

eurohealth

Health challenges in South Eastern Europe



Kosovo, 1999

Explaining regional differences in mortality in the Balkans

Access to health care for Roma in South Eastern Europe

Children in Serbia and Montenegro

The effectiveness of health impact assessment

COMMENT

Lest we forget

No one could fail to be moved by the terrible and tragic events in south east Asia at the turn of the year. The response of both governments and individuals to an event with a truly global impact has been unprecedented, and much more will be required for many years to come. The appointment of former US President Bill Clinton as the UN's special tsunami relief envoy to push for reconstruction is to be applauded. Such events however can understandably take the spotlight off other areas of the globe, where much work is still needed to improve population health.

Much of this double issue of *Eurohealth* is devoted to health in South Eastern Europe, an area that has been blighted by conflict as well as major economic and political upheaval over the last 15 years. As the editors of this section, Bernd Rechel and Nina Schwalbe, note in their introductory article while Slovenia is already a member, and some other countries are well on the road to joining the EU, the prospect for the others remains bleak. The path to EU membership mirrors that of population health. The health of many in the region has been left behind, and a number of highly vulnerable groups in the region. These include the Roma, displaced persons as well as victims of the sex and drug trades. There is also evidence of emerging HIV/AIDS and tobacco epidemics.

Many health system reforms and initiatives have been undertaken, with some success, but the challenges remain great, compounded in many instances by discrimination and mutual distrust. The international community, as urged by Rechel and Schwalbe must continue to play a part in addressing these challenges. They argue that while much international aid has gone into the area little has been targeted to health care and that it continues to remain a low priority for donors. More than ever at this time of terrible tragedy, there is a need to ensure that existing initiatives in regions such as South Eastern Europe are not neglected.

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Facing (uncomfortable) facts:

The European dimensions of health services

*Philip C Berman
and Petra Wilson*

At the May 17th 'Open Forum' of the European Health Forum – the Commission's interface with civil society in health – one of the parallel sessions explored the challenges of delivering high-quality health services in Europe from the perspectives of mobility of patients and health care professionals, access to services and safety of goods and services.

The first thing to note is that the inclusion of the phrase "health services" in the title demonstrates a seismic shift in the perception of European policy-makers. Since the time of the Maastricht Treaty it had been axiomatic that "health services" and "Europe" could not be uttered in the same breath (at least in public) by any Commission official aspiring to career progression. Article 152 TEC, after all, had clearly stated that "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care". Yet here was the Commission sponsoring and hosting an event that implicitly recognised that Europe does indeed have a role to play in the delivery of health services.

The session in question included presentations from the European Health Management Association (EHMA), the European Public Services Union (EPSU), the Standing Committee of European Doctors (CPME), the European Group representing community pharmacists (PGEU), the European Social Insurance Partners (ESIP) and the Group of Pharmaceutical Wholesalers (GIRP).

Given that all the presentations are on the European Health Forum website, this article would do no great service in summarising the presentations. Instead, it seeks to capture the spirit of the debate which followed the presentations. Facilitated by Mel Read MEP with a powerful blend of exper-

tise, control and enthusiasm, the debate was based on the written questions submitted by the audience after the presentations. It was lively, diverse and illuminating, giving a snapshot overview of the issues in EU health services policy which are currently exercising the minds of groups such as EHTEL (European Health Telematics Association) AIM (the Association of Mutuals), PCN (the Standing Committee of Nurses) as well as other individuals who took part in the discussion.

Issues raised during the debate

The discussion began from the perspective that, despite the year's work on the High Level Process of Reflection, Ministers of Health continue to be reluctant to accept any diminution in the principle of subsidiarity when it comes to health services, although probably all of them would readily accept that EU employment law, EU data protection law and EU product safety legislation all have a significant impact on health service delivery. Certainly, they have acknowledged that as EU citizens increasingly move from member state to member state, EU legislation on the free movement of goods, services and people clearly applies to health services.

The debate clearly acknowledged that the provision of high-quality health services and products in an enlarged Europe is an issue of importance not only to health experts (whether in the guise of DG Health and Consumer Protection or Ministries of Health) but also to policy-makers for finance, trade, and employment (and others). These interlinked interests were de facto recognised at the meetings of the High Level Reflection Process with the participation of the Commissioners for Health and Consumer Protection, Employment and Social Affairs, and Internal Market. Yet it is questionable whether the presence of the three Commissioners signified a common Commission perspective or policy on the delivery of high-quality health services, or whether sufficient communications exist between similar ministries at national level. There are powerfully divergent interests at

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stake in the provision of health services which cannot easily be resolved. One perspective is that health services constitute an economic activity which should be regarded as little different from any other economic activity. A very different viewpoint would consider health care to be a public sector service which needs to be protected from the growing influence of the commercial sector.

Only rarely will there be real consensus within a country on the policy direction which should be adopted in relation to the adoption of market principles to health, and it is even less likely that there will be agreement at a European level. It is essential, though, that the key actors should be involved in the debate both at national and European level. So long as the fiction is maintained that it is Ministers of Health alone who hold the decision-making powers in their own hands, it will be difficult to develop a dialogue that will enable any useful consensus to emerge. The same applies at the European level.

Some considerable discussion focused upon new EU initiatives such as the draft Services Directive and concurred that it is increasingly important that Member States and the European Institutions should attempt to agree on policy directions rather than allowing the European Court of Justice to formulate policy in the vacuum created by indecisiveness. Given the fundamental issues regarding the market that are at stake, the danger is that minimal decisions will be taken on the basis of lowest common denominators. Agreement will be reached to do as little as possible for fear of raising issues that might be difficult to resolve. These are symptoms of a leadership vacuum, with Ministers of Health failing to coalesce around a vision of the added value that Europe can bring to its citizens. Real concern was expressed at the Open Forum session that the draft Services Directive was in danger of destroying carefully constructed health services, built up over the last 100 years, because the Commission had asked Member States to remove any health service measures that fail to comply with internal market regulations. Is it really the case that our citizens want health systems that comply with the internal market, or do they regard the principles of equity and solidarity as of greater value and importance? Certainly, the participants at the Open Forum session were strongly in favour of the latter, including the idea that the European Charter of Fundamental Rights might have a role to

play in ensuring that these principles were not lost.

Drawing many health care strands together

The papers and the subsequent discussion highlighted that it is becoming increasingly important to draw together the many health care strands that have a European perspective – most obviously pharmaceutical products and services, e-Health (focusing in particular on issues such as interoperable electronic health records), and the practical issues of increased mobility of both patients and professionals. In the latter case the focus was on the challenges posed by mutual recognition of qualifications, transparency of professional disciplinary proceedings, as well as clinical reference centres. The discussion also looked at the wider social perspective of health services delivery in the context of an aging population. The need to develop better integrated services is a growing focus at national level, and should equally be reflected at European level through greater collaboration between the Directorates General for Health (and Consumer Protection) and (Employment) and Social Affairs. The Open Method of Coordination was highlighted as a means to integrate these strands so that initiatives are not developed in counter-productive isolation but, rather, that the opportunity for synergistic collaboration can be seized.

During the course of the debate it became increasingly clear that there is a need for greater clarity about the terms that are used. What, for example, does the Commission mean by ‘access’? It seems to mean different things in different contexts. In the White Paper on Services of General Interest, ‘access’ is used to refer to the concept of “universal” access which although it is common-place in the networked industries of water and electricity, does not carry the same philosophical connotation as access in health care; the High Level Process of Reflection focused primarily on access in terms of the right to move from one member state to another for treatment; while the draft Directive on Services considers access primarily in terms of the right of the individual to obtain reimbursement for health care received outside the State of residence. Such terminological confusion is almost certainly not limited to ‘access’. Greater clarity on other terms, such as ‘health services’, ‘markets’ and even ‘public health’ might be beneficial in easing the policy-making process.

“There are powerfully divergent interests at stake in the provision of health services which cannot easily be resolved”

"Real concern was expressed that the draft Services Directive was in danger of destroying carefully constructed health services"

Finally, the increasing recognition that there is a significant European aspect to the delivery of health services needs to be reflected in the composition of committees and in the consultative processes adopted by the Commission. While the involvement of senior civil servants from the Member States might have been appropriate when the more limited definition of public health dominated the European agenda, it is now important that, as the Commission begins to address health service issues, those responsible for delivering health services (and not only their Ministry officials) should be involved in the consultative process. While Ministry officials will contribute a governmental perspective, this can be very different to the perceptions of those who are actually managing and delivering services, either in the acute sector or at primary or community levels. It is thus a real missed opportunity that the new High Level Group on Health Services and Medical Care will not enjoy the benefits that a well balanced representation of all those involved in health services delivery could bring. It is unfortunate that the new High Level Group will limit itself, for the main, to civil servants. We can only encourage the DG Health and Consumer Protection and the Group to make good use of their capacity to call upon external expertise and to ensure that this is done frequently and from a wide range of professionals.

Safeguarding central principles of European health care

On a personal note, the authors of this report recognise that the European boundaries of health care have expanded very significantly in recent months, not merely as a result of the expansion of the Union from 15 Member States to 25, but particularly in terms of the (reluctant) acceptance that health services issues have to be addressed in the context of Europe. The danger still persists, however, that the initiative will be seized not by those who have primary responsibility for health, but by others. Until recently, the vacuum was filled by the judges in Luxembourg. Now it seems increasingly likely that those responsible for the internal market will take the initiative. This constitutes a grave risk, for while the judges had some understanding of the core principles of solidarity and equity, it is certainly questionable whether such values would be shared by the champions of the internal market. History would judge our health care leaders and politicians poorly if, in the rush to develop the internal market as a consequence of globalisation, the central principles of European health care were abandoned in favour of a largely free market. This is the moment for Ministers of Health and the Commission, and in particular the Commissioner with responsibility for health, to show real leadership in safeguarding precious European values.



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The health implications of an expanded EU: Threats or opportunities for the UK and Europe?

On 1st May 2004 the European Union underwent an unprecedented expansion, with the accession of ten new members, most of which had until recently been part of the Soviet bloc. British tabloid headlines predicted catastrophe for the UK, with Eastern Europeans "filling NHS beds" or spreading infectious disease. At the same time, health policy makers looked to the new member states as a solution to a looming shortage of healthcare professionals. This conference will attempt to discover the reality behind the rhetoric.

The programme will include the impact on European health (especially the UK) from the expansion, the impact on healthcare professionals' mobility, and the importance and relevance of the new neighbourhood countries. Further debate will cover the economic implications of the changes and the potential for the use of health as a tool of foreign policy.

Audience: Public health specialists, infectious disease specialists, hospital physicians, political analysts, health policy analysts, academic institutes, non-governmental organisations and policy research units.

Health in South Eastern Europe

*Bernd Rechel and
Nina Schwalbe*

*“The business of
improving health in
South Eastern Europe
is unfinished”*

Much of South East Europe became known as one of the world's worst trouble spots during the last 15 years. In addition to the economic and political challenges faced by all transition countries in Central and Eastern Europe, many of the countries of this region have suffered violent conflict on a scale unknown in Europe since the Second World War. The length of the road 'back to Europe' is a good indicator of future political and economic prospects. The most economically advanced country of the region, Slovenia, was included in the first wave of European Union enlargement in 2004, and Bulgaria and Romania are expected to join in 2007. Croatia and the Former Yugoslav Republic of Macedonia have submitted their membership applications. While Croatia looks firmly set on the path to accession, Serbia and Montenegro is lagging behind. But the prospects are bleak for Bosnia and Herzegovina, which barely functions as a state, and a question mark hangs over the future status of Kosovo. Moldova, finally, has been designated one of the European Union's 'new neighbours', with little hope of joining the Union any time soon.

How have wars and transition affected the health of the people of South East Europe and how have governments responded? While the wars in the countries that emerged from former Yugoslavia received wide media coverage, there is scant information on the health of the people living in this region. What is quite clear, however, is

that the impact of transition and conflict has been substantial.

The break-up of Yugoslavia left hundreds of thousands of people dead and millions became refugees and internally displaced persons. The economies in the region plummeted, with a devastating effect on the region's health infrastructure. The regulatory ability of states disappeared, corruption ran rampant, and many people were forced into poverty. In the post transition years, a number of extremely vulnerable population groups have emerged, including victims of trafficking and prostitution, refugees, internally displaced people and Roma.

The governments in the region have responded to this health crisis with a series of reforms and programmes. Health care funding has been based on payroll contributions, primary health care was strengthened and more emphasis put on health promotion. Effective systems for disease surveillance are now being established and there is a push to reform mental health care in all countries of the region. In spite of the scale of the challenges, a number of successful projects and programmes have been implemented in recent years.

But much more needs to be done. Health care financing must be reformed to ensure equality of access, especially for vulnerable populations. An emerging HIV/AIDS epidemic must be stopped, a tobacco epidemic reversed, and greater emphasis given to health promotion and public health infrastructure. The business of improving health in South Eastern Europe is unfinished.

International donors have spent large sums of money on the region in the aftermath of war, but almost none of the post-emergency resources went to health care and the issue remains a low priority for donors. Of the billions allocated for overall development aid, only a small fraction was dedicated to the health sector. In many countries it accounts for well below 1% of total external assistance.

Now that peace has returned and the world's attention has shifted to Iraq, there is a danger that health in the region will again be neglected. Yet, a healthy population will be crucial for economic growth and regional stability, and the international community must play its part in addressing these challenges.

External funding for health for South Eastern Europe in US \$ (1997–2001)		
Albania	37,757,064	3,122,000
Bosnia and Herzegovina	120,991,210	4,067,000
Bulgaria	30,985,432	8,033,000
Croatia	22,265,354	4,446,000
Macedonia	34,115,676	2,035,000
Moldova	16,120,119	4,276,000
Romania	225,152,370	22,437,000
Serbia and Montenegro	34,979,528	8,600,000

Source: World Health Organization, Evidence and Information for Policy (EIP), 2004.

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The European Union, South Eastern Europe and the wider European neighbourhood

*Martin McKee,
Bernd Rechel and
Nina Schwalbe*

*“EU support for
infectious disease
surveillance systems in
the new neighbours is
required”*

The wider European neighbourhood

The historic enlargement of the European Union on 1st May 2004, bringing in eight central European and two Mediterranean countries, has inevitably raised the question of “where next for the EU?” In March 2003 the European Commission published a Communication to the Council and the European Parliament, setting out a vision for a “Wider Europe Neighbourhood”.¹ The document became the basis for the European Neighbourhood Policy, directed at the new eastern and southern neighbours of the European Union (Box 1). The Communication was concerned with countries that do not currently have the prospect of EU membership, and the Council and the European Parliament have subsequently stressed that this policy should be seen as separate from the question of possible EU accession.

The document underlines the importance of working with these countries to promote their prosperity (Box 2). In particular it identifies the need to develop an integrated market with liberalised trading rules, create a political framework that enhances the rule of law and bolsters economic activity, promote environmental protection that will support sustainable development, and develop co-operation in science and tech-

nology that will catalyse economic progress.

The EU’s priorities can best be assessed by examining the concrete actions it proposes. Many of these have major implications for health. For example, the EU advocates broadening and deepening existing free-trade arrangements. Clearly this provides many opportunities for mutual benefit, yet an unintended consequence could be that increased trade would allow trans-national tobacco companies to exploit their powerful positions to subvert domestic tobacco control policies as they have already done in many countries of the former Soviet Union.²

Second, the EU advocates policies on migration that will facilitate movement by “bona fide nationals [...] who have legitimate and valid grounds for regularly crossing the border and do not propose any security threat.” Again, greater mobility can bring many benefits for the EU and its neighbours but the movement of people and goods has always been accompanied by the movement of infectious disease. Strengthening the ability to detect, investigate and contain cross border outbreaks is key. This will require EU support for surveillance systems in the new neighbours.

Box 1 THE “NEW NEIGHBOURS”

Algeria	Lebanon
Armenia *	Moldova
Azerbaijan *	Morocco
Belarus	Palestinian Authority
Egypt	Russia
Georgia.*	Syria
Israel	Tunisia
Jordan	Ukraine

* included in May 2004

Box 2 THE EUROPEAN UNION’S OBJECTIVES FOR THE WIDER EUROPE NEIGHBOURHOOD

- To work with the partners to reduce poverty and create an area of shared prosperity and values based on deeper economic integration, intensified political and cultural relations, enhanced cross-border cooperation, and shared responsibility for conflict prevention between the EU and its neighbours.
- To anchor the EU’s offer of concrete benefits and preferential relations within a differentiated framework which responds to progress made by the partner countries in political and economic reform

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The new European Centre for Disease Prevention and Control can play a key role, but it must have adequate resources.

Third, it calls for the EU to play a greater role in crisis management, specifically in facilitating the resolution of disputes in areas such as Palestine, the western Sahara, and Transdnistria (a breakaway region of Moldova), which will have immediate effects on the health of the people living in these areas. Other areas where health plays a central role in the EU's relations with its new neighbours range from enhanced cooperation to tackle the trafficking of human beings and drugs, developing collaborative industry in science and technology, and promotion of human rights and environmental protection.

The process is moving ahead rapidly and, in May 2004, the mechanisms for co-operation were set out in detail.³ For each of the new neighbours, the European Union envisages the drawing up of Neighbourhood Agreements, with detailed Action Plans and a timetable for the achievement of benchmarks. The jointly agreed Action Plans resemble the enlargement process in many ways. Thus, even though EU membership is not on offer, these plans will be based on a commitment to shared values of human rights (including minority rights), the rule of law, good governance, and neighbourly relations. They will cover political dialogue, economic and social development policies (including involvement in EU programmes on education and research), trade, and justice. The plans will be specific to each country, taking into account their different stages of economic and political development.

The Agreements will be supported by a new financial mechanism, the European Neighbourhood Instrument, backed by €255 million for the years 2004–2006. However, the European Parliament noted in November 2003 that the scale of funding is probably inadequate to support new activities without impacting negatively on existing ones and so should be reconsidered for 2007 and beyond.⁴

Given the integral relationship of health to many of the objectives being pursued, it would seem evident that Directorate General (DG) Sanco and DG Social Affairs would need to participate actively in this process. Yet so far they have not. A Task Force on Wider Europe has been established within DG External Relations and while it includes experts in areas such as the internal market, justice, transport, and

environmental policy, there are no dedicated experts on health.

By launching its European Neighbourhood Policy, the EU has accepted that it must play a role in promoting peace and prosperity in the countries that surround it. The EU already contributes to the development of policies that will promote health among its 385 million new neighbours, through mechanisms such as the Barents Euro-Arctic Council and the TACIS programme. The challenge now is to bring these activities to the forefront of its newly developing relationships in this region.

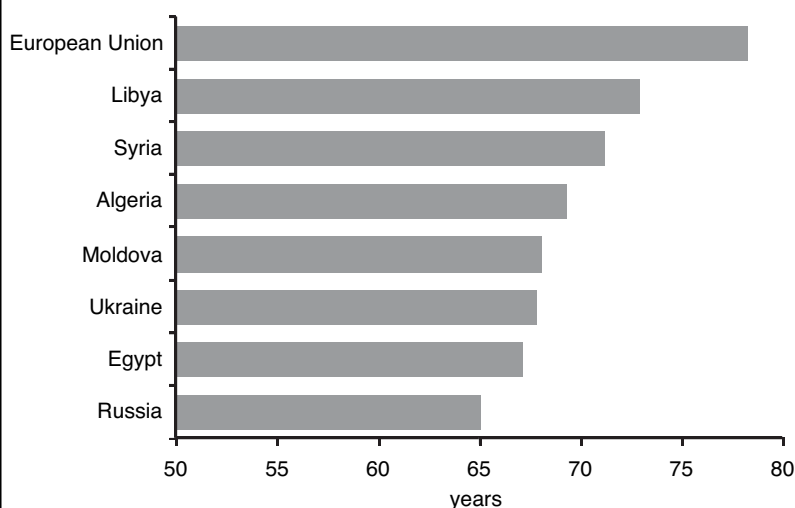
South Eastern Europe

Although the countries of South Eastern Europe would seem by their geography to fall into the “new neighbour” category, this has not proven to be the case. The reasons vary. Some of these countries are already on their way to full integration with the European Union. Bulgaria and Romania are in line for accession in 2007 and Croatia has been awarded candidate status and expressed its hope of joining the EU at the same time as Bulgaria and Romania.

For the countries of the Western Balkans (Albania, Bosnia and Herzegovina, Croatia, the former Yugoslav Republic of Macedonia and Serbia and Montenegro), in 1997 the EU launched the Stabilisation and Association Process. This process offers these countries the prospect of full integration into EU structures. The first hurdle for accession is forming a Stabilisation and Association Agreement with the European Union. So far, only Croatia and the former Yugoslav Republic of Macedonia have

“It is essential that health issues play a central role in the Neighbourhood Agreements, Action Plans, and Stabilisation and Association Process currently underway”

Figure Life expectancy at birth in the European Union and selected new neighbours



Source: WHO

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- signed such agreements. The former Yugoslav Republic of Macedonia, the first country to sign, did so in April 2001, and the agreement entered into force in April 2004. In March of 2004, the country submitted its application for EU membership, but it is unclear when it will achieve candidate status, in view of its dire economic situation and continuing ethnic friction.
- The EU has stressed that its European Neighbourhood Policy does not apply to the Western Balkans. Indeed, the prospect of these countries of becoming members of the EU was endorsed by the European Council meetings in Feira in 2000 and Thessaloniki in June 2003 and has been reaffirmed by the Communication from the European Commission. However, while the EU has maintained this formal commitment, it is still unclear when the remaining countries and territories of the region (Albania, Bosnia and Herzegovina, Serbia and Montenegro, and Kosovo) will be able to join the enlarged Union. For them there are few prospects for signing Stabilisation and Association Agreements with the European Union, not to speak of achieving the status of candidate countries. A study published in 2003 demonstrates that, throughout this region, people can expect to live between five and ten years less than their neighbours inside the EU, infant mortality is almost three times higher, many children have high rates of iodine deficiency and anaemia, and there is widespread use of tobacco, illegal drugs and alcohol.⁵
- The only country from South Eastern Europe which has been included in the New Neighbour policy is Moldova, which is by far the poorest “new neighbour”, with a per capita GDP of only €417.¹ Recently, Moldova has become a member of the Stability Pact for South Eastern Europe, which was launched at the EU’s initiative in 1999, in the aftermath of the Kosovo crisis. The Stability Pact is an initiative of a number of international organisations, including the EU, the G8, the OSCE, the Council of Europe, OECD and the UN. It aims to contribute to stability and development of the region, but is separate from the Stabilisation and Association Process which is led by the EU and associated with integration into the European Union. Moldova has expressed its wish to be included in the Stabilisation and Association Process and in September 2003 presented a Concept for the Integration of the Republic of Moldova into the European Union.
- In the Communication of the European Commission on the wider European neighbourhood, Moldova’s (and Ukraine’s) membership aspirations were recognised, but it was also stated that the EU must await completion of the 2004 enlargement and only then debate further enlargement. Resolving the situation in Transdnistria will clearly be key to the discussion, as Transdnistria was described in the Communication as a “magnet for organised crime”⁶ which can destabilise the process of state-building, political consolidation and sustainable development. During a visit to Moldova in December 2003, Commissioner Verheugen reassured the country that the New Neighbourhood Policy and possible accession are two separate processes, but also made clear that accession of Moldova is not on the agenda for the moment.

