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## ***“Territorial Intelligence and Equity in Health”***

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**Abstract:** What do we mean by effectiveness in health care planning? What and whom does it affect? What methodology should it apply? Such questions refer to methodological (and political) issues that do matter for the purpose of ensuring equal rights to health to everybody. In fact, not only do they “raise the methodological issue”, but also they turn the “methodological discourse” into something that has an impact on reality both in terms of governance and in terms of sustainable action.

All along the last century we have witnessed:

- a) a continuous devaluation of territorial knowledge,
- b) a planning process predominantly targeted to emergency situations,
- c) a series of processes based upon the dual problem-solution methodology.

The immediate involvement of stakeholders in the planning process becomes an ethical principle of planning and governance for health: such method requires the enhancement of knowledge and the continuous exchange of “hands-on” experience among the different groups involved in the planning-acting process, that look at reality from different angles and possess different types of know-how. Only where these two modes and levels of knowledge overlap can we implement health governance as a product of territorial expertise and as a tool for promoting equality.

## **INTRODUCTION<sup>50</sup>**

Territorial planning projects raise some issues as to:

- what is the kind of policy that can change reality?
- what are the right tools for disseminating such changes?
- what are the strategies that can be implemented to increase participation by interested parties?

The obstacles we can identify can be described by these three points<sup>51</sup>:

- there is no communication among the different sectors of territorial reality,
- there is no cooperation among the technical, political and social spheres,
- it's difficult to eliminate the top-down approach that has governed interventions so far.

At this point some questions arise:

- what do we mean by effectiveness in health care planning?
- what and who is the health planning process targeted for?
- what kind of methodology can we apply to organize new more equitable services or interventions within a given territorial and social setting?

Such questions refer to methodological (and political) issues that do matter for the purpose of ensuring equal rights to health to everybody. In fact, not only do they “raise the methodological issue”, but also they turn the “methodological discourse” into something that has an impact on reality both in terms of governance and in terms of sustainable and lasting action.

## **1. SOME INTRODUCTORY OBSERVATIONS**

During the second half of the 20th century we have witnessed a dramatic drop in the general mortality rate and an increase in average life duration and life expectancy; nonetheless statistics tell that the infant mortality rate remains high, as it reaches unacceptable thresholds, while morbidity and mortality of some diseases are going up; moreover occupational morbidity, work accidents and diseases are growing, as well as the disabled at birth or in the earliest years of life.

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<sup>50</sup> Our paper is mainly focused on some problematic areas connected to territorial intelligence, health and governance. It marked the beginning of our participation in the CAENTI (Coordination Action of the European Network of Territorial Intelligence) group, but it also originated from it, as it is based on a number of definitions of territorial intelligence and other more specific notions that emerged during the WP5 meetings.

<sup>51</sup> In this case we refer to UNISA team work, particularly to the document developed for WP5 meeting, in Liège on 18-20<sup>th</sup> January 2007.

Furthermore, for many years epidemiology has been searching for explanations of social inequalities related to health, trying in particular to account for the disease social gradient by which «each level has a worse health status and a higher mortality rate as compared to the next higher level. (...) Such social gradient of mortality is suggestive of cross-cutting factors at play in the society as a whole. Be it relative deprivation or relative lack of access to wealth in affluent society, it is clear that explanations of socio-economic differentials [of mortality] (...) must go beyond the notion of poverty formulated at the beginning of the century» (Marmot, 1994: 305-6).

Finally, the question arises as to why «health-related investments and results, albeit huge, always appear insufficient. (...) Is it possible that despite all the progress we have gradually made, aspirations eventually make them appear perpetually incapable of meeting "needs", - needs that are progressively redefined and updated precisely by the progress made by health care and medicine?» [Callahan, 2000: 13).

In spite of all that, in the course of the last century in Italy there has been a steady erosion of territorial knowledge and intelligence connected to different community cultures and tempers: planning has been mainly targeted for emergency, so services and interventions have been certainly managed successfully in terms of efficiency and delivery, but focus on the implementation of a techno-political planning following top-down provision logics. This kind of intervention has strengthened a task-oriented vision focused on a product that bestows immediate visibility upon decision-makers in the short or very short run and builds political consensus through appreciation by the electorate.

