

eurohealth



Europe, tobacco and health



Cardiovascular disease: fighting Europe's number one killer

Citizen involvement in health care

Economic evaluation of health promotion and disease prevention strategies

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This issue of *eurohealth* brings together two key issues for the health of Europe's citizens. Three articles follow up on the 'Winning Hearts' conference, which took place in Brussels on 14 February 2000, organised by the European Heart Network with the support of the European Commission. Cardiovascular disease is Europe's number one cause of death, and much of it is preventable. Together the articles show how progress is being made in tackling the problem, but also the enormity of the task ahead, not least because of the impending arrival of several central and east European countries into the European Union, which will, as Robert Coleman notes, markedly increase EU-wide health inequality.

It is fitting that this issue combines an examination of the number one cause of death in Europe with several articles on one of its principal causes – smoking. In this context, six articles look at various aspects of smoking and tobacco, focusing in particular on the legislative and regulatory issues facing the EU in controlling tobacco promotion and use.

One article, by Hagland et al, from the International Network of Women Against Tobacco, shows how gender issues are central to the tobacco debate. Another, by Zatoński and Harville, gives an extremely interesting account of the tobacco control policies that are in place in Poland. This article not only highlights the particular problems facing central and east European countries, but also shows how current EU Member States might improve their own tobacco control policies ahead of Poland's accession to the Union.

Further highlighted by the tobacco issue is the incompatibility of European health policies with the Common Agricultural Policy (CAP). As Jeanette Longfield showed in the last issue of *eurohealth* with respect to the distribution of food subsidies, the CAP often distributes subsidises in such a way as to undermine health policy aims, making it not only irrational in economic terms, but also counterproductive with respect to other important areas of European policy. It should therefore be noted in the context of the current issue of *eurohealth* that the substantial CAP subsidies to tobacco production are not consistent with health policy aims, not least because they have failed to reduce imports of the non-European tobacco that is preferred by European consumers.

There is, then, food for thought in this issue, as in the last, about how agricultural and health policy aims mesh together in the European polity, not least, and to reiterate, in light of the obligation in the Amsterdam Treaty to ensure that public health aims are taken into account across the policy spectrum.

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In response to the Editorial by Paul Belcher in the previous edition of eurohealth, 'Would the Commissioner for Health please stand up?', Catherine Taylor MEP raises some critical issues for consideration by the Commissioner in the current debate over a future EU health strategy.



Where's the beef?

Developing a health strategy for the European Union

Catherine Taylor MEP

The health competence of the European Union is relatively new. It was just seven years ago with the Maastricht treaty that public health was given a focus of its own. In May 1999 the Amsterdam Treaty was implemented, adding greatly to the public health powers of the EU. It strengthens the requirement that all policies must be implemented in the light of explicit consideration of possible health implications.

The priority of public health

Romano Prodi, the new President of the European Commission has expressed his intention to make improved public health in the EU one of his top priorities. Health is one of the top five priorities listed by the Environment Commissioner, Margot Wallstrom. A new DG with responsibility for public health and consumer protection has been set up with Commissioner David Byrne at its head. By the end of March a new policy document outlining the general strategic direction for public health policy development over the next five years will be published. So far, so good. Health has been placed on the EU agenda. However, there are some critical points to make – in both senses of the word 'critical'.

In the previous issue of *eurohealth* Paul Belcher commented that a casual observer of EU affairs might be forgiven for thinking that David Byrne has swapped his appointed role as Health and Consumer Protection Commissioner to become 'Commissioner for Food Safety'.¹ This partly reflects the extensive and understandable public concern in the wake of the recent BSE and dioxin food safety crises. Caroline Jackson, Chair of the European Parliament on the Committee on the

Environment, Public Health and Consumer Policy, has pointed out that hardly a day goes by without some new concern being raised about the safety of the food we eat or the air we breathe.²

The Environment Committee has one of the heaviest legislative programmes of all the European Parliament committees and is currently progressing many concrete proposals relating to the environment or food safety. Of course, these issues are important and affect health yet the wider health considerations seem to have been put on hold. The resignation of the former Commission last March is frequently offered as an explanation for the delayed publication of a new EU health strategy, although detailed proposals for food safety regimes have been made during the same period. Yet, to date, few people have died of BSE, while heart disease, for instance, remains a global health epidemic and the leading cause of death and disability in Europe.

Ill-health blackspots

As a Scot I am only too well aware of heart disease as a major killer. A recent comment on Scots and health was that 'the typical Scot has bad teeth, a good chance of cancer, a liver under severe stress and a heart attack pending'. Scotland has often topped the European tables of incidence of heart disease, and the recent Scottish White Paper on Health rightly points out that 'Our position at or near the top of international 'league tables' of the major diseases of the developed world – coronary heart disease, cancer and stroke – is unacceptable and largely preventable'.

“wider health considerations seem to have been put on hold”

Recent figures have shown the merits of prevention as fewer Scots are dying of heart disease than in the 1980s but heart disease still accounts for about a quarter of all deaths. While the EU cannot intervene in national policies on health care systems the European dimension is critical in our approach to combating heart disease across the European Union and illustrates the potential benefits of a positive approach to developing EU health strategies.

Winning hearts

At a conference organised by the European Heart Network and the European Society of Cardiology, 'Winning hearts: actions and policies for a healthier Europe',³ held in Brussels on St Valentine's Day, Robert Coleman, Director-General of the DG for Health and Consumer Protection, gave some indication of the shape of things to come and the implications for tackling heart disease in particular. The aim is to present the proposal for a new health strategy and an accompanying Action Programme on Public Health at the end of March 2000, although Commissioner Byrne uses the more cautious timetable of 'within the Portuguese Presidency', that is, by the end of June 2000.

Mr Coleman echoed the discussion document issued by the last Commission, indicating that emphasis would be on improved health information systems for Europe; development of a rapid response facility to tackle new public health threats; streamlining the various sources of public health funding leading ultimately to one public health fund; and introducing legislation (Directives) in some of the new areas permitted by Article 152 of the Amsterdam Treaty.

There was much to welcome in his presentation: for instance, the recognition of the links between social inequality and ill health, and the announcement that the Communication will describe ways of implementing the Amsterdam Treaty requirement to take account of health implications of policy. He referred to forthcoming legislation relating to tobacco labelling, and the references to information campaigns on appropriate dietary habits and nutritional information and labelling in the recent White Paper on Food Safety.

Yet the presentation also highlighted the fact that we really do need to know what the Commission has in mind for a European public health strategy. There is probably something of a political consen-

"It is vital that a European health strategy does not take a minimal line of 'health protection' and instead aspires to the scope offered by the Amsterdam Treaty to 'improve' public health."

sus on this point. Caroline Jackson observed that the Commission's Communication makes an excellent starting point – 'All excellent aims. But they are meaningless if they are not backed up by concrete action. In particular the Commission will need to come up with specific, realistic proposals based on clearly defined targets, timescales, methods and strategies.'²

Commission proposals

This is indeed critical. It is also vital that a European health strategy does not take a minimal line of 'health protection' and instead aspires to the scope offered by the Amsterdam Treaty to 'improve' public health. There is a need to participate in other DGs' political planning at an early stage and to draw on the work of organisations such as the WHO on health impact assessment in order to measure the health impact of policies. The funding of public health projects might become more strategic, giving 'added value' to the existing criteria that EU-funded projects should be cross-border and/or innovative. There is also a need to extend and simplify health-relevant information for the public and to develop dialogue between patients, medical professionals, NGOs and government.

This last may also develop a more positive public perception of European institutions as directly relevant to everyday life. The EU is often overlooked, ignored and misunderstood. It could be said that apathy won the last European elections in the light of the low voter turnout. Yet Europe is of direct relevance and immense potential benefit to its citizens. While there is political sensitivity on the questions of subsidiarity and health care, actions taken at the European level can complement and lend wider authority to interventions by national governments. The EU has an important role to play in a cross-border health strategy and in the realisation of visions such as that of the recent Winning Hearts conference that 'Every child born in the new millennium has the right to live until the age of at least 65 without suffering from avoidable cardiovascular disease'. But for now, Commissioner Byrne, *where's the beef?*

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The responsibilities of EU ministries of health

This small survey on the level of responsibilities of health ministries in specified policy areas or issues showed wide variation between the European Union Member States.



Tapani Piha

Ministries at national level are responsible for several important issues that at EU level are handled by Council groupings other than the Health Council. The most important of such issues are pharmaceuticals and medical devices. While it would be beneficial to bring the EU and national administrations more in line with each other, many issues will continue to be scattered around administrative structures. This emphasises the need for good coordination both at national and at EU levels as well as between the two levels.

The structure of public administration varies greatly in different European Union countries. On the other hand, all Member States must adapt themselves to the administrative structures of the Union. This applies to the health sector, too. Ministries responsible for health matters differ in their size, scope of responsibility, structure and even the status and number of ministers (politically responsible people at ministerial level).

The Finnish Presidency decided to survey specified areas of responsibility of health ministries as a part of the discussion on ensuring health protection in all community policies, and more specifically, as a part of the discussion on the role of the Health Council.

Materials and methods

The survey on the level of responsibility of health ministries in certain policy areas and issues was carried out in September-October 1999. A structured questionnaire was given to all delegations participating in the Health Questions Working Group. Reminders were sent as necessary. Luxembourg did not respond to the questionnaire. The questionnaire was usually filled in by the representative from the capital who regularly attends the Health Group.

The main part of the questionnaire detailed the level of responsibility of the health ministry for policy areas and issues that

have been the focus of the recent discussions and actions of European Union health policy (see Table 1). The level of responsibility was defined as main, partial or none. The health ministry was defined as the ministry responsible for the Health Council. A further question concerned whether the minister responsible for the Health Council also attends other Council groupings.

Results

The levels of responsibility of health ministries in different policy areas and issues showed marked variation between the countries (see Table 1). The areas could be grouped into three: in the first group, the health ministry in nearly all countries has the main responsibility; in the second, no responsibility; or in the third, responsibility is shared with other ministries. Nearly all health ministries had the main responsibility for health promotion and disease prevention, policy on tobacco, pharmaceuticals, medical devices, blood and blood products. Of these only medical devices were under the main responsibility of health ministries in all countries.

Health ministries were not often responsible for animal and plant health or safety of toys. These areas usually fell under the responsibility of ministries of agriculture or trade and industry. Prevention of traffic accidents belonged also to this group. In other areas the health ministry usually had a partial responsibility. Such areas were consumer health and product safety, environmental health, gene technology and GMOs and health research. Of the 14 ministers involved in the Health Council only four also attended other Councils. In no country was more than one minister involved in the Health Council.

All ministries currently have a website although their content, quality and available languages vary. Interestingly, all respondents did not give the web address for their website, which may mean that they were not very familiar with it. The best lists of available websites can be found at <http://www.who.dk/WHO-Euro/links.htm> (for health ministries) and http://europa.eu.int/gonline_en.html (for governments in general).



*Johanna
Talvensaaari*

Discussion

The questionnaire gave no detailed definitions for the policy areas or the levels of responsibility. Therefore the answers from different countries may not be strictly comparable but for the purposes of this survey this is not a significant problem. Most respondents have been working together on these issues for a long time, which should ensure a high degree of common understanding of key concepts.

The starting point of the survey was the diversity in the European Union. However, there were even more differences than expected in specified areas of responsibility. Health ministries in all countries do not have the main responsibility even for rather basic issues, such as mental health. It is equally interesting that health ministries in several countries have no responsibility for important health-related issues, such as sickness insurance. The reason may be that the responsibility lies so heavily at regional level. This diversity has obvious implications for policy making in the European Union.

Some issues that in the European Commission are linked to public health are not necessarily a part of the health ministry's portfolio in Member States. Such issues are for example safety of food or animal and plant health.

It is not necessary that issues in the Commission and in the Member States are linked together administratively in a similar way but in many cases it would be beneficial. From this point of view the survey strongly supports the idea that issues related to pharmaceuticals and medical devices should be brought into the context of consumer protection and public health, also within the Commission.

The differences in administrative structures and responsibilities of health ministries among Member States as well as between the EU and Member State levels will continue. This is seen as a healthy sign of diversity in European administrations. The diversity, however, imposes a heavy duty on coordination at all levels.

The coordination must be seen in relation to the responsibility of the European Union to ensure the high level of health protection in all Community policies and activities. Bearing in mind the need for coordination, it is interesting that so few health ministers attended other Council groupings than the Health Council. Commissioner David Byrne has attended

Table 1 THE RESPONSIBILITY OF THE EU HEALTH MINISTRIES IN RELATION TO POLICY AREAS AND ISSUES THAT HAVE BEEN THE FOCUS OF DISCUSSION AND ACTION IN THE EUROPEAN UNION

Policy area or issue	Main	Partial	No
Health protection in all policies	9	5	-
Health promotion, disease prevention	13	1	-
Policy on alcohol	11	3	-
Policy on tobacco	13	1	-
Policy on drugs	7	6	1
Primary health care, hospitals	11	3	-
Care of the elderly	8	5	1
Mental health services	11	3	-
Pharmaceuticals (incl. pharmacies, control of medicines, pricing)	13	1	-
Medical devices	14	-	-
Blood and blood products*	13	-	-
Consumer health, product safety	3	10	1
Safety of food	5	6	3
Animal and plant health	2	4	8
Safety of toys	3	4	7
Health professionals, training, mutual recognition	5	8	1
Supervision of health professionals	11	3	-
Environmental health	2	10	1
Drinking and bathing water	3	8	2
Chemicals, hazardous substances	3	7	4
Cosmetics	8	3	3
Gene technology, GMOs	3	10	1
Radiation protection	2	9	3
Health and safety at work	3	9	2
Prevention of traffic accidents	1	6	7
Prevention of home and leisure-time accidents	5	8	1
Sickness insurance	6	4	4
Health statistics	9	5	-
Health research	3	11	-
Telematics in health	8	5	1

* One answer missing

Agriculture, Consumer Affairs and Health Councils and declared his intent to work closely with the Internal Market and Social Affairs Councils. Coordination might benefit from a stronger input by health ministers to those Councils. The Helsinki Summit decided on the reduction of the number of Council groupings and the Commission's internal structures will further evolve. This will keep the question of coordination in a constant development.

Even if there were some alignment of administration of some core issues of health policy, the responsibility for many important health matters will continue to be scattered. Therefore, the role of the Health Council as a coordinating body must be reinforced. The Finnish Minister Eva Biaudet¹ said in June that "The Health Council should deal with legislation and initiatives directly linked to public health regardless of the legal base of the instrument. It would be equally important to coordinate and stimulate discussions on health in other councils and to develop tools for evaluation of the health impact of various measures."

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Tobacco control issues in the European Union



John F Ryan

The development of measures relating to tobacco control in the European Union is characterised by a dual-approach: both preventative and legislative initiatives are considered necessary in order to achieve progress in reducing the level of smoking related mortality in the European Union, estimated at over half a million deaths per year. Thus, the prevention campaigns supported by the Europe Against Cancer Programme and the Community Fund for Research and Information on Tobacco, have been implemented in parallel with the adoption of several legislative measures directly or indirectly affecting tobacco consumption.

A further source of funding for projects is the Community Fund for Research and Information on Tobacco, which consists of a two per cent levy on the support given to raw tobacco producers through the Common Agricultural Policy.

Prevention

The initiatives adopted by the European Union in the field of smoking prevention have largely been focused on the Europe Against Cancer Programme. From its establishment in 1987, the programme already identified smoking prevention as a major vector for reducing cancer, and this priority was incorporated in the successive action plans of 1987–1989,¹ 1990–1995,² and the current plan of 1996–2000.³ Independent evaluations of the two latter plans were carried out.⁴ Generally speaking, in the early stages of the programme, activities supported tended to be small-scale national initiatives with little Community added value, but which were appreciated by those active in the smoking prevention field nationally.

The usefulness of these initiatives as pilot projects should also be underlined. This trend of rather small-scale projects was also present in the second action plan, but has almost been reversed in the present programme, which has concentrated funding in two main networks. These select and

manage a series of large-scale actions and ensure a maximum participation of Member States.⁵ Details of projects supported are available on the European Commission web-site.⁶

A further source of EU funding for projects informing the public of the dangers of smoking was introduced in 1992 with the creation of the Community Fund for Research and Information on Tobacco.⁷ The Fund consisted of a one per cent levy on the support given to raw tobacco producers in the framework of the Common Agricultural Policy. Half of this levy, or about five million euros annually, was available for research into developing less dangerous varieties of tobacco plants, and half for public information projects on the dangers of smoking. Two calls for tenders have been published to date under the Fund, and details of the information projects supported are also available on the Commission website.⁸

In 1998, the Council decided to double the amount of the levy from one per cent to two per cent of the raw tobacco subsidy.⁹ An amendment to the Commission's implementing regulation is imminent and access to the Fund's support will again become available.

Strategy

In October 1996, the EU High Level Cancer Experts Committee met in Helsinki to examine a series of proposals on tobacco control measures, which they passed on to the European Commission.¹⁰ Following this, the European Commission published its first policy document on tobacco control in December of the same year.¹¹ This met with a variety of largely favourable reactions from other EU institutions and non-governmental organisations, and with a more negative approach from tobacco industry groupings.

The Commission Communication recognised that national and EU level action on smoking prevention was complementary, and reflects the varied range of Community and national competence on such issues as taxation, age limits, advertising and product specifications, for example. In relation to

future action at the EU level, the Commission proposed to examine the development of:

- data collection and epidemiological studies;
- protection of children;
- classification of nicotine addiction;
- action on tobacco additives, tar levels and nicotine levels;
- tightening labelling of tobacco products;
- definition of descriptions such as ‘light’ or ‘low tar’;
- protection from environmental tobacco smoke.

In order to follow up certain of these proposals the Commission Services addressed (in 1997–1998) a series of questionnaires to Member States to determine national practice on a number of issues, such as:

- additives in tobacco products;
- tar and nicotine content of cigarettes;
- sales of cigarettes and tobacco to young people;
- sales by vending machine;
- sales of cigarettes in unit packs of less than 20;
- smoking in public places.