Conclusion

It is in the interests not only of their own citizens, but also of the EU, that the countries in South Eastern Europe and the “new neighbours” should be peaceful and prosperous. Yet it is clear that they face many problems, including in the area of health.

Projects such as the Commission on Macro-Economics and Health have provided important new insights into the contribution that good population health plays in economic development, an argument that has proven more persuasive to many policy-makers than the equally important one that health should be a measure of progress in its own right.

A healthy population is the basis for an effective workforce, not just because of reductions in sickness absence but also because the prospect of a long life is an incentive for individuals to invest in their own future, through education and skills acquisition. A healthy population will also reduce the cost of health care, which will benefit not only the state directly but, more importantly, the many families that would otherwise use that money to invest in wealth creation. It is therefore essential that health issues play a central role in the Neighbourhood Agreements, Action Plans and in the Stabilisation and Association Process currently underway. To both be a good neighbour and protect its own citizens, the EU must help surrounding countries to tackle the burden of disease and premature death by investing significant financial and technical resources in the “neighbourhood.”

Explaining regional differences in mortality in the Balkans:

A first look at the evidence from aggregate data

Arjan Gjonça

“Overall mortality trends cannot be explained by changes in infant mortality”

Introduction

While studying mortality in Eastern European countries, scholars have often posed the question of why some of the Balkan countries did not experience the same mortality crises in the 1980s as most of the former communist countries of Eastern Europe? Mesle^{1,2} points out that countries such as Albania and Yugoslavia, which had the worst life expectancy at birth in 1950, were among the leaders of Eastern European countries in 1990. Some authors have tried to provide explanations of this different mortality trend by focusing on particular countries.^{3,4} This research question is not just an important one to study, but it also highlights the fact that despite its diversity the Balkans still remain an area that should be studied as a unit. It is obvious that there is a profound shortage of, and urgent need for, comparative studies of mortality in the Balkans which should not just detail but also try and find plausible explanations for mortality patterns. In outlining the main mortality changes before and after 1990 this paper tries to explain the regional differences in mortality in the Balkans.

The mortality of any population is determined by a complex set of factors. While socioeconomic determinants, such as income or urban-rural status are often considered, longer-standing cultural factors are often hard to assess. Nevertheless, there are parts of the world where issues such as diet and life-style, often linked both to geography and history, are important considerations for a full understanding of a population's health. One such region is the Balkans. It is also important to recall that an awareness of the past is an essential component to any understanding of the present, or presumption for the future. That is why this paper focuses not only on the regional mortality differences in the

Balkans in 1990, but analyses trends and patterns prior to and after 1990.

Data description and methodology

The mortality of the populations studied here are generally well documented; regular censuses and more or less complete death registration data are available for all Balkan countries from the early-twentieth century, or even earlier in the case of Greece and Bulgaria. The detail and the quality of mortality data is of course somewhat varied, and not all data are available classified by region. The quality of mortality statistics for the Balkan countries is high, even in countries where doubts have been raised about the quality of mortality statistics, they are similar to those in most developed societies.^{2,5}

Aggregate level data on mortality is used here, taken from publications of national statistical offices of the Balkan countries, as well as international publications. In order to check the accuracy of these data, as well as to complete possible missing data, other international publications are also used, such as the Demographic Yearbooks of the United Nations. Other data related to possible determinants of mortality patterns in the Balkans have also been collected by national and international publications. One important point to make here is that individual level data that can explain the casual mechanism for mortality patterns are very difficult to find in the Balkans, consequently results are primarily based on aggregate level data, using life table functions and standardised indexes.

The analysis concentrates on the period between the end of the 1980s and beginning of the 1990s for two different reasons. First, most of the Balkan countries experienced the same social, political and economic systems as the rest of Eastern Europe until 1990. Second, after 1990 the Federal Republic of Yugoslavia disintegrated, and the Balkans experienced the formation of the newly independent states Bosnia and Herzegovina, Croatia, FYR

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Macedonia, Serbia and Montenegro and Slovenia, with data on mortality trends often missing or of problematic quality.

The focus is on a national perspective, as well as sub-regions within national states where data are available. It is important to emphasise that focusing on sub-regions, the analysis of mortality patterns reveals similarities or diversities not noticeable at a national level. This is important in the Balkans, which is home to at least twenty identifiable ethnic groups, ten languages, three alphabets and three main religious groups. Behaviour and life style factors are not always generalisable at the national level. They might be related to history, geography, climate and other factors that are not confined by national borders.

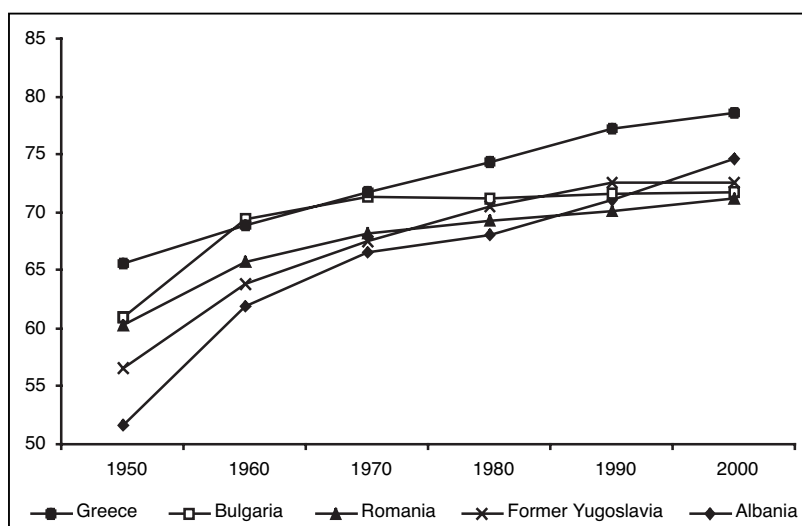
Results of mortality comparisons in the Balkans

Long-term changes

Since the Second World War, mortality rates in the Balkan countries, with the exception of Greece, have been converging. Directly after the Second World War, there was a large difference between life expectancy at birth (see Figure 1). Excluding Greece, life expectancy at birth in 1950 varied by 7 years for men, and 12 years for women. The large variation in female life expectancy is attributable largely to the situation in Albania, where it has been argued that the traditional values of society put female infants at a disadvantage.⁵ The mortality of these countries began converging after 1970, unlike what was happening elsewhere in Europe. In 1990 the variation in life expectancy at birth, again excluding Greece, was around 2.8 years for men and 2.3 years for women. The most substantial improvement during this period occurred in Yugoslavia and Albania. Life expectancy at birth for Yugoslavia and Albania improved respectively by 14.6 and 16 years for men and 17.6 and 23 years for women. Improvement in Romania has been slow compared to the other Balkan countries, while in Bulgaria mortality has worsened since the 1970s, in particular for men. This experience was also observed in other East European countries, where reductions in mortality began stagnating from the 1970s onward.^{1,6}

When different components of overall mortality are considered, a different picture can be observed. Table 1 shows infant mortality rates since 1950. Dramatic reductions in infant mortality rates occurred in all Balkan countries, but more so in Albania and Yugoslavia, where they had been exceptionally high in the 1950s. Contrary to life expectancy at birth, infant mortality rates remain very diverse even in the 1990s. Thus, Albania and Romania, despite improvements during this period, still in 2000 have very high infant mortality rates of approximately 23.7 and 21.9 deaths per thousand live births respectively. In contrast, Greece and Bulgaria have relatively low levels of infant mortality, at 6.4 and 15.1 deaths per thousand respectively. As with life expectancy at birth, Greece has a much lower infant mortality trend. An interesting feature of these trends in infant mortality rates is that despite the high life expectancy at birth achieved by most of these countries in the 1990s, infant mortality rates, including those for Greece as well,

Figure 1: Life expectancy at birth in years, both sexes combined



Note: Data on Albania are corrected for the completeness of death registration. Data for 2000 from the Former Yugoslavia refer to Serbia and Montenegro

Source: Country statistical and UN demographic yearbooks.

Table 1: Infant mortality rate per 1000 infants, both sexes combined

	1950	1960	1970	1980	1990	2000
Albania	134.0	100.9	89.6	66.2	41.6	23.7
Bulgaria	108.2	45.1	27.3	20.2	14.8	15.1
Romania	118.1	75.7	49.4	29.3	26.9	21.9
Former Yugoslavia	139.8	87.7	55.5	31.4	20.2	18.4
Greece	43.6	40.1	29.6	17.9	9.7	6.4

Source: Country statistical and UN demographic yearbooks.

remain high by the standards for developed societies.

Importantly, overall mortality trends seen from the 1970s onwards among some of the Balkans cannot be explained by changes in infant mortality. Changes in adult mortality for those aged 15 from 1950 to 2000 are shown in Table 2. Interestingly quite a large amount of variance in mortality in the Balkans may be due to variations in mortality for this group. Thus, in 1990, life expectancy at age 15 varies from 57.3 years in Romania to 60.6 years in Albania and 63.0 years in Greece. Another very distinctive feature is that instead of a convergence in mortality rates, what one can see is a divergence over time. The countries with the greatest improvements in life expectancy at age 15 with 6.6 years are Yugoslavia and Albania with 6.9 years gained between 1950 and 1990. In Greece, life expectancy increased 4.7 years between 1960 and 2000, while in Bulgaria life expectancy at age 15 was actually lower in 2000 than in 1960.

It is surprising to see a controversial pattern such as that in Albania, where the infant mortality rate has for some time been among the highest in Europe, while adult mortality rates are among the lowest. Previous research has found that this controversial pattern is due to the importance of diet and life style factors.^{7,5} Could similar factors be at play in the other Balkan countries?

Regional patterns of adult mortality

In attempting to analyse patterns of adult mortality in Europe, scholars to date have focused on two major divisions in Europe. The first is the division between Northern and Southern Europe (or the Mediterranean), where the mortality rates of adults in the latter group are much lower. These differences are not just found between nation states, but also within particular countries. Thus, distinctive differences are found between northern and southern Italy, where mortality is much lower in the Mediterranean south compared to the more continental north. This north-south gradient of mortality differences is found also in other Mediterranean countries, such as France, Portugal and recently in Albania.^{7,5} Most of these differences are attributed to the effects of the Mediterranean diet and life style. The second dimension of difference in European adult mortality is that found between western and eastern Europe.^{1,2,6,8} The collapse of communism in Eastern Europe has been accompanied by an increase in death rates

Table 2: Life expectancy at age 15 in years, both sexes combined

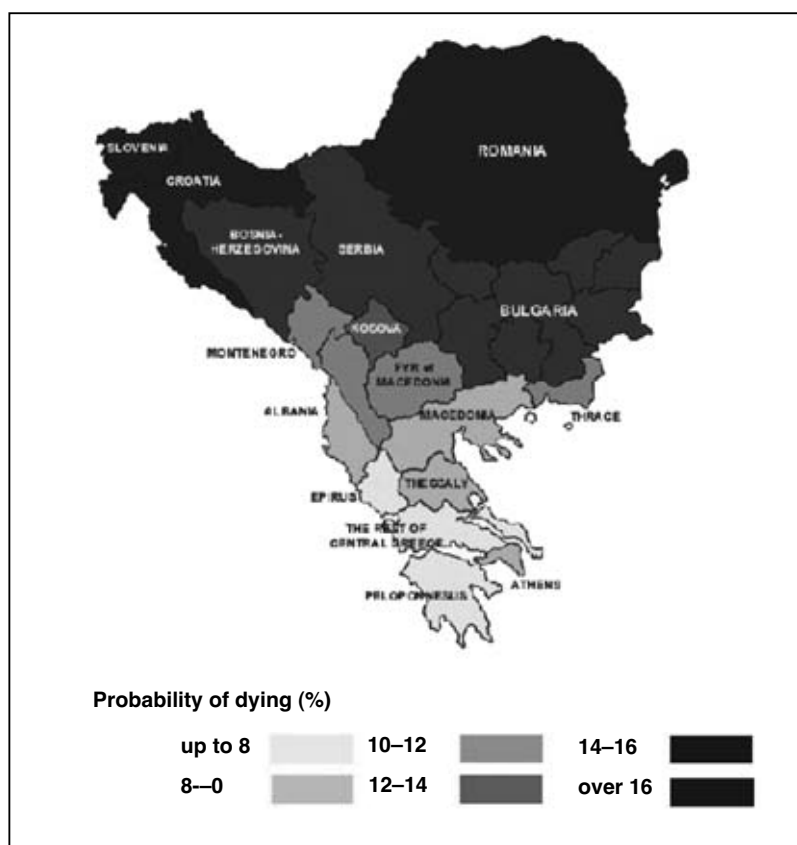
	1950	1960	1970	1980	1990	2000
Albania	53.7	58.5	60.0	60.2	60.6	62.4
Bulgaria		58.7	58.7	58.0	57.9	58.0
Romania		56.7	57.4	56.9	57.3	57.8
Former Yugoslavia	52.5	56.4	57.2	58.2	59.1	58.9
Greece		58.8	60.1	60.6	63.0	63.5

Source: Country statistical and UN demographic yearbooks.

among adults, especially among males, since the late 1980s. Different authors attribute this to a range of factors, including the effects of increased stress due to economic, political and social uncertainty and a rise in smoking and alcohol consumption.

Figure 2 shows the differences in adult mortality by region for all Balkan countries for 1990 (although detailed regional infor-

Figure 2 Sub-regional differences of adult mortality in the Balkans in 1990, measured by the probability of dying between ages 15 and 60



Note: Data on Bulgaria refer to the whole country, not to regions

“Mortality differences are very much related to geographical position”

mation is lacking for Bulgaria and Romania). It clearly shows both gradients of mortality in Europe, the difference between north and south as well as between east and west. Thus the areas with the lowest adult mortality are the Greek regions of Crete, Peloponnesus, Central Greece and Epirus. Then, south-west Albania and the Greek regions of Thessaly, Macedonia and Athens do slightly worse, but better than the rest of the Balkans. The regions that follow are north-east Albania, Greek Thrace, FYR of Macedonia, and Montenegro. The central Balkans follow this group, Bulgaria and Serbia, while the worst adult mortality is found in the extreme north-east, in Romania, and in the extreme north-west, in Croatia and Slovenia. Just looking at this map it is clear that mortality differences in the Balkans are very much related to geographical position.

What are the factors shaping adult mortality in the Balkans?

As noted, individual data on determinants of mortality are missing, not just for the Balkans as a whole, but also for individual countries and at the sub-regional level. In such circumstances any effort to try and find a casual mechanism to identify the influence of different factors on mortality patterns is limited. Discussion must be based on existing evidence from aggregated level data.

Different authors have studied the relationship between socioeconomic development and levels of mortality. In the former Yugoslavia one can possibly relate the level of development of different regions with the level of infant mortality. Kosovo and FYR Macedonia had the highest rate of infant mortality in 1990, while being the most underdeveloped regions of Yugoslavia. However, it is impossible to find any correlation between the level of adult mortality in former Yugoslav regions and their level of social and economic development. Thus, Kosovo and FYR Macedonia have comparatively low levels of adult and cardiovascular mortality. Also Matsaganis found that there was no relationship between the social and economic development of Greek regions and their levels of overall mortality.⁹ The two extreme regions, Athens as the wealthiest and Thrace as the poorest, have very similar mortality rates.

Our own analysis of adult mortality found that, historically, these two regions have the worst levels of adult mortality in Greece. The case of Albania is similar. It

has been shown that there is no relationship between regional differences in overall or adult mortality and the level of education in Albania (education taken as an indicator of development). No relationship was also found between the level of urbanisation and industrialisation and mortality differences.⁵

Where socioeconomic differences cannot account for regional differences in mortality, one has to turn to possible life-style factors. It has been established for a long time that the low mortality in the Mediterranean countries can be attributed to the positive effects of the Mediterranean diet. High intakes of mono-unsaturated fats, low intakes of saturated fats and high consumption of fresh fruit, vegetables and wine have often been cited to account for the differences between northern and southern European mortality.

It is ironic that some of the first evidence supporting the positive effects of Mediterranean diet and life style came from a study which involved some of the Mediterranean populations of the Balkans. The ‘Seven Country’ study, which included 16 cohorts from different populations and countries and followed them over the course of twenty years, included six cohorts from Balkan populations. In Greece two cohorts of men aged 40–59 were enrolled in the study, one cohort from Crete and the other from Corfu. In former Yugoslavia, there were about four cohorts, two of them in Croatia (Dalmatia and Slavonia), and two in Serbia (Velika Krsna and Zrenjanin).^{10,11}

The authors found marked differences in the 15 year death rates and coronary heart disease rates for the Balkan cohorts in the study. Death rates were low in Corfu and Crete, most notably those for coronary heart diseases. Another piece of interesting evidence of this study is that the death rate for all causes and for coronary heart diseases in Dalmatia are much lower than in Slavonian Croatia.

Apart from other factors, the authors looked at the relationship between the rates of coronary heart disease and calorific intake in diet from total fats, unsaturated and saturated fats. The study showed a high correlation between the average percentage of dietary energy from saturated fatty acids and the incidence and death rates from coronary heart disease. The most important finding of this study for us is that, first, differences in mortality due to coronary heart disease between Crete in

the south of Greece and Corfu in the north are explained by the use of olive oil in the two cohorts; and secondly, so are the differences between Dalmatia in the West Croatia and Slavonia in East Croatia. Thus, most of the research coming from this study supports the positive effects of the Mediterranean diet in explaining the regional differences between these cohorts, which reflect the regional differences in adult mortality in the region.

This evidence is also supported by the case of Albania. It was originally argued that the low mortality found in Albania could be attributed to the traditional forms of Mediterranean diet in the country.⁴ But, latterly it has been suggested that even the regional differences in Albania can be explained by different regional dietary patterns of the country.⁷ Thus, the north-east having a more continental dietary pattern, where animal fats are widely used, has a worse mortality than south-west Albania, where a Mediterranean dietary pattern, based on a large use of olive oil, fruits and vegetables is predominant.

Conclusion

It was stated earlier in this paper that the research reported here is only a first tentative step towards a thorough comparative epidemiology of the Balkans. In order to make further progress we need more consistent and detailed aggregate information, including regional information on Bulgaria and Romania, as well as a greater body of individual level data. Obtaining this information becomes even more problematic for the 1990s due to the conflicts that gripped the region.

However, we can sketch out the beginnings of a comparative analysis and advance a hypothesis to form the basis of future research: that diet does indeed play a major role in determining regional mortality patterns. When considering trends over time, diet may be an important consideration in understanding why some South-East European countries, such as Albania and Yugoslavia, did not experience the worsening mortality during the 1970s and 1980s seen in many other communist countries of Eastern Europe. However, this remains highly speculative.

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Access to health care for Roma in South Eastern Europe

Ivan Ivanov

“For many years strategies addressing issues related to Roma health have been inadequate”

Introduction

When examining the state of health of a population it is necessary to examine both the concept of ‘health’ and the population’s access to health care. As a concept, health can be conceived of as: the capacity for each human being to identify and achieve his/her ambitions, satisfy his/her needs and be able to adapt to his/her environment which should include decent housing, normal access to education, adequate food, a stable job with regular income and sufficient social protection.¹

Access to health care is a right and a prerequisite for good health without which full participation in social, economic, and political life cannot be enjoyed.² Unfortunately many Roma people in South Eastern Europe face disadvantages in accessing housing, education, adequate food and a stable income, elements that contribute to overall health. In addition, access to health care for Roma in the region is generally more limited than for the non-Roma population.

For many years the strategies addressing issues related to Roma health have been inadequate. However, the situation has become particularly acute in the post communist period. Studies of health care reforms in the region have brought to light very alarming tendencies, including low life expectancy, high premature mortality and high levels of morbidity among the Roma population. Although these tendencies preceded the fall of communism, the Roma have encountered many additional difficulties with the privatisation of public services and the transition towards a market economy in the last decade. Today, most Roma in the region live in conditions of overwhelming poverty, and permanent stress. Communities lack proper sanitary systems and suffer from poor nutrition, leading to deterioration in their health status.

Roma health

Research shows that the rate of illness

among the Roma is higher than that of non-Roma and that they have lower access to health care. Poverty is the most powerful factor contributing to the worsening of Roma health. Unemployment, poor living conditions, illiteracy, lack of information and isolation negatively influence their health.

Of particular importance is the extremely high unemployment rate. In some Roma neighbourhoods in Bulgaria this is between 90 and 95%,³ with similar figures found in other countries in the region. (This may not however capture informal employment so actual unemployment rates may be somewhat lower). The Roma cannot afford to pay doctors’ fees and buy prescription medicines. Transportation to hospitals and specialised medical centres is often beyond their financial means. Roma settlements are usually located in isolated areas or on the outskirts of a town or village with limited access to public services. They lack the necessary infrastructure for normal living such as sewage systems, indoor running water, power supplies and telephone networks. All these factors directly impact on the health in these settlements. The combination of physical, economic and information-based barriers to preventative health care that many Roma face in their every day life is a consequence of the inter-related effects of poverty, discrimination and lack of familiarity with health care institutions.

Discrimination in accessing health care

Discrimination and prejudicial attitudes are a pressing concern for Roma in all areas of life, including the health care sector. Discriminatory treatment by health care workers including physical and verbal abuse and negligence in examinations works further to alienate the Roma from the health care services. They are often denied medical care because of their ethnic background. Romani women are disproportionately affected by such treatment given their generally higher interaction with health services. As observed in Italy, discriminatory behaviour on the part of

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health care workers can also impact on the rights of children to access health care services.* A recent survey conducted among fourth and fifth year students in Hungary revealed that about 10% of future doctors are strongly and about 40% mildly prejudiced against the Roma. Other studies have shown that many doctors, nurses and other medical staff in South Eastern Europe feel hostility towards the Roma, based on their colour of skin, poverty or lack of education.

A number of Romani women have reported such discrimination to international organisations. A Bulgarian woman told the European Roma Rights Centre in Budapest that she was refused specialised medical treatment after experiencing a miscarriage because of her ethnicity. A specific example of discrimination and negligence based on a patient's Roma origin is a case from Elhovo, Bulgaria. In this case, a Romani woman who was seven months pregnant experienced pain and then examined by a local doctor. After discovering that the unborn child had died, the doctor sent his patient to the regional hospital, but the hospital's doctors were very unfriendly and hostile with both the local doctor and the Romani woman. They informed him that he should treat Roma patients locally and not send them to the hospital. Following this argument, the pregnant woman was left for more than two hours in the corridor and in the evening her condition deteriorated, and as a result she died.

Segregation in hospitals and maternity wards is common practice, being the rule rather than the exception. Roma patients often stay in separate rooms, reserved for the Roma. Many Roma have said that they have been intentionally segregated by medical staff and believe that they receive lower quality medical treatment and less attention than other patients. For instance Roma women from Bulgaria have said that they have been segregated in maternity wards, with one woman and her new born baby placed in the hospital corridor while non-Roma women were in separate rooms. The Romani women also complained that doctors were rude to them and that cleaning staff did not maintain standards of good hygiene in their rooms.

