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Counties Selecting Public Health Priorities – a »Bottom-up« Approach (Croatian Experience)

Selma Šogorić[1], Tea Vukušić Rukavina[1], Ognjen Brborović[1], Andro Vlahušić[2], Nino Žganec[3] and Stjepan Orešković[1]

[1] School of Public Health »Andrija Štampar«, School of Medicine, University of Zagreb, Croatia
[2] Ministry of Health, Zagreb, Croatia
[3] Ministry of Labor and Social Welfare, Zagreb, Croatia

A B S T R A C T

The subject of this paper is how to incorporate a multi-disciplinary and inter-sectored approach into development of public health policy and plans at the local (county) level in Croatia by educational program. Method used was the public health capacity building program »Health – Plan for it«, which was developed with the aim to assist the counties to overcome recognized weaknesses and introduce more effective and efficient local public health practices. Two main instruments were used: Local Public Health Practice Performance Measures Instrument, and Basic Priority Rating System. This program has helped counties to asses population health needs in a participatory manner, to plan for health and, ultimately, assure provision of the right kind and quality of services (better tailored to population health needs). This program's benefits are going beyond and above the county level. It provides support for the Healthy Cities project locally, and facilitates changes in national policymaking body's mindset that a »one-size-fits-all« approach is sufficient.

***Key words**: public health, health policy development, decentralization, community health planning, Croatia*

Introduction

Background

Citizens in the Balkans and South East Europe (SEE) feel a lack of social well being and a sense of vulnerability as a result of the war and post-war experiences[1–6]. The shift from a socialist government with centrally planned economies to democratic governments and more market-based economies has taken place rapidly in the SEE, but the transition has not been without economic problems. Variations in socio-economic factors have had strong impact on the health systems of the countries and the health of their citizens[7–9].

Public health can make a small, but significant contribution to the enhancement of social justice here and now in the SEE region[1]. More than ever, public health is being viewed as a catalyst for peace[10–15] and an important factor in the socio-economic development equation[16]. Of practical importance to the reversal of present negative trends is the strengthening of all public health structures, including policy-making support[17], human resources training[18], and population health research[19–20].

The World Health Organization (WHO) and the Council of Europe have called attention to growing health status disparities and population vulnerability in SEE[21]. The regional Health Development Action Plan for SEE undertaken by the Council of Europe and WHO European Office within the scope of the Stability Pact, led to the Dubrovnik Pledge[22] (2001) – a political instrument to improve social well-being and promote human development in SEE. The Stability Pact is currently targeting the issue of social cohesion, which holds promise for as yet unrealized development.

During the last decade, public health became insufficient due to war and economic and political changes. Today, there is a lack of competence in public health, particularly in health management and strategy development, but also in health surveillance and prevention. There is a need for sustainable collaboration, and support in advanced training and continuous education of qualified professionals to reach required conditions[23].

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The Open Society Institute, New York, and the Association of Schools of Public Health in the European Region (ASPHER) are actively involved in public health developments in the region[24]. In the spirit of the new public health, there is currently a strong initiative to assess the need for human resources in the health sector and to provide much of the needed interdisciplinary training. Such training is described in this paper.

The central challenge for public-health practitioners is to articulate and act upon a broad definition of public health, a definition that incorporates a multidisciplinary and inter-sectoral approach to the underlying causes of premature death and disability[25]. Public health education for much of the world (not only SEE countries) is welcome, and public health leadership programs are under development[26]. These programs will encourage empowerment of local communities, a necessary step in rejuvenation of public health[27]. Nevertheless, questions arise as to whether public health practitioners should be concerned with fundamentals such as employment, housing, transport, food and nutrition, and global trade imperatives, as opposed to just individual risk factors for diseases. A broad focus inevitably leads to involvement in the political process[28], an arena that is as well emphasized in the program described in this paper.

Within the European public health community there is a widespread recognition of the importance of intersectoral collaboration. An extensive research from WHO's Healthy Cities[29] and Regions for Health movements showed what can be achieved by building effective cross-sectoral alliances[30–32].

