Region: South Denmark

Dialogue tool

Methods:
University College South Denmark has used the dialogue tool created within the framework of the "Healthy Regions" project as an inspiration for the questions used in an interview guide for interviewing a manager (Health Director) and a health consultant on the strategic level in the Municipality of Billund. We have been inspired by some of the following eight themes from the dialogue tool: 1) Health and health promotion, 2) Health and learning, 3) Health and culture, 4) Level of strategic health approach, 5) Level of health competencies, 6) Level of empowerment, 7) Level and mainstreaming, and 8) Health as an economic growth sector.

We were also inspired by the model of the mapping tool, also developed for the "Healthy Regions" project (by the University of South Denmark), as they complement each other. This mapping tool has been developed as a matrix and the final version of it is presented in an annex on the Healthy Regions website. In this model the key determinants of health were identified using the Dalhgren & Whitehead model of health as work environment, unemployment, housing, traffic, education, agriculture and food production, water and sanitation, social insurance systems and health services. The core competencies have been identified as assessment and analysis, policy and programme planning, implementation and evaluation, partnership, collaboration and advocacy, diversity and inclusiveness, communication and leadership . Some of the core competencies inspired us in planning our interview guide.

We did the interview in order to learn more about strategic planning in a municipality, how they think health promotion, how they organize the work, which dilemmas and barriers they experience, which resources they already had in the municipalities and what they wanted to do in the future, building on their experiences.

We wanted to use the WHO Health definition as a starting point and as all three tools build on this definition it was obvious to use them.

We had been working on a strategic level in the Municipality of Esbjerg and were then hired as consultants on a health promotion project among employees in the Municipality of Billund. Our experiences from Esbjerg will be described in another report. These experiences were used in the interview guide as well, and were one of the main reasons for not using the tools unaltered.

Targets/Stakeholders:
The target groups for the interview were mainly ourselves as consultants, in order to develop tools for developing health strategies – after that of course students, both trainees and those in further education and the municipalities.

Results:
The interview guide proved to be very suitable to make the informants reflect on all aspects of health promotion , and thus identify weaknesses and strengths in their strategy and their implementation of the strategy.

When we analysed the interview, we could see that the municipality of Billund, in respect of most of the themes from the dialogue tool, were between level 2 and level 3. They wanted to reach the third level in their health promotion project for the employees. In order to that, we can see that it is very important that the consultants be very specific in the questions they ask the staff members participating in the project.

Guidelines for the use of the tool:
Both tools are very good in order to get around the whole field covered by the WHO Health Definition .

The dialogue tool was on a higher level than we wanted to use in this case, but we might have used it on an introductory level in the cooperation with the municipality. However we are quite sure that they surpassed this level when preparing the health politics of the municipality.

As mentioned above, the mapping tool is very good in terms of ensuring that the whole field is covered, but it is a complicated tool with a lot of questions, which take time both to answer and to work up and adapt. Therefore we did not use it unaltered – only for inspiration.

Region: South Denmark

Working Partnership

The partners in Kiel have contacted us at University College South Denmark as they want to use the scenario planning model in a more simple way than we have done. We have drawn up a small manual for the purpose. The manual is described under "Methods".

Methods:
Drawing up a manual for scenario planning in addition to the description below of the scenario planning carried out in the South Denmark Region (UC South Denmark) and sending it to the German partners in Kiel. We are on hand for further consultation or more practical assistance.

Targets/Stakeholders:
Strategic level in Region Schleswig.

Results:
We do not yet have results.

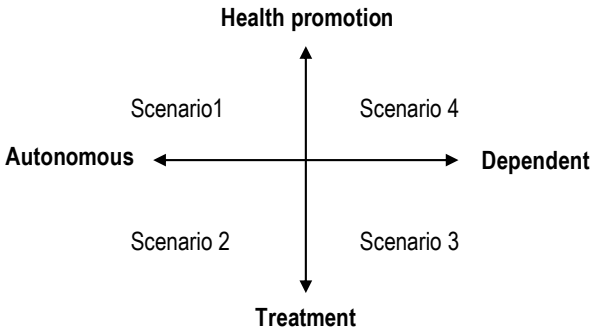
Guidelines to the use of the tool:
The scenario planning in detail:
This description based on the scenario planning manual developed in the EU project "Regional Key Competences" http://www.regionalkeycompetencies.eu/looking/process/combined.pdf

We used the health policy in the Municipality of Esbjerg as a natural agenda and identified "critical uncertainties" – here defined as the core values of the health policy.

