ANNEX 4

TO THE ECHI-2 REPORT, JUNE 20, 2005

MEMBER STATE HEALTH POLICY ISSUES

Below is a concise review of issues and directions emphasized in recent health policy documents, for most of the Member States which were represented in the ECHI project. These include the EU-15 plus Hungary and Norway. Within the context of ECHI-2, it was not feasible to go beyond this set of countries. The rationale of preparing this overview is that the selection of ECHI indicators should be guided by health policy priority issues in the Member States.

AUSTRIA

By 2002, the Programme for the Advancement of Health in Austria formulated the following basic policies:

- Ensure equal access to health care, according to current medical standards;
- This applies throughout the Austrian Federation.
- Improve patients rights and responsibility, as well as community help programmes.
- Examine the possibilities for replacing the current mandatory insurance scheme by private inurance requirement.
- Promote quality assurance in all health care sectors.
- Place more emphasis on preventive care, especially within the medical setting by intensification of check-ups for persons at risk as well as elsewhere in society.
- Promote research on cost-effectiveness of interventions.
- Contain the cost of pharmaceuticals.

In 2003, national targets were formulated, among other things, for reducing the incidence of cardiovascular disease, stroke and cancer by 25%. This should be reached, among other things, by doubling the number of preventive examinations.

DENMARK

In 2002 the government put forth a number of health priorities in the government programme 'Healthy throughout life'. The publication outlines the targets for the public health policy of the Government of Denmark in the period from 2002 to 2010.

The priorities are divided into a number of objectives covering overall targets, risk factor targets and targets regarding major preventable diseases and disorders.

Overall targets:

- Life expectancy in Denmark should be increased substantially.
- The number of years with high quality of life should be increased.
- Social inequality in health should be minimized.

Risk factor targets:

- Smoking: The number of smokers should be reduced considerably through smoking cessation and by reducing the number of new smokers. Smoke-free environments should become widespread.
- Alcohol: The number of heavy consumers of alcohol should be reduced considerably, alcohol consumption among young people should be reduced and children should not consume any alcohol.
- Diet: The number of people who eat a healthy diet should be increased considerably, and healthy dietary habits should be a natural part of everyday life.
- Physical activity: The number of people who are physically active should be increased considerably, and physical activity should become a natural part of everyday life.
- Obesity: The increase in the number of people who are obese should be stopped.
- Accidents: The numbers of road, home and leisure accidents should be reduced substantially.
- The working environment: The total negative burden of the working environment on health should be reduced substantially. This should be achieved through such initiatives as targeted activities to improve occupational safety and health and integration with targeted health promotion activities.
- Environmental factors: The negative effects of environmental factors on health should be prevented, and a high level of environmental protection should continue to be ensured.

Major preventable diseases and disorders:

- Non-insulin-dependent diabetes: The growth rate in the number of people with non-insulin-dependent diabetes should be reduced. Complications among people with diabetes should be prevented through such means as initiatives by individuals to improve their own health.
- Preventable cancer: The number of cancer cases should be reduced by reducing the exposure of the population to risk factors known to be associated with the development of cancer.
- Cardiovascular diseases: The number of new cases of ischaemic heart disease should be reduced. The progression of disease among people at high risk should be prevented through such means as cardiac rehabilitation for patients diagnosed as having cardiovascular disease.

- Osteoporosis: The rate of growth in the number of people with osteoporosis should be reduced. The development of osteoporosis among people at high risk should be prevented through such means as measures to prevent falls and fractures.
- Musculoskeletal disorders: The number of new cases of musculoskeletal disorders should be reduced, and the exclusion from the labour market caused by musculoskeletal disorders should be prevented.
- Hypersensitivity disorders (asthma and allergy): The growth in the number of people with hypersensitivity disorders should be reduced. The progression of disorders and complications should be prevented through such means as self-care initiatives.
- Mental disorders: The prevalence of mental disorders should be reduced. Special initiatives should be taken in relation to children in families with a parent who is mentally ill or a substance abuser.
- Chronic obstructive pulmonary disease: The growth in the number of people developing COPD should be reduced. Complications and progression of the disease should be prevented among people with COPD through such means as smoking cessation activities.

