

# eurohealth

---

## Addressing health inequalities and promoting patient safety under the UK Presidency



*Health Ministers from across Europe – EU Member States, accession countries (Bulgaria and Romania), candidate countries (Turkey and Croatia) – at the Informal Ministerial Meeting held on 20/21 October 2005*

[EU action on health inequalities](#)

[Government action to tackle mental health inequalities in Scotland](#)

[Mental health green paper: a timely opportunity](#)

[Going smoke free](#)

[Health ageing across Europe](#)

EDITOR:

David McDaid: +44 (0)20 7955 6381  
email: [d.mcdaid@lse.ac.uk](mailto:d.mcdaid@lse.ac.uk)

FOUNDING EDITOR:

Elias Mossialos: +44 (0)20 7955 7564  
email: [e.a.mossialos@lse.ac.uk](mailto:e.a.mossialos@lse.ac.uk)

DEPUTY EDITOR:

Sherry Merkur: +44 (0)20 7955 6194  
email: [s.m.merkur@lse.ac.uk](mailto:s.m.merkur@lse.ac.uk)

SENIOR EDITORIAL ADVISER:

Paul Belcher: +44 (0)7970 098 940  
email: [p.belcher@lse.ac.uk](mailto:p.belcher@lse.ac.uk)

DESIGN EDITOR:

Sarah Moncrieff: +44 (0)20 7834 3444  
email: [westminster.european@btinternet.com](mailto:westminster.european@btinternet.com)

EDITORIAL TEAM:

Reinhard Busse, Julian Le Grand, Josep Figueras, Walter Holland, Martin McKee, Elias Mossialos

SUBSCRIPTIONS MANAGER

Champa Heidbrink: +44 (0)20 7955 6840  
email: [eurohealth@lse.ac.uk](mailto:eurohealth@lse.ac.uk)

ARTICLE SUBMISSION GUIDELINES

see: [www.lse.ac.uk/collections/LSEHealthAndSocialCare/documents/eurohealth.htm](http://www.lse.ac.uk/collections/LSEHealthAndSocialCare/documents/eurohealth.htm)

Published by LSE Health and Social Care and the European Observatory on Health Systems and Policies, with the financial support of Merck & Co and the European Observatory on Health Systems and Policies. News section compiled by Eurohealth with some additional input from EurohealthNet.

*Eurohealth* is a quarterly publication that provides a forum for policy-makers and experts to express their views on health policy issues and so contribute to a constructive debate on public health policy in Europe.

The views expressed in *Eurohealth* are those of the authors alone and not necessarily those of LSE Health and Social Care, Merck & Co, EuroHealthNet or the European Observatory on Health Systems and Policies.

The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

Advisory Board

Dr Anders Anell; Rita Baeten; Philip Berman; Nick Boyd; Professor Reinhard Busse; Professor Johan Calltorp; Professor Correia de Campos; Professor Mia Defever; Nick Fahy; Dr Giovanni Fattore; Professor Unto Häkkinen; Dr Maria Höfmarcher; Professor David Hunter; Professor Egon Jonsson; Dr Nata Menabde; Dr Meri Koivusalo; Dr Bernard Merkel; Professor Stipe Oreskovic; Dr Alexander Preker; Dr Tessa Richards; Heather Richmond; Professor Richard Saltman; Professor Igor Sheiman; Professor Aris Sissouras; Dr Hans Stein; Dr Jeffrey L Sturchio; Professor Miriam Wiley

© LSE Health and Social Care 2006. No part of this publication may be copied, reproduced, stored in a retrieval system or transmitted in any form without prior permission from LSE Health and Social Care.

Design and Production: Westminster European  
email: [westminster.european@btinternet.com](mailto:westminster.european@btinternet.com)

Printing: Optichrome Ltd

ISSN 1356-1030

## C O M M E N T

### Health under the UK Presidency: much progress made

Addressing health inequalities and improving patient safety were the two central health themes of the UK's Presidency of the Council of the European Union. Chief Medical Officer for England, Sir Liam Donaldson, writing here on progress achieved on these themes is quick to emphasise the importance of good intelligence and the need for sharing of information across Europe. Europe can play a key role in coordinating Member States efforts on patient safety. This was one of the areas for exploration during a major summit on patient safety held in November. Another important step was the political agreement reached on the European Commission's proposal for the 'Regulation on Medicinal Products for Paediatric Use' at the Council of EU Health Ministers in December.

In terms of knowledge generation two important independent reports on health inequalities were commissioned by the UK Presidency. The first *Health Inequalities – Europe in Profile* is yet further testament, as Sir Liam notes that 'many European citizens do not benefit from the health improvements their countries have made in recent decades.' The second *Health Inequalities: A Challenge for Europe* identifies systematic and comprehensive strategies to tackle health inequalities in some Member States, recognising that others still have a long way to travel. Elsewhere in this issue the importance of health inequalities across the life span remains visible with discussion of actions taken both by the European Commission and a look at steps taken to address inequalities in mental health in Scotland.

Intelligence sharing also needs to be a key feature of what we do here at *Eurohealth*. Regular readers will notice that we have expanded the amount of space for news on health policy and public health developments at both the European institutional and national levels. Further exciting changes will also be phased in to keep us at the cutting edge of the policy debate and I am especially pleased that our new Deputy Editor Sherry Merkur will be a great driving force in instigating these changes – so watch this space!

David McDaid  
Editor

# Contents

Volume 11 Number 4

## UK Presidency

- 1 Health inequalities under the UK Presidency  
*Liam Donaldson*
- 2 Patient safety under the UK Presidency  
*Liam Donaldson*

## Health Inequalities

- 4 Action by the European Union on health inequalities  
*Michael Hübel and Charles Price*
- 6 Government action to tackle mental health inequalities in Scotland  
*Lewis Macdonald*

## Green Paper on Mental Health

- 9 Promoting mental health in Europe: a timely opportunity  
*Eva Jané-Llopis and David McDaid*
- 11 The EU Mental Health Platform  
*Clive Needle*
- 13 Enhancing the policy relevance of mental health related research in Europe  
*Kristian Wahlbeck and David McDaid*

## Healthy Ageing

- 15 A long life – and all of it healthy: the ideal of healthy ageing in Europe  
*Rodney Elgie, June Crown and Michael Tremblay*

## Going Smoke Free

- 21 The medical case for clean air in the home, at work and in public places  
*Richard Edwards and Tim Coleman*

## Mythbusters

- 25 "Myth: An ounce of prevention buys a pound of cure"

## Monitor

27 Publications

28 Web Watch

29 European Union News  
by Eurohealth with input from EuroHealthNet

*Tim Coleman* is Senior Lecturer in General Practice, School of Community Health Sciences, Queen's Medical Centre, Nottingham, UK.

*June Crown* is Vice President, Age Concern England.

*Sir Liam Donaldson* is Chief Medical Officer, England, Chief Medical Advisor, UK and Chairman, WHO World Alliance for Patient Safety.

*Rodney Elgie* is President of The European Patients' Forum, Bruxelles, Belgium, Vice President of The European Men's Health Forum, Bruxelles, Belgium and Immediate past President of GAMIAN-Europe

*Richard Edwards* is Senior Lecturer in Epidemiology, Department of Public Health, Wellington School of Medicine and Health Sciences, University of Otago, Wellington, New Zealand.

*Eva Jané-Llopis* is responsible for the programme for Mental Health Promotion and Mental Disorder Prevention, Mental Health Programme, World Health Organization, Regional Office for Europe, Copenhagen.

*Michael Hübel* is Head of Unit C4 Health Determinants at the European Commission, Directorate General Health and Consumer Protection, Luxembourg.

*Lewis Macdonald* is Deputy Minister for Health and Community Care, Scottish Executive, Scotland, UK.

*David McDaid* is Research Fellow LSE Health and Social Care and European Observatory on Health Systems and Policies, London School of Economics and Political Science.

*Clive Needle* is Director of EuroHealthNet and Chair of the EU Mental Health Platform.

*Charles Price* is a National Expert at the European Commission, Directorate General Health and Consumer Protection, Luxembourg.

*Mike Tremblay* is Partner, Tremblay Consulting, Kent, UK.

*Kristian Wahlbeck* is Research Professor, Mental Health Group, STAKES, Helsinki, Finland.

# Health inequalities under the UK Presidency



*Liam Donaldson*

*“many European citizens do not benefit from the health improvements their countries have made in recent decades”*

The UK Presidency of the Council of the European Union has placed particular emphasis on two key health issues: addressing health inequalities and improving patient safety. Both these issues require a coordinated effort across Europe in order to make a real difference to the health of citizens of all Member States.

In addressing the issue of health inequalities, the UK Presidency commissioned two groundbreaking expert independent reports, published in October. The first, *Health Inequalities: Europe in Profile*,<sup>1</sup> reached some stark conclusions. Most major causes of premature death, such as cardiovascular disease and cancer, are more common among people with lower levels of education, income and occupational status. The health gap in life expectancy is typically five years or more. The report also highlighted that many European citizens do not benefit from the health improvements their countries have made in recent decades.

The second report commissioned by the Presidency, entitled *Health Inequalities: A Challenge for Europe*,<sup>2</sup> helps to identify a way forward in addressing these inequalities. The report found that in some Member States, systematic and comprehensive strategies to tackle health inequalities are already in place. Other Member States have policies, but without an overarching framework, and some are still in a pre-measurement stage. If all Member States continue to work together, and share best practice, good health could become a reality for everyone.

The ‘Tackling Health Inequalities’ Summit, which was held in October to coincide with the publication of the reports, was a significant step in this process as it brought together European and international expertise, including the World Health Organization (WHO) and the Organisation for Economic Co-operation and Development (OECD). The Summit was an inspirational event, with keynote addresses from Ministers and leading international experts, specific workshops to share experience and develop policy, and opportunities to discuss current issues and

network with colleagues. Speakers included European Health Commissioner, Markos Kyprianou, UK Secretaries of State, Patricia Hewitt (Health) and Hilary Benn (International Development) and Mark Danzon, Regional Director of the WHO. The outcomes of the Summit are expected to inform the policy development work of the Commission, as well as Member States.

A key factor in this policy development will be to improve the collection and dissemination of information on health inequalities, in order to help Member States to identify health gaps and to develop and implement appropriate policies to address them.

If this information is shared throughout the European Union, and Member States pool their resources and intelligence, the goal of eliminating health inequalities will be brought significantly closer. Enlisting global support in tackling the problem worldwide will also speed up the process and for this reason, the UK is supporting the World Health Organization’s *Commission on Social Determinants*,<sup>3</sup> chaired by Professor Michael Marmot, which will help ensure that knowledge informs practice across the globe.

A number of specific examples of where cooperation is required have also been highlighted during the UK Presidency. The first is the illicit trade in tobacco and the legal cross-border shopping from low tobacco duty countries. Illicit trade, and vastly fluctuating prices of tobacco across the European Union, are undermining effective tobacco control programmes. Young people, and those on low incomes, are more likely to purchase cheap tobacco from smuggled sources, leading to continuing high smoking rates among these groups, with a significant impact on health and health inequalities. This issue was also highlighted in my Annual Report 2004.<sup>4</sup> A Global response to tackling this smuggling is the WHO’s Framework Convention on Tobacco Control. There is also significant scope for further collaborative action between health, customs and other agencies.

---

Sir Liam Donaldson is Chief Medical Officer, England, Chief Medical Advisor, UK and Chairman, WHO World Alliance for Patient Safety.



## References

1. Mackenbach J. *Health Inequalities: Europe in Profile*. October 2005. Available at [www.dh.gov.uk/assetRoot/04/12/15/84/04121584.pdf](http://www.dh.gov.uk/assetRoot/04/12/15/84/04121584.pdf)
2. Judge K, Platt S, Costongs C, Jurczak K. *Health Inequalities: A Challenge for Europe*. October 2005. Available at [www.dh.gov.uk/assetRoot/04/12/15/83/04121583.pdf](http://www.dh.gov.uk/assetRoot/04/12/15/83/04121583.pdf)
3. WHO Commission on Social Determinants of Health website. [www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/)
4. Donaldson L. *On the state of the Public Health: Annual Report of the Chief Medical Officer 2004*. London: Department of Health, 2004. Available at [www.dh.gov.uk/assetRoot/04/11/57/81/04115781.pdf](http://www.dh.gov.uk/assetRoot/04/11/57/81/04115781.pdf)

The manner in which alcohol is marketed was also highlighted during the Presidency as a particular concern for health inequalities. Across the European Union, there is a trend towards increased consumption by young people, and there is a need for coordinated action to minimise the impact of alcohol marketing on young people, with an effective balance of regulation and self-regulation - for example, through the 'TV Without Frontiers' directive. In future, alcohol marketing may need to be monitored by an independent body.

Attention must also be focused on improving what people are eating, particularly among young people. The number of overweight children in Europe is rising by 400,000 a year. The Presidency Summit raised the need for a harmonised approach across Europe to tighten controls on advertising and the promotion of less healthy foods to children, that is foods high in fat, sugar and salt. The new Commission Green Paper, *Promoting Healthy Diets and Physical Activity: Towards a European Strategy for the Prevention of Overweight, Obesity and Chronic Diseases*, and the EU Platform for Action on Diet, Physical

Activity and Health provide important opportunities for strategic and effective pan-European action.

The overarching goal of the UK Presidency has been to leave a legacy that ensures health inequalities are reduced in Europe and throughout the world for generations to come. At the Summit, Commissioner Markos Kyprianou announced a new European Union Expert Working Group on Social Determinants for Health Inequalities, which will bring together Member States in the future and continue the work begun by the current Presidency. The Commissioner said: "for my part, I pledge my full support as European Commissioner for Health to the task of reducing health inequalities across Europe". This bodes well for the continued work of the Commission in tackling this problem.

The Summit has significantly raised the profile of health inequalities as an issue for the European Union and for Member States. The challenge now is to sustain this purpose and to deliver the changes that will help narrow the health gap.