The replies were analysed, and a Commission Report was drawn up in September 1999 that addresses possible conclusions to be drawn in terms of future action at the EU level.¹²

Existing EU legislation

In 1989, two important measures were adopted. First, the Television without Frontiers Directive, which banned all forms of television advertising for tobacco products. Also, it provided that television programmes may not be sponsored by natural or legal persons whose principal activity is the manufacture or sale of tobacco products.¹³

Second, EU rules on labelling tobacco products with health warnings were introduced in a Directive aimed at harmonising Internal Market provisions, taking as a basis a high level of public health protection.¹⁴

An EU ceiling on tar content of cigarettes was introduced in a 1990 Directive, on the basis that “the higher the tar content of smoked tobacco, the greater the risk of lung cancer.” Significantly, the Directive also states that “smokers must always be

aware that all cigarettes are harmful to health ...[and] ...it is much more desirable for them to stop smoking rather than to switch to low-tar cigarettes.”¹⁵

In 1992, a revision of the tobacco labelling rules was introduced, to establish additional specific warnings for unit packaging of tobacco products other than cigarettes.¹⁶ The occasion was taken to prohibit the placing on the Community market of oral tobacco products. This ban was subsequently the matter of an exception in the Swedish Treaty of Accession to the EU, in respect of the type of oral tobacco known in Sweden as ‘Snus’.

“The importers and manufacturers of tobacco products will have to provide regular information on non-tobacco ingredients (i.e. additives) in their products, and to submit toxicological data on these ingredients.”

A significant decision was taken by the Council and European Parliament in adopting a Directive in 1998 on the direct and indirect advertising of tobacco products, and related sponsorship.¹⁷ The Directive was based inter alia on the differences between Member States’ laws on the advertising and sponsorship of tobacco products, on the transborder nature of this advertising and sponsorship, and on the basis that the differences in question are likely to give rise to barriers to the movement between Member States of the products that serve as the media for such advertising and sponsorship and to freedom to provide services in this area, as well as distort competition, thus impeding the functioning of the Internal Market.

Article 3 of the Directive provides that all forms of advertising and sponsorship shall be banned. Detailed provisions and exceptions are laid down in subsequent articles. Transitional periods are also provided for particularly in respect of the press and the Directive also allows for the possible continuation of existing sponsorship of events or activities organised at world level, subject to certain restrictions. The legal basis of the Directive is currently being challenged in cases before the European Court in Luxembourg.

A non-binding act may also be mentioned here, the 1989 Council Resolution on ban-

ning smoking in public places,¹⁸ which has since been the subject of two Commission reports on its implementation by the Member States.¹⁹

Most recent legislative proposals

The Commission then adopted on 16 November 1999 a proposal for a Directive²⁰ concerning some of the areas referred to in its report of September 1999. The main points to be noted in respect of this proposal are the following:

Legal basis

In line with previous legislation adopted at EU level (tar Directive,²¹ labelling Directives,²² general tobacco advertising and sponsorship Directive²³), the legal basis used in this proposal is Article 95 of the Treaty (former Article 100A), pertaining to the completion of the Internal Market and elimination of obstacles to its smooth operation. In its proposals under this Article, the Commission shall take as its basis a high level of public health protection. Since the amendments introduced by the Amsterdam Treaty, the European Parliament and Council also work towards achieving the same objective (Article 95 paragraph 3).

“High tobacco prices, due to the heavy excise burden, are a significant factor in discouraging young people from becoming smokers.”

It should be noted that Article 152 of the Treaty, dealing specifically with public health, excludes the adoption of harmonisation measures except in a number of specific cases, such as blood and organ safety. Using Article 95 as a legal basis however restricts the type of initiative that may be taken regarding tobacco regulation to those cases where a genuine and substantive Internal Market justification is established. Similarly, the principles of subsidiarity and proportionality entail strict examination of the necessity for EU action on a particular issue and its scope. The recent publication of a Commission Communication on the precautionary principle raises some interesting additional elements on how future legal initiatives in this field may be evaluated.²⁴

Content of the proposal

The proposed Directive is intended to ‘recast’ three existing Directives on tar content of cigarettes and labelling of tobacco products, updating and completing these provisions in the light of new developments based on scientific facts in the context of the completion of the Internal Market, and taking as a basis a high level of public health protection.²⁵

On the tar content of cigarettes, the proposal envisages continuing the reduction to a maximum level of 10mg per cigarette. It proposes to introduce an EU ceiling for nicotine in cigarettes of 1mg and of carbon monoxide of 10mg. These rules are envisaged for all cigarette products manufactured in the EU, and therefore also cover exports, an extension on the present rules, but is an initiative envisaged by Article XX(b) GATT in respect of measures necessary to protect human health.

The existing EU rules on tobacco product labelling are substantially tightened, with a proposed increase in the size of the health warnings, a requirement to print warnings in black type on a white background, surrounded by a black border. The latter requirement is one already imposed by many non-EU administrations such as Canada, Poland and Australia. The health warning messages have been revised.

The existing ban on commercialisation of oral tobacco in the EU is continued, except for Sweden where an exemption is provided for in their Treaty of Accession in respect of ‘Snus’.

The importers and manufacturers of tobacco products will, according to the proposal, have to provide regular information on non-tobacco ingredients (i.e. additives) in their products, and to submit toxicological data on these ingredients. Additional tests may also be required by the Member States, as is presently the case on the national level, but the Directive would provide for the results of these additional tests to be communicated to the Commission.

It is proposed that product descriptions (such as ‘light’, ‘low tar’ etc), which may mislead the consumer on the health effects of a tobacco product, shall be prohibited unless specifically authorised by a Member State.

Discussion of this proposal for a Directive is currently underway in the European Parliament and Council of Ministers. Opinions are also being prepared by the EU Committee of the Regions and the

Economic and Social Committee.

Taxation

Another major area where EU law affects tobacco consumption is through the application of the excise duty Directives. Current rules on excise duty on tobacco products provide in particular for a Commission report every three years on the rates, overall minimum excise duty and the structure of such duties, taking account of the proper functioning of the Internal Market and the wider objectives of the Treaty. High tobacco prices, due to the heavy excise burden, are a significant factor in discouraging young people from becoming smokers. The Community is also involved in important efforts to reduce tobacco smuggling.

WHO International Framework Convention on Tobacco Control

The major international initiative on tobacco control currently underway is the creation of a World Health Organization framework convention. Launched at the 49th World Health Assembly in May 1996, the discussions on how the convention should be structured and on its possible content have been examined in a Working Group that met in November 1999, and again in March 2000. At the EU level, the Commission sought and obtained from the Council of Ministers in October 1999 a formal mandate to participate on behalf of the Community in the forthcoming negotiations for those matters falling within EU competence. The mandate was granted on the basis of Article 300.1 of the Treaty.

Conclusion

A rather poorly known domain of EU activity, smoking prevention activity has been steadily developed since the late 1980's, and in addition to modest prevention programmes has seen the adoption of significant tobacco control measures in the context of Internal Market legislation.

Whereas the limited budgetary resources available to prevention efforts cast doubt on their ability to make a significant and lasting dent in tobacco consumption, the effects of legislation at EU level should not be underestimated, given the size of the Internal Market, the opening of the EU to the enlargement countries, and the application of the same regime in the European Economic Area. Similarly, the development of a binding WHO instrument on tobacco control is also forecast to introduce similar approaches in a wider context.

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A health lobby response to the draft EU Directive on Tobacco Content Regulation

*Philip Morris, the largest international cigarette producer in the world, was recently described as 'a company that has steadfastly resisted government regulation for decades.'*¹



Andrew Hayes

Throughout the world, tobacco products have been manufactured and marketed for tens and hundreds of years with little or no regulation of any kind. Governments have not seen fit to challenge the economic and political power of the tobacco industry, despite the fact that their products cause the unnecessary early death of 500,000 EU citizens each year.

This contrasts with recurrent political crises stemming from concerns about food safety, such as BSE, salmonella, dioxins and GMOs. The fear of mad cow disease has stimulated several years' frenzied activity within the EU and in individual Member States, producing a range of initiatives designed to minimise risk and protect the health of the public. The latest (and welcome) proposal from David Byrne, EU Commissioner for Health and Consumer Protection, is to set up a European Food Safety Authority.

The BSE crisis has been with us for a few short years. During that time, it is believed to have caused less than 100 deaths. Extensive media coverage fuelled perceptions of producer foolhardiness and government incompetence. This, just as much as the fear of a real epidemic, drove forward the political response.

Tobacco regulation: the problems of control

Why hasn't tobacco engendered the same sense of outrage? Partly because tobacco is an accident of history. Tobacco was well entrenched in many different cultures before the relationship between smoking, disease and premature death came to be clearly understood in the mid-1900s. Partly because the media has never felt inclined to make any fuss about tobacco; many journalists and editors are smokers, many newspapers and magazines have benefited from tobacco advertising revenues. For decades, both politicians and the public have been inured to the threat of tobacco, just because it is so much a part of the status quo.

"tobacco is an accident of history ... entrenched in many different cultures"

Then, of course, there have also been vested interests to defend: those of the farmers, the producers, the advertisers, the distributors, the retailers. Less obvious interests spring to mind: sports and entertainment events that are sponsored by the tobacco industry, government revenues that are generated through tobacco taxation etc. The constant complaint from the industry, during the hard-fought campaign for the EU Directive on Tobacco Advertising two years ago, was that of potential job losses: advertising restrictions would hazard people's livelihoods. No mention, of course, of the risks to people's lives. This despite the fact that half of all regular smokers die as a result of their habit, losing on average 14 years of life.

Evidence recently unearthed from industry archives shows that the tobacco industry well understands the deadly nature of its products. It has long been a mantra of the health lobby, but worth repeating nonetheless, that: 'Tobacco kills, when used exactly as intended.' This simple truism makes it all the more outrageous that the industry has managed to avoid regulation for so long, and that governments the world over have completely ignored their responsibility to protect the health of their citizens.

The proposed EU tobacco Directive

Now the tide is beginning to turn. The proposed EU Directive on the 'manufacture, presentation and sale of tobacco products' builds on earlier European legislation concerning tar yields, package labelling and health warnings. The Commission's intentions, well signalled over the past two years, have been welcomed by the health lobby in principle - but with reservations. 'Good, but could be better' summarises our initial reaction.

We believe it is right to regulate maximum yields of tar, nicotine and carbon monoxide. The difficulty lies in the recognition that machine measured yields do not reflect the actual experience of individual smokers, who subconsciously adjust their smoking style to achieve their preferred nicotine 'kick'. They do this by blocking or unblocking air vents in the filter, and by

inhaling smoke more or less deeply into their lungs. The proposal to lower tar yields from 12 to 10 mg makes little sense, given that present testing methods are flawed in this way. The 2mg reduction can be achieved just by making more holes in the filter. The apparent benefit falsely reassures smokers that they are smoking a 'healthier' cigarette.

New testing standards and technologies are clearly required, in order to ensure that tobacco content regulation 'moves with the times'. In our view, this has two implications for the Directive. First, there must be an effective, built-in review mechanism (in EU parlance, this means a Regulatory Committee), to ensure that developments in science and technology are properly monitored and their implications brought into play as quickly as possible. Second, an independent and adequately resourced agency should be established, to provide a European 'centre of excellence' for tobacco content regulation.

Neither of these ideas appears in the Commission's proposal, although we understand that the first, at least, is now under discussion in the Health Council's working group. We hope that the second may be picked up and promoted by the European Parliament.

Then there are some aspects of the Directive that we believe should be strengthened, or made more consistent. There is a proposal to increase the size of warning labels on the front and back of the pack so that they cover 25 per cent of the surface. Yet Poland, one of the 'first wave' countries now in negotiation to join the EU, has recently adopted legislation mandating warning signs covering 30 per cent of the pack. We believe there is no sense in going below 30 per cent, which could undermine the new Polish legislation (See article by Witold Zatoński and Emily Harville in this issue). Indeed, there are early indications that some Members of the European Parliament (MEPs) may push for even bigger warning labels – perhaps up to 50 per cent of the pack size – which we would gladly endorse.

Then there is a proposal to ban the use of words that imply possible harm reduction – words such as mild, light and ultra – from use in brand names. This we support, although we believe it should be extended to include the use of colours and other graphic design in the packaging.

So far, so good. Unfortunately, we fear that another aspect of the Directive undermines

this good intent. There is a proposal to indicate maximum yields of tar, nicotine and carbon monoxide on the packs. This can only be driven by the belief that 'lower yields equals less harmful': an assumption that is now in doubt. In reality, there is no such thing as a safe cigarette. We believe that the packet should indicate the presence of toxic substances, but not in any stated quantity. Specifying amounts suggests that lower means better, and gives individual smokers further false reassurance. It could also be exploited by the industry as a marketing opportunity – just the opportunity that the removal of 'mild, light and ultra' etc is intended to block.

Finally, we believe that the Directive should include measures to combat tobacco smuggling. The extent and implications of smuggling are well described by Luk Joossens in this issue. The EU could be doing more to tackle this problem. The Directive provides just the right chance to introduce regulations covering the transit system, so that individual consignments of tobacco products can be traced from the factory to the point of sale. We shall be lobbying for this to be included. Again, we are heartened by signs of early interest and support from some MEPs.

Industry reaction

What is the probable reaction of the tobacco industry? It is fair to assume that they don't like what they see and will do their best to undermine much of the Directive. Their strongest argument is likely to be that any regulation is premature, given the changing nature of our understanding of the product. We argue, on the contrary, that there is good reason for doing as much as we can now – given our present state of knowledge – to reduce the harm caused by tobacco. But we should not do so with one eye shut and one arm tied behind our back. The Commission's proposal must be amended to ensure a flexible approach, by which we mean a continuous process of review and recommendation, leading if necessary to appropriate modifications to the application of the Directive.

And for this, we can now quote an industry volte-face: according to Steven Parrish, Senior Vice President of Philip Morris, as reported in the International Herald Tribune: "I could see at some point in the future an appropriate way to regulate tobacco products."¹

Right on, Mr Parrish. So could we. Welcome to the ranks of those supporting the EU's attempts to regulate Big Tobacco.

“machine measured yields do not reflect the actual experience of individual smokers, who subconsciously adjust their smoking style to achieve their preferred nicotine kick”

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*Margaretha
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Women and tobacco:

The Europe Project of the International Network of Women Against Tobacco (INWAT)

Analyses of population smoking patterns suggest that women and men 'smoke differently'. Recognising this, tobacco promotion targets women in very specific ways. It is also becoming clear that traditional tobacco control has failed for many women because it was mostly designed for men. What is it that persuades women to smoke, and how do these factors differ from those which will predict smoking among men? What keeps women smoking and what cessation policies are appropriate specifically for women?

These questions have formed the policy agenda of the International Network of Women Against Tobacco since its inception in 1990. INWAT is a network of over 600 professional women working in tobacco control around the world, dedicated to preventing and reducing tobacco use among women. The INWAT Europe Project began in 1997, part funded by the European Commission's Europe Against Cancer Programme with contributing funding from the Swedish Institute of Public Health and the UK's Health Education Authority.

A key element of the 1998–1999 programme was an expert seminar that brought together leading specialists in the domain of women's health and tobacco use. This was an important step in developing Europe-wide tobacco control policies designed for women, following on from the report of 1998 ENSP Paris Conference, *Some Like It 'Light'*.¹

An account of the seminar's main findings and conclusions will be published shortly with financial support from the UK Cancer Research Campaign and will draw attention to three main areas of future development: it will propose policy and research frameworks within which to design and implement women-specific tobacco control policies and to redress shortcomings in current research; it will highlight the need to address wider social issues of the determination of women's health and in doing so for the tobacco control movement to join forces with other groups whose primary interest is in women's status in society;

finally, it will explore INWAT's future role in disseminating high quality research and evaluation results in support of its individual members' activities, in promoting wider networking with women's groups and in drawing the attention of policy-makers to the need to adopt gender-specific programmes.

Gender and health

It has long been recognised that patterns of ill health are differentiated by sex, not least on account of the differing genetic make up of the sexes and their reproductive function. However, recognition of the importance of social status in determining health has also highlighted the need to consider how patterns of ill health among women and men are generated by differing social circumstances. Societies have been described as divided along a 'fault line' of gender with women and men representing different actors, responding to distinct rewards and responsibilities.²

The experience of gender may lead to more or less exposure to particular kinds of risk – for example, occupational hazards, pressure to engage in risk-taking behaviour – to more or less access to the resources necessary to promote health, and to more or less access to health care.

The relatively subservient social position of women in the early twentieth century was, ironically, a protecting factor against tobacco use. Gender norms, reinforcing the notion of women as moral guardians of society, meant that it was much less acceptable for women to use tobacco. In addition, women had less command over the economic resources with which to obtain tobacco products. Recent social and economic change in many societies, particularly in the 'developed' countries of north America, Australasia and some parts of Europe has given women better access to economic resources, whilst the stigma attached to smoking has been reduced. In many other countries, however, the conditions that prevailed in Europe fifty years ago are the current norm.

Gender also interacts with other factors,

particularly social class, but also with age. This is seen clearly in the evolution of the tobacco epidemic curve. Cigarette smoking is first taken up by adult men in high socioeconomic groups, followed by women of similar socioeconomic status. Thereafter, smoking is adopted by men and later by women in lower socioeconomic groups. Higher socioeconomic groups abandon the habit first, leaving smoking in mature smoking economies concentrated in poorer socioeconomic groups among both men and women.³ Gradually the habit is appropriated by the very young such that most initiation into smoking now takes place among adolescents.

In younger smoking economies, tobacco use among women has been characterised as a 'gender challenge' and has been promoted as such by the tobacco industry.⁴ The INWAT seminar saw many graphic illustrations of how tobacco industry promotion exploits a desire for social and professional emancipation amongst women in some societies. In mature smoking economies where smoking is concentrated in lower socioeconomic groups, it is one of the most important causes of inequalities in health outcomes. Work undertaken in the UK has demonstrated how smoking has become a crucial part of every day coping strategies for women enduring lives of deprivation and disadvantage.⁵

Prevention and cessation of smoking among women

Reducing the prevalence of cigarette smoking is a central goal of tobacco control policies. These have followed a two-track approach aimed both at preventing initiation and encouraging cessation. However, designing and implementing successful policies requires an understanding of the underlying factors that shape behaviour. These may operate through individual and family circumstances and/or at a societal level, and the factors that predict cessation are likely to be different for the two sexes. Pregnancy can provide a powerful motivation to quit and Sweden in particular has sought to use this phenomenon as a cornerstone of its policy towards women.⁶

UK based evidence⁷ suggests that tobacco dependence, estimated by the average daily consumption of cigarettes, is another important predictor of cessation among women, with quitters being disproportionately drawn from the largely atypical group of women smoking less than ten cigarettes per day. Increasing cessation rates among heavier smokers in the female population is

thus a major public health challenge, pointing to the importance of primary prevention. The majority of smokers take up smoking in adolescence, and in most countries of the European Union the observed prevalence of smokers amongst adolescents predicts further increases among young adults.

