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Round Table: WHO Director for Health Systems Strengthening and Public Health, Hans Cluge on HiAP Report

The selection of Health in All Policies (HiAP) as the focus of the Third Health Ministers' Forum of the South-eastern Europe Health Network is consistent with other activities currently underway in the WHO European Region. Health in All Policies have been recognized in major European resolutions, charters and communications, treaties, frameworks and action plans, and the approach will be an important goal of the new European Policy for Health, *Health 2020*.

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

WHO has performed analysis based on a review of materials prepared by SEE Health Network member countries' representatives for the Third Health Ministers Forum, "Health in All Policies in South-eastern Europe: A Shared Goal and Responsibility". These materials included presentations and case studies that address the current state of HiAP in each of the countries.

Countries may use different terms to refer to HiAP, and terms may be conceptualized differently. Although implementation processes and design are specific to the historical and social contexts of each country, one aim of this study has been to agree on definitions and language, so that experience and evidence accumulated in south-eastern Europe (SEE) can be used in all regions and by all countries. The study takes account of the contextual background of each country, its structure of government and administration, demographic development, socioeconomic factors and health inequities and health system characteristics, and then analyses the policy frameworks,

mechanisms and tools available for HiAP approaches, as well as the information available for advancing HiAP and capacity building to support them in the future.

Information on the administrative and political organization of the country is of great importance since it can identify whether there is vertical policy integration in the management structure. It can also illuminate opportunities for local authorities to be more involved in advancing HiAP. Understanding the organization of the government and the formal and informal social participation and coordination of the whole government is important for identifying opportunities and possible barriers with respect to a HiAP approach.

Most countries in the region have falling populations, with positive annual growth rates in only three of the nine countries. Significantly for HiAP, demographic data show that a large proportion of the population is in theory more or less accessible to coordination and cooperation among various sectors and actors.

The leading causes of mortality and years of life lost in all countries are non-communicable diseases, which reach over 80% per cent of years of life lost in most countries, and in the two countries where it is slightly lower, there is a high rate of life years lost through accidents. Infant mortality has declined in all countries, but only three countries have single-digit rates per 1000 live births.

While there are generally reliable data on demographic trends and morbidity and mortality, a significant weakness for the purposes of HiAP is the lack of health information broken down by socioeconomic status, such as income, employment status and education. This limits monitoring of interventions and assessments of non health sector policies on health. It also restricts the capacity of public health ministers and professionals to implement evaluate and advocate effective policies and interventions which target the underlying social and economic causes of health and health inequities

Policy frameworks in the countries present a diversity of entry points for multisectoral activities. Several countries identify their recent national and local planning and development plans as HiAP development opportunities. Opportunities are identified in fields of action beyond the direct mandate of the health sector, as are strategies to prevent or minimize any unintended negative impact on health from other policies. National health strategies or policies that could be used as opportunities for advancing HiAP because they incorporate wider determinants and inequities are also cited.

There are many strategies directed at particular groups or issues that provide a basis for intersectoral responses. Across the SEE countries these include plans related to gender equity and/or domestic violence, poverty reduction, social inclusion and the Roma minority, early child development, the environment, climate change, agriculture and illicit drugs. Different plans and strategies imply different types of working relationships across governmental sectors and with civil society and private sector actors. Patterns vary and include informative and collaborative ways of working as well as cooperation, coordination and integration.

Regional factors and administrative organization are important factors. The level of decision-making autonomy at local and regional levels is linked to the particular process of decentralization of the state and reorganization of the government apparatus and health system, in particular the organization of strategies and policies and their intersectoral dimension. All countries emphasize how regional and international developments in HiAP influence opportunities for scaling up HiAP actions in SEE, underlining the importance of support by the European Commission, WHO and other multilateral entities.

Countries have different approaches to addressing health equity and which social determinants are taken into account in policy making. Some approaches seek to provide social benefits to the entire population as a basic right, while others target specific social groups or territories and use means tests to determine eligibility. Some social inclusion and poverty reduction strategies aim at more than simply improving equity of access to services. In all strategies, targeting the most vulnerable groups is the main approach used to address equity. Such groups can be those on low incomes, children and women, the socially excluded and groups with greater risk of certain health problems. The main social determinants addressed by all the strategies are the intermediate or proximal ones, such as access to health services, lifestyle or behaviour, living conditions such as housing and water sanitation and social cohesion.

Various forms of joint working arrangements are identified in the studies, as well as formal and informal structures. These include multisectoral working groups, such as the joint planning mechanism, that are present in most countries. They are associated mainly with specific ad hoc aims or particular issues. Another mechanism is joint assessment associated with specific plans or programmes. There are also formal structures for intersectoral cooperation, whether at ministerial, legislative or other levels. Finally, there are legal instruments such as regulatory frameworks, requiring cooperation between sectors and actors, in most countries in the fields of health promotion and healthy lifestyles.

Very few countries use impact assessment methodologies that affect health or health equity. Environmental Impact Assessment (EIA) is a frequently used methodology, but it does not directly cover health issues nor routinely consider equity dimensions. Studies indicate a limited use of health impact assessment (HIA) but they highlight experiences associated with the assessment of implementation and policy.

The case studies report on access to information that can enable monitoring and assessment of strategies or plans, and the analysis of health equity by different social factors. Studies show that no SEE country has the ability to regularly monitor health outcomes disaggregated by a comprehensive set of socioeconomic indicators. Most of the countries have no mechanisms for joined-up monitoring and assessment of intersectoral interventions and HiAP. However, studies highlight some initiatives that could facilitate or act as entry points for these actions.

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

The case studies highlight challenges to advancing the HiAP agenda in SEE. In general, they suggest that policy frameworks and legislation could better support HiAP; indicators need to be developed to monitor and assess HiAP; training in HiAP for public health professionals could be improved; countries could share experiences more; decision makers should be provided with better information and evidence; and other sectors need to see the direct advantages for their policy aims.

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