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Values, principles and objectives of health policy in Europe

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The European Challenge: balancing solidarities in health

The need for common values, principles and objectives for health policy in a changing Europe

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Introduction

A new focus and debate on ethics and values is occurring in the health field. After a decade of economic debate, professionals are beginning to think more critically about the values that drive health action. This debate is as relevant to the changing European context as it is to the resolution of global challenges. Do “European values on health” exist, and if so, how do they affect health policy-making – nationally, regionally and globally? Are they reflected in the European Constitution or in other documents? Are they clearly stated or they constitute a subtext? Does consensus still need to be established, particularly after the recent expansion of the Union and its growing global role?

Values take their most concrete expression in rights. For Jurgen Habermas, the new European citizenship could be rooted in notion of “constitutional patriotism” in which diverse cultural identity and practices coexist but do not define citizenship. According to Habermas, the nation-state gains its identity from “the *praxis* of citizens who actively exercise their civil rights.”¹ It follows then that European citizenship should be rooted in its *constitutional principles* rather than its cultural orientations. Such principles guarantee citizen’s rights and freedoms in the multicultural European society. Constitutional patriotism would replace the ethnic nationalism that is still a key factor in many European nation states and promote a Europe that is “united in its diversity” (which is the motto of the Union as expressed in Article IV-1 of the Constitution).

Historically health has developed into a right of citizenship in European nation states as represented in the universality of access and solidarity in financing (despite very different approaches to organizing and financing health systems). The health discourse in Europe took its starting point with the enlightenment and has always been at the intersection of values assigned to two spheres: the public and the private, the personal and the political, the public good and individual rights. This historical dimension with its roots in a view of health as a means of empowerment for individual citizens and a responsibility of the state for the health of the public is critical to any discussion of European values in health and health policy. The right to health and medical care was and is an integral part of the claims to rights and citizenship of many of the social and political movements of the last 150 years. Women’s health rights remain to this day the most explicit example of this link.

“In modernity – so Foucault - the sharpest discourse on difference always takes its starting point from the body.” Major health differences exist within and between countries in the new expanded European Union and addressing them will be a challenge that goes beyond individual member states. Just as health played a major role in establishing citizenship, identity and allegiance at the level of the nation state, it could play a major role in the establishment of citizenship, identity and allegiance to the modern European Union (EU). Health is an area that very concretely affects people’s wellbeing and feelings of security. Indeed a strong commitment of the European Union to health could be seen as a concrete expression of the potential that lies in the EU’s commitment to wellbeing and social justice. But at present, health remains an area that member states are highly ambiguous about – with the area of health care jealously guarded by the member states of the Union and the areas of public health kept weak within the Union responsibilities. Also, there is not yet a strong citizen’s movement that advocates for a new approach to sharing access to health rights throughout the Union.

This paper examines the values debate in the realm of health and its applications to policy making in Europe. It discusses the issue of health as a value in itself, as well as other values like equity, dignity, solidarity and diversity that are relevant to the European context. The paper continues by analyzing the values common to the public health and health policy arenas as well as some of the applications for governance, including health targeting and evidence. It discusses participation and accountability as values, followed by questions for future debate and dialogue on this vast topic. Its key intention is to help initiate a systematic debate on European values in health. This is crucial not just for Europe itself but also for its role in relation to global developments.

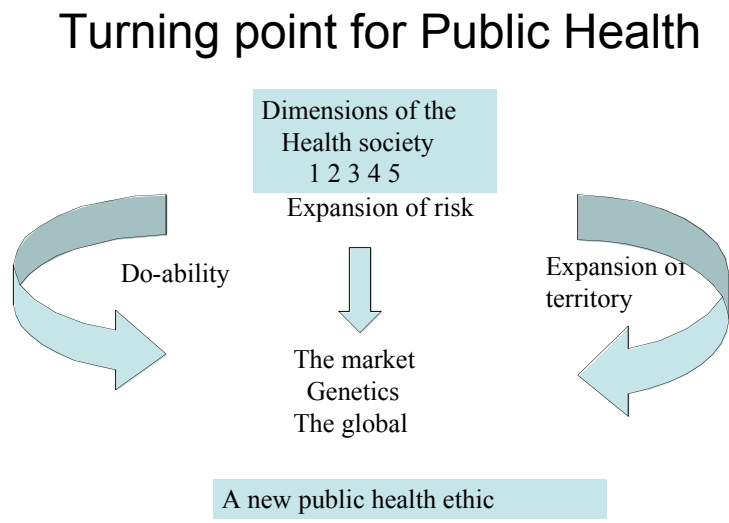
I. The Values Debate in Health: Key Dimensions

Values in health are ubiquitous. They frame European debates and shape evidence that informs health policy and goals. A discussion on the underlying values in health within a new context and framework is timely, as the success of public health in Europe has changed the very nature of modern societies. They have become *health societies*. Health has expanded into ever-wider realms of life and policy, and has become increasingly do-able (see Figure 1). Health societies are defined by five major characteristics²:

- a high life expectancy and ageing populations,
- an expansive health and medical care system,
- a rapidly growing private health market,
- health as a dominant theme in social and political discourse and
- health as a major personal goal in life.