The person chairing the process made a desk research of the health policy paper to identify core elements, target groups and main focuses. Those identified elements emerged from the desk research as relevant points. The health policy did not say anything about drivers leading to fulfilling the policy or any kind of achievements.

As we were only 4 persons including the person in charge of the process everybody (3) made all the scenarios just going 3 years ahead as the health policy.

The scenario matrix:



At first we had to define the concepts, not necessarily to agree on a definition but to reach a common understanding of each other's positions. Each scenario was developed one at a time using the core elements:

- Business
- Leisure environment

- Citizenship
- Neighbourhood
- Community

And target groups:

- Children
- Young adults
- Elderly

We did not use the focus areas, COPD (chronic obstructive pulmonary disease – smoking lungs), obesity and abuse, as they represented concrete tasks. They would come later in the process, when staff from the municipality was involved in the process. However, we did not do this part, as the municipality was not running the process at that time.

Developing each scenario in three rounds:

1: In the coming year the following will characterize the municipality.

2: Examples of drivers leading to this scenario.

3: Examples of initiatives from the municipality leading to this scenario.

We did not use the voting system from the scenario planning manual, as at this stage we just wanted to make a draft of the scenario planning model. It proved to be very useful at this stage as well.

An example of developing a scenario is attached as a Power Point presentation. You might say that developing the drivers is very much like the scenarios and I think that is due to lack of training in working with the model. I think you get better and better at using the model the more you work with it. I have attached it so that it is possible to learn from our process and avoid the same mistakes as we have made.

Region: South Denmark

Scenario Planning / Creating Dilemmas

Methods:

University College South Denmark used the scenario planning model in relation to the Municipality of Esbjerg in order to develop a citizen model.

We chose the scenario planning model as it is a very democratic tool that allows you to think beyond your usual thinking horizon. By using this tool we thought that we were able to get a model which we would not otherwise be able to develop. For many reasons, we did not further develop the tool in cooperation with the Municipality of Esbjerg (they were too ambitious at the time and the project was broken don into smaller projects). One of those projects was the training of health ambassadors. The scenario planning was the starting point for that.

From the scenario planning we had a model for strategic planning and for understanding different approaches to health and health promotion. As the health policy in Esbjerg was build on the WHO health definition, the model from the scenario planning did this as well. It was therefore easily transferred to social work, and it had been used in the training of social workers and in further education.

The model will be attached in the Power Point slides.

Targets/Stakeholders:

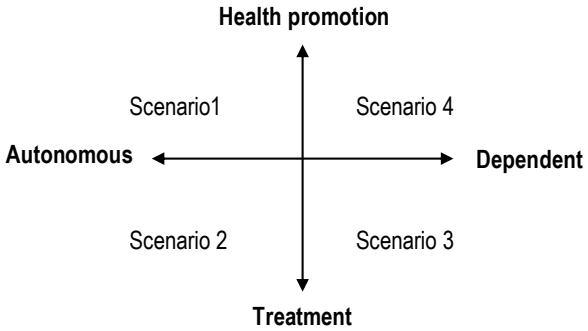
The original target group was a working group in the Municipality of Esbjerg who had the task of developing a citizen model. This group never came to exist in practice. The model became our own tool in understanding different approaches and developing the model has served as training for the scenario planning

Results:

Description of the model:

We used the health policy as a natural agenda and identified the critical uncertainties for the matrix – here in the form of the core ideas which emerged from using a desk research.

We worked with opposite poles, although this is questioned in the manual ,as we wanted to investigate as broadly as possible. The price was that the scenarios may be too schematic, albeit we considered this suitable as strategic guide.



