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SESSION REPORT

559

Hooked on Health Care: Designing Strategies for Better Health

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Foundation



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SALZBURG GLOBAL HEALTH AND HEALTH CARE INNOVATION SERIES

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Session 559

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Hooked on Health Care: Designing Strategies for Better Health

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Introduction

The Health Foundation and the Robert Wood Johnson Foundation are pleased to have been able to join together to support the Salzburg Global Seminar session on *Hooked on Health Care: Designing Strategies for Better Health*. Both foundations work in a context where the burden of disease and demand for health care services continue to grow. And yet, while the case for prevention in both their home countries is strong, as it is elsewhere, the focus of health strategies still largely remain in the provision of health care services rather than through addressing the wider determinants of health. These challenges are not unique to high-income countries, such as the United Kingdom or the United States – they are of pressing concern worldwide.

Faced with these challenges, the foundations wanted to explore how other countries were prioritizing actions to maintain and improve health rather than simply seeing the treatment of ill health as an inevitable cost to governments and citizens. This subject matter is not new – indeed the case has been made many times before for the importance of a “health in all policies” approach. However, while this overall objective might be clear, implementation is far more challenging.

The five-day program convened by Salzburg Global Seminar was intended to be highly participatory, with a strong focus on building new insights, aggregating perspectives and experiences from different sectors, areas of expertise, and regions. Approximately 60 Fellows from 17 different countries came together at the Schloss Leopoldskron in Salzburg, Austria from January 16 to 21, 2016 to discuss the following topics:

- The value of health and wellbeing;
- Why we are hooked on health care;
- The role of business in promoting health;
- The changing role of public authorities;
- Health justice; and
- The role of civil society/non-government actors.

This event report gives a flavor of the discussions across each of the topics. It does not offer a verbatim account nor does it highlight every point that was raised during the Salzburg Global program. This report has been written according to the Chatham House Rule, preserving the anonymity of individual speakers. The views and comments highlighted in this event report are the views of individuals are not necessarily endorsed by all attendees, Salzburg Global Seminar, the Health Foundation, or the Robert Wood Johnson Foundation.



Clare Shine



John Lotheirngton

HOT TOPIC

If not health care, then what is the greatest determinant of good health and what can be done to improve it?

“I don’t think health care is the biggest determinant of good health; we have a lot of good research that poverty is the best prediction of good health.

I personally think the best thing we can do is invest in young persons, pregnant women and even those who are thinking about becoming pregnant, making sure they’re eating well that and they know what help they need to get safe housing and when seeking employment.

We need more creative solutions because we know poverty has a major impact on health. ”

Deborah Bae, Senior Program Officer,
Robert Wood Johnson Foundation, USA

“There has been a lot of work done looking at the factors that influence health and in the case of many of those, health care can do very little to influence them. What we really need to do is promote a good start in life for children with the right kind of communities, work places and to support those in old age. ”

Jo Bibby, Director of Strategy,
The Health Foundation, UK

“I think there are numerous factors, none of which stand alone. Just like the things that determine on life, it’s never just genetics or environment, it’s always a combination of the two. I think some of the factors that affect health in the broadest sense, and not just physical health, includes connectedness and social cohesion whether for individual to individual or in the broader sense of a community. ”

Susan Mende, Senior Program Officer,
Robert Wood Johnson Foundation, USA



Susan Mende, Ricahrd Taunt, Deborah Bae and Jo Bibby

What is the Value of Health and Wellbeing?

During the first session, the sponsors outlined their views on the value of health in its broadest sense. While the two sponsoring foundations operate in different contexts of health system delivery (i.e. a publicly-funded, universal, tax-based system versus an insurance-based system), many of the broader health challenges are the same including how to make the case for prevention and how to best work with different stakeholders such as business and the community. This highlights the importance and difficulties associated with tackling the wider determinants of health in any system context. Both foundations were keen to look outwards, to other countries, and other systems and to facilitate cross-border learning.

The role of health care within the broader objective of improving health prompted much discussion. For example, should the health care system be seen as the driver of health or does that risk over medicalization? How should systems engage health care professionals in the wider determinants discussion? And could the public be better supported to understand that the health care system cannot do everything? Within the US context, the Robert Wood Johnson's Culture of Health vision seeks ways to help everyone live the healthiest lives possible, no matter who they are or where they live. While health is often thought to mean just health care, it should extend to factors such as work, family, and community life. New voices, ideas, and resources are needed to improve health; the role of a city planner can be as important as that of a physician. Without tackling the wider determinants of health, it's difficult to get at the root causes of ill-health.

1. Paul Lincoln and
Arnold Perkins

2. Caroline Chibawe and
Nanthalile Mugala



There was some discussion on the hopes and fears of the sponsoring organizations. It was felt that global aging brought both opportunities and threats: on the one hand increased longevity is positive as is the opportunity to engage better with technology and to collect better data on continued health status, however, there remains a question mark about the extent to which people are living a healthy extended life. There was also concern about the robustness of research and literature on complex, system interventions, for example understanding the impact of multiple interventions to tackle childhood obesity and what more could be done to produce definitive and helpful evidence for decision-makers.

More broadly, it was felt that there had been some clear and positive shifts in considering broader determinants. For example, the mental health sector often offers a more holistic model of care. There was also a general recognition that cross-sector work is important and this is evidenced by various international declarations such as the Rio Political Declaration on Social Determinants of Health.

It was also felt that financial challenges facing health care delivery systems might provide the catalyst for changing perceptions around health. The group also discussed the challenge of making the case for prevention. Ideally prevention should be seen as an investment rather than a cost in a similar vein to long-term infrastructure. Such projects were viewed as capital investments with long-term planning cycles. However, it was noted that



Hugh Alderwick



Deb Basu



Christy Brown





prevention initiatives take a long time to demonstrate return-on-investment and it is difficult to attribute short and long-term savings to different partners.

The wider group discussed whether sufficient progress had been made at an international level despite previous initiatives such as the declaration on primary health care at Alma Ata in 1978. The view from the room was mixed. Some participants suggested that there had clearly been progress in working towards achieving “health for all” but that inequity had been a consequence of progress. There was also some debate on the role of ideology and values in driving (or not) an equitable agenda for health. Others noted that discussions about health needed to take place at the highest levels of decision making noting that the influential World Economic Forum’s annual meeting of global political and business elites would take place in Davos, Switzerland in parallel with the Salzburg session.

Fellows participate in table discussions on the points of leverage in support of health and wellbeing

1. Tracey Cooper

2. Anna Fruttero and
Sridhar Venkatapuram

3. Barry Kistnasamy,
Emma Spencelayh,
Cezary Bednarski and
Gisela Wachinger

4. Darshak Sanghavi

Why are We Hooked on Health Care?

- Why do governments focus on health care rather than health?
- Where has a shift to health started and what have been the contexts, drivers and benefits? Where that shift is held back, what have been the obstacles – funding mechanisms?
- What is the relationship of the state and the individual? What is the nature of evidence in complex systems?

