Guidelines for Wellness towards Social Sustainability: Moving Sweden to Optimal Health

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Abstract:

This paper is a conclusion of a four-month-long research project.

Aging and lifestyle diseases pose a massive challenge for sustainability of societies of the developed countries.

The aim of the study was creation of a set of guidelines and actions that would facilitate interaction between primary health care and wellness organisations in Sweden in a manner conducive to achievement of social sustainability in the area of public health.

The theoretical part provides insights into significance of public health for sustainability. It explores systematic barriers for achievement and maintenance of optimal health within health system and social system.

Research was conducted through interviews with professionals working at the Blekinge Health Arena, doctors and nurses. The results were framed within FSSD to ensure compliance with Social Sustainability Principles. The guidelines and actions promote health through lifestyle change, community empowerment, holistic perspective of the patient and close collaboration between primary health care and wellness organisations.

The authors believe the results may be widely implemented within Sweden, helping transition towards sustainability.

Keywords: wellness, primary health care, sustainability, social sustainability, health, FSSD

Statement of Contribution

The Statement of Contribution indicates what tasks each author was responsible for. For a better understanding, the activities were placed in the general categories below.

The conceptualization of the research design was mainly developed by Natalia and Vaiva, to take advantage of their knowledge and experience with qualitative research and academic work. The development of goals and the overall development of questions and methods were performed by all the authors.

All the authors were involved directly in data collection and data analysis activities, which assumed the form of research and discussion on several topics for the literature review. Responsibilities for initiating contact with the respondents, planning the interviews and their analysis at each stage were evenly spread.

The final report planning, outlining and writing involved all the authors. Concern for the coherence and correctness of the final report should be credited mainly to Natalia. A similar process was adopted for the presentation slides, where Lúcia assured standardization of final slides.

It is important to say that the thesis is the result of a creative, collaborative and dynamic process fuelled by the diversity of our backgrounds and interest in the health care and wellness sector and, specially, in finding a way to reach optimal health. All the authors participated in the different phases of the process. At each phase the work was divided and then the individual's parts were presented and discussed by the authors. The division of the work was made according to experience, personal interest and the current needs in the process.

Lúcia, Natalia and Vaiva

Acknowledgements

We would like to thank all the people who made it possible for us to explore the fascinating area where health care and wellness meet. We are sincerely thankful for your time, friendliness, and patience.

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Finally yet importantly, we are sending our most sincere thanks and warm hugs to the people who always encouraged us to go after our dreams and make them happen: our families and friends, scattered all over the globe but always present.

Lúcia, Natalia and Vaiva

Executive Summary

This study explores the role Primary Health Care can play Swedish society make a transition towards sustainability.

Health-related Social Sustainability Challenge

Health care systems all around the world struggle with keeping populations healthy enough for the society to be sustainable in the long term. In the face of growing pressures, a need for a paradigm shift is expressed by scholars, the public, and the industry itself.

Effective and universally available Primary Health Care focused on prevention and health promotion, in addition to its traditional role in early treatment, is considered crucial to insure general good public health at a sustainable cost (Shi 2012; World Health Organization 2013; European Health Summit 2013). European Union's directives demand that the member countries integrate TCAM practices into their health care in response to both growing popularity of TCAM, along with the necessary evaluation of its safety for the patient, effectiveness, and affordability

Population growth, medical advancements and lifestyle changes, have resulted in new challenges to public health. While great strides in healthcare technology have brought relevant developments and important health benefits, the progress creates also unintended new problems. Developed countries struggle to find resources to fund increasingly popular and expensive treatments for conditions which often have to last for a lifetime (Scheller-Kreinsen, Blümel, and Busse 2009). The countries of the European Union experience health-related social sustainability challenges, which result from several combined trends: aging population ageing, rising rates of overweight and obesity, rising rates of many chronic diseases (diabetes, depression, dementia to name a few). Lifestyle is considered the main risk factor for non-communicable chronic diseases (Mladovsky et al. 2012). Effective and universally available primary health care focused on prevention, in addition to its traditional role in early treatment, is considered crucial to insure general good public health at a manageable cost (World Health Organization 2013; European Health Summit 2013; Shi 2012). Currently, about 3% of European health care budgets are spent on prevention, despite chronic diseases being responsible for 77% of deaths (Mladovsky et al. 2009). An impact of a relatively small early intervention can be very significant long-term in terms of individual health and costs to society.

Sweden is a "high income" country (World Health Organization 2011) with one of the highest Human Development Index values and achievements in gender equality (World Health Organization 2012a). Yet, Swedish health care performance is ranked average compared to other countries from that group, especially when responsiveness of health care services is concerned (Anell, Glenngård, and Merkur 2012).

This study highlights that health care systems need to re-structure themselves: focus on taking care of healthy people and target risk groups, but also offer services and treatments that address prevention needs best, be it exercise programs, relaxation techniques or scientifically verified complementary treatments. A solution is needed to reinforce social

networks, maintain productive power of society, and consequently its ability to face the demands of transition towards full sustainability.

The wellness industry may be considered a good place to start, since wellness organisations, especially those collaborating closely with PHC, have the unique potential for creating environments facilitating healthy choices and patient empowerment. Therefore, our research aims at answering the following question:

> *What guidelines and actions can help wellness organizations that interact with primary health care in Sweden to support society's transition towards sustainable health?*

Literature review and current context

Consideration of the social sustainability challenge related to health requires a holistic concept of health. Health is a dynamic state: health and disease are not mutually exclusive; even severely ill or disabled individuals can be considered in "optimal health", if they make use of their capacity to adapt to the environment and experience as much physical, social and psychological wellbeing as reasonably possible. Evidence suggests that prevention and health promotion should concentrate on creating conditions conducive to optimal health and motivation to

Patients' need for individualized and holistic treatment that they can co-create with health care professionals is often cited as one of the main reasons for growing popularity of Traditional, Complementary and Alternative Medicine (Alivia, Guadagni, and Sarsina 2011).

While the above-mentioned notions are officially embraced by most medical education programmes and government policies, institutional solutions for embedding them in every day practice have been underdeveloped.

The overall goal of this thesis is to identify ways in which PHC in Sweden can facilitate the society's transition towards social sustainability. In order to ensure a strategic approach and a whole-system perspective, the Framework for Strategic Sustainable Development (FSSD) is used. Five Social Sustainability Principles (SSPs) allow to clearly defining success vision, through the following definition:

> *"In a sustainable society, social system is not subject to systematic barriers against: Integrity, Influence, Competence, Impartiality and Meaning" (Missimer 2013a).*

Backcasting from success (Robèrt et al. 2012) was the key to define strategically oriented guidelines for PHC.

The Five Level Framework was used to analyse Swedish health care system. Blekinge Health Arena (BHA), a multi-stakeholder non-profit organisation, whose mission is to unburden the health care system by keeping people physically active and therefore healthier, opened their doors to the present study, contributing with time and availability and, most important, experts knowledge about Swedish wellness sector. BHA is also engaged in prevention, early treatment and complementary treatment of some diseases. Collaboration between BHA and

PHC has been initiated in 2013; how it would progress was a subject of much discussion between the BHA and County Council.

Methods

To explore the research question in a way that highlighted the complex nature of interactions between PHC and wellness, the authors conducted research among stakeholders from various groups engaged in the collaboration. Overall, 31 semi-structured interviews were done with seven researchers, six executives, managers or consultants, four nurses, six TCAM specialists; three nurses also specialists in TCAM and four doctors. The iterative process of qualitative study was used by structuring three rounds of interviews. Phase I involved preliminary and exploratory interviews; Phase II - validation of guidelines and search for actions; Phase III- involved vet of guidelines and inherent actions. Finally, the feedback from all three stages of interviews was incorporated in final recommended guidelines and amended actions.

Results

Guidelines were confirmed and expanded according to the respondents' feedback. Collaboration, Empowerment, Holistic Approach, Health Promotion, Lifestyle Change and Awareness emerged in the interviews and literature as main themes.

34 actions were developed and grouped under corresponding guidelines. Encouraged by the feedback obtained from the respondents, as steps towards "optimal health" in Sweden. Each of them aims to alleviate barriers to social sustainability. Almost all contribute, directly or indirectly, to compliance with Integrity (SP4), many being also strongly related to Competence (SP6) or Influence (SP5).

Discussion

Guidelines and actions were designed to answer needs and concerns of the BHA and PHC. Following final validation by expert respondents, they were analysed according to five Social Sustainability Principles to ensure compliance with FSSD.

Respondents emphasised that many of the actions connected to Impartiality and Meaning constructively addressed problems they faced with engaging socio-economically challenged groups as well as wider social issues related to health (e.g. unemployment, social exclusion).

On the scientific level, a tension between removing systematic barriers and fulfilling needs was constantly present. It is perhaps a topic for further research into formulating principles of social sustainability. Moreover, crucial role of trust was confirmed.

Unclear legal standing and definition of TCAM described by the literature was confirmed in the findings. Some actions address this issue as important for successful collaboration with PHC.

Potentially fruitful topics for further research include role of technology in patient empowerment, healthy ageing in context of social sustainability, comparative studies of

PHC-only and PHC-BHA collaborative treatment. Studies similar to the one presented here, but with wider engagement of GPs and patients would certainly add to the findings.

Conclusion

Our findings confirmed that sustainability challenges in the area of public health are deeply interrelated with other social problems, and the only solutions that may work must take the complexity of the system into account. Addressing the challenges systematically and in a strategic manner requires a global framework. The FSSD proved to be a useful tool.

Most actions are embedded in the local context of the organization taken as a convenience sample. Overall feedback from BHA staff and from other experts showed that the guidelines and actions were seen as highly applicable, complementary to the existing policies and indeed provided helpful insights into how to deal with some persistent systematic challenges of public health. The findings support a notion that intersectoral collaboration in necessary for mass-scale positive lifestyle change and consequent maintaining of optimal health in as many people as possible.

The study contributed to conceptualisation of health within social sustainability field, which may prove helpful in further exploration of social sustainability as related to health. It may also be found useful in formulating visions of success by private and public organizations.

Implementation of the actions outside BHA may require adjustments and additions. Nevertheless, they are probably highly transferable across Sweden, with public and private sector.

Glossary

Backcasting

A planning methodology in which a future desired outcome is envisioned, and then steps are planned and taken to work towards that future.

Collaboration refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector.

Complex system

A system that is constituted of a relatively large number of parts that interact in complex ways to produce behaviour that is sometimes counterintuitive and unpredictable.

Guideline

A relevant business principle or concept put forward to set standards or determine a course of action towards a more sustainable vision of primary health care organizations.

Health

A dynamic state that includes optimal physical, mental and social well-being, and which strongly depends on the individual's ability to adapt to the changing environment.

Health Care (or **healthcare**)

Health care includes diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in humans within institutional framework. Health care is delivered by practitioners in allied health, dentistry, midwifery-obstetrics, medicine, nursing, optometry, pharmacy and other care providers. It refers to the work done in providing primary care, secondary care, and tertiary care, as well as in public health.

Patients

Patients are people who do an individual consulting with a professional for promoting or managing health and wellbeing concerning reasons, not used here in any sense of 'sickness'.

Primary Care

In Europe it often describes a narrow concept of "family doctor-type" services delivered to individual patients. But it can also apply to all first-contact care, including emergency room visits.

Primary Health Care (PHC)

In addition to primary care services, it includes health promotion and disease prevention, and also population-level public health functions. Primary health care is health care received in the community, usually from family doctors, community nurses, staff in local clinics or other

health professionals. It should be universally accessible to individuals and families by means acceptable to them, with their full participation and at a cost that the community and country can afford.

Public health

It concerns disease prevention, health promotion and prolonging life through organized efforts and informed choices of society (individuals, communities and organizations, public and private). Public health uses an interdisciplinary approach involving epidemiology, biostatistics and health services, and needs multidisciplinary teams of professionals with healthcare, environmental, sociologists, communication and community development representatives, between others.

Sustainable society

A Sustainable Society is a society that continues developing without eroding its fundamental life support systems, creating human well-being within the social and ecological limits.

Sustainability challenge

Set of systematic errors in the design of society that are driving unsustainable effects on the socio-ecological system and creating considerable obstacles to fix those errors

Sustainability principles (SP's)

Minimum conditions needed, identified and refined by scientists and academic collaborators, for Earth to support current human and animal species. The 8 sustainability principles are:

In a sustainable society, nature is not subject to systematically increasing...

1. …concentrations of substances extracted from the Earth's crust (SP1);
2. …concentration of substances produced by society (SP2);
3. …degradation by physical means (SP3);

and social system is not subject to systematic barriers against...

4. ...integrity (SP4);
5. ...influence (SP5);
6. ...competence (SP6);
7. ...impartiality (SP7);
8. ...meaning (SP8).

We can refer to the first three principles as "the ecological sustainability principles" and to the last 5 principles as "the social sustainability principles".

Traditional Complementary and Alternative Medicine

There is no widely accepted definition of Traditional Complementary and Alternative Medicine. Generically it is assumed that it covers medical practices that do not conform to the standards of the medical schools and community of a determined country or region.

Wellness (sector)

Organizations working towards a multidimensional state of being, describing the existence of positive health in an individual as exemplified by quality of life and a sense of wellbeing.

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1 Introduction

This paper explores the role primary health care (PHC) can play in helping to move society towards social sustainability[1].

Health care (HC) systems all around the world struggle with keeping populations healthy enough for society to be sustainable in the long term. In the face of growing pressures, scholars, public, and the health care industry itself express a need for a paradigm shift.

General good public health is naturally one of the features of sustainability. Effective and universally available primary health care focused on prevention and health promotion, in addition to its traditional role in early treatment, is considered crucial to insure general good public health at a manageable cost (World Health Organization 2013; European Health Summit 2013; Shi 2012). On the other hand, an inefficient primary health care may weaken social networks, undermine productive power of society and capacity of its members to trust one another and consequently their ability to collectively transform their institutions and the way they relate to the natural environment. Therefore, good public health is both a feature of a sustainable society and a resource that every society needs in order to become sustainable.

This section presents an overview of challenges related to human health in the context of social sustainability.

1.1 Sustainability Challenge

Progress of medical sciences has made it possible to treat conditions like cancer, organ failure (notably kidneys and liver) or type I diabetes, to name just a few. This means that previously fatal conditions are now deemed chronic (Member States 2012).It also allowed containing spread of viruses and bacteria that ravaged human populations in the past centuries. This is an enormous achievement. However, population growth, medical advancements, and lifestyle changes resulted in new challenges to public health.

While large parts of human population are still suffering from undernourishment, lack of medical care and uncontrolled infectious diseases, an increasing burden of chronic and lifestyle diseases, as well as those associated with aging, pose an equally important threat to social sustainability and are no longer limited to the so-called developed countries. Economic growth brought an epidemic of obesity with associated conditions to countries like China, India, Pakistan and Brazil (Prentice 2006; Nugent 2008), putting unexpected pressure on the health care in those countries:

> *"Demographic ageing is not confined to Europe as each of the continents reported some increase in longevity. The on-going ageing process is most pronounced in*

[1] Social sustainability can be broadly defined as a state in which members of a society are not systematically prevented from meeting their basic human needs.

Europe, Latin America and the Caribbean, Asia and Oceania [...]" (European Union 2011, 20).

As population ages and lifestyle diseases persist, developed countries struggle to find resources to fund increasingly popular and expensive treatments for conditions which often last a lifetime (Scheller-Kreinsen, Blümel, and Busse 2009).

Integration of selected therapies from the TCAM spectrum might help alleviate some of those developments in several ways. Often focusing on lifestyle (diet, exercise, daily habits, mental patterns), they may help patients gain better self-control and teach them how to mitigate early symptoms of diseases or treat it completely be it asthma, diabetes or chronic backache. It may potentially contribute to decreased use of pharmaceuticals and surgery. Building up natural immunity within community is a desired alternative to mass-medication.

Improved lifestyle may help lower incidence of cancer and certainly can reduce obesity with all of its associated conditions. Tendency to look holistically at a patient might reduce necessity for visits to multiple specialists, unburdening the health care system.

Although this thesis is intended to explore in detail neither the effects of environmental degradation on human health nor ways to render primary health care environmentally sustainable, it is acknowledged throughout it that strong and healthy ecosystems together with living environment free of pollutants and toxins are indispensable for human health. The focus of this paper however is on social sustainability. According to Missimer (2013b, 20):

"Sustainability [...] is the boundary condition within which the system can continue to function and evolve, outside of which it cannot".

Therefore, even in the conditions of total ecological sustainability and thriving ecosystems supportive of human economic and technological development, major flaws of societal design may undermine society's ability to function, support and even reproduce itself. These flaws must be addressed to ensure that societies remove systematic barriers to sustainability. The authors hope to offer a humble contribution to this ongoing effort by addressing challenges related to one of the pillars of a sustainable society: public health.

1.1.1 Health-related social sustainability challenge in the European Union

The countries of the European Union experience health-related social sustainability challenges mainly in the area of chronic diseases and conditions that accompany ageing. Although these problems are by no means unique to Europe, they are a main point of focus because of distinctive demographic structure of the European population, lifestyle patterns, and a high level of development that diminishes concerns with other problems (malnutrition, neonatal and maternal mortality etc.).

Moreover, most countries in the European Union have, or aim for, full coverage (Dye, Reeder, and Terry 2013) of its residents with a comprehensive and life-long medical insurance. These features of the health care system determine what steps may be taken to tackle health-related sustainability challenges and what assumptions can be made about the future. The European Union recognizes the growing burden of chronic diseases to be its most

important social problem and acknowledges that it needs an innovative approach. The growing burden of chronic diseases results from several combined trends:

- Aging of the population

People aged 65 and older constitute the fastest growing segment of the population of the European Union. In 2010, aproximetly17.4% of the population fell within this age range (~87 million) (European Union 2011).

> *"The EU-27 population stood at an estimated 501.1 million persons on the 1 January 2010; of these some 87.1 million were aged 65 or over [...] By 2060 the median age of the EU-27 population is projected to stabilise at 47.6 years, around 15 years higher than a century before"(European Union 2011, 17).*

- Rising rates of overweight and obesity

> *"The prevalence of obesity has tripled in the last 25 years and if no action is taken there will be an estimated 150 million obese adults (20% of the population) and 15 million obese children and adolescents (10% of the population) in the WHO European Region by 2010"* (Mladovsky et al. 2009).

