REPORT ON THE 3rd MEETING OF THE INTERNATIONAL NETWORK OF HEALTH PROMOTION FOUNDATIONS

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by

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INTRODUCTION

The International Network of Health Promotion Foundations (INHPF) was established in 1999 in Melbourne, Australia with a second meeting following in Bangkok, Thailand in March 2002. The purpose of the network is to enhance the performance of existing health promotion foundations and to assist in the development of new health promotion foundations. Coordination is provided through a Secretariat under Dr. Ursel Broesskamp, Head of International Affairs for Health Promotion Switzerland. Although the network is not funded, members have a wealth of knowledge and experience around establishing and implementing health promotion foundations.

Twenty-three people from 15 countries attended the meeting in Budapest. The BC Health Promotion Coalition (BCHPC) was invited to send a representative by Dr. Rob Moodie, CEO of the VicHealth Promotion Foundation, following an interview with him during our research study that investigated models of funding health promotion across Canada and throughout the world (2002). The Vancouver Island Health Authority, Central Island, sponsored the Coalition's attendance with a grant of $4,500.

The Budapest meeting had four objectives:

- To further strengthen and expand the exchange and mutual learning among health promotion foundations (HPFs)
- To review international experience with various financing mechanisms, which aim at funding health promotion activities through sustainable HPFs or similar infrastructures
- To review advocacy strategies for the introduction of an earmarked tax (hypothecation) on tobacco and alcohol products for creating HPFs or infrastructures
- To advise organizations or countries interested in the creation of HPFs and/or the introduction of an earmarked tax on tobacco or alcohol products to enhance health promotion activities

DAY 1:

Local dignitaries opened the meeting. Dr. Desmond O'Byrne, Group Leader of National and Community Programs for the World Health Organization (WHO) followed, noting that WHO is a key supporter of the INHPFs. The Ottawa Charter (1986) continues to guide the global practice of health promotion with its five action areas. This commitment has been reinforced at

subsequent meetings of the WHO and has led to increasing emphasis on an evidence-based approach to health promotion, one that shows value for effort. The WHO integrates health promotion into all its work and concentrates on strengthening capacity building measures in communities and countries throughout the world. Dr. O'Byrne noted that health promotion foundations play a major role in capacity building and sustainable development. He provided examples of hypothecated or earmarked taxation of tobacco products that have offered a starting point for financing a number of health promotion foundations.

There are seven key elements of a health promotion foundation:

1) The organization is primarily involved in funding health promotion activities
2) The organization has been established according to some form of legislation such as an Act of Parliament
3) The organization is governed by an independent Board of Governance that comprises stakeholder representation
4) The organization exercises a high level of autonomous decision making
5) Legislation provides a long-term and recurrent budget for the purposes of health promotion
6) The organization is not aligned with any one political group
7) The organization promotes health by working with and across many sectors and levels of society

During the last half of day one, six established foundations provided an overview of the structure, process and characteristics that contributed to their operations as an accountable way of channeling public funds into health promotion activities (See Table One). Health Promotion Switzerland, like Canada, has a decentralized health care system in which 97% of the budget is allocated to acute care with only 3% to prevention. Their foundation adds value by complementing the work of government and other players. Dr. Nam from the Korean HPF identified three challenges that they are encountering: (a) management of HP projects (b) use of information technology, e.g., e-health, and (c) measurement of the effectiveness of HP

Dr. Rob Moodie and Barbara Mouy of the VicHealth Promotion Foundation then spoke on the topic of *Earmarked Tobacco Taxes – Taxing Harm, Funding Health.* They noted that the greatest concern of tobacco companies is taxation.

Three general principles support earmarked taxation:

- Community support is high for taxing disease-creating products such as tobacco and alcohol
- Earmarked taxes reduce consumption
- This method provides recurrent funds for improving the health of the population

Following are the advantages of establishing independent Health Promotion foundations: HPFs

- provide for flexibility, responsiveness and innovation
- work *with* government but not *as* government
- are less bureaucratic
- have the ability to harness community involvement
- are non-partisan
- provide for recruitment of specialist expertise
- are accountable and professional

Discussions emphasized that health is an economic issue, and therefore, the Ministry of Finance is the key entry point for government participation in the development of HPFs.

DAY 2:

This session was opened by Peter Makara, Advisor to the Minister of Health, Social and Family Affairs for Hungary. He noted that Hungary is the only Communist country to have participated in the Ottawa Charter discussions. Their country has moved from a top-down Communist style of socialism, to the medicalized public health program (1994), to the new public health strategy of today. Last year the Hungarian parliament adopted a 10-year public health strategy that includes:

a) the settings approach
b) disease prevention
c) development of public health infrastructure, e.g., inservice training and education for health care professionals and communities
d) lifestyle changes

Six Central and Eastern European countries, not currently members of the Network, shared their experiences and progress in establishing Health Promotion Foundations. They are at different stages of development and each has its own unique challenges.