As one Fellow noted, over the years we have seen a general trend of health improvement but some populations remain socially fragile with marked health inequalities and concentration of wealth. Some felt that there is a contradiction between health and health care whereby in some countries health care delivery has become a profit-making sector, which could in turn limit discussion to an economic or industrial model of health. It was felt by some that there are significant economic incentives to invest in pharmacy or corporate insurance companies thereby perpetuating the medicalization of health through health care delivery. Further, the media and industry can influence outcomes for example, by focusing on glamorous and exciting technologies. The group also discussed the potential tensions between viewing health care as a commodity versus viewing health as a right and the impact of wealth being concentrated in the hands of the few.

Susan Mende, K. Srinath Reddy,
Leana Wen, Shirley Cramer and
Felix Rosenberg



The group discussed whether the creation of health care systems – even comprehensive and universal ones such as the NHS in the UK has contributed to the development of systems of illness rather than systems of wellness. It was felt that illness often takes precedence over wellness as a simple facet of human nature: illness is immediate and urgent but wellness is harder to define. There was also discussion about how health care often relate to places or institutions such as clinics or hospitals that are a recognized part of the community; it could be harder to unravel the places and organizations where health-promoting activity occurs. There are also different rewards and incentives for funding different causes or services. For example, the group noted that the opening of a new hospital is always likely to be a very public event. In contrast, the beneficiaries of prevention initiatives are virtually anonymous in comparison.

It was felt that populations and politicians care about accessibility to health care and the quality of that health care (particularly within a high-income country context). However, this could mean that people had unrealistic expectations of health care. When this occurs within a finite budget, something will be squeezed. An example was given from the UK whereby funding operates in silos across the NHS (free at the point of use) and long-term care (means tested); long-term care services are chronically underfunded and thus have a knock-on impact further upstream on the NHS.

More broadly, the group also discussed whether ministries of health have the required levers to mobilize other departments within government to care about health, particularly when the primary mandate for health departments is often health care delivery. While government has a duty to set a strategy for health and to steer partnerships, it is important to recognize that government is not homogeneous and represents many different mandates, priorities, and interests. Interactions across local and national government is also complex. However, it was felt that the Sustainable Development Goals (SDGs) provide an opportunity to galvanize action across sectors and that population health provides a useful summative indicator for broader government performance. Further, it was felt that there are now opportunities to galvanize action around public concern about childhood obesity.

It was also recognized that engaging some sections of society with public health messages is challenging. For example, we heard about community engagement activity in Baltimore, MD, USA which had been associated with the placement of methadone clinics. Many issues relating to poverty and health inequalities were tied to substance use. For example, out of a population of 622,000 more than 73,000 arrests were made every year with the most common reason for arrests being drug offenses. However, community groups were concerned about the placement of methadone clinics



Shirley Cramer



Jennifer DeCubellis



Susan Goldstein



Christine Hancock

A Pre-Mortem on “Health In All Policies”

Participants were asked to imagine it was 2036 and to consider the reasons why a “health in all policies” approach might fail and were then asked to consider potential solutions.

Reasons for failure

- Isolation: Continued siloed working and misaligned agendas.
- Health imperialism: The concept of “health in all policies” was thought to be catchy but was it right for health to be viewed as more important than education or other vital services?
- Too simple: “Health in all policies” appeared to be a simple solution to a complex solution but underestimated complexity.
- Lack of leadership and lack of collective ownership/co-production.
- Lack of community and citizen engagement.
- Short-termism and focus on economic growth: In contrast health might seem less exciting or politically beneficial.
- Money was spent on the wrong things.
- Lack of focus on aims and objectives, measurement and evaluation.
- External shocks: Failed to anticipate possible economic or political crises.
- “Health in all policies” was tried but had some high profile failures.
- Demographic and social shifts: Personalized medicine further emphasized the medical model of health and income disparity grew even further.

Reasons for success

- Collective responsibility with shared metrics and clarity as to what needed to be achieved and clear accountability measures.
- The economic advantage of healthier populations was demonstrated and policies were assessed and scrutinized through health impact assessments.
- Robust measurement of health outcomes: National observatories of social inequalities were established.
- Leadership and political will: Something changed that catalyzed action.
- There were clear links between infrastructure development and health.



in their local communities and the city needed to work to reframe the debate. To do so, it was important to address concerns about issues such as crime, disruption, and antisocial behavior which people had associated with the clinics rather than the underlying problems.

Bromley-by-Bow, a district in East London, UK was also highlighted as a positive initiative where the narrative had been changed. The area was very deprived but a broad range of services are offered, which meet people's needs by providing individually-tailored support. Local GP practices operate a system of social prescribing, connecting patients to services such as employment programs, community activity and social groups, and befriending programs. While there are individual pockets of innovative practice, the challenge is to spread and scale up such initiatives.

There was some discussion about financial incentives. While global or capitated budgets were thought to provide more incentives to health care providers to consider a broader range of health issues compared to fee for service, such payment mechanisms aren't without their own problems. An example was given whereby hospitals in one US state had moved towards global budgeting for hospitals and while the incentives for providers were more aligned with public health goals, each had developed their own case management plans at a hospital- rather than population-level and there were too many case management approaches for the size of the particular population.



Evi Hatziafreou



Vama Jele

Conversation Themes: Why are We Hooked on Health Care?

- The health care system is well established, is a large employer, and motivates people. Health interventions can be more disparate and harder to define.
- There is a clear business model for the health care system but this is not as clear for health.
- When there are finite resources, health care needs are often more immediate and pressing than health needs. However, this immediacy sometimes means that health care budgets could be more effectively deployed elsewhere.
- It is not always easy to make the fiscal or economic case for prevention and measuring the impact of prevention is challenging. Who do you hold to account and for what?
- The skills that are valued in health care may not be the right ones to address health issues. The challenge is recognizing the contribution of different skill sets and breaking down silos. Resource allocation can further exacerbate cultural divisions across different services. Professional powerbases are also very influential, as are the different perceptions of status that comes with different roles.

FELLOW OP-ED

Hooked on Health Care in the UK

Paul Streets, chief executive of the London-based Lloyds Bank Foundation, examines how the health system in the UK has been built – and how it could be changed for the better

We're hooked on health care in the UK because we design it from the health care institution and health professional perspective down rather than the patient up.

The organization of medicine reflects this: respect, expertise, prestige and research funding rise with specialization – rather than a whole person or community-focused approach.

Medical intervention and pharmacological investment reinforces it: with financial incentives geared towards intervention, activity and pills – rather than avoidance.

So the central question around our current funding “crisis” becomes: “How can we reduce the burgeoning cost of our current health care services by providing better community care/other provision?” Rather than: “How we can support people, where they live, and how they live, to avoid the need for health care services if they can?”

If we started to plan from the person/family and/or community up, rather than the hospital and profession down, we'd have very different services and spending. Necessity can be the mother of invention and, from my (admittedly long!) past experience, cash-strapped low-income economies can come much nearer to this. Whilst it might not stack up against a randomized controlled trial or pharma RoI, it can work to provide basic services where otherwise there may be none.