The full Proposals for Action from the Summit, which went to the Health Council of Health Ministers meeting in December, and fuller details of the Summit, including copies of the presentations and a newsletter, can be found on the Department of Health website at: [www.dh.gov.uk/eupresidency](http://www.dh.gov.uk/eupresidency)

## Patient safety under the UK Presidency

*Liam Donaldson*

Patient safety has been a priority theme of the UK Presidency of the EU. Through our Presidency we have aimed to:

- Establish patient safety as a key priority on the European health agenda, both at EU level and in individual Member States and agree priorities for action.
- Initiate concrete mechanisms and practical programmes of activity at the European level to take forward action on agreed priorities.
- Promote greater alignment of European patient safety initiatives with international developments to add value to the efforts of Member States to facilitate real and lasting improvements in the safety of patient care across the EU.

Much has been achieved in a relatively

short time. A highlight has been an inspirational and highly successful Patient Safety Summit which took place on 28–30 November 2005. The Summit highlighted European and world action on patient safety bringing together hundreds of international and European politicians, experts, patients, clinicians and many other stakeholders. The role for Europe in facilitating and coordinating Member States efforts to improve patient safety was also explored. Discussions focused on a number of important areas including:

*The global patient safety agenda* – what are the international priorities for action? How can we best link action at country level and collaboration across Europe with work underway internationally?

*Patient safety from the perspective of*

*“As people move freely across borders, they expect the care they receive to be safe and of good quality”*

*patients* – how do we empower patients to play an active role as agents of their own safety and that of their families?

*“Knowledge is the enemy of unsafe care”* – where are our gaps in knowledge and what are the priorities for research effort which really make a difference to the safety of front line health care?

*Learning from other ‘high-risk’ industries:* how can we learn from the best of experience in industries such as aviation, oil and transport to systematically reduce risks in health care?

*Today’s students, tomorrow’s safe practitioners:* where should we be investing in education and training to create a generation of ‘error wise’ health care practitioners?

*Addressing clinical priorities and risk* focusing on diverse issues such as medical device safety, changing organisational cultures, safer practitioners, and tackling healthcare related infection.

Opening the event, Secretary of State for Health in England, Patricia Hewitt called for ongoing action towards “a lasting legacy of safer healthcare.” She told those present, that “patient safety is a global issue, and countries throughout the world must get better at working together to provide safer healthcare for their patients”.

“Personally, I find it heartening that patient safety is now recognised as a major global health challenge. During the UK Presidency of the European Union, we have been conscious of the opportunity to strengthen existing initiatives and to demonstrate our support for the international effort being spearheaded by WHO through the World Alliance for Patient Safety.”

Fernand Sauer, Director for Public Health of the European Commission, added: “European collaboration can provide ideas and tools to help EU Member States improve the safety of their patients. By working together, we can reduce harm to patients throughout the European Union. This will also give patients confidence when they seek healthcare elsewhere in Europe.”

The Summit has led to renewed commitment, stronger engagement and a deeper understanding of patient safety issues across Europe. Patient safety is an increas-

ingly high-profile issue at the European level. There was consensus that the case for greater action on patient safety is compelling. As people move freely across borders, they expect the care that they receive in any country to be safe and of good quality. Research suggests errors are as likely in fee-for-service or insurance based systems as in state-funded systems.

And of course, the Summit has not been the only focus of our activity. On other fronts, political agreement on the European Commission proposal for *Regulation on Medicinal Products for Paediatric Use* has been secured at the Council of EU Health Ministers meeting on 9 December 2005. This will ensure that medicines will be routinely tested and appropriately formulated for use with children.

The UK Presidency has also spearheaded the development of a coherent package of ongoing work on patient safety at the European level. This builds on the outcomes of the Patient Safety Summit as well as the groundswell of support from Member States generated by the 2005 Luxembourg Presidency in which patient safety also featured. Strong links have also been made to the emerging patient safety recommendations from the Council of Europe, and the broader international programme of work led by the World Health Organization through the World Alliance for Patient Safety.

High-level discussion between the Member States in 2005 has prioritised a concrete programme of action and practical tools that from the European Union perspective set out a substantive work programme for the next few years. A major emphasis has been on action areas that help countries establish their own patient safety programmes. This has the potential to facilitate real and lasting improvements on the safety of patient care across Europe.

We are of course, still only at the start of the journey. Much remains to be done. However, safe health care cannot just be an option. It is the right of every patient who entrusts their care to a health care system and the responsibility of those who lead. I am hopeful that 2005 will be recognised as the year when a growing commitment to patient safety across Europe, and a growing willingness to collaborate, is consolidated into solid programmes of action.

---

Further information, including details of the Patient Safety Summit held in London in November, can be found on the Department of Health website at: [www.dh.gov.uk/eupresidency](http://www.dh.gov.uk/eupresidency)

# Action by the European Union on health inequalities

*Michael Hübel and Charles Price*

*“the Commission recently established an Expert Working Group on Social Determinants and Health Inequalities”*

## Introduction

Inequalities in health have been an important part of the work of the European Union (EU) since 1992 when specific competencies for public health were included in the Maastricht Treaty. This has been taken forward in three main ways:

1. Through the EU Public Health Programme.
2. By facilitating the exchange of information and best practice between Member States and other organisations.
3. Development of key EU policy areas which can contribute to reducing health inequalities.

## Public Health Programme

The EU Public Health Programme provides financial support to projects which contribute to programme objectives. Within the first stage of the Public Health Programme, reducing health inequalities was part of the health promotion programme which ran from 1996 until 2002. Today it is an overall aim of the current Public Health Programme 2003 to 2008.<sup>1</sup> Key objectives are firstly the development of strategies on social and economic health determinants in order to identify and combat inequalities in health and secondly the creation of a sustainable health monitoring system paying special attention to inequalities in health.

In the last ten years there have been some 15 projects on health inequalities with a total amount of EU support of over €5 million. Outputs from these projects include:

- A detailed overview of the health inequalities situation in Europe and the situation of disadvantaged groups.<sup>2</sup>
- An overview of actions on reducing inequalities in health.<sup>3</sup>

- A network of agencies in Member States developing strategies to tackle health inequalities.<sup>4</sup>
- Support to the 2005 UK Presidency Summit on Health Inequalities and related background papers.

## Facilitating exchange of information and best practice by Member States and other organisations

The EU supported a European Conference on Health Determinants as part of the Portuguese presidency in 2000. A review of the role of health promotion in tackling health inequalities was reported to the Health Council under the Belgian presidency in 2002. In 2003 the Commission published *The Health Status of the European Union: Narrowing the Gap*.<sup>5</sup>

The Commission has developed a variety of formal and informal mechanisms for dialogue with Member States and other stakeholders which have considered and exchanged information on social determinants of health and health inequalities as part of their work. These include the EU Health Forum with representatives of key non governmental organisations; the High Level Committee on Health and the High Level Group on Health and Health Services both of which consist of senior officials from ministries responsible for health in all Member States.

In 2004 Commissioner Byrne addressed health inequalities as part of his reflection process on the future health strategy of the EU; a consultation which attracted a record level of high quality responses. Many of these responses welcomed the renewed emphasis given to this topic, and have been taken into account in the proposals for the Health and Consumer Protection Programme 2007–2013.<sup>6</sup>

Health Inequalities were one of the key themes of the UK Presidency of the EU, from July to December 2005. The Presidency Summit: *Tackling Health Inequalities: Governing for Health* produced several proposals for action which

---

Michael Hübel is Head of Unit C4 Health Determinants and Charles Price a National Expert at the European Commission, Directorate General Health and Consumer Protection, L-2920 Luxembourg.  
E-mail [michael.huebel@cec.eu.int](mailto:michael.huebel@cec.eu.int) and [charles.price@cec.eu.int](mailto:charles.price@cec.eu.int)

*“An important part of future EU policy will be the link between action on health inequalities and overall economic development”*

were presented to the Health Council in December 2005. Furthermore the Commission recently established an Expert Working Group on Social Determinants and Health Inequalities, to facilitate communication and sharing of best practice in this area.

#### **Developments of key EU policy areas**

An inequalities dimension is an important element of specific EU public health policy actions in areas such as alcohol, drugs, mental health, sexual health, and tobacco. This includes for example advocacy for a total ban on smoking in the workplace, which will contribute to narrowing gaps in mortality between low status and high status jobs.

Regional policy also plays a major role in tackling health inequalities by helping to narrow the gap in wealth between economically deprived regions and the rest of the EU. Tackling health inequalities through support for community wide health promotion initiatives is included within the guidance for the use of the main funding vehicle for regional policy, the EU structural funds, from 2007.

Another key policy area is that of agriculture and rural development. Poorer health in rural areas is a feature in a number of the newer Member States of the EU. The increasing emphasis on rural development

within the Common Agricultural Policy will help to narrow the health gap between rural and urban areas, particularly in new Member States.

Turning to social policy, employment and equal opportunities, EU legislation on discrimination and on the rights, health and safety of workers is an essential underpinning of the protection of the health of Europeans. The programme on social inclusion as part of the Open Method of Coordination includes a specific element relating to health and access to health services.

There is a strong association between a poor environment and social disadvantage. EU environmental policy objectives of creating higher environmental standards through measures such as the setting of limit values for key air pollutants and the licensing and control of polluters are likely to contribute to a reduction in health inequalities by leading to bigger improvements in environmental quality in areas with poorer health.

A final key area is research. A significant body of research on health inequalities has been funded by the EU framework programmes. This includes work in the ECUTY project. Further funding opportunities will also be available as part of the 7th Framework Programme currently being finalised.

#### **Next steps**

The UK Presidency priority on health inequalities has given an important impetus to the further development of EU wide action in this area. The EU is already making a significant contribution to reducing health inequalities through its equal rights legislation, environmental, regional and social policies and specific public health activities. Further work will concentrate on supporting Member States actions – through the Public Health Programme and through mechanisms to facilitate the exchange of good practice. The EU will also continue to develop its capacity to assess key policies for their health impact, including impact on health inequalities, and this additional transparency could help to foster arguments for modification of both existing and new policies. An important part of future EU policy in this area will be the link between action on health inequalities and overall economic development. Additional work is anticipated to assist understanding of the costs and benefits of action on social determinants and health inequalities.

---

#### REFERENCES

1. Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003–2008). Official Journal L 271, 09/10/2002 pages 1–12.
2. Menke R, Streich W, Rössler G, Brand H (eds). *Report on Socio-economic Differences in Health Indicators in Europe: Health Inequalities in Europe and the Situation of Disadvantaged Groups*. Bielefeld: Institute of Public Health NRW, 2003.
3. Mackenbach J, Bakker M (eds). *Reducing Inequalities in Health: A European Perspective*. London: Routledge, 2002.
4. *Closing the Gap: Strategies for Action to Tackle Health Inequalities in Europe*. [http://europa.eu.int/comm/health/ph\\_projects/2003/action3/action3\\_2003\\_15\\_en.htm](http://europa.eu.int/comm/health/ph_projects/2003/action3/action3_2003_15_en.htm)
5. *The Health Status of the European Union: Narrowing the Health Gap*. Luxembourg: European Commission, Office for Official Publications of the European Communities, 2003.
6. Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: *Healthier, Safer, More Confident Citizens: a Health and Consumer Protection Strategy. Proposal for a Decision of the European Parliament and of the Council Establishing a Programme of Community Action in the Field of Health and Consumer Protection 2007–2013*. Brussels: Commission of the European Communities.COM(2005) 115, 2005.



# Government action to tackle mental health inequalities in Scotland



*Lewis Macdonald*

*“Suicide rates are twice as high in our more deprived communities”*

## The UK Presidency, health and mental health

Health and inequality issues have featured strongly during the UK’s Presidency, and will continue to do so. I had the honour of addressing a recent European conference on Health Inequalities at Westminster and it is right, in this associated event, that we now give prominence to mental health as a key component and determinant of the health and well-being of our countries and of citizens across Europe.

Indeed, we see an unprecedented interest in and commitment to mental health across Europe. First, with the WHO European Ministerial Conference on Mental Health in Helsinki and the signing of the Mental Health Declaration and Action Plan for Europe and second, with the launch last month of the European Commission’s Green Paper on Mental Health.

We need to build on these important developments for Europe and today we can do that by concentrating in detail on the issue of Mental Health Inequalities. This is a vital area for European collaboration, sharing, learning and action, and I am confident that this event provides a good opportunity for exploring the issues and challenges in more depth, and for developing stronger European networks and collaborations.

The conference programme looks at inequality issues head on. We will hear about the *causes and consequences* of mental health inequalities, about the *resource and service inequalities* that exist across Europe and about the *contribution and commitment* that Governments can make. These presentations help stimulate discussions and debate and give an opportunity to consider the actions each of us needs to take, and what we can do together. First I would like to share with you some of the ways that we in Scotland are trying to tackle mental health inequalities in our country.

## Work in Scotland

Responsibility for tackling health and mental health issues in Scotland lies primarily not with the UK government, but Scottish Ministers accountable to a Scottish Parliament. Scotland, while an integral part of the United Kingdom, has always retained distinct legal and administrative structures, and there has been devolved management of the National Health Service in Scotland from the beginnings of the NHS. Devolution of political responsibility and policy making came with the establishment of a Scottish Parliament in 1999.

Our approach as a small country is to build an integrated approach to address health inequalities, both geographic and within specific social groups, as part of what we are trying to achieve in addressing social inequalities. It is our firm belief that addressing social inequalities is the key to tackling health and mental health inequalities, social exclusion, discrimination, social isolation, and risks for suicide; it is also key to helping to achieve a more just and fair society, with better health and mental health, and a country which takes positive action to achieve greater inclusion, restore hope, and build confidence for the future.

## Health and mental health inequalities in Scotland

As things currently stand, those living in the most affluent areas of Scotland can expect to live more than a decade longer than those living in our most deprived communities. Suicide rates are twice as high in our more deprived communities, and men and women with low incomes are twice as likely to develop a mental illness as those on average incomes.

The children of families from the lowest socioeconomic groups are three times more likely to have a mental health problem than those in the highest socioeconomic group. These are gaps in life expectancy, in risk of suicide, and in the likelihood of mental ill-health which arise directly from social and economic advantage and disadvantage.

We are determined to tackle these inequali-

---

Lewis Macdonald is Deputy Minister for Health and Community Care, Scottish Executive, Scotland, UK. More information on the Scottish Executive’s approach to mental health can be found at [www.wellscotland.info](http://www.wellscotland.info)

*“Each of our 32 Local Authority areas now has a suicide prevention action plan”*

ties, to close the opportunity gap and enable the poorest in our society to enjoy positive mental health and well-being on a par with the richest; and, where there are indicators by which we can measure mental health and mental ill-health inequalities we have set targets to reduce those by 15%. (This includes suicides in young people)

### **Health improvement and public health**

In our health improvement and public health work we have an integrated approach which covers physical, mental and social health and well-being and includes life stages, circumstances and opportunities such as employment and working life, education, housing and community regeneration. We also have a focus on the key health challenges in Scotland: coronary heart disease, cancer, suicide and mental illness.