Here, too, gender specific analysis of initiation behaviour is likely to improve the design of prevention policies. For example, recent work based in France⁸ suggests that the influence of family smoking patterns is greater on girls than on boys. Whilst for both sexes the impact of peers is even greater than the role model of parents, different behavioural mechanisms seem to be operative in girls and boys. Boys model themselves directly on the behaviour of the group they want to join – they smoke to be just like the others – but girls are more likely to smoke to distinguish themselves from the crowd.

In a UK study, smoking was also differentially related to peer group affiliation and status by gender with 'top' and 'bottom' girls most likely to smoke, while 'top' boys were less likely to smoke, in part because of their involvement in sport.⁹ The social significance of smoking is thus different for boys and for girls, and it also differs between the cultures in which they live. Successful prevention messages need to take this into account.

The future development of gender-specific tobacco control policies

In the European Union the prevalence of female smoking has risen sharply since the end of the Second World War. The number of female deaths caused by smoking rose from 10,000 in 1955 to 113,000 in 1995 and given the long time lags involved, the burden of mortality and morbidity will continue to increase sharply in the new century. Deaths among women from lung cancer doubled between 1973 and 1992. These trends have been described as a major failure of public health. What is to be done?

First, in Europe, much research into the determinants of tobacco use and the impact of tobacco control policies is based on very specific studies in individual countries. We need to understand better the general applicability or otherwise of the existing research base to all countries of the Union, and beyond. The report of the INWAT seminar proposes structures within which this work might be taken forward. The seminar also identified an important bio-

“There are many graphic illustrations of how tobacco industry promotion exploits a desire for social and professional emancipation amongst women in some societies.”

“there is a need to promote gender specific tobacco control policies to priority status”

medical research agenda to investigate the impact of nicotine use on women's health, as had its forerunner, the Paris Conference.

As important is the need to refine our understanding of what works in the field of tobacco control and how interventions can be designed and coordinated as cost-effectively as possible to reach target populations, particularly women of different ages and in different circumstances. INWAT will carry this work forward by drawing on the extensive experience of its active membership and world-wide networks.

Finally, there is a need to promote gender specific tobacco control policies to priority status in the minds of national policy makers. This can be done by presenting arguments and suggesting strategies and policies based on the best possible evidence, and by joining forces with women's groups and other international organisations dedicated to improving the

social status of women in general.

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Tobacco control in Poland



Witold Zatoński



Emily Harville

“Hungary, which showed similar patterns of cigarette consumption and lung cancer during the 1980s but did not implement substantial tobacco control policies, now has soaring rates of tobacco-related diseases, including unprecedented levels of lung cancer among young women.”

For Poland, as for other Eastern European countries, the high rate of premature death among middle-aged adults is a large challenge. From the mid-1960s until the end of the 1980s, a reversal of the epidemiological transformation was observed, though largely hidden by the Communist government: every year more young and middle-aged adult men died than the year before. The chance of a fifteen-year-old boy living to age 65 was lower in some of these countries than in sub-Saharan Africa. This is due almost exclusively to the ‘man-made’ diseases: cancer, cardiovascular disease, and cirrhosis. A major cause of the first two is, of course, tobacco use, and epidemiologists calculate that nearly every second premature death is connected with tobacco-

dependent diseases. In 1990, 60 per cent of cancer deaths, and 40 per cent of all deaths before the age of 65 in Polish men were caused by active smoking.¹

Effects of the market economy

The introduction of a market economy allowed transnational tobacco companies to begin an aggressive marketing push in Poland, a country where smoking prevalence was already high. As in other new markets, multinational tobacco firms bought out domestic cigarette companies and flooded the country with advertisements, frequently associating smoking with freedom and America. Young people and women were particular targets of these advertisements.

In 1982, 62 per cent of men and 30 per cent of women in Poland smoked. Smoking was highest among those with lower levels of education and urban populations. This was a health risk not only to those who actively smoked: 30 per cent of Polish women smoke during their pregnancies. The populations of women with high rates of low birth weight and other obstetric complications are those with high rates of smoking – that is, less educated women in urban areas. Pollution due to environmental tobacco smoke is a threat particularly to the respiratory health of children living with a smoking parent.

Meeting the challenge from tobacco

In the face of these statistics, upon return to democracy, a health promotion lobby was established in Poland to support comprehensive tobacco control. The work of completing and bringing into force legislation promoting tobacco control took 5 years, an unexpectedly long time, due in part to the strong opposition of the tobacco industry lobby. On November 9, 1995, the Law on the Protection of Public Health against the Effects of Tobacco Use was passed by the Polish Parliament and signed by the Polish President. This law aimed to create conditions (education, economic conditions, laws, and addiction treatment) to limit the health effects of tobacco smoking. The government was obliged to create a programme to reduce tobacco smoking and every year have it accepted by the Sejm. The law's most important provisions were:

1. A ban on radio, television, and some print advertising of tobacco.
2. A ban on smokeless tobacco (the ban on nasal snuff was later lifted).
3. Forbidding the sale of tobacco products to minors (under 18 years).
4. A ban on cigarette vending machines and loose cigarette sales.
5. A ban on smoking in schools, health care facilities, and enclosed workplaces, except in designated areas.
6. The ministry of health was given the power to regulate tar and nicotine levels.
7. Treatment of smoking dependence in public health facilities is free of charge.
8. Large health warnings were required on both advertising and cigarette packages. The warning was required to cover 20 per cent of an advertisement and 30 per

cent of a cigarette packages.

At this time, these warnings are the world's largest. They read: "Cigarettes cause cancer and heart disease." Research conducted by the Centre for Oncology Institute indicates that the warnings on cigarette packages are widely perceived. Three per cent smokers stopped, and about 20 per cent of smokers had modified their smoking behaviour due to their introduction, while another 15 per cent felt better informed about the risks of smoking.

Closing loopholes

In 1999, the tobacco regulations were strengthened and the loopholes closed. In particular, the following provisions were proposed:

1. A total ban on advertising, sponsorship, and donations to political parties by tobacco companies.
2. The creation of a fund for tobacco control activities, consisting of 0.5 per cent of the excise taxes collected from cigarette sales. This fund should amount to about \$10 million in 2000.

"The introduction of a market economy allowed transnational tobacco companies to begin an aggressive marketing push in Poland ... multinational tobacco firms bought out domestic cigarette companies and flooded the country with advertisements, frequently associating smoking with freedom and America. Young people and women were particular targets."

On 10 September 1999 this bill passed its First Reading in Parliament by a vote of 374 to 11. It was signed into law on 5 November 1999.

The law allowed for gradually reducing the amount of harmful substances in cigarettes. Levels are currently limited to 15 mg of tar and 1.5 mg of nicotine per cigarette. They will need to be harmonised with the European Union regulations before accession.

Cigarettes remain rather inexpensive in Poland (about 4 PLN = \$1.00), especially in comparison with nicotine replacement therapy. The government will raise excise taxes by a total of 25 per cent over this year, 17 to

18 per cent above inflation. Smuggling has not been a particular problem to this point.

In addition to legislative efforts, community and population based public health campaigns throughout the country have informed people of the risks of smoking and have encouraged smokers to quit. The focus of these efforts are two annual events, namely the WHO World Day without Tobacco on May 31, and the Great Polish Smokeout, "Quit smoking together with us", in the third week in November. Organised by the Oncology Institute and the Health Promotion Foundation, these campaigns are broadly recognised and are supported by groups ranging from the national airline to the national television stations to the Roman Catholic Church. Each event incorporates contests (the grand prize of the quit and win contest being a trip to Rome and an audience with the Pope), media broadcasts, outdoor festivals, public service announcements, scientific conferences, educational meetings for educators and health workers, and telephone hotlines. As a result of these campaigns, over two million Poles have stopped smoking. In addition, several year-round, community based anti-smoking efforts are in place.

The National Tobacco Strategy

Poland's National Tobacco Strategy has been developed from 1996 to 2000. Accepted by the government in 1997, pilot implementation was begun in 1997, with national implementation beginning in 1999. This strategy focuses on accelerating the current positive trends, encouraging smokers to quit, protecting children, and working with local communities and workplaces.

Poland's tobacco control strategies are considered exemplary by health organisations worldwide, including the WHO. As a result of these efforts, recent years have seen a decline in smoking levels, especially among older and better-educated people. Surveys indicate that a large majority of Polish smokers want to quit. The number of ex-smokers has correspondingly grown; today one in five adult males is an ex-smoker. Tobacco industry figures show that cigarette consumption has declined by ten per cent over the last ten years. Eight to

ten thousand fewer Poles died of tobacco-related diseases in 1998 than in 1991. Lung cancer has shown a stabilisation or downturn in several age cohorts of men, and overall cardiovascular disease rates are falling. As a comparison, Hungary, which showed similar patterns of cigarette consumption and lung cancer during the 80's but did not implement substantial tobacco control policies, now has soaring rates of tobacco-related diseases, including unprecedented levels of lung cancer among young women.

However, in Poland in 1998, 19 per cent of women and 39 per cent of men, or nine to ten million people, together smoked about 90 billion cigarettes. Smoking is most common among those with only a primary education, living in urban areas, and regarding themselves to be in bad economic situations. The tobacco marketing strategies have proved particularly effective among youth, whose rate of smoking has been rising, especially for girls, even as the age of initiation has been falling. Twenty-eight per cent of 15-year-old Polish girls were current smokers in 1998, as opposed to 16 per cent in 1990. Nevertheless, overall, a greater percentage of boys smoke.

The level of smoking by Polish men is currently comparable to that of Western European men, and lower among Polish women than among Western European women. However, the number of teenage girls taking up smoking indicates that the levels may soon be equal. Levels of smoking among youth are lower or comparable to those in neighbouring Germany and the Czech Republic.

Current and future emphases for Polish tobacco control are:

- Targeting youth and women in tobacco control efforts;
- Harmonising tax and harmful substance levels with EU directives;
- Encouraging current smokers to quit;
- Educating the public, particularly parents, teachers, and health educators, on the dangers of passive smoking;
- Making nicotine replacement therapy widely available;
- Training health professionals in treating nicotine addiction.

Together, these will make a major contribution to the health of the Polish people as Poland takes its place as a member of the European Union.

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The illicit trade in cigarettes in the European Union

*“Smuggling is a serious problem, but...even where it occurs at high rates, tax increases bring greater revenues and reduce consumption. Therefore, rather than forgoing tax increases, the appropriate response to smuggling is to crack down on criminal activity”.*¹

According to the report of the European Parliament on the community transit system, the market in contraband cigarettes in European Union would appear to be in the region of 60 billion cigarettes a year.² Since the publication of the report, the situation has worsened in some countries, such as the United Kingdom, where Customs and Excise estimates that in 1999 £2.5 billion in revenue will have been lost through the illegal trade of tobacco products. Increased smuggling is a real concern for many governments. In its report on tobacco product taxes, the European Commission stressed that the smuggling factor must be taken into account when a tax increase is being considered, as the public-health objective of reducing consumption through high taxation will fall short of its target if tobacco products evade this taxation.³

However, combating smuggling is possible: the experience of the EU cigarette task force in Andorra has demonstrated that close cooperation between Member States and effective coordination at Community level, can expose major instances of smuggling. The response to smuggling is not to lower taxes, but to crack down on criminal activity, as the World Bank report suggested.

The Andorran connection

For several years Andorra has been one of the sources of cigarettes smuggled in the European Union. In 1995–1997 the operations began to take place on a very large scale. Large quantities of cigarettes smuggled out of Andorra were seized by the Spanish, French, British and Irish authorities.⁴ The brands of cigarettes imported in Andorra in 1997 suggested that a large part of them was intended for the British and Irish contraband market. Exports from the UK to Andorra for instance increased from 13 million cigarettes in 1993 to 1,520 million in 1997. Taking into account that almost none of these cigarettes were legally re-exported, that Andorra only has a popu-

lation of 63,000 inhabitants and that smokers in Andorra on the whole do not smoke British brands, it was evident that these exported cigarettes would end up in the illegal market.

The unavoidable question was to what extent the tobacco companies were aware of what was happening with their products. It remained hard to believe that the British companies did not know that they were supplying to smugglers. In a recent BBC broadcast, Per Knudsen, the chief EU fraud investigator, said: “British tobacco manufacturers must have been aware that the sudden increase of the brands to Andorra could not be explained by the normal market, either in Andorra or in any of the neighbouring countries, simply because these brands are not widely sold outside the UK and Ireland.”⁵ The Gallaher spokesperson defended his company’s policy. “We will sell cigarettes legally to our distributors in various countries. If people, if those distributors, subsequently sell those products on to other people who are going to illegally bring them back into this country, that is something outside of our control.” The BBC journalist added: “I suggest it is within your control, because you could stop supplying them”, to which the Gallaher spokesperson replied, “That would do nothing to influence the degree of smuggling, because the smugglers would just bring back somebody else’s product.”⁵

Once the companies accept this mode of competition, it hard to see how they can avoid treating smuggling as though it is simply an important distribution channel, with every effort being made to develop the channel and grow sales volume through it.

Smuggling in Andorra has been resolved as the result of combined efforts of the anti-fraud division of the EU, France, Spain, UK, Ireland and Andorra. According to estimates of the anti-fraud division of the European Commission (UCLAF), in May 1997 contraband cigarettes accounted for



Luk Joossens

“British tobacco manufacturers must have been aware that the sudden increase of the brands to Andorra could not be explained by the normal market.”

12.5 per cent of the total Spanish cigarettes market, but by May 1998 this had fallen to 6.7 per cent. The new Andorra anti-fraud law, combined with the tighter border, controls has led to a sharp fall in smuggling of cigarettes in the region. The anti-fraud law strengthens penalties against non-compliance with customs requests, breaking customs seals, false declaration of imports and exports, attempting to bribe a customs official as well as falsification of official documents.⁶ UCLAF estimates that this improved fraud prevention policy should prevent losses of an estimated 300 million ecu in VAT and excise from the exchequers of the various Member States.

A complex problem

It has been argued that higher taxes will contribute to increased smuggling and associated criminal activity. The level of tobacco taxation alone cannot explain smuggling. Public tolerance, a culture of street selling, the presence of organised crime and the complicity of the industry are also factors that determine the level of large-scale smuggling. There is little evidence of smuggling in most of the countries with the highest taxes in Europe, while in Spain, Italy and many Central and Eastern European countries, where taxes are much lower, the illegal sale of international brands of cigarettes is widespread.

The experience in Andorra has shown that there exist better solutions to combat smuggling than to lower taxes. The example of Andorra has also shown that tobacco companies will make their products available to the illegal market, if competitors are doing it also. Kenneth Clarke, deputy Chairman of the largest international tobacco company in Europe (BAT), said recently that tobacco companies have a dilemma: "Where any government is unwilling to act or their efforts are unsuccessful, we act, completely within the law, on the basis that our brands will be available alongside those of our competitors in the smuggled as well as the legitimate market."⁷ An editorial in *The Guardian* the following day suggested that this was an incredible admission.⁸

Cigarettes are usually smuggled in transit between their country of origin and their official destination. Transit is a concession system aimed at facilitating trade. Its essence is to allow the temporary suspension of customs duties, excise and VAT payable on goods originating from and/or destined for a third country while under transport across a defined customs area.

However, many cigarettes fail to arrive at their final destination and 'disappear' during their international transport. Organised smugglers can buy a container of 10 million cigarettes, on which they no pay no taxes under the 'in transit regime', for 200,000 euros. The fiscal value of this quantity of cigarettes varies in the countries of the European Union between one and two million euros. Is it still acceptable that there are cigarettes exported for which there is no legal market, as shown in the example of Andorra? Is it still acceptable that cigarettes are exported without the advance knowledge of national and EU Customs authorities of the final legal destination of the cigarettes?

Taking action

Cigarette smuggling can be reduced, but action must be taken at national, European and world levels. At the international level, the WHO Framework Convention on Tobacco Control should contain a specific protocol on smuggling. In May 1999 the World Health Assembly passed a resolution calling for work to begin on the Framework Convention on Tobacco Control – a new legal instrument that may address issues as diverse as tobacco advertising and promotion, agricultural diversification, smuggling, taxes and subsidies. WHO and Member States plan to have the Convention process completed by 2003.

At European level, record-keeping and tracking systems are needed which place the onus on the manufacturers to prove that cigarettes arrive legally in their end-user markets. Cigarettes should only be transported if all the intermediate traders, the route and the final destination are known. A computerised control system should enable countries to carry out real-time checks and risk analysis prior to the dispatch of each consignment of tobacco products. In this way, countries will also be informed of each individual consignment and will be able to carry out targeted on-the-spot inspections as and when they choose. Each manufacturer of tobacco products should be required to print a unique, legible serial number on all packages of tobacco products. This will enable the authorities to identify the manufacturer of the product, the location and date of manufacture. A chain of custody mark should be required, which would not only tell officials the identity of the manufacturer, but would also indicate the distributor, wholesaler and exporter and the final destination.

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Tobacco control in Europe: progress and challenges

The World Health Organization's Tobacco Free Initiative¹

"The pressure to change comes from a rising awareness in Europe and globally about the way in which the tobacco industry has for years deceived the public."



Derek Yach

Trends and impact

The impact of tobacco on the health of Europeans has been extensively described. For decades studies and routine statistics have shown that tobacco constitutes the largest single contributor to premature death and disease in the region. Currently, about 1.2 million people die annually from tobacco, a figure that is expected to increase to 2.4 million by 2020. Death rates in the United Kingdom and Nordic countries continue to decline while death rates are expected to increase in the Central Asian Republics as well as among women in most countries.

According to the most recent country specific prevalence figures, there is a significant difference between the west and east European countries. For example, the following gradient in smoking prevalence exists amongst men: the smoking prevalence rates are less than 40 per cent in Norway and the United Kingdom, and are approximately 45 per cent in the Southern European/Mediterranean countries, in contrast to prevalence rates of between 50 and 60 per cent in the Eastern countries and 63 per cent in the Russian Federation. For women the situation is quite the opposite: smoking increases from an average of 20 per cent in Central and Eastern countries to about 30 per cent in the Western and Northern European countries, with 27 per cent of regular smokers in France, and 32 per cent in Norway.

The WHO/CDC supported Global Youth Tobacco Survey, conducted in 1999 in the Russian Federation (Moscow) and Ukraine (Kiev City) showed high rates of early initiation into tobacco use. In the Russian

Federation 22.4 per cent of 13 to 15 year olds reported initiating cigarette smoking before age 11. In Ukraine this figure was 24.5 per cent. These percentages are very high by international comparisons and a cause for concern.