Each of these five characteristics (and perhaps even more their synergies) presents a challenge to public health and changes its nature and the extent of its remit. As in the 19th and 20th centuries, the resolution that is adopted will define the progress of 21st century society. How will we treat the old? How will we pay for health? Who has a right to care? To what extent will we enhance our biological capabilities? How do we approach risk solidarity, generational solidarity or global solidarity? Or as Ulrich Beck would frame it *“How do we want to live?”* The answers to this debate will only be found in a European-wide debate involving a wide range of stakeholders and conducted over at least a decade with the aim of developing a new public health ethic within a European democratic public space.

Figure 1. Turning point for public health



I. 1. Health as a Value in Itself

1.1.1 Health as an intrinsic value: an end not only a means

Health itself is often identified as a value. The World Health Organization's Task Force on Health in Development had as a key aim to achieve global recognition of the value of health in itself.³ Amartya Sen, the 1998 Nobel Laureate in economics, also advocated this position by emphasizing health, not only a means, but also as an end of political and societal activity, thereby reinforcing the intrinsic value of health. Various types of capabilities (such as the capability to avoid preventable morbidity and premature mortality, or to be literate and numerate) are considered both as ends in themselves, but they are also key to the achievement of other intrinsically valued ends, such as political freedoms and capability to participate in trade and production. Health and its social determinants, therefore, have both constitutive and instrumental value⁴ - they contribute to capability of a person to live more freely, but they also complement one another.⁵

In many countries, the commitment to a certain system of improving health is seen as a value in itself. The Canadian report "Medicare: A Value Worth Keeping" asserts, "Canada's health care system is one of this country's foremost social accomplishments, a core value that helps define our national identity."⁶ Sorrell claims, "NHS functions in the UK not only as a source of medical treatment but as a prime medium of national solidarity and national identity."⁷ At this level, health and the health system as values are "part of the cultural fabric that allows people to engage each other with language, develop their institutions, maintain the social order necessary for survival and prosperity, play social roles, and assume personal identities."⁸

1.1.2 Health as a public good

The discussion on health as a global public good has also given new impetus to the discussion of health as a public good at other levels of governance. Public goods are non-excludable and are available in the public domain for all to enjoy.⁹ The public good concept implies that health cannot be reduced to a commodity and needs political will and a "public push". It must be supported by a governance infrastructure with public financing mechanisms. In this sense, health is also a *public value*. Public values are "concerned with *State intervention to promote morally desirable ends*."¹⁰ Public values extend beyond both individual preferences and the private realm and, in terms of health, increasingly expand from

regarding only medical care provision into including the realm of social determinants of health. A renaissance of Geoffrey Rose's public health dictum is taking place at national and international levels. "*The primary determinants of disease are mainly economic and social; therefore its remedies must also be economic and social.*"¹¹

This concept forms the foundation of a new and broader public health field and expands it into a wide area of economic and social rights. The new debate on basing health policies on a health determinants approach also reflects this. (For an example, see Box 4 on "Swedish Public Health Policy: focusing on the determinants of health" on page 11.) But the concept of health as a public good and a public value is clearly under threat both from economic developments, such as the growth of the private health care market, but also from social trends such as increasing individualization. In consequence, European societies must debate the values they assign to health: as a right of citizenship and empowerment, as a private product on the market or as an ultimate value.¹²

1.1.3 Health as a human right

As inequities in health become more and more obvious, the notion of health as a human right is gaining new support. The right to health was codified as a human right in the Declaration of Human Rights in 1948 and is stated in the constitution of the WHO. This raises the issue of the interface between European values and what has been termed *universal values*. Nigel Dower points out, "If citizens are increasingly motivated by global concerns then cosmopolitan goals enter domestic policy in that way and people can be effective global citizens by being effective globally oriented citizens of their own states." In particular, this would imply a common notion of social justice and a system of international law where human rights, and in particular the right to health, constitute a legal claim. The right to health approach moves health policy making into the arena of international legal entitlements.¹³ It is relevant to the European Union in terms of access rights of third country nationals within Europe as well as the global social contract that is implicit in the acceptance of health as a human right.