We know that traditional health improvement and public health messages usually seem to have the greatest impact on the more affluent and socially advantaged, and the least impact on those who need them most. We need to step up our health and mental health improvement work to address these inequalities and ensure that as well as universal messages and delivery action we also target those at most risk of social, health and mental health inequalities.

And in that context, I would like to mention two key areas of action we are taking forward in Scotland. From March 2006, Scotland will have one of the most comprehensive sets of restrictions on smoking in public places anywhere in the world. We are convinced that the new arrangements will bring substantial public health benefits to Scotland, particularly in deprived communities, where smoking rates are highest, and where heavy smoking often goes hand-in-hand with mental ill-health.

On suicide prevention, we have a national strategy and action plan in place called ‘Choose Life’. Since its launch in 2002, we have developed an infrastructure of local and national action. Each of our 32 Local Authority areas now has a suicide prevention action plan, supported by new investment and backed up by a national implementation support team, and a national training strategy on suicide prevention training, with over 4,000 people now trained in suicide prevention.

We have also set specific targets for reducing the inequalities in rates of suicide across the Scottish population; and, whilst a single

suicide is one too many, I am pleased to report that the latest figures for suicide rates in Scotland show a reduction of nearly 10% compared with three years ago.

### **Mental health**

On mental health, in general, we are setting in place a comprehensive policy encompassing public mental health, promotion and prevention, improved care and treatment services with the prime objective of promoting and supporting recovery, backed up by modern legislation.

However, we also know that without improving the public’s understanding and awareness of mental health and mental illness and actively working to eliminate the stigma and discrimination that still exist around mental ill-health, we will not achieve all we can in breaking down mental health inequalities and improving the quality of life for those experiencing mental illness.

That is why, since 2002, we have supported the development and delivery of a national anti-stigma campaign in Scotland. The campaign is called ‘See Me’ and has been active nationally and locally in working to change public attitudes towards people with mental illness.

I am pleased to report that real improvements in public attitudes are already evident. One of the most impressive statistics from our bi-annual survey work of public attitudes is that in 2002, 32% of people surveyed thought that people with mental illnesses were often dangerous. By 2004 this figure had dropped to 15%: the number of people frightened by mental ill-health in others, reduced by over half.

This national and local anti-stigma campaigning work needs to be sustained over a long period of time to truly bring about the understanding and behavioural change we need to see. In our experience, this work also needs to be part of wider anti-discrimination actions.

### **Legislation**

The Scottish Parliament passed in 2003 the Mental Health (Care and Treatment) Act that came into force in October 2005. I am delighted that this Act has received recognition across Europe as leading the way in mental health legislation. The Act has built in safeguards to protect people’s rights. These include the right to independent advocacy, the right to make advance statements, the right to appeal against detention and the right to an individual care plan.

The Act also places a duty on Local Authorities and their agency partners to promote the well-being and social development of people with a mental illness and to support their rights to access arts, culture and recreational activities, to be able to take education and training opportunities, and to be able to gain and sustain employment. We see this section of the Act as a very effective driver for greater social inclusion, improved educational, training and employment opportunities for people experiencing mental illness. This is also a positive action for promoting and supporting people's recovery.

### Health care services

On health care in general, we recently published our strategy, 'Delivering for Health'. This lays out the steps we will take over the next few years to shift the focus of our National Health Service in Scotland from an emphasis on acute conditions, treated in hospital, to an emphasis on chronic conditions, cared for and treated in the community.

A significant part of that new emphasis will be about anticipatory care in disadvantaged communities, bringing healthcare out of hospitals to those who need it most. That shift in emphasis will have real benefits in identifying and addressing disadvantage and inequalities in health and mental health.

### Employment

Another key area in addressing inequalities in Scotland is employment. A job can make all the difference in lifting people out of poverty and disadvantage and in providing those with mental health problems with a wider array of opportunities in their lives.

With estimates of 72% as the rate of unemployment for people with mental health problems and approximately 45% of all incapacity benefit claimants in Scotland citing a mental illness as their main reason for being unable to work, there are some real gains to be made for people, their families and local communities if those individuals can be enabled and supported to enter the labour market.

Work is progressing on an Employability Framework for Scotland that will do much more to support people back to and staying in work. This framework includes people with mental health problems and combines employment support with health care support. We have also set up a Scottish Centre for Healthy Working Lives. A key part of the Centre's work is in improving mental

health in the workplace, and improving job retention for people who develop mental health problems whilst at work.

### Race and mental health

Part of the delivery agenda in health and mental health services is in improving their response to the needs of people from black and minority ethnic communities. With 2% of our population now made up of people from black and minority ethnic communities and our 'Fresh Talent' initiative to attract people to live and work in Scotland, this is an important issue for now and the future. We have recently undertaken a race equality assessment of services through our National Resource Centre for Ethnic Minority Health and the recommendations for action are being taken forward in partnership with local services, backed up by support from the Scottish Transcultural Mental Health Network, to help support the development of culturally appropriate and responsive services.

### The Equal Minds report

Race and ethnicity are among a number of 'equalities' groups which are examined in detail in a report 'Equal Minds' that has just been published (and available at [www.wellscotland.info](http://www.wellscotland.info)). It provides an overview of the policy and legislative context for mental health and inequalities in Scotland. It gives an extensive array of facts and figures, and evidence for policy and practice. This is an extremely useful and comprehensive report and resource document for us. I would like to thank the report's principal author Fiona Myers for her hard work and dedication. I would also like to commend the report to you, and I know it will raise a number of issues.

### In conclusion

As I have illustrated, we are committed to the goals of social justice in Scotland and to tackling health and mental health inequalities as one key part of what we are aiming to achieve in our work on addressing social inequalities. This also involves improving our health services, improving public health and public mental health, tackling the determinants of mental health and ill health, and improving the quality of life and social inclusion of people experiencing mental health problems and illnesses in Scotland. We are also hearing and learning about what is happening across Europe, in order to take important lessons back to Scotland, and for us to continue to play a role and help in improving mental health across Europe.

*“Work is progressing on an Employability Framework that will do much more to support people back to and staying in work”*

---

This article is based on a speech delivered to a UK Presidency Associated Event: Mental Health Inequalities in Europe: Government Action to Tackle Mental Health Inequalities held at the Radisson SAS Hotel, Stansted Airport, on 8 November 2005.

# Promoting mental health in Europe: a timely opportunity

*Eva Jané-Llopis  
and David McDaid*

*“the Green Paper  
stresses the need to  
translate existing  
political commitments  
into action”*

In Europe more people die from suicide than from traffic accidents, and one in four of all of us will suffer from a mental health problem at least once during our lives. That means on average, one member of each family. Four of the six leading causes of years lived with disability are due to mental health problems: depression, schizophrenia, bi-polar disorders and alcohol use disorders. Depression alone is the third leading cause of disability in Europe accounting for 6.1% of burden of disease.<sup>1</sup>

People with mental health problems are more likely to have physical health problems, and vice versa, for example those with cancer have up to a 30% increased risk of suffering from depression. There is a strong connection between poor mental health and social deprivation, as well as a greater risk of becoming homeless or coming into contact with the criminal justice system. The long-term impacts on the children of people with mental ill health can also be significant: they may suffer from neglect and are more likely to have problems at school, curtailing their long-term opportunities.

The economic impact of poor mental health is also substantial and impedes progress towards the achievement of the twin goals of economic growth and social inclusion set out in the EU's Lisbon process. Numerous studies indicate that the single most substantial contributor to the economic costs of mental health problems is lost productivity, far exceeding direct health and social care costs, typically accounting for between 60% and 80% of all estimated costs of poor mental health.<sup>2</sup>

But the case for investment in mental health is not only about reducing the substantial burden of mental disorders. It is also about realising the added value for per-

sonal, social and economic development of promoting and maintaining good mental health. “There is no health without mental health”, has been the rallying call of professionals, NGOs, and other key stakeholders for over 20 years but it is only now that mental health is finally on the political agenda

## **The WHO Declaration and Action Plan on Mental Health**

In Europe, a key milestone for mental health initiatives occurred just one year ago, when in January 2005, ministers of health and high level political representatives of the 52 Member States of the European Region of the World Health Organization met in Helsinki at the first ever WHO Ministerial Conference on Mental Health, “Facing Challenges Building Solutions”. At this conference, ministers signed the Mental Health Declaration for Europe<sup>3</sup> and endorsed a European Action Plan for Mental Health.<sup>4</sup> With the Declaration, mental health and mental well-being were acknowledged as being fundamental both to quality of life and also to the productivity of individuals, families, communities and nations.

As a support to the call for action, the WHO programme for prevention and promotion, in strong collaboration with the European Commission, is developing collaborative projects across the important areas of evidence development, programme implementation, policy support and capacity building for prevention and promotion in mental health. This is also to varying degrees being mirrored by efforts undertaken at the national level in many countries.

## **The European Commission Green Paper on Mental Health**

The European Commission (EC) has long supported mental health development through its public health programmes. It also was a strong collaborative partner in the WHO Ministerial Conference on Mental Health, and is currently active in supporting the implementation of the proposed action. In this scope the EC

---

Eva Jané-Llopis is responsible for the programme for Mental Health Promotion and Mental Disorder Prevention, Mental Health Programme, World Health Organization, Regional Office for Europe, Copenhagen.

David McDaid is Research Fellow LSE Health and Social Care and European Observatory on Health Systems and Policies, London School of Economics and Political Science

Correspondence: [EJA@who.dk](mailto:EJA@who.dk)



launched in October 2005 a Green Paper on Mental Health,<sup>5</sup> outlining a framework for cooperation between Member States, aiming to help increase the coherence of actions in the health and non-health policy sectors both within Member States and at Community level, and also stimulating the involvement of a broad range of relevant stakeholders into the process of building solutions.

The Green Paper emphasises the consequences of poor mental health, stressing again for example, that mental ill health has conservatively been estimated to be at least equivalent to a loss of 3–4% of the EU's Gross National Product, whereas good mental health can impact positively on solidarity, prosperity and social justice. In an attempt to propose potential solutions for consideration, the Green Paper stresses the need to translate existing political commitments into action. It underlines that projects under the EU's Public Health Programmes have shown that action to promote mental health, to address mental ill health through preventive action, and to protect the rights and the dignity of both people with mental health problems and those with learning disabilities are possible; more so they can be successful and potentially cost-effective.

One recent report produced by the IMHPA (Implementing Mental Health Promotion Action) network focusing on mental health promotion and mental disorder prevention activities, provides a snapshot of initiatives across the EU.<sup>6</sup> While this particular study did not seek to provide a comprehensive mapping of the situation in Europe, it has highlighted policy developments, challenges and areas for future development. One of these challenges remains the need for greater intelligence not only on what is effective but on how this may be implemented. The pace of implementation will also be dependent in part on available infrastructures, both in terms of personnel and capital resources within countries. This report also flags up some potential possibilities for capacity development but local context is important, for instance, policy makers might wish to consider whether the use of specialist prevention and promotion workers in the field of mental health that can be found in the Netherlands may be a viable option elsewhere.

It is clear therefore that there is a need for a comparable system of information sharing across the EU. One of the final steps proposed in the Green Paper is to develop

an interface between research and policy stakeholders and the creation of a European Platform for Mental Health that would have the involvement of key stakeholders in the field of mental health and the related public policy arenas.

### **The consultation process on the Green Paper: we are all involved**

In October 2005, the EC formerly launched a consultation process on this Green Paper to stimulate a debate between the European institutions, governments, health professionals, stakeholders in other sectors, civil society, and the research community about the relevance of mental health for the European Union (EU), the need for a mental health strategy at EU-level, and its possible priorities. All relevant and interested parties and stakeholders have been called to contribute, engage in the consultation process and provide comments on the Green Paper.\* The consultation closes in May 2006. In addition, to ensure feedback during the consultation process, and taking a lead from proposals in the Green Paper, the Commission has indeed started to develop mechanisms for both a research/policy interface and European platform.

### **Towards an EU strategy for mental health**

During late 2006, the EC intends to present its analysis of the consultation process and a proposal for an EU strategy on mental health. The expectations of those who have long championed mental health are undoubtedly high. If the emergent outcomes do indeed encourage the development of a comprehensive EU strategy, the subsequent steps to be taken after launch will be even more important. The EU strategy per se may not be binding for governments but their commitment and the support from key stakeholders and the scientific and practice communities in the field will be crucial to foster much needed support for the implementation process. That is why this process of open consultation providing an opportunity to involve all stakeholders and organisations in the field, from civil society to international agencies, is essential and welcome in this important initiative. Dialogue with stakeholders cannot of course be confined simply to the current consultation process, continuing opportunities for discussion and input on the way forward will aid in taking truly significant and sustainable steps towards the promotion of mental health in Europe.

---

#### REFERENCES

1. Ustun T B, Ayuso-Mateos J L, Chatterji P, et al. Global burden of depressive disorders in the year 2000. *British Journal of Psychiatry* 2004;184:386–92.
2. McDaid D, Curran C, Knapp M. Promoting mental well-being in the workplace: a European policy perspective. *International Review of Psychiatry* 2005;17(5):365–73.
3. World Health Organization. *Mental Health Declaration for Europe. Facing the Challenges, Building Solutions*. Copenhagen: World Health Organization, 2005.
4. World Health Organization. *Mental Health Action Plan for Europe. Facing the Challenges, Building Solutions*. Copenhagen: World Health Organization, 2005.
5. Commission of the European Communities. *Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union*. Green Paper. Brussels: Health and Consumer Protection Directorate, European Commission, 2005.
6. E Jane-Llopis and P Anderson (eds). *Mental Health Promotion and Mental Disorder Prevention Across European Member States: A Collection of Country Stories*. Luxembourg: European Communities, 2006.