1. The Russian Federation – Dr. Galina Maslennikova. Funding for the health care system in Russia is centralized and constitutes 2.4% of the GNP. Their prime focus is on diagnosis and treatment; health insurance and private sector connections are less developed. Smoking is a key factor in mortality, morbidity and cost. The country is on its way to comprehensive tobacco control.
2. The Czech Republic – Hana Sovinova, Head of the Dept. of Prevention of Addictions for the National Institute of Public Health. Health promotion is part of the national health policy. The CINDI Foundation, founded in 1993 by the National Institute of Public Health, is the main funder of health promotion activities. Their money comes from sponsors and international projects and goes towards training of physicians, publications, clean air, smoking prevention initiatives and public education.
3. Bulgaria – Tzveta Timcheva, Secretary of the Intersectoral Commission on Tobacco Control at the Council of Ministries. Bulgaria is a tobacco-growing country with 2/3 of production used domestically. In 2002 they adopted a National Program for Tobacco Smoking Reduction. The MOH is responsible for health promotion activities via a newly established Directorate. Currently, 1% of excise tax from tobacco goes into the ministry budget for health promotion and tobacco control though it's not clear how much of that goes towards health promotion.
4. Estonia – Sirje Vaask, Estonian Health Insurance Fund (EHIF). Since 1995, the EHIF has invested 0.3 – 1% of the annual budget towards health promotion and prevention. Financing for national and community-based health promotion projects falls under the Ministry of Social Affairs and is managed by a committee of experts who make funding decisions and coordinate evaluation. Priorities include general health promotion, mental health, prevention of cardiovascular diseases, prevention of injuries, nutrition, physical activity and prevention of alcohol, drugs and tobacco use. A six-member evaluation committee selects a random 10% of projects to evaluate. Discussions have been underway with senior officials re: establishing a HPF but there has been no progress to date.

5. Romania – Dr. Luminita Sanda, Counsellor with the Public Health Directorate. The health system is currently under reform. They have a health promotion unit within the Ministry of Health and Family that consists of 42 HP departments from local directorates of Public Health and a National Centre for HP (an advisory body). Funds come from the national budget, international sources, local contributions, donations and sponsorships from private companies. In 2002, 12% of tobacco and alcohol advertising was allocated to the health care system together with 2% of tobacco and alcohol sales.
6. Georgia – Dr. George Bakhturidze, Tobacco Control Alliance. In 1997 a state program called *Healthy Life Styles* was initiated to prevent smoking but hard economic times and political instability have undermined the program. A proposal to levy a special tax on tobacco production for the purpose of funding prevention initiatives is being put forward to the Joint Social Insurance State Foundation this Fall. A Board consisting of interested governmental agencies, NGOs, mass media and independent experts would administer the foundation.

Presentations by these 6 countries were followed by a session on *Advocacy for Earmarked Taxes and the Establishment of HPFs.* The five key questions in planning an advocacy strategy are:

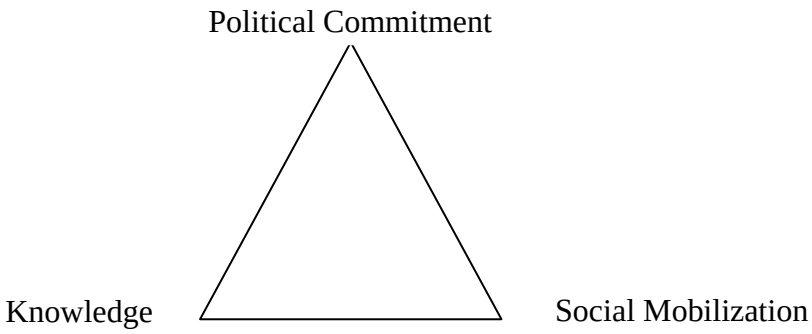
1. What do we want? (The objective)
2. Who can give it to us? (The target audience, those whom we need to convince)
3. What do they need to hear? (Effective message)
4. Whom do they need to hear from? (Effective messengers)
5. How do we get them to hear the message? (Strategies to attract attention of the target audience)

ThaiHealth used a two-step approach. First, they engaged in a movement to increase tobacco taxes (1988-1993) and then they achieved the dedicated tax (1995-2001). The advocacy measures included gathering statistics and conducting a public opinion poll to assess support for a tax increase.