Furthermore, doctors in their capacity as general practitioners (GPs) act selectively and refuse to enroll Roma patients on their patient lists, even though they have very limited rights for doing this. Refusal by GPs to accept Roma patients has a direct effect on their access to health care.

Without advice from a GP and lacking the money to pay for non-subsidised treatment, they have no access to medical tests or specialists.

Conclusion

In order to achieve substantial improvement in the health situation of Roma, the governments in South Eastern Europe should take a multi-sectoral approach to address discrimination, as well as problems regarding access to social benefits, education, decent living conditions and housing. Governments should adopt comprehensive anti-discrimination legislation expressly prohibiting discrimination in access to health care, accompanied by the establishment of special bodies to monitor implementation. It will be crucial that governments also include the Roma in the strategic planning and implementation process aimed at improving Roma health.

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“Discrimination and prejudicial attitudes are a pressing concern for Roma in all areas of life”

* See for example UN Committee on the rights of the child, concluding Observations: Italy. CRC/C/15 Add. 198. 18 March 2003, para 54; and CRC/C.15/Add. 201, 18 March 2003, para 67.

Treatment of drug addiction in South Eastern Europe: A country overview

*Andrej Kastelic and
Tatja Kostnapfel
Rihtar*

*“Experts in the region
are not satisfied with
progress made in most
of these countries”*

This article presents an overview of the treatment of drug addiction in south eastern Europe and of the obstacles to comprehensive treatment and advocacy efforts in the region. It draws on the experience of the South Eastern European Adriatic Addiction Treatment Network (SEEAN).

SEEAN was established in Sarajevo in October 2003. The network is an informal organisation of experts on addiction treatment and harm reduction from the countries of south eastern Europe and the Adriatic coast. It aims to give mutual support in training and in developing substitution treatment programmes in the region. A database of experts and institutions is under construction and a website has been established (www.seea.net). The network has published a regional magazine (Ovisnosti-Ovisnosti-Zavisnosti-SEEA Addiction, available on the website of the network) and several regional conferences have been organised.

A central focus of the article is the availability of drug substitution treatments in the region, particularly methadone maintenance treatment (MMT). The status of available treatment varies widely from country to country.

Albania

Since the early 1990s, Albania has recorded a steady increase in problems related to the production, trafficking and use of illicit drugs. Between 2001 and 2004, an estimated 4,500 drug addicts were in need of treatment. Young people between 20–24 years of age were among the most vulnerable (54% of all treatment demanded), but equally alarming was the high number of those under 19 years of age (23% of treatment demanded), a number rising rapidly in recent years, especially among members of the Roma minority.

Methadone has been registered in Albania since 2002, but its costs are not covered by the state or any insurance agencies. At present, methadone is available only in one licensed private pharmacy at a relatively high price. Although short-term

methadone detoxification was piloted in the Toxicological Clinic in Tirana, the eligibility requirements are fairly restrictive and in 18 months, only 68 patients were treated.

The existing treatment infrastructure is clearly insufficient. For this reason, in 2004 the non-governmental organisation (NGO), Aksion Plus, will begin a MMT programme under the supervision of the Institute of Public Health, with the financial support of the International Harm Reduction Development Programme of the Open Society Institute (OSI) in New York. Uniquely in the region it is the only MMT programme run by an NGO.

Bosnia and Herzegovina

A government-funded methadone detoxification programme was initiated in the canton of Sarajevo in January 2002. MMT began in July 2002 and in the first four months 40 patients were treated. Methadone is also used in other cantons of the country, but it is given only on ambulatory basis. The Public Institute for Alcoholism and Substance Abuse of the canton Sarajevo, however, plans to implement MMT in other large cities.

Bulgaria

Recently in Bulgaria some substantial steps have been taken towards extending the availability of treatment services to meet growing demand. In the Bulgarian National Programme for Prevention, Treatment and Rehabilitation of Drug Addiction 2001–2005 and the National Strategy to Combat Drugs 2003–2008, MMT is now considered a core intervention for opiate dependence and a backbone of the future national system for addiction treatment. MMT is seen as the treatment option of choice, providing a quick professional response to the majority of drug users seeking medical treatment.

The most important developments are the opening of new substitution programmes and an increase in the number of treatment slots. By the end of 2005, the government plans to increase the number of MMT programmes by a factor of three. Such

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programme expansion provides hope for the development of a national methadone treatment system in that it provides individuals with direct programme experience, and thus positively influences attitudes and activities at political, professional, and community levels.

Attaining good quality care is an essential goal together with the establishment of a network of accessible effective programmes. The key will be to provide new programme staff with comprehensive training and to ensure that future methadone programmes are in tune with high standards of quality clinical practice. This will necessitate adopting national standards for clinical quality and developing official methadone treatment guidelines.

Croatia

The first cases of heroin addiction in Croatia were registered in the late 1960s and in 1971 the Sestre Milosrdnice Clinical Hospital in Zagreb opened the first Department for Addiction Treatment. Methadone was introduced in 1991 and continues to be the only substitution medication covered by insurance. Buprenorphine is licensed but patients must pay themselves. Inpatient treatment is organised for short-term detoxification in the psychiatric departments of all general hospitals and in four specialised centres.

Outpatient treatment is the main standard of care and is based on cooperation between centres for outpatient treatment and general practitioners; there are 15 outpatient centres throughout the country. They are the focal point for all types of treatment: drug-free, detoxification and methadone maintenance. Centres typically include a medical practitioner, nurse, psychologist and social worker. Psychiatrists are usually in charge of the centres, but they are often also run by other specialists or GPs.

Although GPs are not allowed to begin methadone treatment or change therapy, they have many other functions in addition to prescribing and administering methadone. They see the patient every day in their offices, know his/her medical history, social circumstances and family history and usually take part in treatment decisions. A well developed network of GPs makes MMT available in "every village". Of 2,400 GPs in Croatia, more than 1,000 have patients on MMT. There are no waiting lists for treatment, no strict inclusion criteria and treatment is practically free of charge.

The former Yugoslav Republic of Macedonia

In FYR Macedonia there is only one MMT programme. It is located in a day hospital for prevention and treatment of drug dependencies, Kisela Voda, part of the Psychiatric Hospital in Skopje. Although services are free of charge, the day hospital is housed in an old building in the suburbs of Skopje, unsuitable for such a health institution. Neither the institute staff nor philosophy of work meet the needs of the clients. The programme is expensive, centralised, and lacking permanent and coordinated support from other social agencies. The number of clients who use methadone intravenously is high. It has been estimated that 70 % of clients have been infected with Hepatitis C. There are no clear treatment guidelines and to date, most psychiatrists do not support or recognise the validity of MMT.

Serbia and Montenegro

According to the latest UNICEF study, there are about 70,000–100,000 drug users in Serbia and Montenegro, including 40,000 in Belgrade and 5,000 in Novi Sad. MMT is available in three cities, with a well functioning programme in Novi Sad. However, there are currently only about 200 clients in the whole country and substitution treatment is entirely absent in Montenegro.

Since MMT was introduced in 1987, it has not fared well following the disintegration of Yugoslavia and poor political and economic situation. Inclusion criteria for MMT in Belgrade are exceptionally narrow. Clients must be at least 25 years old, have several years of dependence, several failed attempts at therapy and be infected with HIV. Detoxification therapy is rarely used, and maintenance therapy is the most frequent form of treatment. Although there are many factors that put Serbia and Montenegro at risk of a significant expanded HIV epidemic, the number of drug users with HIV infection seems to have decreased over the last years, and is now estimated at only 1%. This has reduced the number of clients eligible for MMT.

Because of the marked absence of HIV prevention services for vulnerable population groups in the region, the new project, 'HIV Prevention among Vulnerable Population Initiative (HPVPI)' in Serbia, supported by the UK Government, Imperial College London and the International Harm Reduction Development Programme of the OSI, might serve as a model for effective HIV prevention strategies in south eastern

"More advocacy and capacity building is needed"

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Europe. The programme also plans a country wide launch of MMT.

Slovenia

There are between 10,000 and 12,000 intravenous drug users in Slovenia (corresponding to 50–60/10,000 population). The sharing of injection equipment (estimated to be 80%) as well as unsafe sex are common and increase the potential for the spread of HIV. National guidelines for the management of drug users, including MMT, were adopted by the Ministry of Health in 1994. Since 1995, 18 regional Centres for the Prevention and Treatment of Drug Addictions (CPTDA) have been established, providing far-reaching services including: prevention; individual, group and family therapy; counselling services for drug users, relatives and community health services; substitution programmes; preparation for inpatient treatment; rehabilitation and social reintegration; consultation with health, social, education services and the police; co-operation with NGOs, therapeutic communities and self-help groups; education; research and publishing.

Criteria for MMT are opiate addiction, previous detoxification attempts, written consent, a minimum age of 16, permanent residence in the region where a drug prevention and rehabilitation centre is located, agreement of GP and having health insurance. Methadone guidelines (EuroMethwork) have been translated into Slovenian. Substitution treatment is also regulated by a Law for Prevention and Treatment of Drug Addiction. The opening of the new Centre for Treatment of Drug Addiction at the Psychiatric Clinic, Ljubljana took place in January 2003. Inpatient treatment is also provided for prisoners.

Several conferences have been held in Slovenia: The 3rd European Methadone Conference 1997; 1999 Slovene Conference on Addiction; International Association Symposium on Addiction Medicine in 2001; Meeting of Central and Eastern European Countries on Addiction Treatment organised with the WHO in 2001; International Conference on the Reduction of Drug Related Harm in 2002; and the first Adriatic Southeast European Countries Conference and Symposium on Addiction Treatment organised jointly with Croatia in 2003.

Establishing the network of centres for the prevention and treatment of drug addiction was cited as an example of successful practice in United Nations – Best Practice Case Studies. Slovenian experts act as consul-

tants to the WHO, The Joint United Nations Programme on HIV/AIDS, the International Harm Reduction Development Programme of the OSI, and International Harm Reduction Association. They are also involved in developing treatment programmes in Central and Eastern Europe and in Central Asia.

For the promotion of the treatment programmes and their assistance, the Sound of Reflection Foundation (*Odsev se sliši*) was established in 1998 by staff in charge of the Centres for Prevention and Treatment of Drug Addictions. Training programmes were organized in cooperation with the Foundation and numerous manuals for experts, drug users and their families were published.

Conclusion

Estimated coverage of substitution treatment amongst problem drug users in Western European countries was between 30 and 100 patients for 100,000 inhabitants in 2001, compared with 0.6 in Estonia, 0.84 in Serbia and Montenegro and less than 10 in other Central and Eastern European countries. Coverage is higher in Croatia and Slovenia reaching 21.9 and 103.7 MMT clients per 100,000 population respectively. Estonia, Poland and Slovenia are the only countries in Central and Eastern Europe that provide MMT in prisons. Only a few countries (including Slovenia and Croatia) use buprenorphine.

The International Harm Reduction Programme of the Open Society Institute is strongly supporting substitution treatment programmes in several countries in south eastern Europe. SEEAN makes it possible to exchange knowledge and experience in the region. However, experts working in the region are certainly not satisfied with progress made in most of these countries. Much more advocacy and capacity building are needed.

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Implementing a national TB control programme in minority communities:

Challenges and accomplishments from Kosovo

*Alka Dev and
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*“Kosovo has one of the
highest levels of TB
incidence in Europe”*

Although exact figures of the population size in Kosovo are lacking, estimates of the resident population (persons living in Kosovo) range from 1.8 to 2.0 million people. According to the Living Standards Measurement Survey of 2000 (carried out by the Statistical Office of Kosovo with the assistance of the World Bank), 88% were ethnic Kosovo Albanians. The ethnic Serbian population accounted for 7%, while other ethnic groups together accounted for approximately 5% of the total population.

In early 1989, the Yugoslav government abolished all autonomy for Kosovo and followed with the dismissal of all Albanians working in areas such as administration, teaching, and health. The health situation of Kosovars worsened considerably at this time and continued to worsen over the next decade due to the departure of qualified Albanian health workers and a general distrust of the Serbian-run health system by the Albanian population. In response, the Albanian community organised an informal, volunteer, parallel health services structure, primarily run from homes, which lacked adequate equipment, drugs, reporting structures and supervision.

This article analyses the process of integrating minority areas into tuberculosis (TB) control activities in Kosovo in the aftermath of the NATO offensive in 1999. At that time, the health care situation was precarious as 800,000 Albanians living in refugee camps in FYR Macedonia and Albania returned to find badly damaged infrastructure and health care facilities, including Anti-TB Dispensaries (ATDs), laboratories, and Institute of Public Health (IPH) buildings.

According to the Epidemiology Department at the Institute of Public Health in Pristina, registered cases of TB increased dramatically from 413 in 1990 to 883 in 1997. Although no reliable denominator for population size is available, it can

be assumed that Kosovo has one of the highest levels of TB incidence in Europe, with an average incidence rate estimated by the World Health Organization to be 77/100,000 in 1999.

Given the volatile post-conflict environment and the need to reconcile ethnic-based discrimination and disputes, the international community began to provide large amounts of assistance. In addition to funding for the United Nations Interim Administration Mission in Kosovo (UNMIK) and the Kosovo Force (KFOR), approximately \$2.2 billion was poured into reconstruction efforts. However, no long-term commitment was made by the international community to work with the Kosovo Provisional Institutions of Self-Governance (PISG) in order to bring about sustained changes at the community level, especially for the Serbian minority and the Roma, Egyptian, and Ashkali (REA)¹ communities.

At present, TB health facilities and infrastructure in Pristina and the larger provincial towns are quite good. However, rural areas of Kosovo remain extremely poor, with few local facilities, and damaged infrastructure. Rural communities remain isolated, especially during the harsh winters and access to health care remains a challenge, even more so for rural communities of minorities. Within Kosovo itself there are approximately 22,000 internally displaced people, mainly Serbs and Roma, who are displaced from their homes in Albanian majority areas, but also some Albanians displaced from their homes in the three Serb-dominated provinces in northern Kosovo.

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1. These ethnic identities are, for the most part, self-identified, and describe different parts of the community traditionally known as ‘Roma.’ The distinctions are based on language, history and social structure.

“Most Serbs and certain Roma communities do not feel secure visiting Albanian health care facilities”

Prior to two days of riots in March 2004, there had been some progress towards the gradual integration of minority communities into the Albanian social and political structure. However, the events in March may have a lasting impact in Kosovo, as 4,100 Serbs and Roma were displaced, and many of their homes and public facilities, such as schools and health houses, were burnt or destroyed.²

Background: health care services in minority communities in Kosovo

Access to general health care in minority communities varies considerably, with some communities having relatively easy access to primary, secondary, and tertiary health care, while other enclave communities have almost no regular access. Overall, in terms of access to health care, some communities, such as the Bosniaks,³ the Turks⁴ and, to a lesser extent, the Goranis,⁵ have become almost fully integrated in, or have good access to the Albanian system, while others, such as Serb enclaves, remain isolated.⁶

The situation of the REA communities is more complicated, with some communities having certain freedom to access services, others experiencing difficulties or discrimination by available providers, and others having little or no access to services at all. The degree of access is linked to the language used by each community, as different groups use one or more of three languages: Albanian, Serbian, or Romani.

The groups most integrated with the Albanian majority speak Albanian and are identified as Ashkali or Egyptian. Roma communities speaking Serbian or Romani appear to have difficulties accessing health care in the majority areas, and in some cases, in the Serb areas as well. On the local level, however, both Albanian and Serb communities discriminate against all three groups to a certain extent.

Discrimination continues to reduce this population's access to health care signifi-

cantly. UNMIK and the Kosovar government are in the process of issuing a 'Charter of Patient Rights' that would promote equal health care access for all and integration of all minorities into the majority health care system. As yet, however, most Serbs and certain Roma communities do not feel secure visiting Albanian health care facilities.

There is an ongoing parallel health care structure in Kosovo, operating under the auspices of medical authorities in Belgrade, which serves the Serb enclaves, with hospitals in North Mitrovica and Gracanica. Serbs from other enclaves seek primary medical treatment in small, often inadequately supplied health houses in their communities (if available), and travel to Gracanica and North Mitrovica for secondary and tertiary care. Certain Roma communities are also served by this parallel health care system. Rarely, Serbs may seek and receive emergency health care from Albanian hospitals, sometimes on their own, and sometimes with KFOR or other international escorts.

Setting up tuberculosis facilities in minority areas

As part of its efforts to improve TB prevention and treatment in Kosovo, Doctors of the World-USA (DOW) selected two minority communities in which to set up or rehabilitate TB facilities in 2000: Laplje Selo and Strpce. These locations were identified on the basis of the degree of isolation, the high TB rates, the pre-existence of some health care facilities, the presence of capable doctors, and the size of the communities. A key element of establishing functioning TB treatment centres in these areas was the participation of local medical staff. Local staff were instrumental in designing the facilities, and adapting them to the needs and capacities of their communities. In addition, technical training was undertaken by international consultants, who were perceived as being more neutral than Kosovar trainers.

2. For further details of the violence, see Amnesty International report: Serbia and Montenegro (Kosovo/Kosova)--The March Violence: KFOR and UNMIK's failure to protect the rights of the minority communities, July 2004

3. Immigrants from Bosnia, Serbo-Croatian speakers, with close ties to Bosnia, and the health care system there.

4. Turkish speaking Kosovars, traditionally based only in the south, and in Pristina.

5. Slavic Muslims living in isolated mountainous communities in the southern-most tip of Kosovo, traditionally with ties to Serbia.

6. Serbs currently live in the three northern most municipalities Mitrovica/ë, Leposavic/q and Zubin Potok, where they are in the majority, and in selected larger enclave communities in Albanian-majority municipalities, notably in Gracanica/Laplje Selo area in central Kosovo, and Strpce in the south, and in smaller more isolated enclaves in municipalities throughout Kosovo, such as in Obiliq, Gjiilan, Novo Brdo, and Rahovac among others.

The initial contacts with the medical staff in the Serb community were made and maintained by DOW's TB Project Director. These contacts were based on relationships that pre-dated the war, and the minority doctors' subsequent moves to the minority enclaves from facilities in Pristina. The primary contact was between the TB Project Director, and one Serbian pulmonologist, who has since become the coordinator for the minority areas.

Communication and transportation, both symptoms of the continued isolation of minority areas, have been the causes of most ongoing challenges in minority integration into TB control. It remains difficult for staff of the National Tuberculosis Programme (NTP) and of DOW in Pristina to communicate with minority areas, and to oversee the implementation of the programme from Pristina.

A further challenge facing the doctors in the minority areas is the difficulty they have in transporting sputum for testing. At present, they do not feel secure using the labs in the Albanian areas. The difficulties in transport have meant that not all patients are given a sputum test prior to receiving treatment, contrary to DOTS (Directly Observed Therapy, Short-course) recommendations. Efforts to locate an appropriate site for a lab in the minority areas have not yet been successful, and may be partly stymied by a lack of political will on the part of minority health authorities.

Training minority doctors and nurses in best practices

DOW trained doctors and nurses from all over Kosovo in DOT principles. The training, conducted by outside experts, included training in standardised treatment regimens and directly observed therapy for all sputum smear-positive cases. Training was also conducted in the standardised recording and reporting system to allow assessment of treatment results for each patient and of the performance of the overall TB control programme.

In addition to minority participants, DOW also included two Serb doctors and five Serb nurses practicing in the selected minority areas. It is of note that these medical personnel considered themselves to be under the Serbian health system (of Serbia and Montenegro), and felt they needed 'clearance' from Serbian health authorities to attend training with other Kosovar health care practitioners.

An essential part of the programme was the

training of nurses to implement a patronage nursing system. The patronage nursing system is a visiting nursing system in which nurses monitor TB outpatients in their homes (with an aim to improve outpatient treatment practices). Monitoring activities include inquiry into treatment lapses, overcoming patient barriers to care, patient education about treatment and consequences of treatment failure, and family contact tracing.

A further element in the training was educating the nurses and the doctors in the methods of accurate and consistent reporting. In 2003, patronage nurses conducted 433 home visits, and provided health education to 1,841 TB patients and family members. They also assessed the possibility of TB infection in 106 individuals who came into contact with TB patients.

One major challenge in treating patients in these minority communities was the mobility of the populations. Patients tend to be mobile, travelling to Serbia for extended periods, or migrating due to security concerns. Sometimes, unfortunately, these migrations lead to the interruption of treatment and record keeping.

Health education

Based on the results of two Knowledge, Attitudes and Practices (KAP) surveys, participating staff developed a health education programme aimed at reaching three target groups: the patients, youth in schools, and the general public.

Health education about TB provided by nurses and doctors in TB hospitals has helped to increase knowledge among patients. The comparison of the results of the first KAP survey (November 1999) with the results of the second KAP survey (August 2002) show that in 2002 patients had a much higher level of knowledge about TB. The number of patients not knowing any symptoms of TB decreased from 33.3% to 0%. The results of the first KAP survey of patients showed shame as a major barrier to treatment with 12.9% of patients claiming that TB is a shameful disease. In the second KAP survey only 2% of patients said that TB is a shameful disease, indicating that the information campaign had decreased the stigma associated with the disease.

In order to target the patients, videotapes, brochures, and handouts were developed, which were to be used both in the hospital setting and in home visits. Minority nurses were successfully trained in TB health

"One major challenge in treating patients in minority communities was population mobility"

“Doctors and medical staff from minority areas are cooperating directly with the majority health care system. This achievement should not be underestimated”

education. The training was planned and facilitated by both the Albanian and Serb staff together, which was the first joint exercise for minority health professionals. Subsequently, these nurses returned to their hospitals and were charged with training other nurses involved in patient care. In order to reach the minority communities, Serb nurses were provided with materials in Serbian for their patients. Almost all patients (94%) reported in the second KAP survey to have received health education information in the hospital and 100% of the patients said that education helped them to understand TB.

A second approach to health education was through workshops held in schools to help educate young people about the disease. DOW piloted this project in five schools, and continued in regions with a high incidence of TB. Teachers who were trained at DOW sessions taught modules in schools, using brochures, a comic strip, and posters. Schools were partly chosen based on the percentages of minority children attending the school.

Future goals

The TB programme described above is in the final stages of being handed over to the Institute of Public Health within the Ministry of Health based in Pristina. The handover includes parts of the minority programme, such as the health education component, although DOW will retain an advisory capacity for minority concerns. In 2005, DOW will continue to advise the NTP on strengthening the case detection system in minority areas.

Success factors and lessons learned

The interventions described above have been successful in a number of ways: in establishing cooperation between majority and minority health care systems and providers, lowering TB incidence rates in certain minority areas, improving health-related behaviours, increasing equality of access to TB treatment, and in lowering the stigmatisation of the disease amongst TB patients and their communities.