From Healthy Cities to Healthy Counties – Chronological Order of Events

Healthy Cities Project – gaining experience in bottom-up policy building

The Healthy Cities (HC) Project, initiated by the WHO European Office in 1986, is a long-term international development project that seeks to put health on the agenda of decision-makers in cities and to build a strong lobby for public health at the local level. The crucial notion that stimulates HC project development was the recognition of importance of the political will. The Healthy Cities Project challenges cities to take seriously the process of developing health–enhancing public policies that create physical and social environments that support health and strengthen community action for health. Initiating the Healthy Cities Project process requires explicit political commitment and consensus across party political lines, leading to sound project infrastructure, clear strategy, participation mechanisms and broadly-based ownership[33–34]. Healthy Cities is about change, openness to participation, innovation and formal system reorientation. It is changing the ways in which individuals, communities, private and voluntary organizations and local governments think about, understand and make decisions about health.

European cities in general are challenged with complex public health issues like poverty, violence, social exclusion, pollution, substandard housing, the unmet needs of elderly and young people, homeless people and migrants, unhealthy spatial planning, the lack of participatory practices, and unsustainable development[35]. Due to the war and post-war transition, Croatian cities are faced with many others, like, for example, mental health, posttraumatic disorders, quality of life of disabled, family health, community regeneration and community capacity building, unemployment, especially among young and mid career workers, stress, alcohol, tobacco and substance misuse, etc. The Healthy Cities Project framework provided the testing ground for applying new strategies and methods for addressing these issues in Croatia. Especially helpful was the second phase of the European Healthy Cities Project (1993–1997), which encouraged the process of development and implementation of the strategic city health documents: the City Health Profile and City Action Plan for Health[36–37]. It was a breaking point that renewed dignity and a sense of mission to the public health profession, and emphasized issues of health, participation and community development. While working on those key documents, public health physicians, who act as the process facilitators, had legitimacy and access to all main players – city politicians and administration, professionals and institutions, citizen representatives and NGOs. It gave them a chance to conduct community-based needs assessment and to open dialogue between different interest groups, i.e. future main »health stakeholders«[38–39].

Unfortunately, the Healthy Cities experience has remained quite localized and undervalued by the formal health policy system at the higher County and national levels since the end of the 90s.

The process of decentralization and health and social welfare system reform has imposed a great pressure for change on the local governments and health sector at the end of 90s. It encouraged them to consider new (public health) approaches, techniques and methods. Public health professional involved in the Healthy Cities project decided that future engagements at the higher County level would likely yield more positive results.

Developing the paradigm – situation analysis

Key players able to bring changes in public health policy development and implementation at the county level were identified: as those who can (have political power), as those who know (have knowledge and skills) and those who care (have direct interest in bringing change). Political power at the County level in Croatia is within County Councils* and their executive bodies County Departments for Health, Labor and Social Welfare. Technical expertise is within County Institute of Public Health and Centers for Social Welfare. Citizens groups and associations were seen as the most direct

representatives of citizen's interest. The assumption was that only active participation of all mentioned key players from the political, executive, technical, and community arenas could improve process of creation and implementation of the county's health policy and guarantee better health outcomes.

But due to the centralized state policy and vertical process of decision-making used in the previous years, collaboration among the various players mentioned above has not been established. Non-existence of an articulated County health policy was a logical consequence of the lack of collaboration. County officials had insufficient knowledge of new population health needs resulting from the war, post-war transition and economic and social difficulties, and these needs have not been addressed properly. Consequently, the population is receiving traditional services, hardly those that respond to real needs. Throughout 90s County Councils did not have real political power and County Governors acted more as Central Government than County Government servants. With the exemption of the few old and well-equipped Institutes of Public Health majority of them was established within the last eight years. Through the collection of data, monitoring and reporting they provided primary, information to national Institute of Public Health and did not see themselves as the players at the county level.

The first step in development of public health policy and plans at the local level in Croatia was assessment of present state and conditions. In the summer of 1999, directors of the Motovun Summer School of Health Promotion convened a panel of 25 Croatian public health experts to review existing public health policy and practice at the county level. The group used an assessment tool called the Local Public Health Practice Performance Measures Instrument, which was developed by the U.S. Centers for Disease Control and Prevention Public Health Practice Program Office[40–42]. This instrument recognizes three core functions of public health: assessment, policy development and assurance, and 10 practices associated with them. Three of the 10 practices emphasize important components of the assessment function: assessing community health needs, performing epidemiological investigations, and analyzing the determinants of health needs. Another three practices address the policy development function: building constituencies, setting priorities, and developing comprehensive plans and policies. Finally, four practices relate to major aspects of the assurance function: managing resources, implementing or assuring programs to address priority health needs, providing evaluation and quality assurance, and educating or informing the public. The 10 practices mentioned can be used as performance standards, supported by the 29 associated indicators to measure the effectiveness of local public health practices.