Descriptions of the scenarios:

Scenario 1:

Society is characterised by great flexibility: in working life, where it is possible to flex according to life stages; within housing, where it is possible to choose between a lot of different kinds of housing; and within leisure, where businesses participate as partners. More activities are farmed out, a lot of private schools and private pre-schools are established, and a big difference between rich and poor arises. The individual himself designs his future and the action to be taken. The poor and the weak are supported through network, i.e. the local community, the internet or volunteers. A great deal of citizen involvement is practiced in all cases.

Scenario 2:
The citizens define the services they want and make their own treatment plan maybe in cooperation with a consultant. People have a personal responsibility for their own illness and the amount of “second opinion” advising and alternative therapists in the private field will increase. The citizens consult experts of their own choice, both at home and abroad, supported by private insurances. Everybody has a chip attacched to their case notes enabling them to shop between therapists. You will see a load of networks with patients who have the same problems, e.g., former addicts support each other. You have a free choice and the responsibility for your illness and its treatment is yours. What is to be paid by the state, and what is to be paid for by the individual is not clear, nor what happens to weak and poor groups of people.

Scenario 3:
Illnesses are individual problems which require individual treatment. Therapists and patients are focused on symptoms and defects. Professionals are experts in diagnoses and treatment. The economy is under a constant pressure because of the requirements of existing treatments, new treatment and knowledge of new illnesses. Citizens are categorized and defined on the basis of their difficulties and their treatment (i.e. deaf, blind, KOL and so on), tests and visitation are big working fields for professionals, of whom there will be shortage
We will see the development of hierarchies and a priority of categories as not all are equally prestigious. The field of education will be characterised by sorting. You will see more clientised and patientised individuals and a great pressure from privileged groups of patients and their siblings for treatment.

Scenario 4:
Is constructed after the actual scenario planning, as we did not have the time for finishing it off.
Here ther is a focus on general actions, either for specific groups or the population as a whole, like limited smoking in public, or exercise on prescription. Research knowledge will be transformed into rules and regulations towards citizens, who are dependent on guidance from the state. This concerns rules for use of various ingredients in food and other goods, consumer guidance and so on.

The scenarios represent different tendencies in the development of society. We will here go further into scenario 1 and 3:
Scenario 1 represents basically 2 ideologies which compete within the scenario with comon such values as democracy and citizens' influence .
One ideology is characterized by comunities taking care of individuals, including the poor and weak, the dialectic between individuality and solidarity, as it faces diversity and local decision making – empowerment processes (will be defined later)
The other ideology is characterized by individualism, free competition, individual choice – and individual responsibility for one's own life – and one's own disasters.
The forst ideology represents a decentralized state in an inclusive approach and the other ideology represents a minimal state in a liberalistic aproach.

Scenario 3 represents an individual aproach where the treatment-oriented way of thinking leads to central management and the creation of huge, powerful institutions for diagnosing, visitation, treatment and research. This will result in an enormous pressure on the economy – and it wil be very difficult to fullfil everybody's needs.

Health services today are primary governed within the framework of 3. A health strategy building primarily on this scenario will thus be very expensive – and maybe inappropriate as a solution. The task will be how to lower the level of costs in the health sector. Will you go left in the model and individualize treatment, lower state control and increase health insurances, unauthourized and private treatment and let the individual navigate in a free market with different choices? Will you go diagonally and go for more collective and local solutions with local control – that is, well-being and action in other fields such as housing, environment, etc., or individual choises, farming out, etc., or will you see major centralised actions towards health broadly

speaking as in scenario 4

The WHO health definition has its main focus close to scenario 3, especially the inclusive aproach, but it contains elements from other scenarios as well.

Guidelines to the use of the tool:
You can use the tool for smaller scenario planning operations with a prefabricated natural agenda as we did or you can use it in a bigger scale. I think it is strength of the model that you are able to adapt it to deferent situations.
It is important, no matter on how small a scale you make it, that the scenario planning process is chaired by a person not involved in the process. One person should have the general view of the process and what is going on in order to optimize and guide the process – and the others should concentrate on being in process assuring that the process is taken care of.