I.2. Values in Health

1.2.1 Schools of thought

As already stated, values are inherent in health policies, programs and advocacy. Yet, these values in health are seldom explicit. Clarity on the values and schools of thought underlying the formulation of health goals and targets creates an understanding of the reasons for undertaking the initiative and also helps to determine appropriate strategies and scope of the program. Alkire and Chen argue that a rights-based approach ("fulfilling our obligations so others are dignified") or an equity approach ("achieving a fairer distribution of health capabilities") differs from one that is utilitarian ("maximising aggregate subjective happiness") or humanitarian ("acting virtuously towards those in need"). Frequently, health advocates from various schools of thought do not clearly elucidate their platform in an attempt to keep the discussions more superficial, thereby appealing to a wider audience and generating more agreement.¹⁴

1.2.2 Equity and social justice

From the very beginning of modernity, health has been at the center of debates on inequity, initially within the context of the nation state and today as a key dimension of globalization. Health governance debates are predominantly about social justice. The value of equity commonly arises in relation to access, utilization or financing of health services and also in regards to health outcomes and health status. Two main forms of health equity can be identified: vertical equity (preferential treatment for those with greater health needs) and horizontal equity (equal treatment for equivalent needs). Published literature focuses more heavily on horizontal equity.¹⁵

In the 1990s, new political and moral trends surfaced in the world that emphasized health and equity.¹⁶ John Rawls' work on the universal principles of social justice as set forward in "The Law of Peoples"

takes the issue of justice and fairness beyond states to peoples. Amartya Sen developed the “capabilities approach”, partly based on Aristotle’s theories, which asserts that health has a special and moral importance in society. As mentioned earlier, Sen values health intrinsically and maintains that different kinds of capabilities (such as the ability to participate actively in life) are regarded as both ends in themselves and means for the achievement of other ends (such as achieving good health). It is the expansion of these human capabilities that are the real freedoms of life and the ultimate end of public policy.¹⁷ David Held in turn stresses the need to keep the focus on “public goods” in relation to health, welfare and the environment including new global mechanisms to finance them.¹⁸

1.2.3 Dignity

Another value commonly evoked in the general health debate is dignity.¹⁹ Immanuel Kant defined dignity “an absolute inner worth [of a man] whereby he exacts the respect of all other rational beings in the world, can measure himself against each member of his species, and can esteem himself on a footing of equality with them.”²⁰ In 1997, the Council of Europe adopted the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine. Article one states that Parties to the Convention “shall protect the dignity and identity of all human beings and guarantee everyone without discrimination, respect for integrity and other rights and fundamental freedom...”²¹ And Article two states, “The interests and welfare of human beings shall prevail over the sole interest of society or science.”²² The value of dignity is becoming increasingly important in relation to the ageing of European populations in terms of long-term care as well as death and dying. But it also plays a role at the global level. According to Richard Horton, “A goal for those concerned with global health might reasonably be to create setting that foster the conscious awareness and expression of dignity.”²³ Given the reports in AIDS patients in the developing world, mental health patients in many parts of Europe, older people throughout health systems in the EU, the value of dignity will need to gain increasing importance.

I. 3. Health as a European value

European values, in comparison to other parts of the world, are usually equated with commitments to welfare state policies and frequently include reference to solidarity. Schwartz defines values as “principles, or criteria, for selecting what is good (or better, or best) among objects, actions, ways of life, and social and political institutions and structures. Values operate at the level of individuals, of institutions, and of entire societies.”²⁴ Within a short time span of about 50 years, universal medical care has become a trademark of European welfare states. Martin McKee claims, “European societies have deeply held beliefs that the state has a responsibility for the health of its population. The existence of these beliefs implies an acceptance of policies that seek to enhance population health.”²⁵ Recent statements by Commissioner David Byrne support this notion. In a Europe of the future, “*Everybody has easy and prompt access to affordable, high quality health care – whoever and wherever they are...people will have no trouble finding clear and reliable information on how to be in good health and about diseases and treatment options.*”²⁶ Yet little is said about the mechanisms of solidarity to achieve these goals. How will the three solidarities that need to be developed and clarified interface? These three solidarities include: 1) the still existent but partly eroding national solidarity in health, 2) the European health solidarity through cooperation, redistribution of resources and granting of access to citizens throughout the Union, and 3) global health solidarity.

Part of the debate about European values holds that the diversity of Europe itself constitutes a value to be upheld. This diversity, which is based in the political, cultural, and religious inheritance of each country, is not adequately understood. Given the diversity of values across Europe, a key issue for further exploration is how beliefs in one country might influence the adoption of health policy developed elsewhere.²⁷ Within the European Union the system of “open coordination” and the increasing number of

policy networks on health²⁸ that have emerged throughout the European Union are contributing to the regular exchange of values.

