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HEALTH FOR ALL THROUGH RESEARCH

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John F. Kennedy's vision of man on the moon by the year 1970 set a goal for technological research and development. The World Health Organization's vision of health for all by the year 2000 set a similar goal not only for health policy but also for health research. Drawing on the analogy between these goals, this paper first explores what health for all means as a policy goal. It calls for changes in most aspects of the health care system. In the European Region of the World Health Organization, 38 specific targets show how approaches to health problems, lifestyles, environment, health care and various support measures (e.g., planning, management and training) should be changed to reach the over-all goal. These changes should be based on sound scientific knowledge. Health for all therefore also calls for a health research policy and reorientation of research.

The second part of the paper looks at the research implications of health for all. Assisted by the Regional Office of the World Health Organization, the European Advisory Committee for Health Research analysed the 38 targets to see what kind of research would help to achieve them. The result of this analysis were two publications: »Research Policies for Health for All« and »Priority Research for Health for All«. The first volume explains why a country needs a health research policy. The second one identifies, target by target, research necessary to reach them. Translated into several languages, they have begun to influence national research policies.

The third section of the paper describes the research priorities identified in the two research for health for all volumes. It also aims at showing their relevance for the European health research community. It finally discusses the prerequisites that the countries have to set up to make research for health for all possible. They include changes in the incentives for and financing of research, personnel development, research organization and communication between the researchers and decision-makers.

Key terms: health care system, health research policy, level of health, WHO, year 2000.

BOLD GOALS

In 1961, a newly elected, young and ambitious President of the United States set a goal befitting his aspirations and those of his country: man on the moon by the year

1970. Many praised the goal. It showed man's boldness in expanding the boundaries of knowledge and conquering the universe. Other criticized it. Why should man get on the moon; is it not inexcusable »conspicuous consumption« by a rich nation in a world where most cannot meet their basic needs for food, clothing and shelter? Is the goal feasible? Is the technology there? Is the time span realistic?

Yet, the Apollo Programme got off. On the 16 July 1969 Neil Armstrong took on the moon the step that »was small for a man but big for the mankind«. How was it done? One key was to divide the goal into smaller objectives. They included getting the man off the ground, keeping him alive during the flight and navigating the space ship. A further division into ever smaller objectives yielded a list of concrete research and development tasks. With this list, a chemist could start working on a fuel that would take the rocket off the ground, a biochemist and physiologist studying human metabolism and physiology during the space flight, and an engineer developing a coating that protects the rocket against the hazards of the space. The tasks challenged the nation's universities, research laboratories and industry to produce the knowledge and technology needed. They accepted the challenge and produced what was needed. Man was on the moon before the schedule. The lesson is clear: by dividing a job that first seems impossible into small and concrete tasks, it is possible to reach even the boldest goals.

Sixteen years later, in 1977, a youthful and ambitious organization – the World Health Organization (WHO) – set another bold goal: health for all by the year 2000 (1). In social policy, it is at least as daring a goal as man on the moon was.

Boldness invites criticism

Health for all (HFA) is a »motherhood« goal – nobody can be against it. Yet, it has raised criticism. Oddly, some of the most vocal opponents are health professionals. Many others do not care about the goal although one would assume it to be in their best interest. The critics pose three questions (2):

Why health: Why not food, work, education or peace? Does health merit a special, global programme?

Why health for all: Is it biologically possible? Will there not always be people who risk their life and limb in their professional or free time pursuits such as hang gliding, car racing or mountain climbing? Will there not always be »inborn errors of metabolism«, congenital diseases and accidents?

Why health for all by the year 2000: Is it technologically and scientifically possible? Is the know-how there? What about the political will and the material resources?

WHAT IS HEALTH FOR ALL?