Region: South Denmark

Mapping Tool

Methods:
As a part of the Healthy Regions project, employees of the Region of Southern Denmark have worked as external consultants in parts of municipal strategy processes. In the Municipality of Langeland the mapping tool was presented to employees on the strategic planning level in order to discuss the competencies of the municipality for working with health and health promotion. Due to a structural reforms in Denmark less than two years before, the municipality was an amalgamation of three smaller municipalities, and the municipality was assigned new tasks within health. Therefore addressing competencies for solving these tasks was an obvious action to further develop the municipal organisational capacity.

However, one potential disadvantage with focusing on the tool was that the municipal capacity for health work is dependent on more determinants than competencies, e.g. political priorities and financial resources for the health task, priority within the management across sectors for working with health, etc.

In agreement with the municipality, a full mapping according to the tool was not carried out, as this was expected to add no further value compared to a less detailed discussion. Therefore, a discussion on health competencies was held in a process meeting. The reflections below are presented to give a balanced view on potentials and challenges with the tool.

Targets/Stakeholders:
The target group was employees on a strategic planning level (health consultants).

Results:

Potentials
The health competencies mapping tool has a potential for raising municipal awareness of relevant factors contributing to citizen's health. Thus, the tool is based on the Dahlgren & Whitehead-model[1], which illustrates determinants of health within individual life style factors, within the social environment, and within living and working conditions. From this perspective it is obvious that health work should not be performed solely in a municipal health department but as a cross-sectoral responsibility between more municipal sectors. In accordance with this, the municipality of Langeland has based its health strategy on this model by clarifying the responsibility of the municipality, the citizens and the local communities respectively within these determinants.

The tool also illustrates relevant competencies that should be mastered by the staff working with health. Thus the mapping tool can be used as a guide to discussing necessary competencies when recruiting staff and implementing in-service training for the staff.

Challenges
The major challenge of the tool is the detail level. Thus the tool suggests mapping 6 sets of public health competencies for 9 different health determinants, which creates a corpus of 54 different values related to health competencies. This amount of data is confusing. In addition, the reliability of the tool and the relevance of the detailed data can be questioned. First, the mapping exercise will be very dependent on a rather arbitrary judgement of the subject doing the mapping.

Secondly, one could state that the competencies listed are not essentially different from one health determinant to another – e.g. the communication competencies needed are comparable irrespective of the

[1] *Originally described in Dahlgren G, Whitehead M (1992). Policies and strategies to promote equity in health. Copenhagen, WHO Regional Office for Europe*

health determinant considered. In other words the very detailed distinction in the tool seems to be overkill as some competencies are more general in nature.

Thirdly, some of the health determinants are not very relevant to developed European countries. As an example of this, water and sanitation standards in Denmark are high, which makes sanitation an irrelevant subject for public health workers in Denmark despite the coherence between sanitation and health as such.

Guidelines to the use of the tool:
The mapping tool – or the basic perspective of the tool – is useful for facilitating dialogue on competencies within public health work and can be used at specific dialogue or process meetings concerning this issue.

In addition, the Dahlgren & Whitehead model of health gives a relevant framework for discussing municipal responsibility and possibilities within public health at dialogue or process meetings, or the model can be used in strategic health planning work.

Region: South Denmark

Health Barometer

Methods:
Employees of the Region of Southern Denmark are providing the 22 municipalities in the region with counselling services within health promotion and disease prevention. As a part of these counselling activities, a strategic seminar was held in November 2007 for managers within municipal health work. Due to a structural reform in Denmark in January 2007, municipalities were assigned to new tasks within health. Therefore, the seminar addressed the building up of municipal organisational capacity for working with health. The health barometer was used at the seminar in order to:

- Make the municipalities assess their performance and capacity approximately one year after the reform
- Visualize issues with potentials for improvement of the health work
- Facilitate dialogue on their future ambitions

The tool was not used as a part of a bigger, structured municipal process, but as a means for reflection during a period of ongoing strategy building. The primary reason for using the tool was that it facilitates immediate reflection and dialogue on performance and ambitions. However, it should be noted that the scoring on the health barometer is rather arbitrary and subject-dependent, and that the tool therefore cannot be used for benchmarking or structured evaluation purposes.