The work of the European Regional Office of World Health Organization (WHO) has been the consistent attempt to gain a common language and approach to key values driving European health policy. So to some extent, the values reflected in the WHO European Health For All policy shed light on European values in health – but on the whole they have been developed with nation state stakeholders only – not with the broad involvement of European citizens. They include good governance, participation, solidarity, equity and human rights.²⁹

The Health For All toolbox provides policy makers with the effective means with which to implement these values (see Box 1). The tools for implementing Health For All values are divided into three categories: 1) Sustaining and improving the ethical framework, 2) Basing policy on observation, knowledge and expertise, and 3) Improving decision-making.³⁰

Box 1. Tools for implementation of WHO EURO's Health For All values

Sustaining and improving the ethical framework:

- international treaties, covenants and other legal instruments ratified by countries
- priority-setting, for instance the Millennium Development Goals strategy with its core priority of fighting poverty
- consideration of the needs and expectations of citizens

Basing the policy on observation, knowledge and expertise:

- observation and monitoring of health and health determinants through permanent data collection and analyses
- assessment of health risks, health crisis watch and alert systems
- evaluation of the quality of health settings and units through sound systems of accreditation

Improving decision-making:

- analysis of the regional, national, or local context
- health impact assessment (evaluation of the health consequences of societal choices)
- sound use of scientific knowledge (evidence-based policy)

I. 4. Values, Health and the European Constitution

I.4.1 The European Constitution on values

- The Preamble of the European Constitution emphasizes the need to draw “inspiration from the cultural, religious and humanist inheritance of Europe, the values of which, still present in its heritage, have embedded within the life of society the central role of the human person and his or her inviolable and inalienable rights, and respect for law.”
- Article 2 sets forth the Union’s values. It states, “The Union is founded on the values of respect for dignity, liberty, democracy, equality, rule of law and respect for human rights. These values are common to the member states in a society of pluralism, tolerance, justice, solidarity and non-discrimination.”
- Article 3 outlines the Unions objectives: “The Union’s aim is to promote peace, its values and the well being of its peoples....It shall combat social exclusion and discrimination, shall promote

social justice and protection, equality between men and women, solidarity between generations and protection of children's rights....It shall promote economic, social and territorial cohesion and solidarity among member states."

1.4.2 The European Constitution on health

The commitment to the wellbeing of citizens is seen as a core value of the European Union. Article 3 states, "The Union's aim is to promote peace, its values and the well-being of its peoples." Health is not explicitly mentioned in this article but by applying the WHO's definition of health, wellbeing includes health. WHO states, "*Health is a state of complete physical, mental and social well being, and not just the absence of disease.*"

The EU's formal position on health is outlined in the following way in the European Constitution:

- *Article 16* includes the protection and improvement of human health as one area of supporting, coordinating or complementary action. It states:
 - "A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities."
 - "Action by the Union, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education."
 - "The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action."
 - "The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health."
 - "European laws or framework laws shall contribute to the achievement of the objectives referred to in this Article by establishing the following measures in order to meet common safety concerns."
 - "European laws or framework laws may also establish incentive measures designed to protect and improve human health and to combat the major cross-border health scourges."
- *Article II-31* discusses fair and just working conditions: "Every worker has the right to working conditions which respect his or her health, safety and dignity."
- *Article II-35*, which comments on health care, states, "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities."
- *Article III-132* is on consumer protection. "In order to promote the interests of consumers and to ensure a high level of consumer protection, the Union shall contribute to protecting the health, safety and economic interests of consumers, as well as to promoting their right to information, education and to organise themselves in order to safeguard their interests."

I. 5. European Citizenship and Health

Two views dominate the discussion European citizenship and health: one focuses on cultural identity and one on citizens' rights. Both views have implications for a debate on European values and health particularly since with European expansion significant differences in health status now exist within the EU.

1.5.1 Citizenship as culture

European citizenship, as a new kind of citizenship, cannot derive its sole meaning from national

citizenship. National identity, rights and responsibilities are important in their own right; yet European citizenship is more than the sum of its parts. Since citizenship and identity are closely linked, the development of a meaningful understanding of European citizenship is dependent on the creation of a European identity, which in turn implies the commitment to a common set of values. The notion of a European identity, however, seems problematic due to the linguistic, economic, ethnic and cultural heterogeneity of the EU. This diversity in Europe intensifies even further with the influx of third country nationals who now are a significant element of Europe.³¹ If the European identity is characterized by increasing heterogeneity, how should European citizenship be understood?

Some argue that cultural citizenship is most appropriate in the European context. Distinct from the Habermasian notion of citizenship, this view stresses the centrality of culture for an adequate understanding of citizenship.³² It is closely aligned with multiculturalism and embraces cultural differences rather than promoting assimilation. Cultural citizenship makes cultural identity, not national identity or constitutional principles, the core of citizenship.