Are there answers to these questions? Is health for all only a utopia or is it real? Why health? The question belongs to value philosophy. There is no definite answer; other values will always compete with health. A starving person may value food, a political prisoner human rights and a war devastated nation peace more than health. Why health

for all? The question reflects a misunderstanding. When passing the resolution in 1977, the World Health Assembly did not dream for a moment that disease would vanish from the crust of the earth by the year 2000. The resolution does not speak of everybody being healthy but of a level of health that will permit everybody to live a socially and economically productive life. The resolution calls for a raising of the level of health of all people to the extent possible and for eliminating inequality in the face of death and disease. Why health for all by the year 2000? The year 2000 is not magic. In 1977, it was far enough ahead to give the health politicians, authorities and professionals of the world time to do something about the goal. But it was close enough to compel them to do it without wasting a moment. As a Chinese proverb puts it, »if a tree takes a thousand years to grow, plant it now«.

One big goal, many small objectives

How to improve the health of the people of the world? How to reduce the differences in the health between old and young, women and men, city dwellers and rural inhabitants, rich and poor? And how to do it within the available time? When asked how he and Sir Edmund Hillary conquered Mount Everest, Sherpa Tensing answered: »It was very simple; we just put one foot ahead of the other and kept the goal clear.« It was possible to conquer Mount Everest and reach the moon by dividing the big goal into smaller and more concrete ones and tackling them one by one. The same is possible when trying to attain health for all.

The European Region of the World Health Organization started to climb towards health for all by developing a strategy for health for all (3). It suggested five main areas in need of development: health risks, lifestyles, environment, the health care system and support measures such as planning, education and research.

The Member States found the strategy helpful but wanted more concrete guidelines. They got them in 1984 in 38 regional HFA targets covering the key areas of the strategy (4). The best targets are quantitative descriptions of the desired situation at a given time (e.g., by the year 2000, maternal mortality should be less than 15 per 100 000 live births). Many targets are non-quantified (e.g., development of a health care system in which the resources are distributed according to the health needs by 1990). The targets were a big step towards making HFA operational. Still, WHO could not yet turn to the Member States and their universities, research institutions and industry asking »can you deliver it« as the Apollo programme did. More was needed.

A recipe for change

What characterizes the targets? They call for change, change in the health system, in the training of health manpower, in resource allocation... But change is often resisted; how to make it happen? One recipe is:

$$\text{change} = \text{political will} + \text{knowledge} + \text{action}.$$

The Member States have approved the targets. The political will seems to exist. Much of the knowledge on which to base the health policy and the actions needed to reach

the goal also exists. We know enough about tobacco to adopt an anti-smoking policy without wasting a moment in seeking new knowledge. We know enough about environmental pollution to pass laws against it. The target document claims that »if the knowledge that already exists were put to good use throughout the region, the goal of health for all would not be so far away« (4). We need also new knowledge. We do not know enough about selfdestructive behaviour or the best way to provide health care. We cannot prevent drug abuse and suicide or build an effective health care system. Seeing the key role of knowledge in reaching health for all, the Member States approved a target related to research. It urges them to develop a national health research strategy that supports their health for all policies.

HEALTH FOR ALL THROUGH RESEARCH

Research is the best way to get new knowledge. It helps to attain the health for all targets if geared to them. Unfortunately, many scientists find goal-oriented and guided research an anathema, something they actively oppose. Being very independent, they believe in the auto-regulation of research. With some justification, they feel that research initiated by themselves is the most productive research. The Regional Committee knew that it would be an uphill struggle. Yet, it asked the European Advisory Committee on Health Research, an advisory body to WHO, to develop a European health research policy. It should support the regional HFA targets and be a model for the Member States when developing their national policies. The first step was to look at the targets, one by one, to see what knowledge and research could help to attain them. Figure 1 shows the thought process behind this analysis. The first question is whether a gap exists between the target and the real life. If we have reached the target, we need to study how it was done and to see a new, more ambitious target. If there is a gap, the next question is: »Can knowledge bridge the gap?« If the answer is no, we need to find out why the gap exists. If the gap is related to knowledge, the next question is: »Does the knowledge exist?« If it does, we need to find out why it is not being used. A negative answer – the knowledge does not exist – raises further questions: Does the organization make it possible to carry out the research? Do the resources (money, manpower and equipment) exist? Are there appropriate methods? How to ensure that the decision-makers and managers use the knowledge?

