



1 La reforma de la salut pública a Catalunya

La reforma de la salut pública en Catalunya
The Public Health reform in Catalonia

Informe del comitè científic per donar suport al projecte de reordenació del sistema de salut pública a Catalunya.

The reform of the Public Health in Catalonia

Report of the scientific committee
to give technical and scientific
support to the project of
reordering of the system of public
health in Catalonia



Generalitat de Catalunya
Departament de Salut

Direcció General de Salut Pública

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INTRODUCTION

These are important times for the reform of public health services in Catalonia. There has probably never been such a concerted effort to bring public in line with the needs of the population, the management of health risks and the challenges posed to global health.

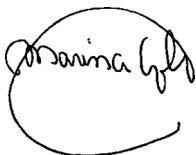
With the commencement of the current Administration a strategic and operative reform of public health services is proposed, with the creation of the Public Health Agency of Catalonia, natural successor to the Agency for the Protection of Health, this being one of the priorities in the health sector..

This process, led by the Directorate General of Public Health is characterized by the creation of a scientific committee, a consulting committee and a technical organ with the specific task of drawing up the principal strategic lines and operative recommendations that will permit the creation of the Public Health Agency of Catalonia (ASPCAT). These instruments are the basic structural elements of this initial stage.

In this document are presented the findings of the scientific committee. This committee was formed in order to draw up a document that would enable the orientation of the principal lines of the process of the reform of the public health services. The order made to its president, Dr. Josep Ma. Antó, who has done a magnificent task together with his team, was carried out from the perspective of the broadest possible vision, with no limits other than those stemming from the awareness of our reality, in order to make recommendations which are bold, yet at the same time realistic, founded on the expertise and the intellectual resources of the committee members. These members have played a dual role; as individual members, contributing their specific knowledge, which has not been exempt from consultation, and as members of a work group, interacting with all of the documents to achieve a collective product of great value.

At this moment in the process, considerations were made from an ideal perspective in order to orient the more specific tasks which will in turn lead to more operative proposals. Bearing this in mind, the points suggested, which form the central axis of this work, are grouped into two blocks. The first focuses on public health as a specific service within public health services as a whole, just as primary healthcare or specialized attention. This first block includes policies and finance, the organization and regulatory frame, and the service prospectus. The second considers transversal dimensions within the public health services as a whole, but from a public health perspective. This second block includes aspects such as intersectoriality, research, training and innovation, participation and communication.

I want to thank their contributions to all members of the Scientific Committee, Those, very surely, will orientate the performances that we carry out in order to favoring an increase of the importance of the public health, including the transformation of their services.

A handwritten signature in black ink, enclosed within a hand-drawn circular border. The signature appears to read "Marina Geli".

Marina Geli I Fàbrega
Consellera
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PUBLIC HEALTH 2010: A STRATEGIC AGENDA FOR PUBLIC HEALTH SERVICES IN CATALONIA

Antoni Plasència, Josep M. Antó, Josep Ll. de Peray

INTRODUCTION

One of the most significant phenomena in the area of public health in industrialized countries in the last decade is the recognition of the insufficiency of the systems of public health. While public health has clearly been founded and developed scientifically and technically during the 70's and 80's, it was not until the 90's that there was a wide recognition of its importance and of the weaknesses of the existing systems¹. For this reason it is not at all strange that during the last few years there have been significant efforts made in various countries such as Canada² or the United Kingdom³, geared towards redefining the bases for the systems of public health for the twenty-first century. It is equally significant, in this context, that in the European Union important steps have been taken towards the creation of a Public Health Agency similar to the Centers for Disease's Control of the United States.

The change of government that recently occurred in Catalonia opens up broad possibilities for advancing the structures and functions of public health in Catalonia. It is a sad but well known fact that until now public health has not been a priority, nor has it received the attention due to it. Conditions, then, seem to be ripe for an energetic political action and the establishment of a political strengthening of public health with a vision that looks to the short, medium and long term. This plan requires a Strategic agenda which is something more than a technical planning instrument, and that takes full advantage of the professional, scientific and civic capacities that have been developed by Catalan society over the last few decades. This process must contribute to the necessary visualization of a new perspective for the public health services.

In this context, the Department of Health, through its Directorate General of Public Health, proposes to engage in a process of consultation that will contribute to the aforementioned Strategic Agenda, framing and giving support to the creation and starting up of the future Public Health Agency of Catalonia (ASPCAT). It is suggested that this process be known as "Public Health 2010 (SP2010): A strategic agenda for the public health services of Catalonia" (SP2010).

WHAT DOES SP2010 AIM TO BE?

The principal aims of SP2010 are twofold: firstly, to give scientific and technical support to the new government of Catalonia in the drawing up of a Strategic Agenda for Public Health, and secondly to guarantee the participation of professional, scientific and social entities and the mobilization of their capacities in the aforementioned Agenda.

SP2010 must constitute a coherent process, with products designed in advance and with a reasonable infrastructure for the achievement of its goals. This evaluative strategy must consti-

tute one of the main points of reference which, together with the priority of government expressed through the regulatory function of the Department of Health – Directorate General of Public health, contributes to giving conceptual and operative support to the Public Health Agency of Catalonia (ASPCAT), as the point of reference for the provision of public health services in Catalonia. The SP2010 strategy, then, is incorporated in the organizational strategy that must include, among other things, the creation and deployment of the ASPCAT.

Furthermore, the strategy must permit the indication of the working lines that will have to define the scope of the ASPCAT as the organization responsible for the management and provision of the essential services of public health through the configuration of the following: an appropriate legislative and regulatory framework; the organizational and functional structure; the prospectus of services; financing; the model for the purchase of services; the human resources structure; its insertion into and coordination with all levels and departments of the public administration and the attention levels of the healthcare system; and a model for relations with municipal councils and with citizens, among other key elements. The characteristics of the deployment of the organizational strategy will be based on criteria of quality, coordination, agility, effectiveness, viability, and of promotion of innovation and research. The assessment and organizational strategies must converge in the operative designs that have to contribute to the creation of the ASPCAT and the real provision of services formulated and executed by public health policies.

CRITERIA FOR THE WORKING METHOD OF SP2010

Structure:

Consultative Council (CCONS) to be broad, with various criteria: representation, experience and leadership.

Scientific Committee (SC) to act as the driving force for the whole process. The SC must have a secretary and a technical unit capable of working rigorously and efficaciously.

The function of the CCONS is to complement and reinforce the proposals of the SC regarding the predefined ambits of work:

1. Policies and finance
2. Organizational models and legislative instruments
3. Prospectus and purchase of services
4. Intersectoriality
5. Participation and Communication
6. Research, innovation and training.

Each work group must draw up a technical report, corresponding to a specific task and will be presided over (and co-presided over) by two members of the SC.

The technical unit will prepare an inventory of materials which, for their characteristics, may be important in the initial stages of the process (both from within Catalonia and from the rest of

Spain and from other countries), it will contribute to formalizing the work agenda, it will produce any support materials that may be necessary, and it will formalize the end products designed by the Strategic Agenda. The technical unit is at the same time responsible for transferring the products of the CCONS and the SC to the DGPH and to the ASPCAT in order that they form part of the organizational strategy of the corresponding organs of management and participation.

Work process and calendar:

Stage 1: Constitution of the Scientific Committee and meeting of presentation. In the last quarter of 2004 were celebrated the plenary sessions of the consultative board and of the scientific committee that included the presentation of:

1. The strategic process that begins and the context in which it inscribes.
2. The strategic and operative contents as well as the description of the assignment to the different work groups that are going to be constituted.
3. The organization, the working plan and the methodology that is going to be used in this stage of the process.

Stage 2: Development of the activities suggested in the working methodology of the scientific committee and of the consultative board during the first semester of 2005.

Stage 3: The technical organ integrates the documents fabricated by the work groups of the scientific committee into a joint proposal.

This process must include the following criteria:

1. Visibility and wide publicity to you jam of the web with all the available materials in Catalan, Spanish and English.
2. Participation of experts in the work groups that require them, with the aim of promoting an approach based on the best available experience.
3. Adoption of the criteria of the public health based on the evidence.
4. Strong presence and visibility in the areas of the public health in which there is the opportunity of presenting the process and the initial results.

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EXECUTIVE SUMMARY

THE REFORM OF PUBLIC HEALTH IN CATALONIA

INTRODUCTION

In the broadest sense, the term public health refers to the process of the local, regional, national or international mobilization of resources in order to guarantee the appropriate conditions for a sustainable state of health of the population. These resources, both human and material, are genuinely destined to the service of the population as a whole and are translated into services of promotion, prevention and protection of health. Vaccination programmes, mother-infant health programmes, programmes of family planning or of early diagnosis of breast cancer, measures taken to control the quality of water, air or food are just some of the better known examples of public health services. Often these services are much less visible and less well known than individual medical services but their importance for the maintenance of the quality of life for societies is paramount.

The change in the political cycle in Catalonia and in the State resulting from the 2004 elections, and the fact that the new coalition in the government of Catalonia considers public health as one of its priority areas for action has opened some very broad possibilities for reform of public health and for the solution of its deficiencies. It is in this context that the Directorate General of Public Health created an integrated Scientific Committee composed of experts from different fields of public health in order to analyse the reforms that need to be done in the future. This text is a summary of the most important aspects contained in the report devised by this committee.

PRESENT SITUATION AND BASIC CRITERIA FOR REFORM OF PUBLIC HEALTH IN CATALONIA

From policies to public health services

In the future, the objectives of public health policies in Catalonia should be articulated around three main general objectives:

1. The reduction of inequalities in terms of healthcare so that the differences in terms of healthcare do not confirm or multiply already existing social or economic inequalities.
2. The control and elimination of social and environmental risks that may have a direct or an indirect effect on health,
3. The effective improvement in the quality of life of all people in our society, by favouring the best health conditions possible. To pursue these objectives it is necessary to favour de-centralization in the range of services offered and their management; to link actions in public health with other actions of attention, to design interventions with a public-oriented perspective, and to make the most of the indirect implications of interventions on health.

The execution of the functions of public health and the provision of services requires the existence of adequate organizational structures. Organizational solutions are often not unique and are derived largely from the historical and political tradition of each country. One of the most relevant aspects of organizational structures in public health is its territorial disposition. One of the keys to the reform of public health in Catalonia lies in its organizational plan. On one hand it is necessary to strengthen the central structures, guaranteeing the conditions necessary to execute the functions of planning and evaluation of public health policies. In this area the most important aspects are the creation of a Public Health Agency of Catalonia and the corresponding reform of the Directorate General of Public Health. By the same measure, it will be necessary for the current organization, in which the services of the Department of Health coexist with their territorial services and town councils with their own services, to give way to a new structure based on the Public Health Agency of Catalonia, the counties, the territorial health organizations, and a network of local providers of public health services.

Another key aspect to the reform of public health is that of finance. Among public health professionals there is a general opinion that policies of public health with a collective target are seriously underfinanced and that a significant increase is needed in the level of finance. Unfortunately, the information available on this matter is very limited. The available data suggest that the average public expenditure per person oscillates between 15 € per inhabitant/year and 17 €. These estimates do not include expenditure on public health activities carried out from primary attention not even the realized one from plans directors that include actions of public health. The information available at international level is also very limited. Faced with this situation it is of the utmost importance to carry out an exhaustive study of the current level of spending on public health as well as of the level and mechanisms of finance that are necessary.

The current legal regulations and structure of public health services are based on norms from the beginning of the twentieth century, updated after the war. The two most recent legal norms that must be born in mind are the Law of Healthcare Administration of Catalonia (LOSC) of 1990, partially modified in 1995, and the Law of Health Protection (LPS) of 2003. Any proposals for the reform of public health that are adopted must bear them in mind, and the formulation of the LPS permits the contemplation of a transitional scheme based on this law to later progress to a new regulatory framework. It must also be remembered that the Law of the Municipal Charter of Barcelona of 1998 upholds the peculiarity of the structure of public health services in the city. Although the necessity for a new law of public health may not be obvious, an evaluation should be made of how far this could be necessary for reasons such as the creation of a public health agency, the reorganization and modernization of the function of authority or the integration of functions scattered among other laws and territorial structures. The creation of the ASPCAT must be realized with the greatest possible coherence, guaranteeing that its role be clearly defined, establishing its mission, competences, responsibilities and powers, the organizational structure, the financing and the institutional form which is most coherent with the previous elements in a way that favours the optimum development of the activities within the framework of all public institutions, avoiding the re-centralization of functions and the internalization of political tensions which must remain at the Directorate General of Public Health. The creation of the ASPCAT must imply greater specialization of the existing functions and activities, the allocation of new functions, the establishment of relations with the other levels of administration and the unifying of functions of contracting which are currently carried out by different entities on small

and inefficient scales, often with a weak contractual procedure. The ASPCAT should have a nucleus of civil servants with the objective of also being able to cover those activities that entail the exercising of authority that legislation reserves for the civil servants of the administration, whether autonomous or local.

PRINCIPAL AXES OF PUBLIC HEALTH

The importance of intersectoriality can be easily demonstrated by the fact that in the majority of municipal councils, and in the Government of Catalonia, there are competences and responsibilities of public health that are not administered by the respective health departments. Despite the efforts realized in this area, the practice of intersectoriality in Catalonia is not yet governed by any global strategy and, on the whole, it is insufficient, fragmented, reactive and uneven. Faced with this situation a more coherent and energetic action is needed that allows us to pass from conceptualizations and discussions to specific initiatives. Given that some important experiences have been carried out in the past, it is necessary that where positive results have been produced, the widening and generalization of the focuses and models adopted is made possible. It is very important to improve information on intersectoriality in the ambit of public health and the realization of specific studies in order to facilitate an exact diagnosis of the situation as well as the formulation of proposals.

Participation has the potential to improve the health of individuals and populations because it represents a greater involvement and, moreover, it is a necessary element for achieving autonomy and exercising solidarity. In the future, and in the framework of the reform of public health, an evaluation should be made of the creation of a forum of civic participation in this field, in conjunction with entities and associations. In parallel, it would be preferable to have available information about the most important experiences of civic participation in the field of health, from the entities and associations involved, and about the resources available. In order to promote participation as having a growing importance in public health policies, it is necessary to promote programmes of evaluative research and studies of the expectations and motivations of the entities involved. Equally, it is important to promote training activities on participation among professionals and students. In order to make all this possible, it is necessary for the ASPCAT to have an administrative unit dedicated to civic participation, possibly in conjunction with matters of communication. In the medium term, and with a more strategic approach, a plan for promoting participation should be designed.

The scope of aspects related to communication in public health is very broad and it is convenient to distinguish three types of communication, depending on whether operating between the different public health services; between the public health services and the community, directly, or between the public health services and the mass media. It is necessary to carry out an in-depth study of the current system of communication between the different organisms and services of public health, analysing also the experiences developed in other sectors, and abroad, such as the one known as the National Public Health Information Coalition (NPHIC) in the United States of America. As regards communication with the population, there are serious deficiencies and it is necessary to promote the adoption of good practices in direct communication with the community. In the ambit of the media, television and the press predominate. Regarding

the future it is necessary to define a specific strategy designed to improve relations between the healthcare system and the media. The strategy should promote a mutual familiarization between healthcare and media professionals, a critical appraisal of the media on the part of society, it should establish systems that allow the detection of situations where there is room for improvement and it should give incentives for the training of healthcare professionals on communication matters and of communication professionals on medical or scientific matters.

Public health activities are principally based on the intensive use of human resources. A basic strategy for enabling the existence of competent professionals is training, but this requires that the present training programmes for public health professionals respond to the health needs of the population and to the reality of the service. Regarding specialized university education in public health, one of the most important programmes is the Master's Degree in Public Health run by the Universitat Pompeu Fabra in collaboration with other institutions. Together with this Master's degree there are other programmes in more specific fields of public health organized by the various Universities and institutions of Catalonia. Although the situation described above is reasonably healthy, there is still a need to establish strategies that enable us to improve the impact of the existing programmes on the practice of the professionals. Some of the commendable initiatives to pursue this improvement are; to promote initiatives that relate more closely training in public health with professional practice, to establish mechanisms of voluntary accreditation of the quality of teaching programmes, to establish a professional career in public health that takes into account professional activity, ongoing training and research performed, and to maximise the potential of new educational strategies based on the utilization of new information technologies.

Research has a strategic importance for health policies since it allows us to identify and monitor the health problems of the population and therefore to identify needs and priorities, to identify determining factors and characteristics and to evaluate the effectiveness of interventions, including the healthcare services themselves. In Catalonia, the research groups in public health have achieved a high level of quality, importance and productivity, with some areas in which the international profile of this research is important. It is essential that in the future actions of support are carried out in this field, geared towards both consolidating and stabilizing the situation of research groups in public health and also facilitating participation in research by the professionals who work in this sector. The creation of the ASPCAT could prove an excellent opportunity to strengthen and unify research in public health.

RECOMMENDATIONS AND PROPOSALS

1. The strengthening of public health requires an improvement of the functions of planning and evaluation of policies and services. In order to facilitate these functions it is of the utmost importance to have information systems of the highest quality. It is necessary to review the present information systems and to facilitate their improvement and expansion.
2. To guarantee a better equality in the distribution of public health services an adequate territorial structure is required. In the territorial organizations responsible for the manageability of the healthcare system, public health must be integrated with the other ambits of healthcare. The functions of government, financing and planning of public health must be structured according to the same organizational lines as the rest of the functions of the Department of

Health. Regarding the ASPCAT, its territorial structure will have to be adapted to its functions, including the possible provision or contracting of services.

3. It is necessary to establish a specific model of financing of public health that takes as its starting point a detailed study of the present level of financing which is only partially known. This model of financing will have to establish some criteria and a budgetary mechanism that avoids negative discrimination against activities of public health as compared to healthcare attention/clinical services.
4. The measures and the scope of the changes that are finally adopted could create a necessity for a new law of public health. Among the changes which could come into play in favour of the need for a new law, the most important are the creation of the ASPCAT, the reorganization and modernization of the function of the authority or the integration of separate functions in other laws and territorial entities.
5. It is necessary to strengthen the organizational structures of public health at central level by reforming the Directorate General of Public Health and broadening its capacity to design and evaluate public health policies. It is necessary that the DGPH, in matters within its ambit, be able to act as arbitrator for all of the public institutions, establishing priorities in the allocation of resources, and acting as first instance of control and supervision.
6. The ASPCAT must have a well defined role which is coherent with all reforms, and must also have an adequate level of autonomy in administrative and scientific/technical fields as well as incorporating the elements of highly specialized technical assessment.
7. This new territorial organization of public health allows for various formulations but in any case it seems reasonable that a homogenous formula should be adopted for the whole of the Department of Health. The number of territorial health organizations may vary but one could possibly imagine some 25-35 organizations that have to serve populations that range from a minimum of 20,000 people to a maximum of 1,700,000 people in the case of the city of Barcelona. These territorial health organizations would have to plan actions and allocate funds to the various activities, which would have to be carried out either by local providers or by the ASPCAT itself. The ASPCAT would have to have a territorial implantation that allowed it to respond to the demands for provision of services, both coming from central level and formulated by the different territorial health organizations.
8. Regarding the immediate future it is advisable to propose a range of public health services that develops to the fullest possible extent the existing regulations on health protection in certain ambits such as environmental health or health in the workplace. In the ambit of the promotion of health and prevention, where the regulatory framework is less important, it would be best to establish a range of services "of minimums" that allows, at least initially, the consolidation of a prospectus that is both of high quality and realistic, that can be progressively broadened.
9. In order to facilitate that the offer of public health services be based on rigorous scientific and economic criteria it is recommended that an institutional process be established of catalo-

guing of public health services using the methodologies of critical appraisal of the evidence and of prioritization. This catalogue should be updated and reviewed on a permanent basis and should be one of the bases for the development of the service prospectus at different organizational levels.

10. All of the levels of responsibility in public health, from the Directorate General of Public Health and the ASCPAT to the aforementioned territorial organizations, should have a prospectus of services. In order to guarantee that the service prospectuses are translated into an adequate provision of services it is necessary to define a contractual model of the activities of public health.
11. It is necessary to preserve the function of authority and to guarantee that this can be exercised without conflicts of interest between the functions of finance/contracting and provision. The experience of the city of Barcelona seems to be positive and transferable to other situations. In the present legal framework of regulatory laws, we must remember the necessity that the professionals and technicians who carry out functions of authority in healthcare be civil servants, since it is necessary to preserve the presumption of veracity and authority, especially in inspection activities.
12. It is necessary to optimize the role of primary attention in the provision of public health services. The presence in Primary Attention Centres of "health technicians", often with a specialized training in public health or similar areas, offers a very important opportunity for the improvement of public health in Catalonia. These professionals could be incorporated into the public health system in a more effective way that would permit a leap in quality in this field.
13. Public health policies must incorporate an intersectorial dimension based on the combined work of all the sectors involved in such a way that all the participating sectors identify the benefits of working together. In order for intersectorial work to be possible it is necessary for stable mechanisms and structures to be created that permit the management of intersectoriality and guarantee work in cooperation between the different sectorial administrations.
14. It is necessary to contribute to the operative development of the right to civic participation recognized in the legal regulations that affect the healthcare system in general (General Law of Healthcare and Law of Healthcare Regulation of Catalonia) and in public health in particular (Law of Public Health). This must be done taking advantage of the capacities of the present Public Health Agency of Barcelona and the future ASCPAT. It is also necessary to favour, by the awarding of specific resources, work groups with the objective of improving our knowledge about participation and to propose specific interventions.
15. It would be preferable to promote the development of good communication practices in public health, identifying the agents who are responsible for communication in each of the services of public health and who possess the necessary resources. Equally, it is necessary to plan systematic strategies of communication with firmly established objectives and criteria for the evaluation of their effectiveness.

16. It is necessary to establish mechanisms of accreditation of training programmes in public health, to define the professional career in public health and to increase the number of places of Preventive Medicine and Public Health offered to the MIR conferences of resident doctors.
17. It is necessary to support the consolidated research groups in public health and to promote participation in research by professionals. It is also necessary to improve the interaction between the research groups and the organizations responsible for developing health policies. The Public Health Agency of Catalonia should have an important role in research matters so as to help in the articulation and promotion of the activities described.

THE REFORM OF PUBLIC HEALTH IN CATALONIA

The synthesis document

Josep M. Antó

INTRODUCTION

Since the establishment of a regime of democratic liberties and institutions in Spain and in Catalonia, essential public services such as education and healthcare have experienced a considerable growth and improvement. In the case of healthcare, a system of almost universal coverage has been established with professional and technical capacities similar to those of many European countries that only thirty years ago were only our points of reference. Among the indicators of this process it is worth underlining the structures of a broad network of public hospitals with a high level of services and specializations and the creation of a structure of primary attention that has radically transformed the first level of contact between citizens and the healthcare system. The State of Autonomous regions and the transference to Autonomous Committees of almost all of the areas of responsibility in healthcare have diversified the healthcare services in the Spanish state.

In Catalonia, among the distinguishing features of the Catalan healthcare system established during the last few decades, it is worth pointing out the notable improvement in accessibility to healthcare attention, owing to a broad network of attention centres, spread throughout most of the territory, integrating centres under different titles. Nevertheless, the Catalan healthcare system has suffered some very pertinent deficiencies such as the slow and delayed development of the reform of primary attention, insufficient territorial equality and the absence of a solid structure of public healthcare services. The change in the political cycle in Catalonia and in the State resulting from the 2004 elections, and the fact that the new coalition in the government of Catalonia considers public health as one of its priority areas for action has opened some very broad possibilities for reform of public health and for the solution of its deficiencies.

It is in this context that the Directorate General of Public Health created an integrated work group composed of experts from different fields of public health in order to analyse the reforms that need to be done in the future. The work carried out has been structured around a series of axes that correspond to the principal points of the Directorate General of Public Health's Agenda on reforms in the sector and especially regarding the creation of a Public Health Agency at Catalan level. In any case, it is necessary to mention that this is not the first time that a reflection of this type and scope has been produced in Catalonia, since there are antecedents in the development of the Public Health Agency of Barcelona and in various reflections that are of interest^{1,2,3,4}. The broad coincidence of criteria and the fact that some members of the present work group have been involved in these antecedents has facilitated the development of the process.

The task formulated by the group had as its principal objectives the provision of elements of analysis that would facilitate the actions of the government in this area and thus the work of the group had to be focussed on the current situation in Catalonia. Nevertheless, it must be born in

mind that there is an international debate on the deficiencies of present public healthcare structures⁵. This debate is centred around the difficulty of achieving a level of social legitimacy, of resources and services proportional to those which in the majority of countries around us has been achieved in the sector of attention. Also pertinent to this debate are the recent crises in public health represented by bovine spongiform encephalopathy, Serious Acute Respiratory Syndrome, avian flu, or the global threats of bio-terrorism. So, despite the local nature of this report, it is wholly desirable that the process of reform of public health in Catalonia have a presence in the international arena.

Some of the terms used in this document often have different meanings according to the context in which they are mentioned. This occurs with the expression “public health” which at times refers to the health of the population and at other times to those actions carried out by society in order to tackle problems of health. The following definitions have as their objective the clarification of the meanings of some of the terms frequently used in this document.

- Public health refers to the process of the local, regional, national or international mobilization of resources in order to guarantee the appropriate conditions for a sustainable state of health of the population.
- Health policy, or public health policy, refers to a group of actions established by a legislative or administrative body and directed to the institutions, entities or providers responsible for their execution.
- Health programme refers to a group of activities, usually initiated by an organization or an institution, that almost always involve a determined number of providers and that is directed at specific sections of the population.
- The term practice or professional practice refers to the activities or procedures organized, either explicitly or implicitly, and implemented by a particular provider or professional.
- Although the term “services “ has a clearer meaning in the ambit of attention than that of public health, in this document it is used frequently to refer to the group of activities and interventions provided by public health structures, whether in the framework of explicit programmes or as part of the habitual functions of these structures. However, on some occasions, the term “services” has been used to refer to the structures and resources that permit the carrying out of activities.

PRESENT SITUATION AND BASIC CRITERIA FOR REFORM OF PUBLIC HEALTH IN CATALONIA

Public health policies

The scope of public health policies existing in a country at any one moment in its history is strongly conditioned not only by the priorities, values and strategies imposed by the ruling political organization, but also by the historical make-up, and its functions, both at international level and in the history of the country itself.

In Catalonia public health policies have often been the consequence of a complex confluence of various factors, not only those strictly related to health. People often speak of the doctor Ramon de Tesserach (14th century), who was contracted by the “Council of A Hundred” (Consell de Cent), for the authority that was recognized in him due to his knowledge, to give advice on the measures to be taken to control epidemics. Those professionals who have succeeded him throughout the following centuries, each better equipped technically and scientifically than the last, have been awarded – to highly varying degrees – resources and powers to establish measures and to implement activities specifically geared to the improvement or protection of the health of the population.

Alongside this healthcare element of public health there is also a broader dimension which lies in the recognition, today widely accepted, that among the determining factors of illnesses there are global social and economic factors. A clear example of this type of factors, to which more and more importance is given as being a cause of loss of health, is poverty. The consequence of this is that one must bear equally in mind the importance that policies not directly related to healthcare may have for the health of populations. Thus the demolition in 1854 of the Barcelona city walls cannot be explained without considering the report of the municipal doctor Pere Felip Monlau about sanitary conditions that were experienced within the walled city. However, history appears to confirm that the influence of Monlau and public health cannot be appreciated without an understanding of the combination of all the contemporary factors such as the necessity for industrial floor-space to build new factories, the increase in rent due to the scarcity of housing, which kept rents at prices beyond the reach of the working classes, the loss of authority of the military at a time of constitutional reforms.

The diverse and multisectorial nature of the determinants of health have been widely assimilated by the scientific body of public health, from the formulations of Rene Dubos and Thomas McKeown to other, more extensive formulations in recent decades, in which the scientific knowledge of the relationship between social factors and health has done nothing but increase. For this reason, to understand the full implications of public health policies requires a broad and integrated vision of the different strategies that can facilitate the improvement of human health and avoid a reductionist and idealized vision in favour of aspects that are strictly healthcare or biologically related. With a broad and at the same time integrated vision, that bears in mind all of the social and healthcare factors involved in the apparition and evolution of health problems, it is possible to cover a wide range of possibilities for action through public healthcare policies. These policies generally combine different principles of public politics, each one with its advantages and limitations regarding distribution of resources, regulation and coordination. Currently governments devise these policies in many different ways but especially through the establishment of rules and the vigilance of the sector or, which is the same, the publication of rules and legislations the planning of services and activities, monopoly contracting, that is to say taking advantage of the capacity for negotiation afforded by being in many cases the only purchaser of services from a provider and the financier of the service.

From the long historical evolution in this field and from the growing intervention of the states and public administrations a group of essential functions and services of Public Health have appeared that have been formulated by the Institute of Medicine (IOM, USA) and that are reflected in the following table ⁶. The essential functions of public health constitute an important frame for understanding the scope that health policies can and must have in this ambit ^{6, 7, 8}.

<p>To evaluate health needs</p> <p>To monitor and evaluate the state of health and its determining factors.</p> <p>To diagnose and investigate health problems and health risks.</p>
<p>To develop policies</p> <p>To inform, educate and empower the population regarding health matters.</p> <p>To encourage collaborations and alliances to identify and resolve health problems</p> <p>To develop plans and policies of public health that give support to individual and community efforts in favour of health.</p>
<p>To guarantee the provision of basic services</p> <p>To apply the laws and regulations that protect health and guarantee safety.</p> <p>To connect individuals with the healthcare services they need and to guarantee the provision of basic services.</p> <p>To guarantee the competence of the personnel who provide public health services.</p> <p>To evaluate the effectiveness, accessibility and quality of services to individuals and to the population.</p>
<p>To conduct applied research</p> <p>To investigate new aspects and innovative solutions for health problems.</p>

This generic proposal of the essential functions and services of public health has been revised in the context of Catalonia by a work group that summarized it along the following working lines; a) authority and healthcare planning, b) healthcare information, c) epidemiological vigilance, d) health promotion, e) disease prevention, f) protection of health and g) the public health laboratory. It is regarding this collection of responsibilities of modern public health that a review must be carried out of its strengths and shortcomings in Catalonia in order to formulate new responses.

The objectives of public health policies in Catalonia, bearing in mind the existing precedents and the essential functions taken as a whole, should be articulated around three main orientating objectives:

- The reduction of inequalities in terms of healthcare so that the differences in terms of healthcare do not confirm or multiply already existing social or economic inequalities.
- The control and elimination of social and environmental risks that may have a direct or an indirect effect on health.
- The search for an effective improvement in the quality of life of all people in our society, by favouring the best health conditions possible.