---

\* To take part in the consultation process see: [http://europa.eu.int/comm/health/ph\\_determinants/life\\_style/mental/green\\_paper/consultation\\_en.htm](http://europa.eu.int/comm/health/ph_determinants/life_style/mental/green_paper/consultation_en.htm)

# The EU Mental Health Platform

*Clive Needle*

*“The Platform welcomes relevant contributions from all interested parties”*

The EU now has more platforms than the central station in Brussels. So how does the inauguration of a newcomer addressing mental health offer extra value?

## **Purpose**

The mental health platform is an artificial rather than organic body, created by the European Commission to contribute to the current consultation on the Green Paper launched in October 2005 in response to growing calls for an EU mental health strategy to be brought forward.

That it has taken until the fiftieth year of European political and economic collaboration to do this is cause enough for shame given the welter of regulations political leaders have found time for, some of them arguably contributing to the burden of mental disorders and linked economic costs that are outlined in the Green Paper. So credit is due to those making it happen now.

I include myself in that criticism, incidentally: I did not give sufficient emphasis to mental health in my 1999 parliamentary report on public health strategies. Now champions such as parliament’s current Green Paper Rapporteur John Bowis MEP are helping to make up for lost time, and having been asked to chair the platform I hope to ensure its impact is considerable and complementary.

## **Participants**

The twenty core member bodies are drawn from interested stakeholders who participated in consultative steps leading to the Green Paper or related strategies. Why should they have a say when national health policies have hitherto been regarded as paramount? Because if the scale of the need is to be tackled, it will not be by top-down imposition but by all relevant sectors and actors working in new partnerships.

Crucially members represent not only leading mental health non governmental organisations such as Mental Health Europe, but also wider public health groups and others from education, employment, industry, and economic, social and cultural perspectives.

This reflects the fundamental need for the outcomes to have widespread support and ownership. The direct competences of the EU to act in support of the ministerial Helsinki commitments are limited, but the wider consequences are significant.

Therefore the core platform will not only consider evidence from the three thematic meetings and early public inputs to the overall consultation, but welcomes relevant contributions from all interested parties. An informal consultation meeting in Brussels in March will provide wider opportunities, and while the remit is finite to produce a report and recommendations by 31 May there is already support for a sustainable, enlarged platform to be considered to help take the strategy forward.

Be that as it may, the partnership approach certainly extends to the other groups of experts and member state authorities, with whom platform members engage in useful plenary debates and liaison. We have determined already that implementation is what matters, so wish lists should be avoided in favour of achievable priorities; assessment of short and long-term goals; realistic calls on capacity and resources; and integration with other EU policy objectives.

## **Priorities**

The Commission has defined the parameters of the consultation in the Green Paper. We test every submission against the three key questions:

1. How relevant is the mental health of the population for the EU’s strategic policy objectives?
2. How would the development of a comprehensive EU strategy on mental health add value to the existing and envisaged actions and does the Green paper propose adequate priorities?
3. Are the initiatives proposed appropriate to support the coordination between member states, to promote the integration of mental health into health and non-health policies and stakeholder action, and to better liaise research and policy on mental health aspects?

To complete the matrix, the given thematic approaches around promotion and prevention; rights and social context; information

---

Clive Needle is Director of EuroHealthNet and Chair of the EU Mental Health Platform.

and data will clearly frame our detailed responses. But while we are working in a disciplined way to provide specific stakeholder perspectives on all that, the platform added value is also to include broader considerations in the context of mental health.

For example, the overarching theme for the next period at EU level is economic growth, exemplified in the Lisbon strategy. The Green Paper estimates that 3-4% of GDP in economic cost alone is attributable to mental ill health; there are also substantial social consequences. Consider the impact of such conditions across young people, a third of working age adults and their families as set out in the accompanying statistics, and clearly the core priority of the whole EU project needs mental health improvement if it is to succeed.

So while the internal market implications are unspecified in the Green Paper, we will welcome views on that, including the cultural impact of multinational media on stigma, discrimination and mental well being. There may be more examples: within our capacity we will attempt to draw on any sound evidence for how the EU might provide additional value to what is being achieved by other actors.

## Progress

Already concepts are being developed: we unanimously feel the EC does and should have a strategic and active role; we prefer work in “settings” rather than stark identification of “vulnerable groups”; education, training and capacity building will be vital; a proactive public health approach is favoured. However the debate is very much open and will not conclude until May on these and the many other sensitive issues that demand careful and responsible consideration.

Already the difficult-to-quantify value of learning from other viewpoints is bringing dividends. In welcoming views to be swiftly channelled to the official address in the Green Paper and also, if you wish, to my colleague, Kasia Jurczak, who is the Platform Rapporteur at [k.jurczak@eurohealthnet.org](mailto:k.jurczak@eurohealthnet.org), I urge responses to help us to maintain the cooperative, constructive approach that has been a hallmark so far.

Whatever shape the European mental health train is in when it leaves this Platform, the passengers are determined its carriage will be as express as possible, but that it will reach its destination as an integrated, interoperable and integral part of the EU strategic network.

## New Journal Launched - Health Economics, Policy and Law



Cambridge University Press have launched a new journal, Health Economics, Policy and Law (HEPL). The first issue is now available freely online at [http://journals.cambridge.org/jid\\_HEP](http://journals.cambridge.org/jid_HEP)

International trends highlight the confluence of economics, politics and legal considerations in the health policy process. Health Economics, Policy and Law serves as a forum for scholarship on health policy issues from these perspectives, and is of use to academics, policy makers and health care managers and professionals.

HEPL is international in scope, and publishes both theoretical and applied work. Considerable emphasis is placed on rigorous conceptual development and analysis, and on the presentation of empirical evidence that is relevant to the policy process.

The definition of health policy is broad, and includes factors that affect health but that transcend health care, and factors that only indirectly affect health, such as legal and economic considerations in medical research. Articles on social care issues are also considered.

The most important output of HEPL are original research articles, although readers are also encouraged to propose subjects for editorials, review articles and debate essays.

HEPL invites high quality contributions in health economics, political science and/or law, within its general aims and scope. The recommended text-length of articles is 6–8,000 words for original research articles, 2,000 words for guest editorials, 5,000 words for review articles, and 3,000 words for debate essays.

All articles should be written in English, and should follow the instructions for contributors, which can be found at: [www.cambridge.org/journals/hepl/ifc](http://www.cambridge.org/journals/hepl/ifc)

All contributions and general correspondence should be sent to:

Anna Maresso, Managing Editor  
LSE Health and Social Care  
London School of Economics and  
Political Science  
Houghton Street  
London WC2A 2AE  
UK

Email [hepl@lse.ac.uk](mailto:hepl@lse.ac.uk)

# Enhancing the policy relevance of mental health related research in Europe

*Kristian Wahlbeck  
and David McDaid*

*“it is perhaps remarkable that mental health policy and practice in many European countries remains far from evidence-based”*

Policy makers increasingly talk about the need for ‘evidence-based policy’. They require rapid and concise information on potential policy options. It is thus important not only to understand whether or not something works, but also what resources this will require and what positive, as well as adverse, wider consequences it may entail.

The demands for an evidence based approach within the health sector seem particularly strong. Much has been made for instance of the work of the Cochrane Collaboration in systematically synthesising robust evidence on the effectiveness of interventions, while Cochrane’s sister organisation, the Campbell Collaboration, has begun synthesising evidence on the effectiveness of interventions in the education, social welfare and criminal justice fields. In all countries we now hear much discussion of the need for interventions not only to be proven as effective but also cost effective. Indeed, strict cost effectiveness hurdles governing both access to and reimbursement of new drugs and technologies have been introduced in a number of countries across Europe and elsewhere.

For instance, much evidence points toward the superiority of balanced mental health services, relying predominantly on a variety of community-based mental health support, backed up by specialist inpatient care.<sup>1</sup> Moreover evidence on economic impact suggests that not only does a greater reliance on community based services have a positive impact on quality of life but often this is cost neutral not leading to an increase in costs to the health care system.

## **Towards evidence based mental health policy**

Yet despite all of this substantial investment in developing an infrastructure to

produce evidence based information to inform the health policy making process, it is perhaps remarkable that mental health policy and practice in many European countries remains far from evidence-based. While it is true that substantial progress has been made in making the mental health system more community orientated in many countries, this process has often been too slow, in some cases being achieved over several decades, while in other countries, most notably in central and eastern Europe, large psychiatric asylums continue to form the backbone of the mental health care system and consume most of the resources allocated to the mental health sector.<sup>2</sup>

What still of public mental health and the promotion of mental well-being, areas that in comparison to treatment remain the Cinderella sectors of the mental health system? Here as well recent research has also indicated that a number of promotion and prevention approaches for mental health are highly effective,<sup>3</sup> but again few countries systematically employ these strategies to improve their population’s mental health. If major improvements may be achievable through rather inexpensive interventions, this is likely to be preferable to incurring substantial and long term costs arising from mental health disorders. This is to say nothing of the benefits of avoiding the stigma and discrimination often associated with poor mental health.

So we actually know quite a lot, not only about drugs and psycho-social therapies, but also about approaches to the prevention of mental health disorders and the promotion of mental well-being. Does this then mean that the apparent lack of investment and a more evidence-based approach on mental health in a number of European countries is simply due to policy makers ignoring what is becoming an ever more compelling case for investment in mental health?

Of course the situation is far more complex than this – too often researchers and others stakeholders are failing connect with the policy making community to get across

---

Kristian Wahlbeck is Research Professor, Mental Health Group, STAKES, Helsinki, Finland. David McDaid is Research Fellow LSE Health and Social Care and European Observatory on Health Systems and Policies, London School of Economics and Political Science.

Correspondence: [Kristian.Wahlbeck@stakes.fi](mailto:Kristian.Wahlbeck@stakes.fi)



their messages on the potential benefits of greater investment in mental health. Reports are often very long, highly technical and not focused on policy. Moreover researchers may not be prepared (or have the right incentives) to participate in the necessary long term iterative dialogue required to genuinely have an opportunity to influence policy and practice.

### Plugging the gap

This gap between what we know about mental health and current policies has been highlighted by the European Commission's Green Paper on Mental Health currently out for consultation.<sup>4</sup> The paper points to a need not only to improve still further our knowledge base on mental health in the EU, but also recognises that there is a need for improved monitoring of mental health and effective dissemination of information not only on what works, but in what settings and at what cost.

The Green Paper underlines that mental health is poorly covered by existing health monitoring systems. This is also recognised by the WHO European Region Member States who have already committed themselves "to develop surveillance of positive mental well-being and mental health problems, including risk factors and help-seeking behaviour" at the Helsinki WHO European Ministerial Conference on Mental Health in January 2005.<sup>5</sup> The Helsinki Action Plan outlined the following tasks:

- Internationally standardised, comparable indicators and data collection systems.
- Periodic population-based mental health surveys.
- Measurement of base rates of incidence and prevalence of key conditions, including risk factors.
- Development of an integrated set of databases on mental health policies, strategies, implementation and delivery of evidence-based promotion and prevention.
- Dissemination of information on the impact of good policy and practice nationally and internationally.

### Interface between research and policy

As one element of the ongoing consultation process on the Green Paper, the Commission services have called upon a group of researchers, policy makers and other stakeholders to form an interface

between the mental health policy and research communities. The aim of this interface is to stimulate a dialogue around mental health information, including both population mental health surveillance and the exchange of information on evidence-based best practice in mental health. It is also importantly considering such fundamental issues as how to ensure that policy makers seek responses to questions that can be answered, or that researchers do indeed produce findings that take account of the everyday context and challenges that policy makers face.

This interface group will debate these issues during three thematic meetings organised as part of the Green Paper consultation process. Contributions can also be provided via the SINAPSE (Scientific Information for Policy Support in Europe) web site. The interface will also explore the need for more sustainable infrastructures for any mental health information and knowledge system. For instance what added value might there be, if any, in the creation of a European Observatory on Mental Health or a European Clearinghouse for Best Practice in Mental Health?

At the end of the consultation process a collated report will be produced including recommendations on research priorities as well as suggested actions to bridge the gap between research and policy and thus enhance policy relevance. It may also consider the infrastructure required to support any enhanced information systems. These outputs will then have an opportunity to be considered by the Commission in the preparation of a future European mental health strategy emerging after the consultation process.

The European Commission faces the challenge of developing a mental health information and knowledge system, both for the surveillance of population mental health and for the exchange of information on best practices in the field of mental health. The work can build on several successful mental health information projects, co-funded by the European Commission. However such information will ultimately be of little value, and indeed perhaps is a waste of scarce resources if it does not have an opportunity to influence both policy and practice. The Green Paper consultation process thus provides a timely opportunity to devise a long term strategy to indeed facilitate the greater use of robust evidence on what works in the policy making process.

### REFERENCES

1. Thornicroft G, Tansella M. *What Are the Arguments for Community Based Mental Health Care?* Copenhagen: World Health Organization, Health Evidence Network, August 2003. Available at [www.who.dk/document/E82976.pdf](http://www.who.dk/document/E82976.pdf)
2. Thornicroft G, McDavid D. *Policy Brief: Balancing Institutional and Community-based Mental Health Care.* Copenhagen: European Observatory on Health Systems and Policies, 2005
3. Doughty C. The effectiveness of mental health promotion, prevention and early intervention in children, adolescents and adults. *NZHTA Report* 2005;8(2).
4. Commission of the European Communities. Green Paper. *Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Union.* Luxembourg: Commission of the European Communities, 2005.
5. World Health Organization. *Mental Health Declaration for Europe. Facing the Challenges, Building Solutions.* Copenhagen: World Health Organization, 2005.