That said the maths has to work – and it should if we take a whole economy cost perspective. We might not then be perplexed as to why community-based work saves money but not enough (health



Paul Streets

care) money to justify (finite) health care resource reallocation. If you start to look at whole economy costs and savings, the maths are more likely to stack up. And they'll likely lead you to Pareto's 80/20 rule – focusing effort on those with the highest costs. This same argument has almost won the day on chronic disease in the UK, but probably only in the last 15 years – the NHS Plan 2000 being a turning point. Applied in the context of community, it would have us focus on those with complex multiple needs and high levels of disadvantage who generate significant local economy costs – many of whom have been, or are being, failed by state actors and state led provision – but can be reached by trusted locally-based community organizations.

But the list of odds stacked against a rebalancing are long. Can we be sure that – even with a blank sheet and zero budgeting – we would end up with a different model?

More interviews are available on the session page: www.SalzburgGlobal.org/go/559



The Role of Business in Promoting Health

- What impact does the health of a population have in terms of social capital and productivity?
- How do we align market interests with health and how should government and civil society work best with business?
- What are examples of businesses that have adopted healthy and profitable strategies? What can we learn from parallels such as business and support for the environment?

The business and health discussion was the session that most polarized participants. For some, business was seen as a vital stakeholder to engage, but for others, collaborating with business when creating new policies was a conflict of interest.

Discussions focused on:

- The role of employers in supporting a healthy workforce;
- The health of the future workforce; and
- The business case of prevention for employers.

The group considered whether we could view health as an investment and if so how to make the case persuasively. It was suggested that within the workplace, employee wellbeing is more commonly referenced than employee health and a broader definition that encompasses social determinants would be more helpful in engaging with the sector. It was argued that employee wellbeing/health needs to be viewed as a hard and not a soft investment. There would be limited impact if organizations view such investment as discretionary or as a “nice to have” rather than a fundamental.

1. Thembokuhle Karigani and Gillan Christie

2. Courtenay Dusenbury, Anita Jain and Ngonya Mwaanga



Ajay Khera



Nidhi Khurana



Klaus Kraemer



Rishi Manchanda



Nanthalile Mugala



Albert Mulley

There were many examples of where employers have put in place employee assistance or wellbeing schemes, as well as broader initiatives such as mental health first aid training or community investment at the location of a factory. Further, the role of businesses in responding to acute events such as environmental disasters was highlighted. However, it was recognized that there needs to be a good business case to convince employers of the value as well as longer-term buy-in. Anecdotally, the group expected that for organizations where staff wellbeing was taken seriously there would be less absenteeism, a more committed workforce, and a longer length of tenure. But, it was felt that the business case for investment in health is not strong enough and more robust evidence is needed. It was also noted that the challenges facing high- and low-income countries are quite different with low-income countries having a significant portion of their population earning a living via the informal rather than formal economy.

The group also discussed the potential opportunities that working with businesses might present, such as the potential for greater investment by businesses in communities and innovative technological development. It was also noted that there was a lot that could be learned from business such as marketing initiatives, efficient logistics, and supply chain management. In addition, business and the media could be viewed as powerful partners in influencing national-level policy as it was recognized that at times government gives a disproportionate weight to the views of business. For instance, given that the business sector has a powerful and influential voice, could it be harnessed to advocate for health? Similarly, should businesses measure the health of their employees as standard?

The group noted that it would be a mistake to view the business sector as a homogeneous entity. For example, engaging with small, local businesses would require very different tactics to engaging with a large, national firm. Large, multinational corporations represented a very different challenge again. Furthermore, it is important to differentiate between the type of business and alignment between their objectives and health outcomes. Clearly, business also have an active role within the health care delivery sector through providers or insurance firms.

The group had mixed views on the value of corporate social responsibility (CSR) or environmental, social and governance (ESG) initiatives. While it was felt that there is a positive role the business sector could play, there were concerns that ESG or CSR initiatives are more about public relations and branding and that ultimately the main purpose of most businesses is to maximize value for shareholders. It was also noted that business do listen to customers, and consumers have a powerful role to play in driving the behavior of businesses. In addition, powerful investment funds could

also drive behavior by adopting specific investment strategies (for example, investing in ethical business or through avoiding shares in tobacco).

There was also discussion about the less ethical aspects of business – particularly the practices of some multinational corporations. There was strong criticism regarding global inequality of practices, for example, mining companies with a significantly worse safety record in low- or middle-income countries compared to high-income countries, or differences in the formulation of foods across borders. It was felt that effective regulation does have an important role to play in such circumstances especially as consumerism and branding have become so powerful with the rise in technology. That said, it was noted that regulation could also stifle innovation and has broader macro-economic effects which needed to be considered.

1. Barry Kistnasamy,
Gillian Christie,
Anita Chandra and
Paul Litchfield

2. Graphic Facilitator
Karen Ijichi Perkins

3. Tatiana Vidaurre Rojas and
Carlos Farias



The Changing Role of Public Authorities

- What do we know works in improving health?
- How do authorities at every level of the system need to adapt to intervene accordingly, given the current variation in health status and health inequity, and what are successful examples? How do we better link health and social protection?
- What are the health outcomes in countries/societies that provide as much social service support as health care services?
- What can we learn from the successes or failures of other models of change at the population level, e.g. recycling, tobacco, climate change?

In this session, discussion focused on some of the challenges facing public authorities at different system levels and scope of their role. For example, in some countries such as the US there was a perception that government is one of the most regulated sectors and therefore the public sector has been confined in scope and mission. It was felt that the millennial generation would expect a different type of relationship with government and this presents opportunities to work towards policies that are co-created and reflect shared values across different stakeholders.

While the challenges facing low- and high-income countries were very different, there were lessons that could be applied regardless of income. For example, high-income countries could learn from the experience of poorer

Ted Smith, Jill Rutter,
Frederico Guanais and
David Chiriboga



countries in community-based care, direct cash transfers, and community support workers. However, low-income countries had some specific challenges that high-income countries did not need to contend with, such as the complex governance relationships that are required to manage donor funding streams to be complementary and not duplicative. For example, when HIV had been a primary focus, there was a need to develop a specific cadre of community health workers to distribute antiretroviral therapy and other interventions focused specifically on preventing or treating the spread of HIV. However, redistributing and training the workforce to focus on broader issues was not necessarily easy.

It is clear that regardless of context, constitutional rights to health are not enough to guarantee cross-government action on improving health outcomes and engaging other departments and authorities is vital. It was felt that finance is seen to be the responsibility of all ministries despite there being a dedicated treasury or ministry of finance – why couldn't be the case for health also? One Fellow gave the example of Bhutan and the role of the “general happiness index” as an alternative measure of progress to gross domestic product (GDP). The SDGs were again referenced as a major opportunity to see cross-institutional alignment. One participant asked whether it would be better to change the name of “health in all policies” to something broader, given the potential for health to be seen as an overarching indicator of development? Why would we focus on health in all policies rather than education or environment in all policies?

The group discussed an example from the UK whereby the narrative had been changed successfully around climate change.