Box 2. The European Constitution and citizenship of the Union

Article 8: Citizenship of the Union

1. Every national of a Member State shall be a citizen of the Union. Citizenship of the Union shall be additional to national citizenship; it shall not replace it.
2. Citizens of the Union shall enjoy the rights and be subject to the duties provided for in the Constitution. They shall have: the right to move and reside freely within the territory of the Member States; the right to vote and to stand as candidates in elections to the European Parliament and in municipal elections in their Member State of residence, under the same conditions as nationals of that State; the right to enjoy, in the territory of a third country in which the Member State of which they are nationals is not represented, the protection of the diplomatic and consular authorities of any Member State on the same conditions as the nationals of that State; the right to petition the European Parliament, to apply to the European Ombudsman, and to address the Institutions and advisory bodies of the Union in any of the Constitution's languages and to obtain a reply in the same language.
3. These rights shall be exercised in accordance with the conditions and limits defined by the Constitution and by the measures adopted to give it effect.

1.5.2 Citizenship as rights

Concepts of citizenship relevant to understanding European values in health include: theoretical/soft citizenship, practical/strong citizenship, active citizenship and social citizenship. According to Ralf Dahrendorf, European citizenship lies between *theoretical/soft citizenship* (such as feeling part of a community, having common goals and values) and *practical/strong citizenship*, which encompasses real rights (such as voting, fair trials, expression and association).³³

Active citizenship, frequently mentioned in citizenship literature, refers to citizens who actively participate in political and social discourse. Historically, national citizenship has been constructed through social participation.³⁴ Active citizenship in the EU means that citizens defend human, political, economic and social rights – including the right to health and health care.

Finally, *social citizenship* is relevant to the European context because it constitutes the core idea of a welfare state. According to Gosta Esping-Andersen social rights are granted based on citizenship, not performance in the market.³⁵ Social services are available as a right, and therefore health is not a commodity.

II. Applications to Health Policy

As can be seen from the above discussion, values in health policy are ambiguous and complicated. This is due in part to the fact that research on values in the health realm is very underdeveloped but also because values are inherently complex. And while it is not possible to encapsulate all values into one grand theory, some reflections can be made.

II. 1. Values in Health Policy and Public Health

Different sets of values appear in discussions on health care versus discussions on public health. When referring to values in public health, the domain of the *public* (thus implying the role of the state) and the domain of *health* (as a more inclusive concept than health care) are present at the outset; action on determinants of health is relevant in this case. Concerning health care, the core issues that seem to emerge are access to health care and universality. Both discussions- whether about public health or health care- are driven by the notion of equity. The importance assigned to one over the other is not necessarily a reflection of values but of interest.

II.1.1 Values in health policy

Giacomini et al.³⁶ conducted a very helpful analysis of values in Canadian health policy. Their research found that most stakeholders agree that values drive policy goals, decision-making and conduct, but disagree on which values matter most. Health professionals do not share a precise understanding of what values even are. Canadian health professionals call a variety of things “values”, including the health system (health care, prevention-oriented system), health states (health, wellbeing, quality of life), equity (fairness, social justice, equality), access (in conjunction with equity- i.e. universal accessibility), economic viability (cost-effectiveness, efficiency), and relationships (caring, inclusiveness, rights), among others.³⁷

Many seemingly objective things contain values. Evidence, for instance, is not free of values. The questions posed by a researcher, the transformation of answers into reported facts and the creation of an audience for research reports are all influenced by values.³⁸ Terminology like “ought” or “should”, or words with positive/negative connotations (like health/mortality) are embedded with values. Additionally, what goods society views as “public” versus “private” is often a reflection of its values. “The privateness or publicness of a good is rarely an innate property. In most instances, it is a policy choice – our policy choice – to make a good more or less public or private.”³⁹ The trend towards privatization of health and health care, for example, is one expression of larger neo-liberal values in modern societies. In the United States alone, the sales of the wellness industry have already reached approximately US\$200 billion and that it is set to achieve sales of US\$1 trillion within 10 years, thus matching the health care industry.⁴⁰ Meanwhile the public health sector faces the crisis of a severe shortage of public funding at local, national and global levels.

Discussions of values rarely include explicit talk of the negative side of values, or their antonyms, also called “disvalues”. Negative values are seldom called values despite the fact that they are equally normative and judgmental as their positive counterparts. (For a list of values and their potential antonyms, see Box 3.)⁴¹ In a case of competition between values, dissenting individuals do not typically advocate a

disvalue but instead minimize a value’s importance or just omit mentioning it altogether. “Negative values language carries a stiff price: it not only judges but also has an accusatory tone that positive talk avoids.”⁴²

Box 3. Disvalues	
<u>Stated Values</u>	<u>Potential Antonyms</u>
Health, ability to function	Illness, dysfunction?
Equity, fairness	Inequity, unfairness?
Access	Barriers?
Compassion	Apathy?
Participation	Exclusion?
Pride	Shame?
Diversity	Uniformity?
Efficiency	Inefficiency?
Prevention	Cure?

