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eurohealth

What's in store during the UK presidency of the EU?

Priorities for European health research

New and emerging infections: the threat to Europe

European emergencies: HIV/AIDS and tuberculosis

Tackling inequalities in health: the role of Healthy Living Centres

COMMENT

Partnerships for health: responding to the threats of today and tomorrow

We are delighted that the Chief Medical Officer for England, Professor Sir Liam Donaldson, has set out the health-related priorities of the UK Presidency in this issue of *Eurohealth*. Indeed, it is a particularly interesting period for the EU, with much attention focused on the challenging issue of paediatric medicines regulation. Moreover, during the lifetime of the UK Presidency, Green Papers are due both on mental health and also on nutrition, physical activity and health

One key threat faced by our continent is the emergence and re-emergence of infectious diseases. As Professor Donaldson notes they "cannot always be contained within national borders". Some of the health emergencies that Europe must face both today and tomorrow are discussed in the issue. Peter Borriello from the Health Protection Agency in England and Wales draws on the historical experiences of the past to highlight ways in which new threats may emerge. What is clear is that, both then and now, the movement of people and goods, concepts at the very heart of the modern Europe, increase the threat of infectious diseases. We live in an increasingly global village where a product packed in one country one day may be on a supermarket shelf half way round the world the next. Both pan-European and national responses are required to deal with these threats; articles on both approaches are presented here.

Health inequalities are one of the key themes (along with patient safety) of the UK Presidency. *Eurohealth* also picks up this theme in two articles: one reflecting on a relatively novel holistic approach to health promotion in the UK, the 'Healthy Living Centre Initiative', while the second article looks at approaches to mapping policy responses to health inequalities across Europe. Regardless of the future political shape of Europe, both today and tomorrow much can be gained through partnerships for health.

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What's in store during the UK's presidency of the EU?

Chief Medical Officer for England, Professor Sir Liam Donaldson, looks at the agenda for July–December

"Two key themes are patient safety and health inequalities"

The UK will hold the Presidency of the Council of the EU from July to December 2005. In preparing our overall Presidency, the UK has worked closely with other countries including Luxembourg (who held the Presidency from January to June) and Austria, who take on the Presidency after the UK, to ensure continuity in addressing the key challenges that face Europe today. We are also working closely with the Commission, the European Parliament and other Member States.

This is an exciting time in health, with growing awareness that health is not just a national issue, but also an international one. Infectious diseases cannot always be contained within national borders; diseases caused by smoking and poor nutrition, for example, are a matter of common concern across the world. Within the EU, people are moving more freely (as patients and professionals) between countries: they expect safe medical treatment wherever they are.

EU action in public health is very valuable, as demonstrated by recent EU cooperation in important areas such as coronary heart disease, cancer, obesity and nutrition. Although the management and organisation of health systems remains an issue for Member States, it is in important areas of public health such as these that enhanced cooperation can lead to a healthier population in all Member States.

The Council agenda

During our Presidency we will seek to take forward many important pieces of health related business from the current Luxembourg Presidency including the new health and consumer protection programme. Other pieces of legislation we will look to progress include nutrition and health claims on food and the regulation on the addition of vitamins, minerals and other substances to food products. In particular we hope to make significant progress on paediatric medicines regulation, which aims to make medicines safer for children

We also expect that, during our Presidency, the Council will be considering a Commission Green Paper on Mental Health (due to be published in September) and a communication on emergency preparedness and pandemics, and on HIV/AIDS.

The Commission has also signalled that it intends to produce, in the autumn, a Green Paper covering nutrition and health. Helping to inform this Green Paper will be the work of the Commission's Platform for Action on Diet, Physical Activity and Health. The Commission has asked the UK to host one of the meetings of this Platform for Action in September. The main aim of the Platform, as set out in the Commission's website, is to bring together industry associations, consumer groups, health NGOs and political leaders to take voluntary action to halt and hopefully reverse the rise in obesity, particularly among children. The World Health Organization (WHO) and the European Food Safety Authority are observers.

UK presidency themes

In addition to taking forward the Council agenda the UK hopes to make a substantive and lasting impact to the EU agenda by stimulating discussion around its two key presidency themes of patient safety and health inequalities. These are both themes of significant interest to the Commission and Member States as well as stakeholders. Empowering people will be an underpinning theme in both these areas.

Patient safety

Ensuring the safety of patients has become a high visibility 'quality of care' issue for those delivering health care worldwide.

In the increasing number of nations where research has been carried out, studies consistently show that as many as ten per cent of hospital admissions involve some kind of unintended error. It is estimated that as

many as half of these are avoidable.

Research from around the developed world suggests that health care errors of equal magnitude, and probably of similar causes with similar solutions, are every bit as likely to occur in fee-for-service and insurance based systems, as in our own state-funded NHS.

During the UK Presidency, we will be working to raise the profile of patient safety as an issue at EU level and for each Member State. Often, quite simple things go wrong – such as confusing colour coding on medicines, poor communication between doctors, nurses or other staff, or a letter that goes astray. Also, as people move more freely between one country and another, their expectations change about the level and quality of care they may receive or the skill of practitioners in other countries.

Addressing some of these key issues, we aim to make significant progress on paediatric medicines regulation and in promoting good practice in information exchange for health workers crossing borders.

As part of the Presidency, we will hold a high level Patient Safety Summit in November 2005. Patient safety is a key health theme for both the UK and Luxembourg EU presidencies in 2005. There is, therefore, considerable scope for collaboration in designing and implementing systems to improve patient safety. We are working to promote cooperation on patient safety issues between the EU and the World Health Organization.

"A high level patient safety summit will be held in November"

As presidencies and with other key bodies, we are collaborating to develop a coherent package of work and on-going mechanisms at the European level. Working together, we aim to leave a sustained legacy of safer patient care for all European nations.

Tackling health inequalities

Health inequalities are substantial to varying degrees across the EU. Almost all important health problems are more common among people with a low education, professional status and income. For example, in Britain, men in social class 5 can expect to live six years longer than men in class 1.

A report published by the EU in 2003, highlighted the need to tackle the uneven distribution of the determinants of health, including alcohol abuse, smoking, drug abuse, poor diet and nutrition. Accordingly the new EU Health and Consumer Protection Strategy refers to the common challenges that require promoting health and preventing illness as well as action on broader socioeconomic and environmental health determinants.

Tackling such stubborn health inequalities is, of course, a daunting challenge. Narrowing the health gap and making good health a reality for everyone, will require political will, and concerted policy development and implementation. A major challenge is to break the cycle by which poor health is passed down from one generation to the next. But anything which helps reduce the health gap in countries should benefit the strength and capabilities of EU Member States' economies and contribute to prosperity.

In this context, the UK will seek to raise the profile across the EU on the wider social determinants of health inequalities and progress key health determinants, such as nutrition, tobacco and alcohol, in the context of the European health strategy and other Commission initiatives. Health inequalities start early in life and the programme will reflect this.

In some countries systematic and comprehensive strategies to tackle health inequalities have already been devised. Others have policies but without an overarching framework, and some are still in a pre-measurement stage. As well as raising the profile of these issues, we hope to promote and galvanise action to tackle them.

As part of the Presidency, we will hold a high level summit, 'Tackling Health Inequalities: Governing for Health' in October 2005. The conference will review and reflect common issues in health inequalities within Member States, including key determinants of health and focus on priorities for action.

Hosting regular meetings

During the Presidency we will be hosting around 20 meetings besides the two summits, including a high level meeting of Health Ministers from across the EU.

The regular meetings of European Chief Medical Officers, Chief Nursing Officers and Chief Dental Officers will take place across the UK during the Presidency. In addition, some of our Arms Length Bodies will be organising meetings of EU officials.

A full list of all the EU Presidency events is available on the Department of Health website at
www.dh.gov.uk/eupresidency2005

What priorities for European health research?

Mark McCarthy

"Medical research has traditionally been an important part of the DG Research portfolio"

In April 2005, the Research and Technology Directorate of the European Commission published proposals for the coming period 2007–2013 described as the 'seventh framework research programme'. Of nine broad thematic areas, health was listed first, and the budget is proposed to double over the period of the programme. This paper considers the place of, and opportunities for, health research in Europe.

Science is a cross-cutting area of EU work. The origins of the programme lie in support for some high-cost fields such as particle physics, and in studies such as environmental sciences, where learning can come from work across national boundaries. The Lisbon Agenda in 2001 committed the EU to developing a knowledge-based economy, with increased investment to support competition by industry at world level and develop science for citizens.

Towards the seventh research programme

Some European Commission directorates with a technological base, for example transport and energy, support research through their own budgets. Medical research has traditionally been an important part of the DG Research portfolio. But health capability within the Commission developed only slowly after the Treaty of Maastricht in 1992, and in the round of discussion leading to the creation of the sixth framework programme (2002–2006) there was limited consultation with DG Health.

For the current round, consultation with Member States and European institutions started in 2004 with high-level issues, for example what type of funding structures best enable research to develop. Earlier research programmes had been criticised because they provided more funds for coordination than for direct support of scientific investigation. The consultation indicated that Member States supported larger programmes, and valued exchange of research expertise across countries through collaboration.

The Proposal (which goes to Council and Parliament) takes the consultation forward to the content of the programme. Nine areas are delineated, with health at the head (although not with the largest budget) (Table 1). The proposal for 'health' is divided into three parts – in brief, biotechnology, translational and system delivery - although with unequal indicative financial allocations between them.

Table 1 Indicative annual funding for research themes proposed for EU Seventh Research Programme, 2007-2013

Research theme*	Average annual budget (indicative) (€ millions)
Health	1188
Food, agriculture and biotechnology	351
Information, communication technologies	1810
Nanoscience and technologies	604
Energy	419
Environment and climate change	362
Transport	848
Socioeconomic and humanities	113
Security and space	566

** under the Cooperation heading of the programme*

Health themes

Biotechnology gained a lot of publicity, over the last decade, in the combined research to define the human genome. The technical method (polymer chain reaction, which enlarges the size of each small part of the genome so that it can be uniquely characterised), is now widely available and does not require large capital investment. Nevertheless conducting a lot of this research takes up many resources. Genome science has not yielded much medical return yet, although there are many small new firms working on drugs 'targeted' for specific diseases.

Two other emerging fields are of importance in medical science. First, there continue to be technical improvements in

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diagnosis and surgery, through improved imaging as well as remote and/or micro-surgery. This is yielding new operations that can be done as day cases or with shorter hospital admission times. Second, there is increased research on tissue cultures, with the possibility of creating replacements for individuals based on their own cells – and thus overcoming immunological rejection. In both these areas, there is already considerable commercial investment.

There is also a call for 'translational' research. Biomedical scientists use this word to indicate the phase between laboratory and general application – for example, in clinical trials of new therapies. More generally, it applies to research on diseases rather than basic mechanisms, research at a higher 'level', the human individual, rather than the cell. Three of the four proposed sub-themes in section 2 of Table 2 are for diseases – brain diseases, infectious diseases and chronic non-infectious diseases.

"Research on prevention and promotion receive much less attention"

In the final section, DG Research is concerned with delivery – clinical outcomes, health systems, public health interventions and monitoring safety. Moreover, health in its broader sense is included in other sections of the Proposal, including food safety/nutrition, information technology, nanosciences, environment and health, transport safety, societal trends and socio-economic indicators. There is a final section, Foresight, which repeats earlier sections (including health) and looks like a hostage for budget cuts.

Deciding the priorities

Followers of the development of health competency in the EU, who know that DG Health has a minimal budget of just over €50 million per year, may be surprised to find DG Research spending ten times as much on 'health'; and may wish to discuss how well the proposed seventh framework programme meets EU objectives for health.

The first report on the Health of the European Community in 1996 described the major health issues and trends by diseases, behaviours and determinants.[1] The 2002 public health action programme defined three broad areas – information, emergencies and determinants – and a wide range of subthemes. However, DG Health supports practical projects rather than research; and health is also recognised to be achieved by 'all means', that is, across the range of EU policies.

DG Research proposals for the seventh programme are welcome in calling for health, rather than medical, research.[2] Moreover, the three broad categories of cellular, individual and system research are appropriate. It is particularly welcome to see that DG Research proposes to include comparisons between health systems, a field of considerable relevance to ministries of health and with potentially important findings from a European level perspective.

A broader research agenda

Nevertheless, in the period of negotiation between the Commission, Parliament and member states, there is a range of issues to address.

Finance In the subdivisions of the EU budget, research is matched up against the trans-European transport networks (TENS). These not only have high profile for politicians: TENS has also signed up several former Commissioners (apparently without payment) as ambassadors for their project. It will be a tough fight for DG Research if its budget is matched against DG Transport. Moreover, EU health research, both in DG Research and at Member State level, has a relatively weak base. Compared, for example, with technical or military research, health research is poorly funded in most Member States, except for research by the pharmaceutical industry. Publicly funded research on prevention and health promotion, which are capable of reducing future health care costs, receive much less attention.

Disease control The focus on diseases in the DG Research Proposal has a likely direction towards clinical trials – and thereby, pharmaceuticals. Yet disease control is much wider than drug treatment and more research is needed on psychological and organisational interventions. We won't control the major contemporary epidemics of lung cancer, heart disease, injury, sexually transmitted diseases or drug misuse, without fundamental knowledge of health beliefs, behaviour transmission, health marketing and policy impacts and system incentives.

Priority Science is needed both to understand phenomena within the cell and widely in society: both cells and societies are extremely complex, and differ one from another in type and size and organisation. Equally, medicine applied in clinical practice has as wide limits on effectiveness as community interventions do for prevention: we know more about individual interventions because they have been more deeply studied. The health theme in the

"It is time to address the politics of health research"

research Proposal can support learning from European comparisons of health care in different societies.

Minorities, disabilities, mental health We particularly need new methods to investigate the needs of sub-populations, both across and within countries, especially minorities, and poor and excluded groups, where disease burden and health inequalities are greatest. Disability is an important part of health, and in particular mental health care needs to be addressed urgently across the EU. It is insufficient to identify a 'translational' subtheme on diseases of the brain: mental health is primarily concerned with interaction in society and each part of prevention, treatment and rehabilitation depends on overcoming issues of stigma, drug and alcohol misuse, and interaction with the criminal justice system.

Collaboration European Member States need to develop better collaboration at the national level. While DG Research is able to propose and fund research, the scientists should come from across the Union. More support should be given to national ministries of science and ministries of health in sharing their research agendas with each other, and in addressing their health and health care research agendas collectively. Without the lead from ministries of health, DG Research is beholden to its scientists – whose interests may be closer to the molecule than the man.

Conclusion

It is time to address the politics of health research, and for the agenda to serve the interests of Europe's citizens. Member State governments need to take more interest in EU health research, to learn from each other and to contribute to EU-wide investigation and innovation. There is also a need to disseminate results from existing collaborative research, and to build capacity through exchange. Creating a healthier Europe is a sound scientific ambition: DG Research is able to contribute resources and direction.

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New and emerging infections – the threat to Europe

Peter Borriello

"Trade and travel are key factors in emergence of infectious diseases"

New, emerging and re-emerging infections have been a topic of great interest and discussion over the last few years. The topic has engaged the interest of infectious disease doctors, researchers, public health professionals and policy makers in almost equal measure. However, the subject is not new to mankind, and has achieved current prominence primarily because scientific advances had led to a view that infectious diseases had been beaten as a serious problem in the developed world, and in Europe in particular.

This article will look at a few historical examples of new diseases and common associated factors to put the present situation into context. It will then give some current examples and the issues they highlight, along with some of the key drivers for disease emergence, as well as drivers and responses for their containment.

Historical perspective

There is no doubt that the great plagues of the middle ages, for example the Black Death of 1347, were devastating to the populations of Europe following their importation along trade routes. The loss of population numbers and infrastructure was such that it became embedded in the collective memory, and remained so powerful an image that it was the subject of a Bruegel painting many generations later (the Triumph of Death, 1556).

However, the trade in devastating diseases was not a case of one-way traffic. So, although Europe 'imported' plague and possibly syphilis, Europeans 'exported' measles and smallpox to the New World. More recently, we have imported pandemic influenza and HIV, but in return exported new variant Creutzfeld Jacob Disease (nv CJD), and probably methicillin resistant *Staphylococcus aureus* (MRSA). Common historical factors associated with these imports and exports are trade and travel; both key factors today. The only real difference is that travel was more about conquest and discovery, for example, the Spanish conquistadors in South America, whereas today it is more commonly for business or leisure. Interestingly, there is little good historical evidence for a major influence of population behaviour and climate change as drivers for new and emerging infections.