In order to pursue the specific objectives linked to the aforementioned general objectives, it is considered that whenever possible, it is necessary to apply a series of common criteria in all of the policies, interventions, programmes, services and other activities that are carried out. These common criteria are; to favour de-centralization in the range of services offered and their management; to link actions in public health with other actions of attention, to design interventions with a public-oriented perspective, and to consider the indirect implications of interventions and stimulate them.

Public health services and the service prospectus

While it is relatively simple to reach agreement on the nature of the functions of public health, it is far less simple to define which are those specific activities into which they must be translated. Although there is a wide consensus in the determination of some of the activities of public health, such as water sanitization, vaccinations or the register of mortality and its causes, this situation does not extend to all of the activities that today make up the mosaic of public health services of our healthcare system. In some cases the difficulty of establishing which activities must be carried out lies in the lack of adaptation of the available services to changes experienced in health problems, in others the apparition of new interventions and technologies that haven't been sufficiently evaluated from the point of view of their effectiveness or safety, in other because even though this evidence is available, the possible gains over other alternatives, or the relationship between the cost and the benefits are doubtful. Faced with these difficulties, and in order to integrate the information continually yielded by research, scientific societies and professionals have been developing more and more guides and recommendations based on various methodologies to advise on which must be the essential services. As a consequence, we can know which services have sufficient validity, although it is also true that all interventions, those that are accepted by consensus and those that are not, must be submitted to a permanent review of their relevance and efficiency.

In addition, and since the integration of our country into the European Union, it is not only judicial ordinance itself that determines, in some cases, the services to offer, but the policies of the European Union that create the necessity of permanent adaptation. Therefore the definition of which services must be provided and at what level they must be executed (local, regional or national) is a product of the legislation in power, of the development of public health policies that seek to adapt resources to changing realities and finally of the territorial and political make-up of the community.

In general an intervention should be incorporated as a public health service whenever it is effective and safe, the limits of the activity and the competent organism can be clearly defined, it is more efficient than the other alternatives, it responds to a need that has to be covered and there are resources available for it to be offered and accepted by the population. When any of the activities of public health cease to meet these requisites, their provision should be reviewed and eventually, if it is appropriate, withdrawn.

It is obvious that in the ambit of public health we do not have all of the services that we should, and that not all those that we have are justified. In practice, the totality of public health

services that the health system offers is the result of influences and decisions of very varied types. In some cases, the continuity of activities carried out in the past, a permanence which sometimes has a high element of inertia; others are the result of particular political decisions taken in response to strong social demands or in situations of emergency or alarm. Increasingly, some new services are established because international experience and scientific literature advise that they are desirable. Nevertheless, it must be observed that in the ambit of public health there is no system of supply and demand such as exists in the sector of attention. Besides, since both sectors are included in the same budget, that fact that the budgetary structure of the attention sector shows a constant increase in its services and expenditure means that in practice the provision of public health services is in effect negatively discriminated against.

The process of deciding which services must be offered has to be dynamic and diligent, both in the identification of new necessities and the available evidence of possible solutions and their effectiveness. This type of information is becoming more and more abundant, thanks to the development of systems of information and the growth of epidemiological research and that of public health. However in some cases the combination of circumstances surrounding the decisions to provide or not to provide a particular type of service make the options particularly difficult. In the case of the effects of environmental contamination or of food poisoning on health, often there is a disparity between the difficulty and the time necessary to gather the scientific evidence necessary for interventions, and the need for anticipation and prevention of the harmful effects. In this ambit the European Union has opted to give growing importance to the principle of precaution as a political strategy to confront environmental health risks.

It is also very important to point out that in the ambit of public health conflict is often produced due to the fact that the interventions that protect the health of the population with a high degree of evidence as to their adequacy, at the same time can represent restrictions for certain groups, individuals, or corporations which leads to a greater difficulty for their acceptance and implementation. These conflicts are often serious and show the importance that public health policies incorporate, besides scientific, technical and economic considerations, also cultural and ethical ones.

In Catalonia, during recent years, it has been more and more usual for the administrations to decide the services to be offered in what they call the "service prospectus". Traditionally the Directorate General of Public Health of the Department of Health has been organized in three areas; promotion of health, protection of health and epidemiological vigilance. Since the year 2001, to these three areas has been added healthcare planning, and in 2004 the Directorate General of Planning and Evaluation was created. Regarding the services provided, there is an inventory of the principal activities that the Department of Health has carried out. Some units of the Directorate General of Public Health and of some town councils use informal prospectus of services, based on functions rather than areas of responsibility. Also from the Public Health Agency of Barcelona an effort has been made to define a prospectus of services⁹, in which are grouped together the activities offered by this entity.

On its part, CatSalut drew up a prospectus of services that includes activities of promotion of health and prevention of disease through a detailed analysis of the interventions recommended in the Catalan Health Plan. In this prospectus, which also has an associated information programme, the objectives and the recommended interventions are related, with the product lines including: primary attention, specialized attention, mental health, sociosanitary attention, pharmaceutical attention, and some other programmes of the Department of Health.

On the other hand, the orientation of reform in primary attention, in conjunction with the transposition of its attention contracts and some of the operative objectives of the Health Plan of Catalonia, have meant that at this level of attention many preventive activities of an individual nature are carried out, such as vaccinations and screenings. Equally, hospitals conduct some programmes of prevention contained in the Health Plan. Both primary attention and hospitals are providers of information critical for the system of vigilance for health. On the whole, the incorporation of preventive activities within attention services offers many possibilities to improve the health of the population, which must be seized by Catalonia. Nevertheless, it is wise not to confuse the role of provision of services on an individual level with that of public health services.

As regards the future, it is necessary to strengthen and broaden the provision of public health services. In the ambit of health protection it seems reasonable to implement and comply to the maximum with existing norms. As far as services of promotion and prevention are concerned, it is preferable, at least initially, to establish some minimum criteria that guarantee the provision of such services as are considered appropriate. Although, in principle, the starting point must be a homogenous range of services for all Catalonia, it must not be forgotten that in some cases territorial variations in health needs must be born in mind, emphasizing more some or other activities according to the necessities of the population..

Although in this document the question of public health services has been dealt with in a generic manner, without specifically considering the problems of different types of services, a reference must be made to the systems of information, given their strategic importance to the system as a whole. During recent decades, in parallel with the improvement in healthcare services there has been a considerable improvement in the systems of healthcare information that presently include information on mortality, information on utilization of healthcare services and information on health problems.. This information is made available in the Health Plan, which periodically, both at the level of Catalonia and of some city councils, allows the integration of the information available, in terms of the identification of needs and the monitoring of the impact of policies and services. Despite all of the valuable efforts made in this field, there are important deficiencies that limit the achievement of a better knowledge of needs and use of the services. These deficiencies are of two kinds. On the one hand the mechanisms for making use of the available information are insufficient. The most notable fact in this point is the insufficient way in which the Health Plan has been translated into health policy, which could end up reducing it to a technical-academic exercise and even threaten its very existence. In this sense it is necessary to review in depth the process of drawing up the Health Plan establishing mechanisms so that the information that it provides can have the greatest possible impact in the improvement of health policies and services in general and those of public health. On the other hand, it is necessary to improve some sources of information, incorporate new ones and broaden the experiences already initiated to incorporate into health surveys the determination of biological parameters and of functional measure relevant for the understanding of the most important health pro-

blems. Also it is necessary to strengthen the connectivity of the sources of information, so that they can carry out studies on a sufficiently wide scale and covering a wide enough section of the population at a reasonable cost, incorporating advances in the geographical analysis of information, both for the descriptive monitoring of health problems and for the study of the impact on health of determining environmental factors. It is of maximum importance that the study and monitoring of social inequality in the state of health and its determining factors be facilitated so that this knowledge can be translated into health and public health policies. Given the importance of the information systems for knowledge of necessities and the design of health policies it is necessary to consider the improvement in the information systems and in the Health Plan as a priority.

Organizational structures in public health

The execution of the functions of public health and the provision of services requires the existence of adequate organizational structures. Organizational solutions are often not unique and are derived largely from the historical and political tradition of each country. One of the most relevant aspects of organizational structures in public health is its territorial disposition. In general three levels must be distinguished; central, regional and local. The central level corresponds to activities that are performed, or could best be performed, centrally for reasons of competence, specialization and economy of a critical scale and mass. It includes a large part of the activities of drawing up and evaluating policies and programmes, as well as their execution when their object is the population as a whole and the territory. It also includes the management of databases and information systems. It makes sense for laboratory support to be set up centrally, in order to achieve economies of scale, especially with the tendency for specialization and centralization that the costs and need for accreditation present. The local level is that in which actions arising from policies and programmes are executed, and also where the information that maintains the databases is generated. The regional level occupies an intermediate position between the central and local levels.

Nevertheless, the territorial distribution of the services of public health varies in every country according to their traditions and characteristics. The federal tradition of the United States has facilitated central technical support to local services in epidemiological vigilance¹⁰. The paradigm of this is the staff of the CDC who give direct support to the local services in certain situations, but also the Internet that the CDC operates. Of note in the French tradition is the centralized body of civil servants of high technical excellence and with unified criteria and protocols, applied in the case of food control. The British tradition has been characterized by the promotion of management professionals with training in public health but belonging to the healthcare services, capable of ensuring a population-focused vision of attention services of a relevance in healthcare that goes beyond individual clinical performance.

In the state of Spain, the territorial distribution of public health services has been influenced by the organization into territorial districts or healthcare sectors in each of the Autonomous Communities, who reformed their public health services after receiving transference from central administration. In the Community of Valencia structures were created in public health itself at district level. In Andalusia structures were created based on the healthcare district, the equivalent of our healthcare sectors, grouping together public health services in a way that is more usual in attention services².

In the case of Catalonia it is necessary to distinguish two levels of organization of public health services; Central and regional/local ¹¹. It must be born in mind that the central administration of the state has a very reduced role in Catalonia, restricted to exterior healthcare. Regarding the central level, its territorial ambit corresponds to Catalonia as a whole and here are concentrated the regulatory functions and more specialized services such as the majority of the information systems or laboratory tasks, which must give support to regional or local services when faced with situations that are beyond them. This distribution is the result not only of reasons of competence but also of economies of scale. The current search for a new organizational expression for metropolitan reality has added complexity.

Regarding the organizational structures of public health at central level, besides the Directorate General of Public Health, it must be remembered that recent years have also seen the creation of the Catalan Food Safety Agency (Law 5/2002), one of a wave of similar agencies that were created throughout Europe in response to the grave dietary crises that occurred in recent years, with a highly elevated intersectorial element. More recently, also, the Health Protection Agency was created (Law 7/2003), still in process of deployment, to respond to problems of coordination between the different levels of the public administration with responsibilities for public health in Catalonia, and to promote an organism of health protection with greater operative capacity. In parallel, in the city of Barcelona a Public Health Agency was finally created for the city, with a more integrated organizational model and a high level of competence, although with more limited responsibilities than those that correspond to an autonomous community.

For regional/local services, their territorial ambit corresponds generally to a healthcare region (in the case of Barcelona, the city itself), a healthcare sector or an operative grouping of sectors. This ambit includes a structure that is capable, on one hand, of being related with central services, and on the other hand, of executing services. Big and medium sized town councils tend to have their own services ¹². Not homogenous in form, public healthcare services also have an expression in the structures belonging to the healthcare attention services, whether in the healthcare regions of the Catalan Health Service or in the case of the providers of primary attention services such as the Catalan Institute of Health, in the SAP. In the healthcare regions of the Catalan Health Service there are usually professionals or units who ensure the coverage of various programmes and activities of great interest for public health and whose execution tends to be tied to the clinics. At the SAP there are usually only professionals attached to the first group (some of the various providers of the Catalan Institute of Health do not have professionals linked to public health). The primary attention teams carry out functions of execution of certain public health programmes, substituting some of the functions of local healthcare workers that are integrated; this aspect has recently been analysed ¹³.

One of the keys to the reform of public health in Catalonia lies in its organizational plan. On one hand it is necessary to strengthen the central structures, guaranteeing the conditions necessary to execute the functions of planning and evaluation of public health policies. In this area the most important aspects are the creation of a Public Health Agency of Catalonia and the corresponding reform of the Directorate General of Public Health. By the same measure, following the general strategy of the Department of health on territorial administration shared with the town halls, it will be necessary for the current organization, in which the services of the Department of Health coexist with their territorial delegations and town councils with their own services, to give way to a new structure based on the Public Health Agency of Catalonia, the counties, the territorial health organizations, and a network of local providers of public health services.

Another key aspect is that of finance. Among public health professionals there is a general opinion that, in comparison with policies of healthcare attention directed at patients, policies of public health with a collective target are seriously underfinanced. Unfortunately, the information available on this matter is very limited. According to data from the year 2004, from the budget of the Department of Health of the Catalan Government, it can be deduced that the total expenditure destined to public health in this year was 66.217.000 €. The administration of this budget falls to the Directorate General of Public Health, the Secretariat General and Territorial Services of the Department of Health. Of this sum, 10.994.000 € were destined to the financing of the Public Health Agency of Barcelona. As regards spending by town councils, information is even more limited and the structure of public health spending is possibly very dispersed. The study of Líndez and collaborators, published some years ago, concluded that direct municipal spending on public health oscillated between 3,6 € and 6€ per inhabitant/year ¹². A recently published study by the regional delegation (Diputació) of Barcelona indicated that in 2001, town councils with more than 20.000 inhabitants incurred a public health expenditure of 10,2 € per inhabitant/year (a total of 24.302.968 €), 58% of which went towards financing activities that do not form part of their areas of responsibility ¹⁴. The same work also analysed the spending of towns between 10.000 and 20.000 inhabitants, placing public health spending at 5,7 € per inhabitant/year (a total of 3.157.166 €), in this case 63% of the funds going to activities that were responsibility of the town councils.

The data from the Department of Health suggest that the average public expenditure per person, including vaccinations, oscillates between 15,6 € per inhabitant/year and 17 €; in Barcelona it would be 15,5 €. It must be pointed out that in these estimates expenditure on public health activities carried out from primary attention are not included. It must be said that the information available at international level is also very limited and that the very structure of public health services makes it difficult to obtain this information. Faced with this situation it is of the utmost importance to carry out an exhaustive study of the current level of spending on public health as well as of the level and mechanisms of finance that are necessary.

The current legal regulations and structure of public health services are based on norms from the beginning of the twentieth century, updated after the war. The two most recent legal norms that must be born in mind are the Law of Healthcare Administration of Catalonia /LOSC) of 1990, partially modified in 1995, and the Law of Health Protection (LPS) of 2000. Any proposals for the reform of public health that are adopted must bear them in mind, and the formulation of the LPS permits the contemplation of a transitional scheme based on this law to later progress to a new regulatory framework. It must also be remembered that the Law of the Municipal Prospectus of Barcelona of 1998 upholds the peculiarity of the structure of public health services in the city. It would be preferable to review the LPS today, with a more temporal perspective, to evaluate just how far some points of this law may have been influenced by the model of service management of the healthcare attention services despite the fact that their logic in the provision of public services was not the same.

Although the necessity for a new law of public health may not be obvious, an evaluation should be made of how far this could be necessary for reasons such as the creation of a public health agency, the reorganization and modernization of the function of authority or the integration of functions scattered among other laws and territorial organizations.

The Public Health Agency of Catalonia

One of the most important elements in the agenda of the Department of Health concerning public health is the possible creation of a Public Health Agency of Catalonia (ASPCAT) that will enable a greater political support to materialize in this field. It is for this reason that, responding to the task entrusted to the work group, it is necessary here to give a more detailed reflection on the advantages and limitations of this option. There is no doubt that the word “agency”, applied to define organizational structures of public administrations, has become in recent years highly attractive.

There is no doubt that the word “agency”, applied to define organizational structures of public administrations, had become very attractive in recent years. The first dissemination of this term, especially during the 80s, occurred in various Anglo-Saxon countries, such as Great Britain or Australia, in the framework of broad initiatives of renewing public policies, which also included an organizational aspect, of the renewal of the public administration itself. Thus the “next step agencies”, based on the principles of the new public administration, were a group of initiatives driven by Anglo-Saxon governments, who wished to maximize the potential of decentralization and autonomy in administration, the utilization of mechanisms of the market and the constant measuring of performance, as a way of improving public administration. In the 90s, the principles of this new public administration were extended throughout the world, and with them the concept of the agency as an organizational formula to be promoted. A formula that is no doubt idealized, but which in many cases encapsulates the spirit of change and renewal of public administrations.

Assuming some characteristics of the new public administration, with greater or lesser degrees of intensity, and breaking with the hierarchical and homogenizing models of the traditional administrations, the model of agency has two key identifying elements: its own, clearly distinctive organizational identity, separate from the departmental structure of the administration, and the presence of professionals who are highly specialized in the tasks which are specific to the organization.

Other aspects may vary, according to the nature of the agency, such as its functions and objectives; however, in any case the important thing to point out is that one of the aspects that we most habitually find in agencies is that they have a function or mission that is well-defined, clearly specified and free of political tensions or conflicts of preferences over which objectives to accomplish. It must also be pointed out that agencies can carry out a broad range of activities and according to their specialization it is possible to distinguish between types of agency as follows; regulating agencies, implementing agencies, evaluating agencies, assessing agencies and coordinating agencies. The fact that an agency incorporates some or other actions has important organizational and management implications.

In general, the role of politicians is lesser in organizations that assume the orientation of an agency, since there tends to be a certain delegation of functions to technicians and professionals responsible for them (which can be more intense or less so, according to the task that the agency performs). Now, this makes sense, and can function correctly, only when there is no political debate, or dilemmas over criteria and values within the agency. As long as these tensions

– habitual in many themes of public politics – remain present, their management has a political nature that makes it more likely that direct responsibility remains in the hands of the political offices themselves and those of the group of political institutions specializing in dealing with this kind of dilemma.

On one hand, their degree of legitimacy to do this directly is much higher, while on the other hand, to transfer to an agency functions that have an essentially conflictive dimension could block the capacity to resolve problems of an essentially technical nature.

It is of the utmost importance that when the ASPCAT is created its role is clearly defined. The definition of this role implies at least the establishment of the following elements; the mission that centrally orients the organizations objectives; the totality of its competences, including their content and the ambit in which they are to be performed; the responsibilities and powers with which it is endowed to carry out the public interventions entrusted to it and to achieve the objectives established; the structure as a means of dividing, then later coordinating work in order to carry out activities according to the functions assigned; a system of financing that guarantees the acquisition and maintenance of resources to carry out activities; and finally, an institutional form that has to be coherent with the previous elements and permit the best possible development of the activities within the framework of all public institutions .

As regards the scope of the previous aspects, there exists a broad range of possibilities concerning both functions and scale. Each option has its advantages and disadvantages that must be accurately evaluated. In the case of opting for an alternative based on the maximum, constructing a macro-organization that integrates many of the responsibilities that are now at various levels of the government, one should remember the complexity that would derive both from the inevitable re-centralization of functions and from the possible internalization of political tensions within the aforementioned organization.

When it comes to creating the ASPCAT there is already an antecedent in the Public Health Agency of Barcelona, an experience which must allow us to evaluate to what extent, beyond being a more flexible management structure, the model of agency can be useful or not as a reference for the deployment of a model of integrated public health functions at the level of Catalonia. In this regard it must be born in mind that the change of scale, from Barcelona to Catalonia, would have to imply a greater specialization of the functions and activities that would need to be carried out, as well as the apparition of new functions requiring more attention, such as relations between different levels of administration, or the connection with a wide variety of business or professional collectives. In the same measure, the agency would have to play a key role in the agglomeration of functions of contracting of many services that are presently carried out by various entities on a small and inefficient scale, and often with a weak contractual procedure. Contracting or ordering on a wider scale could lead to the structuring of a more powerful sector of providers, with apparatus and resources that are more up-to-date and competitive. The ASPCAT would have to have a nucleus of civil servants with the objective of also being able to cover those activities that require the exercise of authority that legislation reserves for civil servants of the administration, whether autonomous or local.

CENTRAL AXES OF PUBLIC HEALTH.

Intersectoriality

The processes related to health are characterized by their complexity, broad social dimension and the multiplicity of their components in a way that cannot easily be resolved by actions exclusive to the health sector. This has meant that, from public health, there has been greater and greater emphasis on promoting an intersectorial approach to tackling health problems, understanding intersectoriality as being a “coordinated intervention of institutions representing more than one social sector, in actions destined, wholly or partially to addressing problems connected with health, well-being and the quality of life”. From this perspective, intersectoriality represents a new logic for administration that seeks to overcome the fragmentation of sectorial policies, considering the concept of “health” in its totality, and seeking a new method of planning, executing and coordinating the provision of services.

The importance and the interest of intersectoriality is not merely an academic question, since it is easy to demonstrate that in our society, in many town councils and also in the Government of Catalonia, areas of responsibility can be found that are directly or indirectly related to health yet do not correspond to the Department of Health. Examples of this are some policies from the ambits of education, employment, social welfare, agriculture, territorial policy, industry, commerce, tourism, the interior and the environment, areas in which various administrative structures other than those of healthcare have responsibilities for public health.

The interest in developing more actively an intersectorial focus on health problems can be observed in the evolution of the Health Plan developed in Catalonia. In the evaluation section of the 1996-98 Health Plan a section was included analysing intersectorial actions during the period 1993-95 which totalled two interdepartmental commissions and some conferences on health promotion, health in the workplace, drug addictions and mental health. For its part, the 1999-2001 Health Plan established five instrumental priority actions, which were considered necessary for the achievement of the objectives established, one of which was intersectorial cooperation and coordination in seven specific ambits; anorexia and bulimia, child abuse, environmental health, health and safety in the workplace, health in schools (PESE), road safety and smoking. In the 2002-05 Health Plan, taking into account both where in the ambit of the expositional part the need to work intersectorially was manifested, and where in its objectives, activities or primary interventions parameters were set that committed to policies of other sectors, it can be observed that out of 29 areas for intervention, in 10 there is mention of the importance of intersectoriality in the exposition of the approach to tackling the problem, and its strategic orientation. Besides, in 14 there is some objective or activity that obliges the involvement of an organization from an administrative sector outside of healthcare. The priority interventions that require other sectorial policies indicate 11 areas. Finally, there is mention of stable structures of intersectorial management in 5 areas. It must be pointed out that in the majority of cases these were proposals of an eminently rhetorical nature or declarations of intention that are often not realized through specific and evaluable actions that have repercussions on sectorial policies.

One way to evaluate intersectoriality more specifically in the tackling of health problems, from public health, consists of analysing some cases in which this aspect has been more prominent.

In this case, AIDS, food safety and health in schools are of special interest. In the case of AIDS, attention must be drawn to the Interdepartmental Commission on AIDS in Catalonia, ascribed to the Department of Health and created by decree in 1999 (352/1999, 13th December), with the objective of facilitating the adoption and implementation of the measures necessary to avoid the propagation of the disease, to improve the quality of life of those infected and the continued establishment of a favourable environment to receive those infected. In the ambit of the town councils, the "AIDS network and the local world" is of special interest as a recent initiative to involve the local world in the tackling of infection by the HIV/AIDS virus. Towards the end of 2004 the act of constitution of the "AIDS network and the local world" was held in Catalonia. Finally, it is also necessary to mention Plan on HIV/AIDS of L'Hospitalet del Llobregat, which since the year 2001 has had a municipal plan to confront problems of AIDS in order to provide solutions to them and offer responses from the different administrative and social ambits of the city.

Food safety can be considered a model case of intersectoriality. In Catalonia - as in other countries - sectorial initiatives have led to the establishment of independent activities of control of foodstuffs on the part of different organisms with areas of responsibility in different sectors, such as health, agriculture, consumption and the environment. Everyone recognizes that any line of advance in the future involves the acknowledgement that control of food products is a shared responsibility that requires positive interaction between all of the interested parties. In this sense, many countries have re-evaluated the way in which the systems of control of foodstuffs are organized. The current tendency in developed countries is to establish food safety organisms to coordinate the official sectorial controls, as for example in Spain, Finland, Ireland, Luxemburg, Sweden, Greece or Great Britain. The creation of the Catalan Food Safety Agency (ACSA) through law 20/2002, ascribed to the Department of Health, falls into this category. It represented an attempt to administer this interaction, breaking with the compartmentalization inherent in the traditional bureaucratic model, through the creation of an interdepartmental agency to assume the areas of responsibility of the four departments with responsibility for food safety.

Health in schools, both at central and local levels of public administration, has been an area of special interaction between the departments of health and education. Currently, one example of intersectoriality is the Health in Schools programme of the Catalan Government, established in October 2004, with the objective of improving the health of adolescents. This programme seeks to develop actions of promotion of health, prevention of risk situations and anticipatory action on problems of health related primarily with mental health, emotional-sexual health, the consumption of drugs, alcohol and tobacco and eating disorders.

Despite the positive aspects of the previous experiences, and despite the existing consensus on the need for intersectorial action to confront health problems, it seems that the practice of intersectoriality in Catalonia is not yet governed by any global strategy and, on the whole, it is insufficient, fragmented, reactive and uneven. Faced with this situation a more coherent and energetic action is needed that allows us to pass from conceptualizations and discussions to specific initiatives. Given that there already exist some important experiences, it is necessary that where confirmable results are produced the widening and generalization of the focuses and models adopted is made possible. The lack of information and studies on intersectoriality in the field of public health limits significantly the carrying out of a more accurate diagnosis as well as the formulation of proposals.

Participation

Etymologically, to participate means to take part, to contribute to the construction of a common enterprise which, in the context of this document, is the health of the population. The purpose of participation, therefore, is the improvement of health, but if we understand that health is also a collective matter, then participation becomes an indispensable element in its own right. In the case of health, participation has the potential to improve the health of individuals and populations because it implies a greater involvement. It would be, then, a desirable characteristic for a utilitarian point of view. But the fact is, depending on how we view health, that participation is a necessary element for the achievement of autonomy and to practise solidarity, two characteristics which the definition of health of the Tenth Congress of Catalan-Speaking Doctors and Biologists attributes to health. Autonomy to live in the least dependent way possible and solidarity with the rest of the components of the community. So, as regards health and civic participation, one cannot limit oneself strictly to the area of healthcare systems, but one must also take into consideration a combination of factors that have a determining influence on the health of individuals and populations. A community perspective that is natural for public health, which, despite being largely developed by the healthcare system itself, occupies a frontier post between society and the healthcare system.

As regards the development of strategies or experiences of participation in the ambit of public health, there is a broad range of possibilities. One of the means of community participation to have been developed is associations for the sick and relatives of the sick who suffer from chronic illnesses and so-called self-help groups. Regarding healthcare systems, the ambits of community participation can encompass the most political dimension, in the sense of establishing priorities and formulating objectives, such as that of the healthcare services to be provided in the community^{15, 16}. Another form of participation in the arenas of politics and strategy could be the practice of criticism which, naturally, is not only limited to these situations. In the most general definition, criticism implies an assessment, well-founded or not. In general the procedures for knowing the criticisms and opinions of the community are limited to the possibilities for appeal, or to complain, or suggest, that are legally established for all public services, including healthcare, or surveys of satisfaction regarding services. Also other forms have been tried, such as the people's tribunals in the United Kingdom, in which a group of people from the community who are remunerated for their participation give rulings on health problems and the interventions for controlling them¹⁷. For their part, methods of qualitative research permit a more rigorous utilization of opinions, evaluations, criticisms, preferences and expectations. In the ambit of collectively administered services of promotion and protection of health that fall within the domain of public health, various forms of participation are also practicable which can range from total self-administration to proposal, criticism or collaboration. One form of participation of growing interest is participative research based on the community, which seeks to return research to the community; the basic characteristics of this are; that it is a participative research, cooperative in nature, involving the members of the community and the researchers in a joint process in which all contribute equally¹⁸. Finally, it must be pointed out that in some cases participation is regulated by the legal norms currently in force which establish the existence of health councils regarding both central structures and more peripheral ones. The general impression, with a few exceptions, is that the experiences are too bureaucratized and at best serve to inform the population about the initiatives of the healthcare services¹⁹.

Civic participation in the ambits of health and the healthcare system faces the same obstacles as social participation in general. Firstly, the technical complexity of health problems must be taken into account, a limitation whose effects are artificially aggravated by the use on the part of the professionals of a lexicon that excludes others.

Secondly, the complexity of the present healthcare systems and organizations. Thirdly, situations that provoke personal anxiety and accentuate the reactive nature of many responses, biasing participation towards an individualized view of personal experiences regarding health and health problems. Bearing in mind these difficulties the strategies or activities that seek to promote participation should take into account some basic requisites such as starting from a sufficient knowledge of the expectations of the population regarding healthcare, public health and participation itself; promoting aspects such as decentralization, feedback and self-organization; favouring initiatives that allow an increase in the availability of public health services; or promoting the assumption of collective responsibility when it comes to establishing priorities for healthcare interventions, and the acceptance of individual responsibility for one's own health. These requisites would become the starting point, from public health, for undertaking strategies of participation.

In the most immediate future, and in the framework of the reform of public health, it is possible to consider the creation of a forum of civic participation in the fields of health and healthcare, open to entities and associations that favour exchange and promote reflection on the initiatives in progress. In parallel, and interactively with this forum, it would be necessary to have available registers and databases of the most important experiences of civic participation in the field of healthcare and health, from the entities and associations involved, and of the resources available, as well as to promote programmes of evaluation and studies into the expectations and the motivations of the entities involved. It would be equally important to promote training activities on participation between professionals and students. To make this possible, one could consider the convenience of creating an administrative unit at the ASPCAT dedicated to civic participation, possibly in conjunction with the topics of communication.

In the medium term and with a more strategic approach a plan for the promotion of participation could be designed based on the experience carried out in the previous period, with the knowledge acquired and commitments established. In this phase it would be a matter of putting to the test various specific interventions such as promoting experiences of participation in the establishment of a limited series of priorities for intervention at different territorial levels, establishing popular evaluation groups in the healthcare regions and some basic health areas, developing projects of interventions of health promotion that consider the assumption of responsibilities for results or introducing community participation in the projects of the health plans devised by each healthcare region, with a specific incentive for the best projects.