Shuhei Nomura



Stephen Samis

Changing the Narrative: Climate Change Policy in the UK

The climate change agenda in the UK has arguably been subject to a series of policy successes which were durable enough to survive a change in government. In 2008, the UK developed long-term climate change targets to reduce emissions by at least 80% from 1990 levels in 2050. Previously, the UK had signed up to the Kyoto Protocol in 1995. However, during the 2000s, problems in implementation had emerged: one department was trying to influence others to take action with limited levers. But this changed once the UK hosted the G7 in 2005 and climate change featured in then-Prime Minister

Tony Blair's speech. This galvanized civil society to campaign for carbon emissions targets to be set in legislation and the campaigns fitted with various political agendas. However, while the climate change agenda is an example of narrative change, there are potential pitfalls. Bold targets do not necessarily mean bold action unless there is political will and the infrastructure to hold people accountable for targets. Secondly, engagement with issue-specific campaigners does not necessarily mean that there is broad public engagement and buy-in.

Health Justice

- How do we best define health justice? How does an understanding of capabilities influence our approach to health?
- What are the key measures of health equity globally and nationally?
- What policy initiatives are necessary to address inequity? And to address the most significant social determinants of health?

The discussion focused on the concept of health justice – the intersection of health policy and social justice. One Fellow suggested that throughout the session, a number of the conversations had focused on three broad areas depending on the context of participants' home countries. For some, the key challenge was in ensuring equitable access to health care as a route to health as a first step. For others, universal access had already been achieved but the priority was to address persistent inequalities in health outcomes. For a third group, the route to tackling health outcomes was to set health within the context of a broader development agenda and achieving human-centered development.

Essentially, health justice could be considered as helping people to lead and have access to a good life. One of the challenges, however, is to consider what the appropriate distribution of progress is, i.e. should organizations or countries be able to improve targets by improving the average or should improving the worst off be viewed as more important? It was noted that health justice could not be truly achieved unless there is global health justice and solutions. For example, the globalization of the workforce has had a significant impact on low- and middle-income countries. One Fellow highlighted analysis that had been undertaken to look at a more holistic index of health systems. The analysis identified those countries that were achieving above average life expectancy for below average GDP per capita (as a proxy measure for resource use) while achieving sustainable climate change standards. Only 14 countries had met those criteria and the work pointed to models that developing countries could aspire to rather than the models adopted by wealthier countries. There was also some discussion relating to intergenerational inequalities and the perception that wealthier countries hoarded resources at the expense of lower income countries and the global health inequalities that this caused. There was some discussion about the inequity between those experiencing poverty (defined by the World Bank as \$1.90 USD a day) and those with excess wealth. Generally, those countries with the greatest life expectancy were the wealthiest ones although there were some exceptions.



Carlos Santos



Prabhjot Singh

One Fellow discussed the challenges of meeting health needs in Zambia, which is sparsely populated in areas and has very limited resources. Different sectors have different mandates and it was easy to blame the health sector during times of disease outbreak for failures despite the fact that other sectors had a role to play. The challenges of dealing with urban and rural populations are very different. Within rural areas, shortages of health workers means that task shifting is important but equally there are inequalities within urban centers with larger populations. The stewardship role of government was felt to be important.

The group also discussed the role of international bodies in contributing to health justice. There were mixed views on the value of top-down approaches at an international level due to the paternalistic overtones, but for some issues, the group suggested that global action and incentives are needed as there are different levels of influence from the community activist to international agreements. There was some discussion about the role of trade agreements and vexatious litigation and the consequences for health justice. It was felt that there were multiple market distortions that make achieving global health equity even harder. It was also noted World Health Organization treaties are not binding, unlike those of the World Trade Organization. It was felt that this contrast further shifted the balance away from health and towards trade and industry. While the SDGs were highlighted as a major opportunity throughout the seminar, it was noted that there are no enforcement options and the targets attached to the goals are not binding. In summary, it was recognized that transnational equity is far harder to achieve than national equity and there is not one silver bullet recipe for improving health justice.

Caroline Chibawe, Juan Garay and
Sridhar Venkatapuram



The Changing Role of Civil Society and Non-Government Actors

- What has worked best in the promotion of health and wellbeing among civil society and non-government actors, and under what circumstances?
- Can such initiatives and the necessary resources be maximized and replicated or scaled? If so, how?
- Where appropriate, how could and/or should they be coordinated with government cross-sectoral policies? What are the barriers to this? What might be critical to success?

This session focused on the role of civil society and the importance of engaging non-government actors from small community groups to large-scale advocacy groups. Participants gave a number of examples of the different roles civil society and community groups could play. It was noted that the state cannot do everything and that civil society could play an important complementary role in achieving better health outcomes for populations.

One Fellow talked about the role of civil society in engaging with and targeting the segments of the population with the greatest social needs (and greatest costs). Such interventions might take place at a population level (for example public health interventions), at a peer group level (for example those with common needs forming support groups) and at a personal level (individual,

Susan Mende and Rick Brush



Community Engagement: Way to Wellville

“Way to Wellville” is an initiative in the United States supported by the Health Initiative Coordinating Council which has sponsored a competition to support communities of fewer than 100,000 people to making visible and lasting improvements to health. The five areas are Muskegon, MI; Lake County, CA; Spartanburg, SC, Clatsop County, OR; and Niagara Falls, NY. Goals are created by the community (although there are

some standard measures across all of the five areas) and initiatives are not imposed from outside. The communities will receive technical support but not financial support and the aim is to create sustainable communities when the program finished. For example, the Oregon project will focus on access to care, obesity, school readiness, and social capital.

bespoke services) with the latter being the most expensive. Civil society has different roles to play at these different levels from campaigning at a population or national level, to organizing networks at a group level and direct service provision at an individual level. It was felt that at the individual level, small civil society organizations could play an important role in rebuilding trust and reaching people that the government might not be able to.

Often these organizations reflected the lives of the people they were trying to serve and could themselves be financially fragile and at risk. Often organizations might spring up from a personal experience and cannot be scaled. Small civil society organizations might have more in common with business and entrepreneurship than the public sector. There are some examples, however, of scale-up such as Emmaus which is made up of 350 member organizations in 37 different countries and runs income-generating activities at a local level with socially excluded people.

Civil society in low-income countries such as Zambia was considered an important stakeholder in dealing with cross sector issues such as human rights and gender issues and civil society groups acted as watch-dogs and/or activists for change. Most groups work at a national level and have a major advocacy role to play in health, for example around the issue of resource allocation and ensuring that districts follow national strategies and guidance. Civil society groups could give a voice to the “voiceless” by engaging with the media or governance organizations as well as acting as providers of services themselves.

Some challenges were raised in relation to engaging with civil society such as managing competing agendas, organizations operating in silos and disparate voices. In addition, there were questions about the stability and accountability of civil society organizations particularly those delivering large public sector contracts. For example, there had been a number of high profile



Rossana Valderrama de Salinas



Jason White



1. William Chilufya
2. Group work in the McGowan Room of Schloss Leopoldskron
3. Table discussions in Parker Hall

failures in the not-for-profit sectors in the United States (e.g. Federation Employment & Guidance Service (FEGS) in New York) and the UK (e.g. Kids Company), which has raised awareness of the precariousness of some large charities. Further, there were questions about how independent a civil society body could remain if a significant portion of its funding came from one or two larger funders.