A series of processes shaped by the dual approach of problem-solving methodology have prevented Italian social and health services from being considered today as true "producers of well-being" and "health promoters": «The full achievement of prevention requires remarkable maturity on the part of physicians and politicians as well, but above all on the part of the entire population of a country. (...) Today medicine is becoming a mix of advanced technology and "performance" (inasmuch as it elicits emotions), so why on earth should we privilege (...) prevention, which is not sensational at all and makes little use of technology? (...) *Prevention is not spectacular.* (...) Preventing deaths due to measles complications for one year in Italy would cost much less than saving an equal number of lives by heart transplantation (...), but who is going to be able to make the list of those who benefit from it? *Prevention does not make use of advanced technologies.* (...) Preventing infectious enteric disease involves an obscure work to build an adequate sewage system that will not glorify anybody» (Fara, 1991: 10-11).

It is worthwhile noting here that the generally accepted definition of health, according to the WHO criteria, states that it is a status of total physical, psychological and social well-being and every day we keep in mind its determinants whenever we wish to design health promoting plans.

**Health determinants.**

<b>Individual</b>	<b>Socio-economic</b>	<b>Environmental</b>	<b>Lifestyles</b>	<b>Access to services</b>
Genetic make-up	Poverty	Air	Nutrition	School system
Sex	Employment	Water and food	Exercise	Health care system
Age	Exclusion	Residence	Volunteerism	Social services
Birthplace	Social and cultural environment	Housing typology	Alcohol consumption Smoking	Transportation
			Sexual activity	Recreational activities
			Drugs	

If we look at them, it appears very clearly that just three or four of them can be considered as independent variables, whereas all the others, that we may call “dependent” variables, can be strongly affected by different approaches to local government and planning. Studies of social medicine, epidemiology, ecology have identified socially and historically determined health and disease factors that can hardly be neglected: today man and the society he has built determine the conditions for environmental health-threatening deterioration; diseases are caused by artificial factors that did not exist in nature before, but were created or elicited or enhanced by man, as they appear and disappear not as a product of natural elements, but as the outcome of factors connected to the environment, to nutrition, to the habitat and to hygiene that are not related to, or sometimes clash with scientific and technological discoveries or can be at times caused by them.

In such a diversified scenario we cannot speak about social context transformations as if they were separate elements, shaping our reflection on health as an analysis of technological, organizational and scientific development: understanding health transformations also implies the analysis of the transformations inherent in territorial social organizations, the enhancement of ongoing changes in trust and mistrust relations, in litigation and in the organizations-citizens relationship, the identification of the widening gap between the need to constrain interventions and the population's demand and/or needs. This kind of vision also compels to stress the contradiction between the urge to constrain and justify expenditure in terms of cost-benefit analysis and the need to pursue policies promoting equity in health in compliance with international directives.

The question we are putting asks what is the ultimate goal of research aimed at promoting people’s health in Europe today and, more generally, what is the perspective from which efficient, yes, but also effective interventions may be planned to meet the population’s real needs in terms of health and of equity in health.

## **2. HEALTH DETERMINANTS AND PARTICIPATION**

### **2.1. Culture and health**

If disease must be observed in the light of processes arising from the interaction between man and the environment, then the individual approach that has historically characterized

the relations between the man of medicine and the man of the street must be revised (and perhaps supplemented with other strategies), since doctors cannot promote public health on their own, by their individual, single-handed daily activity.

The *concept of health* is exquisitely cultural, as it is characterized by traits that can be referred to the physicality of the individual, but are anyhow shaped by the cultural values and patterns shared by a given society at a given historical time. Therefore the concept of health must encompass many issues:

- first, the general behavioural patterns related to health and treatment of disease spread among both decision-makers and different social groups;
- second, the socially and culturally determined images of health and disease do not always coincide with the definitions and acquisitions of biology and medicine;
- third, the modes of relationships among citizens, facilities-practitioners and decision-makers are almost invariably determined by the history of services rather than by public health;
- fourth, the models underlying individual and collective perception of the so-called “states of well-being and malaise”;
- finally, the possibility and capacity for access and communication modes allowing to express malaise, be it real, perceived or objective.

Care for the real health of a population will then have to take into account the need to give voice to that specific group, to that specific population in order to identify social areas that we can involve in the planning and implementation of activities for sharing problems, health promotion and primary prevention: «There is an anti-participatory way belonging to whoever - be it an agency or a person, but more often the former than the latter - believes to be entrusted with the task and capacity to anticipate social demand for health, to forebode it before it has even been expressed, to figure it out before it has been conceived of, finally to meet it when nobody is yet aware of it. The usual word for it is "paternalism", but I would rather call it "providential disposition" as this term better indicates that way of getting in touch with reality without listening to it, that inclination to prepare prefabricated answers without waiting for questions, that interpretation of the administrative mandate that eventually engenders a demand that can only conform to supply» (Maccacaro, 1976: 1).