*Focal points for contact with the "Interface between mental health research and policy" are:*

*Interface Leader: Professor Kristian Wahlbeck, e-mail: [kristian.wahlbeck@stakes.fi](mailto:kristian.wahlbeck@stakes.fi)*

*Interface Rapporteur: Dr Jordi Alonso, e-mail: [Jalonso@imim.es](mailto:Jalonso@imim.es)*

# A long life – and all of it healthy: the ideal of healthy ageing in Europe

*Rodney Elgie,  
June Crown and  
Michael Tremblay*

## Introduction

The population of Europe is ageing:<sup>1</sup> this situation presents one of the great public health challenges of certainly the first half of the 21st century. In 1960 there were around 34 million people over 65 years living in the pre-expansion European Union (EU) 15 countries. By 2001, that figure had nearly doubled to 62 million, with projected increases of a further 25 million between 2010 and 2030.<sup>2</sup> In 2000, 16% of the population was over 65 years, a level expected to reach 22% by 2025 and 27.5% by 2050.<sup>3</sup> In some European countries, the situation is even more striking, with growth in the population aged over 65 expected to be over 30% over the next 15 years in Ireland, Luxembourg, the Netherlands and Finland.<sup>3</sup> The situation is similar for the very elderly, with a projected increase of 44% in the number of people over 80 years old between 2010 and 2030.<sup>2</sup> In Germany and Italy, the European countries with the oldest populations, an estimated 33.2% and 34% respectively of citizens are expected to be over 60 years by 2025.<sup>4</sup>

Properly analysed, this trend towards increased longevity should be regarded as a cause for celebration, and partially reflects the improvements in sanitation, nutrition and medical technology that have led to significant reductions in infant mortality throughout the last century. Other factors, such as better education, improved medical, surgical and diagnostic techniques, greater health and safety at work, social advances and economic growth have increased life expectancy to 78 years in pre-expansion EU 15 countries.<sup>2</sup> Any problems and challenges associated with this ageing popula-

tion stem not from an increase in life expectancy per se, but rather from an increase in the ratio of older to younger people. Birth rates in many parts of Europe are now well below replacement levels, with a trough of under four million births in 1999,<sup>2</sup> increasing the upward pressure on average ages. The most recent fertility data, from 2001, shows a European average of 1.47 births per woman, with the rate declining fastest in countries such as Greece, Spain, Ireland and Portugal, where the birth rate has historically been high.<sup>2</sup>

All of these factors have contributed to Europe's demographic change; the consequences of which are impossible to determine, but will be influenced by current and future public health policy, and by an ever-changing external environment. For example, migration and changes in attitude to working and retirement may mitigate much of what can be presented as a potential social and economic imbalance between young and old (the 'ageing time-bomb'). At the same time, smaller and less stable family structures, the migration of the young to cities, and increased employment among women may reduce the willingness and capacity of family networks to provide informal care for older people, transferring responsibility, and cost, to the formal state health care system.<sup>3</sup>

In the UK, for example, dramatic reductions in the availability of informal care throughout the last century can be partially explained by comparison of the 1911 National Census with that of 1991. In 1911, 90% of the population lived within a 15 mile radius of where they were born. However, the resulting close-family networks, which often crossed three generations and were a basis for mutual support within the family circle, had all but disappeared by 1991 when only 10% of the population lived close to where they were born. The reduction in informal care is likely to be compounded by a reduction in formal care, as increased competition within the labour market reduces the attractions of care work, with its unsocial hours and low pay.

---

Rodney Elgie is President of The European Patients' Forum, Bruxelles, Belgium, Vice President of The European Men's Health Forum, Bruxelles, Belgium & Immediate past President of GAMIAN-Europe (Global Alliance of Mental Illness Advocacy Networks).

June Crown is Vice President, Age Concern England.

Mike Tremblay is Partner, Tremblay Consulting, Kent, UK.

Correspondence to Rodney Elgie, Riverside Business Centre, River Lawn Road, Tonbridge, Kent TN9 1EP, UK; Telephone & Fax no: ++ 44 (0) 1732 367 926; E-mail: [rodneyselgie@supanet.com](mailto:rodneyselgie@supanet.com)

The aim of this paper is to explore Europe's response to its ageing population; in particular, to draw attention to the large differences in health outcomes that currently exist between countries, and to speculate on their causes. These differences in health outcomes are exaggerated in older people, suggesting that the EU is not tackling the problem of chronic disease in a comprehensive and coordinated way, and therefore needs to rise further to the challenge of its ageing population. Finally, some possible mechanisms by which standardised care can be offered across Europe are explored.

### **How has the ageing population impacted European public health?**

One consequence of Europe's ageing population is a marked increase in chronic diseases linked to older age, including cardiovascular disease, stroke, hypertension, diabetes, cancer, chronic obstructive pulmonary disease and other respiratory diseases, mental health conditions including depression and dementia, and musculoskeletal conditions such as arthritis and osteoporosis. Chronic diseases are already the largest cause of death in Europeans.<sup>1</sup> Cancer, for example, kills about 800,000 EU-15 citizens a year, and is the main cause of death in people aged 40–69 years.<sup>2</sup> Respiratory diseases kill around 300,000 a year, although this is predicted to rise in older people as the long-term effects of smoking emerge.<sup>2</sup> The biggest killer of Europeans, however, is cardiovascular disease and related conditions such as stroke. Around 1.5 million deaths per year in the EU-15 are caused by heart disease or strokes; 42% of the total number of deaths.<sup>2</sup>

Anxieties associated with the ageing population tend to centre on the burden of chronic diseases towards the end of life. The vision that exercises some commentators is that of a mass of older, ill people surviving on tiny pensions, whilst plunging health care systems into penury with constant demands on resources, all supported by a diminishing pool of economically active younger people. However, this scenario will only occur if disease and disability increase at a faster rate than longevity. Despite a strong relationship between age and chronic disease, extensions to life expectancy do not necessarily result in more years of ill health. In a second possible scenario, increases in longevity and those in morbidity and disability are balanced, resulting in something like the status quo – people live longer, but with the same

number of years of ill-health as before. A third scenario is that people live a longer active life, but have less ill health and disability in their later years. In this 'compressed morbidity' scenario, illness and disability follow a long healthy life and are squeezed into a short period before death.<sup>5</sup> In other words, life expectancy would continue to climb, but the total amount of time spent in ill health would fall, yielding a total increase in the number of healthy years lived.

Emerging epidemiological evidence suggests that populations in developed countries often resemble the second or third scenarios. Research in the United States (US) has shown that individuals who are healthy at 70 years have total medical expenses until death of no more than for those in poor health at 70 years – despite the fact that the first group are more likely to live for longer.<sup>6</sup> Put simply, the onset of poor health in the years prior to death appears to be cost-constant, regardless of longevity. Therefore, encouraging health promotion and disease prevention does not appear to increase the health cost burden of the elderly, and nor will doing nothing decrease that cost.

There is further evidence to suggest that older people are not just maintaining their independence, but increasing it, as posited by the third scenario of an ageing population. For example, the proportion of years in which UK women over the age of 85 live independently rose from 64% to 79%, and from 69% to 80% for UK men, from 1980 to 1991. Although the proportion of people in this age group living in institutions rose throughout the 1980s, the increase is not sufficient to account for all of this improvement.<sup>7</sup> In the US, there does appear to be a true compression of morbidity. Physical disability or other morbidity is falling by 2% a year compared to a 1% fall in mortality in the US, and the onset of disability is being postponed by 7–12 years – longer than the increase in longevity.<sup>8,9</sup> Longitudinal studies in the US have also suggested that the prevalence of disability has reduced at all ages, and that the trend is continuing.<sup>10</sup> Based on these and other trends, US analysts have estimated that a decline in disability could lower medical spending by as much as 20% over the next 50 years.<sup>11</sup> Such reduced levels of disability allow people to spend a longer time living healthily, and less time battling physical decline and morbidity in the latter stages of life.

Most ill health and consequent use of

*“Increased longevity should be a cause for celebration”*

*“encouraging health promotion and disease prevention does not appear to increase the health cost burden of the elderly”*

health services occurs in the last few years of life; particularly the last year, whatever the age at death. In one Cambridge University study there was little difference in total time spent as hospital inpatients between those who died in their 70s and those who died in their 90s;<sup>12</sup> the use of resource intensive secondary care does not increase disproportionately with age. In another study men aged 90–94 years at death spent 26 days as an inpatient in their lifetime compared to 11 days for men aged 45–59 at death. Women who died at age 90–94 had spent 32 days in hospital in their lifetime compared to 18 days if they died at 45–59.<sup>12</sup> For men and women, the number of days spent in hospital per year of life was similar if death occurred at a relatively young or relatively old age.

It seems clear that old age need not necessarily be associated with a high burden of disease and accompanying high health care costs, and that health care systems that properly cater for older people are effective at reducing disability and dependence. Europe’s health outcomes, however, suggest that European health systems do not cater equally for the health problems of the ageing population. An examination of the burden of ill health at a national level demonstrates that there are large between-country differences in the effects of chronic diseases, which suggests that European countries are not responding in a consistent manner to the continent’s ageing population; in particular, the data show large discrepancies in Life Expectancy (LE). Across the pre-expansion EU-15 countries, average LE is around 78.2 years, with a high of 82.3 years in Spain compared to 77.6 years in the UK.<sup>4</sup> Among the countries that have recently joined the EU, LE is generally much lower: in Poland it is 73.1 years, 74.8 years in the Czech Republic and just 70.65<sup>4</sup> in Hungary, nearly 12 years less than Spain.

### **Healthy Life Expectancy across Europe**

Using a well defined and consistent measure of LE allows relevant comparisons to be drawn and reveals where actions should be taken. Life Expectancy is such a useful measure of health in a population, but by subtracting from total LE the average number of years a person in a given country will spend throughout their lives in ill health, it is possible to arrive at another useful measure of health for comparing populations – Healthy Life Expectancy (HALE). HALE is most easily understood as the number of years a newborn can

expect to live in good health, based on the current local rates of ill-health and mortality, and therefore has the advantage of measuring what is important – not just the raw years of extra life, but measure of the quality of those years. Just as with LE, HALE differs substantially from country to country. Italy has the highest HALE figure in Europe, at 71.20 years compared to a LE of 79.12 years. In Hungary, HALE is more than 11 years lower than in Italy, at 59.90 years.<sup>4</sup> Citizens of the UK spend the fewest number of years in ill-health in Europe, with a difference between LE and HALE of 7.71 years. In Spain, however, the average person spends 11.67 years of their life in ill-health, despite Spain’s high LE, and across the EU-15 countries, the average person spends the best part of a decade of their life (8.37 years) in ill-health.

The startling differences in LE and HALE reflect health outcome differences between countries for many of the chronic diseases previously mentioned. The burden of cardiovascular disease, measured in terms of the Standardised Death Rate (SDR) per 100,000 of population, is far higher in Hungary (SDR 586.48) or the Czech Republic (SDR 495.75) than it is in France (SDR 178.17), Spain (SDR 228.90) or Italy (SDR 256.76). Germany and the UK lie roughly in the middle (SDR 316.90 and 285.97 respectively). Examining the data for respiratory diseases reveals further between-country differences, with the burden ranging from highs in Denmark (SDR 66.7) and Spain (SDR 60.8) to lows in Italy (SDR 35.9) and Sweden (SDR 36.2). Similar discrepancies are found across a wide spectrum of disease areas, and in particular the chronic diseases that affect older people.<sup>4</sup> The emerging picture is not one of coherence at the European level, and reflects national policy and practice differences. The expansion of the EU adds additional dimensions to an already complex situation.

### **Access to European health systems**

The large gap across Europe between LE and HALE is not the only evidence to suggest that the correct mix of factors required to deliver the ‘compressed morbidity’ model of ageing has not yet been found. As in the past, this mix is likely to include a focus on health promotion activities that are environmental (for example improved housing), social (an emphasis on social inclusion), economic (reducing poverty) and personal (lifestyle issues such as smoking, exercise and diet). In addition, the mix



will also include universal access to effective health care, in terms of screening and surveillance, disease management, prophylaxis, timely referral, effective treatment, adequate rehabilitation and up-to-date medical technology.

The positive effects of modern health care on older people can only be realised if older people have full access to such treatments. In some countries there are both formal and informal barriers to health care, and occasionally explicit rationing based on chronological age rather than clinical need.<sup>13,14</sup> Within the UK, for example, discrimination on the basis of age occurs in formal policies, informal and unwritten policies, and through behaviours and attitudes.<sup>13</sup> Examples include provision of psychiatric and stroke services only to those under-65, and more subtle indirect discrimination such as restricting palliative care to cancer patients, but not those with other terminal conditions like heart failure that largely affect older people.<sup>13</sup> Limited physical access to buildings and poor public transport are more likely to be a problem for older than younger people. In addition, older people may be less frequently referred for investigations and treatments than younger people, even in the absence of any clear clinical evidence to support such an approach.<sup>13</sup>

Other limits to access have occurred for new advances in treatment of conditions such as Alzheimer's Disease, where in some areas insufficient funding has been made available to meet demand for treatments recommended by evidence-based clinical guidelines.<sup>15</sup> Greater choice by individuals in how they access health care services would help to expose systemic discrimination against older people, and the problems associated with the proper channelling of resources to where they are most needed. The central planning of some health systems creates a mismatch between planned service levels and what the public would actually choose if they could, and demonstrates a structural failure of health systems in adapting to the needs of the populations they support.

Beliefs and attitudes within health systems also discriminate, by valuing older people less and by offering them fewer choices. These attitudes include assumptions that older people do not need to be fit and physically active because they are not in paid employment. There may be assumptions that all older people are confused, or that the views of those who are confused or have dementia may be ignored.

### A European standard?

The evidence presented in this article suggests that health care across Europe has scope for improvement. Despite this, the World Health Organization ratings show that some of the best health care systems in the world are found here in Europe. Indeed, France topped the rankings, which were based on a combination of the gross domestic product (GDP) spent per capita and the health outcomes achieved.<sup>16</sup> It would be comforting, therefore, to think that European health systems are capable of adjusting and responding to the changing demographic situation. However, the observed heterogeneity of health outcomes across countries points to a lack of engagement in the issue at a centralised European policy level. Undoubtedly, some of this variance is due to cultural factors; for example, comparatively low rates of cardiovascular disease in France are often attributed to the health properties of wine consumption – the so-called 'French Paradox',<sup>17</sup> and those countries with higher rates of respiratory disease correlate with countries afflicted by high rates of smoking.<sup>4</sup>

Cultural differences, however, are not the only factors behind Europe's heterogeneity of health outcomes. The resources allocated to health care (for both young and old) also play a part in determining health outcomes. European countries, although politically aligned to a certain degree by shared EU membership, have markedly different approaches to health provision and levels of access to health care resources. In spite of cost differentials, those countries with a lower GDP per capita, such as Portugal, Greece and many of the ten new EU members, inevitably need to spend a higher percentage of GDP on health care to rival the service offered by countries with higher GDP per capita, and this is not always economically possible.<sup>18</sup> These national differences in health provision and access to resources in turn lead to national differences in disease burden, health perceptions, and other measures of health such as LE and HALE.<sup>17</sup>

Despite the variance in spending levels, organisation and management, there is much good practice within Europe that could be more widely applied to maintain and improve the health of Europe's older citizens.<sup>16</sup> It is a fact that there is no basis in EU law for a united front on ageing or the management of chronic disease, and consequently health systems and outcomes are not held accountable to a European

*“healthy life expectancy differs substantially across countries”*

standard, although standardisation has occurred in other equally or less important areas, such as agriculture, fishing, environment and trade policy, or the distribution of EU subsidies.