There was some discussion about the possibility of social investment or payment for “success” mechanisms to act as catalysts for cross-sector, community support and to ensure broader alignment, although there were some reservations among the group as to the effectiveness of payment by results mechanisms.

There were some conflicting views on the role of civil society versus government and the perception that government would automatically be less effective or efficient than civil society organizations at engaging specific groups. However, it was agreed that both sectors have an important role to play and it was noted that civil society should not be synonymous with communities. Both government and civil society needed to engage with the communities they served.

Community Connectedness: The Role of Belonging

One case study session focused on the concept of community connectedness. A key theme that emerged was the important task of fostering a sense of belonging among members of a community.

The group discussed how sections of society may lack access to early childhood/teen development programs, health care, and transport while at the same time experience unemployment, poor quality education, unequal distribution of food and nutrition, and poor housing – i.e. the wider determinants of health.

When these factors were combined with the physiological effects of the stress hormone cortisol, deprived communities (and individuals within those communities) could be in a constant state of dis-ease (note not necessarily diseased). Alongside these factors were demographic inequalities resulting from class and caste, race and poverty, which can further exacerbate or contribute directly to the sense of dis-ease.

Within a community, there were the dis-eased and those whom are at ease. Those who were not “at ease” might feel excluded from society, lack ownership or pride in their community, be under threat, have experienced adverse childhood experiences, desperation, and isolation. The key challenge was then how to create a sense of hope from the sense of dis-ease. Achieving such a change required a change to education services, law enforcement, and the way in which communities partner with government.

The group discussed the role of building and enhancing the leadership capacity of communities and the opportunities this gave to allow communities to operate in a broad context. However, it was recognized that there could be challenges in engaging with self-appointed, dominant community leaders who might not be fully representative of their local population. In addition, it was noted that a person’s sense of

health or wellbeing was unlikely to be constant over their lifetime. Furthermore, there could be tensions between an individual’s health and their community’s health. As such, there is a need to consider multiple levels: the individual and family level, the neighborhood level, and the system level.

- **At the individual level:** What are the basic needs and what skills are needed?
- **At the neighborhood level:** What is the quality of life, how can communities be assisted to collaborate around common themes, how can social capital be built, and how can capacity be developed?
- **At a system level,** developing links with under-resourced neighborhoods and other partners such as investors, social services with a focus on enhancing development.

The group noted that building communities’ connectedness could be more challenging in poorer countries where meeting basic needs is difficult and there are difficulties maintaining stable funding streams as well as competing priorities for action. This was felt to be particularly challenging in rural, underdeveloped areas or areas where communities were transient and temporary.

There was also discussion relating to the changing nature of communities and whether geographical, place-based definitions are still appropriate when communities might coalesce around specific interests.

Finally, the group discussed the challenges of scaling-up community development activities and the extent to which competition between communities could be beneficial (in terms of driving change and creating political imperative for action) but also risky due to the potential to be divisive or create further inequalities among communities.

Next Steps and Conclusions

Unlike other Salzburg Global Seminar programs, the group was not in a position to produce a consensus-driven “Salzburg Statement” on how to proceed as it became very clear early on that achieving better health was heavily context-dependent. However, there was consensus that it was time to take stock of the current narrative around health because of the unsustainable demand for health care. Session participants noted the need to take action on the wider determinants of health and acknowledged the interconnectedness of our actions in a global setting. *Hooked on Health Care: Designing Strategies for Better Health* highlighted the need to improve health justice within and across countries by harnessing all the drivers of health and forming the environment, communities and health care needed to support all people in having a quality of life that is sustainable within our global resources.

Fellows spent the final days of the program in groups developing and testing project work to take forward during and after the session and committed to bringing the insights generated at the session back to work in their own countries, sharing their knowledge with a wider audience. A number of tangible projects emerged from the session which broadly fitted into the following six themes:

Group work in the historic
Max Reinhardt Library of
Schloss Leopoldskron





- **Engaging citizens:** Empowering individuals to influence health decisions;
- **Supporting community-based co-design:** Developing and applying better strategies for engaging with people in their local context;
- **Aligning wider policies with improving health:** Developing better strategies for engaging the broadest set of decision-makers;
- **Engaging local business and employers:** Seeking to better align commercial interests with the wider society value of a healthy population;
- **Mobilizing wider resources and supporting longer-term investment:** Addressing misaligned financial incentives by developing shared investment initiatives and developing the concept of health bonds; and
- **Developing a global health equity compass:** Developing and promoting analysis of health equity based on sustainable principles of health and health care delivery¹.

Fellows of the session
*Hooked on Health Care: Designing
 Strategies for Better Health*

¹ See more details on page 29

The issues that were seen as the most difficult on which to reach agreement related to the role of business: To what extent should business be involved in policymaking and can you apply one set of rules to “business” per se or do you need a more tailored approach to different type and size of organizations? The other issue that proved contentious was the framing of health versus health care. On the one hand, such a framing might risk alienating clinicians and organizations that deliver health care services. But on the other hand, in some contexts, it was difficult to see how there would ever be a narrative change without a more radical framing that might actively weigh up the benefit of health care versus other services that affect the wider determinants of health.

Some of the polarization and disagreement on the above two issues were directly shaped by ideology relating to the marketization of health care although as one participant noted: “You can’t eat ideology.” But, fundamentally, while there were lessons that could be applied across all contexts, the challenges faced by low-, middle- and high-income countries were very different and the Salzburg Global Seminar program provided an important reminder to participants from high-income countries to consider the international equity implications of domestic policies. One of the themes that resonated with many participants was the concept of health justice and sustainability. Achieving sustainable health equity both within and among countries is unlikely to be realized by doing more of the same or by offering more “health care” services. In short, it is incumbent on us all to consider how we can create the best health in the most cost effective and equitable way through focusing on the social determinants of health.

The Health Foundation, the Robert Wood Johnson Foundation and Salzburg Global Seminar would like to thank all participants for their goodwill and frank contributions. We will be following up with participants as their working group projects develop over the coming year and are confident that the event has helped to foster new partnerships, relationships and space to think and change.

Lisa Letourneau, David Labby and Ronald MK Lam present their group's work on why health matters



Six Big Ideas for Health

Jo Bibby, director of strategy at the UK-based Health Foundation, summarizes the outcomes of *Hooked on Healthcare: Designing Better Strategies for Improving Health*

One of the participants of the Salzburg Global Seminar session: *Hooked on Healthcare: Designing Better Strategies for Improving Health* summed up the five days with a quote from a 19th century architect and urban planner “Make no little plans for they have no magic to stir men’s blood.” Certainly the action and commitment that emerged could not be accused of being “small plans” and let’s hope, given women have such a critical role to play in shaping health, they will stir everyone’s blood!

Our final two days were spent in groups, developing and testing strategies that participants want to progress on return to their workplaces.