The dialogue process was arranged as a workshop within a time frame of 2 hours. After an introduction, the time frame was:

- 00-60 min: Discuss each of the eight dimensions in the health barometer: Rank your performance and describe strengths and weaknesses at your current practice (divided into groups from each municipality)
- 60-90 min: Share your best experience with health work in your municipality (pars of participants from different municipalities)
- 90-120 min: Discuss your future ambitions for health work within some of the eight themes given a high priority in your municipality (groups as in the first part)

Targets/Stakeholders:
The target group was managers within health work in the 22 municipalities in the Region of Southern Denmark.

Results:
Our experience with the tool is that it is useful for facilitating dialogue concerning municipal performance and ambitions within health promotion and disease prevention. The health barometer has strengthened the awareness in the municipalities about the importance of discussing ambitions and reaching and communicating shared goals within the municipal organisation.

Guidelines to the use of the tool:
The health barometer should be used as a tool to facilitate dialogue on specific process meetings in municipalities. The tool can be used as a very simple self-evaluation tool, but not as a tool for structured evaluation or for comparison or benchmarking between municipalities such as benchmarking.

An internal or external consultant with a process manager role can use the tool for facilitation purposes as it makes participants reflect themselves. If your role as a consultant is more advisory, you would need a more detailed and structured tool for the evaluation of municipal performance.

Region: South Denmark

Creating Dilemmas

Methods:

Employees of the Region of Southern Denmark used dilemmas as a method in a political process conference in April 2009. There were roughly 100 participants at the meeting, half of them politicians representing the regional council or the 22 municipalities in the region, half of them key persons from the regional and municipal management level within the health sector. The main objective of the conference was to form a vision for joint health across sectors with a threefold purpose:

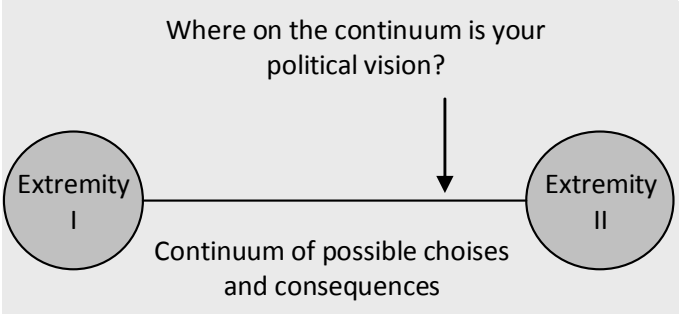
1. To make health an important political agenda during local municipal and regional elections in November 2009
2. To complement the health agreements between the region and the municipalities with a more political, normative part giving the direction for future collaboration between the sectors
3. To establish a basis to form more specific, future joint strategies

After the elections, a regional-municipal political health committee has further developed the vision.

A discussion paper was prepared for the political conference. Basically, the discussion paper presented four major public health challenges. These challenges were presented in a short form as *dilemmas*. In this context, dilemmas were a sheer communication method that can be recommended for the purpose of:

1. Facilitating the participants' understanding and discussion of the issues presented
2. Elucidating that *choosing* one direction of policy *implies choosing to do without* another direction of policy

For each challenge, a dilemma was set up following this model:



To illustrate the dilemma method, let us consider the use of evidence and common sense in planning the services delivered to patients/citizens in the health system. No one questions that services should preferably be based on research showing evidence on their effect. At the same time, no one questions that common sense and sound experience is an important basis for implementing good services. Discussing this issue is not a question of choosing either evidence or common sense/experience as a base, i.e. choosing one extreme for another.

However, when considering the subject deeper, more fundamental questions appear – e.g.: for how long can you justify using the limited municipal resources on health promotion interventions without ever investigating the effects of these interventions? Or, can you – ethically – justify retesting new drugs in medical experiments on patients, when prescribing well-known drugs could immediately relieve pain to some degree? Using the dilemma is therefore a question of giving priority and making policies for action rather than omitting to take a stand on the subject.