By paraphrasing Ardigò (1997: 193), who links his phenomenologically-oriented reasoning to aspects of the patient-doctor relationship, we wish to state that the interpretive scheme of the shift from "transcendental subjectivity" to "intersubjective subjectivity" should be applied to decision-makers and citizens: there can be no good health care and health protection unless there is an agreement of some kind between the assessment of planners, coordinators, practitioners and the perception of citizens, between decision-makers' plans and communications valued as important by citizens.

Public opinion is not influenced by information only, in the same way that behaviours related to health and disease are not the outcome of scientific knowledge only; and

especially in the health care field, public opinion is not the sum total of many opinions: instead, it springs from knowledge, beliefs, values, behavioural patterns acquired and expressed by public awareness, and groups usually judge and adopt their behaviours according to such standards.

Citizens' demand is often seen as "generic" rather than specifically originating from:

- collective subjects working for change in the different societies and communities;
- institutional collective subjects, that is to say those institutions that convey demand oriented to institutional or organizational change;
- individual subjects' demand, which may be detected, it is true, but only when it is codified and can be codified by procedures that may and may not be standardized;
- individual subjects' demand that remains unattended by an agency that lacks codifying ability, or because of crowding, lack of quietness or skill.

## **2.2. Participatory planning and subjectivity**

Those who deal with health promoting strategies state that projects must be implemented within clearly described and demarcated territories, that become the natural partners of those who plan and take action, not only because they constitute a "system" but also because they become "areas of negotiation" providing the settings where planning is developed, checked and carried out. Seen from this angle, they are not only communication areas, but also complex (or I would rather say "complicated") areas, in which policies can only be feasible if they are geared to relatedness originating from the new modes by which "social subjectivities", subjects of communication express themselves, and also from all-embracing social phenomena asking for a project covering the whole societal system.

It is worthwhile remembering that health does not coincide with the health care system, which in turn is not the sum total of the bodies and structures providing health care in the strict sense of the word. Therefore planning processes must use indicators to assess the relations and ways in which the multiplicity of activities and of economic, political, environmental, cultural, health factors impact upon the so-called "quality of life", in particular upon aspects related to health and disease. In terms of implementation, this means that we should not deny the specific cultural vocations of a territory, that we should devise integrated activities that do not waste the cultural heritage, but rather recycle and retrieve experience, by carving out appropriate participatory measures tailored to the different socio-economic and environmental situations, and so on.

Pushing away from center stage "hard technologies" to give priority to participatory logics in planning would mean to undertake a democratization (or sustainability) process with multiple unpredictable ramifications unlike those shaped by traditional dualisms based on the disease *vs* health opposition that evolved into other oppositions such as doctor *vs* patient, health care *vs* health, technology *vs* subjectivity, organizations *vs* society, which may point to a new direction in research embracing the different possibilities to overcome barriers between the "North and South" of treatment and disease. In this respect, we wish to refer to Touraine's thinking (1991) by arguing that the newly-emerging society compels

us to reckon with the shift from an exclusively "vertical" to a "horizontal" society, in which understanding whether they are central or marginal is one of the main priorities for citizens.

Now the question to be asked is whether it is possible to pursue a logic of social integration by means of projects based on interaction with population groups, thus considering even health organizations not only as commodities but also as communities.

Having specified this, we need now to focus on the other element of the participatory process, communication, keeping in mind that knowledge obtained through information is not sufficient to approach activities that strongly challenge cultures and behavioural patterns of the populations involved. The communication process implies a comprehensive revision of knowledge, attitudes and prejudices related to health and disease that are deeply entrenched in the individual and in the society he is embedded in; in fact, each individual and each group utilizes a set of rules, pieces of information, habits that make up the framework of reference in which communicated data are interpreted. Furthermore, the various situations giving rise to such habits contain non homogeneous and often conflictual ways of meaning and pursuing well-being (consumption patterns linked to status symbols, to the myth of physical efficiency, to aesthetic models). As a result of that, conveying scientifically correct news can become useless if they are not accompanied by interventions emphasizing the health and disease models circulating within the group involved and the relation between such models and the knowledge available to the group. Such interventions should also bestow a more significant form upon experiences, knowledge, phenomena, raising the need for more information. Only in this way can we overcome the resistance to change we inevitably encounter whenever we try to modify a behaviour by merely overlapping different systems. As Ongaro Basaglia (1986) argued, «believing that the medical-clinical model is superseded is certainly dangerous, since the WHO variables are actually systematically superseded by the medical-clinical model. (...) The professional culture that has concealed inequality of access, opportunity, culture is still in place, even though the WHO suggests to take an unprofessional approach to health».