European researchers have clearly demonstrated the linkages between poverty, inequalities in health and tobacco use. Tobacco use and death rates from tobacco are substantially higher among the lowest social classes than among the wealthier. This has been demonstrated to be the case for Poland, the United Kingdom and Sweden. Similar trends can most likely be demonstrated for most European countries, and therefore tobacco control represents a powerful means of reducing social inequities in overall health status.

Tobacco industry actions

The actions of the tobacco industry have profound implications for national, regional and global control. Recent actions of importance in Europe include increased concentration of resources, efforts by the tobacco industry to re-invent its public image and continued investment in new products and new forms of promotion.

Considerable structural change in recent years has involved European companies. For example, British American Tobacco (BAT) acquired Rothmans while Japan Tobacco purchased RJR Tobacco International (RJRTI). The international market is now dominated by an 'triopoly': Philip Morris, BAT/Rothmans and Japan Tobacco International, which has a major part of its investment in east and central Europe.

At the regional level, France's Seita recently merged with Spain's Tabacalera to form Altadis. Adding to these colossal mergers, national governments from most parts of the world are actively seeking to sell parts or all of their tobacco assets. For example, after selling 65 per cent of its tobacco holdings to Philip Morris in 1996, the government of Portugal has been planning to sell the remaining 35 per cent.

The major tobacco companies now acknowledge the health risks caused by use of their products and increasingly have tried to offer financial support to governments in Europe for programmes aimed allegedly at reducing youth smoking. Most governments have not been fooled by these offers!

“In France, the liberalisation of nicotine replacement therapy (NRT) and reimbursement of treatment products meant consumers had a better chance of quitting.”

The pressure to change comes from a rising awareness in Europe and globally about the way in which the tobacco industry has for years deceived the public. Its knowledge about the health effects of tobacco; about how it has designed cigarettes as nicotine delivery devices; about how it has set up a vast network of front groups throughout Europe to oppose all legislation and taxation policies and has continuously nurtured doubt about the impact of tobacco use and passive smoking on health is now public knowledge. These practises continue today but are increasingly coming under the spotlight of evidence extracted from the tobacco industry documents, which were released into the public domain as result of the settlement of the American litigation cases. This evidence is helping governments to act more decisively against tobacco.

Successful actions at country level

For decades some of the world's best examples of effective tobacco control have been found in Europe. Although Finland was once the world leader in tobacco consumption, it is now a world leader in tobacco control. In the 1960s, its Parliament requested the government to take strong and immediate legislative measures to reduce smoking. Incrementally, comprehensive legislation has been introduced over a few decades. An early ban on advertising as well as smoking in public places

has been supplemented since then to cover such areas as indirect advertising and protection from smoking in the workplace. Smoking rates in Finland are now among the lowest in Europe at 30 per cent for men and 20 per cent for women in 1988.

France and Sweden have more recently adopted comprehensive tobacco control programmes, and consumption has decreased accordingly. For instance, between 1991 (the adoption of the Evin Act) and 1996, France experienced a drop of 8.5 per cent in tobacco consumption. Sweden has also been incrementally strengthening its tobacco control programmes, and has achieved particular success in smoke-free areas as well as targeted programmes and partnerships to reduce smoking among women. Progress is measured by the change in smoking prevalence between 1980, when 36 per cent of men and 29 per cent of women smoked, and 1997, when the figures were 17 per cent and 22 per cent, respectively.

The United Kingdom has used a combination of legislation, including European Union directives, as well as voluntary agreements with the tobacco industry. Although tobacco consumption among adults has steadily been declining, there was, until recently, mixed political support for more effective policies. However, in recent years, tobacco control in the United Kingdom began to change dramatically. In 1998, a White Paper on tobacco, 'Smoking Kills', was introduced, which includes substantial funding for tobacco control, increased support for cessation, and tough new targets for tobacco control. Poland also represents a recent European success story (see article by Witold Zatoński and Emily Harville in this issue).

Despite the evidence of substantial morbidity and mortality from tobacco, countries such as Germany and Switzerland have been slow to take action on tobacco. Even a comprehensive study on the economic losses in Switzerland due to tobacco has not yet led to real action. Considering such obstacles it is therefore not surprising that many East and Central European countries face formidable challenges from the tobacco industry when efforts are made to introduce even modest laws.

Stronger national action: enhancing capacity and new partnerships

The WHO European Regional office has for decades carried out actions aimed at building the capacity needed within all

countries to develop and implement comprehensive multi-sectoral policies aimed at preventing tobacco use, increasing cessation and reducing exposure to tobacco smoke. The hallmarks of these policies have been: increasing the price of tobacco products, bans on advertising and sponsorship, mass communication and health education programmes, restricting youth access to tobacco and the provision of smoke free areas.

Although there seems to be consensus on what needs to be done to control the tobacco epidemic, there is still considerable difficulty in knowing how this is to be done in each country. Addressing this question of how to do it in country specific circumstances, especially in the areas of legislation, economic interventions, and policy interventions is the challenge ahead. However, this also represents the greatest opportunity to achieve sustainable change. To this end, development of conceptual frameworks to assist European policymakers to understand how to control the tobacco epidemic within the legal, economic and political realities of their countries is receiving the highest attention by WHO.

In addition to long-term primary commitments, a new and novel partnership has developed that complements and strengthens existing work. Established in 1999, the WHO European Partnership Project to Reduce Tobacco Dependence is a public/private sector partnership whose membership represents key policymakers from ministries of health, scientists, non governmental agencies, research groups, media companies, educational institutions and international organisations spanning the European Union and the Accession States. Working together with four private pharmaceutical companies, WHO has increased its capacity to reduce tobacco dependence through the creation of an environment that encourages smokers to quit, by making treatment easily available, accessible, and affordable.

The Partnership Project funds original research projects, and tangible products designed to bring about changes in the policy environment that will encourage smokers to quit; organises workshops to promote consensus on treatment issues; and establishes links to worldwide developments on the treatment issue.

Endorsement from the WHO Director General at the 1999 World Economic Forum, Davos, signalled that the Partnership Project was a highly credible

initiative, and a model for public/private sector partnership. This was followed by ministerial support from the four initial pilot countries: France, Germany, Poland and United Kingdom. The aim is to disseminate lessons learned from these pilot cases, first Europe-wide and then globally.

In 1999, the Project contributed to a number of key policy developments in the target countries. In the United Kingdom, the White Paper 'Smoking Kills' strongly emphasised the effectiveness of treatment and advocated far wider accessibility. In France, the liberalisation of nicotine replacement therapy (NRT) and reimbursement of treatment products meant consumers had a better chance of quitting. In Germany, the appointment of a full time national coordinator by the German Ministry of Health has supported implementation of the Partnership Project. Moreover, Poland introduced major legislation for tobacco control, far ahead of that in existence in many EU countries.

A joint initiative has been established with the World Bank to disseminate evidence on cost effectiveness of treatment products through events and activities organised under the Partnership Project and the Committee for Tobacco Free Europe.² To reach smokers, a global media campaign on 'How to Quit Smoking' is underway.

Interaction between EU Directives and global control

The EU has led the world in approving an advertising ban. The current negotiations on an EU directive on tobacco product regulation will also have major international implications. WHO-EU collaboration in this area will be essential for global success. A WHO meeting addressed this issue recently in Oslo and recommended that within the context of comprehensive tobacco control policies, product regulation should be given explicit and urgent attention in order to reduce the health impact of tobacco use among smokers. Participants in Oslo urged governments to implement the most effective strategies to achieve a unified regulatory framework for nicotine delivery products, including tobacco products, products for treating tobacco dependence, and novel nicotine delivery devices, whether or not these are based on existing tobacco products. International collaboration should start by WHO establishing under its authority an international scientific advisory group on tobacco and nicotine delivery devices to guide international policy development in this field.

"The EU has led the world in approving an advertising ban."

**WHO's new transnational initiatives:
visible media and stronger
international laws**

The media is critical to successful tobacco control. For that reason a new global media project has been launched by WHO. Four countries in Europe are part of this global media and NGO advocacy campaign entitled 'Tobacco Kills - Don't be Duped'. Ukraine, Germany, Switzerland and Norway will join Thailand, Zimbabwe, Brazil and China (to name a few) in this pilot project that aims to strengthen the ability of health communicators to sift facts from fiction about tobacco use, its spread

"A major landmark in the World Health Organization's fifty-year history took place during the 52nd World Health Assembly in May 1999."

and promotion. The campaign's principal remit is to support public policy makers to ensure that effective comprehensive tobacco control measures become a reality.

The Tobacco Free Initiative (TFI) recognises that strong support and active involvement of the NGO community is essential for securing sustained action and support for tobacco control. Following Dr. Brundtland's call for active involvement of the NGO community in WHO's decision-making process, the Paris-based International Non-Governmental Coalition Against Tobacco (INCGAT) and the London-based Action on Smoking and Health (ASH) have brought together representatives from a range of NGOs worldwide to explore activities on issues of common concern.

The content of a global media and NGO campaign needs focus: a new international treaty provides that focus. A major land-

mark in the World Health Organization's fifty-year history took place during the 52nd World Health Assembly in May 1999 when WHO's 191 member states adopted, by consensus, Resolution WHA52.18, which paves the way for WHO's first legally binding global convention. This decision starts a process leading to formal negotiations on the text of a Convention and related protocols. Formal negotiations will commence in about October 2000, and it is planned that the Framework Convention on Tobacco Control (FCTC) and first protocols will be adopted by the year 2003.

The framework convention protocol approach has been used successfully to address environmental, arms control, trade, and human rights issues. The FCTC and related protocols could address issues such as smuggling, tax-free tobacco products, advertising/sponsorships, testing methods, package design/labelling, information sharing, agricultural diversification, and the regulation of tobacco. The eventual content of the FCTC and the related protocols will depend on WHO's Member States, as the negotiation of binding treaties is a prerogative of sovereign States.

Resolution WHA52.18 provides a mechanism for regional economic integration organisations constituted by sovereign states, for instance the European Community, to participate actively in the work of the intergovernmental negotiating body and working group established by the Resolution.

The first meeting of the FCTC Working Group in October 1999 coincided with Finland's Presidency of the European Union. This was fortuitous given Finland's exemplary work and leadership in the area of tobacco control and their recognition that there is a limit to national action. Globalisation is greatly influencing tobacco use throughout the world. In this respect, the FCTC with its related protocols will provide a global complement to nationally and locally based actions.

Conclusion

Combined tobacco control efforts at national, regional and global levels are at last starting to be given the political support needed to address a public health threat of enormous impact. WHO, with the visible and committed leadership of Dr. Gro Harlem Brundtland, is committed to support countries and international partners in really making a difference to an entirely avoidable epidemic.³

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Dimensions of citizen involvement in health care

“individuals still know more about the meal they eat for dinner in a restaurant, and about the past experience of the head chef, than they know about the treatments they undergo in their national health care systems”



Richard B Saltman

Health system reform in Europe in the 1990s has encompassed a wide variety of topics and actors.^{1,2} Provider institutions, health professionals, public and private payers, and political authorities have all seen major changes in their roles and responsibilities. The one actor whose relationship to the health system has changed the least, oddly enough, has been the patient. Despite considerable discussion about increasing patient choice, individuals still know more about the meal they eat for dinner in a restaurant, and about the past experience of the head chef, than they know about the treatments they undergo in their national health care systems, about the doctor who will be conducting the procedure, or about the hospital where the procedure will take place.³ Given the relative importance to individuals of having a good outcome from a medical or surgical procedure as against eating a good dinner, this imbalance in information seems hard to justify.

Types of individual role

In conceptualising the role of citizens and/or patients in health care decision-making, a first step is to recognise the multiple capacities in which the same individual interacts with funders and providers.⁴ The substitution of ‘citizen’ for ‘patient’ in part of the literature is only the tip of a sociological iceberg. At any given time, an individual may come into contact with the health sector in many different roles: as a patient; as a subscriber, if s/he has health insurance; as a taxpayer; as an employee, if s/he has social insurance; as a parent; as a son or daughter; as a group member, of various disease support groups; as a voter; and, finally, as a citizen, through commissions, surveys and political activity. Some roles clearly conflict with others. All of

them bear on each of the four types of influence that individuals may have over health systems, as described below.

Types of individual participation

In practice, four different types of activity can be identified within the general category of the patient’s role within health care systems:

- *Choice* of clinical provider (e.g. typically physician and hospital) or insurer
- Patient *rights* (e.g. procedural protections for patients)
- *Influence* over specific elective *treatment* decisions (e.g. clinical alternatives, for example, to deal with prostate problems or with breast cancer)
- *Influence* over system-level *policy* decisions.

While these four elements include the patient rights component of the Citizen’s Charter in the United Kingdom, they go substantially further to encompass a broader swathe of health sector decision making. Each of these four dimensions is becoming a topic of debate in a number of European countries,⁵ as national policymakers seek to respond to the perception that patients still remain the object rather than the subject of the service delivery system.⁶

Types of accountability

The issues of patient choice and citizen’s rights are a central stimulus to the ongoing debate about accountability in health care. All four aspects of patient and citizen involvement are typically advocated by those who seek more accountability from service providers to those who receive care. Yet accountability, much like patient choice, is a summary concept that refers to

a series of different relationships between various actors inside health care systems as well as between those actors and external elements outside the health sector. Moreover, notions of accountability are not uniformly understood within different national health care systems.

Accountability can be defined as whom one reports to, and who has the ability to reward or punish one's actions. In health care systems, one can observe six major types of accountability:

- clinical – legal
- ethical – financial
- professional – political

While there is a degree of overlap between several of these concepts, each of these six types of accountability has its own characteristics⁷ and reflects back differently on the influence of the individual in the health sector.

“One of the more intriguing aspects of current discussions ... is the changing calculus among patient, citizen, provider and administrator.”

(a) clinical accountability

This phrase encapsulates the responsibility of a provider to practice the highest appropriate standard of medical care for a given patient, and to facilitate a transparent process of monitoring and evaluating that quality of care. Clinical accountability can be either informal or formal in nature. Informal clinical accountability has long been practiced in hospitals, through tissue committees, grand rounds, and meetings between senior and junior house staff. Formal clinical accountability has been facilitated by a growing array of external evaluation instruments to measure patient outcomes and physician performance. Formal clinical accountability can also be linked to payment mechanisms, for example to renew existing contracts with doctors and hospitals. Both formal and informal clinical accountability are often viewed as the main and most important form of accountability by clinicians – it is the form of accountability about which they often feel most strongly.

(b) ethical accountability

Ethical accountability in the medical world involves respect for the autonomy and

integrity of the patient. The organising premises of ethical behaviour for a clinician vary a bit among countries, but start with the Hippocratic Oath, ‘first, do no harm’.⁸ They also include no financial ‘kickbacks’ for referrals, as well as – in direct response to managed care in the United States – no denial of care in order to protect physicians’ salary bonuses, and no ‘gag orders’ that prohibit physicians from mentioning certain expensive treatments to their patients. At a health system level, ethical accountability shifts from an individual to a collective focus. The criterion becomes whether the overall organisation of a health system is consistent with, and encourages, the ethical practice of medicine by the individual physician. Examples of health care systems that were not ethical would include the former Soviet Union’s approach to psychiatry, using it as a device to incarcerate political dissidents⁹ or, of course, so-called ‘scientific’ experiments by German physicians on Jews and others during Hitler’s Third Reich.¹⁰

(c) professional accountability

Professional accountability involves behaviour specifically stipulated by the relevant professional association. For a physician, it typically means maintaining the criteria for certification by these professional associations. Sometimes this involves meeting positive criteria like obtaining annual continuing education credits. It usually also includes not violating negative criteria, for example by engaging in socially unacceptable behaviour such as assaulting patients or engaging in gross financial fraud. At a health system level, as with ethical accountability, the criterion becomes whether the overall organisation of the health system is consistent with, and aligned to the norms of, behaviour stipulated by the professional association. For example, whether a health system requires health providers to be certified by the relevant professional association before they can practice.

(d) legal accountability

Legal accountability means just that: what the law requires of providers. This can vary considerably by country. In some countries, it can be a considerably broader concept than in others. In Sweden, for example, Swedish physicians are required to meet the legal criteria of what is termed ‘huvudmaniskap,’ which, roughly translated, means ‘the main responsible party’. Swedish physicians thus must satisfy a strict set of criteria to discharge properly their professional responsibilities. In the US, physicians must be able to prove in

court that their practice of medicine is consistent with ‘accepted community standards of care.’

(e) financial accountability

This form of accountability focuses directly on how available resources are spent.¹¹ There are many creative ways to structure financial accountability, as hospital managers in some countries are learning. A health system, like a physician within it, is ‘financially accountable’ if required to answer for the overall cost of activities, and can be disciplined should these expenditures not meet previously set standards. Financial accountability has been particularly important not only for physician managers but also for the growing number of clinic physicians who are held responsible either for meeting a fixed budgetary allocation or, conversely, for generating sufficient revenues through patient or contract-related payment mechanisms.¹

(f) political accountability

Political accountability involves holding health care professionals responsible to one or another level of government. In a democracy, this also implies holding the overall health system accountable to the citizenry that forms the electorate, and is nominally the political sovereign. Calls for political accountability have grown considerably over the past decade, as systems that were seen to be health-professional-dominated have found their policies and practices increasingly subject to scrutiny by elected political bodies and officials. Different countries design their forms of democratic accountability differently, with a varying mix of explicit elected as against more implicit appointed models of control.

(g) balancing forms of accountability

Every health system in developed or industrialised countries has in place, to some degree, all six of these forms. What differs among countries, however, is the prominence and importance of these different forms of accountability.⁷ Sweden, for example, with its tax-based finance system and its publicly operated hospitals and health centres, can be characterised as predominantly politically and professionally accountable. Hospitals and physicians must justify their managerial decisions to elected county officials, while clinical decisions reflect a strong role of the medical association in setting standards and – when appropriate – sanctions, as agreed upon by representative bodies of the medical profession working with a strong National Board of

Health and Welfare. In Germany, it would appear as though the health sector is predominantly professionally and financially accountable. This reflects the largely self-regulatory character of medical practice in combination with the financial controls exercised by the association of statutory sick funds and, increasingly, the federal government. In the United States, the health sector is predominantly financially and legally accountable, in that private providers (and insurers) are held accountable for their bottom line financial performance by boards of directors and stockholders or by boards of trustees, and for their adherence to community medical practice standards (often through expensive practice of what is termed ‘defensive medicine’) by the judges and jurors of the legal malpractice system.⁸

“the trajectory of individual empowerment may be upward, but there is still a great distance separating patients and citizens from those who hold most decision-making authority.”