The original Local Public Health Practice Performance Measures Instrument was translated into Croatian, with appropriate revisions. The finished instrument allows situation analysis for each of 10 practices and measurement of associated indicators, i.e., whether or not they exist, whether they are satisfactory or unsatisfactory, and who is or should be in charge of this activity. The panel of 25 Croatian public health experts discussed all topics and identified the following as the weakest points in existing public health policy and practice at the county level: formulating public health policy, especially in selecting priorities among health needs; strategy formulation and comprehensive planning for solving priority issues; coalition building and gaining support from the community and relevant organizations; public health policy assurance, an issue stemming from the lack of objectives and therefore an inability to determine whether they are achieved; and, finally, lack of analysis of the adequacy of existing health resources.

From the results, it was obvious that counties require professional public health guidance and assistance to develop more effective and efficient local public health practices, i.e., to assess population health needs in a participatory manner, plan for the health of the population, and assure the provision of the right kind and quality of services based on the population's needs.

Healthy Counties project development

Given this scenario in mid-2001, the process of change caused by decentralization was seen as an excellent opportunity for improving Public Health practices in Croatia at the County level. A »learning-by-doing« training approach appeared to be the best tool for public health capacity building and strengthening of collaboration between health policy stakeholders at the county level in order to both build knowledge and skills.

Based on Healthy Plan-it™ program[43] (developed by Centers for Disease Control and Prevention, USA) for identifying and prioritizing healthcare needs and developing plans for addressing them, and other materials, the faculty members tailored a public health capacity building »Health – Plan for it« program proposal for Croatia. The program's aim is to provide guidance and assistance to counties, while introducing more effective and efficient public health policies and practice. By the end of 2001, the program was discussed with several panels: public health physicians from County and National Institutes of Public Health, county officials, health managers, Ministry of Health and Ministry of Labor and Social Welfare officials. Finally, it was revised and sent for comments to the pilot group of counties. Topics included were:

a) Public health management (from identification to better satisfaction of public health needs, i.e. provision of the right kind and quality of services)

* As background, local self-government and administration in Croatia are organized into 20 counties and the City of Zagreb. Population of the counties varies from 90,000 to 450,000, while the City of Zagreb has 800,000 inhabitants.

b) Organizational and human resources management (improvement of personal managerial abilities, routine use and application of modern management techniques),

c) Collaboration and community participation (emphasizing the necessity of continuous consultation with the community in all stages of health policy development, and reorienting the health care and social welfare system to make them more responsive towards county specific public health needs).

After two months of consultation the main program stakeholders reached consensus about the aims and content of the program. County teams will first complete four months of intensive training, which will be followed by biannual monitoring and evaluation meetings. Since mutual learning and exchange of experience is an important part of the process, three counties from different parts of Croatia with different levels of local-governance experience will be in training at a time. Each County team should be composed of 9 to 10 representatives: three from the political and executive component (County Council and Department for Health, Labor and Social Welfare), three from the technical component (County Institute of Public Health departments, Center for Social Welfare); and three from the community (NGO's, voluntary organizations and media). The Ministries will support the direct cost of training (training packet development, teaching and staff expenses) and the counties will cover lodging and travel expenses.

The Counties Training Program – Strengths and Weaknesses

Since March 2002 till May 2003 three cohorts of Counties have completed their Modular training. The first, pilot group of counties were Dubrovačko-neretvanska, Istarska and Varaždinska county, the second group Bjelovarsko-bilogorska, Krapinsko-zagorska and Vukovarsko-srijemska county, and the third group Osječko-baranjska, Primorsko-goranska and Zagrebačka county. Each cohort of counties went through the following training scheme:

Module 1 – Assessment functions (4 days intensive training)

During the first module, county team members reviewed the core public health functions and practices and become familiar with the participatory needs assessment approach, methods and tools. Each team developed a framework for its county health needs assessment and decided on methods to involve citizens. Considerable attention was devoted to self-management and group management techniques, especially time management and team development.