The utmost subjectivity is to be found in individuals, who also possess a kind of information that directly depends upon their experience, nevertheless such subjectivity must always be referred and compared to the subjectivities of the group members those individuals belong to. The so-called "non technical experts" hold information that from the qualitative standpoint is richer than information available to single individuals, as it is partially organized, or is gained via the position held by the experts themselves within the community or the profession they practice or the role they play. Both social subjects take part in the production of information originating both from organized groups in the population and from further knowledge accumulated through dialogue and the exchange of individual experience and individual understanding. In the history of the civic battle for health that stands as a peculiarity of the Italian tradition, some of the physicians and epidemiologists involved agreed to define the homogeneous group described as the group of people "exposed" to the same risk situation and characterized by the same lived experience as the subject producing collective information (Oddone, 1974, 1975; Biocca and Schirripa, 1981].



Therefore it is not so much a question of persuading or feeding back the results of research in the field, but rather of analyzing, of discovering correlations, of agreeing upon modes, even taking account of feasibility that can only be assessed by those who take action. In order to do this, it is necessary to share objectives that go beyond the "health promotion" formula: «This requires parties and political institutions that respond more to the influences of organized social forces and movements and at the same time are keen to foster greater participation of the disadvantaged in public life, which can only be obtained by increasing social protection and welfare» (Touraine, 1997: 281). It also requires a change of mind overcoming the feeling that perceives expressions of subjectivity as often colliding with established rules because they are "disturbing".

It requires also a high degree of accountability both for procedures and the utilization of results.

Finally it demands circulation of knowledge and organization of activities.

### **2.3. Research and participation**

Today most accurate researchers can state that the idea of medicine as being able to save population's health on its own is an illusion, since conditions of malaise and disease cannot be really solved away from the social context, preserving the same organization that produces inequality, that again engenders malaise and disease. In this respect, the debate on methodology envisages two approaches at present: the first one has been developed within the health care system, whereas the second one has been worked out over time by health sociologists and psychologists, so it is external to health care and aims to grasp the connections among economic, demographic, macro- and micro-social variables, the changes in attitudes toward health and disease and their influence upon unequal relations between population and services.

If governance is «the sum total of the numerous ways in which individuals and public and private institutions deal with their common problems. It is a steady process, by which different or conflictual interests can form a harmonious whole thanks to cooperative action» (Moro, 1998: 31), so the main target becomes that of redesigning the tasks of all those who manage disease or health by creating new pathways to revise everyday experience through the capacity to match the technical and scientific aspects with the social and communicative ones: «The researcher's will is not the element that elicits dialogue, which instead depends upon the possibility of mutual encounter among the subjects involved, that is to say upon the interconnection of elements difficult to predict a priori: motivations, perceptions, assignment of a status, self-presentation, etc. (...) The sociology of the subject as a being capable of meaningfulness must be defended by taking not the short way of immediate comprehension (...) but the long and mediated way of symbols interpretation» (Corradi, 1993: 51).

A sort of desirable cultural and structural "revolution" should be hinged on some pivots: planning geared to priorities, that is to say planned interventions that can be tested in terms of their effectiveness, costs and, last but not most important, participation, as it is the specific element of knowledge, control, selection, search for solutions eliminating risk and damage

that is focused on validating solutions, even in relation to costs, not only as a device for gaining consensus, but ultimately as a concrete possibility to utilize experience accumulated by million people. So action research means above all, in the case of health, to design and implement projects that go beyond service provision by referring to autonomous ethical value systems and knowledge paradigms and by using an “operative imagination” that is capable to call into play all the actors, involving them in a pluralistic game based on mutual “intelligence”, hence on “tolerance”, so as to allow an effective ego-alter action via co-actions that allow the actors’ social being to unfold.

The word "ethical" fits into this context for the reasons explained by Giovanni Berlinguer, who argues (1991) that a lot has been said about bioethics, forgetting about the distinction between "frontier bioethics" and "daily life bioethics", drawing the attention of citizens, patients, consumers to exceptional problems and thoughts and studies "of excellence", instead of working on what affects "the behaviours and ideas of everybody": «Such a focused concern [for the "frontier areas"] certainly gets out of proportion vis-à-vis present implications» (ibid.: 17); true prevention and promotion of equal health requires hard work, continuous checking while in progress, commitment to processes of change that do not happen without pain: «Daily life in the human territory appears rough and difficult to the observer, in contrast with the progress of science, conflictual for those who distinguish, albeit inadvertently, between morals as they are preached and morals as they are practiced. This is probably the main reason, inherent in the issue of bioethics, why the frontier areas and the implications of the most amazing discoveries get the upper hand over everyday reality in terms of the interest they raise. The other reasons are common to other fields: predominance of the entertainment society, search for the sensational, ruthless race to success» (ibid.: 16).