The report out of these six groups provided some valuable insights and practical suggestions.

1. Engaging citizens in this agenda

We need to think through how we can better engage individuals in the factors that influence their health. This is not to go down the route of suggesting that health is solely the product of our own choices. The decisions that those in public authority and in business make set the environment which shapes our health status. But as individuals, we can influence these decisions as voters, consumers, employees and shareholders if we understand the problem.

We need to make the impact on health of decisions around factors such as housing, transport, education visible in terms of the avoidable harm (or the potential benefit) that may accrue. How can we equip citizens to be just as (or perhaps more?) prepared to lobby their politicians over the levels of nitrous oxides on their local streets, or the lack of street level activity in their housing estates, as the closure of an A&E?

2. Supporting community based co-design to define and solve “problems”

A recurring theme of the session was the importance of starting with the problems as defined by communities themselves, rather than the problem as perceived by the authorities. The world is littered with nationally conceived ideas that, while they may make sense of paper, when implemented locally simply do not get traction.

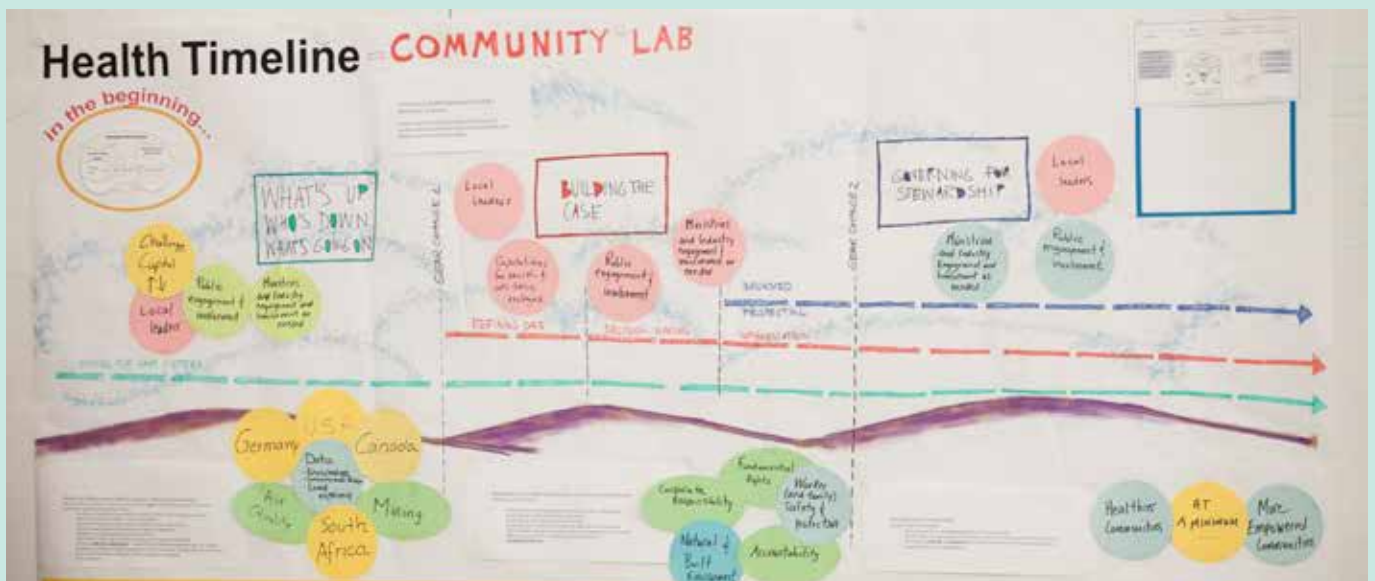
“Five a day” is a great concept and has no doubt worked for some people, but what does it mean if you live in a food desert? Improving access to health services for depression and anxiety is necessary but if for instance, the root cause of people’s anxiety is lack of housing security; a pill or talking therapies isn’t going to solve it.

Developing and applying better strategies for engaging with people in their local context and understanding what they aspire to as a healthy life and the changes that can support this, are the only ways we will get sustained improvements.

3. Aligning wider policies with improving health

Which policy decisions have the greatest impact on health? There is now emerging consensus that the decisions that influence job supply, housing quality, or our ability to lead active lives are going to have more impact on our health than whether we fund a new treatment or build a new hospital.

At policy level, health is largely still seen as the remit of health care chiefs. We need better strategies for engaging the broadest set of decision makers in the consideration of health impact. One group came up with 12 practical steps to do this which we are looking forward to putting into action.



4. Engaging local business and employers

The value of health in a local population to business and employers is one opportunity we tend to overlook. Which is better for the economy:

A downward spiral where commercial interests override the health of the consumer and employer; where the effects of ill health caused by non-communicable diseases, industrial injury and stress affect an individual's ability to contribute to family, community and work?

Or a virtuous circle where responsible businesses and employers provide the conditions and products that enhance employees' and consumers' health and in return reap all the benefits that this ensures?

The consensus of the group was that there was much more that could be done to align commercial and employer interests with the wider societal value of a healthy population.

5. Mobilizing wider resources and supporting longer term investment

A separate group looked at how it might be possible to bring together stakeholders to make the longer term investment in strategies to improve health and wellbeing.

Addressing the "wrong pocket" problem (where those that need to make the investment to improve things are often not those who benefit from the savings that accrue), this group looked at the potential of "health bonds."

Different from current revenue spending and social investment, the concept of the health bond would encourage all stakeholders to put a monetary value of the benefit to them of a specific dimension of better health. Then, pooling this value into the health bonds, it would create a funding stream for upfront investment in start-up ideas. With all the investors being part of the governance arrangements, they would have direct influence in decisions about which initiatives to support.

And with the right choices, would see their initial investment returned through the subsequent savings arising from avoiding the costs of ill health.

6. Developing a global health equity compass

Finally, and perhaps for me the most provocative thought from the five days, was the view that we need to start viewing health as a finite asset. In a world facing resources constraints (financial and human), with consensus on the need to reduce our consumption of natural resources, Juan Garay and David Chiriboga eloquently made the case for a global health equity compass.

In brief, this analysis identifies those countries that are achieving sustainable levels of health status as defined by securing above average life expectancy, below average GDP (a proxy measure for resource use) and meeting the climate change standards as a measure of sustainability. At present there are 14 countries that meet these criteria. They can point the way to the achievable and sustainable levels of health outcomes that all countries can and should aspire. Their work which will shortly be launched on the eqimov.org website will challenge us all to think differently about health.

Final thoughts

I couldn't have hoped for a more stimulating, action-focused five days and to quote Margaret Mead (chair of the inaugural session of Salzburg Global Seminar): "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."

