identifies five priorities:

Promote *social responsibility for health*

Increase *investments for health development*

Expand *partnerships for health promotion*

Increase *community capacity and empower the individual*

Secure an *infrastructure for health promotion*

WHO (1998)

## **Conclusion:**

### **Health promotion and health investment as integrative not additive strategies.**

Despite best intentions , it sometimes seems that whilst everyone knows what they are busy *about* in healthcare systems , what they are busy *for* is easily overlooked.

Primary healthcare teams, health authorities and NHS Trusts in the UK spend 7% of UK GDP on health, but their annual reports might not look much different were all the patients to have died . This is not because healthcare staff do not care about their patients, but that such reports always focus on health services provided rather than health outcomes achieved.

Evidence based healthcare has enjoyed unparalleled prominence as the answer to these problems but the approach has generally overlooked the key issue of allocative efficiency and has thus ignored evidence relating to health investment choices and health promotion.

In fact evidence based health care , and evidence based health promotion / investment might best be seen as distant subjects in search of separate objects.

Evidence based healthcare might ask "What is the most efficient and effective (least cost greatest outcome) intervention that can be undertaken with this group or to this patient, that will restore or maintain health ?" Evidence based health promotion and health investment should be asking " What are the determinants of this populations health status and what are the most effective and efficient interventions to protect and improve it?"

Ironically , the most frequently asked question of health promotion or health investment by all these agencies is - "does it improve health?" But planned health promotion interventions in the UK for instance enjoy budgets of less than 1% of the total UK total spend on health . (Limb, 1996) . With such levels of investment it is inconceivable that they could be anything other than largely irrelevant to population health, except perhaps on a political and symbolic level . Yet researchers undertaking so called 'effectiveness reviews of health promotion' employed by the Health Education Authority, York University and the International Union of Health Promotion and Education (IUHPE) earnestly search for evidence of effectiveness solely within that 1%, as if it might make a difference whatever the awnser was.

Their mistake is to view health promotion and health investment as **additive** activities - something undertaken in a long list of activities along with all other health service related activity.

In fact health investment and health promotion are **integrative** concepts . They arise out of the whole of social organization , the total impact of social systems on individuals. Health investment and promotion arise as a consequence of the impact on populations of housing, nutrition, transport and income policies (etc.) of nation states.

It is changing these social systems to integrate health objectives which is the goal of health promotion and health investment and it is this challenge to which the Verona initiative is addressing itself. Maintaining health damaging social systems then purchasing marginal health promotion programs 'in addition' to ameliorate their effects simply misses the point.

Health investment and population health promotion might be achieved without large additional allocations of financial resources. Liberating health sector resources from inappropriate , ineffective or health damaging clinical interventions would be an immediate 'resource neutral' option to begin this process of transformation. To promote the aims of Health 21 , the healthcare system contribution to health might then focus on new investment in a high level of advocacy and change management skills - both in the health sector itself and within the broader community.

What is mostly needed is the commitment, collaboration and participation of non health care sectors who need to do differently what is already being done.

Health needs to be appreciated as an 'added value' outcome of social organization.

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