### Conclusion

Europe's population is ageing, and will continue to do so.<sup>1</sup> It is wrong to think of the health challenges associated with this trend purely in terms of health care system performance. There are many other factors that determine an individual's health status, whatever their age, and any population health model must include these within its structure along with an understanding of the role that health systems play. However, there is a known association between age and the burden of chronic disease, and also the cost of that burden. Despite this association, evidence exists to show that if people age healthily, with the support of and access to satisfactory health care, the burden of chronic disease need not increase with increased longevity. In the UK, for example, deaths from cardiovascular disease have fallen by 23% between 1995/1997 and 2000/2002,<sup>19</sup> largely due to a commitment by physicians to adhere to guidelines regarding preventive treatments and assessment of cardiac risk.<sup>20</sup>

The Assessing Care of the Vulnerable Elders (ACOVE) project, which was designed to assess the quality of care offered to the over 65s, and to recommend how to improve that care, has suggested that one reason for apparent discrimination against older people may simply be ignorance among health professionals of the complicated health needs of the older population.<sup>21</sup> Evidence-based guidelines for physicians are often conceived from the trials of relatively young sample populations, and do not necessarily take into account other geriatric co-morbidities. The physician, if following the guidelines, may opt for treating the primary condition without necessarily taking into account the holistic needs of the older patient. ACOVE has proposed simple guidelines on common conditions specifically for older people, which represent a minimum standard of care.

The challenge for health care systems is to ensure that resources are used as effectively as possible to achieve good health outcomes. Evidence is accruing that older people largely benefit from the same medical, surgical and other interventions as younger people. What is needed is health care that is as accessible to older as younger patients,

and delivers age-neutral services. One suggestion has been that more of the health care of older people should be carried out by specialists such as cardiologists, neurologists and psychiatrists, drawing on the expertise of specialist geriatricians as necessary.<sup>22</sup>

An understanding is needed at European policy-maker level that older patients are to be valued as much as younger patients. Spending on health care, particularly preventive health care, for older people should be seen as an investment in longer-term health, delaying morbidity and disability, rather than as a cost burden of a group who have already used up an entitlement to health care.<sup>23</sup> Adopting a coherent approach to measuring life expectancy as we suggest will move European policy makers closer to understanding that older patients are as equally deserving of treatment and care as younger patients. Compatible with proposals that emerged under the Dutch Presidency of the EU, spending on health care is really an investment in longer-term health by delaying morbidity and disability. Older persons cannot be removed from this analysis as though they had already used up their entitlement, since HALE data show that older people will enjoy considerable years of post-retirement activity and hence will continue to be a source for health service investment to avoid the disability traditionally associated with the ageing process.

Crucially, this change in perspective must not just resonate across Europe, but be translated into action by policy makers and health system stakeholders. The ageing process is not the problem, but the responsiveness of health systems to how we change as we age – it is the health systems that must adapt and ensure that those who will need care the most are not excluded. We must be vigilant to ensure that this does not happen through design of discriminatory health systems, or through careless planning and design.

But as we have shown here, measurements across Europe suggest that despite the expenditure of vast resources on health services, and supportive social welfare programmes, variances exist and persist, despite high rankings on the World Health Organization ranking of health systems. Clearly expenditure and excellence in these areas are not translating into improved performance for older persons. One can only conclude that greater effort is needed to address the whole spectrum of determinants of improved well-being, which begin

*“there is much good practice within Europe that could be more widely applied”*

with ensuring appropriate and responsive health service support to older people. It is also a sober reminder that the health needs of older people will not be met just by focusing on the performance of the health service system, but will require policies and actions which address a wider mix of determinants.

In this way, appropriate and personal health services to meet the needs of populations as they age will ensure that we realise the European ideal of a long life – all of it healthy.

---

#### REFERENCES

1. World Health Organization. *Active Ageing: A Policy Framework*. Geneva: World Health Organization, 2002.
2. European Commission Directorate-General for Employment and Social Affairs. *The Social Situation in the European Union*. Brussels: Commission of the European Communities, 2003.
3. Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions. *The Future of Health Care and Care for the Elderly: Guaranteeing Accessibility, Quality and Financial Viability*. Brussels: Commission of the European Communities, 2001.
4. Pfizer Outcome Research Group. *The 'Ageing Population' Health Outcomes Report*, 2003.
5. Tallis R. Medical advances and the future of old age. In: Marinker M, (ed). *Controversies in Health Care Policies: Challenges to Practice*. London: British Medical Journal Publishing, 1994.
6. Lubitz J, Cai L, Kramarow E, Lentzner H. Health, life expectancy, and health care spending among the elderly. *New England Journal of Medicine* 2003;349(11):1048–55.
7. Grundy E M. Population Review: (5). The Population aged 60 and over. *Population Trends* 1996;84:14–20.
8. Fries JF. Measuring and monitoring success in compressing morbidity. *Annals of Internal Medicine* 2003;139(5 Pt 2):455–59.
9. Kirkwood TB. The most pressing problem of our age. *British Medical Journal* 2003; 326:1297–99.
10. Manton KG, Corder L, Stallard E. Chronic disability trends in elderly United States populations: 1982–1994. *Proc Natl Acad Sci* 1997;94(6):2593–98.
11. Cutler DM. Declining disability among the elderly. *Health Affairs* 2001;20(6):11–27.
12. Himsworth R L, Goldacre M J. Does time spent in hospital in the final 15 years of life increase with age at death? A population based study. *British Medical Journal* 1999;319:1338–39.
13. Levenson R. *Auditing Age Discrimination: A Practical Approach to Promoting Age Equality in Health and Social Care*. London: King's Fund, 2003.
14. Kmietowicz Z. Elderly women are being denied treatments for breast cancer. *British Medical Journal* 2003;327:1069.
15. Roberts E, Robinson J, Seymour L. *Old Habits Die Hard: Tackling Age Discrimination in Health and Social Care*. London: King's Fund, 2002.
16. World Health Organization. *The World Health Report 2000. Health Systems: Improving Performance*. Geneva: World Health Organization, 2000.
17. *Health For All Database*. Copenhagen: World Health Organization Regional Office for Europe.
18. Eurostat: the Statistical Office of the European Communities. *Health Statistics: Key Data on Health 2002*. Luxembourg: Office for Official Publications of the European Communities, 2002.
19. UK Department of Health. *The National Service Framework for Coronary Heart Disease: Winning the War on Heart Disease – Progress Report*. London: Department of Health, 2004.
20. European Society of Cardiology. *Euro Heart Survey*. 2003.
21. Westropp JC. ACOVE. New tools address unmet need in quality assessment for older patients. *Geriatrics* 2002;57(2):44–51.
22. European Commission Economic Policy Committee. *Budgetary Challenges Posed by Ageing Populations: The Impact on Public Spending on Pensions, Health and Long-term Care for the Elderly and Possible Indicators of the Long-term Sustainability of Public Finances*. EPC/ECFIN/655/01-EN final. Brussels: Economic Policy Committee, 2001.
23. Hall B. Immigration in the European Union: problem or solution? *OECD Observer* 2000; Summer No. 221/222.

“spending on health care is really an investment in longer-term health by delaying morbidity and disability”

---

#### ACKNOWLEDGMENTS

This paper has arisen as a result of discussions held at the launch of the Pfizer Health Outcomes report on *Europe's Ageing Population* (2003). Editorial support was provided by Toby Minton.

# Going smoke-free:

## *The medical case for clean air in the home, at work and in public places*

*Richard Edwards  
and Tim Coleman*



Numerous authoritative reports on passive smoking have concluded that environmental tobacco smoke (ETS) causes or exacerbates a range of important health conditions among adults and children.<sup>1-3</sup> There is broad consensus that protection from ETS exposure is an important public health concern. So why has the Tobacco Advisory Group of the Royal College of Physicians (RCP) published yet another report on passive smoking?

*Going Smoke-free: The Medical Case for Clean Air in the Home, at Work and in Public Places*<sup>4</sup> is the latest in a series of RCP reports addressing the biggest single cause of preventable death and ill-health in most developed and, increasingly, most developing countries.\* In 1962, the first report, *Smoking and Health*,<sup>5</sup> recommended government action to ensure wider restrictions on smoking in public places, a recommendation repeated subsequently.<sup>6,7</sup> For many years there was only limited progress within the UK, and most other countries, on this aspect of tobacco control. However, recently several US states such as New York and California, and countries including New Zealand, Norway, and Ireland, have introduced comprehensive legislation to make enclosed public places and workplaces smoke-free.

This new document does not simply cover the well-trodden ground of previous reports which largely outlined the health effects of ETS exposure. Instead *Going Smoke-free* provides a succinct and comprehensible summary of the evidence, arguments and issues concerning the introduction of smoke-free policies and legislation (i.e. banning smoking from all enclosed public places and workplaces).

The report is particularly timely for the UK where Scotland, and (probably) Wales, will soon introduce smoke-free legislation, whereas in England the situation is uncertain. The English public health White Paper, *Choosing Health*,<sup>8</sup> proposed a partial ban on smoking in public places, with exemptions for private members' clubs and pubs or bars which do not prepare and serve food.

The UK government recently completed a consultation exercise<sup>9</sup> on the *Choosing Health* proposals and subsequently decided to stick with its proposed partial ban, although it subsequently allowed Labour MPs a free vote in Parliament on whether to accept this proposal or alternative amendments including a complete ban. In February 2006 MPs endorsed a total ban in most public places and the bill now is being considered by the upper chamber of the Parliament, the House of Lords. The final decision therefore is still in the balance and continued informed advocacy in favour of comprehensive smoke-free legislation is crucial. However, since ETS exposure is a global problem and few countries have comprehensive smoke-free legislation, the issues outlined in *Going Smoke-free* are of wider relevance.

### **The problem of passive smoking**

Clear evidence that ETS exposure harms individual and public health is crucial to support the case for the introduction of smoke-free policies. The report describes the composition of ETS, how exposure is measured, and summarises the evidence for the many adverse health effects of ETS on adults, children and the unborn child. Evidence cited is strong, and although the increased risks from ETS exposure at an

---

Richard Edwards is Senior Lecturer in Epidemiology, Department of Public Health, Wellington School of Medicine and Health Sciences, University of Otago, Wellington, New Zealand.  
E-mail: [richard.edwards@otago.ac.nz](mailto:richard.edwards@otago.ac.nz)

Tim Coleman is Senior Lecturer in General Practice, School of Community Health Sciences, Queen's Medical Centre, Nottingham, UK.  
E-mail: [tim.coleman@nottingham.ac.uk](mailto:tim.coleman@nottingham.ac.uk)

---

\* This report was written by Richard Edwards and Tim Coleman and published by the Royal College of Physicians of London in July 2005. The Royal College of Physicians of London retains copyright. It is available for £16.00 (UK) £18.00 (overseas) ISBN 1 86016 246 0 Soft cover, 198 pages. To order your copy call 020 7935 1174 ext 358 or visit [www.rcplondon.ac.uk/pubs/brochures/pub\\_print\\_GSF.htm](http://www.rcplondon.ac.uk/pubs/brochures/pub_print_GSF.htm)



individual level are modest compared to active smoking, they are important in public health terms because of the ubiquity of exposure. Thus, ETS exposure is estimated to cause 12,200 deaths annually in the UK, including 500 from occupational exposures, with 50 in the hospitality industry alone. These are conservative estimates due to the assumptions of the model. Also, morbidity attributable to ETS exposure, which will undoubtedly be substantial, was not estimated.

The considerable burden of ill health attributable to ETS contrasts markedly with the far lower and often unsubstantiated risks which have been evident in many recent, well-publicised, but transient health scares. The clarity about the magnitude of harm caused by ETS documented in *Going Smoke-free*<sup>4</sup> contrasts sharply with the language used by the UK government in *Choosing Health*,<sup>8</sup> suggesting that strong advocacy is still required. For example, the latter states weakly that: “The evidence of risk to health from exposure to second-hand smoke points towards an excess number of deaths, although the debate on the precise scale of the impact continues”.<sup>8</sup>

### Solutions and non-solutions

The two main proposed solutions to the problem of ETS in public places and workplaces discussed are partial and comprehensive smoke-free policies. Whilst comprehensive smoke-free policies prevent smoking throughout enclosed workplaces and public places, partial policies seek to minimise harm from ETS by using designated smoke-free or smoking areas with or without additional atmospheric ventilation/filtration.

Evidence cited demonstrates that workers in the hospitality sector, particularly in bars, pubs and clubs, are the most heavily exposed occupational groups. Perversely these venues are often excluded wholly or partially from smoke-free policies, as was the case with the *Choosing Health* proposals. The report cites international evidence showing that smoke-free areas with or without additional ventilation offer, at best, limited improvements in air quality for workers in the hospitality trade and elsewhere. There is absolutely no evidence that these minimal changes in air quality will improve health outcomes and protect the health of exposed staff.

In contrast, there is unequivocal evidence that comprehensive smoke-free policies massively improve air quality, and there is some evidence of direct improvements in

workers’ health following their introduction. Therefore, proposals to introduce partial smoke-free measures (including the ‘smoke-free zones’ around the bar area proposed for pubs in England) will be wholly ineffective for protecting workers’ health. The case for excluding these workplaces from complete smoking bans is impossible to justify, particularly as hospitality workers are the most heavily ETS-exposed occupational group. *Going Smoke-free* illustrates that such proposed exemptions are illogical, unethical and unreasonable.

### Ethical and economic arguments

Not only do comprehensive smoke-free policies offer the greatest potential for health gain amongst the population, but there are strong ethical and economic arguments for their adoption.