This trend led researchers to forecast that the lifespan of the current young generation will be shorter than lifespan of their parents due to conditions associated with obesity.

- Rising rates of many chronic diseases (e.g. respiratory diseases, diabetes, some types of cancer, allergies)

Although exact figures vary from country to country, some examples may be given to give a general idea of the situation:

> *"Between 1990 and 2000, overall cancer incidence rose across the EU25 by an average of 63 new cases per 100 000 inhabitants"* (Mladovsky et al. 2009).
>
> *"Over the last three decades the prevalence of allergic diseases and asthma has risen throughout the WHO European Region"* (Mladovsky et al. 2009). *Prevalence varies highly across member countries, from 1% to 15% among children. Diabetes remains one of the dominant risk factor for development of heart diseases, kidney diseases and neuropathies.*
>
> *"The burden [of diabetes] is expected to increase from an estimated 7.8% of the population between 20 and 79 years in 2003 to 9.1% in 2025"* (Mladovsky et al. 2009).

Moreover, many chronic diseases, traditionally affecting only adults, are spreading to increasingly younger segments of the population (e.g. type II diabetes, with accompanying ailments). This causes serious concerns as to the future of the children and youth and reinforces the need for efficient prevention. EU institutions advise (Member States 2012) that

more focus should be laid on primary, secondary and even tertiary prevention[2] (Member States 2012). Currently, about 3% of European health care budgets are spent on prevention, despite chronic and preventable diseases being responsible for 77% of deaths (Mladovsky et al. 2009). Investment in prevention is intended to reduce not only occurrence of diseases, but also their symptoms (often disabling to some extent), complications and occurrence of other, resulting diseases (e.g. obesity is related to diabetes and both constitute a risk factor for developing heart diseases). Therefore, an impact of a relatively small early intervention can be very significant long-term in terms of individual health and costs to society.

To achieve the vision, health care systems need to re-structure themselves: focus on taking care of (seemingly) healthy people and target risk groups, but also offer services and treatments that address prevention needs best, be it exercise programs, relaxation techniques or scientifically verified complementary treatments.

Lifestyle is the main risk factor for non-communicable chronic diseases, accounting for most deaths (Mladovsky et al. 2009). Addressing this main underlying cause of poor health in many cases may require shift in priorities of primary health care so that it can focus on promoting positive lifestyle change and creating conditions to make this change easier. Crucial role of individuals' involvement in managing their own health cannot be overlooked. Positive lifestyle change on a mass scale is possible when both personal motivation and conditions (healthy natural environment, healthy food, time and space to exercise etc.) are present.

A more detailed analysis of trends in the context of social sustainability can be found in the Sustainability Principles chapter.

1.1.2 Health-related social sustainability challenge in Sweden

Sweden is among "high income" countries (World Health Organization 2011), with one of the highest Human Development Index values and achievements in gender equality (World Health Organization 2012b). Yet, Swedish health care system's performance is ranked average compared to other countries from that group, especially when responsiveness of health care services is concerned (Anell, Glenngård, and Merkur 2012). Sweden's health-related social sustainability challenges are similar to those of European Union. Lifestyle is a primary risk factor. Anell, Glenngård, and Merkur (2012) report that 70% of health care expenditure is addressing health impacts related to smoking, alcohol abuse, and obesity resulting from lack of physical activity. Therefore, there has been an ongoing effort to increase general awareness among health care staff so that they can identify certain risk groups and educate them early enough to prevent diseases or start treating them at an early stage. The same report states that primary health care in Sweden is relatively less developed compared to other countries in the region, which contributes to growing inequalities in access despite state-funded universal coverage.

[2]Primary prevention is about avoiding occurrence of a disease. Secondary prevention is about detecting and addressing an existing disease before symptoms occur. Tertiary prevention is about reducing negative impact of an existing disease.

A more detailed analysis of trends in the context of social sustainability can be found in the chapter *Sustainability Principles*.

1.1.3 Link between health, wellness & sustainability

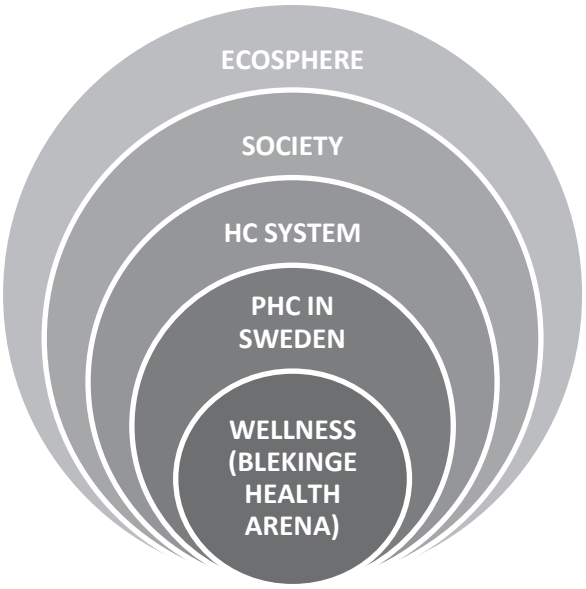

Figure 1.1. Scope.

Wellness can be described as "*a multidimensional state of being, describing the existence of positive health in an individual as exemplified by quality of life and a sense of wellbeing" (Corbin and Pangrazi 2001, 1).*

Wellness organizations are organizations that promote the positive aspect of health. They do not concentrate on disease treatment; instead, they promote health, exercise and relaxation.

As PHC around the world is becoming more patient-centred and more focused on prevention, it is moving outside hospitals and doctor's offices, and closer to patients' daily lives (Seppälä, Nykänen, and Ruotsalainen 2012). Companies increasingly invest in their employees' wellbeing through various wellness programmes in the hope of getting a return in form of decreased absenteeism and increased productivity. There are also examples of local government initiatives targeting specific groups, e.g. elderly citizens. Studies usually find significant measurable benefits coming from such programmes, but also acknowledge limitations of quantification of holistically understood health (Verma, Forsyth, and Flynn 1999).

> *"There is now a growing consensus that health professionals must focus on factors that promote wellness in a more global or holistic sense, as well as to treat and prevent illness and disease" (Corbin and Pangrazi 2001, 3).*

Verma, Forsyth and Flynn (1999) support this idea in their study; while employers' investment is, by all means, desirable, PHC involvement offers scientific foundation and coordination with local and national public health policies, not to mention potential for developing research that may help integrate complementary treatments into mainstream health care. Grootjans and Townsend (2005) posit that care for health must go beyond institutional structures of PHC, and must become responsibility of communities.

Wellness industry may easily be considered a good place to start, since wellness organizations, especially those collaborating closely with PHC, have a unique potential for creating environments facilitating healthy choices and patient empowerment. Therefore, our research aims to answer the following question:

What guidelines and actions can help wellness organizations that interact with primary health care in Sweden to support society's transition towards sustainable health?

1.1.4 Scope of the research

The scope of the research encompasses the area of interaction between Swedish PHC and wellness organizations like BHA. Potential of wellness industry to support PHC and there improve public health and consequently support society's transition towards sustainability is explored.

The research was partially focused at the Blekinge Health Arena, a wellness not for profit organization in Blekinge County in Sweden. This choice was undertaken due to its uniqueness as a wellness organization, to its focus on innovation and, especially, to its collaborative approach with several types of stakeholders, namely Karlskrona municipality, European Regional Fund, Region Blekinge, Blekinge Institute of Technology, Blekinge County Council, between others. Authors had also benefit from its geographical proximity and their staff availability and interest to participate in this particular study.

2 Literature Review and Current Context

In this chapter, a brief overview of literature relevant to this paper is presented, starting with concept and definition of health. Framework for Strategic Sustainable Development is briefly explained. Finally, findings from the literature on health and primary health care are assessed, using FSSD tools as a lens. Blekinge Health Arena is also described.

2.1 Optimal Health

Discussing social sustainability challenge related to health requires that an attempt be made to define the very concept of health. Although a central concept to medical sciences, a clear definition of health is debated and subject to re-formulations. The way the health care professionals understand health determines how they understand diseases and consequently – how they interact with patients and what treatment methods they choose, or if they undertake treatment at all (World Health Organization 2000). The vision of success determines the path.

Literature on the concepts of health and disease is vast. Authors often link flawed perceptions of health and systematic problems of the HC. This tendency may reflect a paradigm shift that has been occurring within medical profession. In 1946, The World Health Organization (WHO) acknowledged multiple dimensions of health, defining it as "complete physical, mental, and social wellbeing" (World Health Organization 1946), marking a departure from seeing health in purely physical terms. Many researchers consider such approach highly unrealistic, and instead posit that health should be understood as individual's capacity to deal with life's challenges while maintaining a sense of wholeness (Mordacci and Sobel 1998; Law and Widdows 2008). So-called "capacity approach" emphasises the importance of keeping balance between individual's resources (physical, social, psychological etc.) and demands placed on this individual by their life's circumstances. Either building up resources (e.g. through stress management) or decreasing demands (changing job to a less stressful one) are ways of achieving health.

It implies that health is a dynamic state: health and illnesses are not mutually exclusive; even severely ill or disabled individuals can be considered in "optimal health", if they make use of their capacity to adapt to the environment and experience as much physical, social and psychological wellbeing as reasonably possible. The concept of optimal health is also useful in defining what is "healthy ageing", since the process of ageing is naturally linked to deterioration of many functions and organs of the body, but is not a disease in itself. Agreeing on what is "optimum" for a patient requires an individualized, patient centred approach.

What is more, recognition of multiple factors of psychological, physical and social nature is necessary to help an individual reach and maintain the desired optimum. In fact, an important part of prevention and health promotion should concentrate on creating conditions conducive to optimal health. As Grootjans (2014) put it:

> *"In a sustainable healthcare… it's not about telling people how to live their lives, but creating an environment that makes the healthy choice easy choices."*

Enabling people to live healthy lives are the responsibility of the whole community. It is emphasised that individual patient's responsibility and commitment to co-creating their own health are no less important (Bircher 2005).

Patients' need for individualised and holistic treatment that they can co-create with professionals, is often cited as one of the main reasons for growing popularity of Traditional, Complementary and Alternative Medicine (TCAM) (Roberti di Sarsina, Alivia, and Guadagni 2012).

The concept of TCAM seems too broad to be informative, since it groups together various medical and therapeutic systems and practices based on different assumptions. Only some of them have been investigated in a scientific manner and results vary greatly. Nevertheless, it continues to be studied in the scientific literature. Isolated elements of TCAM continue to be incorporated into public health care systems and their importance is recognised. TCAM practices seem to have an increase recognized potential to improve cost-benefit effectiveness, improve health- and person-centric approach, promote lifestyle change, and consequently complement mainstream treatments effectiveness. European Union's policy recommends that the member countries integrate TCAM practices into their health care in response to both growing popularity of TCAM, along with the necessary evaluation of its safety, effectiveness and affordability (Varga and Kakuk 2013).

While the above-mentioned notions are officially embraced by most medical education programmes and government policies, institutional solutions for embedding them in every day practice still need further development in Europe.

2.2 Strategic Sustainable Development

To address the sustainability challenges affecting the PHC and help us plan towards alternatives that more directly address these challenges. The Strategic Sustainable Development approach will be employed. It is based on the following concepts:

2.2.1 Framework for Strategic Sustainable Development

The overall goal of this thesis is to identify ways in which PHC in Sweden can facilitate the society's transition towards social sustainability. In order to ensure a strategic approach and a whole-system perspective, the Framework for Strategic Sustainable Development (FSSD) (see Appendix A: FSSD and Five Level Framework) is used. The FSSD is composed of five levels: system, success, strategic guidelines, actions and tools. It helps to understand system's boundaries and interactions between the Earth ecological system and its subsystems, including human society. The FSSD also demands a clear definition of success: achieving global socio-economic sustainability (Robèrt et al. 2012). Detailed description of the five levels is to be found in Appendix (see Appendix A: FSSD and Five Level Framework).

2.2.2 Sustainability Principles

Success is defined within FSSD with the help of eight Sustainability Principles. Use of the SP's throughout the research in this research aims at creating a common simplified language and understanding of sustainability.

The ecological SP's (SP1, SP2 and SP3) can be seen as the minimum conditions needed for Earth to support humanity continuously, now and in the future. The ecological aspects of sustainability, although of paramount importance, are not the focus of this thesis. Therefore, the ecological SPs will not be discussed at length. The social SPs will be elaborated upon instead. They are being developed by Missimer as her PhD research and are still being discussed. One of the aims of the research undertaken for this thesis is to test usefulness of the Principles as an analytical tool. Authors' understanding of the Social SPs and their application is based on Missimer's Licentiate dissertation, her lecture and workshops.

In their current shape, the 8 Sustainability Principles present as follows (Robèrt et al. 2012; Missimer 2013b, 33):

In a sustainable society, nature is not subject to systematically increasing...

SP1	**… concentrations of substances extracted from the Earth's crust**
SP2	**… concentrations of substances produced by society**
SP3	**… degradation by physical means**

... and people are not subjected to systematic barriers against...

SP4	**…integrity**
SP5	**…influence**
SP6	**…competence**
SP7	**…impartiality**
SP8	**….meaning**

Below is an analysis of how various health care issues are related with the five SSPs. It is important to note that one health concern can relate to more than one principle. Nevertheless, one usually holds a stronger relation to a particular problem within a given context.

SP4…integrity

This is the broadest of the Social Sustainability Principles. It conveys a meaning of wholeness and completeness on physical, psychological and moral levels (Missimer 2013c). It is related to basic human rights, such as a right to live, freedom of conscience, physical integrity, access to basic resources and even the right to own property (Missimer 2013b). Integrity holds a strong relationship with the concept of health, and obstacles to maintaining and regaining it can often be classified as violations of SP4 (Missimer 2014). Consequently, most of the social sustainability challenges relate directly to this Principle. Below are listed trends in public health that signal the presence of systematic barriers to Integrity.

Table 2.1. Health-related Integrity violations in Europe and Sweden.

European Union[3]
• Increasing prevalence of chronic diseases like asthma, chronic obstructive pulmonary disease, diabetes and dementia. Poor control of chronic conditions leads to avoidable hospital admissions and may result in complications leading to disability (Organisation for Economic Co-operation and Development 2012). Chronic diseases are a leading cause of mortality in the European Union, representing 63 percent of all deaths (United Nations Statistics report 2010). • Rising incidence of cancer (Mladovsky et al. 2009). It results partly from a higher life expectancy. Due rising survival rates thanks to earlier detection and better treatment, cancer is often considered a chronic disease (Organisation for Economic Co-operation and Development 2012). Cancer incidence rose by 63 per 100 000 inhabitants in 10 years (World Health Organization 2011). • Diabetes, which is a leading cause of kidney failure and neuropathy in addition to being a risk factor for a number of other diseases. Around 7.8% of the population aged 20-79 suffers from it (~31million people) (Mladovsky et al. 2009). Estimated 50% of those people are not aware of their condition. • Increasing overweight and obesity rates (52% and 17% respectively for adults on average). Rising rates among children and adolescents are of particular concern. • Co-morbidity (presence of multiple conditions in one patient at the same time). Co-morbidity makes it hard to coordinate and prioritise treatments (Mladovsky et al. 2009). • Dementia, which affects 6% of population over 60, drastically increasing need for care and contributing to social exclusion.
Sweden
• About 50% of the population aged 16-84 are classified as overweight, 10% are obese (Anell, Glenngård, and Merkur 2012). • Death rate from mental disorders and nervous system diseases have been increasing since 20 years (Anell, Glenngård, and Merkur 2012)

One may argue that occurrence of the above-mentioned diseases does not point to the presence of any systematic barrier to Integrity; many of them are a consequence of bad lifestyle choices, others are a side effect of increased life expectancy. However, the prevalence of those chronic diseases suggests that there is something in the social system that

[3] It is important to note that data from European Union is not always comparable, as there are indicators where the number of countries considered is higher than others, according to information availability.

perpetuates their occurrence. Lifestyle choices are only partially free. Many of them are dictated by a broader social context, e.g. economic status, area of living, conditions at work. In short, they are partially a product of societal design. If healthy choices are hard choices, there are systematic barriers to health in a given society. Wilkinson and Pickett (2009, 91) confirm this notion in relation to health and equality:

> *"Levels of obesity tend to be lower in countries where income differences are smaller"*

In fact, growing inequality can exacerbate psychological problems in a population. Mental disorders are all strongly correlated with inequality and, in societies that are more unequal, a higher proportion of the population tend to suffer from mental illness.

SP5…influence

This principle calls for every individual being able to participate in shaping the social systems they are part of, e.g. through voting on leadership.

Social exclusion resulting from disease results in patients not being able to participate fully in social life. These barriers to influence may have purely physical character (e.g. immobility, inaccessibility of socially important places for wheelchairs) or more complex character (stigmatisation of e.g. obese people).

SP6…competence

> *"...is about safeguarding that every individual (and group) has the opportunity to be good at something and develop to become even better. It includes the securing of sufficient resources for education and other sources for continuous personal and professional development" (Missimer 2013b).*

Lower educational status is strongly linked to poorer health. In Sweden, according to the National Board of Health and Welfare 2009 (Institute and Swedish institute 2012), the number of daily smokers is decreasing in all groups of the population except women with low education. Survival rates from breast cancer are lower in women with low education as well (Anell, Glenngård, and Merkur 2012). Agardh et al. (2011) demonstrated a correlation between low educational level and type 2 diabetes in Sweden.

Unemployment and underemployment, especially among the youth, remains a burning problem in Europe after since 2008, It is clearly correlated to health problems (Maguire et al. 2013). In a vicious-circle manner, chronic diseases often impair daily life to an extent where a patient faces severe challenges in achieving education, professional training and in the job market.

SP7…impartiality

The impartiality principle demands that all people are treated equally both on institutional level (e.g. in courts) and the interpersonal level, what is, in this context, mostly related with equality in access to health care and treatment.

Table 2.2. Health-related Impartiality violations in Europe and Sweden.