New Government targets:

In addition to the above mentioned targets there is a number of other targets laid down in the Government Platform, New Goals, of March 2005:

- The overall principle in Denmark is that The National Health Service must offer high-quality services, ensure short waiting times and coherent treatment programmes.
- The waiting time for hospital treatment must be as short as possible. At present all citizens can choose treatment in a private or foreign hospital that has concluded an agreement with the counties, if waiting times for the public hospitals exceed two months. As an element in the 2005 Government programme New goals, the Government will as of 2007 improve this scheme, granting citizens the right of enhanced free choice if the public hospital is unable to offer treatment within one month.
- Activity based financing must account for 20% of the financing from the hospital owner (the counties and the Copenhagen Hospital Corporation) to the individual hospital. The government aims to increase activity based financing to 50% over a number of years.
- The Government works for openness and transparency regarding treatments in hospitals. One target is therefore to develop precise and comparable information regarding quality between hospitals and wards.

FINLAND

By 2001, Finnish health policy objectives, to be reached in 2015, were formulated as follows (on top of the earlier aims of 'more years and more health to life', 'reduction of health inequalities'):

Age group specific aims:

- Improvement of children's well-being and health, decrease of disorders related to insecurity.
- Decrease of smoking among the young (<15% of 16-18 year-old); no increase of alcohol- and drug-related health problems, and adequate care for these.
- Decrease by one third of accident/violence mortality among young adult men.
- Development of working (and functional) capacity and working life so that people can work longer and retire 3 years later than presently.
- Functional capacity at ages 75+ continues to improve.

Aims common to all age groups:

- Finns will live in good health about two years longer than in 2000.
- Satisfaction with health care, perceived health and perceived environmental health remain at least at the current level.
- Inequity must be reduced, and the health situation of the weakest groups improved. Mortality differences between men and women, and between educational and occupational groups must be reduced by one fifth.

The central prerequisites of those aims are:

- Health must be an important guiding principle in all sectors and levels of public life and organisations, in all policies, and in the private sector.
- This will be provided in settings like schools, homes, workplaces, leisure time environments, traffic, public services. In will include the citizen's possibilities to influence decision-making concerning his/her own environment.
- All of these premises will be strengthened during the whole life-cycle.

FRANCE

France has formulated 100 quantitative objectives for the period 2004-2008 in the field of public health. For each objective, one or more indicators were named. The system has been given the status of law. The objectives can be grouped as follows:

- 65 out of the 100 objectives on 'decreasing mortality, morbidity or functional limitations' for a range of ICD diagnoses, by preventive or appropriate health care interventions.
- 3 objectives on reducing functional limitations and pain in general.
- 13 objectives about smoking, alcohol use, healthy nutrition and physical activity.

- 4 objectives on improving health and safety at work.
- 8 objectives on improving healthy environments (radon, air pollution, water quality, noise).
- 5 objectives on iatrogenic events and safety in health care.
- 2 objectives on inequalities in health and access to health services.

GERMANY

In Germany, a set of health targets ('Gesundheitsziele.de') was formulated for the national level, by the Forum Health Targets Germany. The Forum is a joint initiative of the German Federal Ministry of Health (Bundesministerium für Gesundheit - BMG) and the Association for Social Security Policy and Research (Gesellschaft für Versicherungswissenschaft und –Gestaltung - GVG). It is funded by the Ministry and has brought together experts from a wide range of areas in the health care system. In the selection of targets, the impact of health problems and risk factors the following aspects were taken into account as follows:

- The health problem results in high mortality and health burden.
- The health problem is widespread.
- The health problem results directly in high expenditures (e.g. in-patient treatment).
- Chances that the health problem can be improved are good.
- Instruments and processes for improving the problem are available.
- There is a network of partners together with whom the health targets can be translated into action.
- The problem is of concern to the general public and to politicians.
- Opportunities exist to improve health inequalities.
- Improvements can be measured.
- Members of the public and patients can actively contribute to the health target process.
- There are no ethical reservations related to the health target.