Since the initiation of activities in minority areas for patients and providers, the TB treatment success rate for minority communities has improved to parallel the success rates from majority areas. At the beginning of the interventions, the minority area treatment success rates were at 62% as compared to the overall Kosovo rate of 91%. By early 2003, minority areas were reporting treatment success rates upwards

of 80% and the intervention was also followed by greater case finding. Case notification rates increased between 2001 and 2002 by 16% (from 92/100,000 to 107/100,000).

The Minority TB programme is one of a handful of programmes in Kosovo where doctors and medical staff from minority areas are cooperating directly with the majority health care system. This achievement should not be under-estimated; trust-building activities, close cooperation, and flexibility were essential.

The access of minority patients in Strpce, Laplje Selo, and neighboring Gracanica to TB treatment has been much improved by these interventions. The training of the doctors and nurses, as well as the implementation of the patronage nursing system, has made it possible for patients to be cared for and cured without strenuous and unsecured journeys to North Mitrovica or Serbia, some of which patients would not have been able to complete.

The patronage nursing system in particular had a significant impact in the minority areas. The minority clinician in Laplje Selo reported initial resistance from the patients to the treatment, but their confidence and trust has been won through the visible success of the programme in providing them with appropriate treatment, information and follow-up. The training received by the doctors and nurses also appears to have had an impact on their relationships with their patients.

The health education initiative appears to have had a significant impact on the health and behaviour of patients. Patients reported feeling much more confident in their treatment, and having a better understanding of the importance of the drug regimen. The impact of health education has also contributed to patient confidence in discussing TB with other individuals outside the hospital and within their immediate family. This is important to note, as the stigma attached to TB patients remains high in Kosovo and contributes to patients hiding their disease.

In terms of increased equality of access for minorities, the impact is not uniform across all minority groups. As noted above, there are three broad groups within the minority community. The first group includes Bosniaks in the Peja and Prizren regions, the Turks in the Prizren region, and some REA communities, primarily Albanian-speaking Ashkali groups. While some community members of these groups expressed

some feeling of insecurity or discrimination when accessing health care in general, they had no specific complaints about the TB health staff.

The second group includes those minorities living primarily in enclaves whose access to TB health care has been much improved by the facilities, the doctors, and the nurses in the TB clinics in Laplje Selo, Strpce, and North Mitrovica. These groups include mainly Serbs and Serbian-speaking Roma communities in Gracanica, Laplje Selo, and Strpce.

However, there is a third group of minorities whose access to health care has not yet been affected by the minority programmes of DOW. This group includes Serbs living in enclaves in other regions of Kosovo, isolated REA communities, and REA communities living within Serb enclaves who have difficulty in accessing health care through the Serb parallel system. Patients are either sent to Vranja, in Serbia, or treated in the small health houses available in the communities themselves. This group also includes Roma communities in isolated enclaves or internally displaced persons (IDP) camps, that continue to be severely isolated, have little to no access to adequate health-care, and are very vulnerable (for example, the four Roma IDP camps in Northern Mitrovica and Leposavic). Training Roma nurses might be a way to affect Roma access in the future, as with Serb nurses in Serb areas.

By approaching the problem of TB treatment in minority communities as a collaborative problem to be solved by all parties, rather than by imposing a solution from outside, the programme implementers were able to build a programme suitable for the communities and to establish long-term trust, essential for the sustainability of the programme.

Another element of success was the emphasis on health education, particularly with the patients themselves. This element contributed directly to the success of the programme as it improved patients' awareness levels, compliance and understanding. It also contributed to a change in the approach of health care workers and improved patient-doctor relationships and nurses' buy-in, as they saw the direct impact of their work.

A final lesson is that although the establishment of TB clinics in certain areas has a

direct impact in those areas, links with other nearby minority communities are not necessarily made without a great deal of conscious effort and deliberate programming. Efforts need to be made at a local level on a community-by-community basis to spread the success of specific regions more widely.

Conclusion

Minority communities in Kosovo are fragmented and often isolated and, with limited access to health care, are particularly vulnerable to TB. The continued ethnic tensions throughout the region and political pressures from above have provided very real challenges for the establishment of a TB programme for minorities that is integrated into the national TB programme, but still successfully addresses the needs of those communities.

The DOW Minority TB Programme has tried to emphasise equality of access to health care, tackling political and practical obstacles to produce a locally run programme that has been successful in lowering TB incidence rates in minority communities. The intervention was also followed by a 16% improvement in case notification rates over one year and an 18% increase in treatment success rates for minority areas.

This programme has been successful in a number of other ways: it has established cooperation between majority and minority health care systems, increased equality of access to TB treatment, improved health-related behaviours, and lowered the stigmatisation of the disease amongst the population.

These results, however, are not static, and continued success in the future depends on sustained efforts to maintain and improve links with and among minority communities through collaboration, cooperation, and a concerted outreach effort. Further, rigorous efforts to improve standards in operation, reporting, and training need to be maintained in order to provide minority communities with the same level of health care as enjoyed in the majority areas. Because many disparities affecting minority communities are caused by factors beyond the control or scope of NGO and health-specific activities, political will and support from state actors and structures is essential for gains to be sustainable and less vulnerable to future political upheaval.

“Continued success depends on sustained efforts to maintain and improve links with and among minority communities”

For further information please download the full case study report from www.dowusa.org. This case study was funded by The Child Survival Collaborations and Resources Group (The CORE Group).

TB control and DOTS implementation:

A bridge between the countries of south eastern Europe

Lucica Ditiu

Background information

In late 1999, the World Health Organization (WHO) created the position of Tuberculosis (TB) Medical Officer for Albania, FYR Macedonia and the UN-administered province of Kosovo* charged with the implementation of a project funded by European Commission Humanitarian Assistance Office (ECHO), devoted to strengthening tuberculosis (TB) programmes and Directly Observed Treatment, Short-course (DOTS) implementation. In May 2002 the office was enlarged to also cover* Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Romania, Serbia and Montenegro, Slovenia, and Turkey (from 2003).

There are considerable health problems in the countries of South Eastern Europe. The consequences of war plus socioeconomic transition have led to social insecurity, high levels of poverty and deterioration in the health care systems. All of these factors have contributed to the spread of TB, a disease known to affect the poorest and most vulnerable members of society.¹ The coun-

tries of South Eastern Europe fall into all three of the WHO defined categories for TB burden (See Table).² Romania belongs to Group I, the group of countries with the highest TB burden, with steadily increasing notification rates over the last 10 years, reaching 133 per 100,000 population in 2002. All others with the exception of Slovenia are in Group II, including Bosnia and Herzegovina where the trend is downwards and Serbia and Montenegro where the notification rate is on the up. Special mention should be made of Kosovo where the notification rate has been increasing and in 2002 was 53 per 100,000 inhabitants.

TB control in most of the countries was and is still vertically organised, conducted through a single institution (National Institute or Hospital) with officially recognised national authority for TB and lung diseases. Inpatient facilities are organised through a system of hospitals (or departments in large hospitals) devoted to patients with TB and other lung diseases. Patients are usually hospitalised for the entire intensive phase of the treatment or until no longer smear positive. The average length of hospitalisation is between 40–60 days. The exception is Croatia, where the patients are hospitalised for a maximum of three weeks.

The outpatient system is organised in so-called 'anti TB dispensaries' where secondary level health care is provided through specialists in TB and lung diseases. There is usually one TB dispensary per district, so that the number in each of the countries of the region varies (for example, 10 in Kosovo, 160 in Romania and 271 in Turkey). Outpatient facilities are in charge of follow up and monitoring of patients during the continuation phase (from 4–6 months) as well providing anti TB drugs.

Table TUBERCULOSIS NOTIFICATION RATES IN SOUTH EASTERN EUROPE (most recent year reported)

	Country	Notification rate per 100,000
Group I	Romania	133
Group II	Bulgaria	42
	Bosnia and Herzegovina	41
	Serbia and Montenegro	40
	FYR Macedonia	33
	Croatia	33
	Turkey	26
	Albania	20
Group III	Slovenia	17

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* The UN administered province of Kosovo will be referred to here as Kosovo

** The WHO office is called "Office for TB Control in the Balkans" but includes all the countries from South Eastern Europe, plus Turkey and without Moldova.

There is moderate but increasing interaction between TB dispensaries and family doctors, evidenced mainly by the referral of TB suspects to TB specialists. Sometimes, family doctors are involved in follow up of TB patients during the continuation phase. In the former Yugoslavia a system of 'patronage nurses' was used for follow up of patients. There are still areas, Kosovo, FYR Macedonia, and Serbia and Montenegro, where patronage nurses facilitate the direct observation of patients. However, the absolute number of patronage nurses is totally inadequate and, due to health sector reforms, their future role is uncertain. Diagnosis is based on bacteriological examination, X-ray and clinical examination. Bacteriological examination includes both smear and culture examinations, often with inefficient use of resources for sophisticated methods of culture.

Opportunities for and threats to tuberculosis control

WHO and the International Union against Tuberculosis and Lung Diseases (IUATLD) recommend DOTS as the main strategy for TB control. DOTS is known as the most effective strategy, with cost effectiveness ranging from US\$5 to US\$ 40 per DALY (disability adjusted life year) gained.³ This strategy is a significant opportunity for the region's health care systems.

Most governments agree with the principles of the DOTS strategy, embarking on implementation. One reason for the rapid acceptance of DOTS was that in Bulgaria, Romania and the countries of the former Yugoslavia there already existed under communism a system of strict supervision of treatment, very similar to recommended Directly Observed Treatment (DOT), one component of the DOTS package. There was also a decreasing reliance on mass screening by X-ray, with diagnosis including smear and culture tests in Romania, Bulgaria, and Croatia.

Implementation began at different times through pilot projects: Bosnia and Herzegovina 1997; Romania, Serbia and Montenegro and Slovenia 1998; Bulgaria 2000; Albania in 2001, Kosovo and FYR Macedonia 2001; Turkey 2002. At end 2002 Bosnia and Herzegovina, Kosovo and Slovenia were reporting 100% DOTS coverage, followed by Bulgaria 78%, Romania 54%, FYR Macedonia 50%, Serbia and Montenegro 40% and Albania 30%. All have aimed for 100% coverage by end 2005.

Although governments have expressed their political commitment for DOTS implementation, funds have come from external donors. In Albania, Bosnia and Herzegovina, Kosovo and FYR Macedonia there has been extensive technical and financial support from the World Health Organization (WHO), European Commission and United States Agency for International Development (USAID). Romania received support from the Open Society Institute (OSI), USAID, WHO and the World Bank. Limited external support was offered to Bulgaria by the Swiss-Bulgarian cooperation agency and to Croatia by the OSI. No significant external financial support was forthcoming for Serbia and Montenegro, Slovenia or Turkey.

TB proposals submitted to rounds 2, 3 and 4 of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) by Romania, Serbia and Montenegro and Kosovo were approved and significant funding will now be available for TB control programmes. Funds are mainly for extensive staff training in TB management (from lung diseases specialists to laboratory technicians, family doctors, nurses and volunteers), procurement of equipment for bacteriological laboratories, improving laboratory services, and strengthening surveillance and monitoring.

There are clear indicators of demonstrated improvement in TB control programmes. All countries are using WHO standardised case definitions, treatment regimens, and forms and registers for recording and reporting, thus allowing for cross country analysis and comparison. In terms of data collection, computerised databases including individual information on all TB patients now exist in Albania (700 patients per year registered), Bosnia and Herzegovina (1,700 per year), Kosovo (1,500 per year), and Romania (35,000 per year – the largest individual data base, available since 1994). All other countries use aggregate data for national reporting.

For bacteriological diagnosis, each country and territory now has an established laboratory network, with a National Reference Laboratory coordinating activity and the quality assurance system. It is important to note that quality assurance thus far has only been established in Croatia and Slovenia, but is beginning in Albania, Kosovo, FYR Macedonia, Romania, Serbia and Montenegro. There have been no significant national shortages of anti TB drugs during the last four years, although tempo-

"There are clear indicators of demonstrated improvement in TB control programmes"

*“The major threat
remains the
sustainability of
achievements”*

rary shortages (maximum two months) were seen in some areas of Bulgaria, Kosovo and Serbia and Montenegro.

Between 2000 and 2003, anti TB drugs for Albania, Bosnia and Herzegovina, Kosovo and FYR Macedonia were procured through different donors or international organisations. At the end of 2002, Bosnia, Kosovo and FYR Macedonia applied for drugs from the Global TB Drug Facility (GDF) and received a three-year grant. In Romania, Croatia, Slovenia and Turkey drug procurement and distribution is organised by governments and health insurance funds, with no shortages recorded during the last four years. Most remarkable has been the evolution of the commitment towards TB control in Albania, whose government from 2004 decided to purchase anti TB drugs with national funds through the GDF direct procurement mechanism.

Despite general success in eliminating shortages, the overall drug management system still requires special attention. There is very little knowledge at central level relating to consumptions, inventories, existing stocks and expiry dates for anti TB drugs. Drugs are distributed to peripheral units based solely on the number of TB patients, without taking into account previous drugs received, used and left.

Although HIV prevalence rates seem relatively low, there is a possibility that these are being under reported and/or under diagnosed.¹ Furthermore, there are very few reliable data on TB/HIV co-infection and little initiative to improve collaboration between TB and HIV programmes. However with HIV funds received by Bulgaria, Croatia, FYR Macedonia, Romania, Serbia and Montenegro and Turkey from GFATM proposals it is likely that collaboration may begin soon. For example, in 2004, a joint HIV/TB framework was developed and approved in Romania

There are no current data to show an epidemic of multi drug resistant TB (MDR – TB caused by strains of TB bacteria resistant to at least isoniazid and rifampin) in the region and the absolute number of MDR TB patients ranges between 5 per year in Albania to 400 per year in Romania. However, these figures should be regarded as underestimates, as few drug resistance surveys have been conducted (for example, in Croatia, Romania and Slovenia) and the system of quality assurance for bacteriological laboratories has only just been intro-

duced. Even so the number of MDR TB cases appears to be decreasing, indicating that TB control programmes are improving. Better survey information is needed however to fully understand the situation.

In terms of information, education and communication to the public very little has been done in the region. There is very low public awareness on TB, with little if any coverage in schools, or through public education campaigns. Some projects have been undertaken in Albania, Kosovo and FYR Macedonia, but not as part of a clear national strategy.

TB control as a bridge between southeast European countries

What makes TB Control in South Eastern Europe unique is the collaboration between managers and staff of National Tuberculosis Programmes (NTP) of the different countries. It started in 2000, when the NTP and laboratory managers from Albania, FYR Macedonia, Kosovo, Bulgaria, Bosnia and Herzegovina and Romania gathered to form what is now called ‘The Balkan initiative in TB Control’. The Initiative tries to increase regional collaboration, to help solve the common problems faced by TB Control programmes, and addresses specific topics of common interest. The first meeting, held in Romania, brought together people from countries in conflict with each other; professionals willing to work and collaborate with colleagues from neighbouring countries in TB management and laboratory networking.

On their own initiative in 2002, a second meeting was held in Romania, with the participation of an even larger number of countries, including Serbia and Montenegro, Croatia and Turkey. The meeting addressed fundraising possibilities and introduced participants to the GDF and GFATM. A third meeting in 2003 in Ohrid, FYR Macedonia had a record number of attendees, thirty from all countries of South Eastern Europe, and tried to familiarise the participants with the monitoring and evaluation of TB programmes, as well as with recent updates on TB control in children.

Apart from training and information sharing accomplished at these meetings, regional networking has clear benefits for all, especially for TB patients. It is not unusual to see TB patients going for the continuation phase of treatment from Kosovo to FYR Macedonia and Albania (or vice

versa). Thanks to the use of common data forms and the existing collaborative network it is now very easy to follow up patients when they cross territorial boundaries.

Conclusion

There is strong momentum and potential for controlling TB in most of the countries in South Eastern Europe. Significant achievements by TB programmes have been obtained over the last four years, including the training of large numbers of staff, equipping of laboratories, and improved data collection and reporting. The major threat remains the sustainability of these achievements, the need to expand DOTS to areas not yet covered and the integration of TB control programmes within an environment of changing health systems. Maintaining the interest of donors

and the international community will be critical, as the fragile achievements in TB control still need external support.

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Reducing perinatal mortality in FYR Macedonia

*Dragan Gjorgjev
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Introduction

Several years ago, the perinatal mortality rate in FYR Macedonia was among the highest in Europe. Between 1998–2001, the Ministry of Health, supported by the World Bank, responded to this challenge by starting a project to reduce perinatal mortality. It aimed to develop a national strategy for perinatal care, introduce an evidence-based medical training programme and develop the national neonatal intensive care network.

Challenges faced

The project faced three major challenges. The high turnover of staff slowed down implementation of some activities. More

than four changes of directors in the three main institutions involved took place during the project, while there was also a frequent change of Ministers of Health and a change of local directors in university clinics and medical centres. A second major challenge was posed by the violent conflict in the western part of FYR Macedonia in 2001, resulting in a postponement of consultant visits and a delayed development of education modules. A final challenge was the initial failure to include obstetricians in the training provided and in overcoming the initial opposition of those neonatologists who were not included in the training programme.

Project activities

It is noteworthy that all project objectives were achieved despite numerous obstacles. Project activities included:

- Meeting basic educational needs of neonatal providers at secondary and tertiary level, including both doctors and nurses.
- Structural development of a tertiary care

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“The environment for change is ripe but funding is needed for further educational programmes”

unit in the Clinic for Obstetrics and Gynaecology, relocation of the tertiary care unit in the Clinic for Paediatrics and development of a neonatal transport service.

- Provision of equipment to secondary and tertiary care units and the transport service, staged according to operating bed numbers and training programme.
- Inclusion of neonatal rotations in paediatric training and of basic neonatal information in undergraduate medical training.
- Introduction of advanced neonatal training for nurses and midwives.
- Establishment of a centre for continuous medical education, development of an 8-week training programme for doctors and nurses, and training of ten educators.
- Establishment of a Perinatal Committee to guide and integrate perinatal care at all levels of implementation.
- Development of clinical protocols based on the best available evidence, including the Cochrane database and Welsh database of perinatal trials.
- Establishment of a Maternal, Perinatal and Infant Mortality Committee to investigate all maternal, perinatal and infant deaths.
- Development and implementation of standardised psychometric and neurological testing for all high-risk neonates and to provide audit data on long-term morbidity and appropriate intervention into school age.
- Development of a strategy for perinatal care in Macedonia

Key success factors and lessons learnt

Key success factors included:

- Establishment of an organisational framework for perinatal services
- Regionalisation of neonatal care, transfer of high risk mothers to the capital Skopje and establishment of a national transport service for sick neonates
- Introduction of evidence-based education and practice

A major lesson of the project was the importance of including obstetricians and midwives. Similar projects in the future should aim to include these groups from the beginning.

Major achievements

An evaluation of the National Perinatal Programme was carried out in January 2002, exactly two years after education of trainees commenced. The evaluation aimed to assess the outcomes of the National Perinatal Programme, including its organisational framework, long term strategy and equipment.

The evaluation compared the perinatal mortality rate in the three years before intervention (1997–99) with the rate in the two years after intervention (2000–01), covering 16 hospitals where more than 93% of babies in the country are born. The evaluation established an overall decrease of 21% in the perinatal mortality rate and a decrease of 36% in early neonatal deaths of babies weighting more than 1,000g (7.7 compared to 12.0 per 1,000 live births), reflecting the postnatal thrust of the programme.

The evaluation also assessed the quality of teaching at the Continuous Medical Education Centre. It concluded that the educational programme was sustainable, the methods based on evidence and that the teachers included a skilled team of doctors and nurses, competent in delivering a curriculum using modern, innovative teaching methods and multi-faceted assessment techniques.

The assessment of twelve maternity and two paediatric units found huge improvements in the practice of evidence-based medicine. A significant number of medical professionals underwent training. In total, 115 doctors and nurses were trained, constituting 50% of doctors and 25% of nurses who care for neonates in the country. A survey of trainees indicated a high level of acceptance of the educational curriculum and its teaching and assessment methods.

There were also major structural improvements. Equipment was distributed, installed and corresponding training provided. The intensive care units of the Paediatric Obstetrics and Gynaecology Clinic in Skopje were reconstructed and a newborn emergency transport service is now operational. In addition, a national database for perinatal and neonatal data was developed, its users trained and software distributed to trainees.

In terms of management, an organisational framework for working groups in support of the central Perinatal Committee was completed and a long term National Perinatal Strategy developed.

“all project objectives were achieved despite numerous obstacles”

Take away message of the project

This project can and should serve as a model for reforming other areas of health care in FYR Macedonia, such as the national emergency service. The next milestone in the reduction of perinatal mortality will be to decrease the rate to less than 10 per 1000 live births by 2005. This will require attention to the obstetric/midwifery component of perinatal health. The environment for change is ripe but funding is needed for further educational programmes and should be considered a fundamental part of the National Health Strategy.

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Planning for health at county level: *The Croatian experience*

Selma Sogoric

*“A unique training
programme Healthy
Counties was
developed”*

The war and subsequent disintegration of the former Republic of Yugoslavia during the 1990s resulted in the creation of the independent nation-states of Croatia, FYR Macedonia, Slovenia, Bosnia and Herzegovina, and Serbia and Montenegro. The recent history of armed conflict, political turmoil and severe economic change has resulted in tremendous individual and societal stresses throughout the region.^{1–4}

In the case of Croatia, the transition to new forms of government and economic systems led to a deterioration of public health services.^{5,6} A process of decentralisation of the health sector, which started at the beginning of 2000 mandated that local county governments assume public health planning responsibilities. These responsibilities had formerly been centralised.

This paper describes the evolution of a project aimed at strengthening local public health planning capacity at the county level of Croatia after decentralisation. Local self-government and administration in Croatia are organised into 20 counties and the City of Zagreb. Populations in the counties vary from 90,000 to 450,000, while the City of Zagreb has 800,000 inhabitants.

The World Health Organization's Urban Health/Healthy Cities Programme in Europe provided Croatia with an early model for developing new social structures and organisational relationships to improve local public health. The initiative recognised the importance of political will and cross-sector alliances and strove to develop participatory mechanisms so that individuals, voluntary associations, and city governments in Europe could think about, understand, and make decisions together regarding local public health issues.^{7–9}

Healthy counties

In the summer of 1999, directors of the Motovun Summer School of Health Promotion convened a panel of 25 Croatian public health experts to review existing public health policy and practice at the county level. The group used an assessment tool called the Local Public Health Practice Performance Measures Instrument, which had been developed by the Public Health Practice Programme Office of the US Centers for Disease Control and Prevention (CDC).¹⁰ The Faculty from the Andrija Stampar School of Public Health adapted the instrument to fit the Croatian context and translated it into the local language. The expert panel identified the following as the weakest points in existing public health policy and

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“A ‘learning-by-doing’ training approach was the best tool for public health capacity building”

practice at the county level:

- Priority setting and policy formulation
- Strategy formulation and comprehensive planning for solving priority issues
- Coalition building among community groups and other stakeholders
- Policy assurance, an issue stemming from the lack of objectives and therefore an inability to determine whether they are achieved
- Lack of analysis of existing health resources.