Communication

The first definition of "communicate" given in the dictionary of the IEC is "to make another take part (in that which we possess)". The same is repeated in the dictionary of the RAE, which

also defines communicating as “making another a participant in what we have”. These two definitions clearly demonstrate that there is common ground between communication and participation. The diffusion of the mass media and the expansion of the so-called Information and Communication Technologies (ICT) have added even more ambiguity to the meaning of the words information and communication, the first appears irrevocably associated with the digital world, while the second seems to go hand in hand with the “media” or new forms of telecommunication. The Internet, for its part, represents a medium with substantially different characteristics. In the first place, many web sites allow a genuine two-way (and multidirectional) communication. Besides, the Internet opens an opportunity to any voice, be they from a minority or the majority, individual or collective, trustworthy or not.

The scope of aspects related to communication in public health is very broad and it is convenient to distinguish three types of communication; between the different public health services; between the public health services and the community, directly (as a whole, or with the various groups or collectives of which it is made up); between the public health services and the mass media (as intermediaries in communication with the community).

As regards communications between the different services of public health it must be said that the fact that the health system in Catalonia has experienced significant transformations in recent years has meant that communication between the different dependencies and entities of the Catalan healthcare system is neither agile nor transparent, or at least not as much as one should expect in order to ensure a genuine effectiveness. The lack or deficiency in communication between the different healthcare services very possibly reduces the effectiveness of policies of prevention and health promotion, complicates coordination and cooperation between the different services, leads to an increase in expenditure, generates mistrust on the part of the public and provokes resentment and ill-feeling among the professionals themselves. On the other hand, a good internal communication is essential in order to be able to communicate with the exterior. But, in fact, it must be clarified that this is not a question of an isolated problem, since internal communication is nothing more than the mirror of an organization. Given the complexity of this ambit, it would be necessary to carry out an in-depth study of the current system of communication between the different organisms and services of public health, analysing also the experiences developed in other sectors. In this sense one initiative to explore is the one known as the National Public Health Information Coalition (NPHIC)²⁰. This organization was conceived specifically to resolve the existing problems of communication in public health in the different health departments of the USA. The working of the NPHIC is that of a coalition, with a basic structure financed by the CDC, which uses different tools to ensure a rapid communication and a system of mutual cooperation. Obviously ICT – for their ability to break down barriers in space and time – must play a central role in any design that may be proposed regarding communication within the healthcare system.

Regarding communication between the public health services and the community, until now this communication has taken place primarily in the very dependencies of the socio-healthcare system themselves and, to a lesser degree, in other places representative of the different groups that make up the community. In most cases it is the healthcare administration itself that takes the initiative to communicate with the community in order to achieve its participation by the adherence to a particular public health policy, or in order to deliver certain information. An in-depth

study should also be made of what is being done and what has been done, both in Catalonia and elsewhere. However, notwithstanding this need for a formal review, a superficial overview suggests that there are serious failings such as dispersion of communication initiatives without a global strategy, as well as the lack of evaluation and the discontinuity of many of the initiatives programmed. It would be advisable therefore, when identifying good practice in direct communication with the community, to take into account the way in which previous deficiencies have been tackled.

In the ambit of the media, it is clear that the panorama is dominated by television and the press. Unfortunately, there is little information available on the role of television. In the case of the press, we know that in Spain, for example, the number of texts on health and medicine published in the five newspapers with the highest circulation doubled between 1997 and 2000, and since then has remained at the same level, as has been reported in the Quiral report²¹. The review of the period 1997-2001 shows that a group of 20 subjects accounted for more than half of the information published on health matters in the five newspapers studied. Specifically the subjects that received most press attention were, respectively, BSE (information related to human health), AIDS, cancer, pharmaceuticals (excluding certain products that generated vast numbers of texts in their own right, such as aspirin or Viagra), tobacco, etc. While it will be necessary to conduct a more in-depth review of the literature, the analysis of these observations clearly shows the critical points that define the role of the media: their role in the mass dissemination of information on health, the public interest aroused by information on health as a current affairs topic, the concentration of information on certain topics, many of them within the field of public health, the multiplicity of sources of information on health matters and the use made by journalists, according to their speciality, the media in which they work, or the topic in question, and the problems of comprehension on the part of the general public of a jargon which is too technical, often accompanied by biased reporting that can lead to confusions^{22, 23}.

Regarding the future, it is necessary to define a specific strategy aimed at improving understanding between the healthcare system and the media. This strategy must encourage the mutual acquaintance of healthcare and media professionals, promote a critical appraisal of the media by society, establish systems that permit the detection of situations where there is room for improvement and give incentives for regular training both of healthcare professionals in matters of communication and of media professionals in medical and scientific matters.

In order to put these suggestions into practice there are a number of possibilities. Some that should be considered are: to view communication as an integral part of any action aimed at improving the health of the population, to encourage communication and cooperation on matters of communication between all of the public health services, to separate, as far as possible, communication from political powers, involving to a greater degree public health experts and technicians and promoting transparency in all phases of communication, to develop effective systems of direct communication ("virtual" and "on-site") between the public health services and the community, applying wherever possible models that have demonstrated this effectiveness, to guarantee the development of specific systems of direct communication for those sector of the population that have the most difficulty in using ICT (especially the elderly), and to guarantee the development of specific systems of direct communication for those sectors of the population that are far from the conventional places where such actions take place.

Training

Public health services, just as any other service activity, are principally based on the intense use of human resources. In this sense, one condition necessary for the reform of the public health services is the existence of competent professionals²⁴. A basic strategy for enabling the existence of competent professionals is training, but this requires that the present training programmes for public health professionals respond to the health needs of the population and to the reality of the service. Furthermore, they have to be adapted to the new problems and challenges in public health in the 21st century²⁵: since they are too much oriented by the academic agendas of the researchers, primarily directed at biomedical research. An important characteristic of professional practice in public health is its multi-disciplinary nature, reflected in the diversity of backgrounds of its professionals, whether from healthcare sectors (doctors, vets, pharmacists, nurses, psychologists....) or from outside of healthcare (economists, legalists, sociologists).

In order to facilitate the improvement of training programmes and giving due attention to the diversity of disciplines involved in public health it is necessary to determine which are the professional capacities that are basic and common to any public health professional., regardless of the field in which he works²⁶. These professional capacities must be acquired via ongoing quality processes of teaching-learning, based on the best available scientific evidence²⁷. In accordance with these premises, research, training and professional practice constitute a circle of expertise to continually improve the health of the population. It is obvious that the permanently changing realities and knowledge force us to define strategies to maintain skills through the passage of time, one of which is periodic re-accreditation.

Regarding specialized university education in public health, one of the most important programmes is the Master's Degree in Public Health, started in 1989 by the Univesrity of Barcelona, continued since 1993 by the Institute of Health Studies and developed between 1995 and 2000 at the Institute of Public Health of Catalonia, and organized since 2002 by the Pompeu Fabra University in a regime of co-participation with the Public Health Agency of Barcelona, the Municipal Institute of Medical Research, the Universitat Autònoma de Barcelona, the Directorate general of Public Health of the Department of Health and the Catalan Institute of Oncology. This programme is accredited by the National Commission for the Speciality of Preventive Medicine and Public Health, as a programme validated by the resident doctors in this speciality who in Catalonia constitute 5 teaching units (Hospital de la Vall d'Hebró, Hospital Clínic, Hospital de Bellvitge, IMAS-UPF-ASPB and the Hospital de Sant Pau).

Along with this Master's degree in Public Health, there are other programmes on more specific aspects of public health, organized by the various universities and institutions of Catalonia, such as the University of Barcelona's Master's degree in Preventive Medicine and Promotion of Health and Master's degree in Community Nursing and Public Healthcare, and the Universitat Autònoma de Barcelona's Master's degree in international health and tropical medicine and Master's degree in research methodology. Besides these there are also programmes on the economy of health, administration of healthcare services and public policies, organized by the Pompeu Fabra University. Apart from the aforementioned Master's degree programme, there are three doctorate programmes related with public health, organized by the University of Barcelona, the Universitat Autònoma de Barcelona and Pompeu Fabra University. Also, there is

an increasingly wide range of ongoing training among which one must give special mention to that offered by the Institute of Health Studies, and particularly the old "Diplomas of Healthcare"; also that of the Study Centre of the Barcelona College of Doctors, that of the College of Veterinarians, and more recently the autumn programme offered by the Bloomberg School of Public Health of the Johns Hopkins University, with the participation of the Public Health Agency of Barcelona and the Pompeu Fabra University.

Although the situation described above is reasonably healthy, there is still a need to establish strategies that enable us to improve the impact of the existing programmes on the practice of the professionals. Some of the recommendable initiatives to pursue this improvement are; to promote initiatives that relate more closely training in public health with professional practice, to establish mechanisms of voluntary accreditation of the quality of teaching programmes, to establish a professional career in public health that takes into account professional activity, ongoing training and research performed, and to maximise the potential of new educational strategies based on the utilization of new information technologies. Taking advantage of the drive for reforms in university education within the new European Higher Education Area, we should tend towards the idea that new professionals who are incorporated into tasks of public health should have a basic training that is equivalent at least to a Master's degree, independently of their training to a previous level (doctor, vet, economist, nurse..) and the specific functions that they have to carry out. Finally, it must be pointed out that training in public health, both basic and ongoing, should have a significant research component that strengthens the critical capacity of public professionals to confront problems both new and old.

Research

The activity of research in public health is an important component in the functioning of services, since through research professionals incorporate scientific knowledge generated from their own reality, methodologies of evaluation are disseminated, mechanisms are promoted which improve the gathering of data, and there is a contribution to the improvement of the training of the professionals who participate in it. In the case of public health it is necessary to insist that the nature of research has a strategic element for health policies in a very broad sense since it permits the identification and monitoring of the health problems of the population and therefore of the necessities and priorities, the identification of their determining factors and characteristics, and the evaluation of the effectiveness of interventions, including the healthcare services themselves.

In Catalonia, research in the field of health has been recognized as one of the strong areas of scientific research. Within this context, the research groups of public health have achieved a high level of quality, relevance and productivity, with some areas in which the international profile of the research is considerable. Presently a part of the research in the field of public health is carried out in a reduced group of centres, the most significant of these being the Municipal Institute of Medical Research, the Public Health Agency of Barcelona, the Catalan Institute of Oncology, Hospital Clínic, the Germans Trias Hospital and the Department of Health itself. An important feat in the field of healthcare is the programme of thematic networks established by the Carlos III Institute and the Ministry of Health and Consumption of the Catalan Government.

It is particularly worth pointing out that in this programme, groups from Catalonia are the coordinators of several networks of centres and groups in the field of public health.

Despite this relative strength, research in public health has many deficiencies that need to be evaluated. On the whole, it is relatively unknown within the healthcare sector itself and has little social visibility or prestige. From an organizational point of view some of the groups are situated in institutions that frequently do not recognize research as a constituent of their mission, their organizational make-up or their administrative structures, which implies many difficulties for maintaining stable programmes. As opposed to much of the more biomedical research, research in the field of public health has little access to private sources of funding. Equally its link to the universities is scarce. All of this means that this research finds itself in a chronically precarious position that affects aspects such as financing or the professional and academic careers of the researchers. Of equal or greater importance is the fact that the multidisciplinary nature of research is barely reflected in the research currently carried out in this field in Catalonia. On the whole, research in the field of public health has a strong medical bias and, in a reflection of what occurs in the scientific world as a whole, there are difficulties to consolidate groups and lines of research in public health, in other ambits of social and behavioural science.

Given the strategic importance of research in public health, as well as these difficulties, it is essential that in the future actions of support are carried out in this field. These actions should be geared towards both consolidating and stabilizing the situation of research groups in public health and also facilitating participation in research by the professionals who work in this sector. In order to facilitate these actions of support it would be preferable to conduct a study into areas of importance in public health that are not sufficiently covered. In relation to this we must mention the research conference of the AATRM of Catalonia, which includes in its conferences topics of public health. The creation of the ASPCAT could prove an excellent opportunity to strengthen and unify research in public health. In this sense the agency could have an important role in reinforcing the presence of public health in the structures of government such as the CIRIT in Catalonia and the Carlos III Health Institute in Madrid, to intensify the collaboration in matters of research with other structures of the Department of Health, including the AATRM, the IES or the SCS and to facilitate cross-coordination in matters of research requiring the participation of different sectors within the healthcare structure.

RECOMMENDATIONS AND PROPOSALS

To guarantee the solidity and the homogeneity of the system

1. The public health services of Catalonia have to be prepared to respond to the accumulated delays in this field and to the new challenges posed by current social and technological changes. For this it is necessary that the services achieve the minimum dimensions necessary to be able to respond to the needs with quality and efficiency. For that to happen it will be necessary to achieve a greater degree of specialization, nevertheless maintaining the flexibility necessary in order not to lose the capacity to respond to the problems. Bearing in mind the difficulty of obtaining additional resources, it is necessary to promote scale economies wherever possible.

2. The strengthening of public health requires an improvement of the functions of planning and evaluation of policies and services. In order to facilitate these functions it is of the utmost importance to have information systems of the highest quality. It is necessary to review the present information systems and to facilitate their improvement and expansion.
3. To guarantee a better equality in the distribution of public health services an adequate territorial structure is required, avoiding not only gaps in responsibilities and services but also duplications. Each territory and centre of population should have its corresponding “unique window” so that the existence of different organizational structures should not affect citizens.
4. It is necessary, within the framework of the current tendency to establish territorial entities that facilitate the manageability of the healthcare system and the integration of institutions and services, that public health be included together with other branches of healthcare, all geared to facilitate the de-centralization of public health responsibilities to local level. In this sense, the functions of government finance and planning can be clearly structured following the same organizational lines as the rest of the functions of the Department of Health. Regarding the ASPCAT, according to how far it must be prepared to provide services, whether directly or subcontracting them at local levels, a different structure may be needed.
5. During the process of change that the reform will imply it is necessary to guarantee coherence between the present structures of public health and the areas of responsibility, functions and resources that will have to serve to structure the future scheme. The introduction of changes must be done progressively, avoiding the creation of serious dysfunctions.
6. It is necessary to establish a specific model of financing of public health that takes as its starting point a detailed study of the present level of financing which is only partially known. This model of financing will have to establish some criteria and a budgetary mechanism that avoids negative discrimination against activities of public health as compared to healthcare attention/clinical services.
7. For actions in public health at local level, especially those which are no longer guaranteed by autonomous services it is necessary to consider the possibility of establishing alternative methods of financing, other than the present budgetary fund. One of these methods could be the setting up of specific taxes financed by the establishments receiving services of evaluation or inspection, which would have to be implemented in a general way throughout the territory. These taxes need not have the same collection procedure as the current one, but could correspond to a model like that of the ITV.
8. The measures and the scope of the changes that are finally adopted in the process of the reform of public health in Catalonia could create a necessity for a new law of public health. Among the changes which could come into play in favour of the need for a new law, the most important are the creation of the ASPCAT, the reorganization and modernization of the function of the authority or the integration of separate functions in other laws and territorial entities.

Reform of the organization of public health

At central level

9. It is necessary to strengthen the organizational structures of public health at central level by reforming the Directorate General of Public Health and broadening its capacity to design and evaluate public health policies. One additional possibility is that of creating the ASPCAT, which would permit the delegation of some of the present functions of the directorate General of Public Health and the reorganization and broadening of other functions.
10. The ASPCAT should have an adequate level of administrative and scientific/technical autonomy and should incorporate the elements of highly specialized technical assessment necessary to respond to the needs of government in the ambit of public health. In the same way, we should avoid assigning to the new agency functions oriented towards the development of policies of coordination which should remain within the Directorate General of Public Health or in other structures of the Department of Health.
11. The creation of the ASPCAT would imply the transformation and absorption of the present Health Protection Agency, still in developmental phase. In any case it is completely necessary to reform its model, strengthening aspects of regulation and control in the ambits of epidemiological vigilance and of certain components of health protection.
12. As regards the Food Safety Agency, the existence of some international points of reference which are growing in extension reinforces the maintenance of its identity. In the future it will be necessary to maintain and strengthen its current capacities, particularly its relation with the production sector.
13. It will be necessary to reform the Directorate General of Public Health in a way consistent with all the organizational reforms that are adopted. Its capacities for designing and evaluating policies, acting as arbitrator for all of the public institutions, establishing priorities in the allocation of resources, and acting as first instance of control and supervision of all the actions carried out, should be maintained and broadened. At this level, it is necessary to achieve a higher degree of specialization in tasks of coordination in the ambits of public health that have a more intersectorial dimension and to promote innovation in the public policies of health, incubating new programmes that can later be extended to the system as a whole.

At peripheral level

14. One of the general priorities of the current government in the ambit of health is to maximise the potential of participation of the city councils. In the ambit of public health, therefore, it is foreseeable that the present structure in which the services of the Department of Health coexist with their territorial delegations and the city councils with their own services, will give way to a new structure based on the ASPCAT, regions, territorial health organizations and a network of local providers of public health services.

15. This new territorial organization of public health allows for various formulations but in any case it seems reasonable that as far as the functions of government, authority, planning and finance are concerned, a homogenous formula should be adopted for the whole of the Department of Health. The fact that in the same territorial health organizations there is a coexistence of public health responsibilities and financial capacity will represent a meeting point of responsibilities that will be beneficial not only for the formulating of policies at local level but also for the integration of central and local resources.
16. The number of territorial health organizations may vary but one could possibly imagine some 25-35 organizations that have to serve populations that range from a minimum of 20,000 people (Cerdanya) to a maximum of 1,700,000 people (Barcelona). These territorial health organizations would plan actions and allocate funds to the various activities, which would have to be carried out either by local providers or by the ASPCAT itself.
17. The ASPCAT would have to have a territorial implantation that allowed it to respond to the demands for provision of services, both coming from central level and formulated by the different territorial health organizations. This capacity for response could result both from its own resources and from the capacity to subcontract activities to accredited providers. Its organizational structure would have to meet the principles of agility, flexibility and efficiency, and its presence in the territory will depend on its degree of territorial penetration in the provision of services.
18. The city of Barcelona has its own scheme to preserve, which is compatible with this vision. In the city, the Healthcare Region of the Catalan Health Service and the territorial governing body already exist (within a unique organization, the Healthcare consortium of Barcelona). The Public Health agency of Barcelona is ascribed to the Healthcare Consortium of Barcelona and receives its orders, as well as those from local and autonomous government, which have transferred their services to it, and which are present in its governing organs. The Public Health agency of Barcelona acts therefore as a local provider of public health services, and in some fields also provides services outside the city limits.
19. A territorial organization of this kind has to permit varying degrees of dedication of resources and abilities at the level of the territorial organizations. Its prospectus of services has to reflect the fact that for certain highly specialized services it is necessary to practice economies of scale and not to deploy highly specialized resources to all the peripheral units. Thus, although it is reasonable to think that all the units must have access to laboratory services or to healthcare information relevant to the action, it is not necessary that they all have their own laboratory. The same could be said of other services such as information systems.

Prospectus of public health services

20. Regarding the immediate future it is advisable to propose a range of public health services that develops to the fullest possible extent the existing regulations on health protection in certain ambits such as environmental health or health in the workplace. In the ambit of the

promotion of health and prevention, where the regulatory framework is less important, it would be best to establish a range of services that, under the principle of “as a minimum” allows, at least initially, the consolidation of a prospectus that is both of high quality and realistic. In this stage it is important not to transfer any more areas of responsibility to municipal level without ascribing to them the necessary resources.

21. In order to facilitate that the offer of public health services be based on rigorous scientific and economic criteria it is recommended that an institutional process be established of cataloguing of public health services using the methodologies of critical appraisal of the evidence and of prioritization. This catalogue should be updated and reviewed on a permanent basis and should be one of the bases for the development of the service prospectus at different organizational levels.
22. All of the levels of responsibility in public health, from the Directorate General of Public Health and the ASPCAT to the aforementioned territorial organizations, should have a computerized service prospectus that takes into account all of the provisions of service in an organized way, bearing in mind the agents involved in every activity. These service prospectuses should integrate on one hand, the criteria of areas of responsibility and on the other the division of each area into functions and activities.
23. In order to guarantee that the service prospectus are translated into an adequate provision of services it is necessary to define a contractual model of the activities of public health in which the following, as a minimum, are specified: the objective of the contract, the scope of the service, the ambit of action that would be sufficient for the service to be efficient and its provision to be of quality, the mechanisms of evaluation of the services, the frequency of the activities and evaluations, unitary and global prices, responsibilities for completion or incompleteness and penalties in the case of the latter.
24. Given that the model proposed implies a diversity of providers of public health services it will be necessary to define accreditation criteria for providers of public health services and to establish an adequate regime of incompatibilities, for supplying companies or providers of healthcare services.

Improving public health services and their management

25. Presently, and also in the measures proposed, there exists a diversification of the functions of contracting and provision of public health services that, on the other hand, is already habitual in the sector of attention. This diversification has many advantages but also implies some significant difficulties.
26. It must be remembered that systems of purchasing based on market mechanisms are often not adequate for the conditions of the provision of public health services, whether due to the lack of demand or to the fact that there is no alternative private supply. On the other hand, the risks of failures in managing the outsourcing of services are high, especially when the tasks performed are difficult to monitor.

27. Given the necessary proximity between financers and contractors and the levels of providers of public health services it will be necessary to preserve the function of authority and to guarantee that this can be exercised without conflicts of interest. The experience of the city of Barcelona seems to be positive and transferable to other situations. In the present legal framework of regulatory laws, we must remember that it is essential that the professionals and technicians who carry out functions of authority in healthcare be civil servants, since it is necessary to preserve the presumption of veracity and authority, especially in inspection activities.
28. A closer relationship between the public health services and the services of individual attention could be of great interest both regarding the improvement of coverage of preventive service of an individual and clinical nature and to reduce the medicalization often implied by the incorporation of preventive interventions in attention services or also to improve the scope and quality of epidemiological vigilance.
29. In relation to the previous point, it is necessary to optimize the role of primary attention in the provision of public health services. The fact that in many Primary Attention Centres there are "health technicians", often with a specialized training in preventive medicine and public health or similar areas, offers an opportunity for the improvement of public health in Catalonia. These professionals could be incorporated into the public health system in a more effective way that would permit a leap in quality in the ambit of public health.
30. Equally the economic allocation that finances the partial dedication to tasks of public health of the healthcare chiefs should be assigned to the structures of public health, in a way that the progressive amortization of this staff permits contributions to the financing of the deployment of new public health services.

Intersectoriality

31. A study must be carried out to identify those health problems in the tackling of which an intersectorial approach would be fundamental, and a study of existing experiences of intersectoriality, above all in Catalonia, to identify the strengths and weaknesses and draw conclusions that permit its improvement.
32. Given the transverse nature of intersectoriality it is necessary that there be a general strategy at government level that permits us to establish common objectives, and objectives of interest for every sector, to define the sectors involve, establish a consensus on working methodologies, guarantee the resources necessary as well as the criteria for agreeing leadership and the mechanisms of coordination of each initiative.
33. Public health policies must incorporate an intersectorial dimension based on the combined work of all the sectors involved in such a way that all the participating sectors identify the benefits of working together for their sector.
34. In order for intersectorial work to be possible it is necessary for stable mechanisms and structures to with organizational translation to be created that permit the management of intersectoriality and guarantee work in cooperation between the different sectorial administrations.

35. It is necessary to maximize the potential of training of people in the public health sector, but also in the rest of the sectors, so that they acquire the abilities and skills necessary to work in an intersectorial environment.
36. It is necessary to give impetus to research and evaluation of intersectoriality, analysing the results of its application in real life, to what extent it should be applied and the evaluation of the elements that make it difficult.

Participation

37. To contribute to the operative development of the right to civic participation recognized in the legal regulations that affect the healthcare system in general (General Law of Healthcare and Law of Healthcare Regulation of Catalonia) and in public health in particular (Law of Public Health). This must be done thinking about the present public Health Agency of Barcelona and the future ASPCAT, through special initiatives.
38. To promote the transformation of the healthcare system, both in services of personal and community attention, in such a way that civic participation has a real place, beyond rhetorical theories.
39. To promote research that has participation as its object, so that its potential benefits can be evaluated and if it is appropriate, tangible stimuli can be given to broaden participation.
40. To promote participative research in health, addressed basically to the health problems perceived by the community and counting on the participation of groups and entities of the population in all of its stages, as a process for involving citizens in the development of programmes and interventions of promotion and protection of health.
41. To favour, by the awarding of specific resources, work groups with the objective of improving our knowledge about participation and to propose specific interventions.

Communication

42. To promote the development of good communication practices in public health, identifying the agents responsible for communication in each of the services of public health, developing the necessary resources.
43. To plan systematic strategies of communication with firmly established objectives and criteria for the evaluation of their effectiveness.
44. To create a "health and society" forum tied to the initiatives proposed to promote participation. To also create a specific website on communication in public health.

45. To promote specific communication experiences and to promote case studies, to conduct studies into the public perception of risk, to establish monitoring systems that ensure the respect of ethical principles in communication on health matters or to promote collaborative meetings between public health services and the media.

Training

46. To establish mechanisms of accreditation, obligatory or voluntary as appropriate, of training programmes in public health, including the teaching units of Preventive Medicine and Public Health.
47. To define the professional career in public health so that it takes into account training, research and professional activity in its promotion, not just seniority.
48. To increase the number of places of Preventive Medicine and Public Health offered to the MIR conferences of resident doctors.
49. To establish a programme of ongoing training directed expressly at professionals who act at local levels away from the centre of the system, according to their needs.
50. To establish a process of periodic accreditation for public health professionals.

Research

51. To support the consolidated research groups in public health and to establish stronger mechanisms of interaction with the improvement of health policies.
52. To favour research focussed on practice, favouring lines of evaluation of services and policies and the involvement of public health professionals in the formulation of research projects, to stimulate the quest for excellence.
53. To strengthen participation in research by public health professionals by identifying groups with healthcare activities close to research and favouring mechanisms of participation in research.
54. To promote the international presence and profile of public health research in Catalonia, favouring relations with research leaders in Europe and the rest of the world with specific aids.
55. To establish a research fund in public health in Catalonia, offering attractive grants with annual conferences integrated into those of research finance funds already established.
56. To give the Public Health Agency of Catalonia an important role in research matters so as to help in the articulation and promotion of the activities described.

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ANNEXES

THE CHIEF ORIENTATIONS OF POLICY

Oriol Ramis, Jacint Jordana

INTRODUCTION

To try to explain the reasons that have motivated changes in public health policies in the last few decades, whether in Catalonia, Spain or the rest of the world, lies beyond the possibilities of this report and its authors. We shall limit ourselves to describing some of them and to proposing different paradigms that coexist in the majority of countries with which Catalonia can be compared.

There is a general principle in public health. In every moment in the evolution of humanity and its cultures, health (and its alterations, which medical sciences have classed as illnesses) always have multi-factorial determinants. At times, when the emphasis is placed on research into the origin of some of these alterations, there is talk of causes. Historically public health policies have been directed at trying to modify the determinants, with the belief, which may be more or less well-founded, that a modification of the determinants would have a positive impact on the reduction of alterations of health.

The existence of policies is inextricably linked with the conviction on the part of those who, in a community, demonstrate authority and above all power, or significant parcels of power, that a "political" action can improve health, or can prevent or avoid its deterioration (in all or some of the people). In recent decades, as in so many fields of social politics, in order for authority to be legitimate, it must base this conviction on evidence based on scientific knowledge. Nevertheless, health policies, like all other policies, are also influenced and legitimised by many other factors, apart from scientific evidence, and it would be naive to think that this was any different in the field of health.

FROM THE MOST IMMEDIATE CAUSE TO THE MOST GLOBAL DETERMINANTS

Following on from what we said before, policies must be defined that are aimed at identifying and controlling the most direct determinants of some or several specific illnesses, when this identification is perceived as being effective and feasible with the instruments that are available and deployable. That is to say, to define feasible interventions of public powers to try to transform a specific and controllable aspect of reality with the conviction, knowledge or hope that this will lead to a reduction in the magnitude of suffering or illness. Historically, we can observe policies; measures, coercive or not, in the face of epidemics of transmissible diseases that regularly afflict human communities. For many years this criterion has been being broadened to cover all types of illness: cancer, non-infectious respiratory diseases, etc. In order to press forward with these policies, the majority of countries, including Spain and Catalonia, have public institutional structures established that have knowledge, authority, their own resources and the capacity to influence other institutions. In Catalonia there are resources that are property of the town councils, the regional delegations, the Government of Catalonia (Directorate of Public Health), of

other governmental entities, and it is accepted that a large part of the network of attention, which is directed above all at attending people who have already lost their health, must also perform tasks of “public health”, that is to say, take action on the determinants of health. People often speak of the doctor Ramon de Tesserach (14th century), who was contracted by the “Council of A Hundred” (Consell de Cent), for the authority that was recognized in him due to his knowledge, to give advice on the measures to be taken to control epidemics. His successors, throughout the following 600 years, have been given resources and certain powers to dictate coercive measures and to implement activities and, when powers were not conceded to them, they have attempted to assume authority, to a greater or lesser degree, to influence certain sectors of the community to adopt or abandon certain habits or lifestyles. In the context of this model, we can consider the current public health professionals as the heirs to this situation; but so too are many of the professionals in services of personal attention whom, in this work, we have tended to consider separately.

If we review the principal topics of public health over the last 20 years we will find a list of public health policies which are either the continuation of previous policies or that appear during these years for reasons that would have to be analysed individually, outside of the ambit of the discussions of this committee. These topics have been grouped together with “public health” policies and separated from other policies of “healthcare services”. For reasons that also remain outside of the ambit of discussion of this document, which is also common to other fields of public policies, the setting out of public health policies and the allocation of resources to execute them have not always coincided.

Public health policies in Catalonia

Description	Evolution in recent years 1980-2005
Epidemiological vigilance of known diseases	It seems that it has not managed to achieve financing and effective deployment in the way that has been achieved in other countries. Politically, it tends to give an image of safety that has no basis in reality.
Epidemiological vigilance of new diseases (including bioterrorism), re-emerging diseases.	The same as the above, but in some cases (AIDS, in the 80s and 90s) highly sophisticated systems have been achieved.
Abuse of traditional psychoactive or additive substances (tobacco, alcohol,).	Relative successes (led by Europe) in the control of tobacco addiction. Few changes in alcohol policy.
Abuse of new psychoactive substances (illegal drugs,...)	
Food and nutrition	Growing interest in the quality of food and nutrition. Few explicit policies.
Contamination of foodstuffs	Various food crises that have placed the topic on the political agenda and have led to the creation of specific agencies

Description	Evolution in recent years 1980-2005
Environment and health	Large increase in civic concern and the creation of policies and institutions beyond the traditional terrain of public health
Public oral and dental health	Little activity
Mental health	Continues to be an unexplored area without established policies.