European Union[4]
Countries of the European Union struggle with the effects that economic disparities have on the public health: • Inequalities in life expectancy between socio-economic groups. A strong correlation between income and health status has been observed (Organisation for Economic Co-operation and Development 2012). • Inequality in access to prevention (Member States 2012) • Unequal access to health care is related not only to ability to pay for it. It is often determined by the area one lives. Shortages of skilled staff contribute to reinforce the inequalities: • Although overall number of doctors per capita has increased in Europe, proportion of General Practitioners (i.e. family doctors) has been falling (Organisation for Economic Co-operation and Development 2012). • Shortage of nurses, despite increase in numbers (Organisation for Economic Co-operation and Development 2012)
Sweden
Challenges to Social Sustainability Principle of Impartiality are particularly emphasised (Socialstyrelsen 2009): • Diseases of the circulatory system and diabetes are more common among people with low education. • Diseases of the circulatory system, diabetes, severe chronic pain and general bad health are more common in people with lower income. • Problems with asthma and allergies are more common and more severe in children in lower socioeconomic groups. • Single women are more likely to suffer from domestic violence than other women are. • Women with functional impairments and older women are more likely to suffer from violence.

A statement from the book "The Spirit Level" seems adequate to resume a crucial point in this study:

[4] It is important to note that data from European Union is not always comparable, as there are indicators where the number of countries considered is higher than others, according to information availability.

"Greater equality is the gateway to a society capable of improving the quality of life for all of us and on essential step in the development of a sustainable economic system"(Wilkinson and Pickett 2009, 263).

This Sustainability Principle seems to be particularly relevant as inequality increases in society make people concerned about short-term, immediate problems like unemployment and insecurity. Consequently, larger long-term concerns, as environmental degradation and social problems are pushed to the second plan.

SP8…meaning

The last principle evokes the importance of having a purpose as a human being and as an organization (Missimer 2013a). Meaning is a concept that cannot be directly measured, but can be understood as a feeling of belonging to community (Hawkley and Cacioppo 2003) and having a higher purpose to one's life activities. It is strongly related to creation and support of trust within social networks. An interesting point is that it seems that the levels of trust are lower when income differences in society are larger (Wilkinson and Pickett 2009).

"Inequality is associated with deterioration in the quality of relations" (Wilkinson and Pickett 2009). Emotional fulfilment, behavioural adjustment, and cognitive function come from social relationships. According to recent research, emotional closeness in relationships increases with age, however social relationships and events decrease with ageing triggering loneliness (Hawkley and Cacioppo 2003). This is more relevant in countries like Sweden, where the elderly population is growing (Taube et al. 2013). In fact numerous researchers seem to agree that loneliness contributes psychosocial problems, mental health problems, and decreased physical well-being (Hawkley and Cacioppo 2003). Although more elusive, barriers to meaning occur where holistic approach to patient is lacking both for the patient and for HC professionals. Impersonal interactions between HC staff and patients have similar effect.

2.2.3 Backcasting

Backcasting can be understood as a planning methodology in which a future desired outcome is envisioned and then steps are planned and taken to work towards that future (Robèrt et al. 2012). This study uses the backcasting approach is the key to define strategically oriented guidelines for wellness organizations working with PHC.

2.3 Primary Health Care

The Declaration of Alma-Ata defined PHC as

"...the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (World Health Organization 2000).

The intention behind the Declaration was to re-invent PHC so that it concentrates on health promotion and prevention while empowering communities and guaranteeing universal access. It was adopted by World Health Organization's members, its vision being treated as a goal. The Declaration emphasises importance of PHC as the line of first contact and a warrant of access to health care for all. One of the features of the PHC as envisioned by the Declaration is a focus on long-term relationship with patient as a person. Close and trusting relationships with GPs and nurses is an essential quality to achieve better health outcomes in PHC (World Health Organization 2012c). Continuity of care facilitates, along with early detection and prevention of problems also contribute to both better quality of care and better outcomes (Starfield, Shi, and Macinko 2005).

2.4 Primary Health Care in Sweden

Below, the 5 Level Framework, a basic part of FSSD toolbox, is used to present a resumed picture of the PHC and its integration with wellness and TCAM practices in Sweden.

Systems Level

Swedish health care system is founded on three basic principles: human dignity, need and solidarity and cost-effectiveness (Anell, Glenngård, and Merkur 2012). Representing 9,9% of Swedish GDP (Gross Domestic Product) in 2009, the system is funded in 80% through local taxation (Björkelund 2013). Approximately 17% comes out-of-pocket, mainly through user charges. Around 3% comes from the national health budget (Anell, Glenngård, and Merkur 2012).

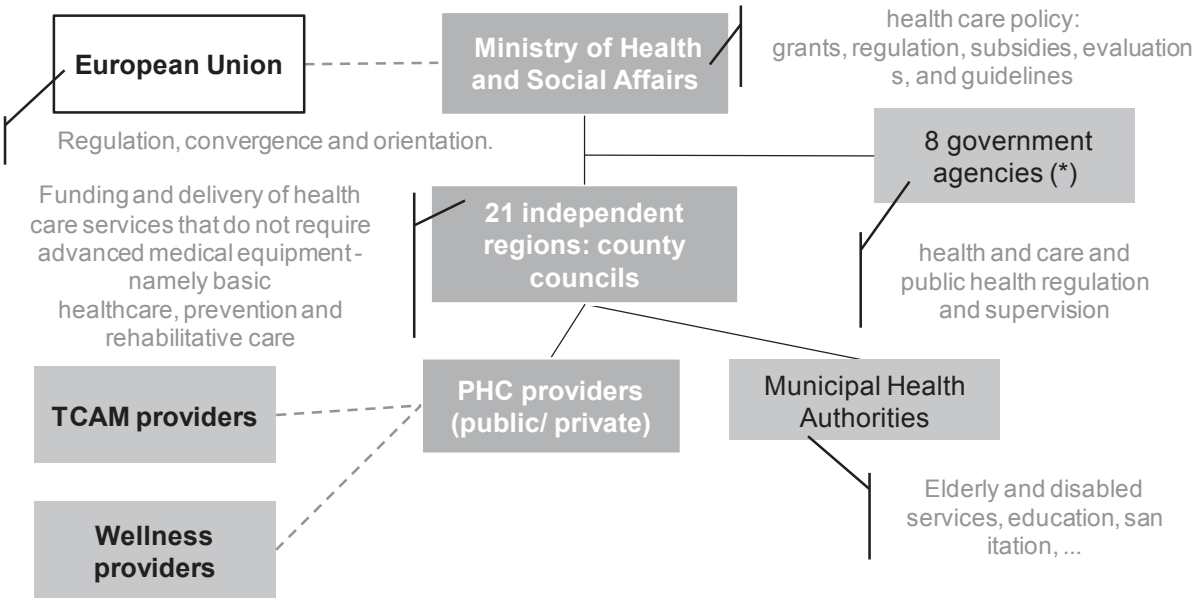

Figure 2.1. Health Care system in Sweden.

Responsibility for provision of health care services lies with county councils and regions, while municipalities are in charge of care for the elderly and the disabled. The central government controls the general policy for the HC through targeted grants, regulations, subsidies, evaluations and guidelines (Anell and Willis 2000; Anell, Glenngård, and Merkur 2012). Private health care providers are obliged to follow the same regulations as public providers, which means that patients have access to very similar services in both kinds of the institutions (Anell, Glenngård, and Merkur 2012).

Main operational concerns include waiting time, patient safety, and discontinuity of patient care. Like in many countries, long-run financing remains an unresolved problem, which is going to be further aggravated by increased demand for services, caused by increased life expectancy, current demographic structure and evolution of public health concerns (Institute and Swedish institute 2012; Anell, Glenngård, and Merkur 2012).

Swedish citizens experience some degree of inequality of access to HC; there are relevant regional differences and inequalities in health indicators when comparing socio-economic groups and other factors such as education, income, and country of birth. Anell et al. (Anell, Glenngård, and Merkur 2012) see the cause in relatively poor development of the PHC stemming from underinvestment. In the year 2000 however, PHC was assigned a priority position in the HC budget. Consequently, about 20% of HC budget for 2009 was spent on PHC (Björkelund 2013). Investment in PHC was based on a premise that it would result in higher efficiency of HC services.

Moreover, Sweden like many other developed countries experienced a rise in inequality since the early 1990's, which is in itself a factor in worsening public health. In fact, psychosocial factors, like the individual's social status, social networks and stress level are considered to have increasing importance in the rich developed countries as determinant of population health (Wilkinson and Pickett 2009).

PHC is decentralised, with 21 independent regions managed by local governments as shown in the picture on the left. They provide health care services that do not require use of advanced medical equipment, i.e. basic health care, preventive health care, and rehabilitation.

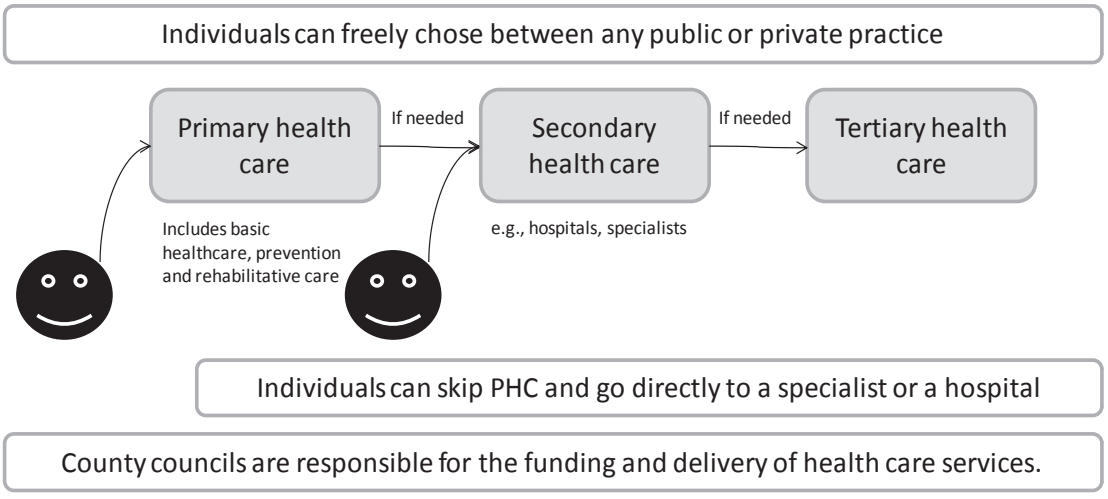

Figure 2.2. Health Care system flow.

PHC is designed to guide a patient rather than act as a gatekeeper. It is considered important to allow patient's choice in contacting directly any HC specialist (Nilsson 2013; Björkelund 2013).

In 2001 the government started to promote patient's empowerment, developing legislation concerning equality, patient's choice, access to information and guidelines on patient's role (Anell, Glenngård, and Merkur 2012). The National Patient Survey and the Health Care Barometer are tools introduced to monitor progress towards the new goals (Swedish Institute 2012). Another recent development was establishment of Swedish National Research School, a reflection of closer collaboration of Research & Development and PHC (Björkelund 2013).

Legal status and integration of TCAM treatments into the mainstream HC has long been an unresolved issue. It can be classified as a policy-practice paradox. The trend of growing use of therapies classified as TCAM is also present in Sweden (Eklöf 2001). However, most TCAM practices cannot be practiced inside HC facilities or by health care professionals, as HC staff is legally required to use only therapies that are based on *scientific and experiential knowledge*. In 1984, a Committee for Alternative Medicine (Kommittén för alternativ medicin) was set up as professional association for the purpose of self-regulation. However, non-members still practice. TCAM practitioners are forbidden from treating several types of diseases (cancer, diabetes, etc) and types of patients (notably children under 8). At the same time, counties do integrate and pay for various TCAM treatments for its residents (this includes acupuncture, acupressure, chiropractics, and yoga) (Fønnebø, Falkenberg, and Knox 2009). Solutions emerge mainly on the county level, with various results: in some there's strong opposition from the medical bodies, in others – process of examination and integration of some TCAM treatments has made progress (Fønnebø, Falkenberg, and Knox 2009). No definition of what is TCAM exists other that the notion that the concept incorporates treatments not used by the mainstream medicine. Patients and researchers often have different perception of what constitutes an alternative or complementary therapy (e.g. massage or garlic).

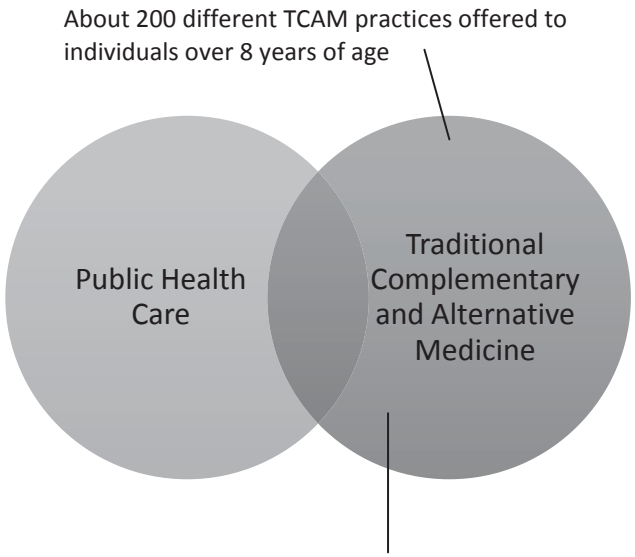

Figure 2.3. Public Health Care and TCAM in Sweden.

Success Level

Swedish health care systems cannot boast a clearly defined vision of success. One of its often-emphasised goals is to ensure equity in access to health care and to factors creating good health (e.g. wholesome food, exercise, nature). Cost-effectiveness in a system funded by taxpayers is another goal. The National Board of Health and Welfare and SALAR (Swedish Association of Local Authorities and Regions) compile data for regional comparisons. In 2011, there were 173 indicators organized in different categories, like prevention, satisfaction and trust, access, drug treatment etc (Anell, Glenngård, and Merkur 2012).

International comparisons are also made based on statistical data of prevalence and incidence of certain diseases (World Health Organization 2011), HC providers per capita (Björkelund 2013; European Health Summit 2013) and expenditure in relation to GDP and per capita (Björkelund 2013; Anell and Willis 2000).

Strategic Level

Decisions regarding PHC are taken at three independent levels of national government, counties and municipalities. The Ministry of Health and Social Affairs determines overall policy, supported by eight government agencies responsible for supervision and regulation of various aspects of HC system. Organization of health care services lies within county councils and municipalities' competence. They have a considerable degree of freedom in shaping decision-making model that suits them best. At least in theory, the Committee for Alternative Medicine supervises of complementary treatments in the country (Anell, Glenngård, and Merkur 2012). In practice, county councils often take regulation of TCAM upon themselves. Criteria for decision-making are predominantly set on county level collaboratively by county council and municipalities. Patients' safety and return on investment seem to be often used.

Actions Level

Over the last few years, the Swedish HC system was subject to several major reforms, which resulted in openness to private HC providers accompanied increased focus on and investment into PHC (Swedish Institute 2012). Simultaneously, the place of TCAM has changed: gradual incorporation of selected TCAM treatments into PHC can be observed at the county level (Anell, Glenngård, and Merkur 2012). Moreover, Karolinska Institutet has launched research and education programmes related to TCAM practices (Nurse Healer 2014). More qualified TCAM practitioners have sought and gained certification (Learning Difficulties Trainer 2014). A similar trend could be observed among wellness professionals: nutritionists, psychologists and training coaches(GP from Malmö 2014). Wellness centres similar to BHA have been set up and function as non-profit organizations (Business Developer 2014).

Tools Level

The analysis did not include this level of FSSD, as tools used by PHC are out of scope.

2.5 Blekinge Health Arena

Blekinge Health Arena (BHA) is a non-profit organization established in 2010 and funded by Karlskrona municipality, European Regional Fund, Region Blekinge, Blekinge Institute of Technology, Blekinge County Council and SISU (Swedish Association for Sport Education). Members include Region Blekinge, Blekinge Tekniska Högskola, Karlskrona Municipality, Blekinge County Council and a number of private firms and non-profit associations. Full list is to be found in Appendix (see Appendix B: Stakeholder diagram of Blekinge Health Arena). Karlskrona Municipality is responsible for running the organization.

The purpose of BHA is to provide continually infrastructure where local population can practice sports and experience non-traditional methods of treatment and relaxation. For this purpose, an experimental test lab was build where various indicators of physical condition can be measured. In addition to services for the population, BHA is also an innovation hub. IT products, related to sports and health, are developed within the project.

BHA was born out of the realisation that negative trends in the population's health would make health care system financially unsustainable in foreseeable future. Important part of BHA's mission is the unburdening of health care system by keeping people physically active and therefore healthier. It is also engaged in prevention, early treatment and complementary treatment of some diseases (Fransson 2014). The key to stopping and reversing those trends is seen in prevention, scientific approach to exercise and lifestyle change along with holistic treatment. BHA integrates complementary treatments, physical activities and science-based health assessment in ways that promote collaboration, encourage patient empowerment and supports PHC. These qualities, along with availability of its staff and managers, made BHA a perfect setting to investigate the research question raised by authors.

Collaboration between BHA and PHC has been expanding and is considered necessary for the project's success. It must be mentioned though that BHA as a rule does not compete with health care institutions or gyms; as a publicly funded institution, it has its distinct mission and tasks

Project *Blekinge Health Arena 2.0* is to be launched in 2014. Its goal is to commercialise achievements of BHA: provide environment for innovation, entrepreneurship and research related to sports and health tourism with the aim of attracting customers from Sweden and abroad (Fransson 2014).