Analysis of information gained through the Local Public Health Practice Performance Measures Instrument that all nine county teams completed before the training (Table 1) brought a new insight on how to improve process of creation and implementation of the county's health policy. Estimation of the assessment function given by all nine county training teams was similar, it doest exist but is unsatisfactory. The biggest differences among counties were noticed in assessment of health policy development and formulation function. In estimation of assurance function counties, again, very strongly agreed that this is the weakest one of all three, since it hardly exists in any of the counties.

Homework assigned to the county teams for completion prior to the next module involved creating a draft version of a County Health Profile. To accomplish this, the teams had to apply one or more methods of participatory needs assessment, identify sources of information inside and outside the health sector, formulate county health status indicators, and collect appropriate data (Figure 1).

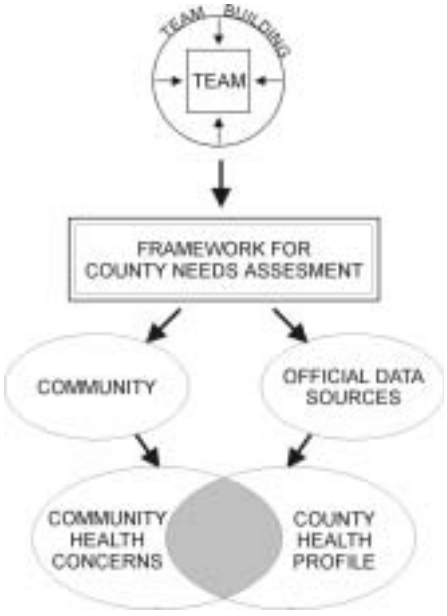

Fig. 1. Module 1. – Program begins with team building and development. During Module 1 team members have to develop a framework for its county health needs assessment and decide on methods to involve citizens. Teams have to apply one or more methods of participatory needs assessment, identify sources of information inside and outside the health sector, collect the data and formulate county »health status« indicators.

Module 2 – Healthy Plan-it™ (4 days intensive training)

At the beginning of the second module, the county teams presented the results of the health needs assessment exercise they performed. Although still in draft form, the County Health Profiles reflected community health concerns and served as a basis for selecting priorities.

Through application of »Healthy plan-*it*™«, an educational program developed by the CDC's Sustainable Management Development Program, county teams were

TABLE 1
PUBLIC HEALTH POLICY AND PRACTICE AT THE COUNTY LEVEL, AS ASSESSED BY NINE COUNTY TRAINING TEAMS

Assessment function All nine county teams recognized that assessment function does exist but were not entirely satisfied with it's fulfillment	a) community health and health needs assessment exists but it is not satisfying; – it is based on morbidity and mortality data collected by the County Institutes of Public Health (due to the national regulation); – does not include community input (opinion and attitude) and participation; – available data are obsolete (1–2-years old), insufficient and inappropriate (not detecting community health concerns), not sensitive enough to reflect changes in health needs of the population, not available for smaller (sub regional or city) areas b) epidemiological surveillance systems – are in place and functioning for infectious diseases and some environmental factors (air, drinking water, quality of sea, food, etc.) – but does not exist for mass, chronic diseases (cardiovascular, malignant), accidents and addictions c) analysis of determinants of health – is unsatisfying, it is not searching for causes; – analysis of the health needs of population groups at highest risk does not exist, nor does analysis of the adequacy of existing health care resources (to what extend they match health needs)
Development and formulation of public health policy The greatest variety of responses was gained when the county teams were assessing Development and policy formulation function	a) advocacy for public health policy and approach is insufficient; – the process of building constituencies, i.e., gaining partners from community and other key institutions, is insufficient in five counties; – there were no revisions of role and mission of departments of health in six counties (one county did not jet establish county department of health); – collaboration with the media is poor, occasional, disease oriented and usually on journalist demand in most of the counties b) the priorities among health needs are not selected properly, – they are either vertically delegated national priorities or politically chosen local priorities (made without consultation with professional groups or community) c) there is no comprehensive health strategy addressing priority health needs (a long-range strategic plan for the health); – some counties have yearly plans, – two counties have health care system development plans, – some counties report to have a community health action plan addressing priority health needs at the city level but not at the county level
Assurance function All nine county teams stated that assurance function does not exist at the county level	a) there is no strategy to identify and secure resources for solving priority health issues b) implementation, i.e. assurance of programs to satisfy identified health needs, is unsatisfying, – even those programs already agreed to are often poorly executed in practice; evaluated only through annual reports c) programs are not reviewed for their efficiency, often there is no evaluation and quality assurance d) education and informing of the public is unsatisfactory, often related to »hot« topics, without feedback on if it reached the right target audience