Nevertheless, there is another, more “political” approximation that consists of the recognition, which is not new, that the determinants of diseases are far more global and less specific than their direct causes would indicate, that is to say that a determinant (for example, poverty) has an influence on many “illnesses”. To give an example, healthcare experts have always known that, besides the Koch bacillus, which is a necessary and direct cause, tuberculosis is a response of the human ecosystem to a determined organization of human communities when these are based in, for example, conditions of malnutrition, lack of hygiene and the accumulation of a large number of the community’s members in one place, and furthermore, these living conditions also favour many other “health alterations”, besides tuberculosis (for example, infant mortality, depression...).

The transformation of the social organization towards a different social order where tuberculosis (and the other alterations) cannot appear and spread, that is to say where most are assured sufficient nutrition and minimal housing conditions, could be an objective of “healthcare policy”, but must be considered an ambitious task for the policies of “public health”. Some consider feasible this type of policies and to others they are disproportionate to public possibilities (and budgets).

Maybe it should be remembered that considerations of public health have, at historic moments, played a key role in social transformations. One example, in 1854, the demolition of the walls of Barcelona, cannot be explained without the explanation of the municipal doctor Monlau regarding the sanitary conditions experienced within the walled city. But history appears to confirm that one cannot understand the influence of Monlau and of “public health” without understanding the alliance with other contemporary factors: the necessity for industrial floor-space to build new factories, the increase in rent due to the scarcity of housing, which kept rents at prices beyond the reach of the working classes, the loss of authority of the military at a time of constitutional reforms, among others.

There is then a certain political sensitivity to public health of which habitually we only remember the successes, but that is also full of “failures”, that is to say, the incapacity to influence or to transform, or to put it another way, slanted by an idealized analysis of the weight of healthcare considerations in the evolution of human communities. In recent years, in many countries, when speaking of healthcare policies, they have worked on the definition of these most ambitious visions that have had a role in global political discourse. Some of these visions, after a few years, have disappeared from public discussion and have been substituted by others, having had a greater or lesser degree of influence on the taking of decisions.

Finally, it must be remembered that the development of universal healthcare attention systems which, let us remember, do not have more than half a century of history, has converted them into an important sector of the economy of contemporary societies. There is then a tendency to wish to influence the way in which these services are administered, with the supposition that there are alternative actions that would improve the results in terms of levels of health, including in some cases, the non-provision of services. Authors such as Ivan Illich already, in the 60s and 70s, made a profound criticism of the suffering and illness that the introduction of healthcare services would end up producing. There is a worldwide tendency to try to influence healthcare attention services to perform activities of health promotion and primary prevention, secondary prevention or early diagnosis, even screening of the population, and tertiary prevention, of the consequences of alterations in health. In these cases there is an effort to establish scientific evidence and criteria for those cases in which this action is advisable. The most well known attempt that has been made by public health is the planning for healthcare objectives, which we summarise locally in the health plan. This instrument set out the drawing up of policies starting from the objectives of health and has been implemented in Catalonia during the last fifteen years with scarcely any evidence of its influence, whether positive or negative. Despite this there are many indications both positive and negative that ought to serve to improve “public health policies” regarding “health care services”.

ORGANIZATIONAL STRATEGIES AND INSTITUTIONAL FRAMEWORK

The dissemination of the “agency” model

There is no doubt that the word “agency”, applied to define organizational structures of public administrations, had become very attractive in recent years. This has meant that, nowadays, we find this word all around the world to define all manner of public organizations, and therefore that its meaning shows a certain degree of ambiguity, now that, without doubt, it also generates a certain fascination as a reference for new models of public administration.

This is not the place to review the genesis of this concept, but it must be recognized that the Anglo-Saxon influence in the dissemination of the word “agency” is very significant. The United States has historically been a habitual user of this word generically to characterize all kinds of public organisms, leaving to one side the classical ministerial departments. Thus we find all kinds of organizations, many of them not formally bearing the name “agency”, that are considered as such. We can also add that the first dissemination of this term, especially during the 80s, occurred in various Anglo-Saxon countries, such as Great Britain or Australia, in the framework of broad initiatives of renewing public policies, which also included an organizational aspect, of the renewal of the public administration itself. Thus the “next step agencies”, based on the principles of the new public administration, were a group of initiatives driven by Anglo-Saxon governments, who wished to maximize the potential of decentralization and autonomy in administration, the utilization of mechanisms of the market and the constant measuring of performance, as a way of improving public administration. In the 90s, the principles of this new public administration were extended throughout the world, and with them the concept of the agency as an organizational formula to be promoted. A formula that is no doubt idealized, but which in many cases encapsulates the spirit of change and renewal of public administrations.

In effect, the number of public organizations which we can denominate, generically, as agencies – in many cases because they are already defined as such – has not stopped growing over the last fifteen years. Being considered as institutional solutions for very exceptional cases, the model of agency has been widely generalized to respond to the various organizational needs in public administrations. Assuming some characteristics of the new public administration, with greater or lesser degrees of intensity, and breaking with the hierarchical and homogenizing models of the traditional administrations, the model of agency has two key identifying elements: its own, clearly distinctive organizational identity, separate from the departmental structure of the administration, and the presence of professionals who are highly specialized in the tasks which are specific to the organization. Other aspects may vary, according to the nature of the agency, such as its functions and objectives; however, in any case the important thing to point out is that one of the aspects that we most habitually find in agencies is that they have a function or mission that is well-defined, clearly specified and free of political tensions or conflicts of preferences over which objectives to accomplish.

In general, the role of politicians is reduced in organizations that assume the orientation of an agency, since there tends to be a certain delegation of functions to technicians and professionals responsible for them (which can be more intense or less so, according to the task that the agency performs). Now, this makes sense, and can function correctly, only when there is no political debate, or dilemmas over criteria and values within the agency. As long as these tensions – habitual in many themes of public politics – remain present, their management has a political nature that makes it more likely that direct responsibility remains in the hands of the political offices themselves and those of the group of political institutions specializing in dealing with this kind of dilemma. On one hand, their degree of legitimacy to do this directly is much higher, while on the other hand, to transfer to an agency functions that have an essentially conflictive dimension could block the capacity to resolve problems of an essentially technical nature.

Types of agencies

We will now present a fairly typical classification of the kinds of agencies. This classification allows us to distinguish agencies in this sense, according to their functions. So, we have:

- **Regulating agencies:** these agencies have the role of monitoring public regulations on different areas of economic or social activity. Their intervention instruments generally have a coercive dimension, since their tasks are oriented towards guidance and control of the regulated economic (and social) activities. The tendency towards autonomy – even independence – of regulating agencies created in the last few years is very intense, above all in questions of regulating markets of products and services with ladder economies and problems of negative external effects. Their objectives are as much concerned with protection from social risks as with the increase in efficiency of the markets.
- **Implementing agencies:** these agencies are oriented towards the management of programmes and policy initiatives, defined in other, different ambits, often of a departmental nature. Implementing agencies have clearly defined missions, that possibly require a certain

technical flexibility, and an elevated level of professional specialization, but which do not generate too many problems of control, because their performance is easily quantifiable and visible. Their levels of “political” autonomy are usually highly reduced, although we can demonstrate many singularities in their organizational characteristics and in the management of their human resources.

- **Evaluating agencies:** the agencies charged with tasks of evaluation have systems of protection that allow them to evaluate units of the public administration itself, or units closely related to it (including other agencies). This is the reason for their autonomy, essentially professional in kind, rather than political. Their tasks are to gather information, to review and to inform the community as a whole, and above all the politicians themselves, of the performance levels achieved by the public policies undertaken, and also to participate in the evaluation of programmes under way (including management of technical evaluation of requests, projects, etc).
- **Assessment agencies:** assessment agencies are concerned with producing specialized knowledge, from within the public sector itself, to contribute to decision making on public policies and to allow a knowledge which is more well-founded, and free of influences, of public decisions. In this arena it is still relatively usual to use the word “agency” to describe these assessment organizations.
- **Coordinating agencies:** coordinating agencies have the role of establishing a connection between the different public administrations, (from different territorial levels, different territories, different sectors) regarding a specific topic, with the aim of avoiding the dispersion of efforts, initiatives etc. in different directions. There is no doubt that it is a complicated model, that only works correctly in special cases, when there is an institutional context that favours coordination (the case of the European Union), and that habitual political conflict is not especially intense, due to the elevated level of specialization of the matter that is the object of coordination.

Organizational models and public health

We can observe great flexibility in the relation between institutional designs and the functions of government since, generally, institutions to a large extent adapt themselves to the functions required. However, that does not mean that they do so with the same results. On one hand, the problems to be faced can be more or less intense, and secondly institutional designs often have a strong influence on the way that preferences are defined, orienting instruments and policies in one direction or another. In this sense, when considering as adequate organizational model for an administrative unit in the public arena, the following elements, at least, must be remembered:

- **A mission** that centrally focuses the objectives of the organization.
- **A group of functions** from which its contents are defined, and the ambit in which they are developed.

- **Responsibilities and powers** that enable it to achieve the objectives established, making use of the capacities for public intervention.
- **A structure:** a way of dividing, and later, coordinating work in order to perform activities directed at accomplishing the functions allocated
- **A system of financing,** that guarantees the acquisition and maintenance of resources to carry out activities.
- **An institutional form,** that must be coherent with the previous element and permit the optimum development of its activities within the collective framework of public institutions.

Once the objectives have been set out and the services to be offered decided, it is plausible to suppose that there are specific combinations of structure, responsibilities, financing and institutional form that allow the optimum performance (although there is no reason why this combination should be unique). In any case, it must be remembered that the complexity of the organizational model of the public sector is much greater, in as much as it encompasses a large number of organizations, each with its own specific model and which has to coordinate with the rest.

Public resources and public policies

In the arena of public health we find that, from the point of view of public policies, there is often a concentration of public resources on offer to the population as a whole, and that therefore there is a strong justification to maintain this in a way that is inarguable within the wider context of public responsibilities. It is a matter of public resources because public healthcare services often have a very strong component of collective services, and besides, it is often not possible to place restrictions on the benefits of public health interventions. In fact, in developed countries we do not find cases in which the basic responsibilities for public health care have been left in private hands, beyond the provision or production of certain services, and always under the supervision of those with public responsibility.

Public healthcare interventions combine three different principles, each of them with its specific advantages and disadvantages. These are; distribution of resources, regulation and coordination. In the first place, it is necessary to make policies based on the distribution of resources. Policies of prevention and promotion of health (vaccinations, screening, information, etc) clearly fall within this category. They imply distributing resources and information to the population, and because of their nature, mechanisms based on incentives or market dynamics do not work too well. Nevertheless, the benefits derived from prevention can more than amply justify – albeit at a later date- the efforts made. These policies imply the implementation of operational programmes, through specific management structures or within already existing organizations, specializing in the provision of healthcare services.

Policies based on regulation and control have two aspects in public health. On one hand, epidemiological vigilance to monitor the situation of infections and epidemics among the population. The objective of these activities is a control of situations with collective risks to health, and at

times they require special, urgent interventions with an elevated technical component. On the other hand, we have activities of health protection, that have a large element of utilization of regulations and the control and monitoring of them, using various forms of coercion where necessary. The habitual problems related to regulation and control arise from the complexity of supervision, and having access to adequate information.

Finally, the third form of intervention in public healthcare follows the principle of coordination, and also has as its objectives the effective promotion of various fields of health protection, in which it is necessary to integrate efforts from different departments or administrative units. When responsibilities are highly scattered, and it is very difficult to reintegrate them – because to do so would create problems in other arenas of public action – the formulae of coordination are more appropriate. There are many different styles of coordination, from the sharing out of tasks informally or by dialogue, to formulae that are supported by institutions of a hierarchical nature, from higher levels.

So, following this brief review, we can deduce that beneath the word “agency” there are very varied institutional and organizational realities, according to the historical or political focus of its design. If we reviewed, for example, the food safety agencies that exist in the world, we would find that some are fundamentally geared to act as organizations that apply regulations and exercise control, while others carry out basically tasks of assessment for government, or rather perform tasks of technical evaluation or public risk assessment. According to their functions, the food safety agencies of each country have differing relationships with their governments, and their powers for regulation and sanction also vary widely (L. Hellebo, “Food Safety at Stake –the Establishment of Food agencies”, Stein Rokkan Centre for Social Studies, 2004).

ORGANIZATION AND LEGAL ASPECTS

Elisabeth Jané, Joan R. Villalbí

FUNCTIONS AND SERVICES OF PUBLIC HEALTH

In order to define an organization it is essential to know what it has to do. Its functions and services tell us this. For this reason it is best to define the functions and services of public health clearly. The result will be the clear outlining of exactly which ambits we refer to when we talk about the organizations of public health.

What are the basic activities of public health that have to cover the whole territory? The grouping together into three main functions proposed by the Institute of Medicine (IOM) is important ¹, but also it would be useful to consider the essential services defined further on ², and featured in the table.

Essential functions and services of public health.

To evaluate health needs

To monitor and evaluate the state of health and its determining factors.

To diagnose and investigate health problems and health risks.

To develop policies

To inform, educate and empower the population regarding health matters.

To encourage collaborations and alliances to identify and resolve health problems

To develop plans and policies of public health that give support to individual and community efforts in favour of health.

To guarantee the provision of basic services

To apply the laws and regulations that protect health and guarantee safety.

To connect individuals with the healthcare services they need and to guarantee the provision of basic services.

To guarantee the competence of the personnel who provide public health services.

To evaluate the effectiveness, accessibility and quality of services to individuals and to the population.

To conduct applied research

To investigate new aspects and innovative solutions for health problems.

Today in Catalonia a large proportion of these functions and services are not carried out exclusively by the public health services. This is usual in our society, where the organization of public services does not respond only to conceptual criteria, but also to criteria that are historical, inertial or related to organizational balanceⁱⁱⁱ. Furthermore, there are matters which are on the border with other disciplines. It would be a mistake to ignore these realities, and to propose an abstract scheme. Nevertheless, from or perspective it is still desirable for all public health functions to be under the umbrella of the same organization.

A FRAME OF ANALYSIS

In general, organizations are structured according to the grouping of people that compose them, depending on the knowledge and technologies they employ, the type of client to whom they provide a service or the territory they have to cover.

From the point of view of the expertise and technology of the staff, it would be reasonable to distinguish four blocks, into which the majority of the professionals in the system can be grouped:

- Professionals with training in public health, who manage information systems (with skills and experience in managing databases, their analysis and their capacity to generate reports), programmes (with skills and experience in the design, execution and evaluation of programmes, often in combination with other structures, which requires good relations skills) and epidemiological vigilance, a task that presents some specific considerations (with expertise in infectious and microbiological diseases, and the ability to form relationships with clinical structures and with the community). The majority are doctors, although there are also other professionals related to health, and they often work in combination with other professionals whose job is more concerned with the gathering of data and the execution of programmes.
- Professionals who carry out tasks pertaining to the healthcare authority, which includes sanitary inspections and tasks related with the coercive capacity of the state in terms of laws governing people and establishments. The majority are veterinarians involved in the control of food safety.
- Professionals who carry out tasks of laboratory support for those previously mentioned. These are generally people trained in chemical and biological sciences, including pharmacy.
- Professionals who carry out tasks of general administration, supporting the tasks mentioned above, among whom economists and lawyers predominate.

Apart from a nucleus of professionals in the central services, a large proportion of the functions of evaluation of needs and development of policies mentioned before are performed by professionals who do not have this function as their main responsibility, but rather do it at the same time as providing basic services. On one hand, this can make it easier for those functions to be very close to the reality that the professionals involved have the appropriate skills and attitudes, but on the other hand it can mean that these functions are not really carried out if they are not in the hands of the professionals who provide services.

From the point of view of the client they have to serve, three groups must be distinguished ⁴.

- a) Firstly, services which are carried out for other public organizations, which include the autonomous administration itself, the municipal councils and structures and professionals of the healthcare services.
- b) Secondly, services which are provided to “end users”, such as those affected by specific health problems or some groups of the population (infants, schoolchildren...)
- c) Finally, those which are provided to individuals or legal entities within the exercise of sanitary authority, especially food establishments and those which entail specific sanitary considerations.

Thinking about the organizational scheme, it may make sense to group clients in three blocks:

- Those that correspond to an institutional scheme linked to the autonomous government or to local governments.
- Those that are concerned with “end users”, i.e. people, families, associations or companies (basically, individuals or legal entities).
- Those related to intermediate structures, that could be connected with institutions of the first or the second group, but which due to their dimensions and their own working dynamic, also correspond to other schemes, notably professional ones (such as schools or centres of primary healthcare attention).

From the territorial point of view it is necessary to distinguish three levels, central, regional and local:

1. The central level corresponds to activities that are carried out or that could be done better centrally for reasons of competences, scale economies, and critical mass. This includes a large part of the actions of definition and evaluation of policies and programmes, as well as their execution, when this does not have to be realized in the field. It also includes the management of databases and essential information systems. It also makes sense to organize laboratory support centrally for reasons of scale economies, especially with the tendency for specialization and automation that are implied by the costs and the need for accreditation.
2. The regional level occupies an intermediate space between the central and local levels, with the peculiarities to be found in the city of Barcelona, which has a regional as well as a local dimension.
3. The local level is that at which the actions dictated by policies and programmes are carried out and, often, is also where the information that maintains the databases is generated.

Now, this territorial scheme must be superimposed onto the institutional distribution of political power. In Catalonia it is very clear that superimposed on the democratic legitimacy of the

local and autonomous powers, guaranteed by local and autonomous elections, are intermediate structures generated by the two levels of government. On one hand, these are territorial structures in which autonomous services are organized. Of importance regarding the Catalan Health service are the Basic Health Areas, the Healthcare Sectors and the healthcare regions. As far as public health services are concerned, until now the provincial scheme was dominant (with the underlying distinction in Barcelona between the city and the rest of the province). On the other hand, there are the group of structures related to local governments; District Councils (barely active on health matters) and Provincial Delegations.

But also it is important to see who defines the way in which activities must be done (regulatory ambit, of definition of policies and of conduct), and who has to execute them. In this sense, the regulatory ambit corresponds more to the two existing levels of government; autonomous and local (municipal), both legitimized politically by electoral processes and with autonomy. While it is true that today the autonomous level predominates, due to the volume of resources at its disposal, it is no less true that the municipal level is also legitimate, and that all large and medium-sized municipalities have their own public health services.

In any case we propose an eclectic evaluation of the two levels of organization of services;

- Central services. Its territorial ambit is Catalonia as a whole. It centralizes the regulatory ambit and the more specialized or technology-based services (in data analysis or laboratory) for reasons of scale economies. It must be able to generate support for regional/local services when they are faced with situations that are beyond them.
- Regional/local services, based on regional or sector organizations. Their territorial ambit is generally a healthcare region (in the case of Barcelona, the city), a healthcare sector or an operative group of sectors. They make up a structure which is capable of, on one hand, relating with the central services, while on the other hand, executing the services. They must maintain a flow of relations with their clients, contribute to the planning and evaluation of services in the region or sector, and generate support for local services when they are faced with situations that are beyond them.

EXPERIENCES OF ORGANIZATION

Experiences of organization are always unique and are largely derived from the historical and political tradition of each country. There are no experiences that can be directly extrapolated to realities other than those in which they were produced. As far as we understand, there are some elements which must be born in mind when thinking about a reform of the public health services for Catalonia. Among others, we would include:

- The federal tradition of the United States of central technical support to local services in epidemiological vigilance ⁵. The paradigm of this is the staff of the CDC who give direct support to the local services in certain situations, but also the Internet that the CDC operates.

- The French tradition of the centralized body of civil servants of high technical excellence and with unified criteria and protocols, applied in the case of food control.
- The British tradition of management professionals with training in public health but belonging to the healthcare services, who ensure a population-focused vision of attention services, but of a relevance in healthcare that goes beyond individual clinical performance (vaccinations, screenings). In recent years, these professionals have had a growing influence on the planning of services through decisions on the purchase of services.
- The organization into territorial districts or healthcare sectors experienced in Spain in each of the Autonomous Communities, who reformed their public health services after receiving transference from central administration nearly twenty years ago. In the Community of Valencia structures were created in public health itself at district level. In Andalusia structures were created based on the healthcare district, the equivalent of our healthcare sectors, grouping together public health services in a way that is more usual in attention services.

THE CURRENT ORGANIZATIONAL FORMS IN PUBLIC HEALTH IN CATALONIA

It must be born in mind that in reality, superimposed upon the two levels of government (autonomous and local – the central administration of the state has a very reduced role) are various territorial frames potentially related with public health ⁶. The current search for a new organizational expression for metropolitan realities adds complexity.

From the territorial point of view, services currently are projected in the central services of the Department of Health and in services which are nearer to the territory, which have an expression in the Territorial Delegations. Large and medium-sized municipal councils usually have their own services ⁷. Not homogenous in form, public healthcare services also have an expression in the structures belonging to the healthcare services, whether in the healthcare regions of the Catalan Health Service or in the case of the providers of primary attention services such as the Catalan Institute of Health, in the SAP. In the healthcare regions of the Catalan Health Service there are usually professionals or units who ensure the coverage of various programmes and activities of great interest for public health and whose execution tends to be tied to the clinics. At the SAP there are usually only professionals attached to the first group (some of the various providers of the Catalan Institute of Health do not have professionals linked to public health). The primary attention teams carry out functions of execution of certain public health programmes, substituting some of the functions of local healthcare workers that are integrated; this aspect has recently been analysed ⁸.

The financing of public health services is currently taken from the healthcare budget transferred by the central administration to the services of the Department of Health, both central and peripheral, (including the cost of healthcare managers), and from the budget of local governments that have their own services. The city of Barcelona presents a peculiar situation, in that the ASPB receives financing from both administrations.

Correspondence between territorial ambits and institutions active in public health, Catalonia, 2004.

Institutions Territorial ambit	Department	Catalan Health Service	Catalan Health Institute and other providers	Municipal councils and Provincial Delegations
Catalonia	Central services	Healthcare area	-	-
Provinces	Territorial delegations	-	-	Provincial Delegations
Barcelona	ASPB	CSB	-	ASPB
Healthcare regions	-	"Staff"	-	-
Sectors	-		Health technicians	If it coincides with a large/medium municipality
ABS	-	-	EAP	If it coincides with a large/medium
Municipality	Local healthcare	-	-	municipality Large or medium municipality

LEGAL ASPECTS

The regulation on the structure of public health services is based on norms from the beginning of the twentieth century, updated after the war. The two most recent legal norms that must be born in mind are the Law of Healthcare Administration of Catalonia /LOSC) of 1990, partially modified in 1995, and the Law of Health Protection (LPS) of 2003. Any proposals for the reform of public health that are adopted must bear them in mind, and the formulation of the LPS permits the contemplation of a transitional scheme based on this law to later progress to a new regulatory framework. It must also be remembered that the Law of the Municipal Prospectus of Barcelona of 1998 upholds the peculiarity of the structure of public health services in the city.

CRITERIA FOR AN ORGANIZATION IN THE FUTURE

From the information gathered and the analyses that have been done, some criteria are proposed for taking decisions in the ambit of the organization of public health.

- Coherence must be sought between the structures in which public health services are now organized and the areas of responsibility, functions and resources that must serve to structure the future scheme. The introduction of changes must be done progressively to avoid dysfunctions.
- The starting point, as regards services other than the central ones, should be the territorial delegations, the healthcare regions and the municipal services, where they exist, as well as the design already predicted by the legislation in power for services of health protection. The city of Barcelona already has its own, reasonable structure, which must be maintained.
- The current tendency to seek entities all over Catalonia that facilitate the manageability of the healthcare system and the integration of institutions and services in a way that preserves the visibility, autonomy and responsibility of each one, can be transferred to public health, without this necessarily leading to an exact correspondence with the structures that are adopted for public health.
- The respect for the autonomy of the local governments and of the autonomous government could lead to the designing of a transition period for the development of appropriate local services starting from the current regional/territorial services of the Department of Health and from the municipal services, where they exist.
- The operative structures of public health must avoid the existence of duplications or gaps in responsibilities or services. Each territory and centre of population should have its corresponding "unique window". The coexistence of different organizational structures should not affect the client.
- The minimum dimensions of the operative services must allow some scale economies and must be able to respond to needs, combining a certain specialization with resources that allow flexibility.
- It will be necessary to combine the proximity and capacity for response of local governments that have developed their own services with the coverage of the whole of the population and the territory which is assumed by the Department of Health. Seeking shared structures of management for populations of a certain dimension could be a reasonable option.
- Bringing the services of public health closer to healthcare services is probably of great interest as regards the coverage of preventive services of an individual and clinical nature, and, probably, for epidemiological vigilance as well.

- The important role of the clinical services on the administration of many services of considerable interest for healthcare must not lead to the confusion of its role with that of the public health services, which have peculiarities that must be preserved.
- Aspects of healthcare authority pertaining to public health services must be preserved, and that gives rise to the need for an entity in its own right, and separate from other structures of provision of services. In recent years, situations have arisen where healthcare authority has had to be exercised over structures providing healthcare services: it must be possible for it to be exercised without interferences.
- The separation of the functions of purchase and provision of services already habitual in the attention sector should be able to allow the necessary proximity between public health services and the structures responsible for the financing of the system, without affecting the healthcare authority. The experience of the city of Barcelona seems to be positive and can be applied to other ambits.
- A capacity for evaluation of public health services should be preserved which is separate from the management of services and which, probably, should correspond to the central services, these being closer to the political authority.
- It is necessary to keep in mind the necessity that the staff that carry out the functions of healthcare authority be made up of civil servants, as it is vital to preserve the presumption of truthfulness and authority, particularly in the carrying out of inspection activities.
- The economic resources that finance the partial dedication to tasks of public health of the healthcare chiefs should be assigned to the structures of public health, in a way that the progressive amortization of this staff permits contributions to the financing of the new deployment of public health services.
- In the medium term it could be thought that the peripheral structure of public health services should be based on a range of organizations within the structure of a consortium, integrated by the local governments and the Department of Health – SAS that cover Catalonia as a whole. The number and size could vary but possibly one could think in terms of some 10-25 organizations that have to serve populations ranging from a minimum of 100,000 people to a maximum of 1,700,000 people (in the case of Barcelona).
- An organization of this type has to allow for differing levels of resources and abilities in these organizations. Its service charter has to be able to respond to the reality that for certain highly specialized services it is reasonable to practise scale economies and not to have resources deployed in all peripheral units. So, it is reasonable to think that all the units should have access to laboratory services or to healthcare information relevant to an action and to criteria for interpreting the results from the laboratory or of data analysis. However, it is not necessary for each one to have its own laboratory or its own team capable of analysing in detail the existing data.

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SUMMARY PROPOSAL FOR THE PROVISION AND PURCHASE OF PUBLIC HEALTH SERVICES

Olga Pané, Ricard Tresserras

CONCEPTS AND DEFINITIONS

The purchase of services. Definition of the client, the providers and the authority

Activities of public health, like any other activity of production or provision of services, are set within a context of a group of transactions that determine an economic frame. When this economic environment is strictly administered within the organs of the public Administration, we speak of the economic budgeting of activities and the assigning of the budget to the organisms of the Administration charged with executing the activities. The budgetary approval of a public activity is an action of the healthcare authority that, with the funds available, determines where and to whom they are assigned. Nevertheless, these political decisions have control mechanisms such as, for example, the approval of the budget in a plenary session, in the case of the city councils.

So, when the destination of the funds is an organization of the public Administration itself, we speak of budgetary allocation, whereas when an activity is outsourced to an organization or entity, either public or private, but outside of the public Administration, we refer to it as the purchase of services.

Traditionally the purchase of these services is conducted through a contract in which, independently of the mechanisms of evaluation and monitoring that the receiving entity in the contract may have in place, evaluation mechanisms are established on the part of the purchaser, and billing mechanisms by both parties.

Those who impart services are known as providers, regardless of their nature, whether public, which could be from the public Administration or not, or private.

All this, translated into the ambit of public health, means that the chain of activities that make up the development of functions have an apex in the healthcare authority that determines what has to be done and how it is financed, the degree of outsourcing of activities. It also assigns resources to its organs in order to carry out activities and purchases services from determined providers, whether directly or through an agency charged with making this purchase.

However, in the field of public health, there is no one single healthcare authority. The function of authority can be exercised by the central government, the autonomous government or the city councils, depending on their areas of responsibility. The areas of responsibility of all three administrations are not always clearly defined. Thus we find that between the autonomous and municipal administration there is a series a series of concurrent areas of responsibility that should be developed by means of agreements or pacts or some mechanism of consensus. In

the city of Barcelona, the Public Health Agency is the product of this agreement between administrations to develop the areas of responsibility attributed to them.

The study of this experience is of special interest, since for the first time we have a “concurrent” organ to manage the “concurrent” areas of responsibility and this could be an interesting line of study as regards the activities and functions that will have to be developed by the new Public Health Agency of Catalonia.

The three administrations provide services directly, but they also purchase services from third parties, either public or private. Equally, there are delegations of functions to organs above local level (district councils, provincial councils, associations or others) or to inter-administrative groups, constituted with the willingness to act as providers in the light of the lack of technical and/or economic resources and thus to overcome the difficulties derived from the exercise of responsibilities. This is the case of the aforementioned Public Health Agency of Barcelona. Both provincial and regional councils can provide services directly, or purchase them.

It is especially important to underline that in public health all functions are outsourced except those that involve the exercising of authority (regulations, sanctions, disciplinary proceedings, etc). In any event, that would not be the case in situations where the state delegates responsibilities to the Autonomous Communities, such as international commerce.

The concept of authority in the ambit of public health does not necessarily have to be linked with responsibility. In the specific field of health protection, where the majority of dispositions affect the development of activities in the productive or service sectors, the responsibility for the quality of particular installations lies with the proprietor of these installations, who has the obligation to carry out a series of measures of self-regulation. The healthcare authority in this case must guarantee that these norms of self-regulation are adequately complied with.

The purchase of services in public health often fragments the continuity of an area of responsibility. A good example is the municipal responsibility for water, where a series of companies or entities may intervene in the same process (collection, distribution, treatment and evaluation of drinking water). (see Appendix 1).