3 Methods

To explore the research question and identify appropriate guidelines and actions to support a sustainable society, in a way that highlighted the complex nature of PHC and wellness practices, the authors conducted semi-structured interviews, which were conducted from early March till the first week of May. The research process assumed the following phases:

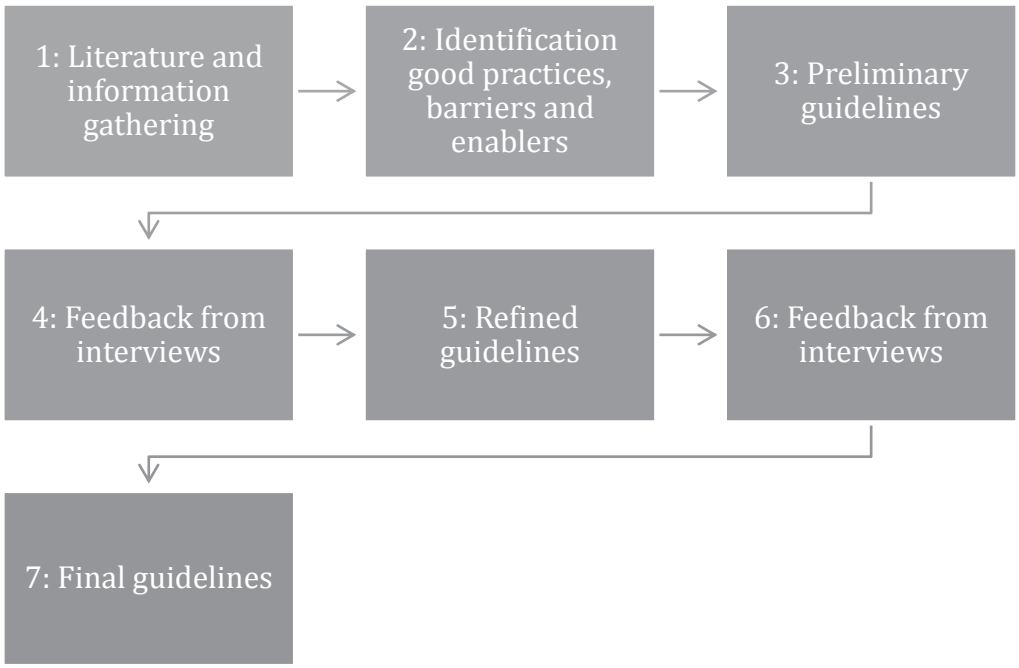

Figure 3.1. Research design.

3.1 Data Collection

Overall thirty one interviews (semi-structured interviews) were made in three phases of interviews with respondents (see Appendix C: Summary of contacts), specifically: seven researchers, six executives, managers or consultants, four nurses, six TCAM specialists, three nurses also specialists in TCAM and four doctors (see the Table 3.1).

The authors intentionally sought a diversity of stakeholders as respondents to bring a systemic perspective of the topic. Generally, the interviews were made in person, by one or two interviewers, in English language, and took between half an hour to one hour, depending on respondents' availability. The interviews were recorded in audio, with a few exceptions according to respondent's will or technological conditions. A few interviews were made by Skype, and five respondents were unable to give an interview in person or through Skype, opting instead for giving written responses to the interview questions sent by e-mail. After each interview, the researchers present written journal entries, reflecting on the interviews.

Table 3.1. Interviews – Respondents by Phase.

	# Interviews			# Respondents
	Phase I	Phase II	Phase III	
Researchers	7	0	1♯	7
Executives, managers or consultants	3	3	1#	6
Doctors	1	1	2	4
TCAM specialists	0	6	0	6
Nurses	0	4	0	4
Nurses practicing TCAM	0	3	0	3
Total	11	17	4	30

(#) respondents involved in previous phases of interviews.

3.1.1 Phase I

First phase occurred between the second week of March until the beginning of April and included 11 preliminary interviews (see Appendix D: Preliminary interview guide (Phase I)) focused topics that we found being relevant in the literature review, like health promotion and prevention, holistic approach to health, patient empowerment, potential of collaboration in primary health care and lifestyle changes. Authors developed the interviews with experts and people from the health sector, namely seven researchers, one doctor and three experienced executives, managers or consultants in the health sector. Respondents from Sweden but also from Australia, Netherlands and Portugal, were included to provide ground context about main concerns and opportunities for sustainability in health in Western developed world.

3.1.2 Phase II

Second phase of the data collection included the development and expansion of the guidelines and of some actions, developed based on the findings from the phase I, through 17 interviews with new respondents, all from Sweden. Eight nurses, from which three were also TCAM practitioners, six complementary medicine practitioners' connected to BHA, specialized in different areas – e.g. chiropractic, acupuncture, aromatherapy, yoga and meditation - one Business Developer, with experience in the wellness sector reviewed, three managers with experience in healthcare and wellness sector, and one doctor commented the guidelines. This round of interviews (see Appendix E: Interview guide (Phase II)) occurred during April.

3.1.3 Phase III

In the final phase of data collection, in the first week of May, authors asked four respondents (see Appendix F: Interview guides (Phase III)), one researcher, one Business Developer, both previously interviewed, and two GPs, never interviewed before, again all from Sweden, to vet the guidelines and respective actions. In fact, there was an intention to involve these two doctors in the second phase, but due to availability constraints, the authors had an opportunity to include their perspective only within the third phase of interviews.

3.2 Data analysis

Data analysis of the three rounds of interviews was done by reviewing interview journals, coding the interview transcripts. Some disagreements were raised between authors during the data analysis phases, namely about the coding and the interpretation of the data. Disagreements were solved through dialogue and, a few times, when consensus was not arising, using the majority rule, although this was rarely the case. The authors' different background from was important to bring different perspectives of the situations. The authors believe that the dialogues and discussions were critical and led to enrichment and strengthening of the data analysis phases.

3.2.1 Phase I

In this phase, the information from the respondents was analyzed and used as inspiration for the first set of guidelines. Each author created her own emerging codes and then codes were assessed and compared, by the other authors. Concerns on the true meaning of transcription and coding were discussed whenever they arose to reach consensus.

3.2.2 Phase II

The process of data analysis for phase II was similar to the phase I. However, additionally, after all the interviews the authors reassessed the codes (see Appendix G: Codes) and recoded all the interviews again. In this phase, the integration of the interviews analysis with the additional research about the health system in Sweden, allowed reframing the guidelines and developing a new set of actions to be vetted during the next phase. Concerns on the true

meaning of transcription and coding and adequacy to Swedish context were discussed whenever they arose.

3.2.3 Phase III

The last phase of data analysis used a similar process to the previous phases. The respondents' feedback and comments were discussed and later incorporated in the final set of guidelines and actions. This final revision intended to facilitate the understanding of some actions and integrate some changes in others to improve the adequacy and relevance to Swedish health context. The final list of amended guidelines is presented in the results section. Concerns on the true meaning of transcription and coding and adequacy to Swedish context were discussed whenever they arose.

3.3 Validity

Authors assured validity by recording, journaling, transcribing, coding, analyzing and discussing, reaching consensus, and questioning the methods against the research question. The triangulation of data around our research question was accomplished by examining different perspectives as represented by various stakeholders. Authors acknowledge that the fact that all interviews were conducted in English, the second language for the authors and for most of the respondents, may have hampered the overall ability to convey and pick up nuances, despite the general level of English of the respondents being good.

4 Results

In the following section, results of the research undertaken for the completion of this thesis are presented and explained. The results are structured according to research phases.

4.1 Phase I and II

Guidelines analysis is based on the respondents' statements, comments and concerns raised during the interviews of phase 1 and 2. Guidelines were mostly inspired by the literature review and subsequently verified and expanded with the interviews analysis. Through the interviews there were six primary categories related to health care that consistently emerged: collaboration, empowerment, awareness, lifestyle change, holistic approach, health promotion. Results related to them and associated subcategories will be presented below. These categories are not intended to be discrete; to the contrary, they influence and reinforce one another.

4.1.1 Collaboration

Collaboration in its many forms and between various stakeholders emerged as one of the dominants themes in the interviews. Respondents, although generally supportive of the idea, had strong opinions on what conditions successful collaboration in health care could happen.BHA is an organization very much relying on collaboration. One of its duties is to reinforce it. Respondents generally agree on the benefits of collaboration for reaching a healthy community:

> *"If everyone's collaborating we can reach the effects that are needed for the change [to happen]" (Business Developer 2014).*

Collaboration of TCAM practitioners with PHC. There has been an evolution towards acceptance of TCAM and its presence in the state health system. The desire for close cooperation was much stronger among TCAM practitioners than among doctors and nurses. BHA Business Developer recapitulated PHC staff's concerns about the methods of evaluation of TCAM therapies, which she thinks can be recommended by GPs

> *"Only if it is supported by research, so we can be sure that the methods are validated. Because if we don't we can lose the trust in primary health care"(Business Developer 2014).*

Majority of TCAM practitioners emphasised that what they do aims at supporting, and not replacing, conventional medical treatment:

> *"What I do is a very good complement to the ordinary healthcare" (Nurse Aromatherapist 2014).*

They cited perceived successful integration of TCAM into PHC systems of countries like England, Norway (Stress Pedagogue 2014), Austria and Germany (Acupuncturist 2014) as an

argument for a similar strategy to be adopted in Sweden. Understandably, for doctors it was only acceptable to introduce TCAM treatments under strict control and as an addition to conventional therapies.

Collaboration with Municipality/County Council. Municipalities and County Councils already cooperate closely on the health issues (Stjenberg 2014; Olander 2014). In fact, the collaboration with schools was referenced by many respondents as a decisive factor in prevention (Learning Difficulties Trainer 2014; Radiologist 2014; Nurse Healer 2014; Business Developer 2014). The respondents perceived the main role of these institutions was to ensure healthy environment and equal access to health promotion irrespective of socio-economic status.

Collaboration of PHC and Wellness. There is already a degree of collaboration between PHC and wellness. Doctors can prescribe exercise, as its benefits for health are proved. However, BHA staff felt that their role should involve active participation in the treatment process:

> *"It would be great if there was a natural collaboration, between the nurses and the physical therapist. People with diabetes type 2 could come to physiotherapist to learn how to exercise and live an healthy life style"(Business Developer 2014).*

Barriers & Enablers. Trust proved to be the decisive factor for collaboration. Distrust of GPs towards TCAM practitioners still was considered the norm. It was mentioned by many respondents that doctors and nurses only refer patients to TCAM practitioners that they know personally (Nurse1 2014; Acupuncturist 2014; Stress Pedagogue 2014).Another obstacle to closer collaboration between PHC and TCAM was general lack of knowledge about TCAM among doctors and nurses (Verrinder 2014; GP from Malmö 2014). The most important enabler of long-term cooperation seemed to be scientific research of complementary therapies credibility (Acupuncturist 2014; Business Developer 2014; Chiropractor 2014; GP from Malmö 2014). All stakeholders groups expressed a need for further scientific investigation in this area. A coherent legal regulation for TCAM was also advocated. Therefore, an environment where various specialists work together, are able to meet in person and exchange knowledge, may be conducive to better collaboration:

> *"I think it is easier when we have the alternative medicine mixed with the traditional medicine, mixed with primary health care, because they are involved here [BHA] as well… It is easier to collaborate"(Business Developer 2014).*

4.1.2 Awareness

The term awareness is to be understood as both individual's knowledge of facts about a health issue and general mindset, outlook on personal and community health. The awareness is a prerequisite for patient's involvement in preventive measures and treatment. It is also usually the first step towards lifestyle change as it linked to building motivation. It was almost universally acknowledged (Chiropractor 2014; Coach2 2014; Stress Pedagogue 2014; Nurse Aromatherapist 2014; Yoga Teacher 2014) that

> *"Changing the mindset is the main problem"(CEO 2014).*

This can be referred to patients, HC professionals and TCAM practitioners.

Education. Importance of school education on health was recognised and upheld (Learning Difficulties Trainer 2014; Nurse Aromatherapist 2014; Chiropractor 2014). Doctors understood raising awareness mostly as making lifestyle recommendations (GP from Stockholm 2014). Other stakeholders seemed to have a slightly broader perspective: a need for community education was signalled by researchers and managers (Brown 2014; Business Developer 2014) based on the premise that logical arguments alone fail to convince people to change:

> *"People don't change if you give them just logical reason" (Brown 2014).*

Discussing health problems within groups of people affected by a given issue was thought to be more efficient than presenting knowledge and lifestyle guidelines.

Barriers & Enablers. Constant barrier to raising patients' awareness within PHC was time scarcity (Stress Pedagogue 2014). Digital channels of communication were considered a promising way of reaching younger generations with reliable information (Business Developer 2014; Larsson 2014). Grounding awareness raising process in the context of – be it family, local community or group of patients – emerged as a potential powerful enabler of behavioural change.

4.1.3 Lifestyle Change

The topic of lifestyle change is a complex one. Improving everyday habits lies at the centre of health promotion and disease prevention. During the research, it was discovered that there was a tension between individual's responsibility and society's responsibility for healthy choices:

> *"Who has to take responsibility for my health? Is it me? Or it is for the society to make the opportunities for me to be healthy?" (Business Developer 2014)*

It could be concluded that only taking responsibility by both individuals and society can result in widespread positive lifestyle changes. Respondents indicated two domains in which changes are particularly called for:

Exercise. Physical inactivity is a disease risk factor on part with habits of smoking or alcohol drinking (Stjenberg 2014). Doctors try to encourage their patients to change their lifestyles by prescribing exercise, for instance directing them to BHA (Business Developer 2014). BHA staff wish the exercise were an integral part of treatment plan developed in cooperation with doctors (Business Developer 2014). Coach 1 (2014) expressed deep concern with the effect of socio-economic inequalities on children's and young people's access to sport facilities and consequently on their lifestyle. Patient-centric approach in exercise is advocated by Olander (2014). Moreover, many respondents (Chiropractor 2014; Nurse1 2014; Nurse Aromatherapist 2014; Coach1 2014) commented on the effect of digital technology: they felt that people in general and youth in particular spent too much time in front of computers, which adversely affected their physical and social health. They advocated parental control and self-discipline in limiting this time.

Nutrition. Verrinder(2014) and Learning Difficulties Trainer (2014) point to the governments' and organizations' responsibility to regulate food quality. Stress Pedagogue (2014) said that

"Changing patient's diet is always a dialogue. She can help find better alternatives and get off addictions"(Stress Pedagogue 2014).

Brown (2014) and Learning Difficulties Trainer (2014) independently pointed out that unhealthy eating habits often have their roots in childhood. Addressing the psychological dimension seems therefore advisable.

Barriers & Enablers. Brown (2014) and Grootjans (2014) drew authors attention to how flaws of societal design drive unhealthy lifestyles. Majority of the respondents supported this notion. Examples of the flaws included: social exclusion, food industry practices, socio-economic inequalities. Moreover, several respondents (Learning Difficulties Trainer 2014; Brown 2014; Stress Pedagogue 2014) emphasised that psychological conditioning and cultural norms play a crucial role in how people relate to food and drinks, often in an unhealthy manner. They pointed out that identifying and addressing these flaws is necessary for mass lifestyle changes.

4.1.4 Health Promotion

Health Promotion refers to activities undertaken to create conditions conducive to healthy lifestyle, raising awareness as well as to prevent diseases. It was considered(Consultant from Portugal1 2014; Consultant from Portugal2 2014; Stjenberg 2014) key to long-term cost-reduction in health care.

Prevention. Coordinator from the County Council (2014) expressed a need for prevention and health promotion getting priority status in Sweden. Practically all respondents agree with that notion, researchers advocating it even more strongly (Stjenberg 2014; Olander 2014). Respondents from different groups emphasised that young generation's health is in danger and should therefore become a priority (CEO 2014). There was widespread agreement that to improve it, whole families have to be involved.

"It's important - the habits they [children] have at home. It's important to work with the parents" (Learning Difficulties Trainer 2014).

Some serious concerns were raised regarding the level of awareness and the ability to prevent and manage mental disorders (Business Developer 2014; Nurse3 and Nurse4 2014; Consultant from Portugal2 2014).

Healthy Environment. At this stage of the research, respondents were mainly concerned with physical inactivity of the general population and children in particular (Coach1 2014; Chiropractor 2014; Nurse Aromatherapist 2014; CEO 2014). BHA Business Developer cited European Union project to prevent young people dropping out of sports as an example of an intervention.

Barriers & Enablers. People's habits and lifestyle were almost universally talked about. Some respondents (Coach1 2014) hinted at inequalities in access to sport facilities. County Councils' investment health promotion was considered necessary for alleviation of the situation. As far as prevention was considered, a crucial difficulty in justifying substantial investment in this area was explained by Stjenberg (2014):

"If you don't see the cost effectiveness, you don't put money into it [...] if the disease doesn't occur, you can't see the cost effectiveness."

While long-term cost-effectiveness of health promotion and early prevention are rarely cast doubt on (Consultant from Portugal2 2014), estimating return on investment for individual investments proved problematic.

4.1.5 Holistic Approach

Holistic Approach denotes a paradigm in diagnosis and treatment that demands that various aspects of an individual's condition (physical, psychological, mental etc.) be taken into account and their interconnectedness be recognised.

Although mainstream medicine advocate looking at health from social, physical and psychological perspectives, it was agreed upon big part of the respondents, that mostly physical health is treated with enough attention by PHC (Business Developer 2014).

Interviews with doctors revealed a different picture. GP from Malmö (2014) claimed:

"We also prescribe exercise as it benefits health, physical, mental wellbeing is proved to be strongly connected, Swedish health system pays for it."

Findings from interviews with coaches indicated that they too, like doctors and nurses, focus on the physical fitness and performance. Coach2 (2014) found it very problematic to raise psychological issues (e.g. alcohol dependence) of the clients with them at all.

Patient-Centric Approach. Individual approach towards patients instead of *"one fix for the whole target group"*(Consultant from the Netherlands 2014)was often mentioned by TCAM practitioners, nurses and managers (CEO 2014; Business Developer 2014) as necessary for providing best possible treatment (Olander 2014).

Disease-Centric vs. Health-Centric Approach. Doctors are seen as concentrating on diagnosis of diseases based on physical symptoms:

"It will be great if it would be more focused on the psychological things… Today most family doctors are just looking at physical conditions…"(Business Developer 2014).

This approach often draws patients to TCAM practitioners. Some TCAM practitioners felt that their services helped those with symptoms dismissed by doctors:

"They [doctors] have their specialists, but also they have problems with diseases or problems that people have nowadays like when people are burnt-out or stressed [...]. So we can do so much. There are so many more diffused problems. It would be better if you could take acupuncture for example"(Acupuncturist 2014).

Concentration on sub-clinical symptoms before occurrence of an actual disease was seen as crucial for successful prevention (Acupuncturist 2014; Chiropractor 2014; Stress Pedagogue 2014) and maintaining good health for years.