In 2001, the Open Society Institute, New York financially supported and facilitated the ongoing collaboration between the Andrija Stampar School of Public Health and the CDC. The same autumn two faculty members from the Stampar School attended the CDC’s Management for International Public Health course in Atlanta. Returning to Croatia they developed a unique training programme, Healthy Counties, aimed at assisting counties assess population health needs in a participatory manner, select priorities, plan for health and, ultimately, assure provision of the right type and quality of services, better tailored to population health needs.

The programme incorporates a multi-disciplinary and inter-sectoral approach, permanent consultation with community (‘bottom-up’ approach) and use of qualitative analysis. The curriculum was developed as a blend of recognised management tools, public health theory and practice and use of Healthy Plan-it™ material of the Sustainable Management Development Programme. The programme’s main goal was to increase county-level capacities to conduct health planning and provide more effective public health services.

After two months of consultations with stakeholders in the Ministry of Health, Ministry of Labour and Social Welfare, County Governors, National Institute of Public Health and the Andrija Stampar School of Public Health, officials reached a consensus about the aims and content of the programme. A ‘learning-by-doing’ training approach appeared to be the best tool for public health capacity building and strengthening of collaboration between health policy stakeholders. All trainees understood from the outset that training inputs were expected to yield measurable outputs within a few months. Each county team was expected to plan and conduct assessments, and elaborate a County Health Profile and a County Health Plan.

Organisation of training

Teams from three counties completed a cycle of four 4-day workshops conducted over a period of four months. Each county team was composed of 9 to 10 representatives: at least three from the political and executive component (County Councils and Departments for Health, Labour and Social Welfare), three from the technical component (County Institute of Public Health departments, Centre for Social Welfare); and three from the community (NGOs, voluntary organisations and the media). In order to maximise the participatory nature of the workshops, the number of trainees at any given training activity was limited to 30.

Since mutual learning and exchange of experience was an important part of the process, each cohort was composed of three counties from different parts of Croatia with different levels of local governance experience. The Ministries supported the direct costs of training (training package development, teaching and staff expenses) and the counties covered trainees’ lodging and travel expenses. A different county hosted each workshop and provided the training venue.

Description of curriculum

Each cohort of counties went through four days intensive training:

Workshop 1 – Assessment

County team members reviewed the core public health functions and practices, and became familiar with participatory needs assessment approaches, methods and tools. Each team developed a framework for county health needs assessment and decided on methods for involving citizens. Considerable attention was devoted to self-management and group management techniques, especially time management and team development. Homework assigned to the county teams for completion prior to the next workshop involved creating a draft version of a County Health Profile. To accomplish this, the teams had to apply one or more methods of participatory needs assessment, identify sources of information inside and outside the health sector, formulate county health status indicators, and collect appropriate data.

Workshop 2 – Healthy Plan-it™

Through application of ‘Healthy Plan-it’, an educational programme developed by the CDC’s Sustainable Management Development Programme, county teams were guided through a health planning

process. They were first introduced to different techniques for selecting priorities among community health needs, then to problem-solving and decision-making techniques. Reaching consensus in groups that were so diverse and new to one another was a potential problem. Consequently, the trainers employed a variety of confidence building exercises and consensus techniques, which assisted in the achievement of desired team goals.

Each team selected five county health priority areas on the second day of the workshop and began to develop plans for addressing them. The teams learned how to identify and analyse problems, find their root causes and trace possibilities for solving problems inside complex, multi-organisational systems. Prior to the next workshop, the teams had to identify county 'health stakeholders' and conduct consultations on selected priorities. Following these meetings, each team revised priorities and began drafting their County Health Plans.

Workshop 3 – Policy development

This module began with an introduction to the process of building constituencies. Participants learned interpersonal communication, partnership, advocacy and negotiation skills. Collaboration with the media, public relations and social marketing were addressed. Homework assigned to the county teams required them to convene local expert panels in their respective counties to obtain advice on appropriate policies and interventions to address priority health issues.

Workshop 4 – Quality assurance

Skills developed in this module included planning change, building institutional capacity for change, and conflict recognition and resolution. Another training objective was to familiarise participants with methods for analysing the wider environment. Presentations given by representatives of the Ministry of Health, Ministry of Labour and Social Welfare and by the leader of the national health system reform project helped participants to view their county projects from a larger, national perspective. Skills like resource planning and management (both human and financial), implementation, quality assurance, monitoring and evaluation were also part of this training.

Homework for this module was to finalise the County Health Profiles and County Health Plans for public presentation six

month later. The assignment required the teams to present results as well as describe the process used, including the participative assessment of health status and needs, selection of priority areas, policies and programmes to address priority health needs, implementation plans, monitoring and quality assurance mechanisms, and evaluation plans. Teams had to present their County Health Profiles and Plans locally to their own County Councils, and then nationally to other counties and ministries.

On-going follow-up

A tutorial system of guidance and monitoring was introduced after the fourth workshop to ensure that team members not lose their commitment and enthusiasm. County team coordinators met mentors monthly and follow-up workshops on county health policy development were held every three months. Alumni from the first cohort were involved in training of the second and third cohorts, providing new trainees with practical advice and guidance from recent graduates of the programme. Expert help and support to the counties was provided by the faculty on request throughout the process of developing County Health Plans.

By the beginning of September 2004, six training cohorts had completed the Healthy Counties programme (15 county teams and the city of Zagreb) and produced County Health Profiles and Health Plans with prioritised health needs and specific recommendations. Nine county councils accepted and approved their own county strategic health documents, five of these guaranteed funding for project implementation in priority areas.

Currently, training continues for a subset of those already trained. Participants consist of 'troikas,' groups of three in county leadership positions: one elected official, one professional civil servant from the county administration, and one professional from the county public health institute. The troikas liaise between their own county team, other counties and trainers from the Stampar School. During 2003/2004 troikas came together on several occasions and received additional training on evidence based public health programmes for early detection and treatment of breast cancer (Mljet, October 2003), comprehensive (medical and social) care for the elderly (Samobor, March 2004), and Total Quality Management for managers in the health sector (Uvala Scott, May 2004).

“A centralised ‘one-size-fits-all’ approach is no longer sufficient”

Discussion

The shift from centrally planned economies to more representative governments and market-based economies is taking place rapidly throughout South Eastern Europe. The simultaneous process of decentralisation and health sector reform has resulted in significant pressures on local governments to better plan and manage their public responsibilities. As local governments are faced with this new challenge, they are also presented with greater freedom in selecting priorities, allocating resources, and satisfying local health needs. These opportunities require increased capacity locally to identify and prioritise needs, plan, implement and evaluate interventions.

The Healthy Counties programme in Croatia has built county level capacity to assess public health needs in a participatory manner, to plan for health and assure provision of services tailored to local health needs. The programme's benefits in Croatia are extending both below and above the county level. The project serves to provide support for the more localised Healthy Cities projects, as well facilitate a paradigm shift in the national ministries' mindset that a centralised 'one-size-fits-all' approach is no longer sufficient.

The project has successfully engaged stakeholders from political, executive, and technical arenas and involved a variety of community groups (young and older people, the unemployed, farmers, islanders, urban families etc.), local politicians, and institutions in the needs assessment, prioritising and planning for health cycle.

County Health Plans are accepted politically (by County Councils), professionally and publicly. Proposed interventions for health improvements rest on local organisational and human resources and are (presently in five counties) financially supported through county budgets. With the experience gained through this programme, the Faculty of the Andrija Stampar School is extending its assistance to neighbouring countries with similar political and economic histories. The first one to try out and test nationally the training model (beginning in June 2003) is FYR Macedonia and Serbia and Montenegro will begin a similar programme in 2005.

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Access to health services for displaced persons in Serbia*:

Problems of income and status

Ozren Totic

“Refugees, IDPs and local residents share difficulties stemming from an inefficient health care system”

As a result of inter-ethnic conflicts in the former Yugoslavia and the consequent break-up into five independent countries, refugees and internally displaced persons (IDPs) ** started to arrive in the Republic of Serbia in 1991. It is estimated that refugees and IDPs now represent nearly 10 per cent of the Serbian population. In 1995 there were 700,000 refugees and since 1999 around 230,000 IDPs have arrived from Kosovo. 120,000 refugees have returned to their countries of origin while another 50,000 have emigrated to a third country. Of 110,000 who acquired Serbian citizenship, some also obtained citizenship in their country of origin and/or, at the same time, maintained refugee status in Serbia. Currently there are around 270,000 refugees registered with the Serbian Commissioner for Refugees. However, these data are not precise as there is still a spontaneous (unregistered) return of refugees to countries of origin, free crossing of the border with Bosnia and Herzegovina, a different definition of the status of returnees to Croatia and no official way to register deceased refugees in Serbia.¹ In any case, the number of IDPs has not changed significantly since 1999, due to the absence of security and other conditions for a return to Kosovo.

As with most other countries, available data from Serbia do not indicate major differences in the physical health of refugees and IDPs compared with the local population. However the Serbian Institute of Public Health has noted that 13% of IDPs have serious medical problems: with high malnutrition among IDPs and refugees in collective centres and displacement seriously affecting mental health. Refugees, IDPs and the local resident population share difficulties stemming from an inefficient health care system, the uncontrolled

growth of the private sector and the lack of accountability of service providers. Local population health deteriorated in the 1990s as a result of the cumulative effects of political, economic and social collapse. Income has become the major obstacle to access to health services, with displaced populations suffering the most.

Financing

Health care services for employees and their families are paid by the Health Insurance Fund (HIF), which is the major purchaser of health services, financed through monthly salary contributions. There is a tradition of universal health coverage inherited from the former Yugoslavia, including solidarity in the financing of health care where those with higher incomes pay a proportionally higher contribution to the Health Insurance Fund. Health care for the small proportion of uninsured (between 5 and 7%) legally should be financed through the Ministry of Health. Refugees have the same (tax based) source of funding as uninsured citizens, this time through the Serbian Commissioner for Refugees.

From 1989 to 2000, state allocations for health (including health insurance and budgetary funding) in absolute terms per capita decreased each year. In 2001, they started to rise again. Per capita spending for health in Serbia, however, is still lower than in 1989. The salary contributions of insured citizens are not sufficient to pay for their own health services, let alone to cover

* Serbia in this article refers only to the Republic of Serbia, one of the two republics along with the UN administered province of Kosovo that constitute the country of Serbia and Montenegro.

** Displaced persons are defined as refugees when they have found refuge in another country and as IDPs when they were forced to leave their home but stayed within their country of origin.

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*“120,000 refugees or
displaced persons live
below the poverty line”*

uninsured citizens, include refugees and a large proportion of IDPs. As a result, the health care of uninsured citizens has never been adequately financed and until 2003, health care for refugees had no specific allocation in the Serbian budget. At present, the state owes more than €30million to public health service providers for health care provided to refugees over the past 12 years; a debt that is probably never going to be repaid. It is also worth noting that, due to inadequate funding for health services in general, the state owes many times more to health care institutions for services delivered to the overall population.

Solidarity

In practice, health services for the uninsured, refugees and a large proportion of IDPs were financed in Serbia mainly from employees' contributions to the Health Insurance Fund and out of pocket. Over the last 15 years, out of pocket payments for health services have become a significant source of health care funding; with estimates of up to 40% of total health care expenditure. These payments are made for drugs, and private services as well as informal payments to employees of public health facilities. As refugees and IDPs are poorer than the resident population, the impact of displacement on income is a predominant issue in access to health and other public services. This pattern has been observed throughout Eastern Europe and Central Asia.²

2003 was the first year a significant allocation from tax sources was made in the budget for refugees. However, per capita, it is more than three times less than the amount recorded by health providers as spent on the health care of refugees. IDPs do not have a special line item within the government budget for health care, although their social, economic and formal status within the country represents a significant obstacle to the utilisation of health services.

Social status

1995 (refugee exodus from Croatia) and 1999 (IDPs from Kosovo) brought a sharp rise in the already numerous displaced population in Serbia, on both occasions more than 200,000 people sought refuge. They left their property, jobs and social networks were shattered. Refugees and IDPs shot to the top of the list of the most vulnerable and poorest populations, with the Roma among them being the worst off. This was also a damaging financial blow to the public services and a population already

exhausted by a failing economy.

It is estimated that over 120 000 or around 25% of refugees and IDPs are living below the poverty line. This is twice the proportion of the poor in the resident population.³ As with the rest of the country's inhabitants, this reflects low income, but also other dimensions of poverty such as inadequate access to health services. This situation is exacerbated in the least developed areas with the highest concentration of IDPs (southern Serbia).

Ethnic and gender issues among the refugee and IDP populations

Roma are the poorest and most vulnerable population group, in particular where they belong to the displaced. Some estimates suggest that there may be as many as 500,000 Roma in the country. A large number live in slums with inadequate housing and it is estimated that these poor living conditions, contribute to a considerably shorter life expectancy compared with the overall population. Displacement aggravates problems faced by this population group. There are no precise data on the total number of Roma or of the proportion of Roma among refugees, but within the IDP population more than one tenth are Roma.⁴ The lack of a fixed address and registration with municipal authorities are major obstacles for access to services. These problems are perhaps best illustrated by the recent case of a Roma IDP, none of whose seven children possessed a birth certificate. Consequently, none of the children have been able to gain access to health care and education.

Other vulnerable population groups include women, children, and households with older people or located in rural areas, all of which have a higher risk of poverty than the average population. Women, for example, have on average wages that are 15% lower than the wages of men. Women belonging to vulnerable populations, such as Roma, refugees and IDPs, face a double disadvantage and have the highest risk of poverty, with consequent difficulties in accessing health services. Women and children living in 'collective centres' for displaced persons are additionally affected by their unfavourable living environment.

Access to health services

Legally, IDPs and refugees have the same rights as local citizens to access health services free of charge at the point of delivery. Moreover, they do not have to pay official co-payments (the so-called 'participation')

for medical services or medicines, which are mandatory for all except vulnerable population groups. The only precondition is that they are registered with the Serbian Commissioner for Refugees and present their registration card. This has somewhat inflated the number of people registered as IDPs and refugees, some of whom may have returned to Croatia and Bosnia and Herzegovina or may never have left Kosovo. They usually seek treatment in Serbian hospitals, when it is more difficult to access these services in their local place of residence.

Refugees and IDPs share the difficulties of the largely inefficient health care system with the local population. State spending on health care is not sufficient; providers are largely unaccountable to public scrutiny, professional or state control, while private health services, out of reach for the poorest segments of population, are completely self-regulated. However, additional difficulties are experienced by displaced persons due to poverty levels that are double those of the local population, rendering them unable to pay for private services or pay "under the counter" in public facilities. They are not within the social networks needed to navigate through the highly inefficient health system, although after five or more years of displacement these networks are being created.

Distance to service and the poor outreach of services to the 14,000 refugees and IDPs (3% of total) living in collective centres is another difficulty. Collective centres are usually situated on the outskirts of urban areas, relatively far from secondary and tertiary hospitals that provide the majority of health services. Residents of collective centres are usually the poorest within the refugee/IDP population. Another problem is the practice by primary health care facilities of not registering IDPs and refugees, preventing adequate medical follow up.

There is also a lack of funds allocated to refugee health services. Regions with large IDP and refugee population have not been given adequate financial means to face the additional costs. This financial burden for public health care provision to IDPs and refugees has also severely affected the capacity of those Health Insurance Fund Regional Offices covering the municipalities where IDPs are registered as temporary residents. This impacts on the provision of care to other vulnerable groups as well as health insurance contributors.

Conclusion

The large number of refugees and IDPs temporarily residing in Serbia makes for a large financial burden on both taxpayers and the overextended Serbian health budget. However, this problem will not be alleviated in the near future, as there is little chance that refugees and IDPs will soon return to their place of origin. Those who came as children are sometimes now parents whose offspring do not have any emotional links to their parent's country of origin. For many Serbs from Croatia, their possessions have been largely destroyed or may be out of reach because of bureaucratic obstacles. Property in Bosnia and Herzegovina is being returned, but the failing Bosnian economy does not offer much incentive for return. Serbs from Kosovo, many of whom have had their property destroyed or sold, cannot return for security and other reasons.

It is more than 13 years since refugees and later IDPs started to settle in Serbia. Due to the inefficiency of governmental administration and/or for quasi-political reasons, 500,000 of these people are still registered as displaced, officially not belonging in the place where they now live. The political and economic situation in Serbia, Croatia and Bosnia and Herzegovina are strongly linked to the economic wellbeing of these individuals, their access to public services (including health) and, ultimately, their health status. Although refugees and IDPs share the problems of local residents in coping with the highly inefficient, underfinanced and unaccountable health services, the additional burden of poverty, unclear arrangements for health care financing for the displaced, their undefined status and the lack of developed social networks makes for a nightmarish scenario.

In 2003 the government adopted a Poverty Reduction Strategy Paper (PRSP) that included the National Strategy for Refugees and Displaced Persons adopted in 2002. The PRSP's objective in the health sector includes the reduction of inequalities for vulnerable groups, with an emphasis on equal access to basic health services. Funding should be available from the Health Insurance Fund for the insured and from the state budget for all other citizens regardless of their socioeconomic status, including refugees and IDPs. In the changing political environment, Serbia will need a continuous political commitment by the government to finance the provision of accessible and quality services for these under served populations.

"Funding should be available for all citizens regardless of socioeconomic status"

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Children in Serbia and Montenegro:^{*}

Health status and access to basic health services

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The opinions expressed in this publication are those of the authors and do not necessarily reflect the policies or views of UNICEF

Introduction

This paper reviews the health status of children (0–18 years old) in Serbia and Montenegro and their access to basic health services. An additional topic is dealt with in some depth – birth registration, which is the key to access to many basic services. The paper closes with an update on the Plans of Action for Children in Serbia and Montenegro and the opportunity this may represent for the first concerted policy approach to children in the country. (Much of the thinking and research work for this was completed during discussions in UNICEF with staff and counterparts in 2003 and 2004).

Serbia and Montenegro has good prospects of meeting many of the Millennium Development Goals (MDGs) at national level, such as further reductions in infant and child mortality, high immunisation rates and universal primary education. However, there are wide and increasing geographical and ethnic disparities in survival, poverty, health status and educational level of children.

Both Serbia and Montenegro have Poverty Reduction Strategy processes (PRSPs) in place, which offer a framework for future development. The UN resident and non-resident agencies have agreed with the government a development assistance framework (UNDAF) for the period of 2005–2009 with three main areas: institutional and public administration reform, rule of law and sustainable development. Building on the work towards the MDGs, the PRSP and the UNDAF, Plans of Action for Children have been developed in both Serbia and Montenegro.

There are 1,663,000 children in Serbia and

Montenegro, constituting 20% of the population. The country faces a demographic challenge with an ageing population, falling birth rate (though high in some minority population groups), continuing migration and brain drain. Some 25–30% of the population live below or close to the poverty line, including over a third of children.¹

Already burdened with the consequences of conflict and sanctions, economic collapse and migration, Serbia and Montenegro faces additional challenges in making the transition to democracy and a market economy. GDP has fallen by 50% since 1990, public debt is rising and estimated to exceed 7 billion USD by 2005, and the weak economic base is constraining public spending. Investment in health and education per child has more than halved over the last ten years.² It will be important that children are set high on the political agenda as development in early childhood is an essential first step for combating poverty.

Health of children

The infant and under five mortality rate is decreasing but children from marginalised population groups are still dying from preventable diseases and 75% of infant mortality happens in the perinatal period. More premature children survive but the number of cases with multiple disabilities is also increasing. Few women die in childbirth; however the quality of services is low, authoritarian, medically driven and service-centred and offers little or no choice or participation for families. Attitudes to mothers are also in need of change as services lack a client friendly approach.

Exclusive and continued breastfeeding rates are low at 10% at four months, although 70% of maternity units have acquired Baby Friendly Hospital status. However, practices remain poor even in some of the country's top referral units. Although children in the majority of families are tradi-

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^{*} Excluding the UN administered province of Kosovo.

tionally put first, information on actual care practices and family choices in different parts of the country is missing. Only 22% of children receive preschool education. Pre-school education is particularly inaccessible for children in greatest need (covering 0.5% of Roma and children with special needs) and those from underdeveloped areas.

Immunisation coverage is high nationally at 92%, although there are regional variations from 70–100%. Immunisation is particularly low among poor and Roma children, although little data has been recorded in this regard. UNICEF in 2003 found 16,000 un-immunised children, mostly Roma, in nine out of 23 regions in Serbia. The government procures needed vaccines for children. Locally produced are BCG (the vaccine against childhood tuberculosis), DPT (protects against Diphtheria, Pertussis and Tetanus), OPV (protects against polio) and MMR (protects against measles, mumps and rubella). Although there is a national policy for immunisation of all newborn children against Hepatitis B, a complete national budget has not been allocated to this and immunisation rates are around 20%. There is no information available on Vitamin A deficiency among children in Serbia and Montenegro. However, high levels have been reported elsewhere in the region, making it possible that there is a problem. National immunisation legislation exists but could be strengthened by intersectoral immunisation committees and new long term immunisation plans in each republic. According to international standards, iodine deficiency has been eliminated, but work still remains to maintain this. Almost one third of children under five and women of reproductive age are anaemic.

Knowledge of the HIV/AIDS epidemic in the country is based on patchy data. The reported countrywide numbers of AIDS cases are 1,250, cumulative to December 2003, (in Serbia around 1,200, in Montenegro 50) with the majority of cases occurring in people aged 20–39 years. Including the time it takes to develop the virus, this means that they were infected when they were 15–24 years old. There is only passive reporting of HIV/AIDS cases, which in 2002 totaled 43 new HIV cases being reported in Belgrade alone.³ Voluntary confidential counselling and testing is still only available in a few centres and the numbers tested are very low. The rate of 1.5 people tested for HIV per 1,000 population (excluding voluntary blood donors) is one of the lowest in Europe. The

epidemic is still in an early stage but the current situation (e.g. needle sharing among intravenous drug users, risky sexual behaviour) suggests a rapid increase in the next 3–5 years.

The government has taken some steps to prepare. Republican AIDS Committees were formed in Serbia and Montenegro in 2002 and HIV/AIDS strategies are under development. All drugs for AIDS are on the list of medicines available in the country and are funded by the health insurance fund. There is as yet no national register or national surveillance for HIV/AIDS. Pregnant women are not routinely tested, thus there is no data on the percentage of pregnant women who are HIV positive. Testing for pregnant women is only provided if the woman is at particular risk and only one woman has tested positive during pregnancy so far. However at least 14 children have contracted HIV by mother-to-child transmission. There have been some initial efforts to strengthen the prevention of mother-to-child transmission and offer HIV testing to all pregnant women. The official recommendation is that HIV positive pregnant women receive up-to-date anti-retroviral treatment and care.

The Belgrade AIDS clinic reports 31 children living with HIV/AIDS. Most children living with HIV/AIDS stay within extended families, even when their parents die. There is no special support provided to them, except medical treatment when needed. Few children living with HIV are involved in the regular school system and those who have, have been exposed to discrimination and hysterical reactions by parents and school personnel. A major problem is a lack of information and awareness in the general population about practical aspects of HIV/AIDS in everyday life. HIV/AIDS prevention needs to begin during primary school and targeted at vulnerable groups, but information and programmes on safer sex or the risks of needle sharing are poorly developed, tending to rely on old-fashioned lectures and talks. Newer programmes include peer-to-peer education. Programmes are largely introduced informally by non governmental organisations (NGOs), although the Ministry of Education in Serbia has now introduced health education as part of its reform of the curriculum.