II.1.2 Values in public health

Public values, as described above, relate to state activity. A report by Staley of the King’s Fund⁴³ in the UK suggest seven public health values:

- “*Equity* reflects the understanding that everybody should get their fair share and that people should only have what is their ‘due’.
- *Compassion and altruism* reflects the importance we place on selflessness and putting others before oneself.
- *Security* reflects the importance we place on controlling the future, minimising risk and reducing anxiety.
- *Efficiency* reflects a desire to get the most out of the resources available, always paying attention to the costs of actions and decisions.
- *Choice and autonomy* reflects the freedom to act and make decisions on the basis of one’s own desires, in the absence of State-imposed restraints.
- *Health* reflects a wide conception of what is ‘good’ for people in terms of how they treat their own bodies.
- *Democracy* underpins the authority of the Government to act, on the understanding that policy implementation requires the consent of the people.”

In analyzing the above values, one can conclude that efficiency not a value in itself but is a means to an end. Also, in this list the concept of health as a value re-emerges. The importance given to equity is reinforced, as it is listed first. And security and choice/autonomy, which are often conflicting, are both listed.

Democracy is a value that can be created through public participation in debates around public values. Involving the public brings legitimacy, limits conflict and encourages consideration of collective concerns.⁴⁴ It may also help policy-makers identify and prioritize the relevant competing values so that they are better able to act on behalf of their constituents. “It is possible to imagine that public consultation could serve as such a statement of preferences. QALY [Quality Adjusted Life Year] estimates, for example, require some understanding of the relative value that individuals place on various combinations

of disease/disability states. One can think of public consultation as a way of providing this sort of information.”⁴⁵

Box 4. Swedish Public Health Policy: Focusing on determinants of health

The new Swedish Public Health Policy, adopted in 2003, aims to create equity in health. In the 1980s, there were large health inequalities in Sweden, and so a parliamentary commission was formed to create a strategy to create equal conditions for good health through a focus on the structural determinants of health. The main objectives include, but are not limited to, economic and social security, secure and favourable conditions during childhood and adolescence, participation and influence in society, healthier working life and increased physical activity.⁴⁶

Many ministries and governmental agencies have to become involved in the implementation of Swedish Health Policy due to its focus on determinants of health. Policy-makers in Sweden have concluded that economic policy (redistribution between income groups, age groups and regions), social welfare policy (accessibility of basic social services), labor policy (employment rate), secure growing up conditions (quality of schools and day care), environmental policy, food and agricultural policy (food subsidies), and alcohol policy (reducing supply) are all integral to creating equity in health in Sweden.⁴⁷

Yet, in all of these sectors, there is political resistance to the foundations of the new Public Health Policy – in large part due to differences in values. Neo-liberal forces, for instance, counter redistributive economic policies and the accessibility of social services (through increased privatization). The Swedish National Institute of Health in Sweden asserts, “There is strong popular opinion for defending and developing the social welfare. On the other hand there are strong opposing forces, especially on the international level.”⁴⁸

Therefore, Ministers in Sweden are required to challenge the dominant neo-liberal paradigm in the world today. The underlying issue in this case is expressed by McMichael and Beaglehole, “Tension persists between the philosophy of neo-liberalism, emphasizing self-interest of market-based economies, and the philosophy of social justice that sees collective responsibility and benefit as the prime social goal. The practice of public health, with its underlying community and population perspective, sits more comfortably with the latter philosophy.”⁴⁹

II. 2. Values and Health Governance

II.2.1 Governance and health targeting

Values, unlike goals, do not necessitate particular policies. Yet values do serve a range of other objectives. Three key aspects of values include the developmental (i.e. creating, cultivating, changing values), philosophical (i.e., apprehending possible values, critically interpreting values), and discursive (i.e., conversing, deliberating, and persuading).⁵⁰ This explains why, when discussing target setting in health, individuals involved so frequently mention the importance of the *process* of target setting, which serves to clarify and reiterate common concepts, approaches, values and learning. “Developing targets – at whatever level of governance from international to organisational – provides a ‘common context of interpretation’ and broadens the legitimacy base for critical choices...”⁵¹ In this way, values are both a means and an end, which goes back to the aforementioned capabilities approach by Sen.