What is a new and emerging infectious disease?

The key difficulty in defining a new and/or emerging disease, is in distinguishing between a disease new to mankind, as opposed to a disease for which the cause has only recently been identified. There are some fundamental public health consequences between these two new classes of disease. A new disease due to a pathogen that has newly emerged in humans and not previously infected them is much more likely to cause epidemics and pandemics. This is due to the fact that the population is naïve, i.e. no immune memory, or absence of selection for resistance in the population over time. The classic example is the human immunodeficiency virus (HIV), where the evidence is that it emerged in the early 1900s following a species jump from monkeys to humans in Africa, probably as a consequence of the use of monkeys as a food source.

Much more recently, there was the emergence of severe acute respiratory syndrome coronavirus (SARS CoV). This has similarities in its emergence to HIV in that it is thought to have crossed-over to humans from hunting and preparing wild mammals for food (for example, possibly the civet cat in China). A difference is that there is evidence that SARS CoV previously existed, unknown at the time, in humans causing mild disease and that a deletion mutation (loss of genetic material) resulted in a virus that caused more severe disease and more readily spread.

A disease may also emerge because developments or changes in behaviour create conditions for a microorganism to more readily cause infections. Three infections exemplify this; legionnaires diseases, antibiotic-associated diarrhoea and colitis, and wound botulism in injecting drug abusers. The modern development of air-condition-

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ing with cooling towers creates an ideal environment for the growth of *Legionella pneumophila*. Escape of the pathogen allows airborne particles to be breathed in, leading to pneumonia.

Antibiotic-associated colitis is a consequence of the use of antibiotics to treat infections in hospitals, which also have an effect on the commensal (harmless) bacteria that live in the gut. These bacteria also serve to help exclude certain other pathogenic bacteria from gaining a foothold. Antibiotic induced reduction of the good-bacteria lowers the barrier to pathogens, one in particular, *Clostridium difficile*, which produces two devastating toxins. This is now a major problem in hospitals worldwide, particularly amongst the elderly.

It is also the case that another toxigenic clostridium has taken advantage of modern changes. Botulism, until relatively recently, was nearly always associated with food-poisoning. However, it is now most commonly seen in injecting drug abusers. As veins become increasingly difficult to find, drug addicts start to inject directly into muscle. In those cases where the heroin is contaminated with botulinum spores, the organism germinates in the muscle tissue, grows and produces the most powerful bacterial toxins known, causing botulism.

So, we have new foes such as HIV emerging within our present life-times, and well-established old foes, such as botulism, coming back through new routes. To this mix we must add old foes who 'were on the ropes' coming back via their traditional routes. Two classic examples are measles (a virus) and tuberculosis (TB) (a bacterium). Measles is a vaccine preventable disease, which is re-emerging because of the unfounded report of a link between the MMR (measles, mumps and rubella) vaccination and autism. This, unsurprisingly, caused public concern, a reduction in vaccine uptake and a consequent increase in measles cases. There are many parallels with the whooping cough vaccine scare in the 1970s, with a concomitant drop in vaccine coverage and increase in infection. The re-emergence of diphtheria in the newly independent states of the former Soviet Union was again due to a public perception of vaccine risk coupled with infrastructure change.

The increasing numbers of TB cases is due to a combination of infrastructure erosion, population mobility and lower effectiveness of TB vaccines in countries of high TB incidence. Coupled to this is an increasing drug resistance in *Mycobacterium tuberculosis*, all factors culminating to make TB a 'wicked' problem cutting across multiple policy considerations.

Risk factors

It is evident from the above that a number of factors contribute to infection risk: jumps in host species by microorganisms (for example, HIV), loss of public confidence in health protection measures (for example, vaccine uptake), emergence of antimicrobial resistance (for example, TB), erosion of public health infrastructure (for example, diphtheria) unforeseen consequences of new technology (for example, legionella) or of healthcare (for example, *C. difficile colitis*), changes in behaviour (for example, botulism in injecting drug abuse).

To this list we can add changes in sexual behaviour, travel to exotic locations and encroachment into unpopulated areas, both bringing naïve people into contact with established or new infection risks. An indication of population churn in terms of travel can be seen from 2003 travel figures for the UK of 90.7 million international arrivals of which 12.2 million were non-EU nationals.

Of course, it is not just people that travel; goods produced in one country can be in scores of countries the following day. It is now equally true that we not only live in a global village, but also in a global food-shop. There have been many recent examples of foods from a single point of export that have caused food-poisoning in many countries. This is especially true of salmonella. The illegal trade in exotic animals and foodstuffs adds a further complication.

Policy makers and health officials are not of course powerless to minimise these risks, and it is important to remember that despite all, public health is much improved and health is better protected. However, there is now an increasing recognition that the best way to prevent the importation of infections is to export health protection, and the best way to prevent emergence of a new disease, is to make detection and recognition local. Current revision of the International Health Regulations and a concomitant improvement in laboratory, surveillance and alerting capability will contribute greatly to improving human health protection. Recognition that an infections problem anywhere in the world is no longer just 'their' problem, but is immediately everybody's problem, will increasingly drive national and international policy.

"the best way to prevent the importation of infections is to export health protection"

This article is based on a presentation made at a seminar: 'The Health Implications of an Expanded EU: Threats or Opportunities for UK and Europe?' organised by the Royal College of Physicians, London, 20 March 2005, in conjunction with the United Kingdom Department of Health, Health Protection Agency and WHO.

HIV/AIDS at Europe's eastern edge:

Economic and demographic challenges for health systems and disenfranchised populations

Magdalene Rosenmöller, Thomas E Novotny and Joana Godinho

The main topic of the 2004 European Health Forum Gastein Saturday morning special interest session was the alarming growth of the HIV/AIDS epidemic in Eastern Europe and Central Asia (ECA). This now traditional session was organised by the World Bank and the European Commission, together with major players in the fight against HIV/AIDS: The Global Fund to Fight AIDS, TB, and Malaria (GFATM), UNAIDS, UNDP, and civil society organisations. The objective of the session was to exchange ideas about the follow-up of the 2004 Dublin Agenda and the 2004 Vilnius Conference, with special attention paid to health systems effects and vulnerable groups.

Grave threat

"If not curbed the disease will threaten development prospects in the region"

Although the HIV epidemic has, until recently, been underestimated, it is a serious epidemiological and economic threat to ECA. About two million people in the region were reported to be living with HIV in 2004, up from a reported 160,000 in 1995.[1] Despite the comparatively low prevalence, the growth rate of new HIV infections is now the fastest of any region in the world.[2] If not curbed, the disease will threaten development prospects in ECA, creating tough challenges for policy makers in the emerging economies of the region.

Several different models show the disastrous effects of the epidemic in terms of population decrease and decline in gross domestic product. Comprehensive and integrative models, such as that developed by the Imperial College London, provide useful insights and can help to raise awareness. Specifying the problem economically allows the engagement of potential opponents, particularly economic policy makers.[3]

Contributing factors

The most important driver of the HIV infection in ECA has been the spread of intravenous drug use (IDU), as well as increasing levels of heterosexual transmission.[4] Aggravating factors include migration, commercial sex work, growing rates of sexually transmitted infection, widening economic disparities, and multiple high-risk behavioural patterns, particularly among prison populations. This parallels the growth of organised crime, international drug trafficking networks, trafficking in commercial sex workers (CSW), and trade in contraband goods.

In addition, there is insufficient public awareness of the disease, frequent stigmatisation, and a lack of adequate policy instruments. Health systems in the region are ill prepared for the epidemic; they reflect decades of decline under the previous centrally planned systems, accentuated by the economic and social crises following the dissolution of the Soviet Union in 1991. Public health services were the responsibility of the highly centralised sanitary–epidemiological (Sanepid) services in the so-called Semashko system.[5] These focused on surveillance, sanitation, and a limited set of public health activities that were somewhat effective in managing straightforward conditions. They were not responsive to newly emerging problems such as HIV and multiple drug resistant TB, and they were inadequate for the complex tasks of prevention, diagnosis, treatment, and surveillance of HIV/AIDS and related conditions.

A 2003 World Bank study, co-financed by the Dutch Government, paints a gloomy picture of the surveillance systems in the region, with little consistency in data collection, incomplete and fragmented data, deficient quality checks, and a general shortfall in information on disease incidence and behavioural risk factors.[6]

Additionally, systems were especially ill

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equipped to engage with the public and critical groups such as non-governmental organisations (NGOs), the workforce, the military, and business community to promote health or encourage the behavioural changes necessary to tackle HIV/AIDS. During times of transition and economic reform, HIV/AIDS was certainly not at the top of the policy agenda. Now, ECA governments are starting to realise that they are poorly prepared in the face of the potentially catastrophic effects of HIV/AIDS, and they have turned to multi-national institutions including: the World Bank, the GFTAM, the World Health Organization (WHO), the European Union (EU), and others for help.

External assistance

UNAIDS (www.unaids.org) an important multi-national organisation, works in synergy with the World Bank and GTFAM in Central Asia, forging alliances and cooperation across the region. A number of different World Bank investments address the epidemic in ECA, not just in terms of health, but also as a development issue. (www.worldbank.org/eca/aids). These have focused on preventing the explosive growth of the disease through early intervention. A regional strategy for HIV/AIDS was drawn up in 2003, based on studies of economic impact and estimates of the required human and financial resources. A supportive policy environment was promoted, and carefully targeted specific interventions were geared towards the epidemic. World Bank-supported HIV/AIDS prevention and control projects have been implemented in Moldova, Russia, and the Ukraine, as well as within a regional programme in Central Asia.

The GTFAM is an independent public-private partnership with the aim of distributing resources to the disenfranchised. So far, a total of over $4 billion in four funding rounds has been allocated to 128 countries, 22 of which are in Europe.

EuroHIV, (www.eurohiv.org) the surveillance network for HIV/AIDS, is part of the European Communicable Diseases etwork and is funded by the EU. This first Europe-wide surveillance system, started in 1984, has been hosted at the Veille Sanitaire (France) since 1999. It collects data from 52 countries in the European region, in collaboration with WHO and UNAIDS. Its main roles are in early detection, confirmation of trends, and in outlining the broader epidemiological situation. European surveillance and international comparisons provide a very positive force in the development of national surveillance systems. Under the umbrella of the recently created European Centre for Disease Prevention and Control (ECDC), EuroHIV will continue to strengthen the link between surveillance and prevention, promote new laboratory technologies, and implement behavioural surveillance.

The fight against HIV/AIDS has been a focus of public health activities in the EU since the 1980s, with networks of experts, development aid, and the recent development of the Clinical Trials Partnership. The alarming incidence of HIV in Eastern Europe and neighbouring countries has been addressed under the European Commission public health programme and other horizontal instruments. The 2004 Dublin and Vilnius conferences have shown that there is a strong political will to act on HIV/AIDS. The Dutch experience of development aid in the fight against the epidemic demonstrates that programmes particularly geared to marginalised groups are very successful, as they are carried out in cooperation with NGOs and other civil society groups that must be viewed as part of the solution.

NGOs play a particularly important role in combating AIDS and reducing related social disruption in ECA. For example, the mission of the Central and Eastern European Harm Reduction Network (CEEHRN www.ceehrn.org) is to support, develop, and advocate harm reduction strategies for vulnerable groups such as IDU and CSW. Founded in 1997, the organisation now has 211 members in 25 countries. Activities include a website, a database of best practices, toolkits, partnership networking, training, and conference organisation. They are also concerned with the increasing numbers of people living with HIV/AIDS, of whom very few have access to expensive anti-retroviral therapy (ART).

In the face of weak medical infrastructures, discrimination and stigma, NGOs are best placed to induce change by making HIV a political priority, supporting the development of national strategies and guidelines, and providing information to people living with HIV/AIDS (PLWHA). Activities include providing services to affected communities; developing new treatment services and training medical professionals. The CEEHRN experience has shown that a mix of services addressing the needs of vulnerable populations can be successful in reducing the spread of HIV/AIDS.

"NGOs are best placed to induce change by making HIV a political priority"

Success stories

As a result of effective partnerships between governments, NGOs and international organisations, the first success stories are now appearing, from which valuable lessons could be learned.

In Moldova, reported cases of AIDS increased in the country at the end of the 1990s, complicated by a context of difficult economic conditions and insufficient surveillance capacities. *The National AIDS Programme*, set up in 2001, represented a joint effort by the government institutions and NGOs to address the problem.[7] Supported by grant funding from the World Bank, GFTAM and USAID, it resulted in 100% availability of ART, a treatment which not only is very costly but also requires very good practical health system infrastructure to assure effectiveness. A national monitoring and surveillance system was established, essential laboratory equipment improved, and professionals trained. Additional activities with NGOs targeted vulnerable groups (with support from the Soros Foundation), armed services (with UNDP), prisons, and others. While the incidence rate of HIV continued to increase, a reduction was seen among IDUs, showing the effectiveness of education and harm reduction activities. Other vulnerable groups, particularly CSW and youths at risk, continue to require intense programme efforts.

Another interesting example of the fight against HIV/AIDS is the successful public-private partnership reported from Romania.[8] With high prevalence rates (particularly among children), insufficient infrastructure, poorly prepared professionals, and a very low level of access to treatment, the Romanian Government approached Merck, the pharmaceutical company in 1997. *The National AIDS Committee* was established within the ministry of health, with the development of national HIV/AIDS treatment guidelines, support for the construction of a national AIDS database, and provision of a national network of treatment centres with test kits and technical assistance. Improved access to treatment was achieved through increased budgetary allocation and a lowering of drug prices. The new goal of 100% treatment with ARTs, set out in 2000, was achieved in 2002. Factors that led to success included improving political commitment, building national capacity, engaging with all relevant sectors, securing distribution systems, and lowering drug prices.

Meeting the challenge

Implementing HIV/AIDS projects is not an easy task. A major challenge is finding the right balance between the key priorities of sustainability, ownership, speed, and accountability. Constraints to speedy implementation include cumbersome procedures, lack of management and institutional capacity, and weak civil society. Targeting vulnerable groups is difficult, with the additional complication of the power struggle that accompanies the distribution of funds.[9] Indeed, the implementation of highly funded programmes is often jeopardised by corruption, which is related to inadequate institutional capacity, a lack of managerial skills, unclear definitions of procedures, and poor monitoring systems. While low incomes might tempt some officials to mismanagement, these problems need to be addressed by training, good monitoring systems, and very prompt actions in case of irregularities.

There were several take-home lessons from the Gastein special interest session.

- The HIV/AIDS situation is indeed alarming and needs urgent action.
- Changing epidemic patterns need to be taken into account, particularly the increase in heterosexual transmission.
- The problems of stigma and discrimination persist and must be addressed.
- The lack of institutional capacity in the countries in question is notable in the fight against HIV/AIDS, while implementation and/or scaling up of projects and programmes are highly dependent on local capacities.
- Training of professionals is a necessary component of the regional response. This is especially true for nurses and primary care providers, who are increasingly needed at the front line of patient care.
- Coordination and collaboration among industry, NGOs, and governments is critical, as public-private partnerships have proved to be quite successful. It is important to understand that the epidemic is not only a health matter, but also a multi-sectoral development issue in need of integrative strategies.

These were discussed in detail at the Gastein special interest session, and this discussion will hopefully lead to increased collaboration, exchange of learning experiences, and dissemination of best practices throughout ECA.

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Harm reduction in Moldova: where are we now?

Results of a HIV/AIDS behaviour surveillance survey among injecting drug users in Moldova

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"Findings from this study suggest that harm reduction interventions in Moldova are effective"

Background: HIV/AIDS situation and prevention in Moldova

From 1996 to 1997, the incidence of HIV/AIDS in Moldova increased more than seven-fold, from 55 new cases in 1996 to 405 new cases in 1997. The main mode of transmission was by needle and syringe sharing among injecting drug users (IDUs) (87% of HIV cases).[1] The actual number of HIV cases is believed to be several times higher than the officially reported statistic. By the end of 2003, 1,945 cumulative cases had been registered,[1] but UNAIDS, the United Nations Joint Programme on HIV/AIDS, estimates that there are closer to 5,500 people with HIV in Moldova, out of a total population of 4.4 million.[2]

In an attempt to address the epidemic, in 2000 five harm reduction (HR) projects were initiated by the Soros Foundation Moldova in the most affected areas. At the end of 2003, nine new HR projects were launched with support of the Global Fund for AIDS, Tuberculosis and Malaria. HR projects in Moldova provide the following through fixed service points and outreach: syringe exchange, distribution of disinfectants, antiseptic materials, condoms and information materials. In addition, seminars, counselling and referrals to treatment (psychologist, gynaecologist, STD specialist, drug addiction specialist, legal advisor, and dentist) are provided in most of the more established projects.