In order to promote the acceptance and effectiveness of the target strategies to be developed within the project, representatives of patient and self-help groups are involved in each phase of the selection and development of exemplary health targets. The selection of targets was debated and closed in Berlin on October 31st, 2001. In order to reach the greatest possible number of population groups, four broad topic areas (A-D) were created and targets were selected for each area. Of the total of eight targets selected from all four topic areas, five (1, 2, 6, 7a, and 8) are currently being developed by working groups:

1. Disease-related health targets:
    1. Diabetes.

2. Breast cancer.
3. Depression.
4. Coronary heart disease.
5. Chronic back pain.

2. Health promotion and prevention targets:
    6. Reduction of tobacco consumption.

3. Targets for specific age and population groups:
    7. Fit for the Future – an integrated programme for the under-20's age group:
        a) Diet, exercise, stress.
        b) Vaccination status.

4. Citizen- and patient-orientated health targets:
    8. Empowerment of citizens and patients regarding their own health:
        a) Improve transparency.
        b) Reinforce rights.
        c) Strengthen competence.

All health targets to be realized must fulfil the following cross-sectional criteria:

- Equal opportunity.
- Integration of actors from all sectors of public health.
- Prevention.
- Citizen and patient orientation.
- Reinforce self-help.

These criteria are taken into consideration when creating a detailed design for sub-targets, strategies, and interventions as well as during subsequent evaluation. The working groups engaged in the development of these targets are equipped with the necessary expertise, competence and the tools to translate them into action.

The Association for Social Security Policy and Research (GVG) web site www.health-targets.de provides up-to-date information on all activities, including programme results and interim results. The web site also serves as a public discussion forum.

GREECE

In Greece, it is a priority to build a so called 'Health Services Map' which will be a systematic information system. This will include:

- data collection on health services and utilisation.
- the development of health indicators.
- the selective use of indicators for policy making and operational management at regional and national level.

The ECHI experience contributed a lot in the desigh of the system of indicators.

HUNGARY

In 2003, the 'Johan Béla' National Programme for the Decade of Health' was approved by the Parliament. It is a target based programme with the primary goal to increase the life expectancy at birth in Hungary by 3 years by 2012. Explicit health targets are defined. This has a boosting effect on health monitoring, since the information on the processes, outputs and on the targets should be provided. ECHI has a direct link to these activities. The programme has formulated goals under four main chapters, as summarized below.

A. Creating a health-promoting Social Environment.

- *Healthy youth:* Guaranteeing an opportunity for a healthy life to everyone, from the moment of conception; making the school, in addition to the family, the fundamental setting for health development; parenthood counseling, prevention of childhood conditions, exercise, health-promoting schools, etc.
- *Improving the health of the elderly*: Improve the quality of life for an ageing population.
- *Equal opportunity for health:* Improve the health of socially excluded population groups – the Roma, persons with disabilities, the homeless; tackling causes of health inequality; equal access to health care and prevention programmes; improving attitudes and knowledge of medical personnel.
- *Health Promotion in Settings of Daily Life:* Health-promoting practices in living settlements, schools, workplaces, health care; health as organic part of local development plans; more prevention and health promotion in health care; health in curricula and training.

B. Programs of healthy lifestyles, reducing risk factors to human health.

- *Cutting back tobacco smoking:* Reduce young people starting; reduce passive smoking by smoking restrictions; reduce social acceptance of smoking.
- *Alcohol and drug prevention:* Reduce alcohol and drug consumption, prevent health and social damage they cause.

- *Healthy nutrition and food safety:* Reduce nutrition-related disorders, improve the general state of health through healthy nutrition; improve quality of food production, better information, better food safety.
- *Promoting physical activity:* Promote an active lifestyle in the broadest sense; increase sports participation and education; more leisure sports opportunities.
- *Public health and epidemiological safety:* Develop ability for rapid reaction to health threats (chemical, microbiological, radiation).
- *National Environmental Health Programme:* Promote health-supporting environment; safe and clean air water, and soil, reduce noise disturbance, etc.

C. Preventing avoidable mortality, morbidity and disability.

- *Reducing coronary heart disease and stroke:* Cut premature mortality due to these causes by 20%; increase appropriate screening and treatment of risk groups.
- *Reducing cancer:* Stop the rising mortality due to tumours; improve oncology prevention and care.
- *Strengthening mental health:* Improve the population's mental health; primary prevention; early recognition; reduce suicide rate.
- *Reduce morbidity by locomotor diseases:* Improve quality of life for people with locomotor diseases; improve prevention and care; retain mobility as long as possible.
- *Prevent AIDS*: Reduce incidence, improve diagnosis; improve prevention, especially in high-risk groups.