*Choosing Health* describes the ethical issues as “hotly debated ... involving as (they do) a conflict between individual rights, and between rights and responsibilities in society”.<sup>8</sup> It argues, with little attempt at justification, that the partial smoke-free proposals represent the ‘right balance between freedoms and responsibilities’. The rigorous exploration of the ethical case for smoke-free policies in *Going Smoke-free*, however, clearly demonstrates that this view is impossible to sustain.

Ethically, the argument for comprehensive smoke-free policies is an almost wholly one-sided debate with the ethical balance being clearly tipped in favour of the individual rights of non-smokers. Put simply, non-smokers deserve protection from the harm caused by ETS released wittingly or unwittingly by smokers. These and a range of other ethical arguments presented in *Going Smoke-free* in favour of smoke-free legislation far outweigh the relatively minor restriction that such legislation imposes on smokers as to where, not whether, they can smoke.

The economic arguments presented for introducing comprehensive smoke-free policies are compelling. The report indicates that from the societal perspective, smoke-free legislation is highly cost-effective, providing substantial benefits to countries’ economies. These are estimated at £4,000 million per year in the UK.

However, arguments about the economic effects of smoke-free policies tend to focus on the hospitality sector. Experience from around the world is that in debates about the introduction of restrictions on smoking, the hospitality industry usually sides

*“Environmental tobacco smoke is estimated to cause 12,200 deaths annually in the UK”*

*“the overall economic effect of comprehensive smoke-free policies on the hospitality industry is broadly neutral”*

with the tobacco industry, aiming to prevent or delay smoke-free legislation, by arguing that implementation would be economically ruinous. The chapter on the potential economic impact of legislation dispels the myth that smoke-free policies would harm the hospitality industry. Hard economic data from many countries show that after adjustment for trends and other key factors, the overall effect of comprehensive smoke-free policies on the hospitality industry is broadly neutral or weakly positive. Judging by the following quote from a tobacco company marketing and sales director in 1994, the tobacco industry has long been aware of this:

*Economic arguments often used by the industry to scare off smoking ban activity were no longer working, if indeed they ever did. These arguments simply had no credibility with the public, which isn't surprising when you consider our dire predictions in the past rarely came true.*<sup>10</sup>

#### **Public opinion**

The remaining argument advanced in *Choosing Health* and subsequently by UK Government Ministers against comprehensive smoke-free legislation is that public opinion does not support legislation for all pubs and bars to be smoke-free. This is based on the findings from a single national survey.<sup>11</sup>

Politicians often seem to delight in ignoring manifest public opinion, generally with brazen declarations of the need to take ‘difficult’ or ‘unpopular’ decisions. Introducing comprehensive smoke-free legislation would demand just such political machismo, if public opinion were indeed strongly against it. The evidence suggests this is not the case.

*Going Smoke-free* reviews rigorously the evidence about public opinion on smoke-free areas. This reveals that public opinion is more complex than the simplistic analysis suggested by the UK government, and is not a substantial barrier to implementing comprehensive smoke-free policies. A review of a range of independent surveys and polls from the UK in the report demonstrates that there is overwhelming support for the principle of the right to work in a smoke-free environment. There is also majority support for legislation to make public places and workplaces smoke-free, and for smoke-free legislation for most specified public places and workplaces. The exception to the latter are bars, pubs and nightclubs, although there is majority support among non-smokers for

these venues to be smoke-free.

These somewhat contradictory findings suggest that pubs and bars are not always perceived as workplaces and that once this is explained support will increase further. This is supported by the finding that where smoke-free legislation has been introduced, public support increased steadily during the run up to implementation as the issues were debated, and increased further after its introduction.

#### **Smoke-free legislation and ETS exposure in homes**

The main source of ETS exposure in the UK, particularly for children, is in the home. The previous UK Health Minister claimed that making all pubs and bars smoke-free would increase smoking in the home and children's exposure to ETS.<sup>12</sup> *Going Smoke-free* demonstrates clearly that this assertion was based on belief not evidence, and that introducing smoke-free legislation is likely to reduce domestic ETS exposure.

The report firstly summarises the overwhelming evidence that smoke-free policies discourage people from starting smoking and encourage smokers to quit or cut down, thereby reducing smoking prevalence and tobacco consumption. This is an extremely welcome side-effect of such policies, though not as the report makes clear the mainstay of the ethical case for introducing smoke-free legislation. Reducing smoking prevalence and consumption should by itself reduce ETS exposure in the home. This is supported by evidence that declines in children's ETS exposure in the UK (as indicated by their cotinine levels) have mirrored declines in population smoking prevalence.

Furthermore, after restrictions on workplace and public place smoking were introduced in the USA, Australia and Ireland, the proportion of smoke-free homes among homes with one or more smokers increased. This suggests that introducing comprehensive smoke-free policies, often with supporting health education campaigns, resulted in smokers implementing their own voluntary, domestic smoke-free policies. Presumably the new legislation helped to change social norms, a possibility that was suggested in justifying the recommendations within the first RCP tobacco report.<sup>5</sup>

Tackling domestic ETS exposure raises complex issues of ethics and civil liberties. However, the evidence suggests that comprehensive smoke-free legislation is likely

to be an effective intervention to reduce ETS exposure in the home. This is an important finding given evidence that behaviour-change interventions to promote smoke-free homes have only a limited impact.<sup>13</sup>

### The tobacco industry

Finally, doctors who are unfamiliar with the strategies of the tobacco industry simply must read about the shoddy, self-interested tactics of this discredited industry in relation to passive smoking and smoke-free policies. A key point is that the tactics are repeated in every setting and hence are entirely predictable. These tactics include: disputing and attempting to undermine the scientific evidence; championing coexistence of smokers and non-smokers in the same environment through smoke-free areas and ventilation; predicting economic meltdown for the hospitality industry; and portraying smoke-free legislation as 'nanny-statism' advocated by health fanatics. The report indicates the motivations of the tobacco industry's stance, revealing that it has long understood the threat which smoke-free legislation poses to its sales and profits – another good reason to support it.

### Summing up

*Going Smoke-free* details exhaustively how ETS exposure contributes to the enormous burden of ill health and premature death caused by tobacco smoking. This alone makes it compelling reading and a formidable reference text for all physicians. By detailing the issues and arguments for comprehensive smoke-free legislation it is invaluable to those who want greater involvement in tobacco control advocacy. We urge that all doctors and other health professionals stand up and are counted on this issue.

What the UK and other non-smoke-free countries urgently need is to repeat the Irish experience of going smoke-free as described in the final chapter of the report. This relates how Micheál Martin, the then Irish Health Minister, demonstrated principled political leadership to achieve a key public health measure in the face of determined resistance from the tobacco and hospitality industries. This section of the report should be compulsory reading for health ministers globally. Introducing comprehensive smoke-free legislation as advocated in *Going smoke-free* requires similar bold political action. Physicians need to play their part to ensure that this happens.

### REFERENCES

1. California Environmental Protection Agency. *Health Effects of Exposure to Environmental Tobacco Smoke. The Report of the California Environmental Protection Agency*. Bethesda: National Institute for Health, National Cancer Institute, 1999.
2. International Agency on Research on Cancer. *Tobacco Smoke and Involuntary Smoking*. Lyon: International Agency on Research on Cancer, 2004.
3. Scientific Committee on Tobacco and Health. *Report of the Scientific Committee on Tobacco and Health*. London: Stationery Office, 1998.
4. Tobacco Advisory Group of the Royal College of Physicians. *Going Smoke-Free: The Medical Case for Clean Air in the Home, at Work and in Public Places*. London: Royal College of Physicians of London, 2005.
5. Royal College of Physicians. *Smoking and Health*. London: Pitman, 1962.
6. Royal College of Physicians. *Smoking and Health Now*, 2nd report. London: Pitman, 1971.
7. Royal College of Physicians. *Health or Smoking? Follow-up report of the Royal College of Physicians*. London: Pitman, 1983.
8. Department of Health. *Choosing Health: Making Healthier Choices Easier*. London: Stationery Office, 2004.
9. Department of Health. *Consultation on the Smoke-free Elements of the Health Improvement and Protection Bill*. London: Department of Health, 2005.
10. Walls T. CAC Presentation Number 4, 8 July 1994. Bates Number 2041183751-90. <http://legacy.library.ucsf.edu/tid/vnf77e00>.
11. Lader D, Goddard E. *Smoking-related Behaviour and Attitudes*. London: Office for National Statistics, 2003.
12. Evidence to the Health Select Committee Enquiry into the Government's Public Health White Paper, 23 February 2005. [www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/358/5022301.htm](http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/358/5022301.htm). Accessed 30/09/2005.
13. Roseby R, Waters E, Polnay A, Campbell R, Webster P, Spencer N. *Family and Carer Smoking Control Programmes for Reducing Children's Exposure to Environmental Tobacco Smoke*. The Cochrane Database of Systematic Reviews 2002 (Issue 3). DOI:10.1002/14651858. CD001746.

“comprehensive smoke-free legislation is likely to be an effective in reducing smoking exposure at home”

### ACKNOWLEDGEMENT

This article is reproduced with permission and first appeared in *Clinical Medicine* 2005;5:548-50.

# Mythbusters

## *Myth: An ounce of prevention buys a pound of cure*

*“There are enormous potential benefits to be derived from health and wellness promotion, disease and injury prevention, public health and health protection and population health strategies, measured primarily in terms of improving the health of Canadians, but also in terms of their positive long-term financial impact on the health care system.”*

*Senator Michael Kirby,  
Senate Standing Committee on Social Affairs, Science and Technology<sup>1</sup>*

Serious illness takes a heavy toll on individuals, their families, and society. So it makes sense to invest in stopping illness before it happens, with strategies from public health programmes that ensure we have safe food and clean water to direct disease-prevention efforts such as mass vaccination programmes. In addition, programmes that educate people on how lifestyle affects health and what they can do to keep themselves healthy provide important benefits to Canadians.

### **Penny-wise and pound-foolish?**

While the over-arching goal of any health promotion or disease prevention measure is improved health, supporters say that investing money in these programmes is also old-fashioned fiscal common sense. They argue that failing to invest in these programmes now is penny-wise but pound-foolish, that spending less now means we will spend more in the future.<sup>2</sup>

After all, mass vaccination of infants saves money by reducing the number of cases of measles and mumps – not to mention the classic example of smallpox, which was eradicated in 1980 and has incurred no prevention or treatment costs in more than 20 years. And helping pregnant women stop smoking also saves money, because they

give birth to stronger, healthier babies that incur fewer healthcare costs.<sup>3,4</sup>

Unfortunately, this evidence does not support the broader argument that prevention and promotion will always save money. Few diseases can be eradicated like smallpox, and postponing a chronic illness is not the same as eliminating it. The so-called ‘Iron Law of Epidemiology’ – that one out of one die – will always apply.

### **Getting in the action**

Given the current epidemic of obesity in Canada, many experts are working to encourage physical activity. And studies in the United States and Canada also suggest millions of dollars in direct medical costs could be saved every year if people were as active as each country’s federal guidelines suggest.<sup>5,6</sup> After all, shouldn’t a population that is less obese require less healthcare?

However, these studies often fail to account for implementation costs, the cost of treating injuries associated with exercise, such as broken bones and muscle strains,<sup>7</sup> the cost of treating people for any condition as they live longer, or the fact that many programmes promoting healthy behaviour just end up preaching to the converted.<sup>8</sup>

In fact, demonstrating the economic impact of physical fitness may always be an elusive goal. Properly conducted randomised controlled trials of exercise are difficult because it’s hard to ensure the control group doesn’t change. ParticipAction, the classic Canadian health promotion programme, was never rigorously evaluated, and it would have actually been very difficult — with national programmes where there can be no control group, there is no way to properly determine if they cause Canadians to exercise more, and if this prevents illness and saves healthcare costs. Without these experiments, the health and cost benefits of these programmes remain largely anecdotal.<sup>9</sup>

---

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](http://www.chsrf.ca/mythbusters/index_e.php). This paper was first published in 2003. © CHSRF, 2003.



## Easing the Pressure

It's easier to test clinically delivered disease prevention programmes for their health benefits, but the cost benefits are still elusive. One example is hypertension, or high blood pressure. Heart disease is the single greatest cause of death in Canada, accounting for 37% of all deaths,<sup>1</sup> so it is important to identify warning signs, such as hypertension, and treat them before they lead to heart attacks and strokes.

Unfortunately, treatment for hypertension is complex and expensive – right from the initial testing. Many people become so nervous at the thought of seeing the doctor that their blood pressure goes up when they're at the doctor's office, only to drop back to normal once they get home. This means people must be re-tested at least twice more to ensure they are not 'false positives.'<sup>7</sup> Not only have they cost the system for the extra tests, but they experience unnecessary stress as well. (The numbers can be significant for other diseases as well; for screening mammography, it is estimated that between 80 and 93% of suspicious or positive results are false positives.<sup>10</sup>

Furthermore, treatment for hypertension usually involves many doctors' visits, lab tests, and medication that patients must take for the rest of their lives. This can cost the system a lot – one provincial drug plan spent more than \$127 million on cardiovascular drugs alone in 1999,<sup>11</sup> and one review shows hypertension drugs can cost anywhere from \$3,800 to \$93,000 per life-year saved.<sup>3</sup> And while this is certainly cost-effective for older patients, it is a bit more questionable for a forty-year-old with only mild hypertension, as the cost of 10, 20, even 30 years of preventive treatment goes far beyond the one-time cost of treating a heart attack.<sup>12</sup> Finally, not all people with hypertension will follow their treatment regimens, leaving them at high risk while incurring costs to the system.<sup>7</sup>

In general, preventing fatal diseases means the healthcare system can end up spending more, because people live longer and become vulnerable to conditions such as mental illness, respiratory disease, and joint and bone problems. These diseases account for about the same proportion of health-

care budgets as cancer and heart disease.<sup>1</sup> However, because they are less fatal, they may cost more in the long term.<sup>13</sup>

## Penny foolish?

Leading longer, healthier lives is in itself justification for disease prevention and health promotion. And it is important to remember that just because something costs money doesn't mean it isn't cost effective. Thus, supporters of health promotion and illness prevention don't need to depend on cost-saving rhetoric to make their arguments, and they probably shouldn't, because the evidence is simply not there.