Behaviour Surveillance Survey in Moldova – context and objectives:

The Behaviour Surveillance Survey (BSS) is a tool developed by Family Health International (FHI) and recommended by the World Health Organization (WHO) to determine behavioural trends among populations at risk of HIV over time.[3] In Moldova, the behaviour surveillance survey was conducted from November 2003 to April 2004. The objective of this article is to provide descriptive statistics of the behaviour patterns of IDUs who participated in eight HR projects in eight cities in Moldova from December 2003 to March 2004, and compare the behaviour patterns between clients of new and old projects.

Methods

The target population were IDUs that injected drugs in the last 12 months and were participants in HR projects. Being a participant in a HR project was defined as having at least one contact with project workers and using at least one of the project services within the past 12 months. Behaviours were assessed through a standardised questionnaire, adapted from the BSS in accordance with WHO recommendations, and used in face-to-face interviews with trained interviewers. The questionnaire was translated into Romanian and Russian and pre-tested. The interviewers, employees of the Sociological Research Centre 'CIVIS,' were trained before conducting the interviews. Field interviews were conducted in January-February 2004 and informed oral consent was obtained before starting each interview.

In total, 507 respondents were interviewed. The respondents in the projects with a high numbers of participants (Chisinau, Balti, Falesti, Orhei, Soroca) were selected through a two-stage time-location cluster method. Interviewers went at different times of the day and on different days to syringe exchange points and also accompanied outreach workers. In projects with a small numbers of clients (Rezina, Ungheni), all clients were interviewed. The instrument included questions relating to demographics, drug use and drug sharing,

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attitudes toward and knowledge about HIV, and sexual behaviour. The statistical package SPSS was used for data analysis.

Results

The results were analysed by comparing two groups: clients from the four projects that began their activity in 2000 (Group 1), and clients from the four projects that began their activity in November 2003 (Group 2). The sociodemographic characteristics showed significant differences among the members of these two groups in gender, age, education, civil status, nationality, and employment distribution. The respondents in Group 1 were significantly older (mean age 28.3 versus 24.3 years), with a lower education level (up to age 13 or lower in 27.6% compared to 6.3%), more likely to be married/living with a partner (32.4% versus 19.5%) and employed (36% versus 25.3%). These differences between the two groups could be explained by the fact that in regions where drug use is well established, drug users tend to be older. Group 1 included cities that were affected earlier by drug use and subsequent HIV infection. Subsequently, the drug users that use harm reduction services in Group 1 tend to be older compared to Group 2.

We observed significant differences with regard to sharing drug equipment, backloading/frontloading and using pre-filled syringes between the groups.* Group 1 exhibited less risky behaviour (Table 1).

A high proportion of respondents reported sexual activity in the past year (92.2% and 96.2% respectively). (See Table 2) The average number of partners was 3.75 and 4.74 respectively, with no statistically significant difference between the groups. There were significant differences between the types of partners: respondents in Group 1 reported more regular and less non-regular partners than in Group 2, and an average of 0.36 and respectively 0.24 commercial partners (prostitutes) per year. Condom use levels with regular partners were 71.0% and 75.2% respectively, with higher condom levels with non-regular partners (91.9% and 93.3% for both groups) and higher still for commercial partners (95.8% and 85.6%). Logistic regression analysis was also conducted. The type of project remained protective for five of ten measures examined. IDUs from established projects were less likely to report syringe sharing, use of preloaded syringes, injecting from the same common jar or front and backloading, but were more likely to use condoms with regular

Table 1

Variable	Total n	Percentage or mean (SD) Group 1 (older projects) n=250	Percentage or mean (SD) Group 2 (new projects) n=257
Gender			
Male	405	74.8	84.8
Female	102	25.2	15.2
Age	507	28.3 (7.3)	24.3 (7.4)
Educational level			
8 grades and less	111	27.6	6.3
medium level	340	61.6	72.4
university and graduate	56	10.8	11.3
Civil status			
Single	282	47.2	63.8
Married/Live-in partnership	131	32.4	19.5
Divorced/Separated	79	15.2	16.0
Other	15	5.2	0.8
Nationality			
Moldovan/Romanian	262	47.6	56.5
Russian	164	34.3	31.0
Ukrainian	50	15.3	4.7
Other	27	2.8	7.8
No Employment	352	64.0	74.7
No Income	163	34.4	56.9
Average income of those reporting, in Moldovan lei	188	744.98 (707.55)	704.32 (699.47)
Duration of injecting drug use, years	449	7.09 (5.64)	3.42 (2.47)
Age at first injection, years	493	20.74 (4.88)	20.26 (5.36)
Injecting equipment at last injection	44	6.8	10.5
No.. of IDUs never sharing equipment the last month	79	63.9	35.1
Never gave used syringes/ needles to someone else in the last month	436	92.4	79.8
Have taken drugs from a common jar in the last month	303	56.9	64.7
Have used preloaded syringe	120	20.4	32.3
Have practiced front/ backloading	123	15.2	35.2

* Indirect syringe sharing includes using preloaded syringes – syringes that have been filled by someone else, and the drug user either bought it or received it already pre-filled; front/backloading – dividing the drug by sticking the needle of one syringe in the front or the back of another syringe; taking the drug from a common jar - a group of drug users take the drug solution from the same recipient with their syringes.

partners. One conclusion is that by participating in previous projects the probability of syringe sharing at last injection decreases by 12%.

Limitations

Several limitations should be considered. The sampling was designed to access the population of IDUs participating in HR programmes in Moldova. Therefore, the results of this study are generalisable only to IDUs participating in these projects. There are no estimates available about the actual number of IDUs or the proportion reached by HR projects.

Due to the cross-sectional design used here and the lack of any control group, it is difficult to make inferences about the net effectiveness of these HR programmes. Additionally, because of the cross-sectional design, participants in Group 1 have not necessarily been participants since 2001, therefore no conclusions about the effects of longer versus more recent participants can be made. However, the comparisons between the two groups of projects and the remaining effect after controlling for confounders supports the hypothesis about the positive effectiveness of the harm reduction strategy in Moldova.

Selection bias towards the most active participants within the projects may be a possibility, although the time location sampling technique and small number of clients refusing to participate in the survey reduces the effect of this bias. All data were self-reported and thus prone to recall and social desirability bias. Recall error, however, should have been minimised by the relatively brief periods of time about which respondents were asked to report (last time, 30 days). Other studies have shown that IDU self-reports are sufficiently valid for behaviour assessment.[4]

Discussion

Several important findings resulted from this study. First, there were significant differences between the two groups in terms of syringe sharing behaviours. (See Table 3) A significantly lower proportion of IDUs in Group 1 shared syringes at last injection. They also had lower indirect sharing rates and a lower number of sharing partners compared to Group 2. This suggests the effectiveness of HR programmes in reducing syringe sharing. At the same time, some indicators are still alarming, despite the relative difference between the groups: 56.9% and 64.4% of IDUs in both groups reported loading the drug from the same jar and

Table 2

Variable	Total n	Percentage or mean (SD) Group 1 (older projects) n=250	Percentage or mean (SD) Group 2 (new projects) n=257
Sexually active IDUs in the last 12 months	478	92.2	96.2
Total number of partners	425	3.75(4.48)	4.74(8.34)
Regular	441	1.52 (.92)	0.97 (0.88)
Commercial	436	0.36 (1.3)	0.24 (0.85)
Non-regular	422	1.93 (3.44)	3.57 (8.03)
Condom use at last sexual contact			
Regular partners	363	71.0	75.2
Commercial	45	95.8	85.6
Non regular	162	91.9	93.3
Awareness about the drug use history of the regular partner	138	43.3	31.5
Awareness about HIV status of the regular partner	231	73.6	51.2
Awareness about male condom availability	490	97.6	95.7
Attitudes			
Would you keep secret about an HIV+ family member?	286	61.6	52.2
Have you shared food with HIV+ person	165	68.0	44.6
Knowledge about effective HIV prevention			
Consistent condom use	431	90.8	80.6
Faithful uninfected partner	358	79.2	63.2
Switching to non-injecting drugs	321	72.0	55.7
Rejecting myths about HIV			
Toilet seat after HIV+	346	76.0	61.7
Sharing food with an HIV+ person	347	74.8	63.2
Testing			
Had an HIV test	313	70.4	54.2
It was voluntary HIV test	228	86.9	54.7
The most recent test:			
last year	245	79.0	77.4
2-3 years ago	49	14.2	17.5
more than 3 years ago	15	5.7	3.6

Table 3 Results from Behaviour Assessment 2001

Variable	April, 2001,% n=200	November 2001,% n=200
Sharing syringes in the past 30 days		
Yes	18	6
Never	59	73
Taking drug from a common jar	65	70
Frontloading	25	20
Backloading	29	28

20.4% and 32.3% reported frontloading/backloading. Therefore a special focus on the behavioural and cultural determinants of indirect sharing might bring additional benefits to HIV risk reduction.

Another set of findings result from an analysis of the present study of Group 1 as compared with a previous behavioural assessment performed in 2001. Although a cohort was not traced over this period, respondents from the same four projects were assessed in both 2001 and 2004 and a comparison can give a sense of the trends over time. The comparisons regarding syringe sharing practices show a reduction over time in indirect sharing, with similar proportions of respondents reporting never sharing or lending a syringe. However, these comparisons cannot be tested for statistical significance.

The trends of the impact of HR programmes in Moldova are consistent with similar evidence from other countries, including one study from the Netherlands.[5] Furthermore, this study appears to be one of the first published to show the positive impact of HR programmes in the former Soviet Union.

This study has also found evidence of good knowledge about HIV among programme clients as well as high rates of voluntary testing for HIV. Questions demonstrating correct and incorrect beliefs about HIV/AIDS transmission and prevention show better results among Group 1. This clearly demonstrates that programmes can have an impact on knowledge and that more, with regard to education, should take place within the newer projects.

The majority of IDUs reported themselves as sexually active with an average of four sexual partners per year. There was a relatively small number of IDUs reporting sex with commercial partners or with commercial sexual partners. Among women, 9.8% have sold sex. A sign of optimism is that participants from both groups report high condom use with both commercial partners and non-commercial partners. Overall, the reported sexual practices among IDUs in Moldova tended to show better indicators than reported in Russia.[6] This fact allows us to reinforce once again the benefit of including a continued safer sex component in these harm reduction programmes.

In parallel with the BSS, HIV Sentinel Surveillance was performed by the National AIDS Center in 2004. The preliminary findings from the HIV/AIDS Sentinel Surveillance 2004, first carried out in 2001 and repeated in 2004,show a decrease in HIV prevalence from 29.28% among IDUs attending HR sites in November 2001 to 22.05% in November 2003.[7] This corroborates the findings from this study that suggest that harm reduction interventions in Moldova are effective.

Compared to similar studies from Russia and Ukraine, countries experiencing some of the fastest growing epidemics in the world, the results of our study appear to be optimistic. Nonetheless, precisely because of their vicinity to higher risk behaviour populations in neighbouring countries and similarities in drug use and risk behaviours, sustainable and continued interventions that carefully target local specific risk behaviours are even more necessary. These findings call for a sustained effort to maintain harm reduction efforts in future years, in order to continue to slow the progress of the HIV epidemic.

Conclusion

The results of our study show that IDUs participating in longer established programmes tend to have safer drug use and sexual behaviour than in the newly launched projects, and these trends are persistent over a three-year period. This suggests that the impact of a project does not wear off over time, but in fact grows. This study might be used as a proxy to prove the effectiveness of the harm reduction strategy to reduce syringe sharing and risky sex behaviours among IDUs in Moldova. At the same time, the HIV epidemic trends in Moldova show a shift to a heterosexual mode of transmission and more behavioural information on bridge populations in Moldova needs to be collected. The findings of this study call for a reshaping of behavioural change messages to IDUs. This is in order to better address residual risky behaviours, such as developing educational messages to address indirect syringe sharing and to increase the use of condoms with all sexual partners. It also emphasises the need to scale up effective programmes for IDUs and ensure that the national HIV prevention effort in Moldova focuses on high-risk populations.

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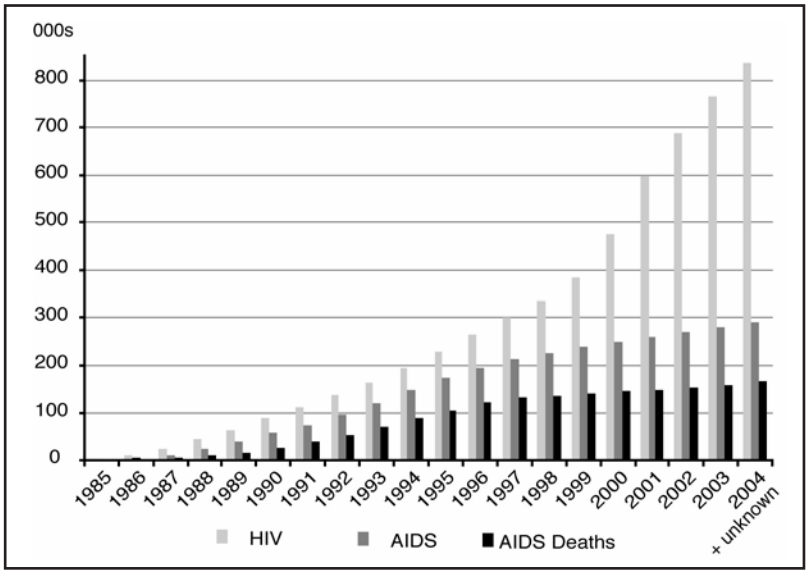
European emergencies: HIV/AIDS and tuberculosis

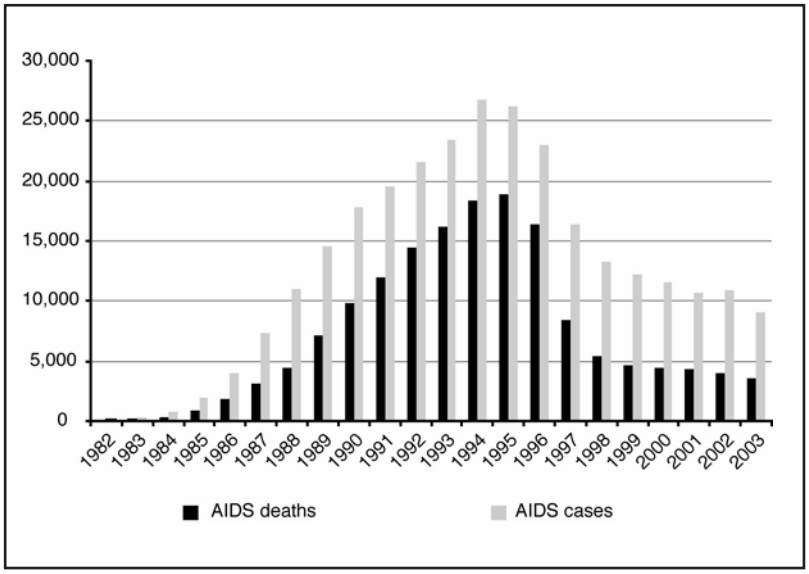
Gudjon Magnusson

Figure 1 Cumulative number of reported HIV/AIDS cases and deaths in the WHO European Region, 1985–2004



Source: EuroHIV

Figure 2 Annual number of reported AIDS cases and deaths, WHO European Region, 1982–2003



Source: EuroHIV

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The HIV/AIDS and tuberculosis epidemics in the WHO European Region are very important threats to public health that deserve wide recognition. Coordinated measures are needed to contain them securely.

The two epidemics are increasingly seen as interrelated, as co-infections are increasing. The challenge to stop both epidemics and reverse the trends by 2015, only ten years from now, is part of the Millennium Development Goals. The probability of fulfilling that goal does not look very high.

HIV/AIDS epidemic

In the last few years, the HIV/AIDS epidemic in eastern Europe and central Asia has been the fastest growing in the world. At the same time, the number of new HIV infections has risen in several western European countries, but on a much lower scale (Figure 1). Part of the increase in the West is due to a growing number of immigrants from countries with a high HIV prevalence, while the increase among the native population in western Europe is not well known. One of the reasons may be the possibilities provided by antiretroviral treatments, which transforms HIV/AIDS from a deadly to a chronic disease, as shown in Figure 2. Another contributing reason may be a more general fatigue after 20 years of anti-HIV/AIDS propaganda.