D. Strengthening the institutional system of health care and public health to improve health.

- Public health screenings: Reduce cancer mortality by 5-10% in under-70 population by screening; breast, cervical and colorectal cancer.
- Improving the provision of care: Development of the health care system in line with public health priorities; expand primary care; improve prevention and rehabilitation within health care.
- Resource development: Build infrastructure for education in public health; information, education, training at all levels.
- Monitoring – information technology: Monitor the progress of the programme, with appropriate indicators, regular data collection.

IRELAND

At the end of 2001, a National Health Strategy for Ireland was approved by Government following widespread consultation. The Strategy is titled, Quality and Fairness: A Health System for You and is based on four principles. These are:

- Equity.
- People-centeredness.
- Quality.
- Accountability.

These principles are to be advanced under the headings of four National Goals. These are:

- Better health for everyone.
- Fair access.
- Responsive and appropriate care delivery.
- High performance.

In turn, attainment of the National Goals will only be possible through the implementation of an identified set of Frameworks for Change comprising:

- Strengthening primary care.
- Reform of the acute hospital system.
- Funding the health system.
- Developing human resources.
- Organisational reform.
- Developing health information.

Encompassing both the National Goals and the Frameworks for Change a detailed Action Plan forms part of the Health Strategy and includes 121 specific actions designed to effect the necessary progress and improvements. These actions identify priorities related to specific population groups, major health status and health determinant issues, to organisational reforms and to service delivery and evaluation requirements.

Since 2002, each of the 6 Frameworks for Change has been further developed through specific Strategy Reports relating to each framework. 'Developing health information', for example, is represented by the National Health Information Strategy which was published in 2004. Based on these reports, a major Health Service Reform Programme is now in the process of implementation which involves the replacement of the existing Health Boards with a central Health Service Executive for the whole country and the creation of a Health Information and Quality Authority.

ITALY

The Italian National Health Plan 2003-2005 provides a strategic approach, expressed in a series of main objectives, principles and guidelines. It does not formulate specific long and short-term targets.

The stated policy priorities that form the basis of the NHP are:

1. To favour the family and to increase the national birth rate.
2. To support disabled people.
3. To fight against extreme poverty.
4. To favour self sufficiency, in particular for elderly people.
5. To actively promote employment (welfare to work).
6. To fight juvenile problems and favour vulnerable groups.
7. To promote equal opportunities between men and women.
8. To prevent drug-addiction and drug dependency.

The NHP measures described in the document regard several policy priorities and address the EU Objectives in the following way:

- Under EU Ob. 1.1 (Facilitating participation in employment), the promotion of employment and skills with a particular attention to women and persons living in South Italy, increasing the activity rate of persons over 55, the labour insertion of disabled people, the social and labour insertion of convicts, the regularisation of illegal employment, the support of geographical labour mobility, the development of CSR (corporate social responsibility), the development of lifelong training.
- Under Ob. 1. 2 (Facilitating access to resources, rights, goods and services for all), the support to family centrality and increasing the national birth rate, networks of family services, custody and adoption of minors, family and work time conciliation in favour of maternity, services for disabled people and people aged over 65.
- Under Ob. 2 (Preventing the risks of exclusion), the reduction of the school drop-out rate.
- Under Ob. 3, (Helping the most vulnerable), extending ICT – services for disable people, the creation of training courses for immigrants to learn the Italian language, the formation of a Commission of practitioners and experts on drug dependency, the social and labour insertion for drug-dependent persons, the fight against extreme poverty, multi-level initiatives in favour of convicts, the CI - EQUAL, the integration between different policies through territorially integrated plans (PIT), monitoring systems on social policies and education quality, the elaboration of systemic statistics on the wide range of indicators on social and related policies.

- Under Ob. 4 (Mobilising all relevant bodies), no specific measures are formulated that follow subsidiarity principles in relation to the significant changes which have occurred in the institutional structures after 1997.

To monitor the progress of the plan, a long list of indicators was devised (SINDIS, Set di INDIcatori per la Salute) under the SISTAN (Italian Health Statistical System - Sistema Statistico Nazionale), for national use but in close agreement with the Italian Regions. Also a core set was developed, for the periodical evaluation of the National Health Plan and to produce a feasibility study to be implemented in collaboration with the specific Regional bodies devoted to Health Monitoring. Part of this work has already been translated into laws. In developing these lists, the ECHI example has played an important role, for instance in the monitoring of health and lifestyle issues by Health Interview Surveys.