»Research for health for all«

To get answers to these questions, the Regional Office consulted the Ministries of Health of the European Member States, national medical research councils and some 500 research institutions, scientific organizations, individual researchers. The result was two documents called Research Policies for Health for All (5) and Priority Research for Health for All (6), jointly known as Research for Health for All (RHFA). In 1988, the Regional Committee approved RHFA with a resolution urging the Member States to develop national health research policies to support health for all (7).

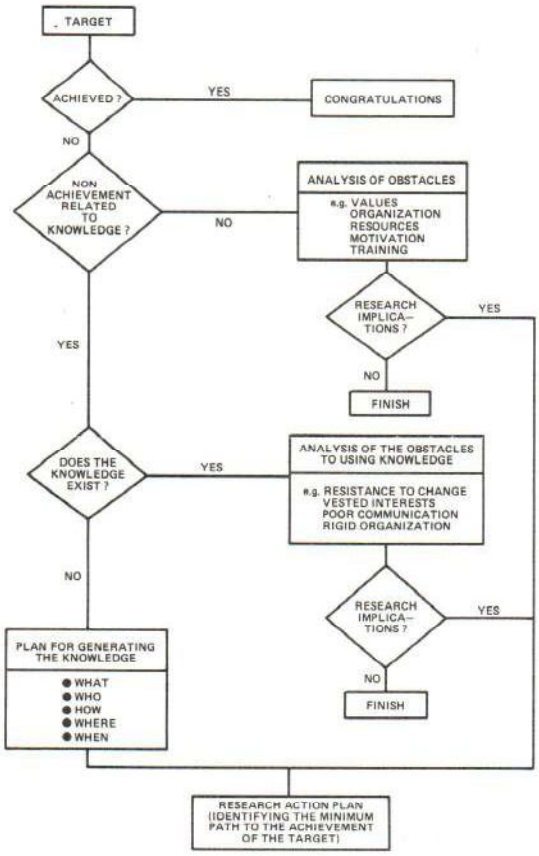

Figure 1. *Flow chart for analysing the research implications of the regional targets*

Research policies for Health for All explains why a country needs a health research policy. It outlines its objectives, suggests criteria for setting research priorities, reviews the prerequisites for priority research and proposes a strategy for promoting such research. Priority Research for Health for All identifies, target by target, research necessary to reach them. Many European Member States have accepted the challenge. Countries with different political systems, e.g., Finland, Hungary, the Netherlands, Spain and Yugoslavia, have either developed or started preparing a national HFA research policy (8, 9).

RHFA and the researchers

The researchers may say that RHFA sounds like an interesting intellectual exercise. But is there anything in it for them? A traditional biomedical researcher may find little.

HFA related research does not take place in the traditional centres of excellence; it does not proceed at the »cutting edge« of molecular biology; it does not need electron microscopes or other high technology equipment; and the chances of getting a Nobel prize are slim. Yet, there is a lot in RHFA for the researchers. While RHFA appeals most to public health researchers, it has got something for all researchers. They will find socially relevant research priorities. They can derive intellectual and emotional satisfaction from helping to solve important problems. They will love to see that RHFA proposes incentives for priority research, career paths for researchers and better use of their results.

HFA research priorities

The main task of research policy is to set research priorities. Public health oriented researchers should be happy with the priority criteria in RHFA. Priority research for health for all should be: carried out on problems with high human, social and economic cost and of epidemiological significance; relevant to the regional or country targets; scientifically sound and significant; likely to succeed; likely to improve health care practice; carried out within the limits of available resources and considering relevant social and cultural factors; and likely to be cost-effective or to ensure that resources already used will yield results.

COMMON THEMES

How does RHFA reflect these priorities? Certain common themes go through the entire RHFA. Three are high-priority areas for research in their own right, two prerequisites for such research: research on health policy and organizational behaviour, research on inequities, research on community participation and intersectorial collaboration, development of information system, and international comparative studies.