### **3. OBSERVING IN A PARTICIPATORY MODE: WHAT KIND OF RESEARCH?**

#### **3.1. Effectiveness and efficacy**

In a paper written for the WP5 group, Laurent Amiotte-Suchet (2007) proposes to envisage three types of observatories: diagnosis-oriented, applied, participatory. As far as health is concerned, we believe we can safely state that in the mainstream culture (of epidemiology and health planning in general, for example) observatories have performed mainly a “diagnosis-oriented” function.

In addition to that, projects were often mistaken for programs. While on the one hand projects are, and must be projected into the future, even the years to come, and if they feature, and they must feature hypotheses, also driven by an ethical component brought by those who design the project, that allow to see and imagine something beyond present reality, on the other hand programs trace and delineate a work pathway. In this sense the image of many interventions is an image lacking the tools necessary for "walking", that is for changing and really eliminating risk situations, if they have ever been identified.

Finally, efficiency was mistaken for efficacy. It looked as though the amount of activities carried out or the amount of services provided could be the functional response to the need for health protection and risk elimination, and risk elimination in the form of early

diagnosis and ex post intervention could be tantamount to a proactive activity. Only recently were "Health Plans" designed in Italy with a view to building "applied observatories" specially designed for feeding back to actors the analyses and assessments carried out by experts as a guidance for redesigning territorial policies.

From the operative viewpoint, what we have argued so far means that we can make some points that cannot be disregarded:

- taking account of the context-related indications (the issue of the territory and the environment);
- defining and interpreting the images of damage, on the one hand, as an indication of the mistakes made and, on the other hand, as an indirect reconstruction of risks;
- constructing and representing directly the images of risk, their dynamics, their diffusion (by surveying and enhancing widely known facts, that are nevertheless often consciously ignored);
- analyzing the forms of health protection and promotion that can be shared and approved (which also means being able, having prepared a mechanism designed for this purpose, to assess the intermediate and final results).

Everybody agrees that the horizon of the relations with different and diverse territorial realities encompasses all the areas in which health care services are involved; nonetheless the responses given by the central and local planning of their activities fall (by a simplification of course for cases that would deserve a much deeper analysis) into three categories:

- *passive*: territorial social reality is only seen as a constraint compelling to case-by-case reparative interventions. This is the vision that counters each statistically proven health or social problem with an activity of the service involved, placing the emphasis on related costs: «Disqualification and chronicity constitute conspicuous abnormalities in the clinical paradigm. (...) The problem-solving approach, the diagnostic/causal approach following from it, the logical and operative dualism comes to be incongruous and, in its turn, pathogenic» (De Leonardis, 1994: 313);
- *active*: territorial social reality is also seen as an opportunity opening up new space for action by the services. This is the vision that aims at prevention in addition to treatment, without losing sight of the centralized decision-making trends of the system: «Abnormalities occur even where the medical system grows (...), providing clues for interpretation and intervention in the life worlds that have not been yet identified as "social problems". (...) Such abnormalities are connected to the pathogenic effects of the so-called medicalization of these social problems» (ibid.: 310);
- *integrated*: the problems of social realities are seen as fitting into a much bigger picture, based on the need to "internalize" the social spheres into the service general behaviour. This is the vision that does not turn the solution to the health/society/services problem into something special, but rather into the product of

a management that takes special care of the relation between health and society, even with a view to the organization of services themselves: «[Institutions] are healthy when they work to identify, mobilize, combine social resources for health in the local settings and to capitalize on them. (...) Healthy institutions are "social enterprises" that promote health inasmuch as they invest on human and material resources, yielding social added value, adding quality to the social habitat in the contexts they work for» (ibid.).

### **3.2. The territory as a dimension of health**

In other words, territorial reality must become a dimension of the concept of health that must be internalized systematically by all the decision-making processes. And both communities and services can do it by establishing a "knowledge technology" that, in the face of a society offering plenty of alternatives, can enrich the subjects, while at the same time undermining the idea of the big institutional body that historically pursues generic purposes in a sectoral manner, thus identifying the data output by providers with the knowledge of those realities that are peripheral to the data collecting and processing centers, which ultimately means to perpetuate a mystifying logic, that mixes up the quantitative tools measuring the efficiency solely pertaining to the inner management system with the tools (that are totally distinct from them) capable of processing the most complete (as much as possible) understanding of the real territorial situations and of the health/disease, well-being/malaise concrete status of the population. This engenders a demand for and production of im-mediate data, their transmission and the re-distribution (when this happens) of their quantitative and numerical processing.