Young people face notable risks during the current transition process. The impact of conflict, poverty and high unemployment, the legacy of isolation, deteriorating economic conditions, a decline in the provision

“Investment in health and education per child has more than halved over ten years”

“Few children living with HIV are in the school system”

of basic services and a breakdown of societal and cultural norms together with gender stereotyping have resulted in the presence of increased risky behaviour amongst young people. Despite satisfactory knowledge of HIV/AIDS and the link with unsafe sex, young people frequently practice unprotected sex. Some groups are more susceptible, and in one study, hardly any Roma used condoms.⁴ Moreover, youth friendly health services throughout the country are quite sporadic, particularly in the area of reproductive health.⁵ Condoms are available and cost €0.5 each, although cost remains a factor for some poor people.

There has been an increase in drug use among young people (cannabis and synthetic drugs).⁶ Drug use and risky sexual behaviour are often related. Sex in return for money or some other benefit has increased in the last decade. This has been reported among girls as well as boys. Cases of violence and rape have been reported and levels of domestic violence are high. An increase in human trafficking, with around 10% of victims under 18, may act as a regional pathway for the spread of the epidemic.⁷ Particularly vulnerable young people such as sex workers, drug users and men having sex with men (MSM) are at particular risk of contracting HIV. According to one survey, 57.1% of intravenous drug users share needles, and only 60.3% of sex workers and 41.5% of MSM use condoms regularly. Targeted and outreach services for these populations do not exist and they experience discriminatory attitudes in accessing regular services.⁶

Access of children to basic health services

The health care system in Serbia and Montenegro is still in a poor condition as a result of the unfavourable events in the economic, political and social sphere to which the population was exposed in the 1990s.² There are other underlying causes including discriminatory attitudes of health staff, registration issues, formal and informal co-payments, insufficient financing and infrastructural shortcomings, problems with the accessibility of health care and low motivation among health care professionals.

Though basic health care is formally free of charge at the point of utilisation, an increasing number of people are faced with out-of-pocket charges even for primary care services. Figure 1 shows that in Serbia in 2002, payment for general practitioners was unrelated to economic status, and reported by around 30% of respondents in the survey. Reported payments are even more frequent for paediatricians, affecting 50% of those who are poor. Similar results were found regarding the utilisation of laboratory, radiology or other support services in health care. Though poorer population groups reported visits to physicians, utilisation of these additional services was much lower (24%) in comparison to respondents living above the poverty line. Private health care services are still not regulated and no official data exist on their use. They form an important stop-gap for those who can afford to pay.

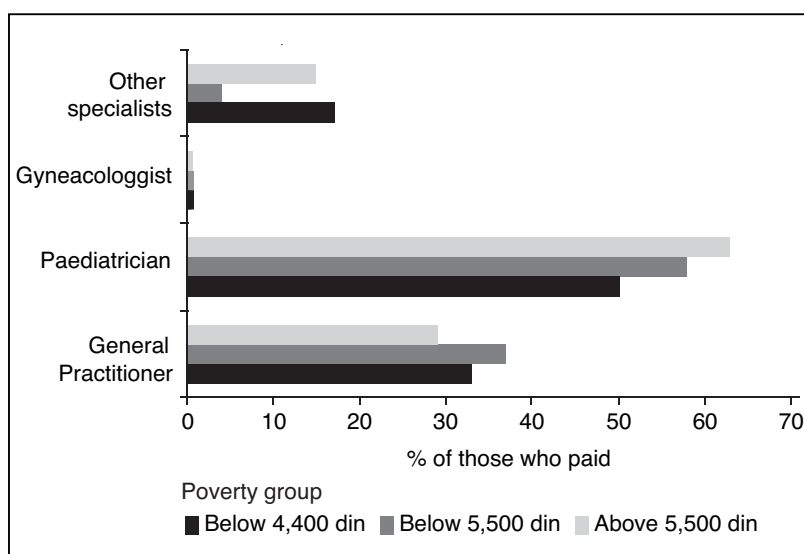
For poor families in Serbia, the most commonly cited reasons for not using health care services are a lack of financial resources (64%), followed by remoteness of health care facilities (13%), which is very typical for rural areas.⁸ A survey in 2002 painted a similar picture. People living in poverty who did not use health care services despite being in poor health provided the following reasons:

1. No health insurance – 39%
2. Minor disorder self treated – 34%
3. Health care services too expensive – 16%
4. Minor disorder not requiring treatment – 9%
5. Too great a distance to health care services – 2%

(Source: PRS Survey database 2002)

In rural areas children must face large geographical distances and inadequate transportation, a shortage of physicians and

Figure 1 Payment for visit to physicians according to income level



Source: PRS Survey, 2002.

other health care providers, a lack of health care facilities, lack of health prevention interventions, low motivation of health professionals, difficulties in getting formal health insurance, and different forms of informal payments.⁸

Roma children face particular barriers. Lack of health insurance is common,⁸ and in some cases families are not even aware of how to obtain a health insurance card or register a birth, nor are there any state outreach services to help them do so. Several NGOs have received funding from international donors to support minority, displaced and poor people with this complex issue of registration. During interviews and focus group discussions, Roma as well as others living in poverty, often mention the poor quality of health care services, including the inadequate behaviour of health professionals and long waiting times. Health strategies were adopted by the parliaments of Serbia and Montenegro in 2004 and 2003 respectively, with a focus in both in particular on people living in poverty, those facing exclusion from service provision or those at risk of human rights abuses.⁹

Registration of births

The right of children to a name and nationality is set out in the UN Convention on the Rights of the Child to which Serbia and Montenegro is a signatory. Birth registration is mandatory, and there are financial incentives to register a child; €1,000 for the first child and higher amounts for subsequent children. There is however no systematic way of checking if this has been done for each child and some are not registered. Birth certificates must be renewed regularly at the municipal office where the child was registered, and a fee must be paid each time. This is not the case in many European countries where the original birth certificate remains valid for life. There are also other financial barriers. While the first copy of the birth certificate is free of charge, subsequent copies may or may not be, depending on the purpose for which they are needed. For school enrolment purposes copies are still free but copies to obtain citizenship require a mandatory payment. Parents have to pay from their own resources and must obtain documents from the municipality where the child was born, making this difficult for the poor, those internally displaced from Kosovo and refugees. A child without registration finds it difficult, if not impossible, to get access to education, health and social services, and is lost from official statistical data.

Plans of action for children

As part of the implementation of the Convention on the Rights of the Child, National Action Plans for Children in Serbia and Montenegro have been formally adopted by their respective governments. This represents a first attempt in the country at a concerted policy approach for children. Both plans are based on the four foundation principles that underpin the Convention: non-discrimination, best interests of the child, right to life, survival and development, and participation. They define goals and targets to be achieved by the years 2010 and 2015, as well as a set of indicators to measure progress achieved. The major priorities of the Serbian Action Plan for Children are:

- Poverty reduction for children
- Quality education for all children
- Better health for all children
- Having a strategy for protecting the rights of children with special needs
- Protecting the rights of children without parental care
- Protecting children from neglect, violence and abuse
- Building the country's capacity for solving children and youth problems

The major priorities of the Montenegro Plan of Action are:

- Protect all children from inequality
- Ensure that all children receive a good quality basic education
- Assure a healthy life for girls and boys
- Protect the environment for children
- Ensure that all children are full citizens

A model project is underway in five municipalities to develop local Action Plans for Children, bringing together key stakeholders from all sectors, including civil society representatives, and preparing data collection of key indicators that can be used to inform decision making at local level. Combined with plans for decentralisation of key services, including health services, this may offer the best chance for improving services for children at the local level. It also offers an opportunity for participation and improved public information on key issues. So far access to health and education has not become an election issue in the country, but it could well do so in future as the transition takes hold and disparities increase.

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The effectiveness of health impact assessment

Matthias Wismar

“HIA opens up opportunities for the proactive management of inequalities in health”

In recent years health impact assessment (HIA) has attracted a lot of attention amongst the public health community across Europe. HIA has received political support from various European governments, some of whom made their commitment explicit putting HIA on the political agenda. HIA was included in official policy papers and pilots and projects were funded. At an international level, HIA also received support. The European Commission included aspects of human health in its directive on environmental impact assessment. An attempt to integrate health in all Community policies is under way. For the purpose EU policy development a generic HIA methodology has been developed.¹ The World Health Organization has supported HIA too, in the European Region including it in the HEALTH21 policy. Additionally, various programmes and centres work in support of the development and implementation of HIA.

Scientifically, a lot of progress has been made too. The international literature on HIA has been growing rapidly. Theoretical, methodological and conceptual progress has been accompanied by fully fledged HIA reports and case studies. Many countries and sub-national entities have developed resources for HIA and embarked on capacity building. Guidelines, tools and instruments have been devised, websites containing HIA-databases, documents and tools are now online. Successful HIA-training courses have been developed in some countries and dedicated HIA units, affiliated with or integrated into academic departments, have emerged.

HIA as a key element of inter-sectoral health policy

These developments reflect an enthusiasm linked to the potential of HIA. It is considered as a major opportunity to integrate health into all policies. It has been so attractive because HIA promises to influence the decision making process, address-

ing all determinants of health, tackling inequities, and providing a new impetus for participation and empowerment in health. Its capacity to influence the decision making process is linked to its prospective character. A widely used definition describes health impact assessment (HIA) “as any combination of procedures or methods by which a proposed policy or program may be judged as to the effects it may have on the health of a population”² There are many other definitions of HIA,³ still, most researchers would agree on two central features of HIA:³

- It attempts to predict the health consequences of different options.
- It is intended to influence and assist decision makers.

This means, HIA is always prospective and geared towards the decision making process. Decision-makers would not necessarily follow the recommendation of the HIA, but they would need to justify why they put up with the potential negative health effects of their decision. The trade off between a healthy public policy and other considerations would become explicit. HIA is a thoroughly inter-sectoral activity since it focuses on the so-called determinants of health. They include housing, agriculture and food production, education, work-environment, water and sanitation. HIA analyses the potential impact of a policy, programme and project on the determinants and in turn how the determinants impact on the health of the population.

Equally explicit HIA addresses the distribution of potential health gains and losses among subgroups of the affected population. This may allow potential health inequalities to be brought to the attention of policy makers, the affected population and the public before damage is done. In fact, HIA opens up opportunities for the proactive management of inequalities in health. Participation plays an important role in HIA too. The significance and integration of lay knowledge,⁴ the creation of ownership and of course the empowerment of the affected population are issues that

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are frequently raised in the context of HIA.

Defining effectiveness

No wonder that HIA has generated a lot of enthusiasm, but there is a lot of scepticism too. This scepticism is linked to the crucial but still unanswered question, does HIA work? This simple question is still unanswered because of a number of highly complex methodological issues surrounding the evaluation of HIA. Outcome evaluation of a given HIA focusing on health gain or loss for an affected population is difficult if not impossible to conduct.⁵ In many cases the long latency of the health effects of the intervention initiated by the decision at stake would require that the evaluation cover a period of more than a decade. We need answers sooner than that, and of course, over this long period the composition of the population group affected by the intervention would inevitably have changed exacerbating the complexity of outcome evaluation. In addition, any intervention initiated by the decision at stake may not remain stable. It is in the very nature of complex social interventions like policies, programmes or projects that they change over time. They get amended, adjusted and may change direction. As with many public health interventions, factors other than the intervention in question that influence health outcomes are rather uncontrollable. Unrealistically long periods of time, vague boundaries of the population group affected and shaky interventions call for other forms of evaluation.⁶

An alternative and feasible strategy to assess the effectiveness of HIA is not to choose health gain or health loss as the endpoint of the evaluation but instead the influence on the decision making process.⁷ There are three ways in which HIA might influence the decision making process:²

- raising awareness among decision makers;
- helping decision makers identify and assess possible health consequences;
- helping those affected to contribute to decision making.

If this constitutes a yardstick for assessing the effectiveness of a HIA, then the link between knowledge production and decision making will be of fundamental importance.

Unfortunately, despite the rapid growth of the literature on HIA, the evidence on the effectiveness of HIA is more than sketchy. No systematic knowledge about the effective-

ness of HIA in terms of influencing the decision-making process is available. After all, anecdotal evidence and selected studies from England, Sweden and The Netherlands seem to suggest that HIA may work. Yet it remains unclear if these are exceptional success stories. It is also unclear if these specific successes are linked to specific contextual conditions that may exist in one country but not in another. In plain terms, the question is not only does HIA work, but also what works and in what context? If we are to develop appropriate solutions for inter-sectoral health that match the diversity of European countries and sub-national entities it will be of the utmost importance to find adequate answers to this question.

“the evidence on the effectiveness of HIA is more than sketchy”

Research into the effectiveness of HIA

In order to address these issues in August the European Observatory on Health Systems and Policies launched a three year multi country project on the effectiveness of HIA, co-funded by the European Commission under the Public Health Work Programme (Grant No 2003101). Currently there are 17 partners from 14 Member States as well as observer partners from 4 countries in the project. (See Box).

European Observatory on Health Systems and Policies, WHO European Centre for Health Policy (project leader)

EuroHealthNet, Belgium

Health Development Agency (HDA), England

Institute of Public Health in Ireland

Institut za varovanje zdravja Republike Slovenije, Slovenia

Jagiellonian University - Institute of Public Health, Poland

Landesinstitut für den Öffentlichen Gesundheitsdienst NRW, Germany

National Institute of Public Health, Sweden

Semmelweis University Budapest Health Services Management Training Centre

STAKES, National Research and Development Centre for Welfare and Health, Finland

Técnicas de Salud SA, Spain

TNO Prevention and Health, The Netherlands

Institute of Hygiene, Catholic University of the Sacred Heart, Rome

University of Southern Denmark

Wales Centre for Health, Wales

WHO Collaborating Centre on Health and Psychosocial factors, Belgium

Trnava University – Faculty of Healthcare and Epidemiology, Slovak Republic

Directorate-General of Health, Portugal

Institute of Health Economics and Management, Switzerland (Observer)

Kaunas Medical University, Lithuania (Observer)

Ministry of Health Malta (Observer)

“a systematic mapping of HIA configuration throughout Europe is overdue”

The overall aim is to map the use of HIA, evaluate its effectiveness and identify the determinants for its successful implementation. Effectiveness in the context of the project refers to the capacity to influence the decision making process and be taken into account adequately by the decision makers. Five specific objectives are derived from this overall aim:

- To map the use of health impact assessment in Member States;
- To map the use of other impact assessment methodologies that have taken up health;
- To develop a set of indicators to measure the implementation of HIA;
- To assess the factors that enable or hinder the implementation of HIA including the institutional, organisational and cultural contexts as well as the decision making process;
- To disseminate the findings to improve the use of HIA in the decision making process in the Member States;

The research into HIA has already brought to light a vast heterogeneity of models. [8] This shows that there is not a ‘one-size-fits-all’ solution in HIA. This diversity in the development of HIA across Europe may reflect the differences in the purpose of HIA and in the contextual conditions in various countries. This diversity has often been formulated in terms of bipolarities: quantitative versus qualitative methods, health versus disease oriented, participant versus expert driven, rapid versus in-depth assessment, separate versus integrated in other assessments.⁹ Therefore, a systematic mapping of HIA configuration throughout Europe is overdue. This mapping can build on previous studies in the field.¹⁰ Part of this mapping is to understand specific inter-sectoral policy related traditions. It has been argued that in some countries other processes exist which resemble some features of HIA,¹¹ and in fact, in some countries the term HIA does not exist at all.

In addition to mapping HIA-configurations across Europe an in-depth analysis on the influence of HIA will be carried out. This in-depth analysis will focus on how HIA has influenced (or not influenced) the decision making process. The analysis will take into account specific HIA-configuration and its interaction with contextual factors. Both the mapping and the in-depth analysis will contribute to the understanding of what works in what context.

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Family care: a conceptual clarification

Challenges for future health policy and practice

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*“family care has been
defined in different
ways”*

The healthcare problems of individuals are often solved without the intervention of professionals through family caregiving. Population ageing, a shortage of professionals and cost-control in the healthcare sector¹, increase the importance of family caregiving in most west-European countries, where comparative research has shown that national governments no longer take full responsibility for care services.² The involvement of family caregivers, however, is not without problems. Family caregivers can experience problems while providing care and while realising their need to fully participate in society.^{3,4} One cause of those problems involves the different conceptions of ‘family care’ that are in use, which has meant that the position of family care compared with other types of care is not clear. Moreover, the plurality of definitions of family care is not beneficial for fine-tuning between policy and practice. For the healthcare sector to function properly, such fine-tuning is indispensable.

This article proposes a definition of family care, based on analysis of several conceptions of family care described in Dutch literature. This definition is meant to form the basis for positioning family care relative to other types of care, as well as theorising and outlining policy. Finally, we deal with the consequences for Dutch policy and practice resulting from the proposed definition.

Family care and its definitions

Since the introduction of the word ‘family care’ in the Netherlands, it has been defined in different ways, for example as “complementary, non-vocational care to the elderly, patients, and others in need of

care”.⁵ This definition differs from another⁶ that describes family care as a form of homecare. “With family care help is given to those in need of care by one or more members of his social environment. This seems to point to a hierarchy in caregiving. When it becomes impossible to take care of oneself, care could be given by members of the family, neighbours and friends (in this order)”. This emphasises the social relationship between patient and family caregiver. In the previous quote, this social link isn’t mentioned, implying that family care could also be provided, for example, by a volunteer who has no social relationship with the patient.

The National Council for Public Health (NRV)⁷ stresses the social link between the family caregiver and the patient in its description of family care, adding that care is not given professionally and thus often becomes invisible. “It is the care which is not given from a professional point of view to a patient by one or more members of his direct social environment, this care directly springing from the social relation”. This definition is also used by others including within the Institute for Advice Research and Development, the Institute for Care and Wellbeing (NIZW) and the Department of Public Healthcare, Wellbeing and Sport. The latter adds that family care is about unstructured, long-term care (from three months onwards) going beyond the day-to-day duties of a family caregiver. Several definitions emphasise that family care is unpaid, and not provided within a professional framework. However, since the implementation of individual budgets for patients, family caregivers may receive some compensation for their ‘unprofessional’ help, as help may otherwise be obtained at a healthcare institute or, individually, from a professional caregiver.

An expansive view is that family care improves both the quality of caregiving and reduces costs.⁸ In this view family care is defined as “care provision which is shared by the members of the social environment on a basis of voluntary reciprocity.

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“the long duration of family care contributes to problems faced by caregivers”

Essential for this type of care is personal involvement, dedication and concern of all those involved. This type of care is always of an emotional nature”.⁸ The core of this description is the social environment of which ‘social relationship’ described earlier is one part. What distinguishes this definition from others is the emphasis on the emotional nature of care coloured by the use of terms such as dedication, involvement and concern. Another distinction is reciprocity, what the caregiver receives from the patient.

While the NRV definition is generally accepted, several definitions are currently in use. One characteristic in particular that features in most is the social relationship between family caregiver and patient. Authors writing about ‘family care’ seem to view this as a necessary condition for using the phrase ‘family care’ appropriately. Other characteristics of family care that can be deduced from the definitions given above are the following: provided outside the framework of professional social care; given over a long time period; not provided in an organised setting; over and above normal care in both duration and intensity; given on the basis of the patient’s willingness to reciprocate; emotional; unpaid; complementary; invisible and delivered in a home setting.

Analysis of characteristics

In order to arrive at a more adequate definition of family care, an analysis of these characteristics is necessary. Four features no longer seem appropriate. Family care as a form of unpaid care has become obsolete ever since the introduction of the individual care budgets in the Netherlands, which allow non-professional caregivers to be paid. Secondly, it is imprudent to indicate that a feature of care is its complementary nature, as this is a major point of discussion: should family care complement professional care, or should it be the other way around?⁹

A third feature best left out is the so-called ‘invisibility’ of family care. Indeed, care given by people who have social relationships with patients has become increasingly visible in recent years in the Netherlands because of the help that the government, support centres, and home help agencies now provide for these people. The final feature to abandon is the notion that family care is only provided in the home. One recent study¹⁰ indicates that in both the family home and in nursing homes care is provided by individuals having a social

relationship with the patient.

Some of the other features of definitions of family care could be seen as being clustered: the patient’s willingness to reciprocate and the emotional nature of the care both involve the social link between caregiver and patient. Two other characteristics of care not provided within the framework of professional social care and family care, and delivery of care in a non-organised setting, are also connected with the fact that family care springs from the social link between caregiver and patient. Therefore, it seems sufficient to put emphasis on this social relationship in a future definition of family care, while it is also relevant to note that family care is provided for long periods of time.

One of the reasons policy with respect to family care is needed is the long duration of family care, which contributes to problems faced by family caregivers. The last feature to include in a future definition of family care concerns the fact that family care transcends ‘the way things are normally run’ with regard to both duration and intensity. Family care is in that respect a form of intense care that often leads to problems.⁹ Based on the above analysis the following definition of family care can be proposed:

‘intense and long-term care given by laymen from the patient’s direct social environment, springing from the social link between the patient and the family caregiver, not coming from an organised setting and not provided within the framework of professional social care’.

The positioning of family care with regard to other types of care

In order to determine the position of family care defined above relative to other types of care, a distinction should be made between professional care on one hand and informal care on the other. Professional care is seen as organised care provided by paid professionals. Assistance can be offered in residential settings or on an out-patient care basis. In general, professional care is granted following a needs assessment and reimbursed through social insurance. The reciprocity between the professional and the patient lies in the financial reward paid to the professional for services rendered. Such care can be both of short-term and long-term duration. A person with learning disabilities who is cared for during a five-day stay in a residential home every week will receive long-term professional care whereas for a client in need of

advice from a general practitioner a seven minute consultation might suffice.

Characteristically, professional care is organised and paid-for care, involving trained social workers. Family care, by contrast, is not organised nor provided within the framework of professional social care. Moreover, family care is provided on a long-term basis and can complement professional care in daily practice.

It is more difficult to define informal care (or informal help), but essentially this may be done in three ways. Firstly to view informal care as family care only,⁴ as help that is instrumental in the patient's daily functioning and which is offered voluntarily and free to people from the social network of the caregiver who have serious physical and/or psychological problems. Care provided by volunteers lies outside this definition because volunteer work isn't necessarily given to individuals from their own social environment. The social link between patient and caregiver is important in distinguishing informal care (in this case, family care) from volunteer work.

Govaert and Morée's¹¹ definition of informal care, by contrast, includes both family care and volunteer work. Informal care consists of a continuum with intensive forms of family care to which the social link is vital on the one hand and traditional volunteer work where people provide care based on their commitment to an organisation on the other. 'Help to neighbours and friends can also be placed on this same continuum: although this help is offered from an existing relationship it doesn't have either the intensity or effort characteristic of family care'.¹¹ On the continuum a wide variety of forms can be placed, with some of them containing more features of family care while others are more similar to volunteer work. Again, the social link turns out to be the defining feature to distinguish family care from volunteer work, although both do fall, within this definition, in the category of 'informal care'.