Optimal Health. Grootjans (2014) outlined what should be health care's vision of success as *"long and fruitful life"* as opposed to long life riddled with limitations imposed by chronic disease. The interview with Coach2 (2014) shed light on how important physical fitness is for efficiency at work and meeting life's requirements in general.

Barriers & Enablers. Lack of time in PHC was most often cited obstacle to adopting holistic perspective. Closer collaboration between PHC and TCAM practitioners and wellness specialists emerged as potential enabler

4.1.6 Empowerment

Empowerment was a multi-faceted theme. It emerged as related to patient's right to information and choice of treatment, their relations with health care professionals, to their motivation to take active role in treatment and prevention. Interestingly, a need to involve whole communities in a similar way was mentioned as well. A subcategory of *co-creation with Patient* was added to accentuate patients' involvement in their own treatment and ensuing responsibility.

Patient Empowerment. Several health care professionals agree that there's a visible increase in the number of people who want to take the ownership of their own health and

> *"Look for their own knowledge, as are no longer satisfied with doctors' verdicts"(Nurse Aromatherapist 2014).*

Many respondents acknowledged the role the Internet and electronic devices allowing to self-monitor play in this shift(Larsson 2014; Consultant from the Netherlands 2014; CEO 2014; Nurse2 2014; Business Developer 2014).TCAM practitioners generally see the new trend as beneficial.

Community Empowerment. The community empowerment was subject of importance for many respondents as there is a common belief that

> *"Individuals and communities should take responsibility for their own lives."*

as expressed by an Australian researcher in sustainability and health (Grootjans 2014). Most respondents think that the governments should have an active role in providing opportunities and tools for communities to take care of their own health (Business Developer 2014; CEO 2014).

Co-creation with the Patient. It is a widespread belief among TCAM practitioners that

> *"[A] Patient who can choose will be more responsible"(Chiropractor 2014).*

They advocate building close relations with patients (Learning Difficulties Trainer 2014). Offering patients options and planning treatment according to their individual capabilities and preferences was seen as crucial for long-term success. They also felt that it is easier to be empowered for a TCAM patient, because usually more time is spent with them (Nurse Healer 2014; Stress Pedagogue 2014).

Barriers & Enablers. Lack of sufficient time for patients experienced by PHC staff seemed to be the most important barrier to empowerment. It was acutely felt by doctors and nurses (Nurse3 and Nurse4 2014; Nurse Aromatherapist 2014; Nurse Healer 2014).

> *"...it is sometimes stressful for the doctors because the time is so short and they feel that they are attacked in a way, because they don't have the ability to give answers"(Nurse Healer 2014).*

> *At the same time, responsibility for decision-making may be stressful for less proactive patients (Nurse Healer 2014; Consultant from the Netherlands 2014; Business Developer 2014). Provision of reliable information and choice of treatment together with devoting enough time to an individual patient seem to be the most strongly advocated enablers of patient empowerment.*

4.1.7 Interrelations between the guidelines

In this section, interrelations between guidelines described above will be briefly explored.

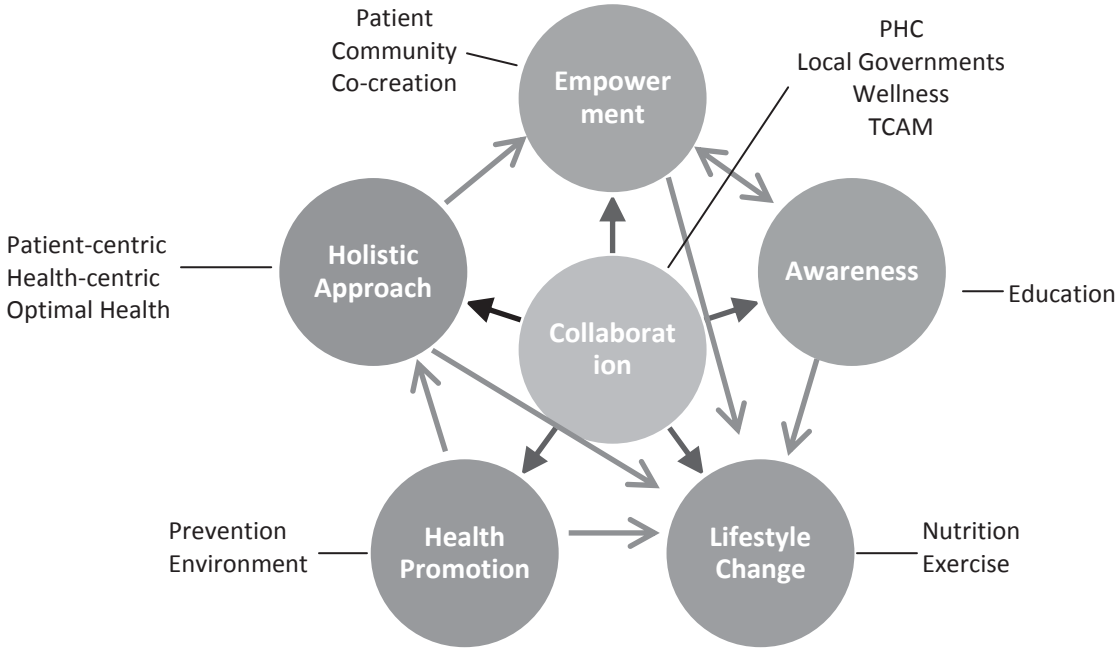

Figure 4.1. Interrelations between guidelines.

The above figure represents interrelations among the guidelines presented in this section. These interconnections reflect a part of complex social reality assessed by respondents. Nevertheless, some patterns may be observed.

Firstly, **Collaboration** has a potential to reinforce and facilitate actions belonging to all other guidelines. It is so because in general several stakeholders' participation is required for an action to be launched. There is a common feeling of the huge effort to reach optimal health and consequently the need to count with all we can get, align efforts and benefit from different competences and resources. It also reflects, to some extent, that the collaborative nature of the BHA project.

"If everyone's collaborating we can reach the effects that are needed to change" (Business Developer 2014).

A strong mutual reinforcement can be observed between **Empowerment** and **Awareness**, where Awareness constitutes a foundation of knowledge, which improves the sense of control and motivation for co-creation and, consequently the willingness to take ownership of own health and treatment. The sense of responsibility of individuals for their own health also increases the need of awareness and stimulates the search for an increasing level of education about health.

"Make individuals be a part of the decision making. If an individual is supposed to change, then he needs to feel that it is him who is changing it, that he has control and the knowledge that he needs" (Business Developer 2014).

Holistic Approach has been credited with strengthening Empowerment by putting the patient in the centre - considering its physical and mental health, as well as the person's own beliefs, social-economic conditions, emotional state, - to be able to work on the causes, be in charge of their lifestyle. **Health Promotion** initiatives may also have stronger and longer-lasting impact if they address all dimensions of health, following a holistic paradigm.

"Dialogue should be more focused on lifestyle, and not in drugs or treatments"(Olander 2014).

Positive **Lifestyle Change** on a mass scale may be contributed to by, directly or indirectly, all other guidelines. Collaboration makes healthy choices easy choices, through agreements between stakeholders (e.g. PHC and food industry).

"It's not about telling people how to live their lives, but creating an environment that makes the healthy choice easy choices" (Grootjans 2014).

Health Promotion works towards lifestyle changes through creating living environment, facilitating exercise and social interaction.

"Start thinking about lifestyle, about promoting health" (Consultant from Portugal1 2014).

Awareness is responsible for providing knowledge basis necessary to make changes and – even more importantly – motivation to do so. Empowerment makes it possible for the patient to set their own lifestyle changes priorities fitting their unique situation in life.

"Increase the knowledge of the individuals, provide the information and the knowledge that they need to do that life changes"(Business Developer 2014).

Additionally, Community Empowerment contributes to Lifestyle Changes in an especially powerful way: people involved in groups and those self-organising for the sake of positive change have stronger drive to stay on the track thanks to reciprocal support.

4.2 Phase III

The final set of 34 amended actions, which intend to support the "guidelines" was developed, taking into account the last series of interviews with two GP's, one former nurse and currently a researcher, and the BHA Business Developer. The majority of the actions reached consensual agreement of the respondents who mentioned the topic or vetted the guidelines and actions (see Appendix H: Saturation of actions). To introduce each guideline's actions we stated the main stakeholders involved addressing efforts to move towards the guideline. Each action is described with a title and a description. A relevant perception from one or more respondents was added, whenever considered relevant, to make a relevant point more clear. It is important to notice that the actions should not be understood in any way as enough, sufficient, the only set of relevant actions or even the best set of relevant actions to address the guidelines. The actions presented here reflect the feedback from our respondents. They are sometimes highly context-dependent, and can be understood more as ideas to consider and to be inspired by those who intend to move a community towards "optimal health" or to address a specific guideline. The involvement of county councils and municipal health coordinators might be considered for the development and implementation of each of the actions in a predetermined context (Olander 2014).

4.2.1 Actions related with collaboration

Main stakeholders involved in the actions related with collaboration are PHC doctors and nurses, local governments and wellness professionals.

1. ***"Practice session voucher" offered to health care professionals.***

Healthcare professionals would be able to personally experience of wellness practices (e.g. yoga, chiropractic's, massage, and acupuncture) and become more familiar with the approaches, reinforcing trust between healthcare and wellness professionals.

No opposition was seen from respondents (Nurse Aromatherapist 2014; Business Developer 2014; GP from Blekinge 2014).

2. ***Multi-stakeholder programme of working sessions around research.***

Sessions should involve doctors, nurses and wellness professionals (e.g. acupuncturist, exercise trainer, nutrition specialist), as well as patients and any other relevant stakeholder (e.g. public health, relevant technology's and patients association representatives).Shared research and identified opportunities for new research to improve health and wellbeing would be the major purpose of the programme. The programme would increase common understanding between the parts. Each session could be targeted to specific groups (e.g. diabetics, overweight).

Researchers (Townsend 2014; Verrinder 2014) and doctors (GP from Blekinge 2014) confirmed that conventional doctors lack of awareness about TCAM. Both managers (Business Developer 2014) and TCAM practitioners (Nurse Aromatherapist 2014; Learning Difficulties Trainer 2014) think such sessions would make a good start for building a mutual understanding.

3. ***Professional development programs for health and wellness***.

The programs should be open for doctors, nurses and wellness professionals (e.g. chiropractor, acupuncturist, nutritionist, psychologist, coaches, Ayurveda specialists) so they can find common topics of study and learn about how to complement each other. Most respondents agree:

> *"They can ask questions, they can learn from each other. It's just this exchange of knowledge, which is important for creating a trust in alternative medicine. And just for them to collaborate with traditional [conventional] medicine, and how they may work together" (Business Developer 2014).*

4. ***Formal certification of TCAM professionals.***

Gradually TCAM professionals should work towards obtaining a formal certification of expertise. Formal certification reinforces acknowledgement and trust from individuals, other health and wellness professionals and specially PHC (at least for those practices that are currently allowed to work with PHC in Sweden, like chiropractic, acupuncture). Additionally, it might increase the probability of TCAM practices to be included in the Swedish public health system. Membership rules for professionals, experts in wellness or TCAM practice, should be adapted to include requirements of certification.

Define protocols of cooperation between wellness and health care professionals. The establishment of rules of cooperation between wellness centres or professionals and healthcare (e.g. County Council and municipalities) should be defined, to facilitate the transfer of the individuals from one to another and promote referrals of complementary treatments.

The need for legal regulation is strongly felt, as expressed by one of the doctors, who believe that TCAM professionals should have studies and be recognised –and cannot be just someone that buys spices from some country, for instance. He adds that there must be regulation to surround their practice, to make sure that the TCAM professionals are doing the right thing, proved by research (GP from Malmö 2014).

5. ***Protocols of cooperation of wellness and PHC.***

The programs should be open for doctors, nurses and wellness professionals (e.g. chiropractor, acupuncturist, nutritionist, psychologist, exercise experts, Ayurveda specialists) so they can find common topics of study and learn about how to complement each other.

Respondents agree that clarification and formalisation are needed. Many respondents acknowledge that doctors and nurses refer unofficially to TCAM practitioners on the basis of personal acquaintance and trust (Acupuncturist 2014; Business Developer 2014; Nurse1 2014). At the same time, doctors can send patients to yoga, chiropractors and gym activities simply on the basis of FAR prescription (Chiropractor 2014; Coach 2, 2014).

6. ***Common vision of main challenges to address and goals.***

A common vision should be developed with the presence of several stakeholders (e.g. BHA, county council, schools and universities, community association) and then to work into identifying the role, contribution and need of collaboration of each to reach the common vision.

BHA Business Developer thought our actions are complementary to the vision created by the politicians, coordinators and experts (Business Developer 2014).

7. ***Government pilot to re-fund TCAM treatment.***

Initiate a pilot project, at the county council level, to re-fund temporarily TCAM treatments and wellness training programmes of choice as part of the health system. The local government could then get information about people's preferences and assess the overall benefits associated with it. Mainly TCAM practitioners agree with this idea, for instance one says that:

> *"...they [government] could see what people really choose, how big the interest is and what would happen" (Learning Difficulties Trainer 2014).*

8. ***More diversified and more numerous TCAM courses (Karolinska Institute).***

Medical schools shall develop courses about TCAM practices oriented to health professionals, to open the public health system to the potential of the complementarity between mainstream medicine and TCAM and the benefits for the patient and for the health system. This action came from the interviewers with a nurse and TCAM practitioner:

> *"At Karolinska Institute they have a course for doctors […]. It is a short introduction of alternative medicine. There has been a donation from a family to Karolinska institute for alternative medicine"(Nurse Healer 2014).*

4.2.2 Actions related with holistic approach

The main stakeholders involved in the actions related with holistic approach to health sector are TCAM professionals, universities, private companies and local governments.

9. ***Broaden the offer of qualified TCAM professionals.***

The wellness centre should broad the offer to their clients to include a diversity or TCAM practices (e.g. acupuncture, chiropractic, physiotherapist) and wellness practices (e.g. yoga, massage, group exercise), like BHA currently does, as well as healthcare services (e.g. doctors, nurses, psychologists). The physical proximity will probably stimulate collaboration between the professionals, with the individual, with clear benefits for the clients. Membership rules for professionals, experts in wellness or TCAM practice, should be adapted to include requirements of qualification

Staff and manager at BHA(Business Developer 2014; Coach1 2014; Learning Difficulties Trainer 2014) strongly support the idea of bringing a medical doctor in, hoping for consults on the patients' capabilities and avoiding injuries this way:

"You should go to one place that has a belief in all methods and there get an individualized treatment"(Learning Difficulties Trainer 2014).

10. Annual check-up for everybody.

PHC and wellness centres should create a periodic check-up for all their customers or patients. The idea should be to check on individual imbalances to apply corrective measures before the situation becomes clinical. Check-ups could be performed by nurses in PHC or qualified TCAM professionals. Business Developer of BHA mentioned that:

"If you do a preliminary check- up you can also find this stuff, like stress and more lifestyle related illness. And if it is an early check- up you can do more to prevent" (Business Developer 2014).

11. Research projects to compare outcomes of patients using TCAM.

Wellness centres and PHC should open cooperation with universities and other research institutions to do comparative studies about the outcomes of patients using integrative approaches with others using only mainstream medicine. The results should be followed by a cost-benefit analysis and possibly used for defining what treatments to fund publicly. As one researcher of the PHC mentioned:

"More knowledge about complementary treatment is needed, and I mean both scientific studies and also meetings in dialogue"(Coordinator from the County Council 2014).

12. New sources of payment scientifically verified TCAM treatments, not re-funded by the government.

Wellness centres should be open to alternative sources of payment (partial or total) for non-reimbursed TCAM treatments (e.g. schools, social support services, special agreements with companies, NGO's) to promote their use. A TCAM practitioner mentioned that price is always a barrier for people who want to access a TCAM practice, and that is why some safe treatment not yet reimbursed by the public HC may help patients to gain fair access

" the money is a problem for some people [to go to TCAM]"(Nurse Healer 2014).

4.2.3 Actions related to awareness

Main stakeholders involved in the actions related with awareness are technology companies, local government, TCAM professionals and wellness organizations.

13. Update 1177.se about authorized TCAM.

Wellness and TCAM practices under the current public health system regulation (e.g. chiropractic, acupuncture and several types of exercise) are considered reliable. Consequently, information about these practices should be available on governmental websites for the public.

As researcher in Sweden mentioned, if patients lack reliable information on governmental websites, they will browse internet and be left to judge between good and dubious information (Larsson 2014).

14. Hälsofestival for community.

Engaging gyms, TCAM practitioners, health care professionals and companies in health festivals - like Hälsofestival[5] from BHA - dedicated to create awareness of the opportunities for healthy lifestyle (e.g. organic food and diet providers, exercise in nature) in the region.

15. Use of national and international days for awareness-raising events.

Healthcare, wellness centres, county councils and municipalities should coordinate efforts to use national or international days (e.g. diabetes day) to raise awareness about specific health concerns in the community and also to present alternatives available in the region for prevention and early treatment methods. A yoga and meditation instructor said:

> *"These days will create a shift in lifestyle, because people are more relaxed" (Yoga Teacher 2014).*

16. Community events for mental illness with PHC/TCAM.

County council, municipalities, PHC, TCAM practitioners, wellness centres, and other relevant stakeholders should cooperate and join efforts to raise awareness about mental illnesses in schools and universities but also in the overall community. It is urgent to change the way people see mental illnesses, to provide knowledge about the main causes and first symptoms, to increase the ability to prevent this kind of disease. As the Business Developer mentioned:

> *"It's ok to be ill, physically, but if you have like mental illness it is not ok, not looked at the same way in the society […] you're ashamed"(Business Developer 2014).*

17. Wiki research database with information on wellness and TCAM practices.

A scientific research database for wellness and TCAM practices, which can be implemented at the level of the organization, association, region, country, would raise the awareness, provide information and increase credibility of the practice to potential customers and health professionals.

Most respondents noted that this information provided in a form of "wiki" research base would be extremely valuable for both patients and doctors, also where is growing interest from people to know about their health more, as one of the Business Developer mentioned:

[5]Blekinge Health Arena created a Health Festival on 5 April 2014to offer a place where people can explore and discover the many different types of therapies, treatments, training, health and lectures; so that citizens of Blekinge realize that they have a more natural choices regarding their health.