guided through the health planning process. First, they were introduced to different techniques for selecting priorities among community health needs (Basic Priority Rating System, ref. 40), then to problem-solving and decision-making techniques. Reaching consensus in groups that were so diverse and new to one another (most team members met for the first time at the beginning of the training) was a potential problem. Consequently, the trainers employed variety of confidence building exercises and consensus techniques, which assisted in the achievement of desired team goals.

Each team selected five county health priority areas on the second day of the workshop and began to develop plans for addressing them. The teams learned how to identify and analyze problems, find the root causes of problems, and trace the possibilities for solving problems inside complex, multi-organizational system.

Prior to the next module, the teams were to identify county »health stakeholders« and conduct consultation with them about selected priorities. Following these meetings, each county team could revise priorities, add or select new ones and begin drafting their County Health Plans (Figure 2).

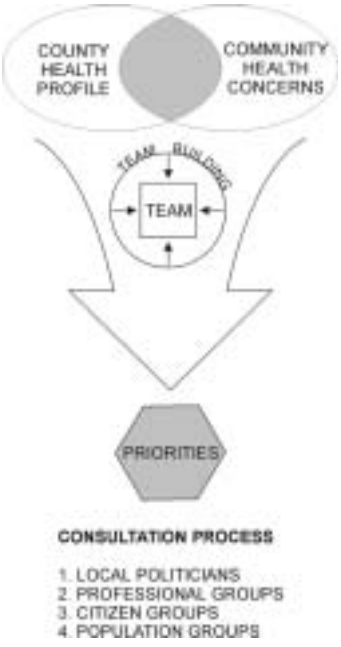

Fig. 2. Module 2. – County health profile (including community health concerns) is analyzed through Healthy Plan-It^{TM} Program to select five county health priority areas. Teams are identifying county »health stakeholders« and conduct consultation with them on selected priorities between Module 2 and Module 3.

Module 3 – Policy development function (4 days intensive training)

This module began with team presentations of the results gained through the consultation process (Table 2). Majority of the county teams found that the parties they consulted shared most of their views, so only minor revisions to the priorities they had developed were required.

The consultations were a good introduction to the process of building constituencies, a key topic in the third Module. Participants learned interpersonal communication, collaboration, advocacy and negotiation skills. Collaboration with the media, public relations and social marketing were addressed, as well. The remaining time was devoted to developing a plan and determining how best to intervene (Figure 3).

Homework assigned to the county teams required them to convene local expert panels in their respective counties to secure their advice on appropriate policies and interventions to address their priority health issues.

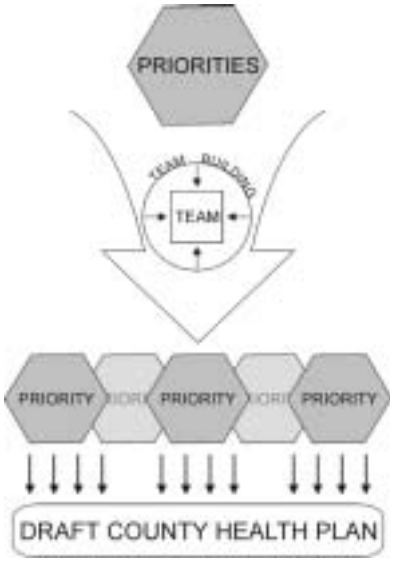

Fig. 3. Module 3. – Selected priorities are processed with second stage Healthy Plan-It^{TM} Program to create draft county health plan for each priority. Between Module 3 and Module 4 teams have to convene local expert panels to advice them on feasible policies and programs to address chosen county priority issues.