WHO/the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that the number of people with HIV/AIDS in the 52 Member States in the European Region was around two million at the end of 2003.

The corresponding figure for eastern Europe and central Asia is 1.4 million. In some countries, notably Estonia, the Russian Federation and the Ukraine, the estimated HIV prevalence in the adult population exceeds 1%, and the number of new cases each year gives incidence rates that are among the highest in the world.

Table 1 Progress in scaling up ART in the WHO European Region, 2003–2005

	Number of countries with:		
	Universal access (> 75%)	Partial access (25–75%)	Poor access (< 25%)
March 2003	27	7	17
March 2005	37	4	11
2005 (projected)	49	0	3

"the HIV/AIDS epidemic in eastern Europe and central Asia has been the fastest growing in the world"

The numbers of people aged 15–49 who are living with HIV/AIDS are estimated to be around 860,000 in the Russian Federation, 285,000 in the Ukraine, 150,000 in Spain, and 140,000 each in France and Italy.

Different epidemics in eastern and western Europe?

It is interesting to compare the general characteristics of people living with HIV/AIDS in eastern and western Europe.

In western Europe:

- transmission is mainly sexual;
- 25–75% of all cases are among men who have sex with men;
- up to 75% of all heterosexual cases are among immigrants from high-prevalence countries;
- more than 50% of all cases are in women; and
- especially vulnerable groups are men who have sex with men and immigrants, especially women.

In eastern Europe and central Asia:

- most cases are in injecting drug users;
- 75–85% of cases are in males;
- up to 30% of infected females are injecting drug users and 50% are partners of users;
- 30–70% of all HIV infections are in people under 25 years of age; and
- vulnerable groups comprise injecting drug users, migrants, members of ethnic minority groups, sex workers and prisoners.

This comparison shows that the general characteristics of the epidemics in different sub-regions vary widely; so then should the strategies to combat them.

Access to high quality antiretroviral treatment

The world community has set the target of providing access to antiretroviral treatment (ART) against HIV/AIDS for an additional three million people before the end of 2005 (the '3 by 5' target). For the WHO European Region, the target is 100,000. The 2004 Dublin Declaration on a Partnership to Fight HIV/AIDS in Europe and Central Asia formalised the commitment of the 52 European countries to provide universal access to ART by the end of 2005 and 'virtually' to eliminate (that is, reduce transmission rates to below 2%) mother-to-child transmission of HIV by 2010.

In addition, a resolution of the WHO Regional Committee for Europe in 2002 calls for universal access for all to high-quality ART. The progress towards both goals is reasonable so far, but serious challenges need to be overcome (Table 1).

WHO expects that 49 of the 52 Member States in the Region will be able to provide universal access by the end of 2005, a big improvement from 2003, and that 85,000–90,000 more patients will have access to ART.

Tuberculosis emergency

More than ten years ago, WHO took the unprecedented step of declaring tuberculosis (TB) a global emergency. Global targets for TB control were set: to treat successfully 85% of detected cases and to detect 70% of all the estimated infectious cases by the year 2005. Nevertheless, it is estimated that nine million new TB cases occur each year, with two million TB-related deaths.

The global situation is still very serious. Of the 22 countries worldwide with the highest burden of TB, one is in the European Region: the Russian Federation. While some progress has been made in the last few years in combating TB in the Russian Federation through a large WHO operation in strong partnership with donors, in general the TB situation is worsening. In 2002 the Regional Committee adopted a resolution calling for the scaling up of programmes to meet the serious challenge of an increased TB burden in the Region. The resolution proposed the following measures:

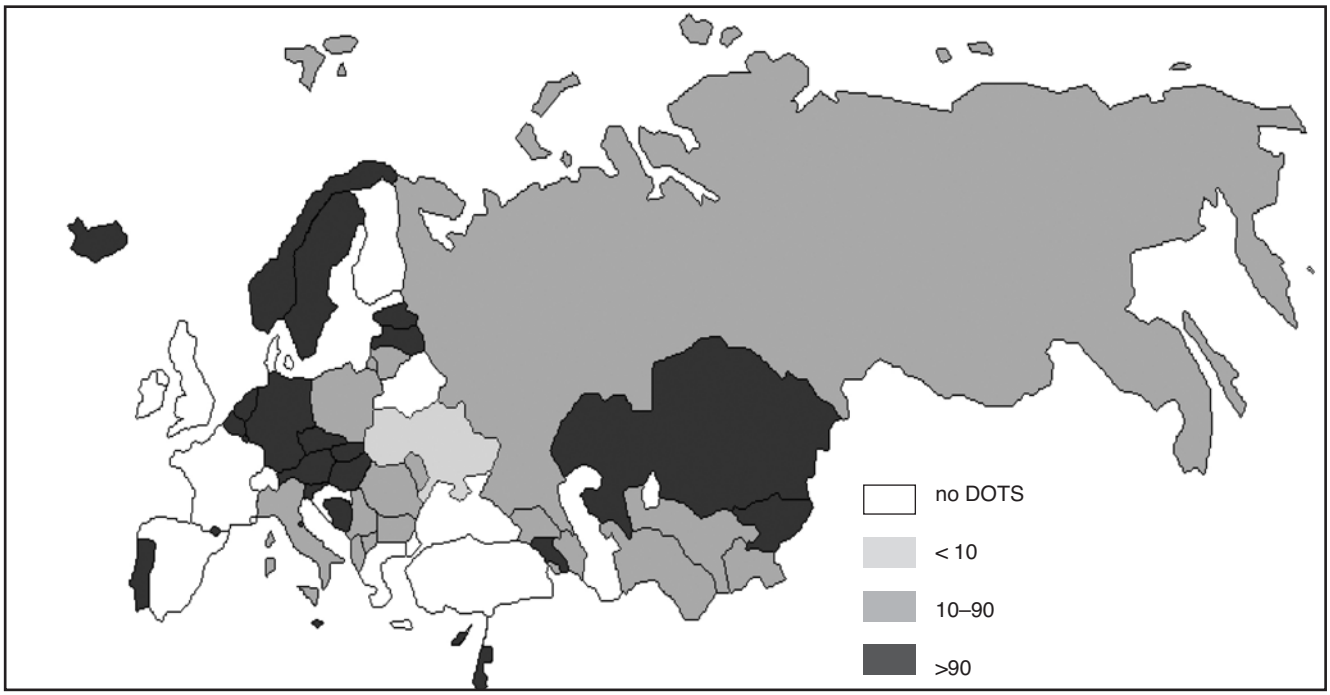
- ensure that TB is one of the highest priorities on the health agendas of Member States;
- strengthen political commitment to the WHO DOTS (directly observed treatments – short course) strategy for TB control;

– promote implementation of the recommended strategy (DOTS-Plus) in countries with high rates of multidrug-resistant TB;
– secure full collaboration between the TB and HIV/AIDS programmes both within the WHO Regional Office for Europe and in the country work.

The scaling-up process has resulted in an increase in countries covered by DOTS (Figure 3) – from 6 countries in 1995, to 34 in 2001 and 43 in 2004 – but only about 40% of the general population is covered.

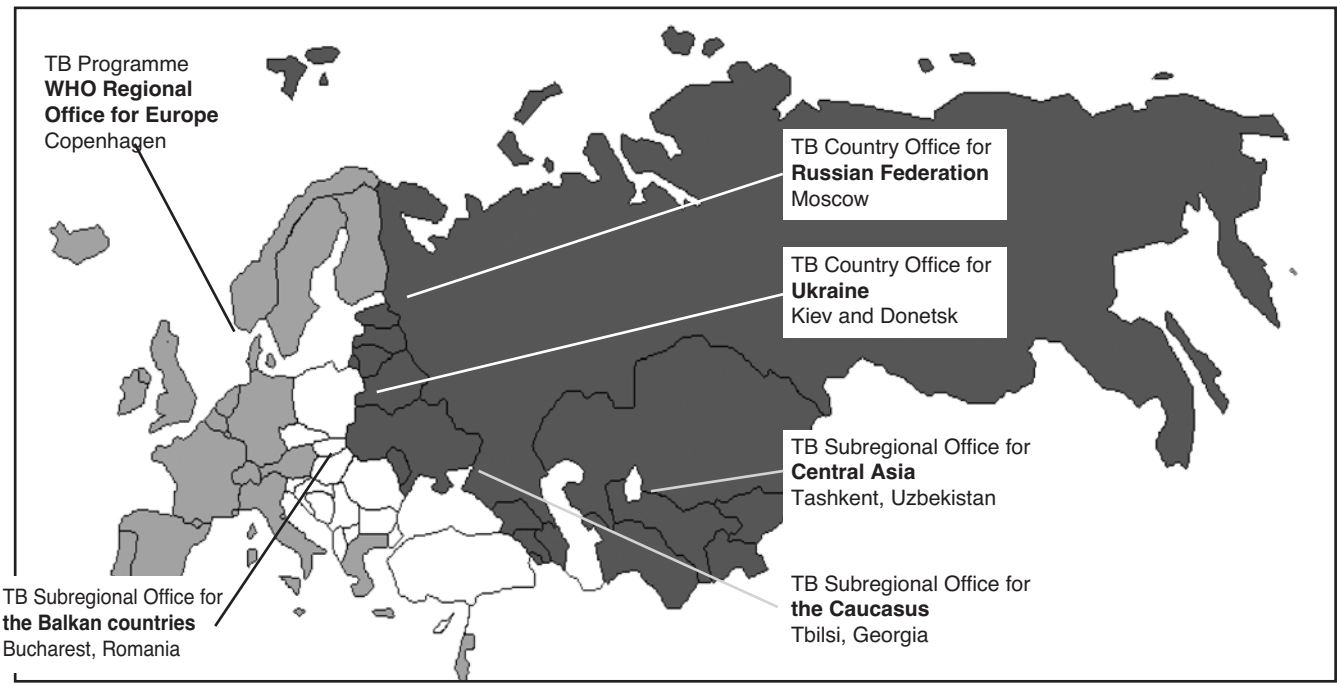
Activities in Member States have increased in terms of direct support, human resources, access to treatment and capacity building. WHO now has five TB country offices (Figure 4); the largest is in Moscow, with more than 25 staff and direct support in more than 25 *oblasts* (regions).

Figure 3 Coverage on DOTS in the WHO European Region, 2004



Source: Global tuberculosis control. Geneva: WHO, 2004 www.who.int/tb/publications/global_report/en/, accessed 26 May 2005.

Figure 4 Resources of the WHO Regional Office for Europe for TB control



"In 2002 the number of new TB cases in the Russian Federation declined for the first time since 1991"

In 2002, the number of new TB cases reported in the Russian Federation declined for the first time since 1991. The number of cases is still high, 8–9 times that in that in western Europe, but unfortunately it is even higher in a number of other eastern countries such as Kazakhstan, Romania and Ukraine.

The situation was recently assessed, and the conclusion was to declare TB an emergency in the WHO European Region. The WHO Regional Director for Europe, Dr Marc Danzon, acting on the recommendation of experts and partners, wrote a letter to all Member States on 21 February 2005, drawing the attention of health ministers to this very serious situation. In the letter, the Regional Director:

- concludes that TB is a regional emergency;
- notes that more than 360,000 new TB cases were reported in 2002, the highest number in the last two decades;
- calls on Member States faced with the high burden of TB to increase their national expenditure;
- calls on the wealthier countries of the Region and the European Union to pay more attention to the TB crisis in the Region and to increase their financial contribution to TB control;
- concludes that the sustainability of TB control depends largely on working with and mobilising new partners to maximise and optimise efforts and resources.

Much more needs to be done to reverse the negative trends of these HIV/AIDS and TB epidemics in Europe.

FURTHER READING

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This article is based on a presentation made at a seminar: 'The Health Implications of an Expanded EU: Threats or Opportunities for UK and Europe?' organised by the Royal College of Physicians, London, 20 March 2005, in conjunction with the United Kingdom Department of Health, Health Protection Agency and WHO.

Tackling inequalities in health:

What role for Healthy Living Centres in the UK?

*David McDaid, Dione Hills, Shirley Russell on behalf of the Bridge Consortium**

Across Europe there is an increasing and welcome attention being paid to investing in health promotion strategies, perhaps in response to the growing burden to health care systems of problems related to issues such as cardiovascular health, obesity and poor mental health. Another high profile policy concern is the focus not just on improving health of the whole population, but of also concentrating on improving the health of those most vulnerable groups in society, with the intention of reducing inequalities in health status.

Looking at England alone, recent years have seen the publication of a raft of policy documents and reports. In 1998 the Independent Inquiry into Health Inequalities,[1] highlighted the need to tackle the underlying determinants of ill health, and that furthermore most of these determinants lie outside the health care system. In 1999 the *Saving Lives:Our Healthier Nation*[2] White Paper set out a number of targets for improving the health of the worst off in society, particularly in respect of cardiovascular disease and stroke, accidents, cancer and mental health. Later targets were set to reduce health inequalities by 10% by 2010, using outcome measures such as the rate of infant mortality.

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Significant additional real funding for health has been committed by the government in England following the publication of the 'Wanless report', commissioned by the Ministry of Finance (Treasury), in 2002. A second 'Wanless report' in 2004[3] placed particular emphasis on the importance of health promotion strategies in helping to inform individuals about lifestyle choices associated with good health. This recognised the profound benefits of promoting better health, rather than having solely to treat the effects of ill health, not only for the individual, but also in terms of overall demands on the health service.

Although some progress has been made in addressing some health inequalities, others including infant mortality and life expectancy, have continued to widen. In England alone between 2001 and 2003 the infant mortality rate was 19% higher than the average rate for those infants whose fathers were working in routine or manual occupations. The comparable rate was 13% higher between 1997 and 1999.[4] It is clear that multi-faceted approaches are required to tackle some of the determinants of ill health. Community based holistic interventions are one potential mechanism for addressing these issues.

The HLC Initiative

One interesting approach has been the Healthy Living Centre (HLC) programme in the UK, initiated by the Big Lottery Fund (formerly the New Opportunities Fund), one of the 'good causes' that receive a share of national lottery proceeds. 352 such centres have received financial support to a total of £300 million from the Lottery since the scheme was first set up in 1998. Funding has normally been provided for five years. Most centres also raise additional funds, from their local authorities, local health centres, and charitable sources, and sometimes also generate very modest levels of income from participants and the rental of centre space. Some centres have also been set up without any Lottery Funding.

Given the size of the programme, a number of evaluations have been commissioned, including three national evaluations (funded by the Department of Health, Scottish Executive and Welsh Assembly governments), as well as a programme wide evaluation undertaken by the Bridge Consortium, and commissioned and funded by the Big Lottery Fund (formerly New Opportunities Fund). Some local centres have also commissioned their own evaluations.

Box: Objectives and activities of Bridge Consortium Evaluation

Objectives	**To understand how HLCs contribute to government policy for health, health promotion and health improvement.**
	To contribute to our understandings on how to improve health and reduce health inequalities.
	To evaluate the programme's success in terms of the aims of the Big Lottery Fund and Healthy Living Centres themselves.
	To draw together lessons for future programme and policy development
Activities	**40 case studies, including 20 high intensive, in depth analyses**
	Policy analysis
	Health monitoring survey of HLC users
	A survey of all HLCs
	Workshops with HLCs, local stakeholders and local evaluators
	It also draws on information from other evaluations, for example, a data base of intentions and baseline information for all HLCs, and economic analysis, funded by the English Department of Health, monitoring information collected by the Big Lottery Fund, and surveys undertaken by 'Support and Development' programmes commissioned by the Big Lottery Fund in each country.

The Bridge Consortium includes several of the Institutes which are also involved in these national evaluations: i.e. the Tavistock Institute, University of Edinburgh, Cardiff University, University of Glasgow, and the London School of Economics. Also in the consortium are Lancaster University and the Institute of Public Health in Ireland; the latter having been recently commissioned to undertake a national evaluation of HLCs in Northern Ireland. The programme evaluation has several objectives and activities (see Box).

What is a 'Healthy Living Centre'?

The vision set out by the Big Lottery Fund in its initial commissioning documents was of local community-based centres, which would adopt a broad based approach to health, setting out to improve 'health and wellbeing' while addressing some of the wider determinants of health. The concept was not a new one, the ethos behind HLCs can be traced back to the 1930s and the founding of the Pioneer Health Centre in Peckham, South London.[5] This provided a holistic non-health care system approach to improving health and wellbeing for local families. The approach recognised that positive wellbeing is dependent not only on access to good quality health care and health promotion but a broader range of factors.