"...even doctors and researchers are not agreeing on what to eat or [how to] exercise" (Business Developer 2014).

4.2.4 Actions related to empowerment

The main stakeholders involved in the actions related with Empowerment are patients and their communities, municipalities and PHC doctors.

18. Feedback meetings with clients.

Meetings with customers and patients are important to assure their involvement and create a successful programme for that person and even serve as an evaluation and inspiration to improve future similar programs in the wellness centre or healthcare organization. A TCAM practitioner mentioned that:

"You have to find the things that are interesting to them. If they cannot start with some food, you can start with breathing and then they can go to yoga"(Learning Difficulties Trainer 2014).

19. Workshops for socio-economically challenged communities.

Workshops would involve health care, wellness professionals (e.g. BHA), community representatives and other relevant stakeholder. The idea would be to improve their education also to listen to their perspective of major concerns and barriers to reach new solutions and alternatives to improve health and lifestyle in the community. As Business Developer mentioned that:

"When we are arranging workshops and seminars, it's always easy to get those to come who are already healthy or already interested in their lifestyle and taking care of themselves. I mean, those who are not healthy, tend to avoid those kinds of things"(Business Developer 2014).

20. Community meetings around health issues and concerns.

The meetings should have an educational purpose and, therefore, should count with healthcare and wellness professionals, the appropriated coordinator of the county council of municipality, and people with personal experience with the disease or concern (e.g. obesity, diabetes). It would allow the community to be aware of the situation as well as the opportunities to deal with it. Business Developer also sees the benefits of involving people who otherwise would not come to BHA:

"Creating those almost informal meetings, I think, it's great. Just encourage them"(Business Developer 2014).

21. More offers to groups of patients with special needs.

BHA has certain experiences with groups of patients with a disease (usually one that is relatively widespread and requires lifestyle changes) led by a mixed team of a nurse, physiotherapist and training coach. As Business Developer mentioned that:

"It will be great if it was a natural collaboration, between the nurses and the physical therapeutic, that people with diabetes type 2 come to physiotherapeutic to learn how to exercise and live a healthy life style"(Business Developer 2014).

22. Increase in the overall time with the patient.

More time with the patient would allow to health and wellness professionals to listen to patients' perspective of personal goals, limitations, experience, ideas and concerns and co-create a more individualized treatment, which would increase the probability of joint success. A nurse mentioned that:

"...it is difficult [to make patient part of the decision] and sometimes it doesn't work… But it would be good for the patient" and

"it is sometimes stressful for the doctors because the time is so short and they feel that they are attacked in a way, because they don't have the ability to give answers"(Nurse 3, 2014).

23. Special conditions for socio-economical challenged groups.

Wellness centres, in close cooperation with adequate coordinator of the county councils and municipalities, should create scholarships or special financial conditions for socio-economic challenged individuals, with recommendation from social services and PHC, to receive advice, learn and experience several wellness practices adequate to their specific health and socio-economic situation. As a Business Developer commented:

"it should not make them feel more out of the society" but

"at the same time it is most important to work with focus groups"(Business Developer 2014).

24. Advertisement of employment, education, volunteering opportunities in wellness centres.

Conscious that the BHA is a place where many young people go, the stakeholder organizations (the employment office, business hubs, the municipality, local university) would create a space there for advertisement of various work-related and volunteering-related activities in the region. Local companies may be encouraged to participate. Opportunities specifically aimed at other disadvantages groups (e.g. the elderly) may be included later. The rationale behind the action is to fight loneliness, social exclusion through making the BHA customers aware of the options out there.

It is interesting to note that professionals working with BHA agreed on this action. BHA Business Developer suggested that this action would:

"Increase the knowledge of the individuals, provide the information and the knowledge that they need to do that life changes" (Business Developer 2014).

4.2.5 Actions related with Health Promotion

The main stakeholders involved in the actions related with health promotion are wellness professionals, local governments, TCAM professionals and private companies.

25. Training in health technology to health and wellness professionals.

Health and wellness professionals should keep up with the main trends of new technology available to individuals to manage their health and lifestyle, to better support the individuals reaching their goals. Training would increase confidence of the health and wellness experts dealing with the early adopters of new technology.

The experience with early adopters would probably create a basis for interesting case studies to replicate in the future:

> *"There is a big upcoming technology market that is trying to support subjects with the making of health apps and mobile health devices"(Consultant from the Netherlands 2014).*

26. Exercise offer for the elderly.

Elderly have a specific exercise needs and schedules that should be taking into account when developing an offer to promote exercise. For instance, as most elderly are retired it might be good to take advantage of less busy hours in the day, when wellness centres are relatively empty.

As a sport facilitator mentioned:

> *"50+ people are using gyms more write now and like to test in the test lab" (Coach1 2014).*

27. Family exercise programme.

The wellness centres should broad the offer with family exercise programs, where all the members of the family could exercise and have fun at the same time (e.g. weekends), together or separately. Caretakers or supervised activities specifically for children should be assured. A TCAM professional pointed out that:

> *"...for people who have children, to have a care taker, for them to go and the children can play when they train" (Nurse Healer 2014).*

28. Offer for businesses of individualized training.

The wellness centres should broad the offer for businesses to reach their employees with individual exercise and treatments, as businesses are interested in having physically active and healthy employees.

In fact, this action is already working as a yoga and meditation teacher mentioned:

"then companies buy training for their employees it encourages them to train after (Ericson employees find out that they can do yoga in lunch breaks)" (Yoga Teacher 2014).

29. Open-day for companies to new experiences and wellness.

Local government should create a programme to give advantages, in terms of taxes, divulgation or other relevant, to companies that promote good lifestyle in the community.

TCAM practitioners mentioned the importance of this type of action because it could broaden the opportunities for TCAM and wellness to show the healing benefits to people. It would:

"...allow people to have small lectures, sitting together and talk about things"(Nurse Healer 2014).

30. Open day for schools/ university: personalized training.

The wellness centres should create an open day event for students, coordinated with a specific school or university, where students could learn about health and wellness, ask questions and try out different wellness practices, getting some personal advice about individual and group training, diet.

A lifestyle coordinator mentioned that schools and universities are an essential party to empower young people:

"I think it's more effective if people go to universities and schools and have a seminar where you (health professional) can talk to them, they can ask you questions… that has to do with you (more individualized)"(Learning Difficulties Trainer 2014).

31. Digital channels to communicate with youngsters.

The wellness centres should privilege more the digital channels in their communication, specially to young people, as they are very common between the younger generation, is a scalable and relatively cheap channel, and its adoption is also increasing in the rest of the population. As BHA Business Developer mentioned:

"We have a young generation today more digital than ever. Just thinking about where can we meet them in the digital world to make them physically active… new ways, new methods" (Business Developer 2014).

32. Local government give conditions companies promoting health.

Local government should create a programme to give advantages, in terms of taxes, divulgation or other relevant, to companies that promote good lifestyle in the community.

A radiologist mentioned that tax benefits can be a way to stimulate other ways to work in health promotion and involve the community, so there it will not be just a problem of the Government, health Ministry (Radiologist 2014).

4.2.6 Actions related with Lifestyle Change

The main stakeholders involved in the actions related with lifestyle change are wellness organizations and local governments.

33. Discounts for friends and family.

The wellness centres should create a discount programme for customers who bring new customers from their friends or family, they are contributing to the increase in business of the wellness centre and to the community wellbeing.

Respondents generally agree that this idea will be very valuable and attractive for people, because exercising with family is encouraging (Nurse2 2014; Nurse Healer 2014; Learning Difficulties Trainer 2014).

34. Parks for people of all ages to exercise and fun.

Universities, County Council and Municipalities and other relevant stakeholders should coordinate efforts to co-create infrastructures for parks where people of all ages can exercise, socialize and have fun, safely and within a short distance from the places they live. Socio-economically disadvantaged areas should be prioritized.

A nurse and TCAM practitioner specialized in aromatherapy mentioned:

> *"Sweden is a wonderful country, but people are lonely"(Nurse Aromatherapist 2014).*

A researcher on sustainable health from Australia mentioned:

> *"Safe places for people to exercise are essential"(Verrinder 2014).*

Therefore, if people will have more places to change their lifestyle there will be a guarantee that they will lead to change.

5 Discussion

This section is dedicated to discussion of the results of the research, presentation of key findings and reflection on how they contribute to progress towards sustainability. A deeper look at the relation of the guidelines and actions to the SSP's is taken. Limitations of the research are outlined. Areas for future research are also suggested.

5.1 Key findings from the Research Question

Guidelines and actions, which constitute the final result of the thesis, answer current concerns in the area of interaction between PHC and wellness, mostly focused on BHA. They also have to be contained within boundaries defined by five Social Sustainability Principles.

As the results show, respondents had no strict and rigorous understanding of the concept of sustainability. At the same time, they generally accepted a notion that the current PHC system is unsustainable and a paradigm shift is needed. Many of the current challenges in the sector, immediately identified and acknowledged by the respondents, are in fact related with social sustainability, mostly with Integrity (SP4) and Impartiality (SP7).

The situation described in the literature found confirmation in the results: clear definitions of TCAM and wellness were absent. Respondents often had conflicting opinions on what might be construed as an alternative or complementary treatment. Consequently, it is believed that a clear definition of what should be included in TCAM and wellness in Sweden, would bring much-needed clarity to the research, legislative efforts and everyday cooperation among health professionals.

Some respondents considered Sweden to have an overly conservative approach to TCAM. Other countries, like Germany, United Kingdom, and Norway were set as examples of more successful integration. Three most potent factors facilitating this process were: trust, scientific research and legal regulations that would reflect reality.

5.2 Relation of the findings to the Social Sustainability Principles

Reflection on the use of SSPs and their applications has been part of this research from the start. The new five SSPs have only recently been introduced into FSSD, and there are no comprehensive guidelines on how to apply them. Therefore, the experience was both challenging and edifying.

5.2.1 Experience of working with Social Sustainability Principles

The SSPs provided a clear definition of social sustainability to work with. Researching health-related topics meant that most of the problems touched Integrity. Integrity is a broad

concept. Consequently, it was not always easy to decide what constituted a big enough barrier to be taken into account.

The tension between *removing systematic barriers* and *fulfilling needs* was constantly present. It is perhaps a conflict ingrained in a discipline where so much depends on personal motivation and individual choices. It was particularly problematic in case of Meaning: a question arose to what extent an organization shall actively promote certain meanings in order to help people find one for them. Similar dilemmas arose in relation to Influence: can patients be encouraged to become empowered even if they would rather not? Another perplexing yet fascinating problem was connected to the question of culture. Can internalised cultural values be interpreted as a *systematic barrier* even in absence of any external pressures or barriers? Or should the mechanisms responsible for inculcating the values be explored instead?

The SSPs cannot be considered completely discrete. Because of that, in any given situation studied in sufficient detail, all five Principles would probably reveal themselves. Complexity and interrelatedness of social phenomena is most likely responsible for this effect. The SSPs were however found to be inclusive exhaustive – no phenomenon escaped the relatively uncomplicated categorisation.

The authors found that implementing the Principles in a real-life project shed a new light on difficulties in classifying social phenomena by raising some serious questions related to interpretation.

5.2.2 Analysis of actions using Social Sustainability Principles

The actions were analyzed assuming a perspective of the *degree of intensity* of a given Social SP. As it was mentioned, all actions were intended to remove systematic barriers to Integrity, directly or indirectly.

Collaboration. Actions belonging to this guideline promoted mostly Competence. Workshops and meetings centred on development of professional skills and research allow participants to gain even more knowledge in areas previously unknown to them. It is assumed that it would make them better specialists in their respective fields. It equals reinforcement of Competence as understood under the SSPs. These same events reinforce also Influence, because they facilitate meetings between various stakeholders (doctors, nurses, patients, TCAM practitioners). Through personal contact, they may influence each other's views and therefore have an impact on the system. Development of cooperation protocols has a particular focus on protecting patient's Integrity from abuse or neglect. Pilot TCAM project is meant to give TCAM practitioners more space to practice and communicate with the authorities.

Table 5.1. Collaboration actions analysis.

		SP4	**SP5**	**SP6**	**SP7**	**SP8**
#	**Collaboration**	Integrity	Influence	Comp.	Impar.	Meaning
1	Offer a "practice session voucher" to health care professionals			■		
2	Multi-stakeholder program of working sessions around research			■		
3	Professional development programmes for health and wellness			■		
4	Formal certification of TCAM professionals			■		
5	Protocols of cooperation of wellness and PHC	■				
6	Common vision of main challenges to address and goals			■		
7	Government pilot to re-fund TCAM treatment		■			
8	More and more diversified TCAM courses (Karolinska)			■		

Holistic Approach. Actions 9-12 are more connected with ensuring Impartiality towards patients: irrespective of their socio-economic status, they are given a wider choice of treatment options. Only action 11 strongly supports Competence: research is to be conducted with doctors and TCAM practitioners using the results. All the actions also contribute indirectly to Influence.

Table 5.2. Holistic Approach actions analysis.

		SP4	**SP5**	**SP6**	**SP7**	**SP8**
#	**Holistic Approach**	Integrity	Influence	Comp.	Impar.	Meaning
9	Broaden the offer of qualified professionals					
10	Annual check-up for everybody					
11	Research projects to compare outcomes of patients using TCAM					
12	New sources of payment for non reimbursed verfied TCAM					

Awareness. Actions aimed at raising awareness have a wide impact across the SSPs. It is a consequence of Awareness being related to both knowledge (Competence), but also to motivation to act (Influence) and to mindset (Meaning). Action 13 is meant to inform patients and raise this way their Competence in helping themselves. Group activities have a potential of offering a sense of belonging, which falls under Meaning.

Table 5.3. Awareness actions analysis.

		SP4	**SP5**	**SP6**	**SP7**	**SP8**
#	**Awareness**	Integrity	Influence	Comp.	Impar.	Meaning
13	Update 1177.se about authorized tcam					
14	Organise Hälsofestival for community					
15	Use national and international days for awareness					
16	Community event for mental illness with PHC/TCAM					
17	Wiki research database wellness and TCAM practices					

Empowerment. Naturally, actions listed under this guideline concentrate around the Influence, as their goal is to remove systematic barriers to patients' ability to have an impact in the system they function on. A connection worth noticing is that Influence and Impartiality are linked. E.g. socio-economically challenged groups do not have a chance to influence the system without being given access to mechanisms that enable them to. It is interesting to see that actions related to Empowerment seem to have the ability to contribute to alleviate the barriers to a lot SSPs.

Table 5.4. Empowerment actions analysis.

		SP4	**SP5**	**SP6**	**SP7**	**SP8**
#	**Empowerment**	Integrity	Influence	Comp.	Impar.	Meaning
18	Feedback meetings with clients					
19	Workshops for socio-economically challenged communities					
20	Community meetings around health issues and concerns					
21	More offers to groups of patients with special needs					
22	Increase the overall time with the patient					
23	Advertise employment, education, volunteering opportunities					
24	Special conditions for socio-economical challenged groups					

Health Promotion. Actions from this guideline are as diverse in terms of attribution to the SSPs as the initiatives themselves. However, they address mainly Integrity and Competence. They aim at providing reliable information on health issues and encourage people to exercise. Two actions – special training offers for families and for the elderly – are meant to couple the two above-mentioned goals with tightening community and family relationship, thence additional emphasis on Meaning. The last action strives to involve enterprises in promoting health, thus giving them a chance to have an impact locally.

Table 5.5. Health Promotion actions analysis.

		SP4	**SP5**	**SP6**	**SP7**	**SP8**
#	**Health Promotion**	Integrity	Influence	Comp.	Impar.	Meaning
25	Training in health technology for health and wellness professionals					
26	Exercise offer for the elderly					
27	Family exercise program					
28	Offer for businesses of individualized training					
29	Open-day for companies to new experiences TCAM and wellness					
30	Open day for schools/ universities: personalized training					
31	Digital channels to communicate with youngsters					
32	Local government: conditions companies promoting health					

Lifestyle Change. The two actions directly striving to promote positive lifestyle change put emphasis on the Meaning. They were created with community-building in mind. Action 34 in particular has a goal of bringing people together and providing opportunities for interaction, therefore potentially alleviating feelings of loneliness and rejection (e.g. on the side of elderly people). Time spent together exercising or simply relaxing in such an environment has an added value of being also time spent with family and neighbours.

Table 5.6. Lifestyle Changes actions analysis.

		SP4	**SP5**	**SP6**	**SP7**	**SP8**
#	**Lifestyle Change**	Integrity	Influence	Compet.	Impar.	Meaning
33	Discounts for friends and family					
34	Parks for people of all ages to exercise and fun					

5.3 Limitations

Despite the authors' attempt to involve health professionals from Sweden since the start of the study, it was only possible to reach doctors in the end of April and first week of May. In practice, this meant that the majority of actions were inspired by TCAM practitioners, wellness professionals, and researchers. Availability of health coordinators working for the County Council and Karlskrona Municipality officials was also extremely limited; inevitably, their insights could not be included. Time limitations along with ethical compliance issues prevented patients from being included in this study.

Relying on convenience sampling, the limitations on possible extrapolation of the results are significant. BHA seems unique in terms of collaboration between various types of stakeholders, especially County Council and Karlskrona Municipality. However, respondents much more familiar with Swedish reality believed that even the findings based on BHA example are potentially transferable and can benefit other organizations on the wellness sector.

Nonetheless, the actions can be more dependent on context and culture. Adjustments may be needed to adapt some of them to different realities and even to find other actions that address better each guideline in a specific context. Additionally, each context will drive the roadmap of actions to be developed, as the reality assessment will speak to what might and can be done right away or later in the future.

5.4 Intended audience

The intended audience for this research includes local governments, public or private health sector organization's executives, health care sector entrepreneurs and anyone concerned with and willing to take the lead to move PHC in Sweden towards sustainability – might explore the results of this study and reassess the action, taking into account the recommended guidelines. However, the prioritization of the actions may be implemented by the organization to assure the right direction towards "optimal health" and compliance with the SSP's, a flexible platform for the medium and long term, and a necessary and desirable return on investment for the organization.

5.5 Future research

The authors are confident that this thesis will provide a foundation for future studies. Indeed, part of the mission of Blekinge Health Arena is to partake in and support research.