Of course it may well be that the widespread use of a thoroughly democratic planning and data processing method makes the work more "time-consuming" and involves a number of people higher than the one that was deemed "necessary". But we must stress that, whenever such a method has been practiced, despite the so-called "loss of productivity" (efficiency), such a huge wealth of creative capacities was released that the loss of efficiency appeared highly productive from the viewpoint of efficacy, and therefore also profitable under the strictly technical and economic profile. So health promotion becomes part of the development of labour that implies a close relation between needs and action, prioritization and participation, the latter being seen as something that arises and progresses to the extent that those who are asked to participate, be they providers or users, are adequately informed and therefore possess knowledge and are sufficiently motivated. Therefore only by a steady and permanent contact with the territory is it possible to pinpoint risk factors, to analyze the socio-cultural features of the community, to intervene by primary prevention and health promotion.

Building upon ideas (which then turn into reality) that are so simple but also so complex, such as the ideas of community, territory, teams working not on people, but with people, means structuring interventions that can be defined as a whole but can also be identified as interventions specific to that territory, and not to others, and also as activities that do not split up the population into many "individual objects" that each practitioner observes on his own, then facing big (and obvious) difficulties when they must chart out "what to do". A

health promotion project can only be implemented by envisaging a participatory, negotiated, concerted action research: that is why both technical and political choices for the use of data and information and work models and methodology become crucial, together with the awareness that any technical or planning action, if correctly and ethically conducted in this sense, also becomes a promotional performance. «Today's society makes two clear demands concerning the way in which research is carried out: in the first place, there is a demand for participatory research (...). Secondly, society is also asking for greater transparency in the dissemination of the results, especially for aspects that have both a substantial impact upon human life and ethical implications, so that the best informed public debate can be produced» (Miedes Ugarte, 2007).

At the operative level, the pursuit of the planned modes of action is hampered not only by the widening gap between the potential planning capacity and the ability to systematize interventions, but also by other factors:

- first of all the lack of a common language and/or the lack of effective communication between decision-makers and practitioners, between practitioners and citizens: between "descending vertical" communication flows, that grow stronger, and "ascending vertical" flows that become weaker, it gets increasingly difficult to let decisions coming from the top of the system be accepted, whatever they are. Communication channels through which citizens and social groups may make their contribution appear increasingly hindered, full of obstacles (and sometimes the techno-political power itself determines the interruption of the communication flow;
- secondly, the consequent problem of the management of power and decision-making processes;
- finally, the complexity of the different territorial realities.

### **3.3. Social compatibility**

These elements and the previous pathway suggest to add a new element to our discourse; we will call this element "social compatibility", by which we make reference not so much to an intervention program, but rather to an attitude of "dialogue-oriented responsibility" towards the social, not towards individual users and citizens, taken by those in charge of health and well-being protection policies. In order to clarify this point, we will take into consideration two possible attitudes:

- if those who should design health promotion projects still intend to take into account only the user/service, patient/physician relation and so on, then a "compatible" project will have to restrict its contents to these relation typologies only, even when the addressees of their action are neither users nor patients;
- if, on the contrary, they intend to deal with (and be concerned about) the way in which promotional activity can establish relations rooted in the environment and situation it fits in, then such promotional activity will be included into that category of thought that we call "socially compatible project", characterized by a close correlation between territorial organizations and territorial intelligence.

One of the first difficulties we encounter when shifting from a vision of research as aimed to reparative interventions to a proactive perspective lies in the need to include socially driven variables into the methodology, if they are not sufficiently internalized at the operative level: instead of belonging to an "esoteric", specialistic language confined to the medical and scientific or welfare and social communities, such variables will have to be "double" like those terminologies shared by experts' communities and non professional people who often use them in their everyday and mainstream meanings, that have nothing to do with the meanings applied in the technical and scientific fields. Hence it seems indispensable to reach a sort of homogenization of languages and a consensus on the different meanings that allow intra-organizational communication to take place, in order to plan in the most effective inter-organizational form that it is possible to obtain.

The second point that flows from this idea of plan-making is that a participatory policy for health thus conceived aims at ensuring intra and inter-organizational interventions that are adequate to the construction of knowledge, evaluating skills, guidance and control on the part of the citizens and of providers, so as to avoid an excess of information within the organization and a lack of it among the project target population: «The fundamental contribution of participatory dynamics is that, when it achieves the complete involvement of territorial actors in the process of converting information into knowledge» (CAENTI WP5, 2007: 5-6).