NETHERLANDS

In December 2003, the Ministry of Health, Welfare and Sports issued a Public Health Strategic Paper. It focuses on 6 priority disease groups, based on their population burden and cost:

- Cardiovascular diseases.
- Cancer (especially of the lung, breast, colon, rectum).
- Asthma and other chronic lung disease.
- Diabetes mellitus.
- Mental disorders (especially depression, anxiety disorders, alcohol dependence).
- Musculoskeletal disorders.

Considering the effective ways to prevent these diseases, three focus items are chosen for action, i.e. smoking, overweight, and diabetes. The latter includes appropriate diabetes care.

There is some attention for integrated approaches in settings (school, work, ‘making the healthy choice the easy choice’, etc.) and also for health problems in lower socio-economic groups and in deprived groups in the big cities. In terms of action, however, these issues are not carried further. The dominant political climate behind the paper is one of ‘everybody should take his/her responsibility’, and abstinence of too much governmental interference.

PORTUGAL

Recently, there has been much emphasis on health care reforms. Among the objectives and associated tools are:

- Improving health by minimizing differences.
- A strong focus on the patient.
- Improve access to health service, by reducing waiting times and improving the availability of local GP's.
- Improve vertical prevention programmes (e.g. cancer screening).
- Ensure financial sustainability, by a 'regulated competitive market'.
- Improve effectiveness and efficiency of health care.

In terms of health information major developments have been:

- Ongoing work on indicators and on statistical concepts.
- The post of High Commissioner for Health was created (2001), to coordinate all health information related issues, supported by a technical secretariat.
- Preparatory work initiated for a first HES in 2 to 3 years from now.
- The Portuguese Health Systems Observatory, was established in 2001. It is a consortium of 4 university departments. Every spring they produce a report.

SWEDEN

In 2003, national goals have been formulated, as being based on scientific evidence. The goals focus on determinants of health rather than on specific diseases or conditions. These determinants are formulated in a rather broad social context, starting from the humanitarian view that the major differences in health between different groups should be reduced. Health is viewed as a partly subjective issue with a strong functional and social component. The overarching aim of Sweden's national public health policy is formulated as: 'to create social conditions that will ensure good health, on equal terms, for the entire population'. There are 11 public health objective domains which cover a number of established policy areas including economic policy, social welfare, the labour market, agriculture, transport and the environment. These are:

- Participation and influence in society.
- Economic and social security.
- Secure and favourable conditions during childhood and adolescence.
- Healthier working life.
- Healthy and safe environments and products.
- Health and medical care that more actively promotes good health.
- Effective protection against communicable diseases.
- Safe sexuality and good reproductive health.
- Increased physical activity.

- Good eating habits and safe food.
- Reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in the harmful effects of excessive gambling.

The objective domains cover the most important determinants of Swedish public health. The benefit of using determinants as a basis for policy is that they enable us to evaluate progress. This in turn supports political decision-making as determinants can be influenced by certain types of societal measures. For more information: http://www.fhi.se/templates/Page____567.aspx

UNITED KINGDOM
(separately for England, Scotland, Wales and Northern Ireland) :

England

The government document 'Saving Lives: Our Healthier Nation' (The OHN White Paper, published July 1999) identified two goals and four priority areas. This public health strategy forms a component of the broader NHS Plan published in July 2000. For each of the four areas, a target was formulated for 2010 and an interim milestone for 2005.
The two goals are:

- To improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free from illness.
- To improve the health of the worst-off in society and to narrow the health gap.

The four priority areas are:

- Circulatory Disease.
- Cancer.
- Accidents (not included in NHS Plan – see below).
- Mental health.

For these areas, the *targets* for 2010 are:

- Circulatory disease - a 40% reduction in the mortality rate.
- Cancer - a 20% reduction in the mortality rate.
- Accidents - a 20% reduction in the mortality rate.
- Suicide - a 20% reduction in the mortality rate.

For each of these four areas, a list of *associated indicators* will be defined, which will allow the assessment of progress, in terms of:

- The targets themselves.
- Improvements in associated risk factors.