It is advisable that future scientific inquiries in the same area involve patients, since their input may provide unique insights and much inspiration for new actions or modification of the existing ones. The same is true to PHC staff, especially GPs. A study conducted on a larger sample of several wellness organizations could provide a solid basis for extrapolation of the results outside Blekinge County and potentially even beyond Sweden. Researching impact of the programmes launched by wellness centres, and more particularly by the BHA, on reinforcement of public health could possibly add to the body of knowledge about cost-effectiveness of early prevention and health promotion. Such a study could also help verify claims about benefits of integration of TCAM treatments into the PHC.

Finally yet importantly, a topic that was only mentioned in this thesis could be explored in depth by incorporating ageing of a population as a social sustainability challenge.

6 Conclusion

The study undertaken in the thesis was intended to create a set of guidelines and actions for wellness organizations to help them contribute to creating sustainable society through collaboration with PHC. The vision of success that the guidelines and actions were built upon included a society where everyone could stay as healthy as possible, maintaining an optimal health and living a long and fruitful life.

The result of the thesis comprised six general guidelines – Collaboration, Holistic Approach, Health Promotion, Empowerment, Awareness and Lifestyle Change – supported by 34 actions. Most actions are embedded in the local context of the organization taken as a convenience sample, Blekinge Health Arena. Almost all contribute, directly or indirectly, to Integrity (SP4), and most are concentrated directly on increasing Competence (SP6) or Influence (SP5).

The findings of the research confirmed that sustainability challenges in the area of public health are deeply interrelated with other social problems, and the only solutions that may work must take the complexity of the system into account. Addressing the challenges systematically and in a strategic manner requires a global framework. The research determined the importance of approaching the topic of health from a strategic perspective, and of defining social sustainability through principles. Framework for Strategic Sustainable Development served as a backbone to the research and formulation of the results.

Overall feedback from BHA staff and from other experts showed that the guidelines and actions presented were seen as highly applicable, complementary to the existing policies and indeed provided helpful insights into how to deal with some persistent systematic challenges on public health.

The authors hope that the research contributed positively to the health and the wellness sector, particularly to the work of the Blekinge Health Arena, and to the field of Strategic Sustainable Development. It showed how health may be conceptualised within FSSD and what role it can play in a vision of sustainable society. It also shed some light on what steps can be taken within current reality to move the society towards sustainability. However, it The prioritization of the actions by the organization can also assure the right direction, towards “optimal health” and the social SP’s, a flexible platform for the medium and long term, and a necessary and desirable return on investment for the organization.

Authors are convinced that the intended audience for this research may find results of this study useful. Implementing the actions in a specific organization’s context would require re-assessment of goals and problems, and perhaps some additions.

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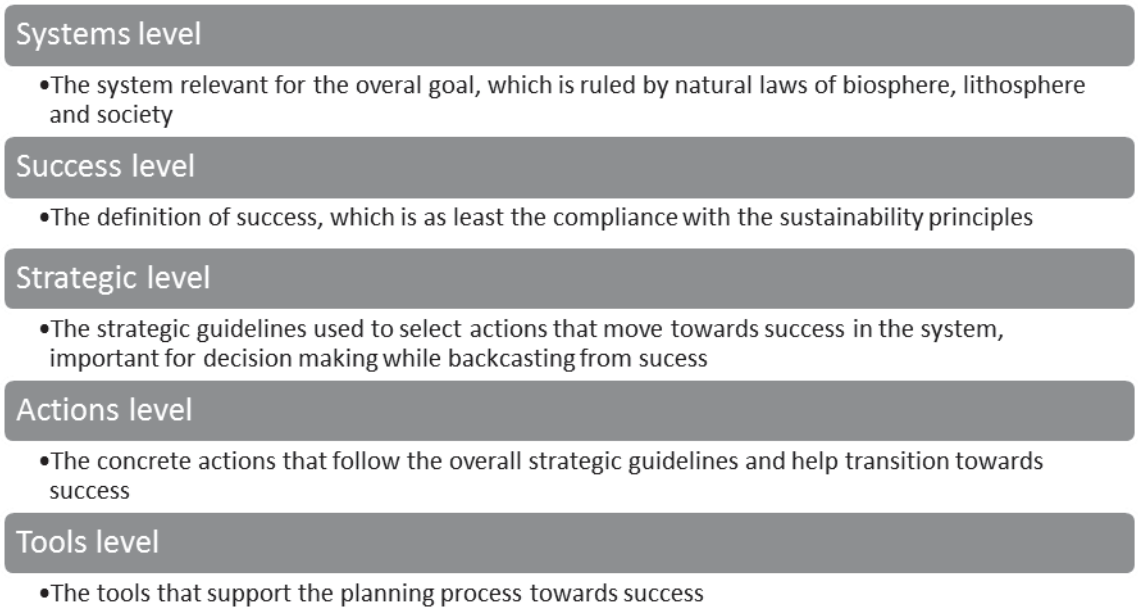
Appendices

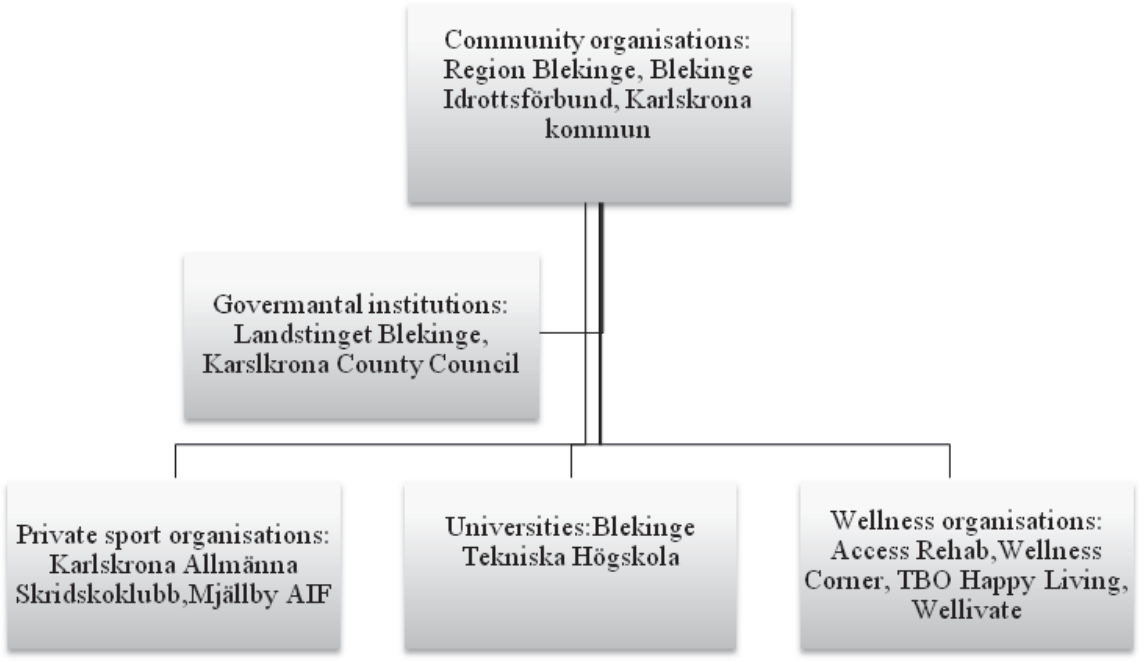
Literature review and current context

Appendix A: FSSD and Five Level Framework

The overall goal of this thesis is to help move the primary health care towards sustainability. In order to ensure a strategic approach and a whole-system perspective, the Framework for Strategic Sustainable Development (FSSD) is used. The FSSD is composed of five levels: system, success, strategic guidelines, actions and tools. It helps to understand system's boundaries and interactions between the Earth ecological system and its subsystems, including human society. FSSD also demands a clear definition of success: achieving global socio-economic sustainability (Robèrt et al. 2012).



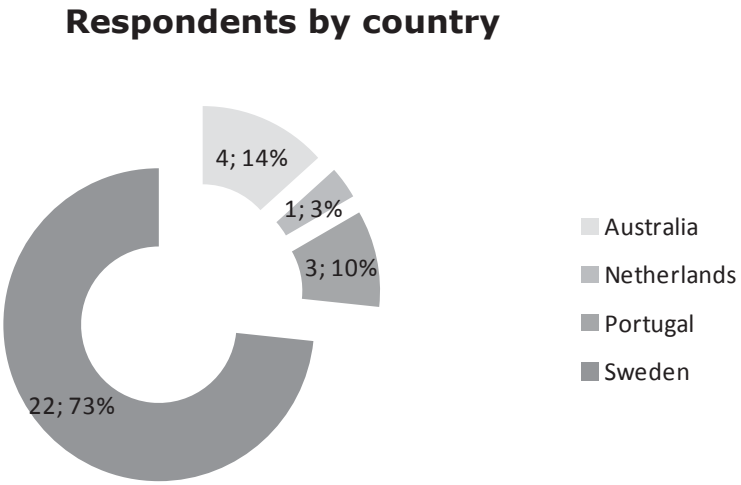
Appendix B: Stakeholder diagram of Blekinge Health Arena

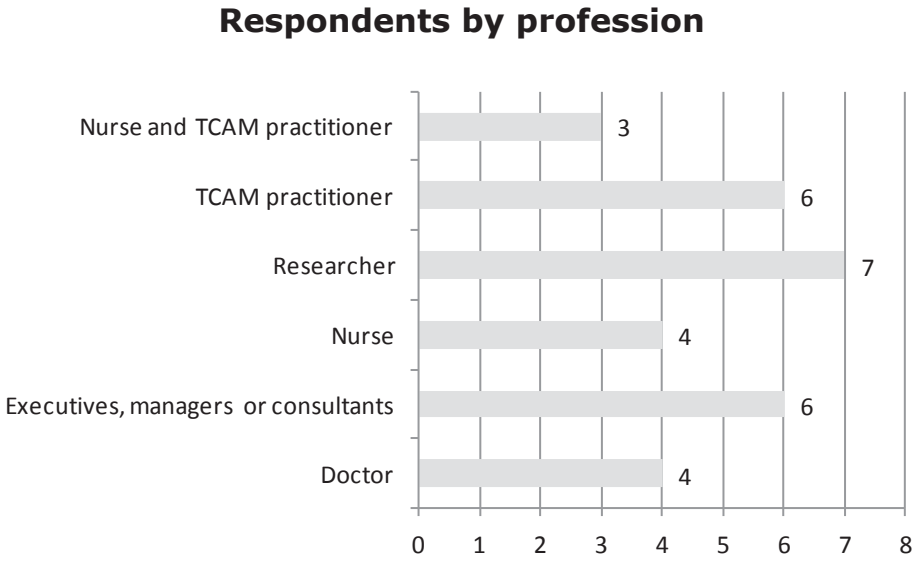


Name	Description
Karlskrona Allmänna SK	Karlskrona General Skating Club
Mjällby AIF	Swedish professional football club
Landstinget Blekinge	County Council
Wellness Corner	Wellness organisation
TBO Happy Living	Training and massage
Carlskrona Floating	Special bath procedures for rehabilitation in wellness industry

Methods

Appendix C: Summary of contacts





Appendix D: Preliminary interview guide (Phase I)

(5 minutes) Presenting our thesis topic and ask the person to record the interview
(45 minutes) General questions: What's your understanding of prevention, health promotion and primary health care? What's your understanding of sustainability in prevention, health promotion and primary health care? Auxiliary questions (to use if they do not understand the term "sustainability"):

- lifestyle diseases
- rate of chronic diseases
- influence of the environment on health
- equal access and treatment
- healthy as they can be & do things they like in live as long as possible
- avoid social exclusion as a result of disease

How has sustainability been addressed in prevention, health promotion and primary health care?
In your understanding to what extent patients have their needs met the health system?
What's your opinion on how the prevention, health promotion and primary health care functions?
How collaboration influence health prevention, promotion and PHC?
In your opinion what solutions might be implemented? or How can the problems that you mentioned be fixed?
In your opinion what are the best practices (what already works well) on PHC, health promotion & prevention that could be implemented elsewhere? Can you give examples?
(5 minutes) Personal perspective of the topic
(5 minutes) Close the interview: Thank and ask if we can contact him/ her again in the following weeks for interview and/or survey
Information request (only applicable if there is specific knowledge of the Swedish reality):

- statistics about prevention, health promotion, primary health care
- information about current business model of PHC
- advise on people that we should contact

Appendix E: Interview guide (Phase II)

Self-introduction: name, your experience in the health sector, and confirm that we can use this interview in our thesis

1. What are, in your opinion, the main...
i. Challenges
ii. Opportunities
iii. Changes needed and how to implement them
... to reach a more healthy community?

2. Collaboration between PHC practitioners (internal health professionals of primary care)
a. What's the collaboration now? What could be improved? And How?
What do you think namely about these ideas:
b. Training about patient-centric teamwork for all health professionals in primary care
c. Incentives from the government to give better training to GP's, nurses and other health professionals in primary care
d. Take administrative work of GPs
e. Reformulate the role of the GPs
f. Reformulate the role of nurses in primary care
g. Any other idea?

3. Collaboration between Complementary and Alternative Medicine (CAM) practitioners and primary health care (PHC) practitioners
a. What's the collaboration now? What could be improved? And How?
What do you think namely about these ideas:
b. Meetings on the personal level to build trust
c. Trainings together to build common understanding
d. IT system for easier information-sharing
e. Any other idea?

4. Holistic treatment (individual health includes physical, mental and spiritual)/Optimal health
a. Do you believe that PHC works for a Holistic treatment and optimal health now? What could be improved? And How?
What do you think namely about these ideas:
b. General practitioners (GP) (or family doctors) in charge of the treatment, leading other specialists
c. GP (and specialists) prescribing TCAM treatments
d. One free check-up a year for everybody
e. Any other idea?

5. Lifestyle change
a. What are the best ways to encourage people in Sweden to change their lifestyle? What could be improved? How?
What do you think namely about these ideas:
b. Encourage people who already exercise to bring friends (e.g. through a discount for both)
c. Organizations to encourage employees to exercise, to create peer pressure
d. Collaborate with the local authorities to create health-friendly and exercise-friendly environments
e. Target specific groups (e.g. disadvantaged socio-economically) with community events to promote health (e.g. education session, organised exercise)
f. Doctors prescribing exercise
g. Doctors prescribing food
h. Any other idea?

6. Co-creation of health with the patient
a. What's the level of active participation of the individual (patient) in the definition of its own health and on the primary care prevention and treatment? What could be improved? How?
What do you think namely about these ideas:
b. GPs informing patient about other alternative treatment methods
c. Patient taking the decision of what treatment to follow
d. Both GP and patient agree together on the optimal health (e.g. what/when/how they want to achieve)
e. Any other idea?

7. Community awareness, education and engagement in health promotion and prevention
a. What is being done to reach community for:
i. Awareness
ii. Education
iii. Engagement
What could be improved? How?
What do you think namely about these ideas:

b. Use of media campaigns: TV, Radio, Press... (general or local)
c. Providing incentives to organizations that help on that (e.g., taxes, deductions)
d. Providing disincentives for organizations bad behaviours (e.g. Extra regulation or taxes for bad food)
e. Community driven programs and events (e.g., online and offline communities oriented to chronic diseases)
f. Any other idea?

8. Children and Young people: changing values, practices and experiences (health promotion and prevention)
a. What is being done to reach and change values, practices and experiences for children and young people? What could be improved? How?

What do you think namely about these ideas:

b. Prioritization of this group children and young people in health promotion, prevention and primary care
c. Any other idea?

9. +50 people: changing values, practices and experiences
a. What is being done to reach and change values, practices and experiences for + 50 people? What could be improved? How?
b. What's the best way to (re)educate them?

10. Collaboration with relevant sectors of society for prevention (food, sports, …)
a. What is being done to work with other sectors of society to:
i. Promote health
ii. Health prevention
b. Who you find important to involve?
c. Do you have ideas on how to involve them more in health promotion and prevention?

Appendix F: Interview guides (Phase III)

In this phase where happened to be two interview guides due to different actions for different people and their validation.

Guidelines validation interview guide (Phase III, for managers and researchers)

Collaboration between BHA and PHC

1. To support mutual trust, offer a "practice session voucher" to health care professionals so they can personally experience yoga, chiropractic's, massage, acupuncture etc. and become familiar with the approaches.
2. Create an annual programme of working sessions involving doctors, nurses and BHA staff to share and develop new research and identify opportunities to improve health and wellbeing for specific groups of people (e.g. diabetics, overweight) with involvement of health professionals, wellness professionals, patients and other stakeholders.
3. Engage doctors, nurses and BHA staff together in professional development programmes.
4. Broaden the offer of BHA, bringing in more qualified TCAM practitioners and doctors.
5. Gradually introduce requirements for formal certification of TCAM professionals to wish to have contracts with PHC. Agree on deadlines.
6. Develop a shared IT system storing patient's history, test results and prescriptions that would be accessible to health care professionals and BHA staff with patient's authorization and assuring an adequate level of security.
7. Define protocols between wellness and BHA staff and health care professionals to agree on the rules of cooperation.
8. Create a common vision of main challenges to address, for community health and some specific groups, and identify the role, contribution and need of collaboration to reach common goals.
9. Update 1177.se with information about health benefits and dangers of various methods of training and TCAM treatments as recommended by specialists.
10. Continue organising Hälsofestival, engaging gyms, TCAM practitioners, medical doctor and companies dedicated to healthy lifestyle (e.g. organic food providers).c

Patient and community engagement

11. Assure feedback meetings with the clients take place at BHA after each programme.
12. Create educational workshops about healthy lifestyle for socio-economically challenged communities, involving health care and wellness professionals.
13. Create community meetings around health issues (e.g. obesity, diabetes) with people from the community who had personal experience of the disease.
14. Create more groups of patients suffering from conditions requiring careful management, where health care, wellness and TCAM practitioners can co-create best lifestyles for themselves based on expert knowledge.