Organisationally, HLCs are very diverse. They do not always operate from a physi-

"Community based holistic interventions are one potential mechanism for addressing inequalities"

"Some HLCs operate virtually, made up of a network of local organisations providing linked activities"

cal centre – some operate virtually, made up of a network of local organisations providing linked activities. Some are located within or close to health facilities such as NHS Walk-in Centres, others operate independently from the statutory sector: around one third have a voluntary/community organisation as the lead agency. Most HLCs have developed partnerships to support their work. Some have a large number of partners, managing and coordinating a wide range of individual projects, while others may have a single focus, and a more limited number of partners and smaller range of activities. Most centres have activities which address the policy priority areas set out in the original 'Saving Lives' agenda (CHD and stroke, mental health, cancer and accident prevention) and many also provide activities which address current priority areas including smoking cessation, sexual health, healthy eating, and the prevention of drug and alcohol abuse.

Activities can be broadly grouped into the following categories:

- Addressing behaviour and life style issues through provision of health information, support for exercise and healthy eating etc.
- Addressing any lack of appropriate local services, through provision of health care activities (often jointly with health professionals) and support services for families and young people, older people and ethnic minority groups.
- Addressing social exclusion and isolation through social activities
- Addressing poverty and unemployment through education and training, advice and counselling and practical help such as credit unions.

Activities are usually mutually supportive, and often have more than one aim: for example, a café may provide social contact, advice on healthy eating and training and employment opportunities. Perspectives on overall aims do differ: some view the improvement of health outcomes as their key goal, whereas others are more orientated towards community development, where the process of engagement with communities, development of social capital and the transfer of knowledge/development of new skills may be seen as being equally or even more important.

Some emerging themes

Most HLCs are now into (at least) their third year of operation and a number of key themes emerging from analysis have been identified by the Bridge Consortium in annual evaluation reports. In this article we have selected three themes from the Consortium's most recent report:[6] how the HLCs have contributed to providing new opportunities to enable individuals to enhance their health and wellbeing; their contribution to their local communities in terms of enhancing the capacities of individuals and organisations to address local issues; and how successful they have been in working with other local organisations and agencies to improve services to the community.

Provision of new opportunities to enhance health and wellbeing

HLCs provide a range of activities that address five different areas widely seen as contributing to health inequalities. Firstly they are addressing behavioural and life style issues as most provide health information, help people address risky behaviours such as smoking, drinking and drug taking, and create new opportunities for physical exercise and healthy eating. General empowerment and support is an important part of these activities.

They also have mechanisms in place to provide new ways of accessing health care, often through providing a base for NHS activities to take place within the community, or through 'signposting' local residents to relevant services. Some have identified gaps in local provision, and developed new services such as support and counselling for vulnerable groups, and activities for parents and children, often running these in conjunction with other agencies. Promoting social inclusion and community involvement is often addressed through the provision of social and arts based activities, and general 'community capacity building' activities (see below). They may also provide training and education (including volunteering schemes) and address poverty issues through provision of activities such as credit unions and benefits advice.

A key challenge for some centres (as with many health promoting interventions) has been to engage participants in activities in the numbers originally anticipated, and to reach some highly vulnerable sections of their community. Their success in finding solutions to these difficulties highlights the importance of flexibility in planning, and the importance of embedding individual activities within a broad programme. Some activities, like a café, a drop-in facility or the provision of complementary therapies

may help attract people into a centre, whereas other activities provide more specific support once they arrive.

Contributing to community capacity building

There is evidence that HLCs are also often working to enhance the capacities of their local communities to respond to local health and health-related issues. This is being undertaken in a number of ways, for instance through developing structures and processes for the consultation and engagement of the community in the work of the centre. The provision of a shared space and resources for example, a building within which groups can meet and new activities take place is another approach, while there is also evidence that many work with and support local community groups and smaller voluntary organisations in their area. Such groups are often among the formal partners of the HLC.

One challenge here is in resource capacity within HLCs themselves. Having the right staff for this kind of work has been important; some HLCs have had difficulty recruiting and retaining staff with appropriate skills. Some have also experienced management difficulties. However, HLCs have also developed a number of creative ways of engaging the community in their work, including their involvement both as volunteers and in paid staff positions. Capacity building work has been particularly important in those areas where little work of this kind took place prior to the establishment of the HLC.

Working with other local organisations

Central to community engagement has been the work that HLCs have undertaken to establish effective partnerships and interact with other organisations in their local 'health economy'. This has often enabled them to increase the resources and services that they are able to offer to local people and to reach sections of the community that are normally difficult to engage. Some have also played a role in strengthening coordination between local agencies and are having an influence on the way other local organisations work with the community.

Work in this area has often been hampered by conflicting agendas amongst local agencies, whilst other local organisations have lost key individuals with whom successful relationships had been built. Being able to identify a clear 'vision' as a unifying point for a disparate set of partners, clarification of boundaries and roles in the early stages, and strong leadership skills in the chair were all reported as important 'success' factors.

Centres successful in navigating these difficulties have usually been able to establish themselves in a strong position vis-à-vis their wider health economy, often providing a focus of communication, at least at a neighbourhood level. Some are looking to these connections as a potential source of funding for the future, once their lottery funding comes to an end, while others are looking to either the community, or individual partners to carry forward some of their activities. However, there is also a level of realism that the statutory sector might take forward some, but not all of their activities.

Evidence of impact, learning and sustainability

One of the longstanding challenges with health promoting interventions has been to identify evidence of impact, some of which may take many years to be observed. Even if health outcomes can be seen to improve, attributing these changes in outcome to contact with the HLC can be difficult to do, especially in situations where randomised experimental studies are not practical. Moreover HLCs are only partway through a comparatively short lifecycle.

"HLCs have the potential to be cost effective"

What is clear though is that many of the interventions provided in HLCs have been shown elsewhere to be effective. Analysis of HLCs might therefore focus more on their capacity to target and engage vulnerable communities with activities that have to the potential to help improve health and wellbeing. Their success in engaging with such communities has varied markedly, although all are looking at ways to increase this rate of engagement.

Case studies of HLCs suggest that they can be very cost effective, even when contact rates vary substantially, and thus probably represent good value for money. To put this in context total funding for the whole HLC programme in England alone is approximately equivalent to the funding for a single Primary Care Trust (NHS body with primary responsibility for ensuring access to health care provision which is responsible for all health care provision for populations of between 100,000 and 200,000 people) over a six month period.

There is also considerable anecdotal evidence of individuals who are benefiting from taking part in the activities of HLCs,

and some harder evidence of impact on health and wellbeing from a small number of local evaluations. Further information on the impact that HLCs are having on the health and wellbeing of their target population will be available from results of the Bridge Consortium's ongoing health monitoring system.

Information on health benefits alone will provide only a very limited picture of the way in which HLCs are working, other important consequences include development of the capacity of their local communities, and ability to network and coordinate with the work of other local organisations. These activities, while going much beyond analysis of a straightforward public health improvement agenda, are often seen to be a vital backdrop to their health-related work.

"Important non health consequences include development of the capabilities of their local communities"

Linking up with the wider policy agenda

One difficulty has been that, until recently, HLCs have not had a particularly strong voice at a national level to make their work more visible within the policy arena and articulate the rationale for the approach that they are taking. This may well have been a consequence of being a non-health sector initiated development, although the commitment of the different governmental bodies in the UK to funding evaluations of the HLC initiative is an indication that they may be seen as one potential mechanism used to implement and progress measures to tackle inequalities in health. For instance, the HLC initiative does appear in some more recent health policy documents in England as one of the government's commitments to achieving its targets on health inequalities.[6]

Clearly it is particularly important, at a time when relevant new policies are emerging, that lessons emerging from their work are fed into policy discussions. Changes in the wider policy agenda since the programme was set up have had important implications for local projects and the potential for their sustainability. Local services have been restructured, public health priorities have changed, and addressing health inequalities and support for partnership working is now part of the mainstream responsibilities of the NHS and local authorities. Many lessons may thus be learnt, in part arising from the very size of the programme, and the diversity of activities funded. What for instance can their experience say about the structures and processes required at a local level to ensure that public health initiatives are effectively implemented in local communities, and with sections of the community which might traditionally be reluctant to engage with statutory agencies?

Next steps

The Bridge Consortium has now been funded to continue evaluating HLCs until the end of 2006 in order to draw out further lessons from the programme. Case study centres will be revisited later in 2005 and there is to be a survey of all centres early in 2006. One key objective will be to assess how HLCs can fit into the changing policy agenda, and how the broader objectives of HLCs such as improved individual life skills and community engagement can play a role in ensuring that specific activities related, for example, to physical activity and healthy eating, are both successful in attracting participants and sustainable in the future.

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National policies to tackle health inequalities in Europe

Kasia Jurczak, Caroline Costongs and Helene Reemann

Box 1 Consortium of Partners for Equity in Health

Czech Republic	National Institute of Public Health (NIPH)
Denmark	National Institute of Public Health (NIPH)
England	National Institute of Health and Clinical Excellence (NICE)
Estonia	National Institute for Health Development (NIHD)
Finland	National Research and Development Centre for Welfare and Health (STAKES)
France	National Institute of Health Education and Disease Prevention (INPES)
Germany	Federal Centre for Health Education (BZgA)
Greece	Institute of Social and Preventive Medicine (ISPM)
Hungary	National Institute for Health Development (NIHD)
Republic of Ireland Northern Ireland	Institute of Public Health in Ireland (All-Ireland body)
Italy	Experimental Centre for Health Education (CSESI)
Latvia	Health Promotion State Agency
Norway	Research Centre for Health Promotion (HEMIL)
The Netherlands	Netherlands Institute for Health Promotion and Disease Prevention (NIGZ)
Poland	Polish Society of Health Education
Portugal	Ministry of Health
Scotland	NHS Health Scotland
Slovakia	Trnava University: Faculty of Healthcare and Social Work
Spain	Ministry of Health and Consumer Protection, Directorate of Public Health
Sweden	National Institute of Public Health (NIPH)
Wales	Wales Centre for Health
Switzerland	Fondation Charlotte Olivier *(observer)*

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Inequalities in health continue to provide a major challenge for policy makers in the European Union and as such they will be addressed as one of the priority themes during the UK Presidency of the Council of the European Union in the second half of 2005. Although the nature of health inequalities differ within each of the member states, each of them faces a 'health gap' between the lowest and the highest socio-economic groups. It is therefore timely and highly important that the 'Closing the Gap: Strategies to tackle health inequalities in Europe (2004–2007)' project facilitates and encourages the exchange of good practices between European partners on reducing health inequalities, both in terms of policy and practice.

'Closing the gap: strategies to tackle health inequalities'

This pan-European project is coordinated by the EuroHealthNet office in Brussels and by the Federal Centre of Health Education (BZgA) in Cologne. The project is co-funded by the European Commission (EC Grant Number 2003318). It brings together 22 national partners who have responsibility for public health and/or health promotion to act as a Consortium of Partners for Equity in Health (see Box 1).

This year the Consortium has undertaken a mapping exercise of health inequalities policies in each of the countries. To reach this objective, project partners filled in a comprehensive questionnaire ('Situation Analysis')[1] reviewing tools, policy papers, the evidence base and key actors involved in tackling health inequalities. The objective of this paper is to summarise the preliminary outcomes of this 'Situation Analysis' exercise in participating European countries.

Awareness raising

Completion of the questionnaire served a dual purpose. It was completed by a multi-disciplinary focus group comprising various stakeholders (civil servants from health and social fields, researchers, representatives of NGOs and practitioners) who through debate agreed on common responses to

"reference to health inequalities in legal texts is a rare phenomenon"

questions. Concurrently, the composition of the focus group allowed for a multi-disciplinary debate on health inequalities and offered different stakeholders an opportunity to hear one another's opinions. Indeed, in some countries this was the very first time that high-level representatives of interested parties sat down together in one place to discuss the issue of health inequalities. Such was the case in the Slovak Republic with the focus group consisting of the Secretary of State from the Ministry of Health, several public health practitioners, academics, director of the WHO Country Office and researchers from regional public health offices. Therefore, not only is the data obtained balanced and objective, but also the exercise has already served as an awareness-raising event that hopefully will bear fruit in future.

Policy response to health inequalities

The mapping exercise has shown that a variety of policy responses to the problem of health inequalities have been adopted in EU Member States. On the one hand, there are countries that already have a comprehensive policy on health inequalities (such as the United Kingdom, Sweden and Finland), where research on health inequalities goes as far back as the 1980s. On the other hand there are countries where even examining the issue of health inequalities is a recent phenomenon only now appearing on the political agenda. This is the case in most of the new Member States.

Turning health inequalities policy into reality to a large degree is dependent on the level of political commitment within each nation state. The spectrum of policy responses varies from non-identification of health inequalities as a key policy issue to comprehensive action.[2] However, even in the absence of national strategies or a commitment to combating health inequalities, action at the regional level is pursued.

All of the questionnaire's respondents pointed to the crucial role of the WHO's *Health for All* policy paper[3] as the major catalyst for the national health inequalities debate. Other crucial factors for Western European countries included: results of academic research, commitment of civil servants and evidence provided by the national committees, such as the independent inquiry into inequalities in health chaired by Sir Donald Acheson (1998) in the United Kingdom, or the Ginjaar (SEGV I, 1989) and Albeda, SEGV II (1995) Commissions in the Netherlands.

In addition, external motivation and strong involvement of international organisations were a decisive factor in the new Member States. In Estonia, the World Bank explicitly asked for health inequalities research to be undertaken as a prerequisite to the provision of loans, while in Latvia the issue of inequalities was a theme of the annual National Human Development Report published by the Latvian United Nations Development Programme Office.

Although the concept of equity for citizens has a long tradition in Europe and underpins many of the national constitutions, the explicit reference to health inequalities in legal texts is a far rarer phenomenon. The only existing legal documents explicitly referring to health inequalities are found in Norway, the Netherlands and England. In other participating countries health inequalities are mostly referred to within the context of general public health policy.

In many countries, where health inequalities are a relatively new concept, the focus of policies is rather on the 'health of the disadvantaged' being linked to the discourse of social exclusion. Documents such as National Action Plans (NAPs) to combat social exclusion illustrate well this example. The Hungarian NAP addresses health disparities, while the document from Slovakia focuses on the health of minorities, in particular the Roma. However, looking at the more comprehensive policies seen in Sweden or the Netherlands, the approach adopted focuses on the social gradient.[4] That is to say that these policies focus on the differences between each and every societal group rather than the difference in health outcomes between the least and best off.

Nature of health inequalities

Just as the policies vary, so to does the nature of health inequalities in each of the participating countries. In all cases the key line of inequalities is along socioeconomic dimensions, but the importance of health inequalities within cities as a particular problem can be seen in the Netherlands, Germany, England and the Czech Republic. Elsewhere health disparities between regions are a distinct problem for Italy, the Czech Republic, Slovakia and Poland. Inequality in service provision poses particular problems in Poland and the Czech Republic.

Throughout this article we have been using the concept of health inequalities. 'Health inequalities' is a generic term used to designate differences, variations, and disparities in the health achievements of individuals

and groups. However our understanding here is that the variations in health that occur systematically between individual members of social groups are inequitable or in other words unfair. It is therefore interesting to note that although the concepts of health inequality and health inequity are well established in the Anglophone academic discourse, translation of these terms to some other European languages can pose problems. There is no difference between concepts of equity and equality in Norwegian, Finish and Swedish. One could though perhaps argue that they are interchangeable as they are strongly embodied in the philosophical principles of the Swedish welfare state. On the other hand there is no clear translation for health inequalities into Estonian or Latvian where the problem is often referred to rather as social disadvantage or poor health. This suggests that 'health inequalities' is a rather academic concept, and not a part of common speech. There is thus a need for more awareness raising. This problem needs to be consistently articulated in order that measures to tackle the issue are enacted!

Finally, it could be said that a descriptive analysis of health inequalities has been conducted in all participating countries. All participants have information systems on mortality and morbidity in place and in the majority this data can be linked to different socio-economic variables. However, measures of inequality differ markedly between countries with several variables being used, such as occupation-based social class, income, education or deprivation levels, which may pose problems for cross-European comparative analysis. In addition, information on the design of systematic, inter-sectoral actions aimed at reducing health inequalities, or on integrated policies to address the wider determinants of health, is rare as is the availability of evaluated best practice. Essential policy exchange will therefore continue to take place over the course of the project, keeping in mind that the issue is complex and that no magic or short-term solution is possible.