- Movement in underlying factors which reflect social, environmental and economic change which the evidence shows to have an influence on health and inequality.
- The implementation of effective programmes/activities (including the development of capacity and capability in public health).

The definition of indicators will be an ongoing task. This approach maintains *the focus and clarity* of selecting only a very limited number of targets. Aside from general monitoring and reporting of progress, there is a more general commitment in the White Paper to review and publish changes at national level to:

- Expectation of life.
- Healthy life expectancy.
- Health inequality.

In addition there are a number of other topic-specific 'supporting strategies' that are identified in the White paper and these are also being taken forward:

- Sexual health strategy.
- Alcohol strategy.
- Communicable disease strategy.
- Smoking White Paper.
- Fluoridation/dental health.
- Drugs strategy.

The NHS Plan published in July 2000 set out a wider strategy for the development of the National Health Service. It reinforced and developed some of the public health themes set out in Our Healthier Nation. In particular it gave added focus to work relating to cancer, heart disease and mental health, older people, and health inequalities (including efforts to increase and improve primary care in deprived areas, introduce screening programmes for women and children, step up smoking cessation services and improve the diet of young children by making fruit freely available in schools for 4-6 year olds.

A series of National Service Frameworks (NSF's) have been established to improve services through setting national standards to drive up quality and tackle existing variations in care. These NSF's cover prevention as well as treatment issues. NSF's have been completed for: Mental health, Coronary Heart Disease, Cancer (The NHS Plan for Cancer), Older People's Services, and Diabetes. NSF's are in preparation for: Paediatric Intensive Care, Children's Services, Renal Services and Long-term conditions (with special focus on neurological disease and brain and spinal injury).

On 16 November 2004, A new English White Paper policy document on public health was published: Choosing Health: Making healthy choices easier.

This new white paper has a twin purpose – to improve health and tackle health inequalities. It sets out practical action to help ensure that people can make informed and healthy choices and that all can benefit from living in a healthier society. Its overarching priorities are:

- Reducing the number of people who smoke.
- Reducing obesity.
- Increasing exercise.
- Encouraging and supporting sensible drinking.
- Improving sexual health.
- Improving mental health and well being.

As the White Paper is based on a thorough public consultation, it has enabled identification of the mandate for change among the public. It has also allowed development of practical policies that are tailored to the needs of people's lives today so shifting policy into effective practical support.

Choosing Health is built on three principles:

- Informed choice:
    - Personalisation: supporting people to make healthy choices especially for deprived groups and communities.
    - Working together through effective partnership.
- It encourages individuals to make sensible choices about their own health by the positive marketing of health, readily accessible and credible sources of accurate information personally tailored to individual needs.
- It proposes establishing a *Health Information and Intelligence Task Force* to lead action to develop and implement a comprehensive public health information and intelligence strategy.

Scotland

The Scottish Executive has a clear and well-established commitment through Towards a Healthier Scotland [1999], Building a Better Scotland [2002], Our National Health: A plan for action, a plan for change [2000] and Improving Health in Scotland: The Challenge [2003] to improving health and shifting the emphasis away from ill health to one that focuses much more on prevention and health improvement. As part of that commitment, and aligned with the Executive's strategies for promoting social justice and closing the opportunity gap, there is a particular focus on tackling health inequalities as the 'overarching aim' of the health improvement agenda. The commitment to improving health, integrated with the pursuit of social justice, includes the need to bridge the opportunity gap for all equally, regardless of age, gender, sexual orientation, geographical or economic position, ethnicity, disability or faith.

The seminal health strategy White Paper Towards a Healthier Scotland [1999] focused on:

- Reducing Inequalities in Health.
- Improving health of children and young people.
- Prevention of Cancer and Coronary Heart Disease (the two major killer diseases).

Headline Targets for 2010 were specified for:
Coronary Heart Disease, Cancer, Smoking, Alcohol Misuse, Teenage Pregnancy, Dental Health in young children.

A range of health strategy documents have been published subsequently, developing structures and methods to deliver the overarching health targets.

Our National Health: A plan for action, a plan for change (2000) identifies the priorities:

- Rebuilding a truly National Health Service through changes to governance and accountability.
- Increasing public and patient involvement in the NHS.
- Service change and modernisation.