Customised health promotion

15. Develop exercise offer for the elderly and schedule it for when BHA is relatively empty.
16. Offer an annual check-up for everybody with a health care or a TCAM practitioner to address sub-clinical conditions.
17. Create a family exercise programme.
18. Promote discounts for friends and family of members than bring another person to the wellness centre.
19. Develop a special offer for businesses providing their employees with individualised treatment & exercise programme.
20. Create an open day for company workers to allow them to experience test lab, training and treatments.
21. Organise an open day for school and university students where they can try out personalised training, diet coaching and group training programme.
22. Take advantage of national and international days (e.g. diabetes day) to spread awareness about the problem in public space and present prevention and early treatment methods.
23. Use digital communications to keep in contact with younger generation and to encourage community building.
Living environment promoting health
24. Work together with Blekinge Institute of Technology, County Council and Karlskrona kommun to build playgrounds where people of all ages may exercise and socialise, within a walking distance from the places they live. Prioritise socioeconomically disadvantaged areas.
25. Create space at BHA where employment office, business hubs, Karlskrona kommun, Blekinge Institute of Technology etc. will be encouraged to advertise opportunities for employment, education, volunteering and social activities for
a. young people.
b. elderly people.

Research

26. Initiate research projects with BHA, Blekinge Institute of Technology and other research institutions to compare outcomes for patients who use integrative approach with outcomes for those who do not. Use the results for cost-benefit analysis and for defining what treatments to fund publicly.
Financing
27. Initiate a pilot project with the county council to re-fund TCAM treatments and training programmes of choice as part of PHC services.
28. Cooperate with private health insurance providers to encourage clients to do check-ups, exercise and lead a healthy lifestyle through reduced premiums system for people who do it.

Guidelines validation interview guide (Phase III, for doctors)

QUESTIONNAIRE:

Now we would like to know your opinion as GP in Sweden about the following actions.
We would like to know in what extent you agree with the decision (e.g., strongly agree, agree, neutral, disagree, strongly disagree) and why, whenever relevant.

AWARENESS

1. Initiate proactive individual meetings with relevant health professionals working in PHC, public and private, to present the additional value of wellness and TCAM practices for specific groups of patients (e.g., yoga practice to manage stress) to create an overview about available wellness practices in the region and begin to build trust relationships.
2. Take advantage of special national or international days (e.g., diabetics day) to jointly with PHC professionals address main health challenges for a specific group of patients (e.g., diabetics, children), through local wellness, TCAM and health marketing campaigns, events and special offers to increase community awareness of the condition and preventive wellness practices, and above all, patients awareness of health and wellness opportunities offered in the region to improve and manage their health.
3. Schools: Create a 1 day event in local schools and universities, with psychotherapists and other TCAM specialists involved in mental illness for children and youngsters, with seminars to increase awareness about how normal it is, the first mental symptoms and the important to address them, and how, as soon as possible.
4. County councils: Create a 1 day event for municipalities , with psychotherapists and other TCAM specialists involved in mental illness, with seminars and debates to increase awareness about how normal it is, the first mental symptoms (for kids, youngsters, active working people and elderly) and the important to understand and address them, and how, as soon as possible.

EDUCATION

5. Create an annual programme of training in seminars, workshops or other events around health issues (e.g., stress) and adequate wellness practices, with speakers from health care, wellness practices, patients and even other stakeholders, to share knowledge and experience.
6. Offer a “practice session voucher” to health care professionals so they can personally experience the wellness practice and clarify doubts (when relevant).
7. Create educational workshops about the importance and benefits of wellness on socio-economic challenged communities, involving health care and wellness professionals (and other stakeholders) with individuals from the community and to, together, reach viable solutions to promote health.
8. Develop short seminars or workshops for health and TCAM professionals, given by accredited TCAM professionals and medical professionals, to understand the benefits and

opportunities provided by the practice and what research, case studies and health authorities say about it nowadays.
9. Contact universities to propose more research in health and wellness perspectives less considered in mainstream medicine (e.g., spiritual/meaning, relational,).
10. Propose more and more diversified TCAM courses for healthcare professionals who are interested in knowing more on complementary medicine practices at Karolinska Institutet (there's already money donated for that purpose), so they could be more confident prescribing or referencing TCAM practices.
11. Contact universities to propose them to research on alternative methods of research for TCAM practices to which standard research methods cannot be applied (e.g., energy healing).

INVOLVEMENT

12. Create a" wellness day pass" to health professionals (e.g., specialized in care for elders)and patients (e.g., elders) so they can see the work being done, talk with patients, debate ideas and maybe come with additional suggestions to improve the wellness practice programme for a specific segment or niche.
13. Arrange a visits programme to PHC centres to alert health professionals about problems in health avoidable with wellness and about TCAM answers to health concerns and to provide some individual advice to patients on how to complement mainstream care for better results...
14. Create scholarships or special financial conditions for socio-economic challenged individuals, with prescription or recommendation from social services and PHC, to receive advice, learn and experience several wellness practices adequate to their specific health and socio-economic situation.
15. Initiate lobby collecting signatures from Swedish people, relevant research and case studies to approve TCAM practices with local health authorities.
16. Create a protocol between PHC and local wellness and TCAM centres to lead patients recently diagnosed with diseases that imply lifestyle changes (e.g., diabetes) to the centres, where they would receive some specific training, individual or in group, to learn how to exercise and live an healthy life style with the disease (food and exercise) with subsequent follow up on a predetermined period of time.
17. Foment TCAM practitioners to acknowledge their lack of expertise in some areas, referencing PHC and health care specialists when ever needed (as there are particular health concerns that can be complemented and/or better diagnosed and treated by mainstream medicine), reinforcing that way the credibility of TCAM practices.

ENGAGEMENT
18. Create a common vision of main challenges to address, for community health and some specific groups, and identify the role, contribution and need of collaboration to reach common goals.

19. Define protocols between wellness and TCAM professionals and health professionals to analyse specific health concerns on specific individuals (e.g., body trainer asks doctor to check problems on a shoulder, or Ayurvedic specialist asks about food allergies).
20. Create a wiki research database about benefits (and disadvantages in specific cases) of wellness practices in health to provide access to health care professionals, where each professional could deposit the most interesting articles for others (colleagues and health professionals) to read.
21. Insert in health care centres TCAM practices (can rotate during the week, month) where individuals can be leaded to, by healthcare professionals, and schedule their consults on the practice of their election to complement their health management and focus on personalized health promotion and prevention. TCAM professionals dedicate usually more time and training to focus on a holistic view of the individual (physical, mental, emotional, spiritual, social, occupational,).
22. Offer a periodic annual check-up assessment to healthy individuals, joining healthcare diagnostic (e.g., blood analysis) and an alternative TCAM practices to find small unbalances (e.g., difficulties to concentrate, sadness, difficulties falling asleep, headaches) and to start taking care of it, using non-intrusive practices (e.g., psychology, physiotherapy, meditation, exercise), as soon as possible, before major symptoms of a disease become visible.
23. Create more groups of patients with specific health issues, where patients meet with HC professionals (doctors, nurses), wellness practitioners and TCAM practitioners to gain awareness on the medical treatment, complementary treatment and necessary lifestyle changes.

EXPERTISE
24.Create an annual programme of working sessions to share and develop new research and identify opportunities to improve health and wellbeing for specific groups of people (e.g., diabetic, overweight), with involvement of health professionals, wellness professionals, patients and other stakeholders.
25. TCAM professionals can ask to the health centre where the patient is registered, through the patient, specific questions about patient's health or additional diagnostic on some identified condition (e.g., food allergies).
26. Develop a shared IT System, accessed by health care and TCAM professionals, with patient authorization and assuring an adequate level of security, to share main relevant health diagnosis, concerns and developments allowing substantial gains in quality of care and time.

EDUCATION
27. TCAM professionals: Promote formal certification of TCAM professionals, giving them higher benefits and supervision roles, and give a deadline to not certified TCAM practitioners to get certification, when available.
28. TCAM practices: Promote meetings with Swedish universities' (e.g., BTH) researchers to ask for studies about the value of TCAM practices in several relevant domains and use them as a key to lobby for TCAM practices approval with adequate health authority.
29. Promote research in the universities or studies by central or local government on current lifestyles in the region, focusing on the "what" and the " why", to be more efficient

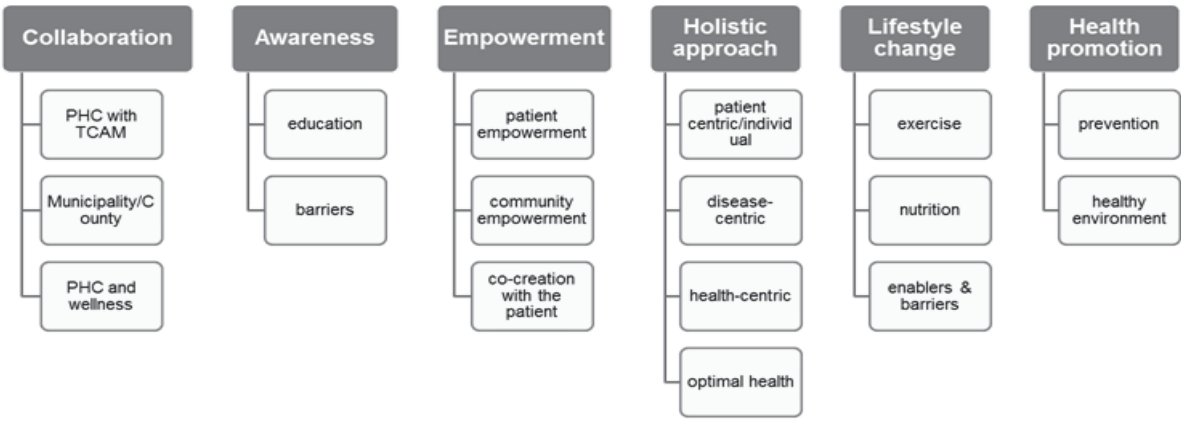
addressing the local concerns through the local health organizations, e.g. public health, county council, health care, TCAM, wellness...
30. Contact and initiate research projects with Blekinge Health Arena, Blekinge Institute of Technology and other research institutions to compare outcomes for patients who use integrative approach with outcomes for those who do not. Use the results for cost-benefit analysis and for defining what treatments to fund publicly.

INVOLVEMENT
31.Socio-economic disadvantaged: Define a quote of pro-bono or low cost prices for non-reimbursed TCAM practices by Swedish Health System to socio-economic disadvantaged individuals recommended by the PHC or social assistance.
32. Identify and divulgate alternative sources of payment (partial or total) for non-reimbursed TCAM treatments (e.g., schools, social support services, companies, NGO's,…) to promote their use
33. Develop usability studies on IT platforms and assessments of the effective use of the information currently required from doctors and nurses in health centres, to identify technological shortcuts and simplify the processes, with benefits on time of health care professionals and on a substantial increase in the quality of services for patients.
34. Promote meetings with local and/or central government to allow a Pilot project, in a county council, where most TCAM practices would get similar conditions (e.g. payments co-financed by government), to provide new information to the governments (like what people choose and why) that could be important to orient future studies, policies and regulation.

ENGAGEMENT
35. Empowered individuals: Reserve substantial time in each consult to listen carefully to patient story and, current and past, experience with health and lifestyle, and especially their own idea of success on health and wellbeing, before advising on any wellness or TCAM practice alternatives, to assure that the person is really motivated and involved on the planning of a personalized prescription or programme.

EXPERTISE
36. Provide periodic training to wellness and TCAM professionals, in recent health technology at home and research developments in their area, for them to be able to better cooperate as useful partners with "qualified selvers" to advise on the definition and reach of their personal health goals.
37.Start inviting and including the patient to be part of the team who discuss their health and wellness case, in wellness and TCAM centres, to co-create a solution that is motivating, adequate and personalized for each individual.
38.Create meetings with the local government, public health responsible, health care, wellness, TCAM entrepreneurs and community representatives for private entrepreneurs starting health-related enterprises to present their projects and together find ways to facilitate conditions (e.g., location, financial, communication, …) and to give extra visibility to the community to other companies already promoting health (e.g., hiking, kayaking, horse riding, …).

Appendix G: Codes



Results

Appendix H: Saturation of actions

		I. Collaboration								
Type of respondent	Country	2. program of working sessions to share&develop new research	3. professional development programmes	4. more qualified TCAM practitioners and doctors to BHA	5.gradually certificate formally TCAM professionals	6.shared IT system with patient consent	7.protocols to agree on the rules of cooperation	8.Common vision of main challenges to address and goals	9.Update 1177.se about authorized TCAM	10.organise Hälsofestival for community
Researcher	Sweden		A			A				
						A				
		A				A			A	
	Australia		A		A					
		A			A					
Executives, managers or consultants	Sweden	A	A	A	A	NA	A	a	a	a
	Netherlands									
	Sweden	A								
	Portugal									
TCAM	Sweden	A	A	A	A	A	A			A
				A	A	A				
						A				
				A						
		A	A		A	D				
						D	A			
nurse and TCAM			A		A					
			A		A	D				
		A	NA			NA				A
nurse						NA				
			A		A					
Doctor	Portugal									
GP doctor	Sweden				A					
						NA				
		N	A		A	D	A	A		

		II. Patient and community engagement					
Type of respondent	Country	11.feedback meetings with clients	12.educational programs for socio-economically challanged	13.community meetings around health issues	14.more offers to groups of patients with special needs	D38.Listen carefully patient story	D39. Trainning wellness and TCAM in health technology athome
Researcher	Sweden		A			NA	
	Australia						
				A			
Executives, managers or consultants	Sweden	a	A	A	A		
	Netherlands	A				A	A
	Sweden						
	Portugal						
	Portugal						
TCAM	Sweden	A	A		A	A	
			A				
nurse and TCAM			A		A		
				A			
					A	NA	
nurse				A	A	NA	
Doctor	Portugal			A			
GP doctor	Sweden						
			N		A	A	N

		III. Health promotion and prevention								
Type of respondent	Country	15.exercise offer for the elderly	16.annual check-up for everybody in healthcare or TCAM	17.Create a family exercise program	18.discounts for friends and family for TCAM and wellness	19.special offer for businesses of individualized training	20.open-day in companies to new experiences TCAM and wellness	21. open day in schools/ university: personalized training	22.Use national and international days for awareness	23.digital channels to communicate with youngsters
Researcher	Sweden									
						A				
	Australia									
Executives, managers or consultants	Sweden	A	a	A	a	a	a	a	a	a
	Netherlands									A
	Sweden									
	Portugal		A							
	Portugal									
TCAM	Sweden	A	A	A	A	A	A	A		
							A			
		A								A
		NA	A			A			A	
nurse and TCAM			A							
			A							
		A	A	A	A	A	A			
nurse			A		A	A				
Doctor	Portugal									
GP doctor	Sweden									
			A	N						

		IV. Living environment			VI. Financing			
Type of respondent	Country	24.playgrounds for people of all ages to exercise and fun	28.Cooperate with private health insurance providers	29.government pilot to re-fund TCAM treatment	D36.Special conditions for socio-economical challenged groups	D37.New sources fo payment for non reimbursed TCAM	26.research projects to compare outcomes of patients using TCAM	D30.more and more diversified TCAM courses (Karolinska)
Researcher	Sweden	A						
		A						
	Australia							
			A					
		A						
Executives, managers or consultants	Sweden	A	NA	a	NA		A	A
	Netherlands							
	Sweden						A	
	Portugal							
	Portugal		A					
TCAM	Sweden	A			A	A		A
							A	
		A						
				A				
nurse and TCAM							A	
		A						
				A	A	A	NA	A
nurse		A						
Doctor	Portugal							
GP doctor	Sweden			D			A	A
				N	N	N	N	A

		V. Awareness & Education						
Type of respondent	Country	26.research projects to compare outcomes of patients using TCAM	D30.more and more diversified TCAM courses (Karolinska)	D31.Individual meetings between PHC and wellness or TCAM	D32.Event schools/university for mental illness with PHC/TCAM	D33.County concil: Community event mental illnesses awareness	D34.more research studies in TCAM and wellness less orthodox	D35.wiki research database wellness and TCAM practices
Researcher	Sweden				A			
	Australia						NA	
Executives, managers or consultants	Sweden	A	A		A	A	A	A
	Netherlands							
	Sweden	A						
	Portugal							
					A		A	
TCAM	Sweden		A	A		A	A	A
		A						
				A				
nurse and TCAM		A						
		NA	A					A
nurse								
Doctor	Portugal				A			
GP doctor	Sweden	A	A	D			A	
		N	A	A	A	A	A	A

	I. Collaboration									II. Patient and community engagement					
No answers	21	19	25	18	15	25	27	27	26	26	23	24	23	23	27
Sum A	7	9	4	11	6	4	2	2	3	3	5	5	6	3	1
Sum NA	0	1	0	0	4	0	0	0	0	0	0	0	0	3	0
Sum D	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0
Sum N	1	0	0	0	0	0	0	0	0	0	1	0	0	0	1
% Agreement	88%	90%	100%	100%	43%	100%	100%	100%	100%	100%	83%	100%	100%	50%	50%
% Negotiated Agreement	0%	10%	0%	0%	29%	0%	0%	0%	0%	0%	0%	0%	0%	50%	0%
% Disagreement	0%	0%	0%	0%	29%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

	III. Health promotion and prevention									IV. Living environment		
No answers	24	20	25	25	23	25	27	27	26	21	21	25
Sum A	4	9	3	4	6	4	2	2	3	8	3	4
Sum NA	1	0	0	0	0	0	0	0	0	0	5	0
Sum D	0	0	0	0	0	0	0	0	0	0	0	0
Sum N	0	0	1	0	0	0	0	0	0	0	0	0
% Agreement	80%	100%	75%	100%	100%	100%	100%	100%	100%	100%	38%	100%
% Negotiated Agreement	20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	63%	0%
% Disagreement	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

	VI. Financing				V. Awareness & Education						
No answers	26	24	25	26	22	24	25	24	26	23	25
Sum A	2	3	2	2	5	5	3	5	3	5	4
Sum NA	1	0	1	0	1	0	0	0	0	1	0
Sum D	0	1	0	0	0	0	1	0	0	0	0
Sum N	0	1	1	1	1	0	0	0	0	0	0
% Agreement	67%	60%	50%	67%	71%	100%	75%	100%	100%	83%	100%
% Negotiated Agreement	33%	0%	25%	0%	14%	0%	0%	0%	0%	17%	0%
% Disagreement	0%	20%	0%	0%							

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