Given the complexity of the exercise of some areas of responsibility and the different capacities of the purchasing agents (for example, small or large municipal councils), the processes of the purchase of services would require an improvement in scale economies and in the availability of contracting guidelines, with clear clauses that specify the needs, the object of the purchase and prices.

Definition of the prospectus of services.

In the commercial world, the total range of products, services or activities that a production or service company has to offer to the market in order to satisfy the needs of the consumer is called the prospectus, or catalogue. Knowing which products it manufactures or can sell is an indispensable tool in the marketing activities of any company.

By way of analogy, leaving to one side the distance between the commercial world and that of public health, we could say that the prospectus of public health services is the whole combination of all of the products, activities and services that are carried out so that the public health needs of the population can be met. However, it is obvious that public health needs are not detected or managed as in a normal market that feeds a rational consumption, nor are the systems of production of services or activities always realized by commercial companies sensitive to the laws of the market.

In public health the prospectus of services has to make very clear what it offers, for whom, in what quantity, and the circle of relationships of the agents from whom this provision of services must be sought.

THE PROSPECTUS OF SERVICES AND THE DEVELOPMENT OF HEALTH POLICIES

The asymmetries and agency relationships that are frequent in the healthcare sector have been amply described and they point to market intervention, on the part of the State, with the objective of protecting the interests of the citizens. This State intervention of the state occurs in many ways, but especially through the regulation of the sector, the planning of services and activities, monopoly contracting and the financing of some activities and not others. All these functions normally respond to a particular health policy. The activities derived from this policy are those that will make up the service prospectus.

Health policies define which necessities must be attended to and with what priority, according to the resources available. They establish which activities must be carried out, how they must be carried out and who are the best people to do them (in-sourcing or out-sourcing). They also determine the norms by which the different agents operating in the sector relate to each other and by what means (for example, in the case of outsourcing of activities, who undertakes the purchase of services? What is the nature of the contract? What are the contents? What prices? And how are the results evaluated?)

Therefore, the development of one health policy determines one prospectus of services or another.

Services that must appear in the prospectus. WHAT.

The ideal situation for defining services of public health in a health system would be that there was no limit, that we had access to resources to make a study of the needs of the population, that these needs were translated into health policies, and that from these policies it were possible to define a series of priorities. However, this ideal situation is impossible. Among other things, because the societies in which nothing has been done in the area of public health would experience such a considerable delay in its development that it would make a proposal such as the one described very difficult.

One of the driving forces behind progress in a society is its level of health and, in general, this can be associated with the implementation of anticipatory activities of public health (water sanitization, elimination of waste, etc). Advanced and developed societies like ours, therefore, do not start from scratch when it comes to defining public health services. They are societies that have a significant legislative deployment in which are clearly defined the services and the territorial level at which it is considered adequate for them to be provided.

While there is a wide consensus on the determination of some of the services of public health (water sanitization, vaccination, registers of mortality and its causes, etc), this situation is not extensive in all of the activities that make up the mosaic of public health services of our health-care system. In some cases it is because of the lack of adaptation to the new health problems that are presented; in others, because of the dubious priority of one activity over another, etc. What is certain is that these are services whose validity is beyond dispute and that on the whole, all of them – those that are accepted by consensus and those that are not – have to be subjected to a permanent review of their validity and efficiency.

In addition, and since the integration of our country into the European Union, it is not only our own judicial regulations that determine the composition of the service prospectus, but also the policies of the Union which generate the need for constant adaptation of the services it contains.

Therefore, which services must be present and at what level they must be executed (local, autonomous or state), is a decision that is the product of the legislation in force, the development of health policies that try to adapt resources to the changing realities and, finally, the political and territorial model present in a country.

Present composition of the prospectus

Traditionally the Directorate General of Public Health of the Department of Health has been organized in three areas; health promotion, health protection and epidemiological vigilance. Since 2001, healthcare planning has been added to these three areas, while in 2004 the Directorate General of Planning and Evaluation was incorporated. In Appendix 2 there is a list of the principal activities which, according to the most recent memo from the Department of Health, were carried out by the Directorate General of Public Health (Memo, Department of Health, 1997).

The current composition of the prospectus of services of public health in Catalonia is difficult to define, given that there is not a complete catalogue of the activities that are carried out by the various administrations that have responsibilities. Nevertheless, there is a preliminary work on the situation in Catalonia, in which reference is made to the actions of public health (de la Puente, 2001). Probably it deals with the more exhaustive attempt that has been made in Catalonia to formulate a prospectus of Public Health services and is based on a scheme comprising the following main sections:

- a) the authority and healthcare planning
- b) healthcare information
- c) epidemiological vigilance

- d) health promotion
- e) prevention of diseases
- f) health protection
- g) and the public health laboratory

In any case, it is a list which is more a summary of what the situation should be, rather than what it is at the moment. However, although it is an exhaustive list, some items are missing which we propose to include, such as legislation, health in the workplace, mortuary policy in healthcare, communication and other aspects. Nevertheless, all the aspects can be introduced perfectly well within the previous sections into which the list is organized. By way of example, intersectoriality or evaluation of the impact on health could be included in the section on the authority. The section on health protection is particularly exhaustive.

Some units of the Directorate General of Public Health and some of the town councils use informal prospectuses of services, based on functions rather than areas of responsibility (see Appendix 3). In these cases, the various activities are classified according to whether they correspond to a function of inspection, of control, of analysis, of authorization, etc. An integration of the two criteria for classification would permit a more practical systemization with a view to identifying minimums and maximums for the future Public Health Agency of Barcelona.

Also the Public Health Agency of Barcelona has made an effort to define a prospectus (Villalbi 2004), in which the activities offered by that entity are grouped together.

As regards the activities performed by the attention services, CatSalut drew up a service prospectus that includes activities of health promotion and prevention of illness, based on a detailed analysis of the interventions recommended in the Health Plan of Catalonia. In this prospectus, the objectives and the interventions recommended in the Health Plan are linked to the product lines of CatSalut. The lines are primary attention, specialized attention, sociosanitary attention, pharmaceutical attention and another line that we can call programmes of the Department of Health. It must be pointed out that this is a prospectus that has been developed at the central services of the Department of Health and that has an online programme with various capabilities regarding the form of representing the results of a consultation, taking into account the territory, the providers, etc. Here we should bear in mind that from the Directorate General of Planning and Evaluation the new healthcare, sociosanitary and public health map of Catalonia is being prepared.

There are many public health activities linked with health promotion and the prevention of illness that presently are carried out by primary attention centres of the providers of attention services. The efficiency and efficacy of some of these should be reviewed and updated. Check-ups in schools are an example, not only because they represent a duplication of the "healthy child" programme but also because of their doubtful efficiency and efficacy. Presently this area of responsibility is attributed to the municipal councils and they receive subsidies to carry out a programme which, in reality, is executed by another institution. The transfer of the subsidies from the municipal councils to primary attention or to activities directed at the citizens has generated a very varied and imaginative range of systems of return on municipal subsidies.

The service prospectus has to be somewhat dynamic and ready to respond to the findings coming from research. A good example of this could be the abundant literature on environmental and food contaminants and their effect on health. Prudence advises that some of these measures be incorporated into the prospectus with the scope and depth necessary to prevent the occurrence of collective alarms or cases of people affected. This could be the case of the control of the waters of the Ebre basin, before and after the news of the contamination of the river at Flix. Presumably another field for expansion in this area are the persistent contaminants in the food chain, for which protocols should already be drawn up and implemented in the territory.

The quality of services. HOW.

The need to determine standards of quality in the production or execution of services is not only due to the fact that these public health services are provided by different agents of the public Administration. Even in services in which all the elements are provided by the administration itself, mechanisms should be established by which it can be proven that what is done is carried out with the greatest degree of homogeneity possible, guaranteeing that services are ideal and that the desired results are achieved.

The policies of quality regarding these products and services are formulated along the lines of the classical triad of:

- Criteria for structures.
- Criteria for procedures.
- Criteria for results.

Actions regarding structures mean the determination of which are the minimum resources necessary to carry out an activity (equipment, premises, people, technologies, etc.). Classically it means the establishment of a system of accreditation of service providers, whether they are public or private.

Actions regarding procedures meant the determination of the effectiveness of the actions and the most efficient way in which to carry them out. Research and evaluation tend to set the guidelines for standards, which in any case have to be established in contracts or in agreements reached with the providers, and in the organization of internal activities. The registers of these procedures are usually the central instrument of activities regarding procedures. It is important to underline two points here:

- The difficulty with which advances in the field of research are reflected in the protocols of public health services.
- The necessity that the protocols used by the providers also be the object of accreditation, and the need to keep a register of activities.

Finally, actions regarding results require the establishment of indicators that permit us to measure them. It is preferable to formulate an objective, so that the system of evaluation of

results may be explicit and transparent, and also in order to give the providers clear criteria regarding the adequacy and relevance of the activity itself. The systems of information, the indicators of procedures and results, and the criteria for the achievement or non-achievement of an objective are the central instruments for measuring results. From the point of view of accreditation, the obligation to complete the appropriate registers and the self-evaluation by the providers themselves are fundamental. This does not mean that the purchaser or the corresponding authority should not verify the results for themselves. The Directorate General of Healthcare Resources has criteria of accreditation of centres and mechanisms of quality control.

The providers of public health services. WHO.

The providers of public health services today are of varying types and, territorially speaking, are unevenly distributed.

In the first place, among the providers are the central, autonomous and local administrations themselves, who through their personnel structures provide services of differing kinds. In general, the administrations usually concentrate on the execution of functions of planning, organization and authority. Local administrations sometimes are assisted by organs from above local level, such as the provincial delegation, or the district councils. In the case of the city of Barcelona, there is the Public Health Agency of Barcelona, in which the city council and the government of Catalonia participate, which acts as a provider and at the same time, purchaser of services. This is a similar profile to that promoted by the Agency of Health Protection of Catalonia (the future Public Health Agency).

The functions of authority, particularly those of inspection, are subdivided in some cases into the functions of evaluation (which an external company can carry out) and those of authority and those of authority (disciplinary proceedings, and sanctions) which are carried out by groups of civil servants.

These functions have recently been the cause of controversy. The indiscriminate transfer of responsibilities and functions to local levels without transferring the resources, or, even more seriously, after having withdrawn them (the case of the control of butchers' shops by the municipal councils, after having assigned the vets to a different level), is one of the topics that has most muddied the waters of the necessary collaboration between the Department of Health and the town halls. Much as the efficiency of many measures may be linked directly to policies of proximity, functions must not be de-centralized to local levels until the available resources and the finance system of local entities have been made adequate.

Also acting as providers of public health services are those who provide attention services, and especially, the facilities of primary attention. In our society, the orientation of the reform of primary attention, in conjunction with the transposition to their attention contracts of many of the operative objectives of the Health Plan of Catalonia, has favoured the performance of many preventive activities at this level of attention, such as vaccinations and screenings. Equally the hospital establishments carry out some programmes of prevention contained in the Health Plan. Both primary attention and hospitals are providers of information critical to the system of vigilance for health.

There is a group of public and private companies that act as providers of public health services, above all in the area of health prevention such as treatment and monitoring of drug addicts. It is in this area where the absence of accreditation criteria is more evident, given that many of the companies supplying services (of revision of equipment or installations) are not subjected to any criteria that indicate any standard in the resources they must have or the level of training of their staff.

It is equally important to establish criteria of incompatibility between the natures of the services provided. Thus it is reasonable that a supplier of water, who has to carry out the required quality controls and register them, should not be the organization that certifies the fitness for consumption of drinking water. An entity that acts as a supplier of swimming pool maintenance services should not carry out the evaluation activities that are implemented periodically by the municipal councils. One clear example of this system can be seen in that of the ITV of vehicles; the entity that detects faults can under no circumstances act as a repair workshop.

Criteria for the incorporation or withdrawal of services in the service prospectus.

The limits of public health services are always imprecise. The cross-sector nature of many of the actions that are considered efficacious for the resolution of health problems makes it difficult to mark the administrative boundaries between departments (for example, between Health and the Environment) or between areas within the same department (activities of attention and public health).

Beyond the rhetoric that recommends integrated and cross sector policies, it is necessary to define compartments that are depositories of resources, because in the end if the policies of whatever kind are not accompanied by resources they have very few possibilities of being carried out.

In health, prospectuses of services in the public sector have often been a preliminary step to delimiting those services that are offered free of charge and those that are not, or rather, which activities remain excluded from the system of public finance.

In public health actions there are horizontal limits, as to the scope of policies, and vertical limits, of responsibility for actions. That is to say, at some moments we have to state what is the catalogue of activities that will be realized by the Department of Health, and which services will be carried out by other departments that contribute to and form part of health policies. Equally, it is important to define what is the level of action most appropriate for each activity and the most adequate level of responsibility to guarantee its application.

An activity must be included in the service prospectus as long as:

- It is effective.
- Its limits and the organism responsible can be defined.
- It is more efficient than other alternatives.
- It has a clientele, that is to say, there is a need to cover.
- There are resources that enable it to be offered (in other words, it has a price).

When any activity in public health fails to meet these requisites, inevitably it should be withdrawn from the prospectus. However, in certain cases, the existence of a norm that obliges the realization of an activity makes this list unnecessary.

BRIEF ANALYSIS OF THE CURRENT SITUATION

According to the place in which public health services are provided, three ambits can be distinguished (A. Segura, 1995). Firstly, if we consider the services provided by the attention network, the activities of health promotion are the ones that are predominantly carried out. Thus we can see that vaccinations, preventive screenings and healthcare advice are performed above all in primary attention. Also it is necessary to consider here activities such as the public programmes of screening for breast cancer. Secondly, if we look at the activities that are carried out in specific public health services, we see that these comprise actions of information and vigilance, health protection and health education. Finally, in third place, we find activities that are carried out from a central level, comprising those actions aimed at the analysis of the state of health of the population, the establishment of priorities, the organization and contracting of services and the guarantee of the safety, effectiveness and quality of the services. .

STRATEGIC PROPOSAL

At the moment of completing the content of the prospectus, it must be born in mind that, on one hand, there are aspects that must be included, given that they have a regulatory element that requires that they be complied with, and on the other hand there are activities that may be included or not, depending on the political mandate. The first case is especially applicable to the case of health protection, while the second is more applicable to health promotion. In any event, in all cases it can be seen that in each one of the activities that can be defined there may be more than one agent involved, which makes it difficult to achieve a complete list.

It will be necessary to reflect on whether it is preferable to incline towards a very exhaustive prospectus, or to opt for a prospectus with a minimal content but whose compliance is obligatory, thus permitting an effective control on the part of the authority. At first glance it seems reasonable to respect to the maximum the regulation for the development of the prospectus of protection, and to opt for a prospectus of minimums, at least initially, for that of promotion. This aspect must also be considered when evaluating epidemiological vigilance, in the sense of respecting the need to control a reasonable number of diseases, but also to respond to any particular situation that might arise.

Although in the beginning it will be necessary to start from a homogenous prospectus, it must not be forgotten that the moment may come when it becomes necessary to take into account territorial variations that mean placing more emphasis on some activities or others, according to the territory in question. The idea would be to arrive at an equity in the effort that is made by the Department of Health, bearing in mind the diversities of the territory which could be, for example, an economy strongly based on a particular productive sector or the predominance of in the population of a particular age group.

In principle it is necessary to consider that in each of the activities of the prospectus, authority had too be exercised by whoever has the responsibility. There can be other agents responsible for carrying out specific actions in the intermediate processes but the final responsibility lies with the organization whose province it is, and that, in our case, could be at state, autonomous or local level. The identification of the agents involved in carrying out the activities of the prospectus and the delimitation of their functions and responsibilities and of their role of purchaser and/or provider, according to the case, is an important component when it comes to establishing the prospectus.

The role of the Public Health Agency of Catalonia must be clearly defined. If its mission is not established with clarity, the role of the agency itself, and of the collection of responsibilities of the public health system, could become very confused. In parallel, the Law of Health Protection must be developed so as not to leave some areas of responsibility unassigned, as has happened in the case of the healthcare authorizations of the food sector (retail establishments of meat products). This is a case of areas of responsibility that do not fall clearly into either in the field of risk evaluation (an autonomous responsibility) nor of risk management (local responsibility).

From our perspective, the agency can have a key role in the grouping together of the purchasing of many services which presently are performed by different entities on a small and inefficient scale, and often with a weak contractual process. This grouping together of purchasing could be carried out by prior accord with the local administrators of those activities that represent vital aspects of the legislation in force.

Larger contracts or orders could lead to the structuring of a sector of providers which is stronger, and at the same time had updated and competitive equipment and resources.

The Public Health Agency would have to have a central group of civil servants with the objective of also being able to share services with the autonomous and local Administrations of those activities reserved to the function of "authority".

OPERATIVE RECOMMENDATIONS:

1. To define a contractual model of public health activities in which the following, as a minimum, are specified: the objective of the contract, the scope of the service, the ambit of action that would be sufficient for the service to be efficient and its provision to be of quality, the mechanisms of evaluation of the services, the frequency of the activities and evaluations, unitary and global prices, responsibilities for completion or incompleteness and penalties in the case of the latter.
2. To define criteria of accreditation for providers of public health services.
3. To establish incompatibilities between supplying companies or public health service providers.

4. To have an online prospectus that includes all of the services in an organized way, bearing in mind the agents involved in each activity. This could take as its starting point the experience of the prospectus of services of CatSalut.
5. To plan a prospectus of maximums only in those ambits in which there is a regulatory support that obliges this to be done at least initially.
6. Not to transfer any new municipal responsibility without ascribing to it the necessary resources.
7. To define a service prospectus that integrates, on one hand, criteria of responsibilities, and on the other hand, the division of each responsibility into functions and activities.

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APPENDIX 1

The example of water.

RESPONSIBILITY	ENTITY	FUNCTIONS
Control of aquifers and river basins	<ul style="list-style-type: none"> - Internal (Catalan Water Agency) - External (Hydrographical Confederation of the Ebre) 	<ul style="list-style-type: none"> Control of outlets Analysis Regulation of volume Authorization of collection* Re-use for irrigation
Supply of drinkable water	<ul style="list-style-type: none"> - Town Halls - Supply company 	All, from the maintenance of the network to administrative aspects

(*): A sanitary report and the specification of the type of treatment to which the water is subjected and the distribution system are essential..

Aquifers and internal river basins are the responsibility of the Catalan Water Agency (Department of the Environment), while the external ones fall to the Hydrographical Confederation of the Ebre (Ministry of the Environment). Both entities are responsible for: a) controlling outlets, b) conducting analyses of water, c) regulating minimal volumes, d) authorization of water collection and e) re-use of water for irrigation.

When the Agency authorizes the collection of what is known as “crude water” it is obligatory to produce a sanitary report and to determine the characteristics of the treatment and the distribution system. Opening a well could be an example.

The city council is responsible for the supply of drinkable water to the resident population. The channelling and distribution of the water can be done directly or via a water supply company. In the latter case the company would be responsible for all the activities, from maintenance of the system to receiving payment of bills. When the company is the city council itself, this organization must regulate itself and it is for this reason that that both self control and non-compliance must be communicated to the autonomous authority. In any event, there is no hierarchy of administrations and the fact that all incidents must be communicated to the Department of Health does not mean that this has more authority than the city council.

The evaluation of risk in water for public consumption corresponds to the Department of Health while the management of water corresponds to the municipal councils. If the municipal council in question does not have sufficient structure, other entities can come into play such as the district or provincial councils.

APPENDIX 2

Present basic prospectus:

1. Epidemiological vigilance:

- Diseases of Obligatory Declaration
- Epidemiological Bulletin of Catalonia
- System of microbiological notification
- RPD
- SISIGAB (Integrated system of healthcare information on flu in the Barcelona area)
- Vigilance and register of other diseases (meningitis, TB or new variant of CJD)

2. Promotion of Health:

- Preventive vaccinations and prog. Of adverse reactions to vaccines
- Advice to travellers and international vaccinations
- STDs
- Hansen's disease
- Healthcare education
- Prevention of chronic diseases and promotion of healthy lifestyles
- Health in the workplace
- Maternal/infant
- Oral/dental health
- Prevention of accidents

3.- Protection of health:

- Environmental health
 - Public water supply
 - Re-use of waste waters
 - Communal swimming pools
 - Solid waste
 - Human living spaces
 - Ionizing radiation
 - Sanitary mortuary policy
 - Disinfection and pest control
 - Control of chemical products
- Classified activities
- Sanitary residues
 - Hospital sector and Primary attention
 - Veterinary clinics
 - Dentistry

- Food hygiene
 - Sanitary register of food industries and products in Catalonia
 - Sanitary control of food establishments and foodstuffs
 - Vigilance and evaluation of food safety
- Public Health laboratory
- Public health veterinarian
 - Health risk of foods of animal origin
 - Inspection of establishments of foods of animal origin
 - Restaurants and retailers
 - Investigation of residues in foods of animal origin
 - Vigilance of microbiological and physical-chemical contamination of foods of animal origin and prevention of zoonoses.

4.- Planning

APPENDIX 3

Scheme of municipal responsibilities.

(Not an exhaustive summary, drawn up by Mireia Camps and Luís Carlos Árias).

All municipalities:

- General: (art. 67. a)
 - Public lighting
 - Cemetery
 - Waste collection
 - Road cleaning
 - Domestic supply of drinking water
 - Sewerage system
 - Access to centres of population, paving and upkeep of public roads
 - Control of food and drink.
- Protection of health: (art. 45 Law 7/2003, of Protection of health; art. 68 Law 15/1990, of healthcare organization in Catalonia).
 - Healthcare education in matters of protection of health in the ambit of local responsibilities.
 - Management of risk to health derived from :
 - Pollution.
 - Drinking water.
 - Public facilities and living spaces, including swimming pools.

- Food products in retail activities, restaurants, the local production sector and urban transport.
- Domestic and semi-domestic animals and plagues.
- Sanitary mortuary policy.
- Other responsibilities on public health matters: (art. 68 Law15/1990):
 - Defence of consumers and users of the healthcare system.
 - Participation in the management of primary healthcare attention.
 - Healthcare education.
 - Any such as may be delegated to them.

Municipalities with a population of over 5,000 inhabitants. (art. 67b)

- All of the above.
- Public parks.
- Public library.
- Market.
- Waste treatment.

Municipalities with a population of over 20,000 inhabitants. (art. 67c)

- All of the above.
- Civic protection.
- Social services.
- Fire prevention and fire-fighting
- Sports installations for public use.

Municipalities with a population of over 30,000 inhabitants. (art. 67d)

- All of the above.
- De-centralized service of public information.

Municipalities with a population of over 50,000 inhabitants. (art. 67e)

- All of the above.
- Collective urban transport of travellers.
- Environmental protection.
- Adapted transport service.

Tourist municipalities: (art. 19 Law13/2002, Tourism of Catalonia).

- Those fixed with a general character.
- Protection of public health and hygiene in all of the municipality, including the beaches and the coast.
- Civic protection and safety.

INTERSECTORIALITY IN PUBLIC HEALTH

Teresa Corbella, Mercè Tor, Eduard Mata

GENERAL CONSIDERATIONS

concept of intersectoriality

This processes which are developed regarding health, well-being and the quality of life are characterized by their high level of complexity, the broad social dimension and the multiplicity of the components which, besides, have variable forms of inter-relation, hierarchical positioning, and combination. Thus, health problems have indistinct frontiers and their determining factors are imprecise and variable, which allows us to affirm that it is difficult to solve these problems by actions exclusive to the health sector.

The subsystem of public health has, then, a set of peculiarities that differentiate it from other spheres:

- **Universality:** Public health is concerned with all people, healthy or ill, regardless of gender, age or social group.
- **Interdependence:** health depends on the interrelations of numerous agents.
- **Extension:** it implies the participation and action of numerous sectors such as the economy, commerce, agriculture, education, tourism, legislation, civic security or the media.
- **Social pressure:** the state of health is an indicator of the level achieved by a society and the citizens consciously demand an elevated level of protection of their health.

These peculiarities have been the reason that, historically, from public health there has been a vigorous defence, even if only in theoretical form, of a systematic tackling of the population's health problems, bearing in mind the different administrative, social and economic sectors that can influence the determining and conditioning factors for health and that, without its ontribution, the activity of the structures that plan or administer public health services would be rendered insufficient. When it comes to putting into practice this integrated model, however, one has to reckon with the presence of significant contradictions between interests, social groups, professional corporations, policies, powers, etc.

There are various definitions of intersectoriality, of which we shall focus on two, one of which is more general and the other more specifically referring to the healthcare system.

"The articulation of knowledge and experiences in the planning, realization and evaluation of actions in order to achieve a synergetic effect in complex situations oriented towards social development, overcoming social exclusion." (Junqueira & Inojosa, 1997).

“Coordinated intervention of institutions representing more than one social sector, in actions totally or partially destined to tackle problems concerned with health, well-being and quality of life” (Castell, 2004).

Both definitions consider intersectoriality from a broad standpoint, bearing in mind not only public administration but also the different social agents, unions and employers’ organisations, insurance companies for work-related accidents, professional colleges and associations, non-governmental organizations, neighbours’ and consumers’ associations, etc.

For eminently practical reasons, we consider intersectoriality for the purposes of this document in a more restricted sense, referring to the articulation of the different sectorial policies developed by an administration, whether central, regional or local, with their corresponding organizational structures, which can have direct or indirect repercussions on the state of health of the population. This would fundamentally be a matter of converting the chance, coincidental or reactive cooperation into actions which, led by Public Health, are strategically oriented towards those problems where the activities of other sectors could be decisive.

We are aware that in current democratic societies it is not possible to carry out any type of policies without competition, of a greater or lesser intensity, from the organizations representing civil society, but in this case we do not consider this to be a variable, bearing in mind, besides, that there is another area of work, that of “civic participation”, that covers this topic in more depth.

Nor will we refer to the relations between that different levels of administration (central, regional and local), which are amply dealt with in the section, “Finances and the purchase of public health services”.

We will deal with intersectoriality, as a new approach to administration that seeks to overcome the “fragmentation of policies, considering the concept “health” in its totality, and that has to provide a new way of planning, carrying out and monitoring the provision of services. This means modifying the entire way of articulating the various sectors of the organizations of government, from the different administrative stages and from other interests, with a clear definition of public policies and the formulation of intersectorial strategies, plans, programmes and projects to seek solutions to health problems.

The conditioning factors of intersectoriality

There is a series of prior conditions that influence the capacity for application of intersectorial strategies, the most important of which, in our opinion, would be;

- The political willingness of governors, at administrative level, to tackle policies related with health and the quality of life following the action principle of intersectoriality. This willingness has to be made explicit, not only with declarations of intent, but also with legislative, organizational and strategic incentives that enable the unequivocal visualization of their commitment.

- Reforms in the organization of public health, oriented towards facilitating intersectorial work, combining the increase in their capacity to locate the health element as a central axis with proactive effort and balanced research, taking into consideration legitimate elements, not directly related to health, of the different sectorial policies.
- The existence of an organizational sub-culture in the subsystem of Public Health, but also in conjunction with the rest of the administrative sectors, inclined towards participative work, mutual cooperation and the understanding of the multisectorial nature of the value "health".

If one wishes to extend intersectorial efforts to more arenas than those in which it is already in effect, or to improve its result, it is necessary to have a prior analysis of the results of these conditioning factors to enable the design of strategies for improvement in the short, medium and long term.

Sectors

In developed countries we find ourselves with an administrative universe with a collection of complex organizations where there is a great diversity of providers of activities that have repercussions for the health of the population.

Therefore, the protection and promotion of public health is, in our position in space and time, a reality that goes beyond the units formally known as relating to public health, and is shared among many other sectors of the administration. In many town councils, and also in the Catalan government, without doing an exhaustive analysis, one can find responsibilities related directly or indirectly to public health in the policies of education, employment, social welfare, agriculture, territorial policy, industry, commerce, tourism, the interior and the environment.

Definitively, various administrative structures besides those of healthcare have responsibility over public health if we agree that the nature of a role or activity is not conferred by the name under which it operates, but by its ultimate end. They are, therefore, organizations that contribute to public health, regardless of their dependence or administrative denomination.

By way of example, without attempting to give an exhaustive study, in our ambit we find ourselves with the following intersectorial ambits:

AREA	OBJECTIVE	SECTORS INVOLVED	CONTENT	LEADERSHIP RESPONSIBILITY
Road Safety	Prevention of road accidents and reduction of injuries	Police Health Education Transport Public Works Automobile Production	Repression Protocols for action towards victims Road safety education Organization and signage Road planning Safety improvements	Hegemony shared by police, health, transport and public works. Co-responsibility between Catalan Government and Town Halls
Drug addictions	Prevention and control of alcoholism and addiction to tobacco and other drugs	Health Education Youth Police Social Services	Employment/Economic Promotion Social workers Promotion, prevention and attention Promotion and prevention Promotion and prevention Repression Prevention and insertion Insertion into the workplace Promotion and prevention	Hegemony shared by health, education and police
Sexuality	Prevention of pregnancies among adolescents and education in personal development and sexuality	Health Education Youth Women Social Services Social Workers	Prevention and attention Promotion and prevention	The dominant sector is health, with an important contribution from Education
AIDS	Prevention and attention of those infected with HIV	Health Education Youth Social Services Employment/ Economic Promotion Social Workers	Promotion, prevention and attention Promotion and prevention Promotion and prevention Prevention and insertion Insertion into the workplace Promotion and prevention	The dominant sector is health
Dietary habits	Prevention of eating disorders	Health Education Youth Consumption	Prevention and attention Promotion and prevention Promotion and prevention	The dominant sector is health

AREA	OBJECTIVE	SECTORS INVOLVED	CONTENT	LEADERSHIP RESPONSIBILITY
Health at work	Prevention of work-related accidents and illnesses	Health Employment Education Prevention Private Healthcare Companies	Collaboration in attention Risk prevention Safety training Attention Prevention and safety	The dominant sector is Employment and its ties with private healthcare and companies
Mother & child	Prevention and protection of groups at risk	Health Social Services Education	Prevention and Attention Services	Hegemony shared by health and social services
Violence	Improvement of attention in violence against women, children and old people	Health Social Services Police Women Justice Social workers	Attention Prevention attention policies Protection Integral Policies Protection, repression Participation	Hegemony shared between all sectors
Dietary safety	Guarantee harmlessness and healthiness of food products	Health Consumption Agriculture Environment Companies	Healthcare control and authority Defence of the consumer Control Contaminants and residues Self control	The dominant sector is health, with an important contribution from the others
Environmental health	Protection of the health of the people from the negative effects of alterations to the environment	Health Environment Industry Licences and activities Companies	Healthcare control and authority Control Self control	Shared hegemony
Immigration	Integration of groups of immigrants	Health Social Services Housing Education Employment	Attention/ public health Attention Facilitate access to housing Integration Insertion in the workplace	Hegemony shared between all sectors.