Module 4 – Assurance function (4 days intensive training)

At the beginning of the fourth module, the county teams presented draft versions of their County Health Plans, including priorities and intended activities. Skills developed in this module include planning change, building institutional capacity for change, and conflict recognition and resolution. Another training objective was to familiarize participants with methods for analyzing the wider environment. Presentations given by representatives of the Ministry of Health, Ministry of Labor and Social Welfare and by the leader of the national health system reform project helped participants to view their county project from a larger, national perspective, anticipate changes and foresee potential obstacles. Skills like resource planning and management (both human and financial), implementation, quality assurance, monitoring and evaluation were also part of this module.

Homework for this module was to finalize the County Health Profile and the County Health Plan for public presentation six months later (Krapinske Toplice, November 2002, Zagreb, May 2003, Topusko, January 2004). The assignment required the teams to present the results as well as describe the processes used to obtain them, including the participative assessment of health status and needs, selection of priority areas, policies and programs to address priority health needs, implementation plans, monitoring and quality assurance mechanisms, and evaluation plans (Figure 4). Teams had to present their County Health Profiles and Plans locally to their own County Councils, and then nationally to other (not jet involved) Counties, and Ministries.

Fig. 4. Module 4. – Teams are developing policies and programs to address priority health issues, work on implementation plans, monitoring, quality assurance and evaluation.

A tutorial system of guidance and monitoring was introduced after the fourth workshop to ensure that team members not lose their commitment and enthusiasm. County team coordinators meet mentors monthly and follow-up workshops on county health policy development were held every three months (Motovun, July 2002, Krapinske Toplice, November, 2002, Jastrebarsko, February 2003, Zagreb, May 2003, Motovun, July 2003, Mljet, October 2003). Alumni from the first cohort were involved in training of second and third cohorts, providing new trainees with practical advices and guidance from recent graduates of the program. Expert help and support to the counties was provided by the faculty on request throughout the process of development of the County Health Plans.

Conclusions

This paper describes a program aimed at incorporating a multi-disciplinary and inter-sectoral approach to developing public health policy and plans at the County level in Croatia, including the educational process used to prepare county health teams to develop and implement these plans.

The Counties training program was initiated at the right time, when the County and national policy makers were eager to accept a professional public health guidance and assistance in order to develop more effective and efficient local public health practices.

Before the training program was implemented, based on the results of Motovun expert panel assessment, training team assumed that the weakest one among three main functions was the policy development function. That was found to be truth for counties with less developed local self-management structure (lover level of local-governance experience) but not for all of them (Table 1). County teams assessment showed that the weakest point is in the assurance function, which was not fully covered through the training, described below. That finding led towards revision of the second stage of the program. Monthly team coordinators meetings and the tutorial system of guidance and monitoring were found insufficient to support expected process of change. County team coordinators have not sufficient level of influence and political power to keep own team together and tutors became les and les available as the number of trained counties increased.

It seems, at the moment, that the best way to proceed with the second stage is to work simultaneously with all nine counties reduced training teams (so called troikas). Three county representatives (one from political, one form executive and one from technical component) will act as the change agents locally, and as connecting tie between own counties and main program stakeholders. They will receive additional training in change management, action planning and implementation (connected with chosen County priorities), quality assurance and evaluation to enable them to steer the process of change locally and report back on developments.

The missing part, which was added to curriculum after second cohort completed training, was the process of continuous consultation with national healthcare planners and health policy makers. Since many of health priority areas selected by the counties reflect national (Ministry of health and Ministry of labor and social welfare) health concerns there was an obvious need to insure better involvement of county representatives to national working parties (on drug policy, alcoholism, cardiovascular diseases, elderly, unemployment, etc.).

There are several changes in counties' health policy and practice that could be attributed to the »Healthy Counties« project. Project has successfully engaged stakeholders from political, executive, and technical arena. It involved variety of community group's (youth, elderly, unemployed, farmers, islanders, urban families, etc.), local politicians, and institutions in the needs assessment, prioritizing and planning for health cycle. County Health Plans are accepted politically (by County Councils), professionally and publicly. Proposed interventions, for health improvements, rest on local organizational and human resources and are (in the moment in five Counties) financially supported by the County (Public needs) budgets.