Finding a new equilibrium

One of the more intriguing aspects of current discussions about the future role of the individual in health care decision-making is the changing calculus among patient, citizen, provider and administrator. In traditionally organised health care systems, whether tax or social insurance funded, the dominant influence has been the health services provider and especially the physician.^{12,13} With the advent in the 1990s of reform models based nominally on new mechanisms such as contracting (United Kingdom) or patient choice of provider (Sweden), the relative authority of the clinician has probably declined somewhat overall, as the role of administrators and managers has grown in power and authority. In this overall calculus, while the role of citizen and patient now receive more attention, both still remain decidedly weaker than the professional actors within the service delivery structure. In effect, the trajectory of individual empowerment may be upward, but there is still a great distance separating patients and citizens from those who hold most decision-making authority.

One major question concerns the likely

impact of the Internet on the existing allocation of health sector authority. Patients have already begun appearing in physicians' offices carrying printouts about alternative therapies and pharmaceuticals,¹⁴ in effect enhancing patients' ability to participate in treatment decisions. Yet physicians may well be stimulated to search the net themselves, to ensure that their clinical decisions reflect up-to-date, internationally available information. In the end, the Internet will likely become a tool to facilitate a better-informed discussion between patient and clinician about treatment options. If this occurs, patients will clearly have gained a greater role in one important sector of health care decision-making, but in collaboration with, rather than at the expense of, health care practitioners.

“One major question concerns the likely impact of the Internet ... Patients have already begun appearing in physicians' offices carrying printouts about alternative therapies and pharmaceuticals.”

Some concluding balances

The paper has reviewed several key points about the debate on citizen and/or patient participation, and discussed specific typologies through which to filter and interpret both that debate as well as future recommendations about achieving progress in this area. These somewhat disparate issues can be drawn together by describing a set of balances that effective national policy necessarily must pursue. In effect, these are the real issues that policymakers must address. The required balances include the following:

- between choice of provider vs. choice of insurer;
- between logistical vs. clinical treatment forms of choice;
- between clinical, ethical, professional, legal, financial, and political forms of accountability;
- between patients, subscribers, taxpayers, employees, voters, and citizens.

The true test of effective health policy making regarding individuals necessarily lies in resolving these dichotomies, and/or picking among these multiple options to establish practical and sustainable priorities.

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Patient involvement in health care

“As long as governments at every level and other stakeholders such as organisations of pharmacists, insurance companies, doctors, industries and so on are able to use our money to represent their interests and we are the only ones without this possibility, it is not correct to talk about patient centred health care.”

Wherever I go in Europe, at present I hear that the patient is at the centre of health care. This presentation of the central position of patients has arisen mainly over the last decade. Is it just a change in words or has it really changed the world of patients?

In a way, the patient has always been at the centre of health care, since there is no health care without patients. During the time of the humoral pathology, going back as far as the ancient Greeks, the liquids of the patients were disturbed. Thomas Sydenham (1624–1689), sometimes called the English Hippocrates, created the modern concept of disease, watching patients carefully.

Object or participant?

The patient always has been the object of the interest of physicians, a case for treatment. The person suffering from an illness needs instant help, no longer able to care for himself. In this tradition the relationship between physicians and patients developed towards paternalism. What started as an unbalanced relationship between a magician and a sufferer, easily changed into the same kind of relationship between the expert doctor and the lay patient.

The humoral pathology dominated the practice of healing until the second part of the nineteenth century. Since that time we have seen a tremendous growth in the knowledge of the human body and in treatments for previously untreatable illnesses. We have seen sound successes in the fight against infectious diseases: tuberculosis is no longer the killer it once was.

Of course, we have also seen progress in the treatment of other conditions, like diabetes. The invention of insulin in 1926 brought a significant change in the treatment of insulin dependant people with diabetes. Before that, such people died within one or two woeful years. Yet they now survive this condition to grow old. The quality of their life has increased very significantly and yet they are an object, rather than the

principal participant in their treatment.

What we obviously missed is the fact that to be cured is no longer the main question of many people, but how to live with their particular long-term medical condition. They want to be participants in the process and they want to be seen as people with their own responsibility for – and the right to be in charge of – the treatment of their condition.

The growth of the patient movement

The joining together of patients is a rather recent phenomenon. Some groups have a history going back as far as the late nineteenth century. Most organisations however, were established after 1970 and the number of newcomers is still booming.

What we see in Europe is the following kind of organisations:

Self help groups: small local groups of patients with a particular medical condition.

Local, regional and national associations of patients connected with:

- A particular disease or disorder, such as ulcerative colitis;
- A combination of related diseases, such as neuro-muscular diseases;
- A particular organ, such as an association for liver patients.

Regional or national cooperation in umbrella organisations

European cooperation, either in disease specific or disease crossing umbrellas

Associations of parents of young patients.

They are at present mainly interested in genetics and prevention. Their umbrella is called European Alliance of Genetic Support Groups (EAGS)

Consumer organisations, which means organisations for the consumers of health care

Patient rights organisations. Often another word for consumer organisations, but it



*Albert van der
Zeijden*

“What started as an unbalanced relationship between a magician and a sufferer, easily changed into the same kind of relationship between the expert doctor and the lay patient.”

might be an organisation of patients

Summarising we see mainly three types of organisation of patients and health care consumers:

- The organisations of people with a long term medical condition
- The organisations of parents
- The organisations working for consumers of health care

Ten per cent of the population of the European Union has been categorised as having a long-term medical condition, a chronic disease. However small, the group accounts for approximately 60 to 80 per cent of the costs of our health care systems. They act from a perspective different from healthy people, since the disease is no longer their main concern, but rather how to live as well as possible, while accepting the reality of their disease. Health care is necessary to support their participation in society and yet the health care systems are not designed to answer their needs, so they do not feel themselves as the ones being central in health care. This is why they started to organise in the first place. This started and will always start with the so-called self-help groups: small local groups of people with a particular medical condition, with no other goal, than to meet other people to discuss their experiences with their common medical condition and to exchange information.

This exchange of information leads patients to a better understanding of their own situation. It also shows them that it will not be enough to discuss their situation only in self-help groups if the wish is to improve the quality of life. Decisions influencing their lives are very often made on a national or even an international level – and national or international policy making is not usually specific to one disease category.

The International Alliance of Patients Organizations (IAPO)

The influence of patients and their organisations in most countries and in particular on the European level is poor. This is easy to understand since it is a young and until recently a divided group. I stated before that they account for around 70 per cent of the costs of our health care systems, but without organisation their perspective will hardly be seen, since nine out of ten people are healthy and will see the health care system from that perspective. This will encourage health care systems to fit their perspective, rather than that of people with a long-term medical condition. There is a

lot to gain in terms of quality and cost containment in this area.

The International Alliance of Patients Organisations (IAPO) is the final step in the joining together of patient groups. IAPO is a global organisation, including regional chapters, such as IAPO-Europe. IAPO itself is not important, but its vision – to build on the creation of patient-centred health care everywhere – is. It is not IAPO’s wish to compete with other already existing organisations, but by creating a European alliance for all items, which are disease and boarder crossing, it will give a voice and a face to the patient movement in its interactions with other stakeholders and politicians.

People wish to be able to decide about the way they like to live their life. This is only possible if they are informed on a personal and on an institutional level. It also means that they have to be involved as partners in the decision making process on every level: discussing their condition and possible treatments with their doctors, their municipality, county, country and the European Union. The patients are ready now but are governments ready to act?

Expectations

Organisations of parents, healthy consumers and others – they all have a place in the decision-making process. However, if you wish to communicate with the people with a long-term medical condition in order to bring in their perspective, you need to see the people themselves. Without proper financial support, their input will always be weak.

As long as governments at every level and other stakeholders such as organisations of pharmacists, insurance companies, doctors, industries and so on are able to use our money to represent their interests and we are the only ones without this possibility, it is not correct to talk about patient centred health care. In principle it might be well meant, but in practice it will be nothing but lip service. We have to wait until someone is willing to invite us and to pay for our presence, for we mostly do not even have the money to travel to Brussels. Yet the only way to involve the perspective of these people in the health care debates is to include them in the whole process of decision making. Remember what they see as quality of life and what they expect of our health care systems, might be different from the perspective of healthy people and also remember that they account for 60 to 80 per cent of the costs of the systems.

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Herbert Hermans

“The Right to Health Care in Several European Countries”

Synthesis of an expert meeting¹



André den Exter

This article is based on the book, ‘The Right to Health Care in Several European Countries’, which is the result of an expert meeting held in Rotterdam, the Netherlands, in April 1998 and hosted by the Department of Health Policy and Management, Erasmus University. The meeting was intended to discuss the right to health care.

Different perspectives

The right to health care – that is, access to health care services and facilities – can be observed from different perspectives. One major perspective is the role of principles, international and European law, national law in Constitutions, acts and regulations and, moreover, the role and function of the courts. Another perspective is the organisational dimension of the right to health care. Different actors play important roles, sometimes they cooperate in the same

direction and sometimes their focuses are quite different and even contradictory. A third perspective is the perspective of the different actors both on an international and a national level. The following scheme was used to focus the discussion on the different actors’ roles and the different ways of regulating the right to health care.

The principal rights and actors

The principal actors in the health care arena who have a say in relation to the right to health care are international organisations such as the World Health Organization (WHO) and the Council of Europe. The WHO Regional Office for Europe has developed a systematic approach to the issue of patients’ rights and health care (Vienonen: 17–29). Studies were carried out and research results have been published. The framework for developing patients’ rights was laid down in the Declaration on the Promotion of Patients’ Rights in Europe (1994) which provides a useful ‘check-list’ of pertinent issues. A further development in this respect was the 1996 Conference on European Health Care Reforms in Ljubljana, which offered an analysis of citizens’ choice and patients’ rights in the context of changing health care systems. The Ljubljana Charter on reforming health care in Europe endorsed fundamental principles that should apply when countries are changing their systems. Increasing consideration has been given to these issues on the national level by the national legislators, which resulted in new legislation on patients’ rights and the revi-

Different levels	Major actors	Major legislation
International level	United Nations WHO	Principles in International treaties Declarations
European level	Council of Europe WHO Regional Office European Commission European Court of Justice	Treaties Declarations
National level	National Governments (Constitutional) Courts National Health Service (national) health insurers (national) provider organisations (national) patient organisations	Constitution Acts Regulations
Regional level	Regions regional health services (regional) health insurers (regional) providers (organisations) (regional) patient organisations	Agreements Self regulation
Local level	Communities community health services (individual) providers (individual) patients	Contracts

“the changing interpretation in the international legal literature, confirmed by several European Court judgements, seems to strengthen the nature of the social right to health care. It is questionable what the effects will be on government’s role in guaranteeing access to it.”

sion of existing legal provisions in acts and regulations.

Distinction between social and individual rights

The analysis of patients’ rights distinguishes between social and individual rights. The right to health care could also be regarded as part of a broader right to care for health (Leenen: 31). This right also includes the right to health protection and promotion. It has to include necessary health care that is vital and part of the necessities of life. From this perspective it can be further differentiated into specific categories like general health services which are vital and indispensable to every citizen (primary care, treatment of diseases and emergency care); health services for those who cannot live independently and have to be cared for; health services for the severe sick and handicapped.

Because the right to health care is often regarded as just a social right, this would imply that governments themselves have to organise the health services (without necessarily being involved in performing health care). Generally considered as a ‘moral obligation’, governments have a certain ‘margin of discretion’ in deciding the extent of access to health care. However, the changing interpretation in the international legal literature, confirmed by several European Court judgements, seems to strengthen the nature of the social right to health care. It is questionable what the effects will be on government’s role in guaranteeing access to it.

Imbalance of powers within national states

Health care demands almost always exceed supply and making choices in health care is therefore unavoidable. This refers to a further dimension of the right to health care and the imbalance of powers within the national states between the major actors in the health care arena: governments (national, regional and local), insurers/third-party payers, providers and patients (organisations). The weakness of the latter calls for strengthening their position in direct and indirect ways.

Right to health care is a multidimensional concept

From the different contributions and discussions, it emerged that the right to health care has to be considered as a *multidimensional* concept. It is changing over time and its content varies from country to country.

It must also be linked to available financial resources – empty promises may lead to more serious negative social and political consequences (Sheiman:110). A right to health and health care therefore seems also to be influenced by the extension in social protection, the macro-economic policy environment and changes in the character of a private health care sector. In general, nations with a larger economic potential can redistribute a relatively larger portion of their national income and allocate larger resources for public financing of health (Sheiman).

Cost containment and cost control

In many countries governments are searching for a balance between the rights of patients to health care on the one side and cost containment and cost control on the other. The introduction of co-payments can have serious implications for the right to health care. Increasing stringent policies (like in Italy) to control public expenditure in general and public health expenditure in particular have contributed to a changed role of jurisprudence and court decisions on the content of the right to health and health care (G. France: 53). In Eastern Europe in particular the right to health care has gained importance because of the radical changes of the political system which have been followed by social reforms (Baginska and Nesterowicz: 115-125). Sometimes provisions in the constitutions guaranteeing citizens free treatment could not be performed because of growing economic problems.

In the very near future, the legal impact of cost sharing measures, as part of the discussion about choices to be made, will increase in importance. Particularly in CEE countries such measures impel a societal debate. Characterised by stigmatised concepts this controversial issue needs a rational value related debate. Until now, normative principles such as the non-discrimination principle threatens to be subordinated by economic objectives which dominate the discussion. Clearly, developing and maintaining an affordable health care system is an important motive in the reforms discussion. Nonetheless, disregarding the legal dimension may even endanger the initiated reforms. Illustrative is the conflicting relationship of certain cost sharing measures with international accepted standards such as the ILO conventions. Might judicial procedures and/or judgements also occur in CEE countries? It is by no means clear that such an interest transgresses national

disputes, which every state has a legal interest in protecting (candidates *erga omnes*).

Despite the uncertainty of the acceptance of the binding effect of both the ILO-Conventions and the (revised) European Code, the potential threats to proposed or already accepted types of cost sharing measures could be substantial. If accepted, the conflicting character of cost containment measures with international documents should be reviewed case by case. Since the scope of own contributions of certain types of care can be quite considerable, the consequences of a posteriori, illegitimately judged measures may threaten the motives that underpin health care reforms. This problem may arise in the short term because recently modified Constitutions already anticipate health care curtailments, despite potential controversy (e.g., Slovenian Constitution, Czech Charter of Fundamental Rights).

The quality dimension of the right to health care

Another dimension of the right to health care refers to the question of how physicians and other health professionals influence and sometimes divert policy makers' intentions about the right to health care and health care delivery (Harrison: 81). Physicians and other professionals greatly influence policy implementation. Top-down quality programmes have been met with opposition and criticism and the use of market incentives to enhance quality in Sweden pointed to the sensitivity of physicians, nurses and hospital managers to direct incentives for increasing productivity. Individual physicians and their associations prefer models of quality assurance. Case studies in Britain, Sweden, Germany and the Netherlands provided evidence that the implementation stage is a critical one in the policy-making process, and that it can be shaped significantly by physicians. In the design and implementation of programmes, policy makers may better assure the cooperation of health practitioners. Therefore, does the last word go to the health professionals, and what is the influence of medical criteria?

Right to health care: A useful concept?

These and other questions, such as the implications for solidarity, have been discussed on the basis of the contributions in the book. Is the right to health care constrained by cost control measures or, on the contrary, is the right to health care to

be seen as a defensive safeguard towards financiers? There is the danger that everything could be brought under the umbrella of the right to health care. One of the most important outcomes of the Rotterdam meeting is that we should regard this right in a focused fashion and analyse the right to health care by filtering the issues at stake. So the targets keep changing. From the patients' point of view there is an increased demand for better medical care, but there is always someone who must provide it. In every country health is highly valued but we should also look at the reverse side of the coin, or as Evans put it: 'A dollar spent on health care is a dollar gained by the health carer'. Therefore, the ongoing debate on the right to health care needs to be 'redressed'. In the very near future, more focus should be placed on the package of health care and health care benefits and the question of what constitutes 'necessary' care should be examined more thoroughly. Is it that only evidence-based medicine counts because vulnerable groups could be endangered, or is it more a question of how to define the boundaries?

The role of judicial power

More and more outcomes of macro-level decision-making concerning priorities will be brought before the courts. A number of questions arise here. What role should the judiciary play in the health care debate? Which judicial powers should be applied? Is this development advisable or not? What criteria should be used – only medical criteria? The danger of undesirable medicalisation of the judicial procedure is not unthinkable.

To conclude

The Rotterdam meeting did not result in the enumeration of a series of concrete recommendations to health policy-makers. As such, the papers and above-mentioned considerations may function as a starting point to further inquiry. It was intended as a first step in an on-going academic discourse designed to exchange knowledge and experience on the right to health care. As in any debate, the process of learning has to include both successes and failures, all of which have been described by the various contributions to this compilation of articles.

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"The question of what constitutes 'necessary' care should be examined more thoroughly."

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The following collection of articles appear on the occasion of the 'Winning Hearts' conference which took place in Brussels on 14 February 2000, organised by the European Heart Network with the support of the European Commission.

Cardiovascular disease in Europe



*Robert Coleman
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EU. These statements were clearly confirmed at the 'Winning Hearts' Conference, which was organised with the Commission's support in Brussels on 14 February 2000.

It is therefore pleasing to note that Portugal, as the current Presidency of the Council, has taken the initiative to hold a conference on health

effectively contribute to improving health in general. Attitudes towards risk factors can be changed: people can stop smoking, they can find time for physical exercise, and they can change their diets. High serum cholesterol levels and high blood pressure can be reduced. But healthy choices to enable these changes must be made available, which are both attractive and affordable.

This is a major challenge. We are all more or less aware that certain changes in lifestyle can lead to substantially improved health. But the way to achieve and sustain such change is difficult and complex. Efforts to encourage healthier lifestyles must therefore be professionally sound, well coordinated and determined.

What can the EU do?

The EU has in the past tried to contribute in various ways to the fight against CVD. We will continue to do so, and will strengthen our actions where possible. Last year the Treaty of Amsterdam, which gave new prominence to health and strengthened provision for public health, came into force. The new Commission has made health one of its key priorities. Moreover we are currently finalising our new health strategy including a proposal for an action programme in the field of public health.

Furthermore, the Treaty places an obligation on all institutions to ensure a high level of health protection in the definition and implemen-

“people can stop smoking, they can find time for physical exercise, and they can change their diets”

One of the challenges in the context of our actions and policies for a healthier Europe is cardiovascular disease (CVD), which in fact comprises a large group of diseases including stroke. CVD is still the greatest health scourge globally and the major cause of death and disability in Europe. It causes nearly half of all deaths, much human suffering and also significant social and economic costs. Moreover, on present trends, it will be even more of a threat in the future.