Experiences

Intersectoriality is an area that is relatively unexplored at international level, and also in Catalonia. One of the challenges to face in this area is, therefore, the analysis of the application of intersectoriality in real settings in order to be able to contrast it when held up against international literature as intuitive concepts, criteria derived from observation or empirical appreciation. We have not found studies with a scientific base that show in what measure intersectoriality is applied or should be applied, where its weak points lie, what are their causes and how they could be resolved.

INTERSECTORIALITY IN CATALONIA

Health plans

From the very beginning, the different health plans showed that the health of the population depends to a large extent on socioeconomic conditions, work, education, town planning, the quality of the environment, accessibility of healthcare services and social support, among other things. And that, furthermore, protection against environmental risks and the reduction of behavioural risk factors depend in many cases on decisions that are taken and actions carried out in sectors other than healthcare (environment, agriculture, industry, the interior, employment, social security, transport, economy, finance, etc).

It is for this reason that the LOSC established that the Health Plan should be the indicating instrument and frame of reference for all public actions in the field of health in Catalonia, recognizing the intersectorial nature of planning in health matters and acknowledging, at the same time, that in order to improve the health and quality of life of the population, it is necessary to act on all of its conditioning factors with the different sectors with responsibilities in the field of health.

In this sense, in the evaluation section of the 1996-1998 Health Plan, a section was included analysing intersectorial activities during the 93-95 period, covering the participation in the drawing up and application of the Plan of different departments of the Catalan Government and other institutions, namely:

- The Department of Education, with its programme for health education in school, to promote healthy lifestyles in schools
- The Catalan Institute of Road Safety, of the Home Office, to reduce traffic accidents.
- Department of Employment, for the prevention of risk in the workplace.
- Department of Justice, General Secretary for Youth, Department of Social Welfare and the Catalan Institute of Road Safety, for the prevention of consumption of alcohol and other drugs.
- Department of Justice for attention to minors in care with mental disorders
- Department of Employment for training and integration in the workplace of patients with severe mental disorders.

The management of intersectoriality is summed up, then, in two interdepartmental commissions and a number of meetings on the promotion of health, health in the workplace, drug addictions and maternal health.

In the section in which the strategies for developing health policies and services are established, however, emphasis was placed on the necessity to continue working with different departments of the Catalan Government, for the development of the interventions proposed and to initiate new lines of cross-sector collaboration to make progress in the application of the

Health Plan, and the following specific proposals were made;

- To develop intersectorial policies to reduce inequalities and improve health, working in coordination with the departments, institutions and organisms that have responsibility in the field of health.
- To stimulate intersectorial actions to promote healthy habits and lifestyles, primarily in the ambit of school, youth and the workplace.
- To stimulate intersectorial activities to promote a more healthy society.

On the other hand, the **1999-2001 Health Plan** established five instrumental acts of top priority, which were considered necessary for the achievement of the objectives put forward, one of which was cooperation and coordination between sectors in seven specific areas;

- Anorexia and bulimia
- Child abuse
- Environmental health
- Health and safety in the workplace
- Health in schools (PESE)
- Road safety
- Smoking

In another section, "The Health Plan in Catalonia beyond 2001", a historic evaluation was made of the planning process since the year 1993 with some reflections on intersectoriality which could be understood as "self-critical";

"With regard to the participation of other sectors, collaboration and collective work has been unequal, and has not reached the level which should be expected, considering the intersectorial and interdisciplinary nature that healthcare planning ought to have. On the other hand, the participation of the citizens has been represented by the organs of formal participation."

In the document "Evaluation of the objectives for the year 2000 of the Health Plan of Catalonia", in the chapter reflecting on what has been the process of planning for health in Catalonia during the period 1990-2000, it is stated that the focussing carried out in our country has permitted intersectorial work, but further on, when outlining key issues for the future, it is more critical;

"Intersectoriality and the allocation of resources are two crucial aspects for the development of the Health Plan, in which the role of political requests is key. While intersectorial involvement has to be present across all policies, until now, work with other sectors has been valuable but irregular. In order to ensure the viability of interventions it is essential to identify the resources needed and those responsible for carrying them out. Currently, there is a widespread preoccupation in the sense that the responses to health needs and the expectations of the public should be in harmony with the availability of resources, and it is recognized, more or less explicitly, that, it is essential to decide the allocation of resources destined to health keeping priorities in mind."

And as a line of progress the Cat-21 Plan is proposed, formulated by the previous government and based on intersectoriality.

“The new focus which is intended to be given to the working of the Administration of the Government of Catalonia and which is included in the reform project Governmental Plan Cat-21 attempts to improve the process of the taking of political decisions and the efficient allocation of resources in order to perfect the quality of service to the citizens and to guarantee the well-being of the people, social cohesion and the sustainable development of society. Interdepartmental work coordinated around common objectives constitutes one of the key aspects of the project. In this sense, this proposal for change to the Catalan Administration offers new opportunities for the inclusion of proposals of the Health Plan among governmental priorities and the consolidation of its intersectorial projection.”

Furthermore, it proposes a tool for leadership of the healthcare system over other policies;

“With regard to the future, there will need to be introduced what will be known as the evaluation of impact on health (Health Impact Assessment, HIA). This is based on the incorporation of an assessment of impact on health. When it comes to carrying out certain strategies and projects, identifying beforehand the possible adverse effects for health and how to overcome them by establishing corrective measures, the HIA is increasing in relevance in the European context and in other developed countries such as Canada, Australia and New Zealand. The European Union has proposed the challenge of promoting the HIA in its policies abed in the treaty of Amsterdam. It would be a question of instigating the development of the HIA in our own ambit to lend a greater degree of rationality to the decisions which are taken in different sectors.”

Finally, the 2002-2005 Health Plan situates intersectorial cooperation among its strategies for making effective its health policies. In this sense, after commenting on its importance for interventions on the conditioning factors and reminding us that the Health Plan is the indicative instrument and frame of reference for all public actions in the ambit of health in Catalonia, it states that;

“Considering the intersectorial involvement in the maintenance of the health of the population, the Health Plan stimulates work with other departments of the Catalan Government and other institutions involved in the ambit of health, which have participated in the drawing up and application of the Health Plan: The Programme of Education for Health in Schools (PESE) ascribed to the Department of Education, the Catalan Institute for Road Safety, ascribed to the Department of the Interior, the Catalan Women’s Institute, the Department of Employment, trade union organizations, the Catalan Council of Social Security and Health at Work, the Interdepartmental committee of Safety and Health at Work, the Centre of Medical Acknowledgements and Evaluation, the Directorate General of Juvenile Justice, ascribed to the Department of Justice, the General Secretariat of Youth of the Presidential Department, the Department of Social Welfare, local administrations and various non-governmental organizations for the development of activities of prevention of disease and promotion of health. It must be noted, however, that there are ambits in which the responsibility is exclusively that of the state Government (policy of taxes on tobacco, alcohol, legislation on transport matters, consumption of illegal drugs, social security policy, housing etc).”

And it acknowledges, further on, the weaknesses of the intersectorial approach;

“While work has been done with the participation of different sectors, this collaboration has been unequal and in the coming years it will be necessary to make advances in intersectorial involvement for the drawing-up and achieving of the objectives established in the Health Plan.”

Making a comparison between the institutions and administrative sectors mentioned in the present Health Plan, and those related to the 1996-98 Health Plan, it could be inferred that no substantial change has been produced in the approach to intersectoriality in the last few years. Furthermore, at the fringe of this declaration of intentions regarding strategic orientation and some partial mentions, also statements of intentions, intersectoriality is treated in a manner that is clearly insufficient in the objectives and interventions for tackling the various health problems in the 2002-05 Health Plan.

In a summary table the degree of consideration given to intersectoriality in the different health problems included in the 2002-05 Health Plan can be described. For this it has been taken into account whether, in the context of the expositional part, the need for intersectorial work is manifested or if in the objectives, activities or primary interventions parameters have been set that involve other sectorial policies.

Area	Consideration of intersectoriality in:			
	Expositional part	Operational objectives / activities	Priority interventions	Structure coordination
Smoking	+	-	-	-
Dietary habits	+	+	-	-
Physical exercise	-	+	+	-
Cardiovascular illnesses	-	-	-	-
Cancer	-	-	-	-
Respiratory diseases	-	-	-	-
Injuries caused by accidents	+	+	+	-
Injuries caused by violence	+	-	+	+
Mental health problems	+	+	+	+
Diabetes	-	-	-	-
Obesity	-	+	-	-
Excessive alcohol consumption	-	+	-	-
Consumption of drugs	+	+	-	+
Oral/dental health	-	-	-	-
Health problems related to locomotive apparatus	-	-	-	-
Health in the workplace	+	+	+	-
Diseases prevented by vaccination	-	-	-	-
Infection by HIV	-	-	-	-
Sexually Transmitted diseases	-	+	-	-

Area	Consideration of intersectoriality in:			
	Expositional part	Operational objectives / activities	Priority interventions	Structure coordination
Tuberculosis	-	-	-	-
Hospital infections	-	-	-	-
Maternal/infant health	+	+	+	-
Healthy ageing	+	+	+	-
Environmental health	+	+	+	-
Food safety	+	+	+	+
Food poisoning	-	-	-	-
Legionnaire's disease	-	-	+	-
Transmissible spongiform encephalopathies	+	+	+	+
Good use of medicaments	-	-	-	-

Out of 29 areas for intervention, only in 34% is reference made to the importance of intersectoriality in the exposition of the approach to the problem and its strategic orientation. In 48% some objectives or activities appear that require an organization from an administrative sector outside of health care. The priority interventions that require other sectorial policies number some 11 areas (38%). Finally, stable structures of administration of intersectoriality are maintained in 17% of the areas to be tackled.

These statistics do not offer an optimistic balance of the situation since the majority of the references to intersectoriality, above all in the expositions and the priority interventions, are merely rhetorical and declarations of intentions, without being confirmed in specific or evaluable actions that have repercussions for other sectorial policies. Furthermore, the majority of references to other administrative structures in the operational objectives and activities to be developed for the 2002-05 Health Plan, mention them passively. That is to say, in the majority of cases, the healthcare system foresees carrying out some public health activities, designed and decided internally, in the "territory" of other organizations (education, youth, etc), with a passive participation of public interest.

Worthy of separate mention is the practical absence of stable structures of coordination and management of intersectoriality.

THREE CASES OF MANAGEMENT OF INTERSECTORIALITY

The case of AIDS

Aids, because of the problems associated with it, both from a healthcare and a social perspective, is a good example of the necessity for all the agents involved in the fight against this disease to coordinate and draw up joint strategies.

We will now set out three initiatives of intersectorial work that are carried out in Catalonia on a regional and local scale.

Interdepartmental commission on AIDS in Catalonia, ascribed to the Department of Health

This commission was created by decree in the year 1999 (382/1999, 13th December) with the objective of facilitating the adoption and implementation of the measures necessary to avoid the propagation of the AIDS virus, the improvement of the quality of life of people affected and the continuity and creation of a favourable environment to accept those infected.

As specified in the degree, its functions are;

To coordinate and follow the activities of public administrations and non-governmental organizations and entities involved in the fight against AIDS, and to propose these corrective measures:

- To orientate healthcare policies that affect the fight against AIDS
- To analyse and evaluate the diversity of resources in matters of prevention, attention and treatment
- To formulate lines of action in the field of prevention
- To tackle the sensitisation and training of the people who give assistance to those affected by the disease, from different ambits

The commission is composed of people representing different departments of the Catalan government (Health, Welfare and Family, Employment, Justice, etc), representing town councils (through the Federation of Municipal Councils of Catalonia and the Catalan Association of Municipal Councils), of associative movements (through the Catalan Federation of Non-Governmental Organizations of Services on AIDS, and the First of December Committee Association) and "The AIDS network and the local world".

With the experience gathered since its creation, the Commission proposes a change in order to act more operatively and to respond to the needs and problems detected. Until now the Commission met once a year, but with the objective of being more operative they have decided to meet three times year and to create specific work groups to tackle and solve specific problems. These work groups will be set a time limit, they will analyse the problem, they will propose a strategy for its solution or improvement, and they will evaluate the result of its execution. After this, the group will disband.

AIDS network and local world: working in a network

This is a very recent initiative to promote the involvement of the local scene in tackling the HIV/AIDS infection. On 13th December 2004 the act of constitution was held of The AIDS Network and the Local World in Catalonia.

The local world is understood to be the territorial ambit that includes each and every one of the agents that are involved in it, be they public administrations, professional collectives, civil or social entities, giving it a community dimension, since the local ambit is the best place to find cooperation dynamics. Research into agreement on objectives is easier if a specific and practicable territory is marked, such as that represented by the local ambit. It is from this starting point that willingness is born and the creation of The AIDS Network and the Local World is justified.

From the local world work has been carried out since the start of the epidemic to prevent the disease, to sensitise the population and eliminate stigmatization, seeking the necessary political commitment. However; there has been no model to follow; nor have the opportunities of the different local worlds been the same.

The constitution of the network commits its members to:

- Define the bases for a common model of community intervention at local level, aimed at the prevention of AIDS and the treatment of related social problems.
- Give support to the agents who intervene in the local setting for the application of this model.
- Drive forward initiatives to favour the sustainability of intervention programmes
- Drive forward initiatives of intervention and common actions.

Given its condition of open and participative project, it is intended that the Network be administered by means of a formula similar to that of other networks of cities (sustainable, educative, healthy cities).

Action plan on HIV/AIDS in L'Hospitalet del Llobregat: a city approach.

Since the year 2001, L'Hospitalet del Llobregat has had a plan to face the problems of AIDS, to give solutions and offer answers.

The Plan enjoys the participation and consensus of all of the municipal political groups, in collaboration with the Hospitalet Technical Commission on AIDS. Taking part in this commission are representatives of the different public administrations (the Catalan Government, the provincial council and city council), in conjunction with technicians, professionals and representatives of NGOs that intervene on HIV/AIDS.

The philosophy of the plan is to be participative, people-focused, mutually binding, scientifically innovative, efficient and sustainable.

The mission of the Plan, when it was created in the year 2001, was to conceive a collection of short, medium and long term actions on HIV/AIDS related matters, for an initial period of four years (2001-2004).

Food Safety

Food safety can be considered a paradigmatic case of intersectoriality. In Catalonia, as in the vast majority of countries, sectorial initiatives have led to the establishment of independent activities of control of foodstuffs on the part of different responsible organisms from various sectors. These activities are the responsibility of different departments; health, agriculture, consumption and the environment. The functions of each one of them are well defined, but very different.

The analysis of the causes of the food crises that have occurred in the last decade, conducted by the European Union and by the WHO, coincide in detecting important deficiencies in the systems of control of foodstuffs. These deficiencies are fundamentally centred around three areas; scientific evaluation of risks lacking in independence, little management of intersectoriality and deficient and non-transparent communication about risks.

The proposals for advancement in food safety consist, in part, of measures to improve the management of intersectoriality. The supranational organisms identify that the division of responsibilities among various sectorial administrations leads to serious inconveniences (the price of non-intersectoriality):

- General lack of coordination
- Duplication of activities with inefficiencies
- Deficiencies in coverage
- Contradictions between different sectorial regulations and between the objectives of public health and the promotion of commerce and development of industry
- Unequal application of the mechanisms of control.

Any line of advancement must recognize that the control of foodstuffs is a shared responsibility that requires positive interaction among all the interested parties. In this sense, many countries have re-evaluated the way in which they organize their systems of control of foodstuffs. The current tendency in developed countries is to establish organisms of food safety to coordinate the official sectorial controls, as for example in Spain, Finland, Ireland, Luxemburg, Sweden, Greece or Great Britain.

The creation of the Catalan Food Safety Agency (CACSA), through Law 20/2002, ascribed to the department of Health, was devised in this context. It was concerned with trying to manage cross purposes, breaking with the traditional bureaucratic model, by way of the creation of an interdepartmental agency that would assume the responsibilities of the four departments responsible for food safety.

What it sought was the participation, in the strategic definition of food safety policy, of the economic agents, the various departments, the local administrations and the consumers via a

Management Council, as organ of management of the Agency. That implies a certain loss of control of the subsystem of Public Health, with the substitution of the hierarchical lines by self-governing powers, with the control of civil society. In any case, with this model a *de facto* increase was produced in the responsibility and the capacity for influence of the healthcare system since there was an increase in the capacity to intervene in other sectorial policies that make up food safety (animal and vegetable health, animal feeding, environmental contamination and labelling and information for the consumer).

In order to administer intersectoriality, three fundamental elements are proposed;

- The Management council, as an organ of government, counts on the participation of not only representatives of the Catalan government and local administrations but also that of representatives from organizations of farming professionals, of business men from the food sector, and of consumers. This act represents, in part, a sharp transference of power towards the civil society related with food safety, since it is not merely a question of consultative participation, but a sharp intervention in the design and execution of food safety policies in Catalonia.
- The food safety plan must include objectives to be achieved and the directive lines of deployment of programmes and activities developed by the different departments of the Catalan Government and the local administration. It must be an instrument of government and is subject to control by the Catalan Parliament.
- Co-ownership through the budgetary participation of the four departments involved in food safety in the financing of ACSA, was established at 55% on the part of the Department of Health, 25% from the department of Agriculture, orchard farming and fishing, 15% from the Department of Commerce, Tourism and Consumption, and 5% from the Department of Environment and Housing. This is one innovative solution within the Administration of the Catalan Government, since it is the only autonomous administrative organism co-financed by more than one department. It was considered that this "co-ownership" makes easier, conceptually, the "concession" of some functions of evaluation of communication of risk, of planning, of coordination and of supervision from the departments.

Food safety is, therefore, an area in which the management of intersectoriality is becoming a priority of the first order and to achieve it innovative mechanisms were sought.

health in schools

The Programme of Health in Schools

The Programme of Health in Schools, created by the decree of 17th March 1980 and ascribed to the Directorate General of Public Health of the Department of Health and Social Security, has as its objective the improvement of children's health in Catalonia, by means of tasks of prevention and promotion of health to be developed on the part of healthcare staff within the ambit of educational centres.

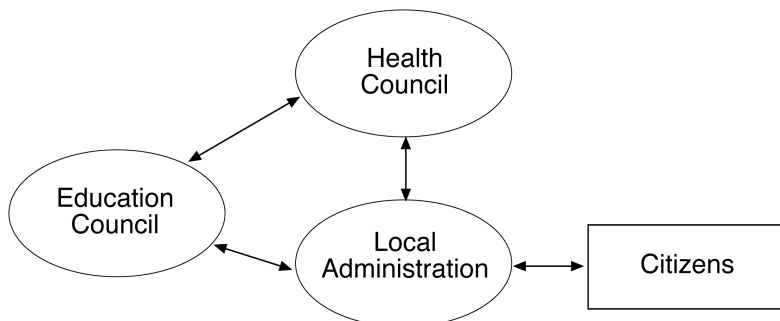
The planning and evaluation of the Programme are the responsibility of the Directorate General of Public Health, and its monitoring and control falls to the healthcare regions of the Catalan health Service. The execution of the programme in educational centres corresponds to the town halls by way of professionals from the corps of civil servants in the local administration or through staff contracted specifically to perform these tasks.

Until the present day intersectoriality in the Health in Schools programme has only come about as a result of the execution on the part of the town halls of the fulfilment of their obligatory commitments in all public and private teaching centres that impart general education and schooling to pupils aged between 3 and 16.

Municipal technicians have carried out the assigned tasks of protection and promotion in schools individually and have then communicated the data to the healthcare region of the Catalan Health service. The situation has been occurring in the vast majority of town halls in our country, although with the passage of time, in some town halls new formulae for interventions and/or actions have arisen, and healthcare professionals in primary attention centres are now the executors of the aforementioned activities in educational centres.

The town halls have been at the forefront of the Health in Schools programme in the centres, de-centralizing medical check-ups, vaccinations and healthcare education programmes. Their experience is considerable. Also, for the realization of healthcare education programmes, they have carried out research tasks in order to really get to know the problems surrounding the health of the scholastic population, in order to design and conduct healthcare education programmes and later evaluate them.

The Plan of intersectoriality in school health implies the participation therein of all agents who are directly or indirectly involved, and has come to be a process of collaboration between regional administrations, local administrations and the social agents. It must allow the sharing of responsibilities, resources, instruments, not only institutional and collective but also of individuals and families.



Education programme for health at school

By means of Decree 79/190 of 20th March of the approval and application of the Educational programme for health at school, which has as its objective the overseeing and incorporation of health education in all of its aspects (sexuality and emotional behaviour, eating habits, prevention of drug addiction, etc) in educational centres, in order that the educational community as a whole achieve healthy attitudes and lifestyles.

The Education for health at school programme is an interdepartmental programme between the Departments of Education and Health. Organically it is located at the Service of Special Education and Educational Programmes of the Directorate General of Educational Regulation and Innovation of the Department of Education. The lines of action are defined at the Interdepartmental commission formed by the heads of the two departments.

Intersectoriality in the Education Programme for Health at School is identical to intersectoriality in the programme for health in schools, which means that all of the interested agents must participate and arrive at a process of collaboration between the regional and local administrations, having to share responsibilities and resources.

Health and School Programme

In the month of October 2004 the Project "Health and School" was presented, which has as its objective the improvement of the health of adolescents through actions of promotion of health, prevention of risk situations and early interventions/actions on health problems related, respectively, to mental health, emotional and sexual health, consumption of drugs, alcohol and tobacco and eating disorders.

This work proposal is not new, the cooperation between the department of Health and the Department of Education will serve to reinforce the experiences that are already occurring in the ambits of health and education, among which we can point out; educational psychology assessment teams, activities in schools health conducted by town councils, activities of some primary attention teams and the experiences of professionals from the ambits of education and health.

So we can confirm that this new programme that has been devised is a reality of intersectoriality, in which all of the interested parties are involved: Department of Health, Department of Education, town halls and social bodies.

CONCLUSIONS

1. There is a broad consensus, in the subsystem of public health, on the necessity for intersectorial action to be able to confront health problems.
2. The practice of intersectoriality in Catalonia when it comes to tackling the different health problems of the population is not governed by any global strategy, but is rather insufficient, fragmented, reactive and unequal.

3. Nevertheless, there are, in our country, firm examples of interest that must be analysed in depth in order to take from them practical knowledge applicable in different situations.
4. In any case, the analysis of the results of intersectoriality is made difficult by, among other things, the lack of studies of its management with a scientific basis.

RECOMMENDATIONS

1. In dealing with intersectoriality it appears to be necessary to make the transition from conceptualization and discourse to specific actions. It is necessary to stimulate intersectoriality within a strategic approach to the treatment of health problems. Furthermore, whenever confirmable results have been produced, advances must be made in order to perfect them, seeking a relationship which is integrated, conscious and interactive.
2. An in-depth analysis must be produced to identify those health problems for whose solution intersectoriality becomes fundamental.
3. The existing studies of intersectoriality must be studied, above all in Catalonia, to identify the strengths and weaknesses and draw conclusions that permit its improvement.
4. Intersectorial actions should not be reactive relationships between different sectors of the Administration to solve specific problems but a joint effort to promote policies that produce health improvements where all the sectors involved benefit. That is to say, situations in which the participating sectors identify the benefits of working together for their sector, and that create frameworks to facilitate changes in the desired direction.
5. Global strategies must be established for the country, but which can be translated into operative projects that must clearly define:
 - a) Common objectives and objectives of interest for each sector
 - b) Sectors that will intervene
 - c) Agreed methodology of work
 - d) Activities that will be developed and carried out
 - e) Resources that each will contribute
 - f) Leadership and mechanisms of coordination
6. It would be best to make the most of regulatory mechanisms that permit the intersectorial approach to health policies and that give support to the different strategic plans.
7. Stable structures must be created, in some cases, with organizational repercussions, to manage intersectoriality and take responsibility for guaranteeing cooperative work of the different sectorial administrations.
8. There must be improvement in the training of people in the sector of public health, but also in the rest of the sectors, so that they acquire the skills and abilities necessary to work in an intersectorial setting.

9. Intersectoriality must be produced at all administrative levels, and must count on the different representatives from civil society.
10. Research into intersectoriality must be encouraged, analysing the results of its real application, to what extent it should be applied and evaluation of the elements that make it difficult.

PUBLIC HEALTH TRAINING IN CATALONIA

Fernando G. Benavides

GENERAL CONSIDERATIONS

This proposal takes as its starting point the need to establish a strategic alliance between academics and professionals, an alliance which foments synergies between the two, overcoming the existing mistrusts, and in which activities of training, research and investigation form part of the career of public health professionals. Furthermore, teaching and research activities carried out in academia circles must be relevant to the health problems and requirements of the population.

Public health activities, just as any other service activity, are principally based on the intensive use of human resources. Therefore, the quality of service in public health depends directly on the competence of those professionals practising in that field. In this sense, one condition necessary for the reform of public health services is the existence of competent professionals (Benavides, 2002).

So, as has been pointed out recently (Beaglehole et al., 2004), the current training programmes for public health professionals have to be adapted to the new problems and challenges in public health in the 21st century: possibly irreversible environmental changes, the ageing of the population, migration on a wide scale, to which must be added increasing social inequalities in health, partly brought about by new factors of a psychosocial nature. On the other hand, training programmes on public health are too much oriented by the academic agendas of the researchers, primarily directed at biomedical research.

The public health professional that we need to confront the new challenges must have the ability to collaborate with other disciplines and have a bearing on decision-making in political and administrative spheres. The focus on factors of biomedical and individual risks (cholesterol, hypertension, etc.) must be complemented by another, wider vision that connects with the complexity of the social, economic and political factors that directly or indirectly influence the health of populations.

In addition, public health, as opposed to other areas of healthcare activities, has several specific responsibilities which are developed from local levels. These responsibilities are not only executive in nature, but also, in many cases, "regulatory", ensuring that town or city councils have the capacity to give ordinances on these matters. At local level, often political activities are confused with technical activities. It is, therefore, important to point out that the limitation of resources adds to this confusion of roles. So it is relevant, more than in any other area of healthcare, to consider agreements and bonds between the academic world, the political world and the local professional world in order to formulate programmes that make training accessible in this field.

The necessary multi-disciplinary nature of public health is reflected in the diversity of backgrounds of its professionals, whether from healthcare sectors (doctors, vets, pharmacists, nurs-

es, psychologists, etc.) or from outside of healthcare (economists, legalists, sociologists, etc.). This diversity, imposed by reality, leads us to define certain basic *professional competences* (Segura y Benavides, 2000), common to any *public health professional*, regardless of the field in which he or she works (public health control, health protection, healthcare administration, etc.).

These professional capacities must serve to meet the new challenges, and therefore which must include skills and knowledge related to modern public health practice, with the ability to lead in the healthcare system, to collaborate with other social sectors, outside of the healthcare system, and with the organisations of the community, besides having the capacity to understand and act on actions stemming from political processes.

These professional capacities must be “acquired via an ongoing, quality process of teaching-learning, based on the best available scientific evidence (Fielding JE, 1999). This means, among other things, that conducting and interpreting research is an essential part of the training and practice of any public health professional, but without losing sight of the fact that the *raison d’être* of the professional is to improve the health of the population, by converting scientific knowledge into actions which protect and promote health. Actions which must also be systematically evaluated.

In accordance with these premises, research, training and professional practice constitute a circle of expertise to continually improve the health of the population.

Furthermore, the central professional competences can help us to establish a sense of belonging to the public health profession, and at the same time, must be revised periodically (Segura et al, 2004), revisions in which professional organisations, such as the Society for Public Health in Catalonia and the Balearics should also participate. The public health professional should see himself as a specialist in his own right, not as a medical specialist, however closely associated with the healthcare system.

One guarantee of the maintenance of professional competences throughout the professional career is *periodic re-accreditation*, which should initially be voluntary, and then after a trial period a study should be carried out into making it obligatory. Ongoing training programmes will be a key element, but not the only factor, in this process of periodic re-accreditation. Professional experience and research should be the other parameters in professional re-accreditation.

To sum up, training, research and innovation constitute key elements for the efficacy and viability of the public health system.

ANALYSIS OF THE SITUATION IN CATALONIA

The training of the majority of public health professionals in Catalonia has been, until recently, mainly anecdotal and autodidactic in nature, in which time spent at universities or centres abroad were the usual alternatives if one wished to receive quality training. This has succeeded in creating a distance between public health professionals with a high quality training, who work

mainly in the academic world, and other professionals whose training was of a lower quality. A hypothesis which ought to be verified, and if this distance is shown to exist, it should be reduced as quickly as possible.

Other circumstances, such as individualized work or work in isolated territories, increase the distance between the academic and scientific world and the professional world.

The creation of the University Institute of Public Health of Catalonia (ISP) in 1995, as a consortium involving participation by the Department of Health, Barcelona City Council and Barcelona university, represented the most notable effort yet seen in Catalonia to improve the quality of training and the quality of public health professionals. But sadly it did not prosper. A detailed analysis of the causes of its failure has yet to be carried out, which would doubtless help us to improve the future of teaching and research resources in public health in Catalonia. The existence of approximately 60 public health schools in Europe and 30 in the United States (Beaglehole and Bonita, 2004) obliges us to rethink this option.

Despite this negative fact, the organisation of the **Masters degree in public health** since the year 2002 by the Pompeu Fabra University has given continuity to this effort, begun in 1989 by the University of Barcelona, followed since 1993 by the IES and which from 1995 until 2000 was developed in the ISP, together with other training programmes, covering a range of aspects of public health (diplomas in health, Diploma in health and the environment, Diploma in veterinary public health, besides other permanent or in-depth training courses).

In the consolidation of the current Master's degree in Public Health programme, it is worth noting the recognition it has received from the National Commission on the Speciality of Preventive Medicine and Public Health as a valid programme for the MIR of the 5 teaching units presently accredited in Catalonia: Vall d'Hebrón (3 MIR), Clínic (2), Bellvitge (3), IMAS-UPF-ASPB (3) and Sant Pau (1). These Teaching Units should be audited in accordance with the new programme and accreditation criteria that were recently approved.