See more at:

www.health.org.uk/blog/six-big-ideas-health

Appendix I

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Appendix II

Daily Recaps

Day 1

Health is more than just health care

www.SalzburgGlobal.org/topics/article/hooked-on-health-care-day-1-health-is-more-than-just-health-care

Day 2

How did we get hooked and how can we get clean?

www.SalzburgGlobal.org/topics/article/hooked-on-health-care-day-2-how-did-we-get-hooked-and-how-can-we-get-clean

Day 3

The role of civil society, public authorities and health justice

www.SalzburgGlobal.org/topics/article/hooked-on-health-care-day-3-the-role-of-civil-society-public-authorities-and-health-justice

Day 4

Global case studies and the power of data

www.SalzburgGlobal.org/topics/article/hooked-on-health-care-day-4-global-case-studies-and-the-power-of-data

Day 5

Salzburg Global Fellows call for focus on health and not just health care

www.SalzburgGlobal.org/topics/article/salzburg-global-fellows-call-for-focus-on-health-and-not-just-health-care

Interviews

William Chilufya

Can we start to think of good nutrition as a human right?

Country coordinator for the
Zambian Civil Society Scaling Up
Nutrition Alliance on his broad view
of health, addressing social justice
and experiencing his first snowfall
www.SalzburgGlobal.org/topics/article/william-chilufya-can-we-start-to-think-of-good-nutrition-as-a-human-right

Caroline Chibawe

“We lose a lot of women in Zambia”

Director for Mother and Child
Health at Zambia’s Ministry of
Community Development discusses
maternity and child health issues
and her work to counteract them
www.SalzburgGlobal.org/topics/article/caroline-chibawe-we-lose-a-lot-of-women-in-zambia

Ronald MK Lam

“Traditional medicine has a role in the medical system and culture”

Assistant Health Director from
Hong Kong SAR talks about the
popularity, regulation and benefits
of traditional medicine
www.SalzburgGlobal.org/topics/article/ronald-mk-lam-traditional-medicine-has-a-role-in-the-medical-system-and-culture

Prabhjot Singh

“It’s helped locate where we are in a broader global conversation”

Global Health Director discusses
his work in Harlem and Uganda and
what advice he will be taking home
from Salzburg
www.SalzburgGlobal.org/topics/article/prabhjot-singh-its-helped-locate-where-we-are-in-a-broader-global-conversation

Ted Smith and Christy Brown

“The population needs a healthy environment to be happy”

Louisville, KY residents and
founders of the Institute for
Health, Air, Water and Soil on the
definition of a population and
the environmental determinants
of health
www.SalzburgGlobal.org/topics/article/ted-smith-and-christy-brown-the-population-needs-a-healthy-environment-to-be-happy

Videos

Cezary Bednarski

“Design can damage your health”

Architect and Director at Studio Bednarski Ltd talks urban environments, urban organisms, and the impact of design on health
youtu.be/DM-SbpjFX0

Jennifer DeCubellis

The benefits of integrating services in health care

Deputy County Administrator – Health and Human Services for Minnesota’s Hennepin County talks about the Hennepin health service and its holistic approach to health, the effect of unstable housing on health, integrating sectors and community engagement
youtu.be/jB5czsp9zBQ

Barry Kistnasamy

Pension funds and long-term thinking for health funding

Compensation Commissioner of the Compensation Fund for Occupational Diseases in the Department of Health in Johannesburg talks about pension funds as a means of promoting long term thinking and convening power and holders of capital for long term investments and global equity
youtu.be/U5rzY9ms9Hc

K. Srinath Reddy

Health and the Sustainable Development Goals (SDGs)

President of the Public Health Foundation of India on his input on the sustainable development goals, the benefits of SDGs over its predecessors the MDGs and what needs to happen to meet the SDGs
youtu.be/l1Cual2PP1w

Leana Wen

“Every challenge has its roots in health”

Baltimore City health commissioner discusses the importance of health across all sectors, the challenges of tackling health and poverty in the city, and how key community leaders can help build strategies to combat the causes of poor health
youtu.be/Vs_5i_-uWJ8

Fellow Highlights

Our Fellows of Hooked on Health Care: Designing Strategies for Better Health tell us about their highlights from their Salzburg Global Session and what they will take home with them.
youtu.be/3GWOD9VxNhs

Video Series

During *Hooked on Health Care: Designing Strategies for Better Health* we asked our Fellows “Besides Health Care, what is the most important area we need to focus on to improve health?” This is what they had to say
youtu.be/W1QrB_-9BXI

Christy Brown

Understanding the links between our health and the health of our environment is key
youtu.be/aiQAwwLAWKw

Tracey Cooper

We need to improve societal health, not just health systems
youtu.be/dW1udZxDWoE

Frederico Guanais

Integration of sectors outside of health care provide profound results for vulnerable groups
youtu.be/L2Z71ejrRn8w

Prabhjot Singh

Health coaches can have a more positive, prolonged impact on improving community health by helping to translate “clinical messages” into everyday terms
youtu.be/SZxNbG_ExU8

Vama Jele

Focusing on occupational health and engaging in conversations about health and social security benefits can help improve the health of mine workers
youtu.be/cZ-QCIQEPn4

Appendix III

Session Agenda

Day 1

16:00 – *Welcome*

Clare Shine

Vice President & Chief Program Officer,
Salzburg Global Seminar

Jo Bibby

Director of Strategy and Innovation

Richard Taunt

Director of Policy, The Health
Foundation

Deborah Bae and Susan Mende

Senior Program Officers, Robert Wood
Johnson Foundation

16:15 – *Introductions of
Participants*

John Lotherington

Program Director, Salzburg Global
Seminar

17:15 *Coffee & Tea Break /
ML*

17:40 – *Fundamentals: what
is the value of health and
wellbeing?*

Jo Bibby

Director of Strategy and Innovation

Richard Taunt

Director of Policy, The Health
Foundation

Deborah Bae and Susan Mende

Senior Program Officers, Robert Wood
Johnson Foundation

18:10 – *Why have we not made
more progress on health,
despite previous initiatives such
as the declaration on primary
health care at Alma Ata in
1978?*

Followed by table discussions and Q&A

19:30 – *Dinner*

Day 2

09:00 – *The Points of Leverage
in Support of Health and
Wellbeing*

11:00 – *Hooked on Healthcare*

In conversation:

Shirley Cramer

Chief Executive, Royal Society for Public
Health, UK

Srinath Reddy

President, Public Health Foundation of
India (PHFI)

Felix Rosenberg

Head of the Forum Itaboraí: Politics,
Science and Culture in Health, Fiocruz,
Brazil

Leana Wen

Commissioner of Health, City of
Baltimore, USA

Followed by table discussions and Q&A

12:45 – *Lunch*

14:30 – *Business and Health*

In conversation:

Anita Chandra

Director, Justice, Infrastructure, and
Environment, RAND Corporation

Barry Kistnasamy

Compensation Commissioner,
Department of Health, South Africa

Paul Litchfield

Chair, What Works Centre for
Wellbeing; and Chief Medical Officer, BT
Group Plc

Followed by table discussions and Q&A

16.30 – *Knowledge Café*

1. Health in all policies: what has
been achieved, what more needs to
be done?

**Richard Taunt and Emma
Spencelayh**

the Health Foundation

2. Behavioral insights for policy
design

Anna Fruttero

Senior Economist, The World Bank Group

3. Parks for the Planet: Nature,
Health and a New Urban Generation
Clare Shine

Vice President & Chief Program Officer,
Salzburg Global Seminar

4. A new community health worker
model: an example from Harlem

Prabhjot Singh

Director, Arnhold Institute for Global
Health, Icahn School of Medicine at
Mount Sinai, USA