The problem

CVD is by no means – as often thought – only a killer of men and old people. Many deaths and many disabilities are among middle-aged women, and people in lower socio-economic groups. In other words, this disease may also be caused by inequality in health. Inequality in health in general is not only a major challenge for us today within Europe, but it is one that is likely to grow with the enlargement of the

determinants in March 2000. The Commission has been pleased to support this initiative, which will offer an opportunity to discuss and examine the latest information and should produce important new ideas for our activities.

However, even though the problems are huge, there are reasons to be optimistic. Illness and premature deaths from CVD are largely preventable. We have medical and epidemiological knowledge as bases for effective prevention of CVD and for promotion of heart health. What we need to do is to apply the available knowledge and of course to continue to invest in research. A number of major causal risk factors have been identified, and can thus be tackled. Moreover some active measures to improve heart health can also prevent other non-communicable chronic diseases.

Health promotion policies aiming at bringing about changes in certain life styles related to heart health can thus

tation of all Community policies. This is our point of departure.

In the health strategy and action programme the Commission will set out ways and means to assure that health related aspects form an important part of our policies and actions in sectors that have a powerful influence on factors affecting health. These are many: the internal market, agriculture, consumer protection, research, environment, transport, to name a few.

As the Directorate-General for Health and Consumer Protection a few weeks ago acquired the responsibility for processed food, it seems even more obvious that nutrition and healthy diets are areas where we in house will explore synergies for future actions. Despite a vast body of scientific evidence, nutritional messages to the consumer are often contradictory and confusing. One central task should therefore be to streamline the flow of information to enable consumers to make more informed and healthy choices.

Community action

Hitherto actions at Community level within public health have been carried out through eight largely disease specific action programmes. The Commission has revised this approach that was chosen some years ago. We have arrived at the conclusion that the disadvantages connected to this approach outnumber the advantages.

Consequently the Commission has decided to propose one coherent action programme. The other institutions, the European Parliament, the Council and in fact the wider health constituency have warmly welcomed this approach.

The future action programme will concentrate on activities centred around the following three themes:

- improving our knowledge through collecting, analysing, evaluating and disseminating health information to all relevant actors in the health field;
- strengthening our capacity to respond rapidly to the threats to health by developing rapid reactions and surveillance mecha-

nisms covering different health hazards;

- tackling the roots of illness through health promotion and diseases prevention measures.

The programme will be built upon those elements in the existing Public Health Programmes that have proved effective and that are relevant to the concerns and problems that the Community will be confronting in the coming years. In this context the first and third theme are of particular importance.

EU policy will continue to focus on generating, collecting and disseminating relevant knowledge and on a variety of prevention measures aiming also at contributing to the prevention of heart ill health.

“Illness and premature deaths from CVD are largely preventable.”

But we hope to do more. These actions will be complemented – whenever possible – by other actions in particular in the legislative field. Tobacco is one example. The Commission has just tabled a proposal for an updating and broadening of the scope of previous Directives on labelling (health warnings) on tobacco products and content of tar. Likewise the Commission is involved in the fight against tobacco on an international level. We are actively participating in negotiations on the WHO framework Convention on Tobacco Control.

From a health promotion point of view there are two priorities: we have to convince nonsmokers, especially children, not to start smoking. And we also have to persuade smokers to stop smoking and to demonstrate to them how their health and their well being will benefit as a result.

Other areas to mention are contained in the recent White Paper on Food Safety such as information campaigns on appropriate dietary habits and nutritional information and labelling that supports consumers in making informed choices. On dietary issues in general I hope we can establish a European scientific consensus. European dietary guidelines could then serve as an important input to other Community policies relevant also to heart health.

Specific CVD targeted actions

Our approach in the future will not be the same as in the past. This is not the same as saying that we will start from scratch. Obviously we will build on the experience gained so far and pursue actions that have proved effective and that are relevant to the concerns and problems that the Community is confronted with over the next years. CVD is clearly one such problem and concern!

An attempt to tackle these is the European Heart Health Initiative, which is one of the most important projects of the Health Promotion Programme. The aim of this project is to strengthen European cooperation in order to promote effective and evidence based actions and interventions and, by doing so, to contribute to a reduction in the incidence of CVD throughout Europe, finally to improve national policies in the area, the practices of health professionals, and the lifestyle of the general public.

It is expected that the project will deliver clear guidelines on how CVD should be tackled in the European Union and on what actions and policies for a healthier Europe should be developed and implemented in this respect.

Outlook

Our new health strategy and action programme will create a solid basis for continuing efforts to combat CVD and help to realise the goal in the declaration of the ‘Winning Hearts’ Conference of St. Valentine’s Day 2000 in Brussels: Everybody has the right to a healthy, long life free from avoidable CVD.

Winning Hearts:

Policies and actions for a healthier Europe



Susanne Logstrup

Saint Valentine's Day Appeal

Appropriately, the European Heart Network (EHN) chose the first Saint Valentine's Day of the new millennium for a conference on reducing the incidence of early death and disability due to cardiovascular disease (CVD), particularly coronary heart disease and stroke. In the context of a much wider pro-

the conference published a declaration with a vision formulated by the European Heart Network and its members and supported by the European Society of Cardiology: *"Every child born in the new millennium has the right to live until the age of at least 65 without suffering from avoidable cardiovascular disease."*

This vision underlines that CVD is not a normal part of the ageing process but mostly the consequence of unhealthy lifestyle habits often picked up early in life. Calling upon the European Commission and all European and national policy-makers to share this vision, the declaration:

- Encourages European and national decision-makers to cooperate closely with non-governmental organisations and alliances concerned with the prevention of cardiovascular disease, in support of a common strategy to promote cardiovascular health and to create a healthy environment in which children can grow up;
- Asks all health professionals to communicate effectively the benefits of a healthy lifestyle to individuals at high risk of developing cardiovascular disease and to the public in general.

"CVD is not a normal part of the ageing process but mostly the consequence of unhealthy lifestyle habits."

ject – the European Heart Health Initiative – the conference was specifically aimed at policy makers and health professionals. It sought to emphasise that promoting heart health – and health in general – is to a very large extent the responsibility of policy makers, not least of European Union policy makers. The conference emphasised that CVD is largely a preventable disease and that the very heavy burden both in terms of human suffering and economic cost can be alleviated if our European policy makers understand and assume their obligations to promote a society which is conducive to heart health.

To stress the importance of the policy makers' responsibility to provide a health-promoting environment,

- Welcomes the creation of the European Commission's Directorate-General for Health and Consumer Protection and calls for the Commission to give maximum emphasis to health considerations in all its policies, through an efficient and effective health impact audit, to reflect the true spirit of Article 152 of the Amsterdam Treaty;
- Urges the European Commission to give cardiovascular disease prevention a high priority in the European Union's forthcoming framework programme on public health, and to propose a common strategy to the Member States to tackle this disease, aiming at an average reduction of at least 40 per cent in deaths from cardio-

CVD number one killer – myth or reality?

Newly compiled European statistics on cardiovascular disease were released on the day of the conference. These statistics confirmed that CVD remains the number one killer in Europe. Even though remarkable results have been achieved in reducing the death toll over the last 25 years, worrying trends in the CVD risk factors indicate that there is no room for complacency. On the contrary, Europe-wide CVD prevention efforts must be stepped up. It should be noted that part of the significant fall in death rates from CVD has been due to improved treatment. Thus, although lives have been saved, many people survive with the effects of the disease and therefore with a considerably reduced quality of life.

CVD prevention was given only scant mention in the programme on health promotion, education and training established under the 1993 framework programme on public

health. However, following the adoption of the health promotion programme and a fruitful dialogue with the relevant Commission service and with firm support in a Council Resolution on CVD passed in June 1994, EHN obtained a contract from the Commission to carry out a project – the European Heart Health Initiative (EHHI) - which has two aims:

- To strengthen European cooperation to promote effective action and interventions to reduce the incidence of CVD throughout Europe; and
- To create awareness among policy makers, health professionals and thus also, in the longer term, the general public of the importance of fighting CVD and of ways and means which make prevention possible.

The European Heart Health Initiative

Starting in early autumn 1998, the project was designed to implement the proposals set out in an expert report entitled the European Heart Health Initiative. The report proposed a three-phase approach with the following elements:

- education & training
- effective interventions
- policy
- research
- monitoring

The first phase would concentrate on creating and expanding networks at national level as well as across national borders. These alliances are essential in mapping ongoing prevention efforts by improving the information flow. From this exercise, the national alliance coordinators will be able to identify gaps that can be filled by extended cooperation across sectors. The alliances are expected to provide guidelines and policy recommendations for tackling CVD at European level.

The alliances have already agreed that the pan-European theme for 2000 is children and young people. The vision formulated for the Saint Valentine conference reflected this agreement. From the broad discus-

sions, it was evident that CVD is a disease of people in the lower socioeconomic classes. Consequently a strategy for CVD prevention needs to adopt a life course approach, beginning with a focus on children. Clearly, tackling health inequalities is not limited to making children aware of the benefits of healthy lifestyles, but focussing on communicating with children in a way that they will accept is certainly a high priority.

European politicians on health and heart

The second aim of the EHHI was to make politicians aware of the burden of CVD and to inform them about the ways and means of prevention. The Saint Valentine Conference served to profile heart health as an issue that must be placed high on the EU's agenda.

Within the framework of the EHHI project and to determine the extent to which politicians in Europe are aware of the major causes of deaths in their countries, a survey was carried out prior to the conference. The questionnaire of parliamentarians in 13 European countries (twelve EU Member States and one EEA country) and Members of the European Parliament sought to identify their health policy priorities while also probing their attitude towards adopting policies broadly recommended as useful tools for preventing CVD.

Twelve out of the thirteen countries identified CVD as the most important cause of death in their respective country. Danish parliamentarians referred to cancer as the most important cause of death, although the number one cause of death in Denmark is CVD as in all the participating countries. Twelve out of the thirteen countries agreed that CVD

“Twelve out of the thirteen countries agreed that CVD is the disease with the best scope for prevention.”

is the disease with the best scope for prevention; the Spanish parliamentarians spread the scope for prevention over several causes of death.

Given a choice of ten health policies, the top priority was the promotion of health and the prevention of diseases (the choices included promoting greater efficiency in the hospital sector, reducing waiting lists, and reducing shortages of doctors and nurses). Only Italy, the Netherlands and the UK did not have prevention as either their first or second priority. Moreover, the parliamentarians questioned were almost unanimous in saying that preventive efforts must be put into practice in schools so that children can adopt healthy lifestyles at the earliest possible time. And over half of the parliamentarians surveyed were in favour of legislative measures to reduce smoking and to improve diets.

The results of the survey carried out among the Members of the European Parliament are identical to those of the survey of national parliamentarians. Nonetheless, although health promotion and disease prevention were given priority by the majority of the respondents, it was clear from the additional comments offered by the respondents from the national parliaments that prevention perpetually falls behind in competition with treatment.

I suggest that the European Commission, currently reviewing its future public health strategy, has a unique opportunity to offer added value to its Member States. Health is the most important asset to EU citizens. If the Commission really cares about bringing the EU closer to its citizens, it should make health the ‘big idea’ during its term of office. To underpin the new public health strategy, the Commission should ensure a much-improved funding base. And finally, to use the funds most effectively it should focus on a few priorities. One major priority should be the prevention of CVD – the scope for important health gains is obvious and the support structures are in place. A long term commitment from the European Union to tackle CVD in its new health strategy could make the difference.

What is the problem with cardiovascular disease in Europe?



Mike Rayner

“as the EU expands, problems with CVD are likely to get worse rather than better”

Cardiovascular disease (CVD) seems to have been a neglected issue under the first framework for action in the field of public health implemented under the provisions of the Maastricht Treaty. Perhaps this was because CVD was seen as a disease that only affected old people (unlike, say, AIDS) or was relatively quick and painless (unlike, say, cancer). But CVD is rightly coming to be seen as a major public health problem in Europe and one that the European Union should tackle in its forthcoming strategy for public health.

But what is the problem with CVD in the EU and what can be done about it? The first part of this question needs considering

before tackling the second part. You need to characterise a problem before working out how to solve it. Does CVD cause a lot of early deaths? Does it cause a lot of suffering? Furthermore – important as they are – death and suffering are not the only things that people, and more particularly governments, are concerned about: there is also money. So how much does the death and suffering from CVD cost?

Identifying the problem

Characterising the burden of disease has recently come to be seen as essential when developing public health strategies. The Global Burden of Disease Study, carried out by Christopher Murray and Alan Lopez for the World Health Organization, is perhaps the best known recent example of this type of research.¹ This study is impressive, in particular because it acknowledges that measuring the burden is not just a matter of counting the numbers of deaths.

The British Heart Foundation Health Promotion Research Group in the University of Oxford has recently begun a study to characterise the burden of CVD across Europe and to assess where it is the greatest problem. The first report of this study was published on 14 February this year to coincide with the ‘Winning Hearts’ conference organised by the European Heart Network in Brussels. The summary of this report – *European cardiovascular disease statistics* – is given in the box.

The study looked particularly at the problem of CVD for the EU, but it also looked at the situation in Europe as a whole – taking ‘Europe’ to consist of all the member states of the World Health Organization European Region – from Iceland in the West to Kazakhstan in the East. Some of the biggest problems with CVD, however defined, are within Central and Eastern European countries of the WHO European Region. This means that as the EU

EUROPEAN CARDIOVASCULAR DISEASE STATISTICS: SUMMARY

- ✦ Cardiovascular disease (CVD) causes four million deaths each year in Europe and over 1.5 million deaths each year in the European Union (EU).
- ✦ CVD causes nearly half of all deaths in Europe (49 per cent) and in the EU (42 per cent).
- ✦ CVD is the main cause of death in women in all countries of Europe and is the main cause of death in men in all countries except France.
- ✦ CVD is the main cause of years of life lost in early death in the Europe and the EU.
- ✦ Nearly 30 per cent of years of life lost in Europe are due to CVD (over 30 per cent in the EU).
- ✦ CVD mortality, incidence and case fatality are falling in most Northern, Southern and Western European Countries but rising in Central and Eastern European countries.
- ✦ Each year smoking kills about 1.2 million people in Europe (400,000 from CVD) and about 500,000 people in the EU (130,000 from CVD).
- ✦ Smoking has been declining in many European countries but the rate of decline is now slowing. Women are now smoking nearly as much as men in many European countries and girls often smoke more than boys.
- ✦ Diets are generally improving in Northern and Western European countries but deteriorating in Southern, Central and Eastern European countries.
- ✦ Dietary patterns across Europe — once very different — are now converging.
- ✦ Levels of obesity are increasing across Europe.
- ✦ The prevalence of diabetes is increasing across Europe.

Source: British Heart Foundation.³

expands, problems with CVD are likely to get worse rather than better.

The study confirmed that CVD kills more people than any other disease in the EU and in fact kills more people in all countries of the EU than any other disease. Even in countries such as Greece, Italy, Portugal and Spain where CVD death rates, particularly in younger age groups, are low compared with some Northern and Western EU countries – CVD causes more deaths than the next biggest killer – cancer. Overall, 42 per cent of deaths in the EU are due to CVD and 26 per cent to cancer.

Assessing CVD relative to other diseases

But does CVD cause a lot of early deaths in the EU? A person's definition of what counts as an early, or premature, death seems to depend on how old they are! Moreover as life expectancy increases people expect to live longer so, in general, definitions of 'early' are getting 'later'. Perhaps the best way of looking at early deaths is to count years of life lost in relation to average life expectancy, which is around 78 in the EU.

On this basis CVD is the main cause of years of life lost in early death in the EU – 31 per cent of years lost are from CVD compared with 26 per cent from cancer. This is despite the fact that many more people die from cancer before the age of 65 than from CVD: 36 per cent of deaths before the age of 65 are from cancer, compared with 23 per cent from CVD; and even with deaths before the age 75, slightly more (36 per cent) are from cancer than from CVD (31 per cent).

As with total deaths, early death from CVD is just as big a problem for some Southern European countries as Northern and Western countries. For example even in Italy – famed for its Mediterranean diet and having relatively low rates of CVD compared with other European countries – 29 per cent of deaths under 75 are from CVD.

Does CVD cause a lot of suffering? When it comes to suffering CVD is still a big problem, but not such a big a problem as some other diseases. For example the Global Burden of Disease Study shows that only six per cent of years of life lost in disability are due to CVD compared with 47 per cent from neuro-psychiatric disorders – the biggest cause of years of life lost in disability. Still six per cent is greater than three per cent – the percentage of years of

life lost in disability due to cancer.

Paying for CVD

And how much does CVD cost in financial terms? Our latest estimate – based on four separate cost of disease analyses carried out for the UK, the Netherlands, Sweden and Germany – is that each year about 60 billion euros are spent on treating cardiovascular disease (CVD) in the EU but that CVD also costs an additional 97 billion euros a year in lost production of goods and services because of early death and disability. In total CVD costs the EU about 157 billion euros a year.

Having worked out how much death and suffering is due to CVD, and how much this costs, the next step is to work out how much death, suffering and financial costs are avoidable.

Developing a strategy

This is the next phase of our study. There are already some good studies on certain aspects of this question. For example, due to a detailed investigation by Richard Peto and his colleagues in Oxford,² we have good estimates of the number of early CVD deaths are due to smoking: about 27 per cent of CVD deaths in men aged 35-69 and twelve per cent of CVD deaths in women of the same age are from smoking. But it remains to be calculated how many early deaths could be avoided if people were to change their diets or increase their physical activity. There are some estimates here – and it looks as if just as many early CVD deaths are due to poor diets and physical inactivity as they are to smoking – but the calculations have not been done as thoroughly and precisely as for smoking.

Of course an understanding of the burden of the major health problems facing Europe and how much of this burden can be avoided is only the start of developing a comprehensive and coherent public health strategy for Europe. This task I leave to others – including the other authors in this issue of *eurohealth*.

“Overall, 42 per cent of deaths in the EU are due to CVD and 26 per cent to cancer.”

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The economics of health promotion and disease prevention:



Miriam Wiley

Assessment of the application of economic evaluation in EU Member States¹

While EU member states have historically pursued a range of policies in support of health promotion and disease prevention, the public health provisions of the Maastricht Treaty set out a new Community framework for public health activities with specific relevance to health protection and the prevention of diseases.

“The experience of economic recession and public expenditure crises, combined with increasing demands for health system development in many member states has ... resulted in more intensive and routine economic evaluation of many health service interventions.”