Lessons Learned:

- Educate policy makers and the public about the benefits of a tax increase
- Provide statistics to the Minister of Finance demonstrating advantages of an earmarked tax
- Calculate the effect of a tax increase on the numbers of children smoking
- Calculate the increased revenue from the tax increase
- Conduct opinion polls showing public support for a tax on tobacco products
- Take the approach that the Ministry of Health receives the credit; we are the partners
- Do not request a dedicated tax at the same time as you lobby for the tax increase

The Triangle for Social Movements:



The process used by ThaiHealth was to (a) gather statistics via research, (b) approach the Minister of Finance, (c) establish a committee to draft the proposed Bill, (d) submit the Bill to Cabinet.

Evaluation of HPFs:

Health Promotion Switzerland is evaluated by a team of evaluators from outside Switzerland who interview staff and other stakeholders. Recommendations included more visibility, increasing the number of partners, optimizing processes through feedback on what is happening with their projects, better use of their advisory board, increased communications about good projects, strengthening coordination and collaboration and better integration of partners' needs.

Healthway is evaluated by the Evaluation Unit at the University of Australia. Cost is approximately 250,000 Australian Dollars plus additional costs for project evaluations. Their budget is 16-17 million AD per year which works out to 10 AD per person. The main areas of evaluation are: scope of the programs, sponsorship achievements and capacity building.

DAY 3:

This half-day session covered HPFs and tobacco control and preparation of a draft statement to the World Health Assembly.

Poland – Krzysztof Przewozniak talked about the Polish experience. The Polish HPF was established in 1991 under the Maria Sklowska-Curie Memorial Cancer Centre and Institute of Oncology to improve public health in Poland. The foundation is focussed on preventing smoking-related diseases and on changing the Polish diet. Tobacco control legislation and programs have contributed to rapid declines in smoking prevalence and a marked improvement of health in Poles.

Hungary – Dr. Tibor Szilagy spoke about *Building Coalitions in Tobacco Control.* Some key points were:

- Gather all stakeholders with a common interest
- Examine the roles of each and capitalize on the strengths of partners
- Prepare a Position Paper on tobacco advertising
- Conduct a letter writing campaign re: direct and indirect tobacco advertising. This led to a total ban on advertising.
- Always take a positive approach

When questioned about the ethics of taxing disease and harm causing agents for the purposes of health promotion, the group responded that this has often been discussed. The conclusion was that ethical issues are present with any form of government taxation, e.g., even with the tax on health insurance, an ethical dilemma exists because those who live the longest are paying for those who die earlier.

Healthway – Dr. Jo Clarkson spoke about *Approaches to Tobacco Control in Disadvantaged and Ethic Minority Groups.* She noted that there's difficulty in acquiring accurate lifestyle data on Aboriginal people. However, it is known that smoking prevalence is 50-70% amongst

Aboriginal populations as compared with less than 20% in white Australians. Healthway has found that programs must be culturally appropriate, and fully involve Aboriginal people in planning and implementation stages. They must build capacity through trainerships and scholarships. Project officers must be Aboriginal and address small, community-based projects that communities want to address. Up to 10,000 AD are made available to develop skills, knowledge, education, environments and access. An example is the Aboriginal Imaging Project that promotes positive images of Aboriginal people through the media and through local stories.

Health 2004 – World Conference on Health Promotion and Health Education

Dr. Rob Moodie gave an overview of this conference that will be held in Melbourne, Australia on April 26-30, 2004. The title is *Valuing Diversity, Reshaping Power: Exploring Pathways for Health and Wellbeing.* 2000 participants are expected to attend this "state of the art" forum. It will highlight a global exchange of views and information on health promotion and education from the most credible sources across a range of health areas, health promotion, methodologies, population groups and settings. Registration and proposals can be submitted through the following website: www.health2004.com.au.

Conclusion of the Meeting:

The last part of the morning was taken up with discussions on a draft set of recommendations on financing health promotion activities. The content of this one-page statement provided a brief background of the meeting and summarized conclusions. It will be submitted to the World Health Assembly and recommends that consideration be given to initiating the establishment of new Health Promotion Foundations as a means of funding health promotion.

GENERAL OBSERVATIONS:

Being able to participate in the 3rd meeting of the International Network of Health Promotion Foundations was a valuable experience. Discussions provided an excellent overview of the varying stages of development of HPFs, particularly in Australia, Thailand and Central Europe. Much of this development is tied to tobacco reduction, a direction that is supported by the World Health Organization and the majority of the foundations represented at the meeting. My observation is that this leads to the establishment of funding bodies that have tobacco reduction as their primary objective, particularly during the early years of administration. It is also the case when a tax is levied on both tobacco and alcohol, e.g., ThaiHealth and Malaysia, where the focus is twofold – tobacco reduction and preventing alcohol abuse. Other determinants of health are included but they do not seem to be emphasized as much until the foundation is better established.