The UPF's Master's degree in Public Health programme is given a solid institutional and economic stability by the participation in its organisation of an array of key institutions in the professional practice of and research into public health in Catalonia. These institutions include the Public Health Agency of Barcelona, the Municipal Institute of Medical Research, the Universitat Autònoma de Barcelona, the Catalan Institute of Oncology and the Institute of Health Studies, along with other collaborating institutions such as the Consortium of Hospitals in Catalonia, the Agency for the Evaluation of Medical Technology and Research and the Health, Society and Innovation Foundation.

Along with this Master's degree in Public Health, there are other programmes on more specific aspects of public health, organized by the various universities and institutions of Catalonia, such as the University of Barcelona's Master's degree in preventive medicine and promotion of health and Master's degree in nursing in community and public healthcare, and the Universitat Autònoma de Barcelona's Master's degree in international health and tropical medicine and Master's degree in research methodology. Besides these there are also programmes on the economy of health, administration of healthcare services and public policies, organized by the

Pompeu Fabra University. In table one there is a selection of some of the features of this wide range of available courses.

Apart from the aforementioned Master's degree programme, there are three doctorate programmes related with public health, organized by the University of Barcelona, the Universitat Autònoma de Barcelona and Pompeu Fabra University.

The doctorate programmes have long been considered as one more stage in training, open to all professionals who want to improve their professional competences, not just those professionals, always fewer in number, who wish to pursue a career in teaching and research.

Finally, the range of courses of ongoing training on offer is increasing becoming ever wider, a large part of these being specific in nature. Of a more systematic nature we should highlight the programme offered by the IES (which could be integrated as a part of the Master's degree in Public Health) and that of the Centre of Collegiate Studies, and more recently the programme offered by the Public Health Agency of Barcelona and the Johns Hopkins Bloomberg School of Public Health (see table 3).

SHORT TERM (2006) AND MEDIUM TERM (2010) STRATEGIES

One key element in the improvement in quality of training programmes on public health is to closely link public health training to professional practice in public health, not only in order to train new professionals but also to bring up to date the competences of active professionals.

The voluntary accreditation of the quality of teaching programmes on public health on the part of the Administration is a key way to improve these programmes. The revision of the units living training on preventive medicine and public health which the Administration is obliged to carry out may serve as a could example of how to develop this function.

At the same time, the Administration has to establish a professional career in public health based on professional activity, ongoing training, and research carried out, identifying different levels throughout the professional's career. An example is provided by the experiences already seen in institutions of healthcare attention.

Ongoing training programmes must be defined and prioritized in accordance with existing needs and problems, but also the demands of the professionals themselves must be born in mind. Furthermore, these programmes must be accessible, and it is advisable that senior professionals involved in the performance of services participate in their development. Distance learning or courses combining distance learning and attendance have a significant part to play in these training programmes, although courses requiring attendance have the added advantages of personal contact between the professionals themselves which are for the moment irreplaceable.

An important point lies in the fact that the new professionals who undertake tasks of public health must have received a basic training in public health, the equivalent at least to a Master's

degree (within the new European Higher Education Area), independent of their previous qualification (in medicine, veterinary medicine, economics, nursing etc) and of the specific tasks that they will have to perform.

Finally, public health training, both basic and ongoing, must have a significant research component, not only quantitative but also qualitative, which gives the public health professional the necessary capacity to face up to problems, both new and old. This means disposing of finance, through grants, to complete Masters' and doctoral theses, within the framework of the research projects conducted by the institutions involved in the training.

In the development of this strategy there are strengths and weaknesses. Among the former, we can stress that:

- The current range of training on offer in Catalonia may be considered wide and of high quality, even though it still needs to be adapted to the professional competences that have been identified.
- The deployment of the new European Higher Education Area, accrediting the Master's degree in public health and related areas, can help to renew and improve the quality of the training programmes.
- The existence of different research groups consolidated in Catalonia.
- The recent reforms in the MIR programme of preventive medicine and public health, now approved by the Human Resources commission of the SNS
- The willingness to develop the specialization of nursing, in which would be included the specialization of public health nursing.

Among the weaknesses we should point out that:

- The current range of training on offer is scattered and designed more with regard to academic criteria than to the needs of the professionals and system of public health.
- There has not been an identification of priorities in research and training in public health on the part of the administrations (autonomous, provincial and local) with responsibilities for public health which would help to establish training programmes.
- The diversity of the academic backgrounds of public health professionals (social sciences, experimental sciences, medical sciences, etc) often makes communication and even collaboration difficult between them.
- The complexity, and at the same time the specific nature of some public health tasks makes the designing and deployment of training programmes difficult.

KEY ACTIONS TO BE CARRIED OUT IN ORDER TO FURTHER THE IMPROVEMENT OF PUBLIC HEALTH TRAINING

1. Definition of the criteria and procedures for accreditation for public health training programmes, especially Master's degrees and doctorates. This accreditation need not necessarily be obligatory.
2. Coordination and inspection of teaching units on preventive medicine and public health presently accredited in accordance with the new criteria approved by the National Commission on Preventive Medicine and Public Health.
3. Increasing the number of MIR places for preventive medicine and public health.
4. Revision of professional competences in public health, an activity which could be led by the Public Health Society of Catalonia and the Balearics, bearing in mind the different groups of professionals working in public health.
5. Setting up of an ongoing training programme aimed specifically at those professionals operating at local level, away from the centre of the system, according to their needs.
6. Definition of the professional career in public health, to bear in mind training, research and professional activity in its promotion, and not just seniority.
7. Definition of a process of periodic professional re-accreditation, for example every five years, initially voluntary in nature, which should be conducted by an institution independent of the Administration.
8. Creation of an official register of public health professionals.
9. To dispose of financing for the completion of Masters' and doctoral theses related to the needs for research identified in the field of public health.
10. To take full advantage of the definition of the European Higher Education Area to develop the Master's degree in public health, adapted to the needs and challenges of public health in the 21st century.
11. Definition of public health nursing as a speciality.

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Table 1
Programmes for the Master's degree in public health and related topics in the universities of Catalonia

Organizing institution	Programme	Credits	Duration	Final stage
Pompeu Fabra University	Public Health	80	1 year (possibility of doing it in 2 years)	On-site
	Economics of Health and Medication	42,5	-	Distance
	Administration and Management of Healthcare Services	40	1 years and a half	On-site
	Social and Public Politics	95	2 years	On-site
University of Barcelona	Preventive Medicine and the Promotion of Health	30	2 years	On-site
	Community and Public Health Nursing	70	2 years	On-site and distance
Open University of Catalonia	Master's in clinical management of public health services. Diploma in the Evaluation of Healthcare Services	Various options Master: 60 credits(=1.500 hours)	2 years	Not on-site
Universitat Autònoma de Barcelona	Diploma and Master's en research methodology: design and statistics in health sciences	Diploma: 30 Master: +24 (1 credit = 20 hours)	4 years	Not on-site
	International Health and Tropical Medicine	50	1 year	On-site
Institute of Health Studies	Diploma in Healthcare	25	1 year	On-site in Barcelona, Lleida and Girona
Virtual School of Health (CHC-Central University of Barcelona)	Master's in administration of health-care centres and services	?	2 years	Not On-site

Table 2
Doctorate programmes in public health in the universities of Catalonia

Institution	Programme	Characteristics
Pompeu Fabra University	Health and life sciences, public health itinerary	http://www.upf.edu/cexs/doctorat
Universitat Autònoma de Barcelona	Public health and methodology of biomedical research	http://www.uab.es/servlet/Satellite?cid=1090073549391&pagename=UAB%2FPAGE%2FTemplatePageLevel2&param1=DoctoratProgrames&param2=1090573141841
Universitat de Barcelona	Public Health	http://www.giga.ub.edu/acad/cgi/bienco20_99.pl?pr=D10812&accurso=20032

Table 3
Programmes of ongoing training in public health in Catalonia

Institution	Characteristics
Institute of Health Studies	http://www.iesalut.es
Publish Health Agency of Barcelona/ Johns Hopkins Bloomberg School of Public Health	http://www.jhsph.edu/Dept/HPM/Non_Degree/institutes/index.html
Centre of Collegiate Studies (Col. Medicine BCN)	Hi ha alguns cursos de metodologia i de matèries afins a la SP. http://www.comb.es/cat/serveis_profes/cec/cec-Page-T_cursos_cat_menu-cursos_1035979309944.htm

PUBLIC HEALTH RESEARCH IN CATALONIA

Xavier Bosch

Collectively the public health research teams in Catalonia constitute a powerful group, with some areas of international impact. Internally they are little known among the doctors and logistically the groups are located in various institutions.

A significant proportion of the decision-taking arenas on research topics are linked to political life and its vicissitudes, and administratively, suffer from a management of resources which is not well adapted to the characteristics and priorities of research. One example is the displacement of certain professional profiles in the context of hospital organization schemes, particularly of the non-medical professionals.

IDEAS FOR THE REINFORCEMENT OF RESEARCH IN PUBLIC HEALTH.

Consolidated research groups

To identify those groups performing research activities in public health. In Catalonia the research groups in public health currently number five, located at IMIM, ASPB, ICO, Hospital Clínic and the Department of Health. In the last few years they have been structured within the Network of Public Health promoted by the Carlos III Institute. These groups must be sources of topics for final papers and theses for students in public health and administer research training of health-care staff.

Associated healthcare groups

To identify groups conducting healthcare activities close to the area of research who could be associated with research activities. Groups of this type are, for example, those related to the control of diseases, environmental health, administration of healthcare statistics, among others.

Among the possible activities of these groups we included the expansion of the base for collecting and administering healthcare information, the generation of study hypotheses and collaboration in the development of research projects.

It would be very useful to create a series of incentives of promotion and prestige for health-care workers who offer occasional participation in research programmes.

Activity of identification of healthcare problems meriting research activities.

It would be useful to propose a discussion on important areas in public health that are, or are perceived as being, insufficiently covered by the present research activities and that in some

sector of society tend to be seen as priorities. An example of this debate is that which is regularly offered by the Agency of Evaluation of Medical Technology and Research in Catalonia in the months prior to conferences on research aid. The objective is to perfect the balance between what the researchers want to investigate and what other sectors would like to see investigated.

Examples of this type of interaction were produced most notably in the demand for research into the effects of microwaves and some malignant tumours, toxic waste at Flix, the control of outbreaks of legionnaire's disease, prionic disease and the food chain, and others.

International presence and visibility

It is important to develop activities of communication and scientific associations with leading research groups. Contacts with European organizations of collaboration in Catalonia and international project partners should be encouraged with special aids.

Generation of research funds in Public Health in Catalonia

To generate attractive grants with an annual conference. This type of support gives credibility to the project and stimulates the presentation of projects. It is important to integrate this with the funds established by the financing of research with administratively flexible agreements between the FIS, networks and local organisms

Role of the Public Health Agency of Catalonia

The structuring of the Public Health Agency of Catalonia on research topics can help to articulate and promote the abovementioned activities. It is important not to add to the administrative complexity by duplicating some of the many efforts made in the country with this end.

Possible peripheral activities of research support:

- Organize debates on public health and research. They could have a certain regularity, renown and public resonance, and associated publications
- Administration of the Office of International Relations by the Circle of Opportunities, Influence and Finance of Research Projects in Public Health
- Creation of a bank of work and training opportunities
- Calling of aids for research, methods to be defined (projects, requested projects, support to consolidated groups or others)

CIVIC PARTICIPATION IN THE DEVELOPMENT STRATEGY OF PUBLIC HEALTH IN CATALONIA 2010

Andreu Segura

INTRODUCTION

Etymologically, to participate means to take part, to contribute to the construction of a common enterprise which, in the context of this document, is the health of the population. The purpose of participation, therefore, is the improvement of health, but if we understand that health is also a collective matter, then participation becomes an indispensable element in its own right. A participation which is an expression of the empowerment of the public with regard to the factors that determine their own health ^{*1}. Civic participation ^{*2} in the arenas of health and the public healthcare system shares some characteristics common to any other arena, but also has some which are specific to those fields.

The degree of participation by citizens in collective matters is an indicator of the democratic development of society. This characteristic is in effect a civic right, so that administrators must favour the existence of the channels and procedures that facilitate this participation ^{*3}.

It is realistic to assume that the primary motivation for participating - independently of the rational decisions that hold sway in the construction of democratic societies - depend on some tangible benefit to be gained that compensates the effort entailed by the act of participation. The tendency, shown by humans and all social creatures, to feel themselves integrated in the group itself, gives material satisfaction in a way that contributes directly to the survival of the species. A tendency which, in the context of the chaos of humanity, also implies moral well-being and social cohesion.

The evolution of human cultures, the growth of societies and the increase in the complexity of organizations, implies substantial modifications to the very nature of communities, and impedes the attainment of the benefits attributable to participation. Differing objectives appear, at times contradictory, which give rise to conflicts of interest and confrontations. The sense of participation is also diversified according to the defence of personal interests. The existence of con-

*1 "Empowerment" is one of the elements essential to the promotion of health

*2 The adjective "civil" is used instead of the word community that figured in the preliminary version of this document because it is difficult to operatively define the community, since in a population various communities can coexist (M. Lluïsa Vázquez) and also because it has more tradition (J. Martínez)

*3 It is a right because all must be able to contribute, but it can also be considered a duty, because without participation the democratic nature of the political organization of the community cannot be maintained. Nevertheless, various correspondents deny that it can be seen as an obligation. The difference in criteria surely reflects the degree of responsibility held by individuals and institutions. However, despite the fact that individual responsibility may be less, as people we have some responsibility for the political organization of the society we live in.

flicts of interest and of confrontations is, therefore, a key element, which must be taken into account in order not to fall into assumptions which are naïve – based on a simplistic concept of altruism – or hypocritical, which end up being obstacles to participation. The participation of citizens enables us, in fact, to face these conflicts of interest in an open manner.

All of which is not unconnected with the generalized deficit in civic participation in collective matters, which in countries with democratic regimes is manifested in electoral abstention, low membership of political parties and trade union organizations, among other things. This situation reflects these institutions' lack of adaptation to social transformations, resulting occasionally in obstacles to participation.

Various authors have studied the evolution of civic participation in Catalonia, using analyses that take into account, among other aspects, the existing limitations, ultimately a consequence of those who seek political or economic power; of the hidden agendas of groups or institutions who feel their interests threatened by the participation of others; and of the tendency for people to be inhibited by the lack of guarantee of achieving individual or collective benefit. Individualism is, also, a widely promoted cultural value. On the other hand, the legally established channels of participation are often too bureaucratic and restrictive, not dynamic and hardly, if at all, binding. Lack of confidence in the possibilities of participation is a general feeling. Studies that consider the various alternatives and that in general signal the importance of the local ambit to develop, experiment with and evaluate new formulae for participation. A bibliography that merits particular attention when formulating specific strategies in the area of health and public health services

As far as we can perceive, the natural ability of humans to recognize and identify with others is limited to some one hundred and fifty individuals¹⁰. The creation of cities some 10,000 years ago meant the emergence of new forms of relationship and the tendency to form subgroups, for example neighbourhoods^{10 11}. Participation, then, is more intense in groups of reduced dimensions, so that the smallest demographic and territorial units are ideal for experiments with direct activities of participation. The larger the groups, the more complicated the formulae for participation become and the greater the need for indirect procedures to make them possible, even though new advances in communication technology permit the development of instruments of participation that bring closer those who are physically remote.

SCOPE AND PECULIARITIES OF PARTICIPATION IN THE AMBIT OF HEALTH AND THE PUBLIC HEALTHCARE SYSTEM

Since the health of populations and people does not depend solely on healthcare interventions, but is also sensitive to determining biological, social and environmental factors, the improvement of health is not attributable exclusively to the interventions of the health system, and less so to the element of personal attention. Moreover, the activities of the public healthcare system can cause problems for the health of individuals and populations. Not just as a result of the secondary effects of healthcare interventions, which are rarely innocuous, nor medical errors¹², but also as a result of the inadequate use of healthcare services and the lack of indirect interventions¹³.

That said, in the case of health, participation has the potential to improve the health of individuals and populations because it implies a greater involvement. It would be, then, a desirable characteristic for a utilitarian point of view. But the fact is, depending on how we view health, that participation is a necessary element for the achievement of autonomy and to practise solidarity, two characteristics which the definition of health of the Tenth Congress of Catalan-Speaking Doctors and Biologists attributes to health. Autonomy to live in the least dependent way possible and solidarity with the rest of the components of the community. So, as regards health and civic participation, one can not limit oneself strictly to the area of healthcare systems, but one must also take into consideration a combination of factors that have a determining influence on the health of individuals and populations. A community perspective that is natural for public health, which, despite being largely developed by the healthcare system itself, occupies a frontier post between society and the healthcare system.

In any case the healthcare system as such deserves a special consideration, being recognized by society as one of the principal elements for controlling health problems and also because it is the healthcare system itself that suggests the benefits of community participation. In this sense a clear distinction between public health and the rest of the healthcare system could lead to confusion because the interests of the population do not easily encompass demarcations that do not correspond directly with their needs. For this reason we professionals should not subordinate participation in our schemes.

Civic participation in the ambits of health and the healthcare system faces the same obstacles as social participation in general, but also others that are specific to the field. Firstly, the technical complexity of health problems must be taken into account – the requirement for professional knowledge and skills and the fact that contributions from those outside the profession are limited, a limitation whose effects are artificially aggravated by the use on the part of the professionals of a lexicon that excludes others.

Secondly, the complexity of the present healthcare systems and organizations and, from the point of view of healthcare policy, the lack of clarity when it comes to outlining general objectives which are essentially non-technical in nature.

Thirdly, it must not be forgotten that health and sickness are phenomena that provoke personal anxiety and accentuate the reactive nature of many responses, biasing participation towards an individualized view of personal experiences regarding health and health problems.

Just one of the means of community participation to have been developed is associations for the sick and relatives of the sick who suffer from chronic illnesses and so-called self-help groups. They are laudable examples of participation for the way in which they imply the active assumption of responsibilities regarding the individual's own health or that of those close to them and, in general, represent necessary and useful initiatives, although they can cause conflicts of interest with other associations and with the community as a whole. Although these conflicts may be for the most part legitimate and logical, these associations are susceptible to manipulation, whether by healthcare workers themselves, be they professionals or institutions like the pharmaceutical or electromedical industries, or by those with political objectives, susceptible to political partiality. Both cases involve assuming more attention or resources than would normally be allocated if assigned following global criteria.

POSSIBILITIES OF CIVIC PARTICIPATION IN THE SPHERE OF HEALTH.

Although it is possible to imagine some possibilities for community participation from the perspective of public health itself, trying to put oneself in the position of the community in order to improve its health, it should be born in mind that the perspective from which these considerations are made is that of the professionals; so that at least in part there is a certain substitution which, taken to its extreme could be translated into usurpation and alienation - in the Marxist sense of the word - of the kind that Ivan Ilich¹⁴ denounced.

It could be supposed that this attitude is justified, since the professionals have more knowledge and competence to resolve health problems. But this is not always the case. Independently of variability in healthcare practices, above all in clinical practice, which at least partly depends on the professionals themselves, these have received a training which is basically pathology-oriented, and, moreover, with a predominantly biological perspective.

So, the issue is the assumption of an equilibrium that allows the harmonization of the knowledge and competences of the professionals with the participation of the citizens. For that reason it is preferable that, together with proposals for participation as suggested by the professional world and by democratic administrators, the direct participation by the community be promoted.

In any case, one should bear in mind those functional areas of public health in which there is scope for community participation, those which are concerned with the formulation of policy and those related to services administered to the population, and those territorial ambits where the se services are put into effect.

Regarding healthcare systems, the ambits of community participation may take in the most political area, in the sense of establishing priorities and formulating objectives, such as the area of healthcare services administered to the community. When considering public health in particular, these more functional areas are specified in the design of strategies and the provision of specific services of promotion and protection of health which are themselves community-oriented.

In this case the expression, more or less active, of preferences regarding the priorities and objectives of the intervention programmes designed to meet health problems; regarding the nature of organizations or services; or, also, regarding the characteristics of supplies, is an opportunity for participation. An expression that can be manifested by elections, by opting for the alternative proposals put forward by various political powers, in the case that the differences between these proposals are clearly explained, something which by and large tends not to be the case. Generally speaking, everyone offers a lot, and of everything.

The healthcare services also form a part of the plans for social and urban development. Some projects of this kind in the city of Barcelona have enjoyed the collaboration of professionals from first aid teams and from civic entities in the so-called Nuclei of Participative Interaction (NPI). The active contribution to the decision-making process which is necessary in order to explicitly choose priorities and to select the health objectives of healthcare intervention programmes could be performed by means of consultation procedures organized to that end. Experiments of this kind can be geared towards the evaluation of the relative importance of current health problems, with a view to arranging them in a chronological sequence in order to deal

with them one by one, or this evaluation could be restricted to those problems of which there is evidence and which are susceptible to interventions.

One known trial of participation in the choice of which interventions would be entrusted to public services was conducted in the state of Oregon ¹⁵. Other international experiments of participation in healthcare planning are being carried out in Brazil ^{16, 17, 18}.

Another form of participation in the arenas of politics and strategy could be the practice of criticism which, naturally, is not only limited to these situations. In the most general definition, criticism implies an assessment, well-founded or not. In general the procedures for knowing the criticisms and opinions of the community are limited to the possibilities for appeal, or to complain, or suggest, that are legally established for all public services, including healthcare – although in the sphere of healthcare the formalisation is more general – or consultation of public opinion in the form of surveys, usually of satisfaction, regarding services. Surveys whose prestige and usefulness is open to question. But also other forms have been tried, such as the people's tribunals in the United Kingdom, in which a group of people from the community who are remunerated for their participation give rulings on health problems and the interventions for controlling them ¹⁹.

Methods of qualitative research permit a more rigorous utilization of opinions, evaluations, criticisms, preferences and expectations. Thus, from Delphi-type studies to nominal groups, passing through a wide range of procedures, it is feasible, to use different consulting groups, from those that are more or less representative of the community to those that are specifically chosen for a strategic purpose: leaders of the community; professionals from related disciplines, etc.

In order that contributions of this type - which, naturally, are voluntary – are not sporadic or too much related to particular interests, it is necessary that they have palpable repercussions, that is, that they serve to modify those services or strategies that are being evaluated. Therefore the participation in consultations must count on the commitment of those who organize them and those who take part.

In the ambit of collectively administered services of promotion and protection of health that fall within the domain of public health, various forms of participation are also practicable which can range from total self-administration to proposal, criticism or collaboration.

The self-administration of programmes of promotion and protection of health is that which corresponds to community groups that organize themselves in order to carry out interventions designed to improve or preserve health. The promotion of this kind of participation could be done by way of project meetings, with the establishment of incentive, either financial or of another kind, for the best proposals or results.

One form of participation that has been developed from differing viewpoints and under different names ^{*4} is participative research based on the community, which seeks to return research to the community ²⁰; the basic characteristics of this are; that it is a participative research; cooperative in nature, involving the members of the community and the researchers in

^{*4} Among the various denominations of this mode are; participative research, action research, mutual investigation or participative feminist research

a joint process in which all contribute equally; one which permits mutual learning; that implies the systematic development and the construction of the community's local capacity for decision-taking ; empowerment via a process in which the participants can increase control over their own lives and which assumes an even balance between research and action ²¹.

Although no record of experiments of this type has been published in our country, it is probable that some attempts have been made. In Barcelona, for example, one association, "Barceloneta Alerta", was created with the principal purpose of resolving the problem of old people who live alone in the higher floors of apartment buildings with stairs but no lift, and in precarious conditions. The members of the association, in which representatives of the EAP of Barceloneta / Medical Services participated, designed a research protocol in which volunteers from the neighbourhood participated jointly with the researchers ²².

Just recently a book was published that goes over the theoretical and methodological bases, as well as the difficulties of various experiments ²³. This approach requires, in addition, the adequate training of the professionals which should be started in pre-degree programmes, for which reason it is necessary to confront the barriers that complicate its implementation ²⁴.

The proposal of projects for the promotion or protection of health implies a different commitment because it is understood that it is the public services that will have the duty of carrying out those projects that receive the go-ahead from the competent authorities, which could also receive the participation of people and entities from the community as members of supervisory committees.

The direct collaboration with projects already established with a greater or lesser degree of participation also offers possibilities for involvement. The nature and scope of the participation can vary greatly. Although the adherence to experts' recommendations, as occurs when groups of healthcare professionals issue proposals for modifications to so called lifestyles, personal behaviour relating to diet, physical activity or the consumption of legal or illegal drugs. In any case it would be a very weak form of participation, even though in order for recommendations to be in some way successful, adherence to them would have to be voluntary.

So that participation can have its maximum effect, and in order to avoid some of the problems that can be caused by abstract decision-taking - namely that when the time comes, the decision taken is not adhered to - it must be ensured that it is conducted responsibly, that is to say, being prepared to accept the consequences.

Besides, it must be remembered that the first source of healthcare information available to patients are doctors (in 94% of cases, according to Demoscopia's 2002 survey) ²⁵, so that the collaboration of the clinic must be kept in mind. Therefore we must consider the development of activities of participation from the primary attention team, never forgetting that Primary Health Attention doctors are specialists in family and community medicine, and that nursing professionals carry out activities of health promotion and prevention of illness. The relationship of primary attention with the population is more direct than that of the public healthcare services, providing an opportunity for joint intervention between primary attention healthcare services and public health services with a community focus.

A first approximation to the expectations of civic participation in the provision of health services in Catalonia was achieved in 1999 in the context of the health plan ²⁶. The importance of participation in the framework of the healthcare system has been analysed in the context of the creation of the official guidelines for healthcare professions. What patients expect of the professionals is set down in a monograph of the ES ²⁷

Participation is regulated by the legal norms currently in force which establish the existence of health councils regarding both central structures and more peripheral ones. Sadly no evaluation has been made of the impact of the councils nor the contributions made by the representatives of the citizens. The general impression, with a few exceptions, is that the experiences were too bureaucratized and at best serve to inform the population about the initiatives of the healthcare services ²⁸. Although in some cases, above all in base areas of rural health, such as in Vilaseca, the neighbours' associations have played a significant role in the choice of those health problems for which community focussed primary attention interventions were to be instigated ²⁹.

Precisely in order to reach a more operative scale of participation, the ruling body of public health of the Barcelona city council recently called the first official conferences on civic participation and public health ³⁰; an initiative parallel to that of the Social Welfare Council of the same city council which has already been in existence for 25 years and that since that time has had a group specifically dedicated to health ^{*5}.

BASIC ASPECTS FOR DRAWING UP STRATEGIES TO PROMOTE PARTICIPATION

In the design of strategies to promote and facilitate the participation of the community in public health it would be preferable to base them on an adequate knowledge of the expectations of the public regarding healthcare and public health and also regarding participation itself, as well as the motivations that lead people to participate.

At the same time, there must be a decided willingness to avoid obstacles to participation, especially those that have their origins in the health system itself: willingness to win credibility in the public eye; to replace the traditional despotic attitude more or less shown; to mobilise the organizations and services of public health.

Nevertheless, this may help to define some fundamental general aims, among which the following can be underlined:

- Promoting decentralization, feedback and self-organization when it comes to proposing and carrying out initiatives of promotion and protection of health.

- Increasing the credibility of public health services through the undertaking of commitments to the public; to increase the capacity for the resolution of collective health problems – particu-

^{*5} This group is a continuation of the one which, for some years, has been devoted specifically to health. It is a collective of people from various civic entities who during the course of their activities produce a set of recommendations in order to have them reach the town council

larly epidemic outbreaks – the obligation to give accounts (accountability), and transparency in information – both in quantity and in quality as regards their comprehension and relevance.

- Promoting the assumption of collective responsibility when it comes to establishing priorities for healthcare interventions and to encourage the acceptance of personal responsibility for one's own health, with the principal objective of gaining autonomy and rationalizing the dependence on the healthcare services.
- To encourage the adequate use of healthcare services and products, including preventive interventions, with the principal aim of reducing as far as possible their undesirable effects and with the secondary objective of contributing to the improvement in efficiency in the utilization of shared resources.

These aims – or those which it is eventually decided to undertake – represent the starting point for public health but must be accompanied by research that allows us to know our community's position on this matter, research which should be conducted in parallel with specific interventions promoting participation, configuring a dynamic process whose elements would be mutually developed and enriched.

With this in mind, these studies of the attitudes and preferences of the community ought to include an evaluation of the initiatives in place. The design of strategy requires not only that its aims be made explicit but also the definition of priorities, the formulation of objectives and the creation of intervention programmes.

This process should be fixed within certain spheres of activity. The main sphere is that of the community that can be reached globally through the collaboration of the media, but it is best to design a progressive strategy that permits "feedback", beginning with limited programmes that can produce results and that serve to evaluate procedures.

In the generic sphere of the community, associations related with health and the healthcare system have a special relevance; schools (nursery, primary, secondary and vocational training) and, for their activities in the field of communication and dissemination, schools of dramatic arts (cinema, television and theatre); information technology and communication (journalism and multimedia). But it is also worth including institutions in which people congregate together, whether for reasons of association (sports and leisure) or for other reasons (markets).

The academic world is another of the spheres of interest for the promotion of participation and communication. Just as the institutions related to health sciences, both for their eventual involvement in the training of the professionals in these aspects, and for the initiatives of innovation that they may generate. In this sphere are included scientific schools and faculties and also societies.

Professional components such as the official colleges of health professionals and social organizations (of both employers and unions) can play a decisive role.

Finally one must bear in mind the role of the various public administrators, especially at local level, the town councils and their associations (The Federation of Town councils of Catalonia and the Catalan Association of Town Councils), the regional councils and delegations. Nor must we forget the organs of promotion of the participation of the Department of Institutional Relations or the Síndic de Greuges.

SHORT TERM STRATEGIC APPROACH (2005-2007 HORIZON)

In order to maintain as naturally as possible a policy of civic participation it is advisable to improve knowledge of the present situation, to systematically evaluate present experiments and to establish the bases for the development of a scheme that would allow the setting of priorities, the formulation of objectives, the exploration of forms of research, with the aim of facilitating its generalization.