Next steps and further information

This has been an initial overview of national policies to tackle health inequalities and further steps in the project are set out in Box 2. A more comprehensive report will be published at the end of 2005. It will aid project partners in the development of national strategies for action. In addition, project partners have identified the following key issues to be taken forward in the course of this project:

- Examination of the evidence base and evaluation of policies;
- Awareness raising;
- Working across policy sectors + implementation of health impact assessment;
- Support for regional policy development.

More detailed information on national level policies, as well as on examples of local good practice to tackle health inequalities, will be available on the Health Inequalities portal: www.health-inequalities.org. This is intended to be a comprehensive electronic information resource, and is one outcome of the 'Closing the Gap' project. The portal will be operational in the autumn of 2005.

"measures of inequality differ markedly between countries"

Box 2: Key steps in the project

Year 1: June 2004 – May 2005
Finalising the Consensus Paper on the definition of health inequalities
Setting up national focus groups and responding to the Situation Analysis Questionnaire
Setting up Health Inequalities Portal
Year 2: June 2005 – May 2006
Collection of good practice information to tackle health inequalities and feedback into electronic database
Presentation of case studies on how EU policies impact on health inequalities at the national level
Year 3: June 2006 – May 2007
Preparation of National Strategies for Action to Tackle Health Inequalities
Organisation of National Seminars on Action to Tackle Health Inequalities
Final Conference

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Mythbusters

Myth: The ageing population will overwhelm the healthcare system.

Fact: the proportion of Canadians over 65 is increasing. Another fact: the elderly need more medical services than younger people. Put together, these snippets of reality conjure up a familiar image, where healthcare costs of the ageing population in Canada balloon until the system gets blown away.

Despite that intuitive assumption, things don't quite work that way. Healthcare costs don't go through the roof just because there are more senior citizens. The real issue is with changes in the number and nature of medical services for elderly patients.[1]

The price of ageing

Nobody disputes healthcare costs increase with more old people. But — provided use rates of the different age groups stay constant — this increase will happen along a gradual slope, easily cushioned by the economy. It won't swamp the system. In fact, the impact of the ageing population will actually be quite small, says Morris Barer, a health economist at the University of British Columbia: about one per cent each year in total healthcare costs for the whole population.[2]

Where do all the costs come from?

The most dramatic role in the ageing 'crisis' isn't played out in the numbers of the elderly but in changing patterns of health services utilisation. Namely, heavier, more intense treatment for those over 65.

Researchers studying the use of health services found that in 1995/96 (figuring in hospital downsizing effects), almost one-third of all inpatient days in British Columbia hospitals were provided to the young and the middle aged. The remaining two-thirds went to patients over 65.[3] That seems like the expected norm – but it's the flip side of what was happening about 25 years before, when young and middle-aged patients used about two-thirds of all inpatient days in hospitals, and senior citizens only used one-third.

In Quebec, between 1982 and 1992, the proportion of senior citizens grew from 8.9 to 11.2 per cent, while their costs of physician services more than doubled. Some of that increase can be attributed to higher physician fees and the growing numbers of senior citizens. However, the main reason was that they had radically upped their visits to the doctor within the ten years.[4]

In other words, it isn't the number of the elderly driving the increase in healthcare costs — it's that they're using healthcare services more and more. But why? Are the elderly now much sicker than they used to be? Or, is the system treating geriatric health needs very differently than before?

The elderly: healthy and unhealthy

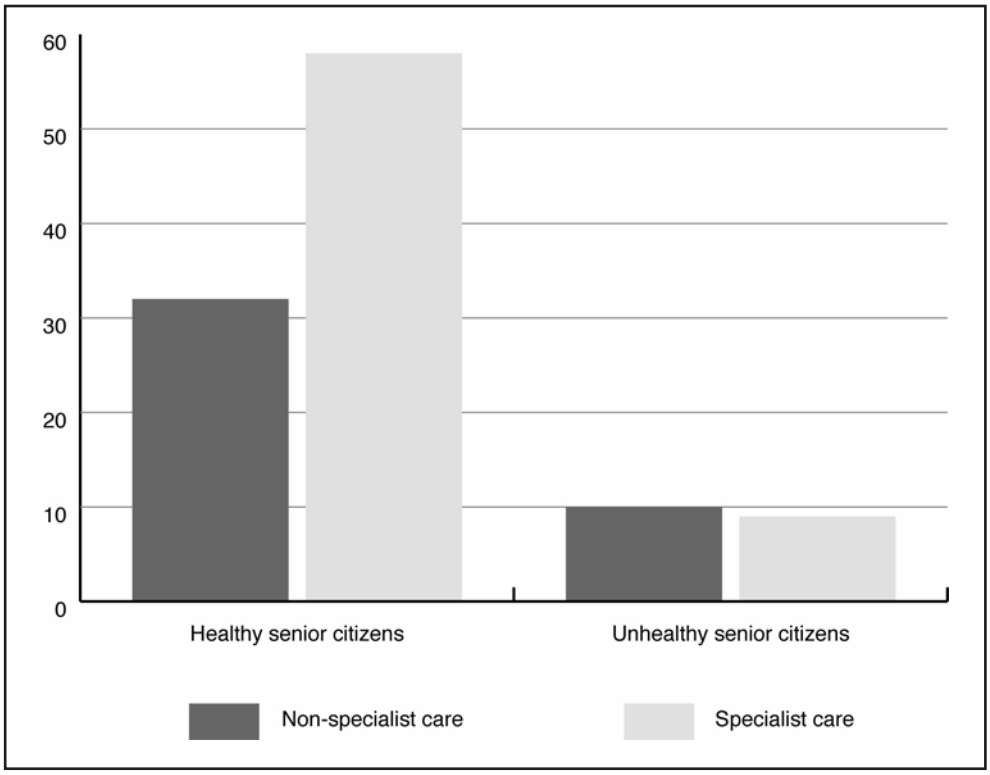
At first glance, the former scenario seems to explain it all. It's true people are living longer, but they spend a greater proportion of their years after 65 in ill health.[5] Manitoba researchers found that not only did the number of elderly people in the province increase between the early 1970s and 1980s, more of them were living in poor health.[6] More sick senior citizens: that seems to justify the need for more services…but the big picture tells a different story.

Despite the rising numbers of the elderly in ill health, it's actually healthy senior citizens who have driven the most significant increases in healthcare use – their visits to the doctor went up by 57.5 per cent, far more than unhealthy senior citizens increased theirs. The fact that there were more sick senior citizens played only a

Mythbusters are prepared by Knowledge Transfer and Exchange staff at the Canadian Health Services Research Foundation and published only after review by a researcher expert on the topic.

The full series is available at www.chsrf.ca/mythbusters/index_e.php. This paper was first published in 2001.

INCREASE IN MEDICAL USE BY SENIOR CITIZENS IN GOOD AND BAD HEALTH



Why are healthcare costs for the elderly rising so rapidly?

Between 1971 and 1983 in Manitoba, senior citizens in good health got many more medical services than unhealthy senior citizens.

Healthy senior citizens accounted for a 57.5 per cent increase in specialist care and a 32 per cent increase in non-specialist care, while elderly individuals in bad health accounted for ten and nine per cent respectively.

Data from Black C et al. Rising use of physician services by the elderly: The contribution of morbidity *Canadian Journal on Aging* 1995;14(2):225-244.

small role in the drastic increase in healthcare use among the elderly, the researchers conclude.[7]

The question at large

Why are senior citizens given so much more treatment than they used to get? It's a question that needs to be asked, especially since this increase is even more striking compared to the healthcare use of other age groups, which may have been growing – but certainly at a much lower rate. Is intensified care for healthy elderly people appropriate and necessary? William Dalziel, the head of geriatrics at the University of Ottawa, notes the value in routinely giving the elderly procedures such as flu vaccinations, cataract surgeries and hip replacements.[8] But more research needs to be done, he says, to identify procedures that truly improve living standards for the elderly.

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NEW PUBLICATIONS

Eurohealth aims to provide information on new publications that may be of interest to readers. Contact David McDaid d.mcdaid@lse.ac.uk if you wish to submit a publication for potential inclusion in a future issue.

The Public Financing of Pharmaceuticals: An Economic Approach

Edited by Jaume Puig-Junoy.

Cheltenham: Edward Elgar Publishing, 2005

ISBN 1-8454-2088-8

272 pages. Hardback

£65.00

This book edited by Jaume Puig-Junoy from the Research Centre for Economics and Health, Department of Economics and Business, Pompeu Fabra University, Barcelona, brings together a wide range of issues related to the public financing of pharmaceuticals. The book, like others in this field, draws on information from across many OECD countries, but written exclusively by Spanish academics, it places many of these issues within a Spanish context. As a revised and updated English translation of a book previously published in Spanish in 2002, this different perspective is also however a limitation, as the material is relatively dated with few literature references after 2000 cited in the text.

Notwithstanding this limitation, the book remains of considerable interest to policy analysts and economists, highlighting some of the economic incentives and regulatory mechanisms that can be used in determining the contribution of pharmaceuticals to both efficient and equitable public health systems. The impact of regulatory mechanisms and competition with the pharmaceutical sector on innovation and pharmaceutical prices are discussed. Other topics covered include analysis of the role of co-payments and how methods of economic evaluation can be incorporated into the regulatory process. Incentive policies that may be used to influence prescriber decision-making are also outlined. Finally the book ends with a discussion of the current situation and future outlook for pharmaceutical expenditure in Spain.

Contents: Introduction: Public pharmaceutical expenditure; Incentives for innovation in the pharmaceutical market; Price regulation systems in the pharmaceutical market; Regulation and competition in pharmaceutical markets; Mechanisms to encourage price competition in the pharmaceutical market and their effects on efficiency and welfare; Reference pricing as a pharmaceutical reimbursement mechanism; Insurance in public financing of pharmaceuticals; Economic evaluation and pharmaceutical policy; Prescriber incentives; Economic considerations regarding pharmaceutical expenditure in Spain and its financing; Review of economic studies of the pharmaceutical industry published over the last 20 Years by Spanish economists.

Contributors: X Badía Llach, JR Borrell Arqué, M Cabañas Sáenz, L Cabiedes, A Costas Comesaña, J Darbà Coll, B González López-Valcárcel, R González Pérez, P Ibern Regàs, F Lobo, G López-Casasnovas, R Nonell Torres, V Ortún, JL Pinto Prades, J Puig-Junoy, J Rovira Forns

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BSE: Risk, Science and Governance

Patrick van Zwanenberg and Erik Millstone

Oxford: Oxford University Press, 2005

ISBN 0-1985-2581-8

308 pages. Hardback

£35.00

This book is essential to all those interested in public health and public risk management policy. While it concentrates solely on the BSE (bovine spongiform encephalopathy) crisis that emerged in the UK in the late 1980s, the lessons learnt on what went wrong and why, may be applied across all areas of risk policy making. A key feature is the interaction between scientific experts and those policy makers who must consider a range of issues including economic, social, political and cultural factors. The authors both from the University of Sussex in the UK argue that a key challenge in the policy making process is "to outline a way in which risk appraisal and decision making can become both scientifically and democratically legitimate."

The book analyses some of the enormous volume of documentation and submissions made freely available as part of the Phillips Inquiry on the handling of the crisis. It addresses three questions: how BSE policy was decided, how can policy making processes of this kind be understood, and how can policy making institutions and procedures be changed to avoid a repetition of the failures that characterised the crisis? The book looks also at the reaction of policy makers to the crisis across the European Union, arguing that in the case of the European Commission, policy until 1996 (when the scientific evidence on transmission of BSE to humans became overwhelming) was similar to that of the UK. It was framed by an agriculturalist perspective intended to "ensure that public anxiety and impediments to the free flow of trade were avoided, and therefore diminish the adverse impact of BSE on the economic welfare of the farming and food industries." The impact on policy making post 1996 across Europe is also discussed, together with recommendations on how science based risk policy making should be understood and reorganised.

Contents: Introduction; Analysing the role of science in public policy-making; The evolution of UK's agriculture and food policy regimes; A new cattle disease; The Southwood Working Party; Regulatory rigor mortis; BSE policy in Continental Europe; The aftermath of 20 March 1996; BSE and the partial reform of food policy making; Summary and conclusions

WEBwatch

E-mail d.mcdaid@lse.ac.uk to suggest websites for inclusion in future issues.

UK Presidency of the EU

www.eu2005.gov.uk

News and information on the UK Presidency of the European Union.

AcademyHealth

www.academyhealth.org

Washington based AcademyHealth promotes interaction across the health research and policy arenas by bringing together a broad spectrum of players to share perspectives, learn from each other, and strengthen their working relationships. The organisation works to expand and support the scientific basis of the field; increase capabilities and skills of researchers; and promote the development of necessary data resources and infrastructure. It also translates research findings into useful information for clinical, management and policy decisions. The overwhelming majority of its work is focused on the US health system although some information focuses on comparative international analysis.

The website contains a wealth of resources including much on the current programmes, conferences and membership. There are also tools, such as research syntheses, a glossary, directory of training programmes and access to the HSRProj database of health services research projects. Many in-house publications are available to download.

Institut de Recherche et Documentation en Economie de la Santé (IRDES)

www.irdes.fr

IRDES (The Research and Information Institute for Health Economics) is a leading source of health policy and health economics information in Europe. Based in Paris its multidisciplinary team monitors and analyses trends in the behaviour of consumers and healthcare professionals from a medical, economic, geographic and sociological perspective. Information is provided on presentations, working papers, a monthly newsletter and other publications and there are links to websites for health economics. While it is clear that the French version of the website is more detailed, providing access to a far greater range of publications, the website is also available in English.

The Observatoire social européen (OSE)

www.ose.be/en/default.htm

The Observatoire social européen was founded in 1984 to foster a better understanding of the social implications of the building of Europe. The principal tasks include monitoring developments in Community policies, particularly social policies, and analysing the forces and players at work. The Observatoire attempts to act as an interface between public authorities, academia, trade unions and social groups, by putting forward critical views while duly respecting academic research criteria. They are also involved in research activities related to the impact of European integration on national healthcare systems, and provide expert advice to the Belgian federal public authorities and the national health insurance institute (RIZIV/INAMI). Information on publications to download and links to European institutions, databases, social actors, NGOs, social security and health care organisations and provided. The website is available in both English and French.

Bandolier Journal

www.jr2.ox.ac.uk/bandolier/journal.html

Bandolier is an independent monthly journal about evidence-based healthcare produced at the University of Oxford. With more than one million hits each month the goal of the journal is to find information about effectiveness (or lack of it) and present the results in a clear and concise fashion, highlighting what works and what does not. Information comes from systematic reviews, meta-analyses, randomised trials, and high quality observational studies in the US National Library of Medicine's MEDLINE and the Cochrane Library. The website provides subscription information, links to articles, a knowledge library, healthy living zone, extended essays, a learning zone and a glossary of medical and statistical terminology.

Centre de Recherche Public de la Santé (CRP-Santé)

www.crp-sante.lu

The Centre de Recherche Public de la Santé (Public Research Centre for Health) is a scientific and technological public institution that is run under the supervision of the Ministry for the Arts, Higher Education and Research and the Ministry of Health in Luxembourg. CRP-Santé seeks to ensure dynamic and continuous development in fundamental, applied, clinical and industrial research in healthcare, public health and biotechnology. Information is available on the website regarding their areas of focus, research laboratories, news and services provided for individuals, companies, the scientific community and health service institutions. There is also a list of useful links and contact information organised by specialty and research centre. The website is available in both English and French.

EU news

Press releases and other suggested information for future inclusion can be e-mailed to the editor David McDaid d.mcdaid@lse.ac.uk

COMPILED BY EUROHEALTH WITH ADDITIONAL INPUT FROM EUROHEALTHNET

EU may be able to save up to €161 billion a year attributed to air pollution related deaths

In Berlin on 14 April the WHO Regional Office for Europe presented evidence on the cost of air pollution to human health. Air pollution with particulate matter (PM) claims an average of 8.6 months from the life of every person in the EU. Evidence indicates that PM increases deaths from cardiovascular and respiratory diseases. Even a short-term rise in PM concentrations increases the risk of emergency hospital admissions for cardiovascular and respiratory causes. PM comprises tiny particles, varying in size, composition and origin. Inhaled, the coarse fraction (PM10, particles with a diameter less than 10 µm) may reach the upper part of the airways and lung). What are called fine particles (PM2.5, those with a diameter less than 2.5 µm) are more dangerous, as they penetrate more deeply into the lung.