The program's benefits in Croatia are extending both beyond and above the country level. It is providing support for the more localized Healthy Cities project, as well as facilitating a paradigm shift in national Ministries' mindset that a centralized »one-size-fits-all« approach is no longer sufficient. With the experience gained through this program Croatian faculty are extending their assistance to the other South East Europe countries, which are undergoing the same process. The first one to try out and test nationally our training model (since June 2003) was Republic of Macedonia.

Acknowledgments

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TABLE 2
HEALTH PRIORITY AREAS SELECTED BY COUNTIES

Varaždinska County	· to improve quality of drinking water · to reduce health complications caused by Lyme disease · to reduce mortality caused by cardiovascular diseases · to reduce alcohol consumption among youngsters · to reduce mortality caused by malignant diseases (especially colon cancer)
Dubrovačko-Neretvanska County	· to decrease substance misuse among youngsters, · to improve health and social care for elderly · to reduce waiting time for secondary care services (improve accessibility and quality of secondary care) · early detection and treatment of cardiovascular diseases · mental health promotion
Istarska County	· early detection of breast cancer · early detection and treatment of cardiovascular diseases · to improve health and social care for elderly and people with special needs · to decrease substance misuse among youngsters · to improve quality of drinking water
Vukovarsko-Srijemska County	· mental health promotion · reducing unemployment · to improve health and social care for elderly · to decrease substance misuse among youngsters · to improve quality of drinking water
Bjelovasrko-Bilogorska County	· to reduce alcohol consumption among youngsters · reducing unemployment · to improve health and social care for elderly · to improve availability and usage of preventive services
Krapinsko-Zagorska County	· to improve quality of drinking water · to reduce alcohol consumption among youth and working population · to reduce mortality caused by cardiovascular diseases · to improve health and social care for elderly · to prevent depopulation of the area
Osječko-Baranjska County	· to reduce mortality caused by malignant diseases (especially lung cancer) · prevention of allergy · to reduce mortality caused by cardiovascular diseases · to reduce incidence of trichinelosis
Primorsko-Goranska County	· to reduce alcohol consumption among youngsters · to improve health and social care for elderly · to reduce mortality caused by malignant diseases (especially cervical cancer) · to reduce injuries
Zagrebačka County	· early detection of breast cancer · to improve health and social care for elderly · to reduce mortality caused by cardiovascular diseases · to reduce alcohol consumption among youngsters · prevention of allergy

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List of abbreviations used in this paper:

SEE	South East Europe
WHO	World Health Organization
PH–SEE	Public Health – South East Europe
ASPHER	Association of Schools of Public Health in the European Region
CDC	Centers for Disease Control and Prevention
MIPH	Management for International Public Health

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S. Šogorić

»Andrija Štampar« School of Public Health, Rockefellerova 4, 10000 Zagreb, Croatia
e-mail: ssogoric@snz.hr

ŽUPANIJE BIRAJU JAVNO-ZDRAVSTVENE PRIORITETE

SAŽETAK

Svrha ovog rada je prikazati kako putem edukacijskog programa uključiti multidisciplinarni i intersektorski pristup u razvoj javno-zdravstvene politike na županijskoj razini. Upotrijebljena je metoda razvoja javno zdravstvenih resursa »Planirajte za zdravlje«, programa razvijenog s ciljem pomoći županijama prilikom prepoznavanja postojećih slabosti i uvođenja učinkovitijih i korisnijih lokalnih javno-zdravstvenih funkcija. Korištena su dva glavna instrumenta: matrica temeljnih funkcija javnog zdravstva i osnovni sustav rangiranja prioriteta. Ovaj program omogućio je županijskim timovima da steknu potrebna znanja i vještine (participativne) procjene zdravstvenih potreba stanovništva županije, da nauče planirati za zdravlje te da znaju kako osigurati (i omogućiti) korištenje svrsishodnih i kvalitetnih usluga koje udovoljavaju prepoznatim potrebama. Koristi ovog programa prelaze okvire županijske razine, pružajući podršku projektu Zdravi grad na lokalnoj razini, te ubrzavaju proces promjene u samom vrhu nacionalne zdravstvene politike, koja postaje svjesna neadekvatnosti jedinstvenog centraliziranog pristupa i načina odabira javno-zdravstvenih prioriteta.