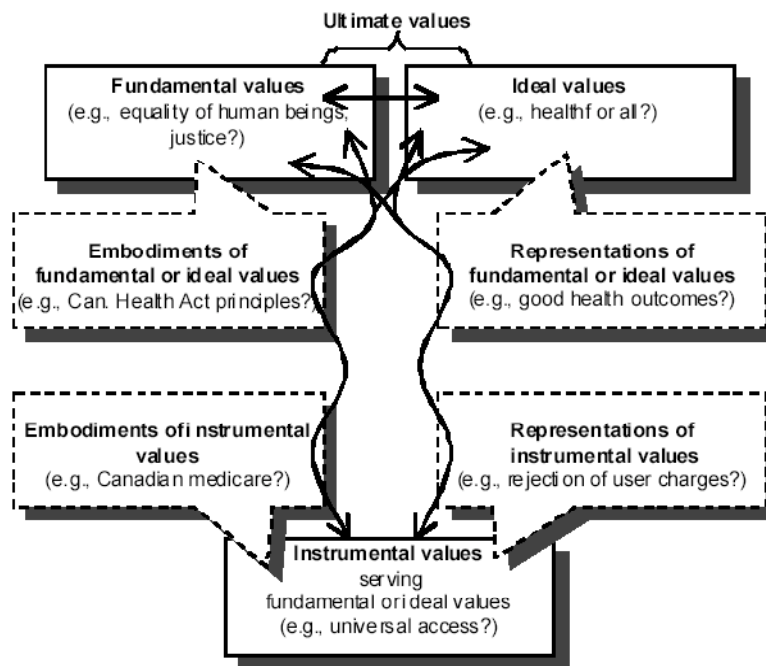
Values in health policy can be viewed on a continuum. *Ultimate* values, or those that are moral and abstract and do not direct activities clearly (such as equality or health for all) are on one end, and *instrumental* values (such as universal access to health care) are on the other. The values that lie in between

“operationalize” the ultimate and instrumental values. (See Figure 2.)⁵² Being involved in setting health targets as a broad inclusion process creates a political space to actually consider the values along the continuum between the ultimate values on one end and the instrumental values on the other.

Policy makers involved with instrumental values make choices and take specific action. They deal less with what matters and more with what must be done, such as in health care financing. In comparing the policy processes in Germany and Sweden, one can see that policy makers in Europe deal with both ultimate and instrumental values. There are little to no debates in Germany about the ultimate, or fundamental values, except in extremely hot debates over party politics. Yet, as described above, the Swedish Public Health Policy is first and foremost focused on an ultimate value- that is, achieving equity in health.

Figure 2. A proposed model of values reasoning in policy analysis

(Key: boxes represent types of values; arrows represent flows of policy reasoning)



II.2.2 Values and evidence

Translating the evidence or facts into policy requires also value trade-offs (not to mention that the evidence itself is not free of values).⁵³ Policy decisions involve giving more weight to one value over another. Sometimes values can work synergistically. For example, policies that reduce inequalities in health can also increase security by reducing risks of life-threatening diseases. More commonly, however, values conflict in health policy making.⁵⁴ “Conflicts between autonomy and other public values are the most common, since the Government’s desire to promote the health of the population often comes at a cost to individual freedom.”⁵⁵

No hierarchy of values exists, and so individuals will trade-off values in a way that reflects their priorities. Values basically reflect how one thinks the world should be organized, and this becomes particularly important when final evidence is not available. The everlasting debate between equity and

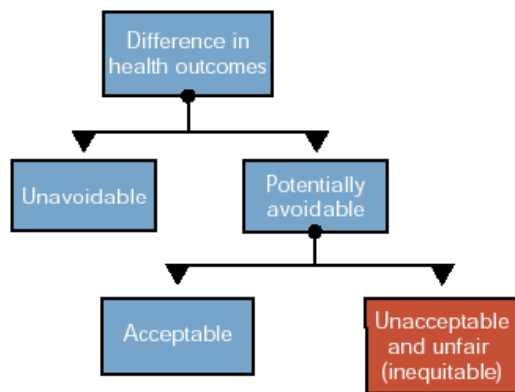
efficiency is one such example.⁵⁶ Prioritizing public values can give rise to political controversies in public health because values are often deeply held and individuals have conflicting beliefs on what values are most important. Often, policy-makers hide behind technical evidence because tough decisions that might seem to counteract supposedly held (or really held) values might need to be explained politically. In order to achieve support, “health programmes also must build consensus among a diverse constituency of resource-holders as to the central value of the initiative.”⁵⁷

One example is the fact that the majority of policy makers continue to frame health in terms of expenditure and consumption of health care services. Very few institutions, organizations and funding programs clearly differentiate between programs that focus on *health* and its determinants and those that focus on *health care*. One potential reason for this gap, among many others, is that little Cochrane-type evidence exists on what are successful interventions to address the determinants.⁵⁸ The historical and common sense evidence, of course, abounds but is not utilized. As Kimmo Leppo so eloquently stated, “One of the great paradoxes in the history of health policy is that, despite all the evidence and understanding that has accrued about determinants of health and the means available to tackle them, the national and international policy arenas are filled with something quite different.”⁵⁹ It is in exactly this area that a new type of European debate spearheaded jointly by the EU and the WHO regional office should move forward. The WHO has now created a new Commission on social determinants and health chaired by one of the leading academics in Europe. Herein lies the possibility of developing a new health policy model based on European values and bringing it into the global debate as a guide for health development.