The third description of informal care is more elaborate. Provincial policy on informal care in the Netherlands¹² defines this as 'care offered by laymen to (elderly) patients with (chronic) diseases and disabilities who cannot function completely on their own without this care. This help includes household tasks and activities of daily living and is offered on a short-term or long-term basis'. In Dutch policy on informal care, this third definition is used to describe collectively all forms of care not

provided professionally: family care, volunteer work and contact with patient groups. Family care is here defined similarly as in the definition of the NRV⁷ and volunteer work is described as 'a voluntary offer of help in an organised context, by individuals without any form of payment'.¹² Finally, contact with other individuals and patients with the same condition is seen as 'group-orientated, organised as a series of one-to-one exchanges aimed at solving shared problems. Those involved give help in both ways, without any professional guidance through a mutual exchange of lived experiences'.¹² Family care, volunteer work and mutual patient support share their informality, but they can also be distinguished from one another.

The principal differences between family care and volunteer work are that family care, in contrast to volunteer work, takes place between people who already have a social link with each other before the need of care arose. Volunteer work is provided within an organised setting, the work does not have to be intense or long term, and is provided freely without obligation in order to help others on social grounds.

When comparing family care and mutual patient contacts, the following points stand out: that mutual patient contacts take place in an organised setting, consisting mainly of efforts to better the situation through discussion of common experiences, and participation in such contact groups is a matter of choice, which may not be the case for family care.

The three forms of care discussed each have their own niche in the field of informal care and are complementary. For example volunteers can help to alleviate family caregivers' burden by offering social support and practical help. "Volunteers can take over certain activities of family caregivers when asked, they can prevent or decrease professional care as well as provide information on professional or other activities in the field of care and welfare".⁴ The features of the proposed definition of family care are of help in distinguishing family care from other types of informal care such as volunteer work and mutual patient contact groups.

Reflections

The fine-tuning of policy and practice regarding family care, which is needed if public health care is to function efficiently, is hampered by great diversity in current definitions of family care. A clear-cut definition of family care will contribute to a

"Mutual care should be appreciated by society"

"a custom-made policy would lead to a better adjustment of policy and practice"

fine-tuning of policy and practice.

By comparing different definitions of family care and by analysing the features resulting from such a comparison, a more adequate definition of family care has been proposed. Although this definition, 'intense and long-term care given by laymen from the patient's direct social environment, springing from the social link between the patient and the family caregiver, not coming from an organized setting and not provided within the framework of professional social care', recognises all relevant features of family care, some aspects remain opaque.

Characteristics that could be interpreted in different ways, should be inspected in closer detail, including two features in particular: the long-term character and the intensity of family care. What ultimately is meant by taking care of someone close on a long-term and intensive basis? The Dutch National Organisation of family caregivers (LOT) and the Organisation of Voluntary Home Care and the Assessment Boards have determined the dividing-line between occasional care and long-term family care at three months,⁴ on the assumption that family caregivers usually experience social, physical and emotional problems only after a three-month period. Whether or not the family caregiver actually has these problems does not determine if someone is a long-term family caregiver, so the critical argument runs. For example, someone who takes care of a relative in need every day for a long time and who has no problems is a long-term family caregiver. Yet whether or not problems are encountered does say something about the burden of caregiving. This always has both an objective and a subjective element. A valid argument for choosing a three-month period is the incipient structural character of family care.

Besides being long-term, family care also should be intense, so that the family caregiver offers help going beyond day-to-day activities. Situations are often characterised by a collision between duties to society and the personal preferences of the family caregiver. Intense family care, for example, is provided to family members who are chronically ill or who have physical or mental disabilities. Consequently, cleaning up the house occasionally for an unwell sister is not intense family care. Intense family care seems to begin with the patient's need for professional care, with this need being filled by someone with whom the patient has a social link. In this definition, family care is more or less a need for professional

care, but where this is received instead from a family caregiver. If the government would agree with this definition, it would be legitimate to suggest that family caregivers are entitled to the status of employees, as they perform tasks normally undertaken by professionals. Thus, the use of the proposed definition certainly has consequences for health care policy, among other things.

Using the proposed definition in practice decreases the number of family caregivers entitled to family care support. It is vital to note though that people who look after a relative in need but do not fall into the proposed category, still retain their social importance. Occasionally taking care of a relative in need is a form of solidarity which society requires. Mutual care should be appreciated. Looking after an ill relative occasionally, however, differs from intense and long-term caregiving. There is more risk of experiencing social exclusion, of feeling exhausted and of caregiving becoming disjointed.⁹

A third consequence of using the proposed definition has to do with positioning family care in relation to other types of care. By regarding family care, in addition to volunteer work and mutual patient support groups, as being a part of informal care, family care's position in relation to other types of care is clarified. Confusing the notions of family care and informal care is prevented. Distinguishing family care, volunteer work and mutual patient support groups from each other will diminish the risk of informal care becoming a kind of 'one size fits all' notion.

Governmental policy regarding family care might in particular focus on those family caregivers who meet the criteria of the proposed definition. This policy could take into account any problems arising from within this group. In other words: a custom-made policy aimed at a particular target-group would lead to a better adjustment of policy and practice.

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Luxembourg Presidency News, information and publications from the Luxembourg Presidency of the European Union.

www.eu2005.lu/en

Open Society Institute (OSI) and Soros Foundations Network

www.soros.org

The OSI, founded by investor and philanthropist George Soros in 1993, is a private operating and grantmaking foundation based in New York City and Budapest that serves as the hub of the Soros foundations network, a group of autonomous foundations and organisations in more than 50 countries. OSI and the network implement a range of initiatives that aim to promote open societies by shaping government policy and supporting education, media, public health, and human and women's rights, as well as social, legal, and economic reform.

The website can be searched by regions where the OSI operates, including central and eastern Europe, providing an enormous amount of information on activities and links to Soros foundations in the region. One programme focuses on issues related to the Roma in central and eastern Europe and the former Soviet Union. The programmes' Roma-related efforts, are aimed primarily at improving the social, political, and economic situation of Romani populations. Information on a number of public health programmes and initiatives in the region is also provided.

European Disability Forum (EDFF)

www.edf-feph.org

EDF is a European umbrella organisation representing more than 50 million disabled people in Europe. Its mission is to ensure disabled citizens' full access to fundamental human rights through their active involvement in policy development and implementation in the EU. The website (English and French) provides information on the latest news and developments across Europe, together with updates on forthcoming events and publications. A monthly news bulletin in English and French updates readers on activities and views of the EDF and EU policy developments.

Mental Disability Advocacy Centre (MDAC)

www.mdac.info

MDAC is an international non-governmental organisation based in Budapest that promotes and protects the human rights of people with mental health problems and intellectual disabilities across central and eastern Europe and central Asia. MDAC works to improve the quality of life for people with mental disabilities through litigation, research and international advocacy. A database with country specific information is provided on the website (in both English and Russian).

Implementing Mental Health Promotion Action (IMHPA)

www.imhpa.net

IMHPA aims to support the development and implementation of mental health promotion and mental disorder prevention action across Europe. With partners across 28 European countries, IMHPA is developing a set of tools, for health professionals, practitioners and policy makers, to support implementation and dissemination at national and regional levels. The network aims to develop and disseminate evidence-based mental health promotion and mental disorder prevention strategies across Europe and to facilitate their integration into countries' policies, programmes and health care professionals' daily clinical work.

Since April 2003, IMHPA has been engaged in developing three strands of products to be disseminated, implemented and tested across European countries. These include the development of a standardised internet database of evidence-based mental health promotion and mental disorder prevention programmes and policies; a training manual for primary health care professionals to include mental health promotion in daily clinical practice; and a European policy action plan for mental health promotion and mental disorder prevention.

Personal Social Services Research Unit (PSSRU)

www.pssru.ac.uk

The PSSRU's mission is to conduct high quality research on social and health care to inform and influence policy, practice and theory. It was established at the University of Kent at Canterbury in 1974, with new branches opening at the London School of Economics and Political Science and at the University of Manchester in 1996. PSSRU researchers come from a wide range of disciplines and backgrounds, including the caring professions. The Unit's work has had an important influence on theory, and policy development and reform in several countries: for instance, in care-managed community care of older people and the study of costs and the costs of outcomes. In addition to contact details and information on current research activities the website provides access to a searchable database of reports and other publications.



Implementing Change in Health Systems. Market Reform in the United Kingdom, Sweden and the Netherlands

Michael I. Harrison

London: Sage Publications, 2004.

ISBN 0-7619-6175-5

240 pages.

Cloth £60

Paperback £21.99

This concise and sharply written book by Professor Michael Harrison of Bar-Ilan University, Israel and Senior Research Scientist at the US Agency for Healthcare Research and Quality looks at the implementation in the United Kingdom, Sweden and the Netherlands of market reforms in the health care sector through the 1980s to the late 1990s. Reforms in various guises over this time period were intended to improve efficiency, contain costs and promote quality. In all three countries reforms included initiatives to encourage managed competition between health care providers and/or insurers. After describing the historical and institutional contexts for health care systems in all three countries, and their experiences in implementing reform, the book goes on to analyse what the potential contribution of market-orientated reforms for efficiency and quality in publicly funded and regulated health care systems may be, and also what can be learnt more generally from these three case studies to aid in the implementation of public policy.

One key observation is that in all three countries competitive reform encountered serious technical, organisational and political obstacles, but nevertheless reforms still helped instigate both system and health policy change. The book concludes with a short set of guidelines for 'a decentralised, learning-focused approach to implementing health system change'.

Contents: Health system reform and policy implementation; Market reforms in the United Kingdom; Outcomes of market reform in the United Kingdom and Labour's new health policies; Market experimentation within the Swedish health system reform; Reform outcomes in Sweden and the emerging mix of public and private care; Regulated competition in the Netherlands; Reform outcomes and new policy trends in the Netherlands.

Promoting Health: Global Perspectives

Edited by Angela Scriven and Sebastian Garman

Basingstoke: Palgrave Macmillan, 2005

ISBN 1-4039-2137-7

297 pages.

Hardback £52.50

Paperback £18.99

This book edited by Angela Scriven and Sebastian Garman, both from Brunel University, UK, critically examines a range of issues argued to be central to informing the promotion of health in the global arena. The overarching theme of the book is the interconnectedness of the world we live in, where boundaries between individuals and societies are being eroded, with consequent implications for global health. Chapters offer insights into the key determinants of health between and within countries; how effective health promotion is in achieving health gain at a global level and the significant health challenges to be faced in the twenty-first century. Case studies on strategies for promoting health in different parts of the globe are presented. Contributors include representatives from the World Health Organization, The International Union of Health Promotion and Education and the World Bank.

Contents: Promoting Health: A Global Context and Rationale, Angela Scriven; Key Global Health Concerns for the 21st Century, Basiro Davey; Inequalities in Health: International Patterns and Trends, David McDaid and Adam Oliver; Global Health Promotion: Challenges and Opportunities, Maurice Mittelmark; The Social Context of Health Promotion in a Globalising World, Sebastian Garman; Globalisation and Noncommunicable Diseases, Derek Yach, Robert Beaglehole and Corinna Hawkes; Food, Health and Globalisation: Is Health Promotion Still Relevant? Martin Caraher, John Coveney and Tim Lang; Tobacco: The Global Challenge for Health Promotion, Samira Asma, Prakash Gupta and Charles Warren; HIV/AIDS: Lessons For and From Health Promotion, Peter Aggleton; Global Environment Change and Health, Paul Wilkinson; Promoting Health in Low and Middle Income Countries: Achievements and Challenges, John Hubley; Trends and Factors in the Development of Health Promotion in Africa, 1973-2003, David Nyamwaya; Health Promotion in Latin America, Hiram Arroyo; A Public Health and System Approach To Health Protection and Health Promotion in Hong Kong, Sophia Chan and Gabriel Leung; Public Health in the Former Soviet Union, Joana Godinho; Health Promotion Development in Europe: Barriers and New Opportunities, Erio Ziglio, Spencer Haggard and Chris Brown; Health Promotion in Australia and New Zealand: The Struggle for Equity, Shane Hearn, Hine Martin, Louise Signal and Marilyn Wise; Health Promotion in Canada: Back to the Past or Towards a Promising Future? Ann Pederson, Irving Rootman and Michel O'Neill; Health Promotion in the USA: Building a Science Based Health Promotion Policy, Debra Lightsey, David McQueen and Laurie Anderson.

COUNCIL OF EUROPE MARKS 50 YEARS OF HEALTH ACTION

In Strasbourg on 16 November the Council of Europe's European Health Committee (CDSP) marked 50 years of work with the launch of a book *Health, Ethics and Human Rights – The Council of Europe Meeting the Challenge*. Deputy Ambassador of the Netherlands, Cees Meeuwis, symbolically handed over the first copy of the book to Council of Europe Deputy Secretary General, Maud de Boer Buquicchio, at the beginning of the meeting held at the Palais de l'Europe. The book details the development of half a century of work on health, including milestones such as the development of international standards in blood transfusion, action on organ donation and transplantation and the campaign to promote and protect the human rights of people with HIV/AIDS.

Ms de Boer-Buquicchio said "When we speak about human rights, in our mind's eye we see, quite stereotypically, images of courtroom deliberations or people in prison cells, or images of people abused by the police, or maybe images of demonstrations and public leaders speaking in opposition to the government. We rarely think about people being treated in hospitals and clinics, visited by doctors and nurses, or resting in homes for senior citizens. Yet, the ever-evolving concept of human rights and our understanding of it have been constantly enlarging their scope over recent decades. Through this evolution in our thinking and vision, we have come to realise that the right to good health and its protection is as much a human right as other commonly recognised rights and freedoms. It could hardly be otherwise: health is an issue at the core of our existence. Good health is the gateway to life and to the enjoyment of all human rights."

She also acknowledged the important contribution made by cooperation with other international agen-

cies, noting that "cooperation with the World Health Organization has led to a pioneering type of joint assistance programme - the South-East Europe Health Network" and that "in this connection that the Council of Europe is prepared to co-organise the second Health Ministers Forum on 'Health and Economic Development' in 2005 to mark the transition of this successful joint activity to full regional ownership and sustainability." The European Network of Health Promoting Schools organised in conjunction with the WHO and the European Union was also held up as a significant achievement. She also referred to the many challenges which Europe must face including ageing societies, medical and patient migration and the application of genetics. Ms de Boer-Buquicchio concluding with a hope that one day "the words "human rights" will conjure up in our minds images not of courtrooms and prisons alone, but of a cohesive society where everyone enjoys equal rights, also of access to state-of-the-art medical care and protection of their health, which would pave the way for harmonious living."

The full text of the Deputy Secretary General's speech is available at http://www.coe.int/t/e/SG/SGA/documents/speeches/2004/ZSP_2004_%2016%20Nov_Strasbourg.asp

CRITICAL MID-TERM REVIEW OF THE LISBON PROCESS

In Lisbon, in 2000, the heads of States and Governments of the EU-15 decided to start an economic and social reform process with the ultimate aim of becoming by 2010 "the most dynamic and competitive knowledge-based economy in the world capable of sustainable economic growth with more and better jobs and greater social cohesion, and respect for the environment".

A mid-term review chaired by former Dutch Prime Minister, Wim Kok, is critical about the process achieved so far and doubts whether the goals can be reached by 2010. Mr Kok believes there is a risk that the Lisbon strategy will become "a synonym for missed objectives and failed promises" and that "progress to date has been inadequate largely due to lack of commitment and political will." The report focuses mainly on the lack of competitiveness of the European economy, and puts forward a recommendation on healthy ageing. European institutions will debate this in the period leading to the Spring Council meeting.

Latest updates on the Lisbon strategy can be found at http://europa.eu.int/comm/lisbon_strategy

ENGLAND: WHITE PAPER ON PUBLIC HEALTH SETS OUT NEW MOVES ON SMOKING, OBESITY AND SEXUAL HEALTH

Health Secretary John Reid published 'Choosing Health – the Government's White Paper on improving public health in England'. The document aims to make it easier for people to change their lifestyle so they eat more healthily, exercise more and smoke less. It also sets out moves to improve sexual health, encourage sensible drinking and improve mental well-being. It proposes that

smoking could be banned progressively by the end of 2008 in workplaces and establishments where food is served across England.

The White Paper can be accessed at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor

CALL TO ENHANCE THE SOCIAL PILLAR OF THE LISBON STRATEGY

On 20 October, the Social Platform published two major position papers, their proposals for the next Social Policy Agenda 2006–2010, and their mid-term evaluation of the Lisbon strategy preceding the official report of the High Level Expert Group chaired by Wim Kok.

The Social Policy Agenda 2006–2010 provides detailed and practical proposals for the next five years to create a European social policy based upon fundamental rights. It covers many areas of social policy and draws upon the expertise of Platform's members in a wide range of social sectors.

The Evaluation of the Lisbon Strategy assesses the extent to which the EU is currently meeting the goals it set – particularly the social goals – at Lisbon in 2000. It provides a clear assessment from social NGOs in the form of a short question and answer paper, outlining the challenges in stark terms.

The two papers can be accessed at:

www.socialplatform.org/module/FileLib/SocialPolicyAgenda2006-2010_Final_EN.pdf

www.socialplatform.org/module/FileLib/ENSPEvaluationLisbon2005final.pdf

YOUNG PEOPLE'S LIFESTYLE AND THE ROLE OF SPORTS

The European Commission has published four studies on sports in the EU. On of them, entitled "Study on young people's lifestyles and the role of sport in the context of education and as a means of restoring the balance", deals with the sedentary lifestyle and lack of exercise of young people. The European Year of Education Through Sports ended in December. An evaluation report will be published later in 2005.

More information at
http://europa.eu.int/comm/sport/whatsup/index_en.html

REPORT ON PRIORITY MEDICINES FOR EUROPE AND THE WORLD

On 18 November WHO released *Priority Medicines for Europe and the World*. Commissioned by the Dutch Government under their EU Presidency, and discussed at a high level conference in The Hague, it identifies a priority list of medicines taking into account Europe's ageing population, the increasing burden of non-communicable illnesses in developing countries and diseases which persist in spite of the availability of effective treatments. The report looks at the gaps in research and innovation for these medicines and provides specific policy recommendations on creating incentives and closing those gaps.

It also identifies gaps for diseases for which treatments do not exist, are inadequate or are not reaching patients. Threats to public health such as antibacterial resistance or pandemic influenza, for which present treatments or preventive measures are unlikely to be effective in the future, also require immediate action. In total 17 priority conditions were identified:

Future public health threats: infections due to antibacterial resistance; pandemic influenza;

Diseases for which better formulations are required: cardiovascular disease (secondary prevention); diabetes; postpartum haemorrhage, paediatric HIV/AIDS, depression in the

elderly and adolescents;

Diseases for which biomarkers are absent: Alzheimer's disease; osteoarthritis;

Diseases for which basic and applied research is required: cancer; acute stroke;

Neglected diseases or areas: tuberculosis; malaria and other tropical infectious diseases;

Diseases for which prevention is particularly effective: chronic obstructive pulmonary disease including smoking cessation; alcohol use disorders: alcoholic liver diseases and alcohol dependency.

The report suggests that Europe can and should play a global leadership role in public health. The problems now experienced in many developing countries are similar to those seen in Europe. Efforts to shorten the medicine development process without compromising patient safety would greatly assist in promoting pharmaceutical innovation. The report calls for the EU to help create and support a broad research agenda for a critical review of regulatory requirements within the medicine development process looking at their relevance, costing, and predictive value.

The report can be accessed at
<http://mednet3.who.int/prioritymeds/report/index.htm>

RIGHT WORK-LIFE BALANCE IS A WIN-WIN SITUATION FOR ALL

The European Foundation for the Improvement of Living and Working Conditions Forum on *Living to work – working to live, Tomorrow's work-life balance in Europe* took place in Dublin in November. Established as a platform for top-level debate, the Forum is a biennial event, bringing together international policymakers, government leaders, social partners, researchers and other high-level actors to exchange experiences. "A better work-life balance leads to reduced stress for workers and increased productivity. It is not just an issue of importance to the individual, it is also of strategic importance to our economy.

Indeed, a future shortage of workers and skills is likely to force our economy to adopt successful work-life balance policies", warned Ireland's Taoiseach, Bertie Ahern.

Acting Director of the Foundation, Willy Buschak, called for fresh thinking to deal with what he called 'obstacles to our attempts to meet the Lisbon targets'. Particular challenges include the ageing of the EU workforce, the need to develop a knowledge-based society and to improve productivity.

More information available at
http://www.eurofound.eu.int/newsroom/archive_pressrelease/pressrel_041104.htm

OUTGOING COMMISSIONER BYRNE BECOMES SPECIAL ENVOY TO WORLD HEALTH ORGANIZATION

Former Commissioner for Health and Consumer Protection, David Byrne, took up a new role as the WHO Special Envoy on the revision of the International Health Regulations from 1 November. The International Health Regulations are the main piece of international law governing the control of infectious diseases. They were first adopted in 1969 for a small number of diseases and with minor amendments have remained largely unchanged since then. The revision of the Regulations to broaden their scope has been under way for several years and is now approaching a crucial decision point. The revision has become more urgent in light of the recent outbreaks of SARS and avian influenza. David Byrne said on taking up his appointment that "the revision of the International Health Regulations is a cornerstone

of internationally accepted rules on communicable diseases. Next time there is a SARS outbreak there will be rules. This is deadly important "

Officials from WHO's 192 Member States came together from 1 - 12 November to negotiate a revised draft of the Regulations. A final draft will be presented to the World Health Assembly in May, 2005. Mr Byrne's role is to facilitate this process of negotiation between the Member States. He is working with the Member States and with the WHO Director-General to resolve outstanding difficulties and to build support for the solutions proposed.

More information on the International Health Regulations can be found at
<http://www.who.int/gb/gbs/e/index.html>

NEW REPORT ON ACTIONS AGAINST DEPRESSION

A new report *Actions against depression. Improving mental health and well-being by combating the adverse health, social and economic consequences of depression* has been prepared for the Commission DG for Health and Consumer Protection. Depression and depression-related problems are today among the most pressing public health concerns. Estimates for total disease burden quoted in this report indicate that they account for more than 7% of all estimated ill health and premature mortality in Europe, only exceeded by ischaemic heart disease (10.5%) and cancer (11.5%). Moreover there are other burdens caused by depression, beyond the health systems: These include the loss of quality of life for the affected and their families, a loss of productivity for firms and an increased risk of unemployment for individuals. Depression can mean that people withdraw from family life, social life and work, and far too many

people with depression commit suicide.

The report builds on a whole range of past and current mental health-related activities under the Programme of Community action in the field of public health (2003-2008). They focus on better information about the mental health of the population as well as on the promotion of good mental health and the prevention of mental disease. It describes the illness of depression, highlights economic and social consequences, and presents the evidence base and areas for effective interventions. It also identifies some of the challenges in developing promotion and prevention strategies and possible solutions. Finally, it presents conclusions and suggestions for the way forward.