Current policies to reduce emissions of air pollutants by 2010 are expected to save 2.3 months of life for the EU population. This is the equivalent of preventing 80,000 premature deaths and saving over 1 million years of life in the EU. Reducing long-term PM concentrations and exposure would also bring important financial savings. In the EU, the estimated annual monetary benefit from decreased population mortality attributed to PM is €58–161 billion, and savings on the costs of diseases attributed to PM account for €29 billion.

Speaking on the publication of this information Dr Marc Danzon, WHO Regional Director for Europe said "the data presented emphasise that health damage due to PM exposure, its costs for European society and the ability of the current European legislation to reduce this impact, are critical arguments for the continuation and strengthening of all stakeholders' efforts to reduce air pollution."

According to the WHO, activities to manage air quality at local, regional and national levels need to be integrated to improve air quality in cities. Providing alternatives to private cars, particularly transport such as trains, cycling and walking, may lead to changes in people's behaviour and would reduce traffic congestion and influence long-term trends in transport demand and pollution emission. Other measures include increasing energy efficiency, using cleaner fuels in households, industry and vehicles, and using end-of-pipe controls such as particle filters.

WHO and the European Commission are working together on the long-term Clean Air for Europe (CAFE) programme to develop an integrated policy to protect both the public health and the environment against significant negative effects of air pollution, and on the United Nations Economic Commission for Europe (UNECE) Convention on Long-range Transboundary Air Pollution, which will serve as a basis for national strategies on pollution abatement.

More information on these issues is available at www.euro.who.int/air.

Luxembourg Council on Employment, Social Policy and Health

EU Health Ministers met in Luxembourg on 2–3 June. Among the outcomes of the council were:

Medicinal products for children: The Council stressed the need to have research and provide medication adapted to the specific needs of children.

Nutritional claims: The Council reached unanimous political agreement on a draft Regulation on nutrition and health. In order to avoid advertisers misleading consumers and to ensure the proper use of claims as a marketing tool, the draft Regulation intends to allow only claims which are clear and meaningful to the consumer, subject to certain conditions. The person marketing the food should be able to justify the use of the claim. The draft Regulation covers foods to be delivered as such to the final customer or supplied to restaurants, hospitals, schools, canteens and other large-scale caterers.

Health and Consumer Protection Programme: The Council held an initial debate on the proposal from the Commission for a joint health and consumer protection programme 2007-13. Broadly the priorities were considered relevant to respond to EU citizens' health needs. They particularly welcomed the fact that consumer protection and health will be combined in one programme, but urged greater cross border cohesion against health threats. The proposal will now be determined by the co-decision procedure between Council and Parliament in coming months, and may also be affected by decisions on the overall EU financial perspective for that period.

Fight against obesity: The Council adopted a series of conclusions including the importance of promoting healthy diets and lifestyles, tackling inequalities between Member States concerning obesity, the need to provide a global response to the epidemic at European, national, regional and local level, the need to counteract misleading adverts aimed at children, and the need to train medical staff to prevent and treat obesity.

HIV/AIDS: The Council adopted a series of conclusions recognising the need to reinforce the EU's capacity to fight the spread of the disease, acknowledging the negative effect of the HIV/AIDS pandemic on social inclusion and on the economy, enhances the need to promote the development of research, surveillance and methods to fight efficiently

against the various forms of the disease. The Council also recognised the link between social exclusion and HIV/AIDS, and called for an enhanced cooperation between Member States, neighbour countries, the Commission and international organisations.

Mental health: The Council adopted a series of conclusions welcoming the declaration and action plan endorsed by ministers of health from all countries in the WHO European Region at Helsinki in January. They also considered that mental health needs to be further developed as an integral element of the present and future health strategy of the Community and welcomed the publication of a Green Paper on mental health later in 2005. They also invited member states to collect comparable and reliable data on mental health problems and their economic and social consequences, and to design and implement comprehensive integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery. They also invited the Commission to ensure that integrated impact assessment of future relevant Community legislation takes account of mental health aspects.

The full text of the Council's conclusions are available at *http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/lsa/85263.pdf*

Swedish monopoly on retail sales of medicines ruled contrary to Community law

On 31 May the European Court of Justice (ECJ) ruled that the system of selecting medicines operated by Apoteket, the State controlled company, was liable to place medicines from other Member States at a disadvantage compared with Swedish medicines. As such the Swedish system was contrary to Community competition law.

Since 1970, Apoteket has operated a monopoly in the retail of medicines in the country. Under Article 4 of Law No 1152 of 1996 on trade in medicinal preparations, retail trade in non-prescription and prescription medicinal preparations can be engaged in only by the State or by legal persons over which the State has a dominant influence. The government determines who is entitled to carry on such trade and lays down the detailed rules applicable to such trade. With some minor exceptions only Apoteket has such authority. Its sales network comprises about 800 pharmacies which it owns and manages, while in rural areas, it uses the services of about 970 Apoteksombud (pharmaceutical agents). They are private operators, in general local food businesses, which issue prescription medicinal preparations to consumers and may also sell certain non-prescription medicinal preparations.

A criminal case was therefore brought against the manager of a Swedish company, Bringwell International AB, that sold 12 packets of nicotine chewing gum and nicotine plasters in Stockholm in 2001. These products were considered to be medicinal products by the Swedish authorities. In his defence, the manager, Mr Hanner contended that those rules established a State monopoly contrary to Articles 28, 31 and 43 of Community law. The case was referred to the ECJ for clarification.

In ruling that the system was contrary to Community law, the Court noted that it had previously ruled that as far as sales monopolies are concerned, they should be arranged in such a way that trade in goods from other Member States is not placed at a disadvantage as compared with trade in domestic goods. The Court observed in that connection that the agreement concluded between the Swedish State and Apoteket does not provide either for a purchasing plan, or for a system of calls for tenders which would provide an opportunity for the producers of products that are not selected to ascertain the reasons for the selection and to contest selection decisions before an independent supervisory authority. On the contrary, under the current agreement, Apoteket appears to be entirely free to select a product range of its choice. Thus, the agreement does not ensure that all discrimination is ruled out and no other measure appear exist to compensate for that lack of safeguards.

While the judgement implies that the form of the State pharmacy monopoly must change, the initial response was that the prohibition on the sale of medicines without authorisation would remain. Director of the Medical Product Agency, the body responsible for the regulation and surveillance of the development, manufacturing and sale of drugs and other medical products in Sweden, Gunnar Alvan, speaking immediately after the decision said "the judgement means the prohibition on all other traders besides Apoteket selling medicinal products, including those available without prescription, remains in place. Consequently, the judgement involves no changes for the Medical Products Agency; our role will continue to be one of upholding current legislation"

Some retailers however saw the ruling as an opportunity to break into the market for non-prescription drug sales. Nils Wahl, professor in European integration law at Stockholm University, considers that the ECJ's decision means that it is no longer illegal for other companies to sell over the counter medicines. Speaking to the local Swedish press he said "the judgement says that the current system doesn't exclude discrimination and is therefore illegal. The judgement seems to assume that the government can implement a system which excludes discrimination. But to conclude from that that a monopoly in over the counter medicines is allowed goes too far"

Subsequently in an interview with news agency TT, Swedish health minister Ylva Johansson on 16 June said that certain products (including nicotine patches and gum) could be sold in retail shops such as supermarkets in future. A commission will be established in the autumn to look at the future of the Apoteket.

The full text of the ECJ judgement can be found at *http://curia.eu.int/*

Commissioner Kyprianou welcomes implementation of tobacco advertising ban

Markos Kyprianou, European Commissioner for Health and Consumer Protection, welcomed the entry into effect of the EU's Tobacco Advertising Directive on 31 July. Passed by the European Parliament and Council in 2003, the Directive bans tobacco advertising in the print media, on radio and over the internet. It also prohibits tobacco sponsorship of cross-border cultural and sporting events.

According to the Commission around 650,000 people die each year in the EU from smoking related diseases and commenting on implementation of the Tobacco Advertising Directive, Commissioner Kyprianou said "banning tobacco advertising is one of the most effective ways of reducing smoking. This Directive will save lives and reduce the number of Europeans who suffer from smoking related illnesses."

The 2003 Tobacco Advertising Directive applies only to advertising and sponsorship with a cross-border dimension. Advertising in cinemas and on billboards or using merchandising (for example, ashtrays or umbrellas) falls outside its scope. So too does tobacco sponsorship at events which are purely local, with participants coming from only one Member State. Tobacco advertising on television has been banned in the EU since the early 1990s, and is governed by the TV Without Frontiers Directive.

The 2003 Directive was passed using the EU's powers to regulate its internal market. By the 1990s differing national rules on tobacco advertising and sponsorship were becoming a barrier to the free movement between Member States of the products and services carrying them. In 1998 the EU attempted to resolve this problem by passing a directive banning all forms of tobacco advertising and sponsorship. This directive was annulled by the European Court of Justice in 2001, which ruled that a total ban went beyond the EU's powers. However, the Court stated that the EU could legitimately introduce a more limited ban on tobacco advertising and sponsorship. The 2003 Directive adheres strictly to the limits laid down by the Court in its 2001 judgement.

In a separate development, the Commission has adopted a report on the implementation of the Tobacco Products Directive. The report found its provisions on health warnings and maximum tar, nicotine and carbon monoxide are being respected. However, public authorities have a very incomplete picture of the ingredients being used in cigarettes and their functions and their health effects on consumers, mainly due to incomplete disclosure of information by tobacco companies. A consultation on how to make the disclosure rules on additives more effective will be launched in the autumn.

More information is available at at
http://europa.eu.int/rapid/pressReleasesAction.do?reference=IP/05/1013&format=HTML&aged=0&language=EN&guiLanguage=en

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Treaty to prevent water-related diseases in Europe enters into force

While most Europeans enjoy access to clean water the WHO estimate that almost 140 million (16%) do not have a household connection to a drinking water supply, while 85 million (10%) have not seen improvements in sanitation and in excess of 41 million (5%) still lack access to a safe drinking water supply. Children are at particular risk. In the WHO European Region, the incidence of infectious diseases caused by poor quality drinking water is often highest in children aged 6–11 months, causing over 13,000 deaths from diarrhoea among children aged 0–14 years (5.3% of all deaths in this age group) each year, with the countries of central and eastern Europe and central Asia bearing the largest share of the burden.

On 4 August the Protocol on Water and Health to the 1992 Convention on Protection and Use of Transboundary Watercourses and International Lakes came into force, following ratification by the minimum required 16 countries: Albania, Azerbaijan, Belgium, the Czech Republic, Estonia, Finland, France, Hungary, Latvia, Lithuania, Luxembourg, Norway, Romania, the Russian Federation, Slovakia and Ukraine. It is hoped that the Protocol will improve health by contributing to the prevention, control and reduction of water-related diseases. It covers both the provision of safe drinking water and adequate sanitation and the basin-wide protection of water resources. The Protocol calls on the ratifying countries to strengthen their health systems; improve planning for and management of water resources; improve the quality of water supply and sanitation services; address future health risks; and ensure safe recreational water environments.

Such cooperation between countries is vital; some rely on their neighbours for between 50% and 90% of their water supply. Implementation of the Protocol is jointly coordinated by the WHO Regional Office for Europe and the United Nations Economic Commission for Europe (UNECE). WHO Regional Director for Europe, Marc Danzon, stressed the significance of the Protocol for public health, stating that "the Protocol on Water and Health is the world's first legally binding international agreement in the fight against water-related diseases" and "an effective instrument to help ratifying countries achieve the Millennium Development Goals."

The countries that are Parties to the Protocol will review their systems for disease surveillance and outbreak detection, and implement the most appropriate measures to reduce disease, including vaccination or water treatment and distribution measures. Chemical contaminants of drinking water and related diseases are also under review.

Further information on the Protocol and the water and sanitation programme of the WHO Regional Office for Europe is available at www.euro.who.int/watsan.

Proposed regulation on medicines for children

Children often have to take smaller doses of medicines designed for adults; few pharmaceuticals companies produce drugs aimed specifically at children because the clinical trials are more difficult and the time taken to perfect them is longer. The proposed Commission draft regulation aims to encourage the pharmaceuticals industry to invest more in this area, essentially by extending the life of patents or supplementary protection certificates by six months.

The proposal was debated in the European Parliament and the motion put forward by the rapporteur French MEP Francoise Grossetete to her fellow members of the Environment, Public Health and Food Safety committee was adopted on 13 July. She said that "for far too long Europe's children have been waiting, and parents' and patients' organisations have been calling, for special paediatric medicines." The vote could pave the way to an agreement with the Council at first reading under the co-decision procedure.

Some MEPs would have liked the time extension to be proportional to the profits earned, shorter in some cases and longer in others. However, the rapporteur, the Commission and a majority of Member States feared that variable protection regimes might cause insurmountable problems for implementation. In the end, no alternative proposal achieved majority support in the committee, which positioned itself de facto on the side of the Commission's initial text: six months in all cases. There will, however, be one exception: the exclusive commercial rights of 'orphan drugs', intended to treat rare illnesses, will be increased from 10 to 12 years if they are invented specifically for children.

Under current legislation, a medicine covered by a patent and a supplementary protection certificate is protected for a maximum of 15 years. A further six months of protection would, according to Commission estimates and depending on the case, produce extra profits of €0.8 to €9 million, compared with the average cost of a clinical trial, which can be as much as €4 million.

Research boost

The Committee also called on the Commission to review the regulation six years after it enters into force and amend it if it has not produced the desired impact, notably on research. MEPs also want to boost research now by other means. One of their amendments calls for the creation, within a year after the adoption of the regulation, of a special EU programme for research into medicines for children, to be called MICE (Medicines Investigation for the Children of Europe).

To optimise research efforts, the regulation would set up, under the auspices of the European Medicines Agency, a network of researchers and research centres to avoid duplication of research and or tests on children. The agency should also, say MEPs, compile an inventory of therapeutic needs in the two years after the entry into force of the regulation, and this should seek to establish priorities for research.

The regulation will also set up a Paediatric Committee, and MEPs would like this to be created no later than six months after the entry into force of the regulation. They want to amend some of the provisions regarding its composition and call for its opinions to be published. These would include opinions on paediatric research plans submitted by companies seeking the extra six months protection.

More information at www2.europarl.eu.int/omk/sipade2?PUBREF=-//EP//TEXT+PRESS+NR-20050713-1+0+DOC+XML+V0//EN&LEVEL=2&NAV=S#SECTION4

Vice President Verheugen outlines a new pharmaceutical strategy

Günter Verheugen, Vice President of the European Commission and responsible for Enterprise and Industry, delivered a keynote speech at the European Federation of Pharmaceutical Industries and Association (EFPIA) in Brussels on June 1. He addressed the difficulties now being faced by the European pharmaceutical sector and outlined elements of a new Commission industrial strategy for the sector that goes beyond regulatory interventions by enhancing the environment for innovation and investment, reflecting on ways to give more market flexibility to industry and improving quality of information to patients and patient safety. The new strategy is also an acknowledgement that the challenge comes not just from the United States, but also from emerging economies such as China and India.

Verheugen began by stating that the European pharmaceutical industry "once the bastion of pharmaceutical innovation, and the pharmacy of the world, is increasingly under threat. In 1992, six out of the top ten medicines were developed in Europe; by 2002, this had fallen to only two. Europe, the Commission and Member States, must decide whether we want to continue to be a leading player in pharmaceutical innovation or whether we simply step aside and let others overtake this job." While in the late 1980s only 41% of the top 50 innovative drugs were of American origin, in the late 1990s the US percentage climbed to 62%.

For his part the Vice President signalled that he has no intention of stepping aside on this issue, affirming his belief that "not only is the pharmaceutical sector vital to our economy and science base but it will be a key component in the enormous health challenges which will dominate the political agenda for the foreseeable future."

The new European strategy for the pharmaceutical industry will be based on two key core building blocks: the Lisbon agenda for economic development in the EU together with developments already achieved through the adoption of the Pharmaceutical Review in 2004 legislation and the G10 process. The Vice President drew attention to progress

that had been made in supporting innovation in specialist areas, such as the regulation of orphan medicines, arguing that this has, so far, led to twenty-one medicines being developed and authorised for rare diseases. Moreover he stated that "there is clear evidence that the orphan regulation has led to the creation of small and medium-sized enterprises. Thus it is fair to state that the orphan regulation has stimulated innovation for the benefit of patients and increased the competitiveness of the European pharmaceutical industry."