Research on health policy and organizational behaviour. RHFA suggests four reasons for research on health policy and organizational behaviour: lack of action despite knowledge; poor functioning of the health care system; need to change the system to reach the targets; and stress on community participation and consumer satisfaction. Why don't we use the available knowledge? What role do vested interests or rigid management play? Does the system function poorly because we do not use all resources? Do we need new types of manpower or new division of labour? What causes consumer dissatisfaction? Do the training, attitudes and working environment of the health professionals make them unable to meet the emotional needs of the patients?

Research on inequities. Why don't high risk and vulnerable groups use or get the services they need? How much higher is their risk anyway? What happens if one is underserved? How to master cultural, attitudinal and financial barriers to the use of services? How to make the services to meet the needs of the people?

Research on community participation and intersectorial collaboration. WHO stresses community participation: the people have the right to participate in planning, running

and evaluating health care. What models exist? How do they function? What makes community participation successful?

Research on intersectorial collaboration. Many sectors of the society contribute to the improvement of health. In most countries, intersectorial cooperation is poor. Why is this? How can cooperation be improved? What models for organizing it exist?

Information systems. Knowledge is power. Modern health care needs information. Yet, most health information systems are inadequate. They are often simple »head counts« showing, for example, the amount of money spent or the number of operations. They focus on diseases, patients, services and process when they should focus on health, population, problems and outcomes. They provide data neither for planning nor for evaluation. It is up to the researchers to develop relevant, sensitive, specific and reliable indicators.

International comparative studies. HFA calls for profound changes in health care. Reforms can be risky and costly. They can be less so if the policy-makers and managers know about the experience of other countries. International comparative studies can give better insight into many aspects of health care than studies conducted within a single country.

SPECIFIC PRIORITIES

Besides the common themes, RHFA suggests specific priority areas under the following headings: support for health development; appropriate care; healthy environment; lifestyles conductive to health; and fundamental requirements for health for all. The following is synopsis of the main ideas.

Support for health development

We need more research on: making health policy; educating health personnel; and assessing health technology.

Health policy. Nothing succeeds like success. We need comparative studies, policy research and stimulation models to identify and analyse »success stories« and to find which systems best meet the goal of improving people's health at least cost and in an equitable way.

Educating health personnel. The success of modern health care has created the need to change the education of health personnel. The central question is how to adapt it to the new health needs of the chronically ill, the elderly, the mentally ill and long-term patients. We need to compare different models.

Assessing health technology. The health personnel often heeds the »technological imperative«; they demand whatever technology is available. First we have to decide what technology most needs assessment. Next, we must evaluate the technology selected for its efficacy, efficiency and impact on society. Finally we must translate the results into health policy.

Appropriate care

WHO's health for all and primary health care policies call for: a health care system based on primary health care and responding to the needs of the people; distribution of the resources according to the health needs; a wide range of health-promotive, curative rehabilitative and supportive services with special attention to high-risk groups; cooperation and teamwork between health care providers, individuals and families and community groups; and mobilization of community resources for primary health care. These changes presume two types of studies: development of new methods for providing services and organizing work and evaluation of both existing and new approaches. The study of the role of different professional and lay groups is important. While much information on health care exists, it is often poorly used and cannot be compared. The researchers need to develop new indicators to describe the system and combine them into a comprehensive information system.

Healthy environment

We need more research on: specific agents and their effects; risks and their management; monitoring systems; and community participation in environmental health. Basic research on health hazards in the environment should include studies on genetic variability, ecogenetics and environmental genotoxicology. We need an inventory of available data on both environmental agents and their effects. Research must show what we need to monitor in the environment and how to do this. Studies based on the behavioural and social sciences must find ways to provide people with better information on health concerns and risk factors. This will enable them to take a greater part in handling environmental health issues.