Arising from this initiative, action programmes on AIDS and other communicable diseases, cancer, drug dependence and health promotion have been operating since 1996.² Other programmes concerned with pollution-related disease, injury prevention and rare diseases have also been developed. These programmes cover a range of activities, including the developments of networks, exchange of information and so on. Of particular importance is the development of guidelines and recommendations in such areas as cancer screening, osteoporosis, nutrition etc. Other initiatives arising from this new framework relate to combating tobacco consumption and adopting common practice on tobacco advertising and blood safety and self-sufficiency, together with specialised reports in a number of areas, including health status.

While the development of the Community's role in public health is to be generally welcomed, this advancement has been taking place at a time of increasing financial pressure on the financing of health systems in Member States. The application

of economic constraints to health system development is not, in itself, a particularly recent development given the inherent expansionist tendencies of this area. The experience of economic recession and public expenditure crises, combined with increasing demands for health system development in many member states has, however, resulted in more intensive and routine economic evaluation of many health service interventions.

The application of economic evaluation techniques will be most widespread where there is general recognition that resources are scarce so choices must be made regarding their deployment. In this context, the specification of resources is very broad and includes such elements as time, technology, expertise, personnel etc. Given that resources can be combined in many different ways towards the achievement of a range of objectives, techniques of economic evaluation may be deployed as a framework for comparing alternative courses of action in terms both of their costs and consequences.³ Considering the ongoing pressures on the financing of health system interventions, what is of particular relevance to this enquiry is the extent to which economic evaluation, in any form, has come to be applied specifically to health promotion and/or disease prevention policies in member states. To assist in addressing this question, a limited information gathering exercise was undertaken among member states.

Scope of health promotion and disease prevention activities

Information was collected through a number of channels, including questionnaire distribution to relevant agencies in member states and interviews with individual experts as required. A two-pronged approach to information collection was pursued with the scope of health promotion and disease prevention activities

accounting for the first level of enquiry followed by solicitation of views, where relevant, on the approach to economic evaluation of these activities within the relevant health system.

The determination of priorities for investment in health promotion and/or disease prevention is primarily undertaken at the national level in member states, with the majority of countries also reporting some operation of these functions at the regional level. Not surprisingly therefore, the national health Ministries are generally acknowledged as being to the fore in policy development in this area. In many countries, centres for health promotion and/or specialised health agencies may also have a significant input into this process. For some countries, the importance of the regional level is reflected by dedicated agencies at this level. Where there is significant decentralisation of the responsibilities of government, for example in the Nordic countries, local government may also have a substantial input in the determination of priorities for investment in this area. As NGOs are particularly active in this area, the majority of countries report a substantial contribution to policy and priorities from these bodies.

Despite some diversity, it is apparent that for the majority of countries the determination of investment priorities for health promotion and/or disease prevention at the national level is informed by such factors as perceived threats to population health and national policy objectives which may reflect internationally agreed strategies like Community Programmes and the WHO's Health for All (HFA) policy. While the areas targeted for intervention, together with the ranking of these priorities, may vary between countries, some commonality may also be observed. The areas targeted by Community programmes, particularly tobacco control, drug abuse and communicable diseases like AIDS are generally considered as high priority areas for investment in health promotion and/or disease prevention programmes in member states.

Diversity in the priorities proposed for investment in these programmes is consistent with the fact that targets primarily arise from the national policy process, with some reference to Community/international policy in this area. Some variation between member states is also evident in the extent to which economic criteria may be applied in the determination of these priorities.

Economic evaluation of health promotion and/or disease prevention activities in Member States

When posed with the question of whether economic criteria are generally applied to the assessment of investment proposals for health promotion and/or disease prevention, the general view forthcoming from the relevant agencies in member states is that while such proposals may be considered in the context of overall budgetary policy, the conduct of economic evaluation is generally not a pre-condition for approving such investment. What is interesting, however, is that many of these agencies report an increasing awareness of the need for assessment of such investment proposals within an economic evaluation framework. When asked whether cost effectiveness, specifically, would be considered a reasonable criteria to apply in this context, the majority of responses indicate a positive acceptance of this approach, with caveats applying. The caveats proposed include the fact that it would not be appro-

“While there is considerable ambiguity regarding the real and/or potential contribution of economic evaluation techniques ... there is an apparent gradual, if hesitant, recognition that such techniques may have a useful contribution to offer.”

priate for cost effectiveness to be the only criteria for assessment and that the scientific standard of any measures applied must be assured.

Given the observation that economic criteria are generally not applied to proposals for investment in health promotion and/or disease prevention despite a general openness to the potential benefits of this approach, agencies were also asked to suggest the factors which are considered to mitigate against the application of these criteria. It is interesting that the problems noted are consistent with those forthcoming from the literature on the application of economic evaluation within this area and include concerns with such factors as the data sources, available techniques, problems of time preference, cost/benefit estimation, and so on. Widespread recognition of the potential usefulness of the economic evaluation framework, coupled with expert

knowledge of the challenges arising with application, suggests a substantial knowledge base of the issues arising among these agencies.

Conclusion

The objective of undertaking this enquiry was to generate a view from relevant agencies regarding the relevance of the economic evaluation framework for assessment within member states of investment proposals in the health promotion/disease prevention area. Given the tenuous nature of the required information, a number of sources of information had to be pursued though it is readily accepted that neither the avenues pursued or the resulting information could be considered representative

- data sources
- the time dimension
- benefit/cost estimation
- professional and political acceptability

Irrespective of the specific area of interest, all investment decisions in the health area need to be addressed from a range of perspectives to ensure that policy objectives at the health system level, together with the needs of the community, are adequately addressed. Exclusive application of the economic evaluation framework will not therefore fulfil all expectations in the health promotion /disease prevention or any other health area. Again, like all other areas within the health system, it seems reasonable to assume that economic pressures may be expected to become more intensified with the continuing expansion of demands on more constrained resources. An informed response to these pressures would suggest the increasing use of economic evaluation techniques, combined with other relevant forms of assessment, to assist in the determination of priorities for investment in health promotion and/or disease prevention. Any evaluation framework, whether economic or otherwise, must be appropriate and valid if the findings are to be acceptable. Measures to address deficiencies of available economic assessment tools and techniques must therefore be advanced if more widespread application of economic evaluation is to be pursued for health promotion and disease prevention interventions.

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“problems noted ... include concerns with such factors as the data sources, available techniques, problems of time preference, cost/benefit estimation, and so on.”

or comprehensive in a scientific sense. Notwithstanding these reservations, key findings from this enquiry include the following:

- Some consistency in the prioritisation of health promotion interventions across member states is evident with input from Community and international programmes being combined with national and local commitments;
- The resourcing of health promotion and disease prevention interventions is becoming increasingly challenging;
- While there is considerable ambiguity regarding the real and/or potential contribution of economic evaluation techniques to the prioritisation of investment for health promotion/disease prevention interventions, there is an apparent gradual, if hesitant, recognition that such techniques may have a useful contribution to offer;
- Constraints to the widespread application of techniques of economic evaluation for assessment of health promotion/disease prevention investment priorities are readily recognised and particular difficulties include:
 - the measures available

Economic evaluation of health promotion and disease prevention:



Christine Godfrey

Issues and challenges

Few economic evaluations of disease prevention or health promotion interventions have been undertaken. The lack of evidence on cost-effectiveness may partly explain the low levels of funding across Europe. This article gives a brief outline of some of the issues and challenges that need to be overcome in order to gain data on the costs and value for money of health promotion interventions.

Economic evaluations involve identifying, measuring, valuing and then comparing the costs and consequences of alternative interventions. The costs include the value of all the inputs from the agency directly running the interventions, other agencies involved and those individuals participating in the interventions. The consequences, also taking a number of different forms, are normally positive but may also include some negative effects.

Evaluative questions

Many different types of evaluative questions arise from different cultures across Europe and the different organisations involved in financing and delivering health promotion and disease prevention programmes. The most cost-effective interventions may widen rather than narrow health inequalities. Specific questions may be framed around the most cost-effective means of satisfying a specific policy goal, for example, reducing smoking in pregnant women. A broader question involves priorities across diseases or groups within a prevention budget, for example, the balance of resources between smoking and youth programmes. However, health promotion funds are usually part of a larger health or social budget and there may be questions about the balance between prevention and treatment across all health problems.

Economists generally seek to include all costs and consequences in their evaluations, whoever bears them, that have a societal perspective. Many health promotion interventions involve inputs from a number of different agencies. Also the benefits may be

wider than those targeted by the intervention. However different agencies may only be concerned with the costs they bear and the consequences for which they are responsible. If a narrow perspective is taken an intervention which uses resources from other agencies could be favoured over one delivered entirely by the agency. Similar issues may arise for consequences, and different organisations may put different weights and values on the range of outcomes and this could affect the comparative cost-effectiveness results.

One of the most significant issues is the choice of alternatives to evaluate. The main dimensions of health promotion interventions are the setting, the target group and the intervention type. However, there are also less direct but important roles, such as training and facilitating in the work of health promotion specialists. There is also the whole area of policy development and advocacy.

Selecting study design

If the alternatives have been chosen, the next step is to choose the study design. As there is more emphasis on evidence based practice, one of the major challenges for health promotion interventions which are not individually focused, and therefore could not necessarily be subjected to the gold standard, randomised controlled trial, is to establish rigorous methods to establish effectiveness.

Part of the study design involves the choice of economic evaluation method: cost-effectiveness; cost-utility; or cost-benefit analysis. These methods differ in the form in which health benefits are measured with all other consequences and the costs of the alternative interventions being measured in money terms. Cost-effectiveness involves some specific outcome measure, such as the number who stop smoking. More generic health status measures such as life years gained could be used. Life years gained, however, is only one dimension of health gain and health promotion interventions

“The most cost-effective interventions may widen rather than narrow health inequalities.”

“Using productivity values of life implies those of non-working age have no value, and in most European countries, women would have lower values put on their lives than men.”

can affect the quality as well as the quantity of life. A composite health measure designed to measure a number of dimensions of health is combined with a valuation component and life expectancy to obtain these utility outcome variables. For example, the EQ5D measure has five dimensions: mobility; self-care; usual activity; pain/discomfort; and anxiety/depression.¹ What is not yet established is whether such measures will be sensitive to the changes in health status occurring through health promotion interventions.

For cost-benefit analyses all outcomes are measured in monetary terms and evaluators have to put a monetary value on life itself. Using productivity values of life implies those of non-working age have no value, and in most European countries, women would have lower values put on their lives than men. Alternative methods attempt to seek monetary values through willingness-to-pay studies and generally result in much higher values of life.²

At what time point should outcomes be estimated? Obviously long follow-ups to chart the sustainability of, say, a behaviour change add to the research costs. Tracing the effect on health as a result of behaviour change would involve an even longer period. Hence many studies will use epidemiological models to measure the impact of changing behaviour or disease risks on future morbidity and mortality.

Additional effects and benefits

There are other individual effects that utility measures may not include. For example, Cohen has argued that health promotion may have consumption benefits.³ Purchasing a smoke alarm has benefits in the reduction of anxiety; screening for some diseases may have a similar impact. However, there may also be some negative effects, for example, the ‘worried well’ created from information campaigns about the risks of certain diseases, health problems or lifestyles.

There may be other non-health benefits. Some health promotion specialists would argue that the primary outcome should be to enable individuals to make choices or raise self-esteem. In this model of health promotion, changes in behaviour or disease outcomes are secondary. Measurement of such concepts may be problematic but a willingness to pay methodology could be used.

Other consequences may impact on a wider group than those targeted by the

interventions. For example, lifestyle changes by one individual can have spill-over benefits for the family as other members join in the healthy change or benefit in other ways, e.g. reduction in passive smoking, or alcohol related violence. Rosen and Lindholm also point to a wider social diffusion effect of many interventions.⁴

One argument for health promotion is that future health care costs could be avoided. Although as Cohen suggests this is not the motivation for most health interventions, rather their potential capacity to improve health.³ The most obvious costs to identify are those related to the disease or specific lifestyle factor, for example smoking related diseases. Most studies have indicated that smokers make more demands on health care than non-smokers of the same age and gender. However, non-smokers live longer and health care costs of the elderly are larger on average than those of a younger age. Overall there may not be any financial savings. Another issue is whether such future costs should be discounted. Discounting puts a lower weight on effects that occur in the future than those occurring in the current period. With discounting, the smoking related disease costs that occur earlier outweigh the costs of quitters living longer. However, economists also disagree about whether these financial calculations, including the costs unrelated to the behaviour in question, should be included in economic evaluations.²

Assessing programme costs

Costing health promotion programmes also involves a number of measurement problems. Health promotion agencies can undertake a wide range of activities and defining the ‘production process’ of any intervention may be difficult. Finally some programmes may also require inputs from individuals, for example, nicotine replacement products, exercise equipment or time inputs.

There are a number of specific issues surrounding the discounting of costs and consequences that are putting a lower rate on future events. Should the same rate be applied to health and financial consequences? Discounting health benefits has a major impact on prevention programmes and clearly impacts differentially on different age groups.

What do we currently know? Reviews of cost-effectiveness are more difficult to undertake than those for effectiveness. There are only a few studies that would be

making similar comparisons in terms of interventions included or the groups of the population targeted. There is a danger, therefore, of comparing apples with oranges. Also it is not clear that all items in a cost-effectiveness analysis can be readily compared across times and locations. Resources, such as different professionals or building costs, have different relative values in different countries or regions.

Conclusions

Some tentative conclusions can, however, be drawn from the available literature. Brief interventions for smoking and alcohol are known to be effective when compared to a control group. The costs of such interventions when conducted opportunistically are also relatively modest. These interventions therefore yield very good cost-effectiveness ratios when compared to a doing nothing or usual care alternative. In general, behavioural interventions are more cost effective than drug therapies although results vary considerably with the population groups and levels of risk factors considered. More resources are required for more structured programmes especially where patients are screened. Not all screening programmes are

good value for money. Also, there are many health promotion interventions where the costs and cost-effectiveness are unknown. Currently the research resources and capacity to undertake economic evaluations are very limited but the questions to be addressed are vast. It is clear that European and national research funding bodies could play a major part in determining the priority questions that would inform decision making, and in helping to build the infrastructure support that could tackle many of the issues raised in this article.

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Implementing cost-effective disease prevention and health promotion

A view on future European prevention policy from the lowlands

The Netherlands perhaps has a popular image of being 'good' at disease prevention and health promotion. The dismal science, however, is not so much concerned with 'good' as perhaps 'better' or even 'best'. To increase the cost-effectiveness of prevention programmes and services, the Netherlands is making increasingly systematic use of economic evaluation. But efficient parts do not necessarily guarantee an efficient whole.

From an economic perspective, there may be gaps between actual and an ideal policy. Given the extended possibilities for the EU

commission in the area of public health and prevention under the Treaty of Amsterdam (Art. 152), the gaps in national policies are perhaps windows of opportunity to complement national efforts in health promotion and disease prevention.

Assessing prevention programmes

Considering only resources in the health sector, the original investigation considered three basic efficiency questions:

1. Is prevention a more efficient use of society's health resources than other health care interventions?



Grant Rhodes

2. Which prevention programmes are the most efficient?
3. What is the most efficient implementation strategy in any given prevention programme?

With respect to the first question the position is somewhat confusing. The Ministry of Health's own summary of prevention policy exerts: 'Prevention is necessary. It is an effective component of health care: it achieves more positive effects than medical treatment, and at less cost'.¹ On the other hand, the four yearly Public Health Projections (VTV) Report on which the government bases its prevention policy takes the view that, 'from an economic perspective it is not...rational to give absolute priority to prevention over curative care'.² Prevention must prove its value in terms of costs and benefits against other interventions.

Similarly, with respect to choosing which prevention programmes are the most efficient, the simple truth is there is too little evidence on which to make choices – an implicit conclusion of the last VTV report. The most relevant conclusion of much of the research that has been conducted into prevention is that few problems directly concern the formal health care sector. This is reinforced by the only existing large-scale comparisons of cost-effectiveness of life-saving interventions.³ The most cost-effective life saving measures are not in the formal health care sector but, for example: non-smoking, nutrition, traffic safety, environmental and occupational health etc. Relevant also are reports on inequalities in health, which have only recently begun to include measures involving formal health services.

The use of economic evaluation methods has, then, been largely limited to the third question. Since an advice from the Health Insurance Council (CVZ) in 1983, numerous regulatory authorities have recommended that health care programmes and interventions should be evaluated on the basis of their cost-effectiveness. There have also been clear lists of those interventions that most need to be evaluated. Prevention has been a field where recommendations have been pursued more vigorously, as many measures are, for example: not requested by the recipient, are imposed on the healthy, involve some sacrifice, and are typically very large scale in character. The most striking examples are to be found in national screening programmes.

The Dutch experience

The decision to start national breast cancer screening was underpinned by thorough cost-effectiveness research. On the basis of a subsequent consensus conference, guidelines for mammography screening were introduced in 1988. Within the Health Insurance Council, a programme-specific committee has continued the analysis and established a long-term (economic) evaluation team. Continuing (economic) evaluations led to programme revisions in subsequent years – for example, in the age categories to be screened. Similar developments occurred in the other national screening programmes for cervical cancer, where in 1996, age categories (30–60) and screening intervals (five years) were revised as a result of economic evaluation.

Dutch national screening programmes represent an interesting example of the institutionalised use of economic evaluation in health policy making. Considering the three basic efficiency questions however, it is clear that the importance of cost-effectiveness criteria has been limited to tweaking individual programmes to increase their performance. There is virtually no use made of cost effectiveness information to increase the performance of prevention policy as a whole. Certainly numerous reasons for this might be cited, for example: there is little evidence on which to base choices and perhaps no sense of a need to do so. The current Minister (Borst) refers to the need for 'consensus' rather than 'evidence based' medicine.⁴

However two practical problems also persist:

- Prevention policy is articulated in the medical sphere
- Responsibility for the financing and implementation of prevention policy is largely decentralised. The principal role is fulfilled by local government health services, but independent insurers, privatised occupational health services and a plethora of more condition specific organisations also play an important role.

Dutch prevention policy is then confronted with a number of limitations. First, the responsibility for prevention is fragmented. Secondly, there are few mechanisms to take advantage of the information coming from empirical research. Thirdly, those mechanisms that do exist to inform prevention policy are entrenched in medical research, leading to an inappropriate emphasis.

“The most relevant conclusion of much of the research that has been conducted into prevention is that few problems directly concern the formal health care sector.”