The third point, stemming from the previous one, concerns the need for "accountability", that cannot be disregarded with disdain as unsuitable for daily professional activity: it is necessary to build information systems connected to the different projects that are "pertinent" to, that is to say "account for" the decisions made and the results eventually achieved to the different parties involved, thus allowing them at the same time to make other decisions concerning social choices and the targets of actions and resources: «The action-research processes must have as their objective an increase in the transparency of the results, both of the research and the action, facilitating decision-making and contributing to this becoming more democratic» (CAENTI WP5, 2007: 9).

#### **4. AN EXAMPLE**

In the last decade in Italy some regions have started a series of experiments based on the principle of "participatory planning"; the official and well-established experiences of Tuscany, Emilia-Romagna, an area of Basilicata (Venosa), of the Zonal Plan for the area of the Salerno Province called "agro nocerino-sarnese" (main cities Nocera and Sarno). We will not describe all these experiences in detail, but we would like to highlight the key words and the consequent actions that unify the different experimentation settings, that differ a lot as to their geographic position, territory social history, cultural roots and connection capacity of services and of health and social services providers. On the other hand the regional Plan for prevention of the Emilia-Romagna Regional Government is the outcome of a strategy carried on for several years that has implemented health promotion policies along with disease control and prevention services.

A Plan For Health (PFH) is defined as a «pluriennial action plan developed and implemented by a plurality of actors, coordinated by local government, investing human

and material resources for the purpose of improving the population's health even by upgrading health care» (Biocca, 2003). PFH's represent a break with the past, since they operate on health determinants, rather than by a reparative health care intervention. Furthermore, they are deeply rooted in the territory and supported by a strong involvement of citizens, so that "participating" does not mean "being listened to", but rather playing an influential role during the planning, implementation and project evaluation phases (Altieri, 2002; 2004).

PFH's hinge on three concepts: knowledge, social strategy, political will, where knowing means identifying priorities, which requires the acquisition of documentation concerning the socio-demographic, economic characteristics of the population's morbidity (health profile). Political will regards the construction of a vision of reality through the development of participatory actions and plans: «In the territories cultures and lifestyles mature and develop: services (...) risk, because of their extraneousness, to start up interventions that may become a disturbance. For this reason they must develop the ability to tune in with reality, (...) which is not a mere backdrop, but a domain of actors, resources, early natural response processes» (Ferrario, 1996).

So the Plan For Health introduces a new concept vis-à-vis the previous planning forms: participation as a strategy for reaching the objective of health and of a planning that includes all actors, both technical and non technical. Communities express their needs, claim the citizens' right to participate in the decisions that affect them, in close contact with political decision-makers, influencing and directing the monitoring of many factors that must be considered over time. The stage of needs detection gives voice to the population of interest for the purpose of taking stock of problems. The general picture emerges both from social, health care and epidemiological statistics and from the public's perception. Even the phase of priority selection is participatory and foresees moments of more or less extended consultation to identify the agenda of a "Social and Health Care Territorial Conference".

If participation can be experienced at different levels (of the citizen/provider relation, of the reticular level of the citizen's life worlds), in this case the level of participation concerns the moment when interested citizens discuss and try to affect decisions about interventions and resources allocation. But above all, a "global level" of participation develops and establishes a correlation between the issue of health and the wider ecological-environmental issue, which redefines, as a consequence, the role that each citizen plays within his own community. So, a particular outcome of social participation stemming from PFH's is represented by "competent citizens" strongly committed to their community, institutions, social organizations, who do not hold any decision-making position but have developed guidance and stimulating capacities; moreover they showed interest in acquiring cultural competence. They represent a possible example of "active citizenship" taking part in discussions and decisions over various issues, expressing opinions in a democratic way, helping to define priorities for action and, probably, to assess health care policies (Biocca, 2006).

In other words, the primacy of an approach based on prevention and health promotion rather than on treatment has been acknowledged (Saccheri, 2000 and 2003): «Participating directly in devising actions aimed at improving health has a twofold value. On the one

hand it gives you a sense of personal commitment that positively affects health. (...) On the other hand it allows to check even in this field the efficacy of the decision-making processes that political scientists call “inclusive”» (Biocca 2003). A series of activities developed according to these characteristics certainly raise some problems for administrators (Corposanto, 2006). *First* of all, there is a problem in terms of applying the code of ethics to behaviours: all too often the pretended participation in the end just consisted of a series of formal consultations in which decisions were not agreed upon with the citizens concerned. *Secondly*, there is a problem concerning the visibility of planning: a high level of participation also entails a high level of verifiability of the organization's effectiveness and efficacy. *Finally*, there are some issues at stake in the concept of trust, that in the case of PFH's must necessarily be a "critical trust": more direct communication channels imply the possibility to bring criticisms and observations that cannot be ignored owing to the principles enunciated above.