With respect to financing, Health Promotion Switzerland is an exception in that it is funded by a mandatory health insurance levy. Their goal is to promote the optimal use of resources and complement the work of government and other players. Similarly, Estonia is financed from an earmarked share of the Estonian Health Insurance Fund budget. However, it is not a foundation, government determines their priorities and health promotion measures are targeted to the risk factors of non-communicable diseases.

Being able to participate in an international meeting such as this provided an opportunity to consider the big picture and link it to what is happening in our own country. It is my personal belief that provincially, nationally and globally, we are running the risk of returning to the behavioural approach to health promotion that was prevalent in the 1970s. This era focussed on individual behaviours, lifestyle orientation and physical wellness, i.e., the age of “blame the consumer” and its parallel philosophy of “people need to take more responsibility for their own health”. Although all groups cite the Ottawa Charter as their guiding document, there seems to be no clear, coordinated comprehensive vision of how to implement health promotion measures as they apply to the broad determinants of health and the principles of empowerment outlined in the 1986 Charter.

TABLE 1: FINANCING HEALTH PROMOTION FOUNDATIONS

Foundation	Population	Method(s) of Financing	Governance	Funding Priorities
VicHealth Promotion Foundation - Tobacco Act of 1987	4.9 million	An appropriation from Treasury from excise duty, customs duty & GST on tobacco – determined by the Treasurer and indexed at 3% per annum. Funds transferred electronically in equal monthly installments.	Independent Board with 3 politicians appointed by parliament – significant delegation to CEO. Advisory and standing committees.	Promotion of good health, safety or prevention, early detection of disease; awareness programs through sponsorship of arts, sports and culture; healthy lifestyles, research and development.
Healthway HPF	1.8 million	An appropriation from Treasury as with VicHealth.	Independent Board- no political representation. Board makes final decisions. Advisory committees.	Promoting health (young people); HP projects and research; replacement of tobacco sponsorship; sponsorship for sport, arts and racing.
Austrian HPF - Health Promotion Act of 1998	62 million	Import tax on tobacco products - $ 7.6 million/year appropriated from Treasury. A fixed amount that is reviewed every 4 years.	Board makes final decisions on the advice of an advisory committee.	Priority is projects and initiatives that work with the principles of the Ottawa Charter, e.g., project & research funding, structural development, training, transfer of knowledge, cooperation networks, public relations and campaigns on avoidable diseases, social & mental determinants of health.
ThaiHealth Promotion Foundation - 2001		2% surcharge tax on tobacco and alcohol	Board of 21 members, Prime Minister is chair, Minister of Health is 1st VP	Settings programs (schools, workplace), research, programs focussed on risk factors (tobacco, alcohol, infectious diseases), sport/art and culture projects.

ThaiHealth has divided their priorities into three areas:
a) Systems change – (20% of the budget). What can ThaiHealth do to have the greatest impact?
b) Healthy communities – (60 % of the budget). Demonstrate to society that health promotion can happen.
c) Social capital – (20 % of the budget). Supports the other two areas of focus and includes information systems, leadership and education, e.g., medical schools, public health training.

HP Switzerland - 1996, Article 19 of the Law on Sickness Insurance	7.5 million	Mandatory financing via health insurance levy of 2.4 Swiss Francs per person	Financial supervision by government; content and program decisions made by a 17-member appointed Council of the foundation; 9 member advisory committee	Physical activity, nutrition, and relaxation; health and work; adolescents and young adults. Also education and quality promotion, communication and information, and public campaigns.
Korean HPF – 1995 Established under the Health Promotion Act	45 million	Tobacco excise taxes are transferred to the National Health Promotion Fund - $8 million USD/year	Not discussed.	Anti-smoking projects, training and accreditation of health education; healthy living and working conditions; public education; research; HP in local health centres.
Malaysia (in the process of establishing a HPF)		Dedicated taxes on tobacco and alcohol. Initiated by Cabinet (2002) on the advice of the Min. of Health to address smoking among youth.	Process is proceeding under a Project Manager, Legal Advisor and Health Promoter.	HPF will strengthen tobacco control and replace tobacco sponsorship of sport, racing and other events.

Edmund Ewe of Malaysia offered the following suggestions when developing a HPF:
a) Have a bold, clear vision of what you want to do
b) Ensure well-defined functions to avoid deviation and duplication
c) Strong legal mandate to ensure autonomy, authority and sustained funding
d) Make provisions for the fund to be managed independently and competently
e) Good governance and accountability
f) Supportive organizational structure and staffing
g) Be non-partisan – this leads to more public support as well as commitment from other sectors.
Have clear, unambiguous sponsoring policies and guidelines.