The following could be proposed as specific activities:

- Establishment and maintenance of a register of experiments of civic participation in matters of health and healthcare systems in Catalonia. This register could be created or maintained from the office of the Director General of Public Health or from the Institute of Health Studies in collaboration.
- Establishment and maintenance of a specific register of the entities and organizations that carry out activities of participation, including mutual aid groups. On the part of the Director General of Public Health or the Institute of Health studies. Possible collaboration from the Josep Laporta foundation.
- Drawing up of a form for civic participation in the field of health and healthcare, open to entities and associations, which favours exchange, encourages reflection on present initiatives and facilitates evaluative research. This could be done through the creation of a specific web site.
- Promotion of programmes of evaluative research into civic participation in health and healthcare in Catalonia. With the collaboration of the IES and the AATM
- Production of a study into the motivations for civic participation in the spheres of health and healthcare.
- Creation of a database with the most relevant experiences of civic participation in healthcare. On the part of the DG of Public Health or the IES
- Production of a map of resources, equipment and services – to include sectors outside of healthcare that might be involved (educational, social, cultural, etc) Of particular interest might be the AMPA (FAPAL, FAPAES and FAPAEL) and business associations, including those devoted to the healthcare industry, pharmaceutical laboratories, sanitation supplies, etc. On the part of the Public Health Office or the Health Studies Institute. Possible collaboration with the Federation of Town

Councils of Catalonia, the Catalan Association of Towns and Municipalities and the office of Civic Participation of the Catalan Government's Department of Institutional Relations.

- Exploration of possible alliances between the diverse sectors directly involved in health, such as the food industry and the pharmaceutical industry, but also others less directly related such as the urban sector, real estate, or those institutions and entities in general that have an interest in the environment and sustainability.
- Creation of a programme of information and dissemination regarding aspects related to public health (in collaboration with communication groups). To take advantage of opportunities occasioned by any situation of healthcare alert in order to open up debates.
- Promotion of lines of ongoing training of healthcare professionals – not only those working in public health but also those working in the field of attention, and particularly primary attention – in aspects relating to civic participation. On the part of the IES.
- Development of training programmes for healthcare students and professionals with the aim of facilitating community participation.
- Bringing up to standard the development of the Public Health Agency in aspects related to civic participation. On the part of the DG of Public Health.

The imminent starting up of the Health Protection Agency and the experience of the Public Health Agency should be used in such a way that both participate in this phase. One could consider the convenience of creating as administrative unit at the Health Protection Agency dedicated to civic participation, possibly in conjunction with topics for communication, basically about risks to health.

MEDIUM TERM STRATEGIC APPROACH (2010 HORIZON)

The main element should be the development of the Plan for the promotion of participation, based on the experiments carried out in the previous period, with the knowledge gained and commitments established. In this phase it should be a question of putting to the test specific interventions, including, for instance, the following;

- Participation in the establishment of a limited series of priorities for intervention in territorial ambits (basic area; sector; region); preferences; expectations; rationalization (relative importance of problems; existence of efficacious interventions, etc)
- Analysis and evaluation of real healthcare situations; public evaluation groups in each healthcare region and in some basic healthcare areas chosen to carry out projects.
- Production of project interventions for the promotion of health to include the assumption of responsibilities for results; incentives on achievement of objectives.

- Promotion of the adequate use of healthcare services, particularly of those activities whose aim is preventive, those performed in the community ambit or those of attention; through programmes of information and education and the establishment of tangible incentives for users and communities who achieve better usage (justified demand of hospital emergency services; adequate frequency of primary attention services; complying with prescriptions; proportion of correctly monitored patients suffering from diabetes, hypertension, dislipaemia etc).

Development of an active policy for the stimulation of participation through activities such as the following;

- Introduction of incentives for results of community health programmes related to lifestyles – physical activity, road safety, etc- in the ambit of healthcare regions, in order to obtain budgetary aid.
- Introduction of community participation in the projects of healthcare plans devised by each healthcare region, with a special incentive for the best project.
- To provide incentives to encourage pilot projects of participation in the ambit of the basic health areas where there are community-oriented primary attention units. These incentives could include the availability of human resources and materials and contributions to financing.
- To call a meeting to award an annual prize for the best community participation project designed by students of any of the health science disciplines (nursing, chiropody, nutrition, social work, psychology, medicine, pharmacology, veterinary science, etc.)
- Research into the attitudes of the public regarding participation.
- The awarding of an annual prize for the best community participation project presented jointly by civic entities, primary attention units and services peripheral to public health. With a jury formed according to proposals from civic entities.

RECOMMENDATIONS

- To contribute to the operative development of the right to civic participation as recognized in the legal norms affecting the healthcare system in general (General Law of healthcare and Law of healthcare regulations in Catalonia) and the future Public Healthcare Agency of Catalonia, through specific initiatives.
- To promote the transformation of the healthcare system, both personal attention services and community services, in such a way that civic participation has a real place beyond the rhetorical theories.
- To promote research that has participation as its object, so that its potential benefits may be evaluated and tangible stimuli produced to broaden participation.

- To promote participative research into health, basically directed at those health problems perceived by the community and counting on the participation of public groups and entities at all stages, as a process for the involvement of citizens in the development of programmes and interventions for the promotion and protection of health.
- To favour, by awarding special resources, working groups whose aim is to further knowledge and propose specific interventions.

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COMMUNICATION

Gemma Revuelta

GENERAL ASPECTS

Definitions

The first definition of **communicate** given in the dictionary of the IEC is “to make another take part (in that which we possess)”. The same is repeated in the dictionary of the RAE, which also defines communicating as “making another a participant in what we have”. These two definitions demonstrate that there is clearly common ground between communication and participation, an aspect which is not always taken into account and which marks the substantial difference that exists between communication (including the need for relation and participation) and information (an action which can be purely unidirectional).

The diffusion of the mass media and the expansion of the so-called Information and Communication Technologies (ICT) have added even more ambiguity to the meaning of the words information and communication, the first appears irrevocably associated with the digital world, while the second seems to go hand in hand with the “media” or new forms of telecommunication. Hence the need to clearly state that, although to all intents and purposes in this document we will use the word communication in its traditional sense of transmitting and sharing information, it will always be remembered that this activity falls within a framework of participation and relationship (between people, collectives, entities, etc). So, then, in the specific ambit of public health, communication is considered as being the action of transmitting and sharing information that aids participation, in the sense of contributing to the construction of the health of the population.

While communication is established via numerous channels, the “mass media” (television, the press, radio and the Internet) without doubt play a central role in modern society as the principal means by which citizens access information on health; advances, recommendations, news, etc.

Mass communication is usually unidirectional, from transmitters to receivers. Communication in the opposite direction is limited to a small number of spots open to public participation such as, in the case of the press, letters to the editor; calling or sending text message to TV or radio; public participation in magazine programmes or “reality shows”, etc. It could be said that there is, besides, an indirect channel of communication between the public and the media that consists of the variations in habits of media consumption on the part of the public (for television and radio, audience figures and ratings; in the case of the press and magazines, readership and circulation; market studies etc). Here we are particularly interested in the nature of the transmitter (a public service or a pharmaceutical company have very different interests) and the effect on the receiver, who can be passive or – if permitted – active, in the sense of responding to the message in the form of civic action.

The Internet, for its part, represents a medium with substantially different characteristics. In the first place, many web sites allow a genuine two-way (and multidirectional) communication. Besides, the Internet as a medium of communication extends an opportunity to any voice, be they from a minority or the majority, individual or collective, trustworthy or not, etc.

These peculiarities of the mass media and their role in the transmission of information on health are largely responsible for society's perception of certain matters related to public health. It could be argued that the influences of the media on social and individual behaviour in the area of health are complex and one should not expect that the mere broadcasting of a message or a piece of information should directly result in a change in behaviour. As the study of social psychology has repeatedly shown, opinions, attitudes and behaviour are related to objective knowledge, but also to personal experiences, value systems, the perception of the opinions of the majority, fear of sanctions and many other factors, many of these more closely tied to the emotions than to knowledge ¹. That is why any strategy aimed at improving communication in health must take into account not only the explicit contents of the information, but also the other variables that condition behaviour.

But apart from the mass media, communication on public health is also produced in many other ambits. The communication established between healthcare professionals and citizens, the users of the social healthcare system, whether in consulting rooms, hospitals or any other socio-healthcare dependency is one such ambit. Also there is a direct communication between healthcare administrators and a group of entities that bring together certain sectors of the population (schools, libraries, neighbours' associations, patients' associations, big companies, etc.)

In fact if one wished to make an exhaustive scheme of all the ambits in which communication takes place in public health, it must be recognized that there are as many of these as there are environments of human relationship. Thus communication is established between family members, between friends, between a writer and his or her readers, etc. All of these relationships imply a transmission and exchange of information and opinions that contribute, along with those generated by the media, to those that are established around the socio-healthcare system and, with many other elements (such as personal experiences and value systems), to the creation, maintenance or public modification of opinions, attitudes, behaviour, etc.

Furthermore, in this document, we do not attempt to touch on all of the arenas of communication, only those in which it is feasible to design a scheme aimed at improving the health of the population, originating from the administration and defining for the purpose medium and long term objectives, priorities and a definite plan of action.

In this context, from this point on our attention will be mainly centred on three types of communication relationships, namely

- Between the different public health services
- Between the public health services and the community, directly (as a whole, or with the various groups or collectives of which it is made up)

- Between the public health services and the mass media (as intermediaries in communication with the community).

Problems and obstacles to communication

The general question of the manipulation practised by groups in power is one of the central issues of communication, probably because its central object, that is to say, information, is an element that is relatively easily manipulated, hyperbolized, biased, concealed or just directly made up.

Furthermore, communication shares some specific obstacles in common with participation; the technical complexity of health problems and of healthcare systems and organizations (to which we should add the particular complexity of medical terminology), the anguish associated with suffering and death, the vulnerability of those who suffer from certain illnesses or are at risk of suffering from them, etc.

Changes in power relations

A group of factors that must be particularly taken into account are those that define new forms of relationships in the field of healthcare. In this case it would not be correct to talk in terms of obstacles (especially in view of the negative connotations of this word), but rather of new variables which, while creating opportunities, can also create situations of confusion and lack of confidence if not all of their possibilities are taken into account. Within this group of factors, the following should be given particular consideration; the change in power relations between health service professionals and health system users, the diffusion of alternative medicines and the expansion of social pressure groups in the field of health.

The progressive disappearance of the traditional paternalistic relationship allows the individual greater participation in the decisions that affect his health, but also give him the option to question the expertise and the interests of the doctor in his recommendations. For this reason, the change in power relations also means the need to communicate trustworthiness, efficacy, efficiency and empathy, among other things.

To the previous point has been added, in recent decades, the proliferation of alternative medicine, for the most part with exquisite care taken over personal relations and patient-professional communication, accompanied by a more or less explicit criticism of conventional medicine.

Finally, it must be remembered that the present communication has been established within a framework in which social control is increasing. That which was until now "untouchable" can be subjected to more controls, and in this way citizens can limit the abuses perpetrated by professionals and by the healthcare system itself. For example, consumers' organizations have a significant impact on healthcare planning or the provision of services in places, like Australia, where the tools of scientific evidence are used (Cochrane Health Consumers – Australia). But this same social control can create doubts and distrust towards healthcare professionals and/or

their practices and recommendations (experimental research on animals, vaccination programmes, etc).

The central role of the mass media in communication with society

Of all the obstacles that communication has to face in public health, probably the biggest one is the heavy dependence of the healthcare system on the role of journalists and media professionals as a whole (photographers, publicists, columnists, editors, etc.) , since it is they who finally transmit health-related messages to society in general.

Accepting that the objectives of healthcare professionals and the media do not always coincide, often situations of controversy arise which generate, ultimately, mistrust and suspicion in the relations between the two. On the other hand, since few media rarely have specific healthcare sections or journalists specializing in this field, information relating to health is usually to be found in among the rest of the news on “current affairs” or in the “society” section, and that means that it must compete with a number of topics of various kinds, such as politics, events, the economy or sports. The competition for space (physical space in the case of the press, air-time in the case of radio and television), means that every day a selection has to be made out of all possible news items. And the same criteria that are applied to determining the newsworthiness of any current event (from a hurricane to the wedding of a prince) are also applied to decide whether a piece of information about health is “news” or not. It is evident that this situation leads to a tendency to sensationalism and to present an image of extremes; from alarm to false expectations.

That is to say, although the public is more and more well informed, the question is whether or not all the information made available (a large proportion of it via the Internet) is truthful. *The information available is not always accurate, objective or impartial, and often healthcare professionals have to remind their patients of the unreliability of some of the sources of information*³.

So then, one of the great challenges is to achieve awareness on the part of the communication professionals of the effects that their work has on the health of the population and to play an active part in health education, in the sense of promoting among the general public knowledge, habits and attitudes that have a positive effect on health promotion, both of the individual and collectively. Just as can be read in the document, “Healthcare information and the media”, *the citizen is better informed and has more awareness of his rights and duties. The quantity of information now available is staggering; the challenge to professionals is to offer high quality information on healthcare*. But this challenge does not only concern the media; in order to offer high quality healthcare information you need the healthcare system that generates it and that puts it into accessible language.

The Internet as “intermediary-bypass”

It could be thought that the Internet, thanks to its role as “intermediary-bypass” – that is to say, that it allows communication to be carried out directly between two people or entities with-

out the intermediation of the mass media – would be able to help solve this problem of dependence on the media. Nevertheless, in order for this direct communication to be truly effective there needs to be a concerted effort to bring the electronic resources available (web sites, portals, discussion lists, forums, electronic services, etc.) up to the standard necessary to meet the real communication needs of the public. In this sense, it is necessary to reflect on this observation, as demonstrated by the population of the United States ⁴ in the National Science Foundation's 2001 study "Science and Engineering Indicators"; there already exists a duality between passive access to general information about science (the media publish a news item and the public receive it without making any special effort) and the active search for in-depth information on a specific topic (the individual who wants to learn more logs on to the Internet). This new context is especially important if we remember that the use of the television or radio is falling in direct proportion to the rise in use of the Internet ⁵.

It must be considered that, while access to the conventional media is potentially universal in our society, access to the Internet has not yet reached the entire population. Currently, one of the sectors of the population that has been most marginalised in the use of this resources is the elderly, who, even when they have the use of a computer at home, have real difficulties when it comes to using this technology. Among other problems, because for this age group the effort required to learn how to type using a keyboard is difficult to compensate, at least in the short term. Which means to say that, even if we improve the resources, contents and accessibility of Information and Communication Technologies, it is inevitable that a certain sector of the population will never be able to receive this benefit.

Therefore it is necessary to identify which are those sectors that would benefit from a specific development in health communication through ICT (probably, the majority of the population) and which are those who are highly unlikely to benefit, in order to design specific strategies for each case.

Communication of risk and communication in crisis situations

It is also necessary to consider two specific aspects of communication that are associated with particular problems; the communication of risk and the communication of crisis situations. The first of these requires us to consider that risk perception does not only depend on information, but on many other factors (the perception of control of the situation, familiarity with the problem, etc). Therefore it is necessary that all information regarding health risks should guarantee maximum accuracy and transparency, and be easy to understand.

Currently there are various groups who work precisely to help to communicate health risks. In this regard it is worth drawing attention to a paper, practically a monograph, on communication and the perception of risk in health, published by the *British Medical Journal* (27TH September 2003) ⁶ in which different situations in communication of health risk are analysed and recommendations given (terminological, graphic, etc).

The same principles should also be applied to communication in situations of crisis, adding in this case the basic need to establish beforehand a relationship of trust between the healthcare

administrators and the media, as well as adequate foresight and planning for possible situations that could generate a crisis in public health.

Communication and the unfair treatment of certain groups

Finally, we must touch on another problem of communication in general that may end up being very serious in the case of health, and which consists of the unfair treatment of certain groups. This problem means, in some cases, treatment of people or groups is either disrespectful or unworthy or could consist of the absence of information on problems that affect certain sectors of the population, but that are less visible than others. Of particular importance in this regard is the low visibility for the media of problems of women's health and the repetition of certain stereotypes, both in verbal and visual format (photographs, images) that encourage sexist behaviour among the population.

The problems put forward in the preceding points can be observed not only in the media but also in all of the other channels of communication. It would be necessary, therefore, to analyse in greater depth the means of dissemination (leaflets, posters, adverts, etc). What do they entail? What is the relationship between cost and effectiveness? What services do they provide? What are the possible differences and contradictions that might be transmitted in their messages? Also, it would be necessary to conduct an in-depth study of how to tackle the problems mentioned at interpersonal level, between healthcare staff and users, as well as the need for training in this regard.

POSSIBILITIES

The three areas of communication on which this document primarily focuses (communication between the different health services, direct communication with the public, communication conducted through the media), present their own peculiarities with regard to future opportunities and challenges.

Communication between the different health services

The health service system in Catalonia has undergone radical transformations in recent years. To the expansion of competences must be added the changes in the organization of the healthcare systems, technological development and the changes in the very population residing there. Finally, one must bear in mind the relationship of dependence that has existed with the ruling political powers in the different geographical and territorial areas, at different points in the past, and the change entailed by the present political landscape.

As a result of all these circumstances, we find that communication between the different dependencies and entities of the Catalan healthcare system is neither agile nor transparent, or at least not as much as one should expect in order to ensure a genuine effectiveness.

The lack or deficiency in communication between the different healthcare services leads to, among others, the following consequences:

- **It reduces the effectiveness** of policies of prevention and health promotion (as directives do not reach the possible agents of communication)
- **It complicates coordination and cooperation** between the different services, a deficiency particularly in evidence in crisis situations.
- **It leads to an increase in expenditure** (having to repeat studies and acts of communication in different dependencies owing to their lack of awareness).
- **It generates mistrust on the part of the public** (who receive contradictory messages)
- **It provokes resentment and ill-feeling among the professionals themselves**

A good internal communication is essential in order to be able to communicate with the exterior. But, in fact, it must be clarified that this is not a question of an isolated problem, since internal communication is nothing more than the mirror of an organization. Therefore it would be necessary to carry out an in-depth study of the current Catalan system regarding communication (agents, networks, resources, etc) as well as an analysis of the systems of internal communication that have been developed in other fields: structure, range, technical and human requirements, results, etc.

In this sense one initiative to explore is the one known as the National Public Health Information Coalition (NPHIC) ⁷. This organization was conceived specifically to resolve the existing problems of communication in public health in the different health departments of the USA. The working of the NPHIC is that of a coalition, with a basic structure financed by the CDC, which uses different tools to ensure a rapid communication and a system of mutual cooperation.

Among other activities, the NPHIC carries out the following; electronic distribution of brief and immediate data on relevant communication actions on public health (press releases, recommendations, alerts, etc); electronic distribution of other messages, especially from other agents that make accessible the rest of the material created by diverse communication actions (posters, leaflets, electronic resources, etc); a periodic bulletin for more in-depth information (description and analysis of experiments in different states, etc); prizes for good practice in communication in healthcare; an annual conference at which the members from the health departments of every state (totalling approximately one hundred people) meet.

Obviously ICT – for their ability to break down barriers in space and time – must play a central role in any design that may be proposed regarding communication within the healthcare system.

Direct communication between the public health services and the community

Until now, this communication has taken place primarily in the very dependencies of the socio-healthcare system themselves (health clinics, hospitals, residences etc) and, to a lesser degree, in other places representative of the different groups that make up the community (schools, companies, nursing associations, etc). In most cases it is the healthcare administration itself that takes the initiative to communicate with the community in order to achieve its participation by the adherence to a particular public health policy, or in order to deliver certain information. In some cases it is the community (or a particular group from the community) that seeks to communicate with the administration in order to solve some problem or to ask for explanations for some action.

An in-depth study should also be made of what is being done and what has been done, both in Catalonia and elsewhere. However, notwithstanding this need for a formal review, a superficial overview reveals the following problems;

- **Dispersion.** Acts of direct communication with the community are usually proposed in response to specific situations (e.g. a crisis) or otherwise as part of a programme aimed at a certain sector (e.g. as part of a campaign to prevent adolescents from beginning alcohol consumption), but there does not appear to be any global strategy.
- **Lack of coordination** of the contents related to health and their transmission to the public (schools, summer camps, town halls etc) with the exception of certain specific initiatives.
- **Lack of evaluation.** Although currently, and despite the infinite criticisms that this kind of behaviour has received, many acts of communication with the community cannot be evaluated in terms of meeting their objectives. This deficiency is responsible for the lack of scientific literature on which to feedback base future actions
- **Discontinuity:** many of the actions programmed in the field of health cease to have continuity when the politicians responsible for their implementation change. The same thing happens when resources are used up, in cases where despite the fact that the action's proposal was for the long term, these resources were only allocated for a certain project or a specific timeframe.

It would be advisable therefore, when identifying good practice in direct communication with the community, to take into account the way in which previous deficiencies have been tackled.

Communication conducted through the media

According to the various surveys, information about health is one of the topics of most concern to the general public⁸. Whether as a result of this interest or due to many other possible factors, information about health is increasing in its presence in the media.

Without doubt, television is the most prominent medium in our society. But the complexity posed by gathering material to study has meant that scientific literature on the relationship between television and health is relatively scarce. (In fact this is a general problem in the study of television, not only in the field of health. Martínez Segura ⁹, in a chapter of the 2002 Sespas Report, devoted to this topic, concluded that the orientation of efforts in information, education and prevention towards the medium of television meant adapting to the requirements of the medium (image, movement, debate, simple messages and redundancy).

But the press also has an important role. Particularly in order to be able to take action regarding opinion-formers and decision-making sectors. In Spain, for example, the number of texts on health and medicine published in the five newspapers with the highest circulation doubled between 1997 and 2000, and since then has remained at the same level, as has been reported in the Quiral report ¹⁰. This report, which analyses journalistic coverage of health topics in Spanish territory, as well as a later study ¹¹ that takes as its point of reference the data from that same report, show that the information is concentrated on a limited number of matters. So, the review of the period 1997-2001 shows that a group of 20 subjects accounted for more than half of the information published on health matters in the five newspapers studied (El País, ABC, El Mundo, La Vanguardia and El Periódico). Specifically the subjects that received most press attention were, respectively, BSE (information related to human health), AIDS, cancer, pharmaceuticals (excluding certain products that generated vast numbers of texts in their own right, such as aspirin or Viagra), tobacco, etc.

It is evident that this group of topics (illnesses, research areas, etc), is heterogeneous and has no direct relationship with the real magnitude of these matters for the public. But on the other hand, it is also evident that among this group of topics predominate many of those which have traditionally been the focus of public health actions (communicable diseases, drug addiction, cardiovascular diseases, etc). As for the analysis of the sources of information, this showed a fixed distribution according to which political sources featured in news items on current events, while reference to sources from the spheres of attention or research were more frequent in items that dealt with subjects in greater depth. The use of one or other source also differed depending on whether items appeared in "society" sections or in a section specializing in health or science.

While it will be necessary to conduct a more in-depth review of the literature, the analysis of these observations clearly shows the critical points that define the role of the media:

- Their role in the **mass dissemination** (even more so in the case of television) of information in the field of health.
- The public **interest** aroused by **information on health** as a current affairs topic.
- **The concentration of information on certain topics**, many of them within the field of public health.
- The **multiplicity of sources of information** on health matters (with the particular interests of each one) and the use made by journalists, according to their speciality, the media in which they work, or the topic in question

- The **problems of comprehension** on the part of the general public of a jargon which is too technical, often accompanied by biased reporting that can lead to confusions. In fact, in recent times, besides talking about the need to improve the contents of the media, there is emphasis above all on **education for a genuine “media literacy”**¹², or the public’s ability to perform a critical appraisal of the media.

Despite the extraordinary role that the media potentially could have in the dissemination of information and opinions that help to improve the health of the population, often the way in which certain information is covered (the explicit content and the implicit message, the sources of information used, graphic resources, interpretations of the data etc) can have completely the opposite effect. In fact the literature on the subject is full of cases of transgressions and biases in the media regarding information on health.

On the other hand, it is not yet feasible to think in terms of a global strategy of communication in public health that doesn’t anticipate, at some point, the participation of the media (the so-called “media advocacy” is, in fact, one of the main strategies in the promotion of health, with results that begin to show a long trajectory¹³). But to trust in the spontaneous complicity of the media has not been shown to be a wise policy.

It is necessary therefore to have a specific strategy aimed at improving understanding between the healthcare system and the media. A strategy that must focus at least on the following points:

- To encourage the mutual acquaintance of healthcare and media professionals so that each gets to know the needs of the other, and thus to encourage cooperation
- To promote a critical appraisal of the media by society, while providing it with alternative systems for acquiring this information, that are not only those provided by the media. Here the Internet could play a very important role (for example, as a system by which a citizen could contrast information received through the media with a specific source).
- To establish systems that permit the detection of situations where there is room for improvement; dissemination of erroneous or biased information, unfair treatment of certain groups, presence of other sources of information that distort messages related to health.
- To give incentives for regular training both of healthcare professionals in matters of communication and of media professionals in medical and scientific matters.

DESIGN OF STRATEGY. CONSIDERATIONS

Many of the fundamental general purposes identified for participation are equally applicable when it comes to designing a communication strategy (especially in matters regarding the promotion of civic autonomy and the transparency and credibility of public health services).

On the other hand, and also taking into account some of the points identified throughout this document, other basic points should include the following:

- To consider communication as **an integral part of any action** aimed at improving the health of the population and, as such, to consider it as a process that must be studied, planned, applied and evaluated in the best way possible and not left to improvisation.
- To encourage communication and cooperation on matters of communication **between all of the public health services**.
- **To separate, as far as possible, communication from political powers**, involving to a greater degree public health experts and technicians and promoting transparency in all phases of communication.
- Development of **effective systems of direct communication** for those sector of the population that have the most difficulty in using ICT (especially the elderly)
- To guarantee the development of specific systems of direct communication for those sectors of the population that are far from the conventional places where such actions take place, such as schools and healthcare centres (for example, young people who are not in the education system and who rarely visit healthcare centres)
- To favour training and the acquisition of communication skills on the part of public health professionals, both in regard to relations with the community and relations with the media.
- To favour the training and acquisition of basic knowledge of public health on the part of the media professionals and to encourage a greater involvement in the improvement of the health of the population (an aspect particularly necessary on the part of the publicly owned media), as well as in health education.
- To encourage communication and cooperation between healthcare professionals and journalists.
- To promote among the population a critical **appraisal of the media** (media literacy) and a greater capacity for autonomy in the active search for useful information via the Internet or other channels.

RECOMMENDATIONS

Apart from the recommendations shared with the ambit of participation (such as those that refer to the creation of a forum for debate, or a specific website or a programme of information and dissemination), the specific recommendations regarding the design of strategy of communication are principally the following;

Analysis and identification of good practice

- Identification of the **agents** responsible for communication in each one of the public health services; identification and analysis of the existing networks of communication established between these services; creation of a global platform of operation (whether in the form of a network or a coalition) and development of **resources** (preferably using ICT) in order to guarantee an effective communication and cooperation between all agents.
- Analysis of the degree of **public knowledge and trust** regarding the public health services. Identification of critical points. Identification of other sources of information that could have a disturbing effect on messages relating to health.
- Identification, analysis and evaluation of the current communication **relationships** established **with different groups** of the population. Establishment of objectives, stages and priorities in direct communication with the population.
- Identification of experiments and studies into good practice around the world in the **creation of electronic communication resources** in public health that promote autonomy in the search for information and in decision-taking, as well as in participation with the aim of improving the health of the population.
- Creation of an **annual prize for the best practices** in communication in public health to be designed, applied and evaluated by the different public health services.

Planning of strategies and the creation of a communication platform

- Definition of the **objectives** – global and specific, medium and long term – planning of **strategy** and definition of **the agenda** and systems of **evaluation**. It is understood that this strategy will be tied to the group of actions of the Department of Health, and must be placed within the framework of its relations with town councils, the state, the European commission and the international community as a whole.
- Creation of a “**health and society**” **forum** (ideally linked to the participation forum) to promote debating activities – regarding matters of current concern and general topics – about the critical appraisal of the media on the part of the public, and training (of healthcare agents, in communication skills, and of the communicators, in knowledge of health matters, and training of the public regarding both subjects, with particular attention paid to new electronic resources as they are developed.) Furthermore, the forum would also have the function of detecting (by observing the media) information of dubious provenance and exposing it to public scrutiny, and to adopt the appropriate measures in the event that such action is deemed necessary.
- Creation of a specific **website** (or remodelling of the existing ones) on communication in public health:

- That follows those models identified as being examples of good practice:
 - that adapts itself to Catalan society, both as a whole and in the different social groups towards which acts of communication are directed
 - That guarantees the continued pursuit of the general and specific objectives outlined
 - And that permits the flexibility and speed necessary to face unexpected situations or those in which immediate action is required.

Recommendations for the treatment of specific aspects of communication

- Planning of communication strategies making use of resources made available by experience (social marketing techniques, media advocacy, etc) in order to raise the level of public confidence in the healthcare systems and to create a **framework for the Public Health Agency** that is synonymous with authority, thoroughness, transparency, expertise and the quest for social welfare and justice.
- Study of previous cases, prediction of possible **crisis situations** in public health and establishment of protocols of action. If these already exist, evaluation of these.
- Analysis of information and of the **public's perception of risk** from the principal agents to which the Catalan population is exposed (globally and specific groups). Establishment of recommendation guidelines, for both media and healthcare professionals.
- Establishment of systems of supervision (commissions, work groups, observatories etc) to oversee the respect of **ethical principles** that affect communication relations in health matters (the right to information, the right to health, questions of respect for image and dignity, conflicts of interests etc).
- Establishment of systems of ongoing observation to oversee correct communication in **matters of top priority** (such as , currently, communication on epidemic outbreaks, addictions, abortion among adolescents, etc), **and** in questions of a more **oblique** nature (communication of problems of women's health and the use of sexist stereotypes, communication with the immigrant population, etc).
- Establishment of a formal commitment of collaboration between public health services and the principal communication media (especially those in public ownership) in order to develop systems that contribute to improving public communication on health matters. Some of the systems could be:
 - The holding of **regular meetings** between journalists and healthcare professionals to discuss the needs of each one and to establish in a participatory and progressive manner systems of mutual cooperation

- Revision of the **ethical aspects** that affect communication in public health, the acquisition of a formal commitment to ensure that they are complied with and the establishment of a system of rewards for those who are most respectful of ethics in questions of health (both on the part of the media and of the healthcare agents).
- Creation of a **database** of experts who can be consulted by journalists.
- Professional service of **assistance to TV scriptwriters** on health matters, review of scripts and volunteering of ideas in matters of public health.
- Holding of **conferences on real cases of situations of crisis** in public health (at first on past cases, then, once the dynamic of communication of crises is established, also on present cases)
- Inclusion of **special health spots** in media programming (at least in publicly owned media) linked to programmes of health promotion and prevention.

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