The full report is available at
http://europa.eu.int/comm/health/ph_determinants/life_style/mental/depression_en.htm

NEW COMMISSION FINALLY IN PLACE

The new Barroso team finally received approval from the European Parliament and took office on 22 November. In October President Barroso chose not to submit his team to a vote in the Plenary after two Commissioners were rejected by their respective Parliamentary Committees, the original Italian nominee for Justice and Home Affairs Rocco Buttiglione was rejected by the Committee on Civil Liberties, Justice and Home Affairs, while Laszlo Kovacs, from Hungary was considered not to have the necessary expertise for the job of Energy Commissioner. Latvian nominee, Ingrida Udre, also came under pressure after questions about her involvement in an ongoing investigation into funding irregularities within her political party. Both Buttiglione and Udre resigned to be replaced by Franco Frattini and Andris Piebalgs. Lazlo Kovacs was then moved to the Taxation and Customs Union portfolio with Piebalgs taking the job of Energy Commissioner.

Details of the full new Commission team are available at

http://europa.eu.int/comm/commission_barroso/index_en.htm

Details of Health and Consumer Protection Commissioner Kyprianou's new cabinet are available at

http://www.europa.eu.int/comm/commission_barroso/kyprianou/cabinet_en.htm

THE SITUATION OF ROMA IN AN ENLARGED EUROPE

A new report published by DG Employment and Social Affairs examines the conditions Roma, Gypsies and Travellers face in education, employment, housing and healthcare (among others). It sets out both good and bad practice in policies and programmes for Roma, as well as recommendations on how to improve existing policies in order to tackle the widespread discrimination and social exclusion which Roma, Gypsies and Travellers face.

START OF THE LUXEMBOURG PRESIDENCY

Luxembourg holds the Presidency of the European Union from 1 January until 30 of June 2005. Mars di Bartolomeo, Minister of Health and Social Security has set out priorities in the field of public health, these include work on the service directive; humanitarian support to victims of the Tsunami in South East Asia in the field of health and reconstruction; promoting healthy lifestyles; young people's health (including mental health); the fight against obesity and smoking; the European Regulation on Nutrition and Health Claims; the European Regulation on Medicine for Children; International Health Regulation; coordination of national social security systems.

On the services directive, Mr di Bartolomeo said that there is nothing as precious as one's health: 'Health is one's unique and irreplaceable capital' that should not be sacrificed for the sake of competition and that issues of access and quality should not be forsaken. The Luxembourg Presidency will organise conferences on patients' security, e-health, rare diseases, access to health care in the Internal Market, and long term care for elderly people.

More information at
<http://www.eu2005.lu>

HEALTH COUNCIL PLEADS FOR A LONG-TERM SUPPORT AFTER THE TSUNAMI

Meeting in an extraordinary session on 7 January 2005, the EU's Foreign Affairs, Development and Health ministers have agreed that humanitarian aid should be the main focus of tsunami relief efforts at this point. The Council highlighted the importance of actions to prevent the emergence of epidemics and protect human lives by ensuring food supply and access to drinking water, medicines and vaccines.

http://ue.eu.int/uedocs/cms_Data/docs/pressdata/fr/gena/83322.pdf

NEW EXECUTIVE AGENCY FOR PUBLIC HEALTH PROGRAMME

The European Commission has created an "Executive Agency for the Public Health Programme" for the management of Community action in the field of public health. The agency was established on 1 January 2005 until the end of 2010 and based in Luxembourg. The Commission remains responsible for the project programming stage while the new agency will be responsible for the project implementation stage: managing all the phases in the lifetime of specific projects, carrying out all the operations necessary for the execution of the budget and for the management of the programme, and providing logistical, scientific and technical support.

More information at
http://europa.eu.int/eur-lex/lex/LexUriServ/site/en/oj/2004/L_369/L_36920041216en00730075.pdf

TOBACCO CONTROL MOVES IN SCOTLAND AND MALTA

On 10 November the First Minister of the devolved Scottish Government announced to the Scottish Parliament the cabinet's decision to bring forward legislation for a comprehensive ban of smoking in all enclosed public places in Scotland. The decision-making process included public consultation and more than 52,000 individuals and 1,000 groups and businesses responded. The target date for full implementation is Spring 2006.

More information at
<http://www.scotland.gov.uk/Topics/Health/health/smoking>

Meanwhile in Malta legislation was passed in September 2004 that bans smoking in any enclosed private or public premises which are open to the public except for designated smoking rooms". The ban includes bars and restaurants, and is accompanied by a guide on how smoking rooms should be constructed

UK: REPORT ON HEALTHCARE IN A RURAL SETTING

In this report, by the British Medical Association, the key areas of medical education and training, recruitment and retention, and accessibility and sustainability of healthcare are examined in the rural context, with a focus on primary care. UK and international examples of good practice are included and recommendations for action made. The report is aimed at all healthcare professionals and organisations that can respond and improve healthcare in rural areas

Rural areas make up four-fifths of the UK landmass and include up to a quarter of the population. The proportion of older people living in rural settings is higher than in the general UK population therefore doctors may have to deal with more cases of chronic disease such as heart disease, stroke and mental illness.

Despite the image of the 'rural idyll' there are poor people experiencing disadvantage throughout rural areas and they often live near people with very different circumstances. This results in pockets of deprivation existing alongside relative affluence. Deprivation and poverty are important determinants of health and disease.

Commenting on the report, Dr Vivienne Nathanson, the BMA's Head of Ethics and Science, said: "The UK needs to learn from countries like Australia, the USA and Canada which have developed innovative solutions to the problems affecting rural healthcare."

She added: "A major problem is the myth of the 'rural idyll'. Deprivation in rural communities has been ignored for a long time. There is a real case of the haves and the have-nots. There are those with private transport who can access services, while those with lower incomes have limited access and choice."

The report is available at
[www.bma.org.uk/ap.nsf/Content/healthcarerural/\\$file/rural.pdf](http://www.bma.org.uk/ap.nsf/Content/healthcarerural/$file/rural.pdf)

COMMISSIONER KYPRIANOU CALLS FOR MORE ACTION TO PROMOTE POSITIVE MENTAL HEALTH

Speaking at the European Ministerial Conference on Mental Health "Facing the Challenges, Building Solutions" organised by the WHO, and co-sponsored by the European Commission, Council of Europe and Government of Finland Commissioner Kyprianou called for more action to be taken to promote positive mental health in Europe. He outlined three areas, the need to invest more in the promotion of good mental health and the prevention of mental disorders, the need for the health sector to engage in partnerships with other policy areas and stakeholders, and finally discussed the Commission's agenda to address these issues.

The Commissioner said "We should invest more in the promotion of good mental health and the prevention of mental disorders. Indeed, one of the main, and well-known, challenges for public health policies is not only to improve the availability of treatments of illnesses but also to ensure the effective promotion of good health: these are two sides of the same coin. In such a context, the promotion of mental health should seek to strengthen the abilities of people, as soon as possible in their life, to avoid the development of mental illness."

The Commissioner emphasised the link between mental health and key policy objectives of the European Union saying that "Mental health is a central dimension of human health and that it supports quality of life, economic growth, innovation and social cohesion. These constitute key policy objectives of the European Union. A high level of mental health is needed for the transition of the European Union into a dynamic knowledge society."

An important aspect of the Commissioner's address to the Conference was his emphasis on positive mental health rather than seeking to alleviate the burden of poor mental health alone. He noted that "we should try to improve the mental health of the population as a matter of priority rather than only seek to reduce the burden of a mental disease when it is overt. Measures

for mental health promotion, embedded in mental health strategies, can make a valuable contribution towards pursuing this objective."

Speaking on the need to strengthen partnerships, the Commissioner stressed that "the health sector should engage in partnerships with other policy fields and relevant stakeholders, such as educational institutions and employers in order to advise them and to co-ordinate action." One sector highlighted by the Commissioner where co-operation can be strengthened is that of employment, as "a high level of mental health of the work force is in the interest of employers. It supports productivity; it supports innovation; and it helps keep rates of absenteeism low."

The human rights of those with mental health problems were also highlighted during the speech, both within health, social care and criminal justice systems. Concluding his speech the Commissioner outlined two areas of action where the Commission will concentrate activities: mental health information and

mental health promotion together with the prevention of mental disorders. The new European Health Strategy will be one vehicle for this, and there will also be a Commission Communication on Mental Health to Member States and Parliament with the objective of "being to pave the way for actions by the Commission on mental health in a later phase and to present options to policy makers and other stakeholders. It will cover different areas: the place of mental health in a broad health policy context and the need to mainstream mental health in other policies, the rights of mentally ill people, the creation of partnerships with the relevant actors and the launch of a dialogue with EU Member States to identify and address health inequalities." A third activity will be the presentation in late 2005 of a Working Paper on co-ordinated actions to reduce alcohol-related harm.

The full text of the Commissioner's speech is available at

http://europa.eu.int/comm/health/ph_determinants/life_style/mental/ev_20050112_en.htm

HOW MOTHERS TREAT THEIR BABIES IS KEY TO MENTAL HEALTH IN LATER LIFE

Early findings from a five-country study on early intervention in childhood indicate that investing a small amount in training professionals in the community to support mothers with new babies makes a difference to young people's mental health. Mental health in children and adolescents was one of the topics under discussion at the WHO European Ministerial Conference on Mental Health, held on 12-15 January 2005, in Helsinki, Finland.

The European Early Promotion Project, taking place in Cyprus, Finland, Greece, Serbia and Montenegro and the United Kingdom, is an early intervention to help children, underway for four years. With expert back-up from experienced mental health profes-

sionals, primary health care providers working with general practitioners (such as health visitors and nurses) are given specialised but inexpensive training in supporting mothers with newborn babies and intervening early if problems are detected. Compared to a group without this training for providers, the mothers and babies in the intervention group were found to have a better relationship. The mothers were more involved and facilitative, and less controlling and punitive. The research has been coordinated by Professor John Tsiantis of the Athens Medical School, Greece and Professor Hilton Davis of the South London and Maudsley Trust, United Kingdom.

More at http://www.who.dk/mediacentre/PR/2005/20050111_1

WANLESS REVIEW OF SOCIAL CARE FOR OLDER PEOPLE IN ENGLAND UNDERWAY

The King's Fund has commissioned former NatWest Group chief executive Sir Derek Wanless to carry out a fundamental review into the long term demand for and supply of social care for older people in England.

This report will follow the two independent reviews Sir Derek conducted for the government on future health care spending in the UK and on public health in England. Although the social care review will focus on older people, the King's Fund hopes to move into other areas of adult social care, such as mental illness and learning disabilities once this review is complete.

Sir Derek, who is expected to report back the findings of his review by

the Spring of 2006, will consider three issues. He will examine the demographic, economic, social, health, and other relevant trends over the next 20 years that are likely to affect the demand for and nature of social care for older people aged 65 and over in England. Secondly he will look at the financial and other resources required to ensure that older people who need social care are able to secure comprehensive, high quality care that reflects the preferences of individuals receiving care, and finally will consider how such social care might be funded

Sir Derek said: "Now is the right time to conduct a comprehensive review of the provision of social care for older people to find a sustainable, long-term financial settlement for

social care. Our task is to set out the key factors driving demand for social care, and the likely costs over the next 20 years. We will then have to consider the resources required and how they should be paid for"

King's Fund chief executive Niall Dickson said: "A serious, long-term analysis of how we fund social care is overdue. It was the missing piece in the original Wanless jigsaw and it remains one of the big unanswered policy questions. We believe this review should have a major impact on the way care and support for older people is delivered in this country." Julien Forder, senior research fellow and deputy director of LSE Health and Social Care, of which the Personal Social Services Research Unit is a part, is being seconded to the review as project manager.

More information at
<http://www.kingsfund.org.uk/healthpolicy/wanless.html>

BILL AND MELINDA GATES FOUNDATION CALLS FOR PROPOSALS TO PROMOTE EUROPEAN SUPPORT FOR GLOBAL HEALTH

The Bill & Melinda Gates Foundation invites proposals to build the capacity of non-governmental organisations working within Europe to advocate in support of achieving the three Millennium Development Goals related to global health. This would be accomplished through a new European Global Health Network comprised of six Core Members based in the United Kingdom, France, Germany, Italy, Spain, and Brussels (for the European Union).

Through the Network, Core Members would receive funding to increase their advocacy efforts within these six jurisdictions, and one of them (serving as Network Coordinator) would receive additional funding to support network-

ing activities among the Core Members and other organisations working on related efforts. Optionally, a seventh organisation could serve the role as Network Coordinator that would not have responsibility for any jurisdiction-specific activities. Funding will be provided for up to five years. The size of the grant award will be determined according to the approach and budget identified in the successful proposal, but will not exceed \$2 million per year for a total of \$10 million.

More information at
<http://www.gatesfoundation.org/nr/downloads/globalhealth/Grantseekers/RFPs/GHA-05-02EuropeFinal.pdf>

THIRD HIGH LEVEL MINISTERIAL CONFERENCE ON EHEALTH

The Norwegian government, in conjunction with the Luxembourg Presidency of the European Union and the European Commission, will host this conference to be held on 23–24 May 2005 in Tromsø. The conference is organised in close collaboration with the Norwegian Directorate of Health and Social Affairs and the Norwegian Centre for Telemedicine and focuses on important health issues, and the way in which they can be supported by eHealth, to make major advances that benefit the people of Europe. Norwegian Minister of Health and Care Services, Ansgar Gabrielsen has said that "Health policy-makers in all countries have a clear responsibility to pursue the needed orientation in relation to eHealth: We can't all be captains of all ships, but the conference can provide all those involved with the lighthouses with incentives, initiatives, and ideas."

More information on the conference and programme can be found at
<http://www.ehealth2005.no>

THE SOCIAL SITUATION IN THE EUROPEAN UNION 2004

The report provides an overview of population trends, living conditions and social coherence in the European Union. It seeks to portray the social dimension of the enlarged Union, looking at both social trends and emerging policy challenges. The complete report is available only in English. A summary is available in other languages.

The report is available at http://europa.eu.int/comm/employment_social/publications/2004/keap04001_en.html

Primary health care: detection, management and outcome of depression

Depression is a common healthcare problem, largely managed in primary care, with little or no specialist input from secondary care services. The quality of care is often low, with poor recognition of the condition, inadequate prescription, poor compliance with medication and poor provision and uptake of psychological interventions. So states Simon Gilbody from the University of Leeds in a new report prepared for the Health Evidence Network.

The report indicates that a substantial evidence base exists to support the effectiveness of collaborative care, case management and stepped care in improving patient adherence with treatment and improved clinical outcomes. Clinician education and guidelines, when offered on their own, are largely ineffective strategies. Improved outcomes will require a greater allocation of resources to primary mental health care than is currently the case in many health care systems

The report is available at
http://www.euro.who.int/eprise/main/WHO/Progs/HEN/Syntheses/capdepr/20041208_2

World Aids Day 2004

EU Commissioners Markos Kyprianou and Louis Michel spoke about EU actions to tackle the HIV/AIDS epidemic on the occasion of World AIDS Day 2004, which was dedicated to "Women, girls and HIV and AIDS".

Speaking at the European Parliament, Commissioner Kyprianou re-stated that "the Commission is addressing the HIV/AIDS issue both within and outside the EU. Together with the Member States the EU is the biggest contributor to the Global Fund, which is the main financial instrument in the struggle against the HIV/AIDS epidemic globally". He also emphasised the importance of issues such as prevention, information, access to treatment, stigma and discrimination. Commissioner Michel affirmed a commitment to education and prevention.

EC Report on young people and drugs

The European Commission has launched a report on young people and drugs in the European Union. This survey was requested by Directorate General "Justice and Home Affairs" and coordinated by Directorate General Press and Communication.

Key themes include: Exposure to drugs; Why do young Europeans experiment with drugs?; Difficulties in stopping drug use; The consequences of consuming drugs; Ways of tackling drug-related problems; Sources of information on drugs; The danger of drugs; The opinion of young people on various drug-related issues.

The report is available at
http://europa.eu.int/comm/health/ph_determinants/life_style/pub_drug_en.htm

Smoking ban comes into law in Italy

The new legislation came into effect from January 2005 and banned smoking in most indoor spaces, although smoking rooms are permitted in completely enclosed areas with a good ventilation system. Both smokers and proprietors who flout the ban can be fined. The ban had been delayed by one month to give businesses more preparation time.

Nordic countries to fight alcohol policy as a block

The health ministers of Finland, Sweden, Norway, Iceland and Denmark have agreed for the first time to align their alcohol policies in order to reduce alcohol consumption.

The Nordic system – high prices and low consumption – is under pressure from the EU's internal market which allows private consumers to buy low-taxed liquor in other countries. Norway, Sweden and Iceland, who charge the highest prices for alcohol, are also among the five nations in Europe with the lowest annual consumption of pure alcohol per person.

More information at
<http://www.euobserver.com/?sid=9&aid=17557>

Director named for new EU health agency

The Management Board of the European Centre for Disease Prevention and Control (ECDC) has nominated Mrs Zsuzsanna Jakab, a senior public health official from Hungary, to be the Centre's first Director.

Markos Kyprianou, Commissioner for Health and Consumer Protection welcomed the decision saying that "Mrs Jakab has an impressive track record in international public health cooperation. I am sure she will provide the ECDC with the leadership it needs to start up its activities and establish its reputation".

She will appear in front of a European Parliament committee in early 2005 before her appointment. Once the appointment is confirmed the Director can begin recruiting staff for the Centre and establishing its Europe-wide network of disease control experts.

More information at
http://www.europa.eu.int/comm/health/ph_overview/strategy/ecdc/director_ecdc_en.htm

Obesity roundtable – workshop on best practice

The European Commission organised a round table on Obesity in late October. The workshop enhanced the role of nutrition labelling, the importance of education through campaigns, examined the range of products that are reduced in energy, fat, sugar and salt, and debated on the advertising regulation especially for children.

The agenda, different contributions, conclusions and follow up can be found at:

http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/ev_20041029_en.htm

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THE HEALTH IMPLICATIONS
OF AN EXPANDED EU:
THREATS OR OPPORTUNITIES FOR THE UK AND EUROPE?

ONE DAY CONFERENCE

Thursday 10 March 2005

At the Royal College of Physicians,
11 St Andrews Place,
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London NW1

Organised in conjunction with
Department of Health,
Health Protection Agency and
World Health Organization

THE HEALTH IMPLICATIONS
OF AN EXPANDED EU:



**Royal College
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Setting higher medical standards

THREATS OR OPPORTUNITIES FOR THE UK AND EUROPE?

On 1st May 2004 the European Union underwent an unprecedented expansion, with the accession of 10 new members, most of which had until recently been part of the Soviet bloc. British tabloid headlines predicted catastrophe for the UK, with Eastern Europeans "filling NHS beds" or spreading infectious disease. At the same time, health policy makers looked to the new member states as a solution to a looming shortage of healthcare professionals yet, in the first 3 months after the enlargement, only 53 nurses had moved to the UK. This conference will attempt to discover the reality behind the rhetoric.

The conference has been designed to discuss several different areas related to the expansion of Europe. These include the impact on European health (especially the UK) from the expansion, as well as the impact on healthcare professionals' mobility, and finally the importance and relevance of the new neighbourhood countries. Further debate will cover the economic implications of the changes and the potential for the use of health as a tool of foreign policy.

Audience: Public health specialists, infectious disease specialists, hospital physicians, political analysts, health policy analysts, academic institutes, non-governmental organisations and policy research units.

Conference organiser: Dr Michael Pelly, Associate Director, International Office, Royal College of Physicians and Chelsea and Westminster Hospital, London.

PROGRAMME

09.00

Registration and coffee

09.30

Welcome and introduction

Professor Carol Black CBE, Royal College of Physicians

BACKGROUND

Chair: Professor Roger Williams CBE, Director, International Office, Royal College of Physicians

09.40

EU enlargement and health: an introduction and overview

Professor Martin McKee, European Centre on Health of Societies in Transition, London School of Tropical Medicine and Hygiene

10.00

Discussion

10.10

A cordon sanitaire: micro-organisms do not respect borders

Professor Peter Borriello, Interim Director, Centre for Infection, Health Protection Agency

10.30

Discussion

10.40

Perspectives on the trends in non-communicable diseases

Dr Imogen Sharp, Head, Health Improvement and Prevention, Department of Health

11.00

Discussion

11.10

Coffee

IMPACT

Chair: Professor Pat Troop, Chief Executive, Health Protection Agency

11.30

Impact of healthcare mobilisation: challenges for some, opportunities for others

Professor James Buchan, Queen Margaret University College, Edinburgh

11.50

Discussion

12.00

Closing the gap: health and wealth in a divided Europe

Professor Witold Zatonski, Maria Skłodowska-Curie Memorial Cancer Center, Warsaw

12.20

Discussion

12.30

Health as a tool of foreign policy now and in the future and the economic implications of expansion and healthcare/population movement

Speaker tbc, Foreign and Commonwealth Office

12.50

Discussion

13.00

Lunch

INITIATIVES CURRENTLY UNDERWAY

Chair: Dr John Martin, Director, World Health Organization Office at the European Union, Brussels

14.00

Health Protection Agency: response to communicable disease threats

Professor Angus Nicoll, Director, Communicable Disease Surveillance Centre, Health Protection Agency

14.20

Discussion

14.30

Prevention of obesity and smoking. Lessons from initiatives for healthy living

Professor Peter Kopelman, Barts and The London School of Medicine and Dentistry, Queen Mary, University of London

14.50

Discussion

15.00

HIV/AIDS and TB in Europe: a World Health Organization perspective

Dr Gudjón Magnusson, Director Technical Support, World Health Organization Regional Office for Europe, Copenhagen

15.20

Discussion

15.30

Tea

CONCLUSIONS

Chair: Dr David Harper, Chief Scientist, Head of the Health Protectorate, International Health and Scientific Development Directorate, Department of Health

15.50

European Commission perspective on health: objectives and current priorities

Dr Bernard Merkel, Head of Unit, Health and Consumer Protection and Directorate-General, European Commission

16.10

Discussion

16.20

Department of Health perspective on the opportunities and challenges of an enlarged Europe for health policy

Mr Nick Boyd, Head of International Affairs, Department of Health

16.40

Discussion

16.50

Panel discussion

17.20

Closing remarks and summary

17.30

MILROY LECTURE

Winners and losers: the health effects of political transition in Eastern Europe

Professor Martin McKee, European Centre on Health of Societies in Transition, London School of Tropical Medicine and Hygiene

18.30

Close of conference and reception

ROYAL COLLEGE OF PHYSICIANS

THE HEALTH IMPLICATIONS OF AN EXPANDED EU: THREATS OR OPPORTUNITIES FOR THE UK AND EUROPE?

Thursday 10 March 2005

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**THE HEALTH IMPLICATIONS OF AN EXPANDED EU:
THREATS OR OPPORTUNITIES FOR THE UK AND EUROPE?**

Thursday 10 March 2005

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THREATS OR OPPORTUNITIES FOR THE UK AND EUROPE?**

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