Fundamental requirements for health for all

This area combines old and new research needs. The old ones include research on: the prevention, treatment and rehabilitation of common diseases; the cause and outcome of chronic diseases; and the effectiveness of intervention. The new needs comprise studies on inequities, impact of social factors such as unemployment on health and the quality of life. Longitudinal studies, studies on small-area variation and health surveys on people's perception of their health are important.

Lifestyles conductive to health

Many regional targets recognize that the way people live and other individual, societal and environmental factors shape health or illness. Social and behavioural sciences play a major role in assessing the health effects of lifestyles. We need research in four main areas: We need to understand the subjective aspects of health-damaging behaviour and the individual and collective functions it serves. We also need to clarify the concept positive health and study the positive health effects of certain lifestyles. Aiming at changing lifestyles, health promotion may lead to ethical problems. Their solution presumes that all concerned parties participate in the planning and carrying

out of intervention programmes and the related research projects. An important research task is to evaluate and compare the experiences from such participation.

PREREQUISITES FOR PRIORITY RESEARCH

Besides setting priorities, a research policy should state the prerequisites for conducting priority research. RHFA makes proposals concerning incentives, financing, personnel development, organization and communication.

Incentives. The research will not take research for health for all seriously unless the health and research authorities explicitly support health for all. Expressions of political will give prestige to HFA research. Scientists are also much more likely to carry out priority research if they have a say in setting priorities. Much of HFA research takes place in health care institutions such as hospitals and health centres. The administration often resists such research because it interferes with the work of health personnel and »wastes« resources that could be used for health services. The attitudes must change and the administration must create settings conductive for clinical and health services research. Talented researchers should be able to make careers in working for health for all. This requires opportunities for research training, posts for researchers, and arrangements that ease interdisciplinary cooperation.

Financing. Adequate resources, both money and equipment, are one of the best incentives to research in any field. A lack of sufficient funding could set up a vicious circle: limited research results in low status, rewards and morale; high-quality staff cannot be recruited; good research cannot be done; and status and morale sink lower. Increased funding should preferably come from new sources. Social security, private foundations and industry need to join government in contributing funds, as they, too will profit from the success of health for all. Regional and local levels of government are an untapped source of funds.

Personnel development. While money is important, the greatest bottleneck is a lack of trained people. Areas in which training should be stepped up include: community and social medicine; epidemiology; statistics; computer sciences; social sciences related to health; systems analysis; operational research; geriatrics, toxicology; environmental risk assessment and health economics. In all fields, training in research methods is a priority. Research workers should have the chance to take advantage of available research training, for instance, by getting leaves of absence or sabbaticals.

Organization. HFA research should be incorporated into existing research programmes and use available infrastructure. New forms of cooperation between the sciences need to establish fertile ground for multidisciplinary work. The organization of science administrations should be responsive to society's basic health needs and support its policies. For instance, all relevant disciplines must be represented in a country's medical research council.

Communication. The results of HFA research are intended for immediate use in planning and running health care. In many countries, the links between research and health policy are weak. On the one hand, policy-makers and health professionals do not

systematically review and use the scientific knowledge. On the other, many researchers are ignorant of key issues in health policy. Researchers seldom point out the practical implications of their work, and decision-makers seldom use scientific knowledge to support their decision. The research community needs to spread the result of their work not only in scientific journals but also in publications read by decision-makers and administrators. They must present their findings in a language understood by all who will use them. Research projects relevant to the policy-making should include a publishing plan to meet the needs of the different users of the results.

Remember – you have got a friend

Some years ago, a big bank used to advertise: Remember, you have got a friend at Chase Manhattan. RHFA is a proof that the research community, particularly those in public health research, have a friend in WHO. WHO shares their concerns, helps them to set up a good research environment, distributes and makes use of results of research and stresses its social relevance.

Friendship is a two-way street. WHO is looking for the help of the research community to make the ideas in the Research for Health for All policy and thus health for all a reality.