5. Can the social determinants of
health and wellbeing be addressed
one person at a time?

Albert Mulley

Director, Dartmouth Center for Health
Care Delivery Science, USA

Vama Jele

General Secretary, Swaziland Migrant
Mineworkers Association

6. Health and education: the often
untapped potential of schools

John Lotherington

Program Director, Salzburg Global
Seminar

Ngonya Mwaanga

Principal Education Officer for Colleges
and Universities, Zambian Ministry of
General Education

19:30 – *Dinner*

Day 3

09:00 – *The Changing Role of Public Authorities*

In conversation:

David Chiriboga

University of Massachusetts Medical School, USA

Frederico Guanais

Health Principal Specialist, Social Protection and Health Division, Inter-American Development Bank

Jill Rutter

Program Director, Institute for Government, London

Ted Smith

Chief of Civic Innovation, Louisville Metro Government, Kentucky, USA

Tobacco as an example

Carlos Farias

Chairman, Permanent National Commission on Tobacco Control (COLAT-PERU)

Tatiana Vidaurre Rojas

General Director, National Institute of Neoplastic Diseases

Followed by table discussions and Q&A

11:00 – *Health Justice*

In conversation:

Juan Garay

Head of Cooperation, Delegation of the European Union to Mexico

Sridhar Venkatapuram

Lecturer in global health and philosophy, King's College London, UK

12:30 – Lunch / Free afternoon

17:30 – *The Role of Civil Society/Non-Government Actors*

In conversation:

Richard Brush

Wellville Accelerator; Founder and CEO, Collective Health, USA

Nanthalile Mugala

Country Director, PATH Zambia

Paul Streets

Chief Executive, Lloyds Bank Foundation
Followed by table discussions and Q&A

19:00 – Dinner

Day 4

09:15 – *Case Studies of Health Promotion, and Health Communication with Diverse Stakeholders/Audiences*

1. The first thousand days of life

Tracey Cooper

Chief Executive, Public Health Wales

Ajay Khara

Public Health Consultant and Deputy Commissioner, Ministry of Health & Family Welfare, Government of India

2. Housing

David Labby

Health Strategy Advisor, Health Share of Oregon, USA

Cezary Bednarski

Architect; Director, Studio Bednarski Ltd, UK

3. Community-connectedness

Arnold Perkins

formerly Director, Alameda County Department of Public Health, US

11:15 – *Working Groups: Constructing a Health Timeline*

12:45 – Lunch

14:30 – *Working Groups – Developing Draft Action Plans/Recommendations/ Collaborations*

16:15 – *The Promise of Data in Designing Strategies for Better Health* (via Skype)

Yael Harris

Senior Researcher, Mathematica Policy Research

Keith Lindor

Executive Vice Provost and Dean, College of Health Solutions, Arizona State University

Lucy Savitz

Director of Research and Education for the Institute for Health Care. Delivery Research, Intermountain Healthcare

17:00 – Working Groups

19:00 – Dinner

Day 5

09:00 – Peer Review

11:30 – *Finalize Plans/ Recommendations/ Collaborations*

12:30 – Lunch

14:00 – *Plenary Presentations of Plans/ Recommendations / Collaborations*

16:30 – *Taking the Work Forward: The Salzburg challenge to implement a drive for health across sectors*

18:00 – Close

18:30 – Reception

19:00 – Concert

20:00 – Final Banquet Dinner

Day 6

Departure Day

Salzburg Global Seminar Staff

Senior Management

Stephen L. SALYER, *President & Chief Executive Officer*

Benjamin W. GLAHN, *Vice President, Business Affairs*

Clare SHINE, *Vice President & Chief Program Officer*

Daniel SZELENYI, *General Manager – Hotel Schloss Leopoldskron*

Pia VALDIVIA, *Vice President & Chief Finance Officer*

Program and Administrative Staff

Chanel Bell, *Program Associate –*

Mellon Global Citizenship Program (M-GCP)

Thomas Biebl, *Director Marketing and Communications*

Ian Brown, *European Development Director*

Jemma Clerkin, *Program Associate (on leave)*

Michelle Dai Zotti, *Development Associate*

Lauren Dickel, *Development Assistant*

Kristina Dortschy, *Program Development Assistant*

Charles E. Ehrlich, *Program Director*

Marty Gecek, *Chair – Salzburg Seminar American*

Studies Association (SSASA)

David Goldman, *Program Consultant – M-GCP*

Michaela Goldman, *Internship Program Manager*

Barbara Grodecka-Poprawska, *Program Associate*

Louise Hallman, *Editor*

Jan Heinecke, *Fellowship Manager*

Andrew Ho, *US Development Director*

Paul Jansen, *Program Director*

Julie L. Jones, *Contract CFO*

Lisa Karl, *Assistant Finance Director, Salzburg*

Astrid Koblmüller, *Program Manager*

Kevin Kolesnikoff, *Program Associate Trainee*

Brigitte Kraibacher, *Assistant, Admissions Office*

Tatsiana Lintouskaya, *Program Director*

John Lotherington, *Program Director*

Sharon Marcoux, *Senior Finance Manager, US*

Paul Mihailidis, *Program Director –*

Salzburg Academy for Media and Global Change

Edward Mortimer, *Senior Program Advisor*

Klaus Mueller, *Program Consultant –*

Salzburg Global LGBT Forum

Beth Pertiller, *Director of Operations*

Bernadette Prasser, *Program and Admissions Officer*

Michaela Radanovic, *Assistant Director Finance, Salzburg*

Ursula Reichl, *Assistant Director Finance, Salzburg*

Manuela Resch-Trampitsch, *Director Finance, Salzburg*

Antonio Riolini, *Program Associate*

Katharina Schwarz, *Manager, Campaign Planning*

Susanna Seidl-Fox, *Program Director, Culture and the Arts*

Sarah Sexton, *Special Assistant to the President*

Nancy Smith, *Program Consultant – M-GCP*

Molly Walker, *Davidson Impact Fellow*

Hotel Schloss Leopoldskron Staff

Richard Aigner, *Hotel Operations Manager*

Jürgen Chum, *Executive Chef*

Niklas Geelhaar, *Front Office Supervisor*

Karin Maurer, *Reservations and Revenue Supervisor*

Tamas Nanasi, *Service Supervisor*

Matthias Rinnerthaler, *Maintenance Supervisor*

Karin Schiller, *Sales and Marketing Manager*

Marisa Todorovic, *Executive Housekeeper*

Interns (at time of program)

Alina Giesen, *Program Intern*

Kevin McCormick, *Library Intern*

Haben Mebrahtu, *Program and Development Intern*

Patrick Wilson, *Editorial Intern*

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Salzburg Global Seminar & Health and Health Care Innovation in the 21st Century series

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The Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen. We use what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

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