An example of current interest in the Region of Southern Denmark is the research project "Space for physical activity" examining the effect on structural multi-interventions on physical activity habits for 11-15 year old adolescents. The project was initiated in co-operation between the South Denmark Region, the University of South Denmark and the Danish Institute for Health Services Research. In May-June 2009, municipalities have deliberated whether to participate in the project or not. A dilemma here is: If they are not participating; can they justify their present interventions without having evidence of their effect? And if they are participating; can they justify spending many resources on one school; i.e. for a limited number of children for a period rather doing at least a little for every school and every child? In other words: is it a fair choice to suspend action to gain useful knowledge for future action? Is it a democratic right of the citizens to gain from their income taxes here and now, or is it a right to have better services in the long term?

The discussion paper containing the dilemmas was sent to the participants before the conference. Each of the four challenges was presented within 1-1½ pages following a template with these elements:

Content		Task
1.	The challenge to face (~10 lines)	State the relevance of the issue
2.	The dilemma (3-6 lines)	Show the two extremes of the continuum of possible choices
3.	Suggestions for values (3-4 lines)	Identify some values that will possibly be basic for the politicians' direction of choices
4.	Suggestions for vision statements (3-4 lines)	Identify some specific potential vision statements
5.	Suggestions for the way forward (~ 30 lines)	Identify some possible strategic directions that will follow the vision

The suggestions for values and vision statements were given in order to facilitate the discussion process by illustrating examples of the outcome.

The discussion at the conference was organized in groups producing political statements within each dilemma. In the political conference, the context was to form a specific vision. Therefore, health planners from the administration were used as "table secretaries" to guide the discussion towards formulating specific vision statements.

Targets/Stakeholders:
The target group was politicians and key persons from the management within the municipal and regional health sector.

Results:
The general experiences with the dilemma-method during the conference were good as the process forming the vision helped creating a good collaboration atmosphere across municipal and regional politicians.

The politicians were deeply involved in the discussion and a vision was formed from the conference. The challenges chosen in the discussion paper were rather overall ideological questions by nature. More politicians gave a positive response after the conference, as they had an opportunity to be *politicians*, i.e. discuss ideological issues.

Another relevant experience from the conference was, that politicians from the region or the municipalities, respectively, did not seem to discuss on the basis of their own organisational interests. One could have suspected that specific regional or municipal agendas would be at the back of the politicians' minds as a precondition in the discussions. However, it appears to be easier to agree on overall visions rather than more specific strategies or plans of action, as the latter is more binding to the partners having consequences for priorities, economy etc. One reason for this may be that the discussion can take place in the *domain of*

aesthetics (referring to the Maturana theory of domains) where some unity in values and ethics seems present. Discussing strategies and actions in the domains of reflexion and production, different experiences, professional traditions etc. may occur and cause less unity. A relevant strategic approach is therefore to build an atmosphere of collaboration by first discussing issues on an overall level where consensus can be reached across sectors. On the basis of the collaborative atmosphere, more demanding discussions towards binding strategies can be made.

The process showed that values and specific vision statements suggested in the discussion paper were not really used during the political discussion. However, they served well as preparation for the health planners guiding the discussion. It should be noted, that depending on the context, a less guided discussion can be chosen - e.g. if no specific vision statements are to be formed, less guidance seems appropriate.

Guidelines to the use of the tool:
The dilemma method can be used facilitating discussion whenever you are facing processes implying choosing directions of a rather complex nature on an overall level such as the vision level. The method can be used both in strategy work within a new collaboration or within an already well-established structure. Using the dilemma method can help promoting a good collaborative atmosphere between partners and thus form a basis for development of more specific joint strategies.

The key learning points when designing a strategy process including the dilemma method are:

- Aim for a vision or strategy on a sufficiently overall level to reach consensus across sectors, partners, or stakeholders
- Prepare the process with a discussion paper containing major challenges of relevance to this overall level
- Use dilemmas as a communication method to facilitate discussion