The proposed regulation on medicines for children is another way of creating opportunities for the industry to develop paediatric pharmaceuticals and create new markets. The Vice President also stressed that new regulation is required for innovative treatments such as gene therapy, cell therapies and tissue engineering, stating that "the industry needs a clear regulatory framework for new technologies so that it can design its studies and develop products for the benefits of patients. If the regulatory framework is unclear then this increases the uncertainty and risks for industry and reduces innovation. The Commission is committed to ensuring that a clear regulatory framework for these advanced therapies is put in place as quickly as possible."

In addition to strengthening the legislative framework three focal areas of the proposed Commission industrial strategy were outlined:

Boosting innovation

To regain the competitive advantage Europe once enjoyed, the long-term competitiveness of the pharmaceutical sector depends on support for its science base. In particular, to take advantage of the new 7th Research Framework Programme (FP7) to support R&D projects that are relevant to the industry. In parallel, the Commission has proposed a new €2.6 billion Entrepreneurship and Innovation Programme which will support small and medium sized enterprises and start-ups, a major feature of the European pharma-biotechnology sector. Of particular importance will be the new Technology Platforms to foster public-private partnerships at the European level and bring together Academia, Industry, Member States and the Commission in order to pool limited resources to create added value.

Enhancing competitiveness

The Commission wants to look at ways industry can be given more flexibility in establishing prices without sacrificing any capacity of Member States to protect their health care budgets. In addition, this reflection should look at the speed of access to the market, lifting of pricing controls for medicines that fall outside the state sector, parallel trade and the impact of the Transparency Directive.

Improving information and safety for patients

The Commission will establish a public-private partnership to improve access to quality information on medicines for the public. Noting that there have been safety concerns which have highlighted the need for a review of pharmaco-vigilance in Europe the Commission intends to facilitate public debate on options for improving the safe use of medicines at both the national and European level. A review of national and European pharmaco-vigilance has already been commissioned.

The Vice President's speech is available at http://europa.eu.int/rapid/pressReleasesAction.do?reference=SPEECH/05/311&format=HTML&aged=0&language=EN&guiLanguage=en

European Community Health Indicators now available

The first set of EU-wide health data from the European Community Health Indicators (ECHI) project has been published. The aim of ECHI is to produce better and more comparable data that will enable policy makers to track developments in the health status of EU populations. The indicators aim to cover the 25 Member States, the EU Candidate Countries, the West Balkan Countries, the USA, Canada and Japan and the data they contain is available in English, French, German and Spanish. The ECHI pages on the Public Health website will be developed over the coming months and updated on a regular basis.

Until now, the content-specific co-ordinating functions relating to the ECHI indicators have been provided by the ECHI-1 and ECHI-2 projects. Some parts of the overall information and knowledge-based system are nearing implementation. More emphasis will now be placed on action. The Commission has recognised the need for a coordinating working group known as the Working Party Health Indicators, which also will deal with indicators and their implementation. A pre-meeting was held in Luxembourg in May. Many of the major health monitoring functions are to be built into the functions of this new Working Party.

Much of the proposed work builds on existing work such as the Eurostat NewCronos database, WHO HFA database, the OECD Health Data database, the HIS/HES database, EU projects such as ECHI-2, HIS/HES, EHRM, Eurostat task forces on health surveys and hospital data project, and Eurostat's Partnership for Health Statistics and the Eurostat/DG Health and Consumer Protection plan for a European Health Survey System (EHSS). It will be assisted by a Secretariat combining the expertise of five national public health institutes led by the Finnish National Public Health Institute (KTL). The Secretariat's work draws on the expertise and extensive experience of the individuals working in the core group and in the institutes involved. It will work on development and implementation concerning indicators and health monitoring as a whole, and studies in support of Working Party activities will be carried out.

More information available at www.europa.eu.int/comm/health/ph_information/dissemination/echi/echi_en.htm

News in Brief

England: Tackling health inequalities: status report on the Programme for Action

On 11 August an independent progress report on the English Department of Health's plan to reduce health inequalities by 10% by 2010 was published. The report indicates that while much progress has been made in dealing with income inequality, some inequalities in health status across social groups continue to widen.

Chair of the Independent Scientific Reference Group, Professor Sir Michael Marmot, while acknowledging the real progress made with strong government commitment, warns that much action is still required. "To change social inequalities in life expectancy means both important social changes and translating these differences into changing disease rates. This report gives no grounds for complacency that enough has yet been done." He expected that the progress in halving the number of children living in absolute poverty between 1998/99 and 2003/04 'would probably feed forward to a reduction in inequalities in life expectancy over the long term, though not by 2010.'

The report is available at www.dh.gov.uk/assetRoot/04/11/76/98/04117698.pdf

World Health Report 2005 – Make Every Mother and Child Count

WHO estimates that out of a total of 136 million births a year worldwide, less than two thirds of women in less developed countries and only one third in the least developed countries have their babies delivered by a skilled attendant. This can make the difference between life and death for mother and child if complications arise. Deaths among children under five years of age are attributable to just six conditions, and most are avoidable through existing interventions that are simple, affordable and effective.

The report is available at www.who.int/entity/whr/2005/en/index.html

Tackling alcohol-related damage in Europe

The European Commission, DG Health and Consumer Protection has published a working paper on alcohol. The paper makes recommendations for actions by the EU institutions, national governments, alcohol industry and NGO community. The working paper is expected to evolve into an EU strategy by the end of 2006.

More at www.europa.eu.int/comm/health/ph_determinants/life_style/alcohol/documents/ev_20050307_rd01_en.pdf

13th European Social Services Conference

'Putting People First: Partnership and Performance in Social Care and Health in a Changing Europe' took place on 4–6 July in Edinburgh. This UK Council Presidency event was organised by the European Social Network.

Conference presentations are available at www.socialeurope.com/edinburgh/presentations.htm

Sweden: Smokefree pubs, restaurants and cafes from 1 June

Legislation banning smoking in pubs and restaurants came into law on 1 June. The legislation was a response to the deaths each year of more than 6,500 people due to smoking, while an additional 500 people die from passive smoking. A study recently showed that over 80% of the Swedish people support the decision. Two out of three smokers support the introduction of smoke-free cafés and restaurants. The Government's proposal is based on the health of employees, increased access to public entertainment for people suffering from allergies and asthma, and on young people having access to smoke-free premises, such as cafés. Restauranteurs who wish to set up a smoking room may do so. However, out of consideration to the staff, no service, eating or drinking is allowed in the smoking room.

More at www.sweden.gov.se/sb/d/5625

Ireland: 93 recommendations to tackle obesity

On 16 May the National Taskforce on Obesity presented its report, *Obesity – the Policy Challenges*. The taskforce chaired by 1984 Olympic marathon silver medallist, John Treacy, now chief executive of the Irish Sports Council, was set up in 2004 by the Department of Health and Children as a direct response to the emerging problem of overweight and obesity in Ireland, particularly in children. The report includes recommendations on banning vending machines in primary schools, a new education and training programme for health professionals, guidelines for food labelling, an examination of fiscal policy and its impact on overweight and obesity, and guidelines for the detection and treatment of overweight and obesity. Treacy said "Irish lifestyles in terms of diet and a decline in workplace or recreational activity have changed dramatically over the past 60 years. There is no doubt but that we have a major challenge on our hands and successfully tackling the problem can only be achieved by a concerted effort across all sectors of society, public, private and commercial"

The report, is available at www.dohc.ie/publications/report_taskforce_on_obesity.html

EurLIFE: an interactive database of quality of life indicators

The European Foundation for the Improvement of Living and Working Conditions, the Dublin-based EU agency, has launched EurLIFE, an interactive database of quality of life indicators. Results from the Foundation's European Quality of Life Survey and other statistical resources will be made available online as part of the new online searchable database.

Access the EurLIFE database via www.eurofound.eu.int

EuroHealthNet

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Guest Speakers (2005)

BARCELONA

Philip Berman, PhD, Director, European Healthcare Management Association. Dr. Berman has considerable experience of healthcare systems in Western, Central and Eastern Europe. He has acted both as a World Bank and WHO consultant, advising on healthcare management strategies in Poland, Hungary, Romania and Turkey.

Gillian Morgan, MD, Chief Executive, National Health Service Confederation, England. Previously Dr. Morgan was Chairman in 1996–97 and President in 1997–98 of the National Council for the Institute of Health Services Management.

Octavi Quintana, MD, Director for Health Research of the European Union. Dr. Quintana is responsible for the 6th Framework Programme for research and technological development. He has served in several positions in the Spanish Health Administration and as President of the European group on Ethics in Science and Technology.

Rafael Bengoa, MD, Director, Department of Management of Noncommunicable Diseases, World Health Organization.

Richard Feachem, MD, PhD, Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria. Previously Professor of International Health, University of California, San Francisco and Berkeley and Director for Health, Nutrition and Population, World Bank.

BERKELEY

Bruce Bodaken, President, Chairman and CEO of Blue Shield of California, a 3.2 million member not-for-profit California health plan that provides HMO, PPO, Medicare, and life insurance products for the commercial, individual, and government markets.

Molly Coye, MD, MPH, Founder and CEO of The Health Technology Center, a non-profit organization dedicated to advancing the use of beneficial technologies for healthier people and communities. From 1991 to 1993 Dr. Coye was the Director of the California Department of Health Services, managing a budget of more than $16 billion, 5,000 employees and 160 branch and field offices throughout the State.

Harvey V. Fineberg, MD, MPH, President, U.S. Institute of Medicine of the National Academies of Science. Dr. Fineberg also served as provost of Harvard University from 1997–2001, following thirteen years as dean of the Harvard School of Public Health.

Donald W. Kemper, Chairman and CEO, Healthwise, a not-for-profit organization dedicated to helping people make better health decisions. Chairman, Information Therapy Commission

John Kitzhaber, M.D. Legislator and two-term Governor of Oregon. Author and implementor of The Oregon Health Plan.

Kenneth W. Kizer MD, MPH, President and CEO of National Quality Forum. Dr. Kizer previously served as Under Secretary for Health in the U.S. Department of Veteran Affairs (VA) and is widely credited for transformation of VA health care since its creation in 1946.

David Lawrence, MD, Retired CEO and Chairman of the Board, Kaiser Foundation Health Plan and Hospitals, America's leading integrated health care organization with 8.1 million members.

Murray Ross, PhD, Director, Health Policy Analysis and Research, Kaiser Permanente Institute for Health Policy, Kaiser Permanente Medical Care Program

Leonard Schaeffer, President and CEO, WellPoint Health Networks. Mr. Schaeffer joined WellPoint's predecessor, Blue Cross of California in 1986 as President and CEO. He managed the transition to WellPoint, which now exceeds $17 billion in revenues and is one of the U.S.'s most recognized and respected health insurance companies.

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Attention: Meg A. Kellogg

Advanced Health Leadership Forum
Universitat Pompeu Fabra, Barcelona
July 14-22 2006
University of California, Berkeley
January 7-14, 2006

For more information visit:
http://ahlf.berkeley.edu

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Universitat Pompeu Fabra,
July 14–22, 2006

Barcelona

CATALONIA, SPAIN

ADVANCED HEALTH LEADERSHIP FORUM

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January 7–14, 2006

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CENTRE DE RECERCA EN ECONOMIA I SALUT CRES
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School of Public Health
UNIVERSITY OF CALIFORNIA, BERKELEY

A program of the Management for the XXI Century of the Department of Economics and Business and iDEC-UPF

ADVANCED HEALTH

LEADERSHIP FORUM

An international program to rethink health policy and health systems change

Program Format

A 14-day program with renowned senior faculty located in two stimulating venues with histories of health care innovation—Berkeley and Barcelona

Lectures by high-level policy and management leaders from the United States and Europe

In consultation with expert faculty, participants select and complete a project based on "real world" country or company issues. Participants will continue to work with faculty advisors during the six month interim between sessions.

Participants

(visit http://ahlf.berkely.edu)

Senior executives of nations: health ministers or senior policy leaders, legislators and regulators

Senior executives of organizations (e.g., World Bank, OECD, PAHO) or enterprises (e.g., insurance, pharmaceutical, health care delivery, care management)

Participant Quotes

"This program taught me to acknowledge the importance of communicating with other countries with past experiences"

"I learned to perceive new solutions for old problems. These solutions are more flexible, less dogmatic"

"I am inspired to create strategies to better respond to the voices of customers"

"Better readiness for future changes of environment"

"Potential long-term business development came out of this program and its networking"

"Clarifies and updates concepts of management of health care"

"It was a great experience, both professionally and personally"

Focus

Key health policy and management issues: what solutions have been used internationally; what has worked and what hasn't; how to request and interpret policy analysis

Leadership skills; effective policy implementation and strategies for health systems change

Curriculum

Participants grapple in a practical manner with the health policy and management issues that have been converging for countries and organizations internationally. To insure that the program is relevant to their needs, participants prioritize issues prior to the forum and engage in lively interactions with expert faculty, speakers and advisors.

Sample Issues to Be Addressed

Evidence-based leadership and management

How to assure quality

Public vs. private health insurance mix

Innovations in payer and health delivery connections

Pharmaceutical innovation, pricing and regulation

Defining benefit packages, explicit priority setting and rationing

Making effective use of the new consumerism

Lessons learned from managed care techniques

Dealing with aging, long term care, mental health

Technology changes and future health care predictions to prepare for

2004 Participants

Barcelona Faculty

Pere Ibern, PhD, AHLF Academic Coordinator, Adjunct Professor of Business, UPF

Guillem Lopez-Casasnovas, PhD, Director of CRES, Professor of Economics; Department of Economics and Business, UPF

Vicente Ortún, PhD, Associate Professor in Business, Deputy Director of CRES, UPF

Marisol Rodriguez, PhD, Associate Professor of Economics, University of Barcelona

Jose Luis Pinto Prades, PhD, Associate Professor in Health Economics and Applied Political Economy, UPF

Vicente Salas-Fumas, PhD, Professor of Business and Organizational Behavior, Universidad de Zaragoza

Núria Más, PhD, Associate Professor of Business Strategy, IESE Business School

Ana Rico, PhD, Institute of Health Policy and Management, Erasmus University. Expert on consumer surveys.

Peter Zweifel, PhD, Professor, Socioeconomic Institute of the University of Zurich. Prominent expert on health insurance.

Berkeley Faculty

Stephen M. Shortell, PhD, Blue Cross of California Distinguished Professor of Health Policy and Management; Dean, School of Public Health; Professor, Haas School of Business

Richard M. Scheffler, PhD, AHLF Academic Coordinator, Distinguished Professor of Health Economics and Public Policy, School of Public Health and School of Public Policy

Jennifer Chatman, PhD, Distinguished Professor of Management, Haas School of Business

Teh-wei Hu, PhD, Professor of Health Economics, School of Public Health

James C. Robinson, PhD, MPH, Professor of Health Economics, School of Public Health

John Ellwood, PhD, Professor of Public Policy, School of Public Policy

Paul J. Gertler, PhD, Professor of Health Economics and Finance, School of Public Health and Haas School of Business

Harold S. Luft, PhD, Caldwell B. Esselstyn Professor of Health Policy and Health Economics, Director of Institute for Health Policy Studies, UCSF

Edward E. Penhoet, PhD, Professor of Health Policy and Management, School of Public Health. President, Gordon and Betty Moore Foundation.

Kristiana Raube, PhD, MPH, Adjunct Professor and Executive Director Graduate Program in Health Management, Haas School of Business

Thomas G. Rundall, PhD, Henry J. Kaiser Professor of Health Management and Public Policy, School of Public Health

Program Fees

(Fees cover both Part I in Barcelona, Part II in Berkeley and interim project consultation.)

$12,000 tuition:

- Daily curriculum with distinguished faculty plus special events with outside speakers
- Quality time with faculty members
- Interactions with fellow participants and advisors during interval between Barcelona and Berkeley, and beyond

$8,000 for high-end hotel accommodations, meals, field trips and local transportation.

Scholarships are available, including a special scholarship rate for World Bank employees and contractors.

Early Enrollment Encouraged

Space is limited and there is a discount for applications completed early. Please check our website http://ahlf.berkeley.edu for deadlines. The previous cycle of the program SOLD OUT. If the program is full, your application can be held in queue until the next cycle of the program.

Request for Application

To apply, see our web site at:
http://ahlf.berkeley.edu

To request an application write to:
ahlf@berkeley.edu

OR

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