II.2.3 Fairness as an instrumental policy value

Health inequities exist due to unequal access to resources, including education, health care, job security and clean air and water.⁶⁰ *Inequalities* that are unfair, or arise from social injustices, and are also avoidable are considered *inequities*. Fairness is used in this context to describe the unacceptable disparities in health (See Figure 3).⁶¹

Figure 3. Determining the inequity of health outcomes



Benchmarks published in the WHO Bulletin⁶² contain criteria for evaluating specific aspects of fairness of health reform proposals. Relevant in a developing country context, the benchmarks include analysis of:

- 1- Intersectoral public health
- 2- Financial barriers to equitable access
- 3- Non-financial barriers to access

- 4- Comprehensiveness of benefits and tiering
- 5- Equitable financing
- 6- Efficacy, efficiency and quality of care
- 7- Administrative efficiency
- 8- Democratic accountability and empowerment
- 9- Patient and provider autonomy

These benchmarks do not attempt to provide a universal scale of fairness across health systems but instead emphasize the need to be context-specific. They are meant to be supplementary to other efforts of monitor equity in health systems.

II. 3. Participation and Accountability as Values

II.3.1 Do-ability and accountability

Public health is about collective efforts. This is of importance because, as Europe becomes increasingly interdependent, there is an expansion of the territory of health into an increasing array of personal and political spaces and a concurrent expansion of the do-ability of health. This do-ability raises the issue of responsibility and accountability. Because health is do-able, whose responsibility is it to promote and provide it? Who is accountable for the individuals lacking access to health and health services?

Knowledge and power in contemporary societies are so widely distributed that cooperation becomes “a new categorical imperative.”⁶³ It follows that accountability needs extend horizontally just vertically. This is expressed, for instance, through the Verona Benchmarks, which relate best practice to partnership building.⁶⁴

II.3.2 Role of the citizen

As health expands in modern societies, the role of the citizen in health does as well. The citizen becomes an individual who takes care of her own health, as a consumer in the health market place, as a patient in the health care system, as a voter on health care issues, and as a social actor together with others in NGOs and social movements. As this critical role of the citizen/consumer/patient gains in importance, participation and accountability become key values in health governance.

II. 4. Future European Dialogue on Health and Values

In the 21st century, the increasing overlap between government, civil society and the market pervades all debates on new governance. Definitions of social justice, public and private goods, and the new social contract between the state and the citizen are issues that commonly surface.⁶⁵ And indeed this is the case here. The values debate in health reflects this trend, a natural evolution in modern society. In response to this, Europe needs to widen the health debate with many stakeholders about the role of health and the values of health in the European Union. Health can become a positive force of European citizenship. The expansion of health into areas other than the health sector implies that there needs to be a new and broader dialogue at the European level. It is not enough to have agreement on values with regard to health within the health sector alone.

This paper brings to light areas for further exploration and discussion in the values debate (see Box 5). A key ambiguity in this assessment seems to be the difference in what professionals consider a value versus an interest. Perhaps this could be an area of future review. A comparative value study of European health documents as undertaken by the Canadians would probably reveal, just as the Canadian study did, that European health policy makers call a great variety of things “values”. Also, a process to develop European health goals and targets would create the political space to discuss the common European core and also the key values relevant to European public health policy. Europe cannot escape the debate that builds on moral philosophy as in efforts to build a healthy Europe and healthier world. Yet it is essential

to find ways to instrumentalize the values that come to the fore and make them reference points. This means taking values out of the realm of moral speculation and putting them into the realm of rights at all levels of governance.

The key complexity is that in an interdependent world no national approach will be sufficient. Equity, solidarity, universality and dignity will need to be matched at European and at the global level. Indeed what is needed is a new global social contract. Elements of this are under way as the rich states examine their approach to debt relief, trade and development policies. But it will be crucial that European citizens themselves engage in this debate.

Box 5. Questions for further debate in Europe

How are values manifested in European health policy?

Does it help to make these values explicit?

Whose values matter?

How can policy makers take public values into account? Is this possible given the diversity in the EU?

How are values manifested in technical goals?

Are there “priority values” by which European policy makers should follow in policy making and target setting?

If evidence is not value free, what does that mean for evidence-based policy making?

How are values manifested in the implementation process of target setting?

How can conflicts of value prioritization in target setting be resolved?

How does the distinction of “old” versus “new” Europe impact the values discussion?

What kind of frameworks can be constructed to help guide policy making and target setting?

What are relevant mechanisms through which to implement health values in Europe?

Europe has the potential to be an international leader in shaping policies that promote health through the global acceptance of responsibility. Health, first and foremost, needs to be at the centre of EU policy-making,⁶⁶ especially in relation to citizens’ needs and rights. The social Europe of the future requires a focus on European identity in which health is inextricably linked to the concept of modern European citizenship. Such a concept of citizenship also accepts a commitment to global solidarity. Europe needs to apply the lessons learned in the historical development of public health in Europe to its global responsibilities.

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