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Sažetak

ISTRAŽIVANJEM DO ZDRAVLJA ZA SVAKOGA

Vizija Johna F. Kennedya o čovjeku na Mjesecu do 1970. godine odredila je cilj tehnološkom istraživanju i razvoju. Vizija Svjetske zdravstvene organizacije o zdravlju za svakoga do 2000. godine postavila je sličan cilj ne samo u pogledu zdravstvene politike već i u pogledu istraživanja koja se tiču zdravlja. Polazeći od analogije koja postoji između ova dva cilja autor prvo istražuje što znači zdravlje za svakoga kao cilj politike. Ovaj cilj zahtijeva u velikoj mjeri promjenu sistema zdravstvene zaštite. Primjer 38 točno definiranih ciljeva u evropskoj regiji Svjetske zdravstvene organizacije pokazuje kako je, da bi se ostvario konačni cilj, potrebno mijenjati pristupe zdravstvenim problemima, stilovima života, okolišu, zaštiti zdravlja i raznim popratnim djelatnostima (npr. planiranje, upravljanje, obrazovanje). Ove promjene trebaju počivati na čvrstoj znanstvenoj osnovi. Zdravlje za svakoga zato iziskuje dobro definirana zdravstvena istraživanja i njihovo preusmjeravanje. U članku se nadalje razmatraju implikacije istraživanja čiji je cilj zdravlje za svakoga. Uz pomoć Regionalnog ureda Svjetske zdravstvene organizacije Evropski savjetodavni komitet za istraživanje u vezi sa zdravljem analizirao je 38 ciljeva da bi ustanovio koja bi vrsta istraživanja pridonijela njihovu ostvarenju. Rezultat analize bile su dvije publikacije: Smjernice istraživačke politike u vezi sa zdravljem za svakoga i Prioritetna istraživanja u vezi sa zdravljem za svakoga. Prva publikacija objašnjava zašto je za neku zemlju nužno planirati zdravstvena istraživanja. U drugoj publikaciji navode se istraživanja koja su potrebna za ostvarenje svakog pojedinog cilja. Ove su publikacije prevedene na nekoliko jezika i već su počele utjecati na istraživačku politiku u drugim zemljama. Članak se također bavi opisom prioritetnih istraživanja koja su istaknuta u dvije gornje publikacije. Namjera mu je da pokaže njihovu relevantnost za Evropsku zajednicu zaduženu za istraživanja u vezi sa zdravljem. Također raspravlja o preduvjetima koje svaka zemlja treba ispuniti da bi omogućila istraživanja čiji je cilj zdravlje za svakoga. Oni podrazumijevaju promjene u stimuliranju i financiranju istraživanja, obrazovanju kadrova, organizaciji istraživanja i komunikaciji između onih koji istražuju i onih koji odlučuju.

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Ključne riječi: sistem zdravstvene zaštite, zdravstvena istraživanja, nivo zdravstva, Svjetska zdravstvena organizacija, godina 2000.

* U Zagrebu je 12. i 13. lipnja 1989. godine u organizaciji Međuakademijskog odbora za organizaciju zdravstvene zaštite, Međuakademijskog odbora za znanstveni rad u medicini i Škole narodnog zdravlja »A. Štampar« održan radni sastanak »Stanje i ciljevi znanstvenog istraživanja na području zdravstvenih znanosti u Jugoslaviji«. Na sastanku su ocijenjeni stanje, potrebe, očekivanja i položaj zdravstvenih znanosti u okviru medicinskih znanosti u nas. Razmatrani su prioriteti daljih istraživanja s obzirom na potrebe zdravstvene zaštite i razvoj znanstvenih kapaciteta. Upozoreno je na poteškoće te su predložene mjere za praćenje i unapređenje u povezivanju tih istraživanja. Prilozi sa sastanka objavljeni su u časopisu Zdravstvo 1989;31:85 – 151. Ovaj prilog koji nije dosada tiskan uvodno je iznio dr. H. Vuori da bi sudionike upoznao s ciljevima i prioritetnim istraživanjima na području zdravstvenih znanosti u Evropi.