To some extent efforts have been made to correct these problems. The important 'basic tasks' of Local Authorities in prevention are becoming more clearly defined. Considerable funds have been earmarked for the evaluation of health related programmes with prevention programmes receiving special emphasis. More fundamentally, not only is there a 'facetbeleid' (multi-sectoral prevention policy) but attention has also been given to the possibility of *ex ante* 'Health Effect Screening' (GESs) to evaluate the likely health impacts of public policy before implementation.⁵

Unfortunately, large, even increasing numbers of advisory committees, research-granting bodies, research coordination bodies and implementing agencies, ensure that this lack of coordination continues. Finally, 'facetbeleid' is rather an ambition than a reality and GESs, have only been very selectively applied, for example to make a multi-sectoral approach to discourage smoking.

The European context

European public health policy has similarly been criticised for its fragmentation.⁶ To resolve such problems some have advocated Ministers of Prevention, as without formal authority it was felt that coherent prevention policies would remain a paper exercise.⁷ Twelve years later little has changed *within* member states such as the Netherlands. The Ministry of Health largely determines the prevention agenda. The likelihood of a coherent prevention policy is then further limited as the Ministry of Health is also subject to the all-too-often-conflicting goals of government. The Ministry of Health may want: less tobacco use, but the Treasury more; or minimum prevention packages provided by local governments, while local governments still have to pay.

On the other hand, ten years has seen many developments *between* member states. The European Union has been playing a steadily more important role in public health, particularly with respect to health protection and the regulation of risk factors. Consumer safety, food and agricultural policy, environmental standards, drug licensing, and working conditions have been amongst those areas to transcend the subsidiarity test. More recently, a commission press release (15th April 1998) expressed a need to develop such public health affecting activities of the EU into a clearer strategy. Nevertheless, the EU still needs to define this strategy.⁸

Developing European policy

Experience in both the Netherlands and the EU would seem to support Stein's conclusions for a future European public health and prevention policy, namely to:

- Identify how the definition and implementation of all.... policies and activities will contribute to the achievement of the health protection objective.
- Identify priority areas where the greatest contribution to health protection can be made through concerted multi-sectoral ... action.

"it is clear that the importance of cost-effectiveness criteria has been limited to tweaking individual programmes to increase their performance."

The primary cause is therefore efficient (cost-effective) primary prevention initiatives, particularly in the area of health protection. In essence, a continuation and strengthening of the EU's current role. A great opportunity for expanding on these successes might be a more systematic and comprehensive approach to 'global health impact assessments'.

As to a champion for such causes, the vacancy has yet to be filled. In the Netherlands, suggestions have in the past been made, and rejected, for a Food and Drug Administration type organisation. Perhaps at a European level such an organisation would be less incongruous. Considerable economies might also exist by combining numerous national initiatives, for example in the development of best practice and evidence-based medicine databases, or sharing (co-developing) global health impact assessment methodologies. Such developments would seem in tune with the subsidiarity clauses in the Treaty of Amsterdam, demanding both the independence of member states in the organisation and delivery of health care services, and that EU action should complement rather substitute national policies. In the Netherlands, a more systematic multi-sectoral prevention strategy, precisely independent of health care services, would seem to be the remaining gap in an otherwise comprehensive prevention policy.

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REPORT ON THE STATE OF YOUNG PEOPLE'S HEALTH IN THE EUROPEAN UNION

The European Commission has recently presented the latest in a series of reports on health in the European Union. The new report focuses on the health status of young people (aged 15–24).

Despite the fact that the transition from childhood to adulthood is crucial in establishing the foundations for health in future life, the importance of this phase is generally under-appreciated. Data on aspects of health relevant to young people are not easily available and the health and wellbeing in this age group have rarely been addressed in EU-wide comparative studies. The following are some of findings included in the Report:

- According to data on life expectancy, mortality and chronic diseases, the vast majority of young people enjoy good health, and the trends from the mid-1980s to the mid-1990s suggest that the situation will improve further. Life expectancy for a 15-year old is 75 for males and 80 for females. However, some chronic conditions such as asthma, allergic disorders, diabetes and obesity are increasing.
- Each year, 30,500 15 to 24-year olds lose their lives in EU Member States. Premature deaths are more common in males (23,000) than in females (7,500). Traffic accidents account for the biggest killer (about 10,000 males, 2,000 females), whilst suicides account for one in ten premature deaths.
- There is marked diversity within the European Union in terms of both the status of young people's health and health trends. Major challenges with respect to improving young people's health are caused by economic, social and cultural determinants of ill health, including poverty; tackling these determinants should therefore be placed high on the policy agenda.
- On the basis of the information

available, only a rough indication can be drawn on mental-health trends. Almost one in ten young people seem to experience clinically recognisable depressive symptoms, about five per cent have problems with addictive substance abuse and one to two per cent have eating disorders. Mental disorders and substance abuse tend to become increasingly intertwined even in early adolescence.

- Levels of unintended pregnancies and Sexually Transmitted Diseases (STDs) are used in the Report to indicate the status of reproductive health among young people. For Member States with available data, teenage abortion rates per 1000 women range from 5 to 22 (8 to 28 in the 20–24 age group); these rates are basically at the same level as they were in the mid-80s. Chlamydia is by far the most common of the sexually transmitted diseases, carried by five to seven per cent of young people. Very little is known about the true incidence of HIV infections among 15–24 year old people.
- Although reliable data on trends in physical activity are not available there is evidence that many young people are not participating in sufficient levels of physical activity to attain health benefits. The rising trend in obesity is particularly alarming.
- The Report points to a clear need to improve the quality and comparability of data, to develop comparative indicators of health and to analyse both the statistical information and the research findings in the differing contexts of individual Member States.

Early warning and response system for communicable diseases

As a result of two Commission Decisions adopted on 22 December 1999, a new European early warning and response system for communicable diseases was launched on 1 January 2000.

According to Commissioner Byrne. "As Europe becomes increasingly integrated there is a corresponding increase in the cases with which such diseases can be transmitted. We need, therefore, to have well developed mechanisms to identify suspected or actual outbreaks and to take appropriate measures to bring them under control."

The first decision concerns the terms of action for an early warning and response system. Events that are potential public health threats are to be monitored and reported. The decision describes procedures for the exchange of information, and it stipulates the action to be undertaken in case of potential threats and in the case of confirmed threats to public health.

The second decision identifies the communicable diseases and special health issues that have to be covered by epidemiological surveillance in the Community network. The network focuses on the permanent surveillance of tuberculosis, travel associated legionnaires' disease, AIDS and HIV, human salmonellosis and the bacteria *E.coli* O157. This list has now been extended to include a range of other diseases, such as those preventable by vaccination, as well as food and water-borne diseases of environmental origin. The growing resistance against antibiotic agents will also be monitored.

The aim of the system is to ensure a timely reaction to major threats to human health through guidance to health professionals and the public and through the adaptation of legislation to scientific findings. The system will be run by the European network for the epidemiological surveillance and control of communicable diseases that was set up in 1998.

The Report on the state of young people's health in the European Union has been published as a Commission services working paper. The Report is available on Internet site: <http://www.europa.eu.int/comm/dg24/#news>

Commission Reform Strategy

The European Commission has published a White Paper on Commission Reform, which contains the most far-reaching modernisation strategy in the institution's 40-year history. This detailed design for Reform is set out in an Action Plan and in a Timetable that specifies target dates for each of the changes to be implemented.

The Reform Strategy is built on three related themes: the comprehensive reform of personnel policy, thorough modernisation of financial management and control, and a new system of strategic planning. The aims of these measures are to reinforce a working culture based on service. Two of the steps that will be taken towards this latter goal are the development of a European Committee on Standards in Public Life to advise on appropriate ethical standards for all EU institutions, and the establishment of a Code of Good Administrative Behaviour for Commission officials.

The White Paper on Commission Reform can be obtained on Internet site: http://europa.eu.int/comm/off/white/reform/index_en.htm

Commission opinion on the reform of the institutions of the European Union

The Commission has presented its opinion on the forthcoming revision of the Treaties of the European Union, in light of the pending Enlargement of the European Union. During the Helsinki European Council held in December last year, EU Ministers decided to begin accession negotiations with six new applicant countries and to confirm the admission of Turkey to the European Union.

The first part of the document addresses the operation of the European institutions in the enlarged Union. Amongst the opinions given, the Commission proposes retaining 700 as the upper limit on the number of members of the European Parliament. For the Commission, either the number of Commissioners be kept at 20, and

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rotated amongst Member States, or that it should be made up of nationals of each Member State, which would entail major adjustments in its organisation and operating methods.

To streamline the decision-making process, unanimity should be required only when there are serious and lasting reasons for it, and, as a rule, replaced with qualified majority voting used. The opinion also proposes making the Union's decision-making procedures simpler, more effective and more coherent. Regarding the voting system in the Council, the Commission recommends adopting a straightforward and democratic system of 'double simple majority'. This means that a decision will stand adopted if it has the support of a simple majority of the Member States and a simple majority of the total population of the Union.

The document includes proposals for new Treaty articles as well as annexes on, for example, matters that could in future be the subject of qualified-majority decisions.

Commission adopts proposed regulation on public access to documents.

The European Commission has adopted a proposal aimed at ensuring the greatest possible public access to the documents of the European Union institutions. Under the new code, the public can access all documents relating to the policies, activities and decisions of the Parliament, the Council and the Commission, whether these documents are in the form of paper, electronic files or recordings. Certain exceptions do, however, apply. Documents intended for discussion, internal administrative notices and informal messages are excluded from this rule. Other exceptions regard the need to safeguard the public interest, respect for personal privacy, commercial, economic or industrial confidentiality, and confidentiality where it is requested by a third party providing information or documents.

The Commission unveils its five-year Strategic Objectives

The Commission has approved a policy document outlining the strategic objectives that will guide its work over the next five years. The Commission's objectives fall under four key headings: creating new forms of European governance, giving Europe a stronger voice in the world, promoting a new economic and social agenda, and improving the quality of life.

To Improve Quality of Life, the Commission aims to coordinate, improve and accelerate Europe's response to the issues that affect people's daily lives, notably the environment, food safety, consumer rights, justice and security and transport. In particular, it will aim to implement the ambitious White Paper on Food Safety and to turn Europe into a common area of justice and security.

The Strategic Objectives paper is accompanied by a second document outlining in greater detail the Commission's work programme for the year 2000.

Both documents are available on Internet site: http://europa.eu.int/comm/off/work/index_en.htm

1999 General Report on EU Activities

The General Report on the Activities of the European Union is available on Internet. This report gives a comprehensive picture of what the EU has done over the past year. The report contains a detailed index, reference throughout to the Official Journal, previous General Reports and the (monthly) Bulletin of the European Journal. It also includes a chronological survey of the main events during the year and tables showing the progress being made with legislation that is in the course of being adopted and agreements that have been made between the Community and other countries.

The Report is available at Internet site: <http://europa.eu.int/abc/doc/off/rg/en/welcome.htm>

IMPRESSIVE RESULTS FOR MEDICAL RESEARCH

During a press conference that was held on 7 January 2000, Phillippe Busquin, European Commissioner for Research, praised breakthroughs that have been made by four EU-funded bio-medical research projects in the areas of cancer, AIDS, diabetes and cardiovascular diseases.

The research into AIDS included a study of 15,000 patients, and was thereby the largest undertaken to date on this disease. A network of 60 hospitals in 20 different countries across Europe collected and analysed data to monitor the effectiveness of anti-HIV drugs. The study showed that for patients with AIDS undergoing antiretroviral treatment the chance of death is reduced by a factor of ten.

Research on Diabetes has identified the genes involved in this disease. This has been hailed as one of the most important breakthroughs in research on Diabetes in the past 20 years, since the discoveries have clarified understanding of the mechanisms of the disease, and generated hope for a cure. Diabetes affects some ten million Europeans and accounts for eight per cent of medical spending in Europe.

Research into cardiovascular diseases that focuses on arteriosclerosis has led to the discovery that Vascular Endothelial Growth Factor (VEGF), known for developing blood vessels in the foetus, can also play a role in preventing the blockage of arteries.

Eurogene, a company set up to develop the applications of these findings, now employs 32 people in two laboratories located in Finland and in the UK. Several patents have resulted from the research.

Research on Cancer that focussed on methods of controlling metastatic growth has shown that a particular gene, MET is responsible for tumour metastasis. Researchers hope that their findings can be applied by biotechnologists to find ways to prevent cancer cells from developing and spreading.

These projects were partially funded under the Biomed 2 biomedicine programme as part of the Fourth Framework Programme for Research and Technological Development (1994–1998). Each project involved an average of ten organisations from different European countries. Financial support granted through Biomed 2 contributed to 600 projects, 6,100 scientific teams and a budget of ECU 336 million. The funds to be allocated to the fifth R&D Framework programme (1998–2002) have been increased by 100 per cent.

European Campaign to reduce work-related disorders

Musculoskeletal disorders (MSDs) are one of the most common work-related ailments. They affect millions of European workers in all sectors and cost billions of euros every year in lost productivity and increased health care and social costs. MSDs cover a wide range of problems including back pain and 'repetitive strain injuries'.

The European Agency for Safety and Health at Work is therefore launching a major information campaign that aims to cut the number of work-related back injuries and other musculoskeletal disorders. The Agency, which is based in Bilbao, was set up by the European

Union with the objectives of improving the lives of people at work by stimulating the flow of technical, scientific and economic information between all those involved in occupational safety and health issues. The Agency's campaign aims to raise awareness of the existing guidelines, EU directives as well as national legislation. The campaign will run until October, culminating in the European Week for Health and Safety at work. Each member state will decide on the precise week for their national event.

More information on this campaign can be found on Internet site: <http://osha.eu.int/ew2000>

STRATEGY FOR A REAL RESEARCH POLICY IN EUROPE

The European Commission has adopted a document that discusses how to develop a European Research Area. The document responds to the need to stimulate scientific research within the European Union.

Despite the fact that we are entering a 'knowledge-based society', there is, according to EU Research Commissioner Philippe Busquin, "not yet a real research policy in Europe and research hardly ever leaves its national shell. The research done within the European Union is fragmented and insufficiently coordinated and Europe's investments in research are failing to keep pace with competitors in Asia and America."

Although science and technology account for 20 to 50 per cent of economic growth, the public's image of this field remains unfavourable and involvement low. Nevertheless, according to a Eurobarometer opinion poll, 70 per cent of Europeans expect Europe to play an active role in shaping the future of research.

In order to improve this situation, the EU aims to create a frontier free area for research where scientific resources are used to create more jobs and to increase Europe's competitiveness. Special attention will be given to establishing networks between successful research institutions, and to developing a European approach to large research infrastructures,

Measures will also aim at encouraging patent on new technologies and on generating better access to risk capital. Commissioner Busquin believes that the Commission should act as a "coordinator and catalyst" of European research. A first step is to persuade Member States to open up their national research programmes to non-nationals.

NEWS IN BRIEF

Vegetable oils in chocolate?

In most Member States, chocolate may not contain fats or oils other than those found in cocoa and milk, although some EU states, such as the UK, have traditionally allowed some vegetable oils and fats (such as palm oil) in the production of chocolate. A common position on a chocolate directive has now been agreed by the Council that will allow some such fats to remain. This follows a lengthy and controversial debate about the presence of such fats on chocolate, which can not only change the character of the product but also give rise to serious allergies, as in the case of peanut oil.

EU-US HIV/AIDS prevention and awareness programme in the Ukraine

HIV/AIDS is growing at an alarming rate in the Ukraine. In 1995 the World Health Organization (WHO) described the Ukraine as a country with a low HIV prevalence. By 1997 UN AIDS classified it as having the worst HIV epidemic in the region. There were some 28,000 registered cases in the country in June 1999 compared to some 40-80 cases per year before 1994. This is thought to be the tip of the iceberg, given that there is a very limited testing programme and a marked reluctance amongst the high-risk groups to register for testing.

The European Union and the USA have therefore decided to launch a joint programme to help the Ukraine tackle this rapidly increasing threat. This programme aims to help the Ukraine address the threat through better public awareness and prevention measures and better coordination and sharing of best practice amongst those engaged in the front line fight against the disease. It also aims to provide direct support to local NGOs and other groups who are working with high-risk groups. The programme will be financed with grants of 1.8 million euros from the EU and \$2.0 million from the US. It will begin in 2000 and run for three years.

EU launches Car Free Day 2000

The Commission and nine countries launched the European Car Free Day initiative. They have pledged themselves to facilitate the organisation by local authorities of a car free day event on 22 September 2000. Recent surveys indicate that European citizens are becoming increasingly concerned about the air pollution, noise, danger and stress caused by traffic. At the same time the number of cars on the road in European cities continues to grow. A significant majority of car journeys are of less than three kilometres. The initiative aims to raise awareness of the need to change mobility patterns and to raise citizens' consciousness about the benefits of a 'car free' environment, as well as to generate discussion about the development of transport and urban planning.

Winning Hearts Conference

The statistics on Cardiovascular Disease (CVD) are alarming. It is estimated that some 170,000 people in the European Union die of CVD before the age of 65, of which 60,000 die as a result of unhealthy diets and about 60,000 because of smoking. Despite widespread public belief that CVD has been conquered, coronary heart disease and stroke remain the two leading causes of death. A conference on this issue organised by the European Health Network in association with the European Society of Cardiology and with the support of the European Commission, was held on 14 February 2000 in Brussels.

Second EU conference on drug policy

The Parliament, the Commission and the Council held a conference on drug policy on 28-29 February in Brussels. This is the second such conference to be held by the three institutions. The aim of the conference, which was not open to the public, was to build consensus on the future direction of drug policy at the EU level. Workshops focused on demand reduction, supply reduction,

legal aspects and international cooperation. The Council is expected to develop an action plan on drug policy during the first half of this year.

Listeriosis outbreak in France

Seven people died and 20 were reported ill following an outbreak of listeriosis in France at the end of February. French consumers were warned to avoid products such as cheeses made from raw milk, meat products and smoked fish. It is the second outbreak this year in France. Although no other Member State notified the Commission of listeriosis cases under the EU rapid alert system for communicable diseases, France was also asked to make enquiries into whether infected products had been exported to other EU countries.

Commission pursues infringement cases concerning health professions

The European Commission has decided to pursue or step up infringement procedures against a number of Member States concerning their failure to respect Community law on the recognition of diplomas and training relevant to doctors, nurses, dentists and hospital administrations. Countries that the Commission believes contravene EU law in some way in this area include Spain, Portugal, France, the Netherlands and Ireland.

EU logo for organic foods

The European Commission has adopted a regulation to create a European logo to label organically produced farm and foodstuffs. The logo serves to raise awareness amongst consumers about organically produced goods and thus to increase producers' sales. The logo can only be used on agricultural crop products and on foodstuffs that contain 95 per cent organic ingredients. The products must have been submitted to the inspection system throughout the entire production and preparation process including processing, packaging and labelling.