Building on the principles stemming from Towards a Healthier Scotland a 'next steps' strategy for health service delivery was published on 15 December 2004, entitled: Fair to all, Personal to each. The next steps for NHSScotland.

The document reiterates the fundamental principles of healthcare in Scotland and notes that success in improving the health of children and young people and in reducing premature mortality from the big killers has not produced a reduction in inequalities in health. A variety of public health measures are proposed to further improve health with an emphasis on reducing health inequalities. Importance is placed on the active role of individuals in preventative health care, a role that is supported by comprehensive and high quality health services that are free at the point of use. A range of service targets are set for 2007 covering waiting times from GP referral to outpatient appointment and maximum waits for specific conditions are capped.

Northern Ireland

A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025 [2005] A Healthier Future is organised around five main ideas or themes:

- Investing for health and wellbeing.
- Involving people – caring communities.
- Responsive combined services.
- Teams that deliver.
- Improving quality.

Key policy directions include:

for '*Investing for health and wellbeing*':

- A focus on bad habits – smoking, alcohol-related harm, drug misuse, obesity and lack of exercise.
- Outcomes relating to cancer, circulatory diseases, respiratory diseases and diabetes.
- Promoting joined-up action across agencies involves with health, education, employment, sport and the arts.
- Emphasising health promotion amongst vulnerable groups.

For '*Involving people –caring communities*':

- Active involvement of people in promoting health and wellbeing, managing chronic conditions and designing and managing services.

For '*Responsive combined services*':

- Break down barriers between services delivered and communities.
- Focus on disadvantage.
- Clear standards of access.
- Develop community based multi-skilled teams.
- Improve the role of hospitals in supporting community based services.
- Tailoring services to the needs of particular groups.

For '*Teams that deliver*':

- Health and social service providers to become 'employers of choice' to recruit and retain staff.
- Develop shared learning skills across all sectors of employment.
- Plan for the development of changing roles and skills across health and social services.

For '*Improving quality*':

- Meeting clear quality standards.
- Setting in place flexible plans, appropriate structures and efficient processes to support putting the health strategy into practice.
- Continue to promote a positive, active and responsive relationship with private, community and voluntary sectors.

A Healthier Future develops and extends the overarching goals in Investing for Health [April 2002], which are on:

- Improving life expectancy and healthy life expectancy.
- Reducing Inequalities in Health.

Key Targets for 2010: In addition to targets on improvements in Life Expectancy and Health Inequalities, other key targets (related to the prime objectives of the strategy) are on:

- Reducing poverty and improving housing for households on low incomes.
- Improving educational attainments in young people.
- Promoting mental health and emotional well being.
- Reducing accidental injuries and deaths – home, workplace and road traffic accidents.
- Improving neighbourhoods/wider environment (quality of air and water) - with special focus on reducing levels of respiratory and heart disease.
- Enabling people to make healthier choices (smoking, nutrition, exercise) with special focus on obesity, and in very young children - dental decay.

Wales

Better Health Better Wales [for the period 1999-2002] focused on improving health and well-being and reducing health inequalities. Targets formulated include the following conditions: Cancer, Coronary Heart Disease, Stroke , Accidents and Suicides, Mental Health, Low Birth Weight, Smoking, Alcohol, Consumption of Fruits and Vegetables, Dental Caries, Back pain, and Arthritis.

Promoting health and well being: Implementing the national health promotion strategy was published in 2001. Five priorities were identified that needed to be addressed as part of a co-ordinated and sustained effort to improve health. The priorities were:

- Helping communities to develop a shared responsibility for health and to take action to improve people's health.
- Promoting healthier lifestyles as part of wider action to address the social and economic factors that affect people's health.
- Better communication on health issues – improved quality of information and people's access to it.
- Developing the tools, resources and skills for health promotion
- Ensuring action is effective.

The strategy's overall message was that everyone could contribute to promoting health and well being. Individuals can take greater responsibility for health and should do what they can to look after their own health and that of their families. Some individuals can help to improve the health of others through their jobs and the roles they play in local authorities, health services, businesses, voluntary and community groups, and more generally within communities and families. The strategy urged organisations in all sectors to reflect on how they contribute or could contribute to promoting better health as part of their role.