## 5. OPEN-ENDED CONCLUSIONS

Following this reasoning we became convinced that a new public government cannot meet people's need for health only by revising administrative rationalization objectives, since governance and culture are inextricably connected by a network of meanings through which men and women interpret experience and orient action. Therefore the only possible type of observers are the “participating observers” who aim to make knowledge and expertise mutual by putting together in a collaborative structure the “technical” expert and the expert “layman”.

### Understanding

- the social and territorial distribution of diseases,
- the makeup and functioning of the social context within which specific risk factors are at work,
- the dynamics of communicative interaction,
- the cultural dynamics of special social groups,
- mass media processes,
- (professional and non-professional) concepts of health and disease,
- objective and subjective matrices of lifestyles,

Builds a process corroborated and supported by many influential studies that demonstrate how the environment and lifestyle affect health as much as other determinants.

But for this same reason, once we acknowledge that multiple elements and factors concur in determining the health status of a community, even the question that must be answered by the methodological model does change, so the initial formulation: “how to...” becomes: “how to...taking account that...”. Today health does not only depend upon the type of drug or techniques that are prescribed, but also upon the relations established with citizens, upon the modes of relations with health, with disease, with complex life-worlds: there is an accumulated knowledge that settles down in those realities where more room is made for



thinking (and more people claim to have a say). Nonetheless a paradoxical situation is emerging in which the increased awareness by groups and realities that health must be ecologically managed via proactive attitudes and thinking is accompanied by an enhanced managerial approach to health care and by a move away from the settings in which malaise arises.

Health policies today cannot bypass the debate on technical specialized sectors and public consensus: the problem was raised by the increased trust in “media” (technological, diagnostic, for quality assessment and analysis and so on) that are seen as “absolutized”, free from any constraint, for the most part neglectful of the anthropological, ethical and symbolical universe. Transferring these elements from the analysis of inter-individual relationships to social analysis means working, for example, on the levels of internalization achieved by services to “subjectivities” and to “world experiences” carried by population groups with whom (and not on whom) they must work.

The public health that we imagine is based upon a kind of research that does not necessarily draw upon the official and functional categories of medical and epidemiological disciplines: we place it at the level of “life communication”, of experiential exchange and it gives voice to life-worlds’ needs, not as side effects of physical and psychical components, but as inherent elements of the processes of “getting well” and “getting ill”. We need to figure out unstable balances, coexisting spontaneous and/or subjective factors, emerging non-organized trends in research on treatments: a shift from the dual medicine-patients relation to a medicine-citizens-society relation.

So a project targeted “for health” cannot be seen as something based upon disciplines and modes of behaviour “to be taught”; instead, it implies a lifelong communication pathway, aimed at rearranging not so much the structures, but rather the disciplines. Therefore it requires a different organizational management that plans to change the operational dynamics and to shift from risk-analysis-oriented activities (that can be, from many viewpoints, objectified, hence even more easily “subjectified” by the actors involved in them) to a work focused on activities and projects, shifting from aspects of relevance, spreading, etc., to a target-oriented model. A promotion policy forces each project to come to grips with the assessment not only of economic resources, but also of human resources able to build results that can spread to the whole framework of reference. As a matter of fact, the achievement of wellbeing and health objectives depends very much upon the way in which they are pursued by the individual operative units in their strategies.

We should ask ourselves: do the strategies and practices of different institutions influence and modify either directly or indirectly the resources and bargaining power of individuals, communities, social groups, generations? Are they compatible with the social priorities widely accepted and officially stated? And with citizens’ aspirations? Only when a project meets such prerequisites can it be called “socially compatible” and from certain viewpoints, following this path, we should go back to the notion of “discussion of the social budget” of interventions, rather than pursuing evaluation as exclusively based on efficacy and effectiveness criteria issued by the same agency that builds projects and interventions and then assesses them (often validating them).

Hence

- change,
- sustainability,
- transparency,
- co-responsibility,
- co-learning

Are the principles for a good political project for health and also the principles for action-research stated in the “Letter of Quality” proposed by CAENTI.

A voluntary technical and scientific action can provide information, but the illusion that planning means preparing refined technical, technological, organizational, legislative grids, thus optimizing projects and ensuring their implementation and development has been denied by reality, as is proved by so many projects that fail, and they almost invariably failed because they lacked social compatibility. The immediate involvement of stakeholders in the planning process becomes an ethical principle of health planning and governance: such method requires the enhancement of knowledge and the continuous exchange of “hands-on” experience among the different groups involved in the planning-acting process, that look at reality from different angles and possess different types of know-how. Only where these two modes and levels of knowledge overlap can we implement health governance as a product of territorial intelligence and as a tool for governing and promoting equity.

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