---

## REFERENCES

1. Kirby M (Chair) *The Health of Canadians – The Federal Role: Interim Report: Volume Six: Recommendations for Reform*. Ottawa: Senate of Canada. The Standing Senate Committee on Social Affairs, Science and Technology, 2002.
2. Fries JF, Koop CE, Beadle CE et al. Reducing health care costs by reducing the need and demand for medical services. *New England Journal of Medicine* 1993;329:321–25.
3. Tengs TO, Adams ME, Pliskin JS et al. Five-hundred life-saving interventions and their cost-effectiveness. *Risk Analysis* 1995;15(3):369–90.
4. Partnership for Prevention. *Guide to Smart Prevention Investments*. Washington, DC: Partnership for Prevention, 2001.
5. Katzmarzyk PT, Gledhill N, Shephard RJ. The economic burden of physical inactivity in Canada. *Canadian Medical Association Journal* 2000;163(11):1435–40.
6. Pratt M, Macera CA, Wang G. Higher direct medical costs associated with physical inactivity. *The Physician and Sportsmedicine* 2000;28(10):63–70.
7. Russell LB. *Is Prevention Better Than Cure?* The Brookings Institution, Washington, DC: The Brookings Institution, 1986.
8. Harvey K. Health promotion is a waste of time and money. *British Medical Journal* 1998;317(7162):887.
9. World Health Organization. *The World Health Report 2002 – Preventing Risks, Promoting Healthy Life*. Geneva: World Health Organization, 2002.
10. Wright CJ, Mueller CB. Screening mammography and public health policy: the need for perspective. *Lancet* 1995;346:29–32.
11. British Columbia Ministry of Health Services. *Pharmacare Trends*. Victoria: British Columbia Ministry of Health Services, 2000.
12. Russell, LB. The role of prevention in health reform. *New England Journal of Medicine* 1993;329(5):352–54.
13. Bonneux L, Barendregt JJ, Nusselder WJ, Van der Maas PJ. Preventing fatal diseases increases healthcare costs: cause elimination life table approach. *British Medical Journal* 1998;316(7124):26–29.

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

## The Public Health Observatory Handbook of Health Inequalities Measurement

Roy Carr-Hill and Paul Chalmers-Dixon.

Edited by Jennifer Lin

Oxford: South East Public Health Observatory, 2005

Freely available on line at [www.sepho.org.uk/extras/rch\\_handbook.aspx](http://www.sepho.org.uk/extras/rch_handbook.aspx)

This new handbook primarily focuses on the measurement and interpretation of health inequalities. Written by Roy Carr-Hill and Paul Chalmers-Dixon from the University of York, it provides a comprehensive collection of material for those concerned to document and understand health inequalities.

Speaking on the publication of the book Sir Donald Acheson said "...Resources are going into research and development to advance our knowledge and understanding of what works. In parallel with that we need to be able to measure inequalities, in order to plan, set targets, monitor and evaluate. I recommended in my report the need to establish mechanisms to monitor inequalities in health and to evaluate the effectiveness of measures taken to reduce them.

This book therefore is a welcome contribution to the resources available to people working to reduce inequalities in health in their communities. I commend it to anyone involved in addressing health inequalities. The measurement of inequalities is a complicated and convoluted science, but this book brings together much of that science in a rigorous but accessible way. It is a rich source of information and will contribute to advancing our knowledge and practice, with the ultimate aim to reduce inequalities and to make this country a more equitable society..."

*Contents:* Introduction; Measuring inequality by social categories; Measuring inequality by health and disease categories (using data from administrative sources); Measuring inequality by health and disease categories (using data from surveys); An introduction to the use of indexes to measure deprivation; A selection of indexes of multiple deprivation; Indexes: properties and problems; Data sources: availability and problems; Designing surveys to measure inequality; Inequalities and methods of measurement; Context, history and theory; Index

---

## Decent Work – Safe Work

J Takala

Geneva: International Labour Organization, 2005

ISBN 92-2-117750-5 (print)

ISBN 92-2-117751-3 (web pdf)

Freely available at [www.ilo.org/publns](http://www.ilo.org/publns)

Written by J Takala, Director of Safework at the ILO in Geneva, this report provides an overview of the most recent estimates of occupational and work-related accidents and diseases, world-wide, some of the causes for recent changes and what the ILO and its member states are doing to improve conditions in the workplace for the millions who are at risk from injury.

Throughout the world, there is growing acceptance that accidents and ill-health at work impact not only on the lives of individual workers, their families and their potential for future work, but also the productivity and profitability of their enterprises and ultimately the welfare of the society in which they live. In short, safety and health at work makes good business sense, and maintaining acceptable standards is seen as an integral and key component of societal development, poverty alleviation and of 'decent work'.

Globally, the statistics appear to show an increasing trend in occupational accidents and diseases. Many Conventions, Recommendations and other instruments on occupational safety and health (OSH) have been adopted over the years, and these have helped to improve working conditions throughout the world. This impetus has been maintained, and recent years have seen the adoption of a Global Strategy for OSH.

The report concludes that this Global Strategy has already had a profound impact on OSH policies and programmes at both international and national levels. The systems approach and national programming for OSH are also gaining momentum at the national level, and national profiles including a set of indicators of progress are being progressively developed. Continuous and stepwise improvement of both national OSH systems and national OSH programmes, which have measurable targets and are governed by tripartite dialogue, will also help to achieve better OSH outcomes in reality.

*Contents:* Part I – Estimates of occupational accidents and work-related diseases; Costs of occupational injuries and diseases; Productivity and competitiveness; Employability; Gender aspects; Age-related aspects; Absenteeism; Workers' health promotion and well-being at work; Part II – A global occupational safety and health strategy; Promotion, awareness raising and advocacy; Development of new instruments and related guidance; Technical assistance and cooperation; Knowledge development, management and dissemination; International collaboration; Conclusions; Statistical annexes.

**Austrian Presidency of the EU** News and information on the Austrian Presidency of the European Union.

[www.eu2006.at/info/de](http://www.eu2006.at/info/de)

**Royal College of Physicians**

[www.rcplondon.ac.uk](http://www.rcplondon.ac.uk)

The Royal College of Physicians, based in London sets standards for clinical practice, conducts examinations, defines and monitors education and training programmes for physicians, supports doctors in their practice of medicine, and advises the government, public and medical professions on health care issues. The College has 21,000 fellows and members worldwide. Information is available on publications, organised events, clinical guidelines, continuing professional development, and online learning. The 'hot topics' section draws attention to pertinent health issues, such as alcohol, medical professionalism, the new consultant contract and women in medicine. The web site also includes press releases, an international component and sections for specialists, patients and carers.

**Belgium Scientific Institute of Public Health**

[www.iph.fgov.be](http://www.iph.fgov.be)

The Belgium Scientific Institute of Public Health conducts scientific research in view of supporting health policy. Based in Brussels, it also provides expertise in public health, including the surveillance of communicable and non-communicable diseases, verification of federal product standards, risk assessment, environmental health, and the management of biological resources. Reports and publications are available for download and topics can be searched by keyword. The web site is available in English, French and Dutch.

**World Health Organization – Essential Health Technologies (EHT)**

[www.who.int/eh/en](http://www.who.int/eh/en)

This web site provides information on essential health technologies, which are evidence-based technologies that provide cost-effective solutions to health problems. The department's aims are to develop and maintain basic operational frameworks for safe and reliable health services and technologies; help WHO Member States complete the basic operational frameworks through project proposals; develop norms and standards, guidelines, training materials, reference materials and estimation of burden of disease; and focus on diseases of the poor. There are links to WHO and other publications and information about relevant events.

**The International Society for Pharmacoepidemiology (ISPE)**

[www.pharmacoepi.org](http://www.pharmacoepi.org)

ISPE is an international organisation dedicated to advancing the health of the public by providing a forum for the open exchange of scientific information and for the development of policy, education and advocacy for the fields of therapeutic risk management and pharmacoepidemiology. Pharmacoepidemiology is the science that applies epidemiologic approaches to studying the use, effectiveness, value and safety of pharmaceuticals. The web site contains newsletters and journals, lists of conferences and courses, a career centre and links to related web sites.

**Health Council of the Netherlands**

[www.gr.nl](http://www.gr.nl)

The Health Council of the Netherlands is an independent advisory body in charge of providing Ministers and parliament with scientific advice on public health matters. The Council produces advisory reports in response to requests from ministers as well as unsolicited advisory reports, which have an alerting function. There are three main themes, including general issues (i.e. population screening, blood safety), effectiveness and efficiency of diagnosis and treatment (i.e. cholesterol lowering therapy), and the prevention and treatment of infectious diseases. The web site has news items, a newsletter for subscription, and reports and publications for download. Both the web site and newsletter are available in English and Dutch.

**Norwegian Knowledge Centre for the Health Services**

[www.kunnskapssenteret.no](http://www.kunnskapssenteret.no)

Based in Oslo, the Centre was founded in 2004 from the merger of the Norwegian Centre for Health Technology Assessment (SMM), parts of the Division for Knowledge Management in the Directorate for Health and Social Affairs, and the Foundation for Health Services Research (HELTEF). The Norwegian Knowledge Centre for the Health Services gathers and disseminates evidence about the effect and quality of methods and interventions within all parts of the health services, and works towards the uptake of evidence by the health services. They produce HTA reports, systematic reviews, overviews and early warnings, and surveys for patients and employees. Available for download from the web site are published articles, presentations and strategic reports. The web site is available in both English and Norwegian.

## NEWS FROM EUROPEAN INSTITUTIONS

### EU budget for 2007–2013 agreed by Member States

European Heads of States and Governments reached an agreement on the EU budget for 2007–2013 in the early hours of the morning on 16 December in Brussels.

They agreed on a budget of €862.36 billion, corresponding to 1.045% of the gross national income of the EU. Although this amount was less than that hoped for by some governments, the reaction to the final budget across Europe has generally been positive. The UK gave up €10.5 billion of its rebate, about 20% in total and in return secured agreement on a wide-ranging review of EU spending in 2008–9, which could theoretically lead to cuts in farm spending.

Development aid for poorer EU countries will be set at €157 billion. This is €7 billion more than the UK envisaged in its first proposal on 5 December, but less than Luxembourg proposed at the last summit in June. The rules for accessing funds are also relaxed.

UK Prime Minister Tony Blair commenting on the deal said “We have delivered an EU budget deal which is €160 billion cheaper than the original Commission proposals, which provides for a huge transfer of spending from the original 15 to the new member states of eastern Europe.”

€3.64 billion (€520 per annum) have been allocated to ‘internal policies’ in particular culture, youth, audiovisual matters and health and consumer protection. The Council proposal is now being discussed in the European Parliament.

For more information on the budget: [http://ue.eu.int/ueDocs/cms\\_Data/docs/pressData/en/misc/87677.pdf](http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/misc/87677.pdf)

### MEPs reject proposed health budget

Members of the European Parliament’s Environment and Health Committee, meeting on 31 January voted to allocate €1,500 million over seven years to the new Community action programme on health. The European Parliament has already expressed opposition to the figures proposed by the December European Council for the 2007–2013 financial period, which MEPs regarded as too low. They rejected by a high majority the budget proposed by the Council on the basis that it “did not guarantee prosperity, solidarity and security for the future”. They have rarely used such powers to block any deal previously.

The Environment and Health Committee has now signalled its intention to continue to support greater funding for health. According to Antonios Trakatellis, rapporteur for the Committee, the objectives of the Community action programme, “must always be matched by the resources available to achieve them.” He also stated that “there is no guaranteed match between these two in the proposed programme. I therefore propose that the funding be increased, in the certainty that the Council and the Commission will realise that this proposal is perfectly reasonable.” The rapporteur received overwhelming backing from the committee and his report was adopted by 54 votes to 1.

The European Commission originally suggested a single action programme for health and consumer protection, with an overall budget of €1,203 million with €969 million earmarked for health. The Commission hoped to achieve more efficiency by combining the two areas but Parliament, while in favour of pooling administrative resources, decided that the areas, which come under different legal bases (Articles 152 and 153 of the EC Treaty) in which

the EU has different powers, should be split into separate programmes. Parliament’s Committee on the Internal Market and Consumer Protection will adopt what is now a separate programme on 20 February, probably without modifying the initial budget of €233 million.

The Environment and Health Committee chaired by Karl-Heinz Florenz believe that MEPs want a higher standard of health protection to be a goal of all EU policies and have called for greater transparency between national healthcare systems. MEPs also want to see greater cross-border cooperation, in particular for the treatment of rare diseases, plus exchange of information on the services and treatments available and on reimbursements. The new Community action programme also includes special measures on risk prevention, information for practitioners and the public and the exchange of best practice. Talks on the budget will continue in a trilogue between the European Parliament (President Borrell), European Commission (President Barroso) and Council President Chancellor Schüssel (Austria).

### Open consultation on nutrition and physical activity

On 8 December 2005 the Commission adopted a Green Paper on the promotion of healthy diets and physical activity to begin an extensive public consultation on how to reduce obesity levels and the prevalence of associated chronic diseases in the EU. The Green Paper invites contributions on a broad range of issues related to obesity, with a view to gathering information for a European dimension to reducing obesity levels which could complement, support and coordinate existing national measures. Around 14 million EU children are currently overweight or obese, of which more than 3 million are obese. This figure



is expected to continue to rise for the foreseeable future. The Green Paper calls for concrete suggestions and ideas on action that can be taken in all sectors and at every level of society to address this serious problem and to encourage Europeans towards healthier lifestyles.

Health and Consumer Protection Commissioner Markos Kyprianou said: "The rise in obesity is a Europe-wide problem which requires a coordinated Europe-wide approach if we are to contain and reverse this trend. More than 400,000 children are estimated to become overweight every year, and today's overweight teenagers are tomorrow's heart attack or diabetes victims. The Commission's Green Paper aims to stimulate discussion about effective initiatives to promote healthy diets and physical activity, so best practice can be replicated across Europe. Apart from the health benefits and cost savings to be made from tackling obesity, a coordinated European approach will also ensure that the single market is not undermined by the emergence of a patchwork of uncoordinated national measures."

Contributions are invited on a range of specific questions in the Green Paper, including:

- Which kind of Community or national measures could contribute towards improving the availability, accessibility and affordability of fruits and vegetables?
- What contribution can Community policies make towards enabling and encouraging consumers to shift towards diets lower in fat, sugar and salt?
- Are voluntary codes ('self-regulation') an adequate tool for limiting the advertising and marketing of energy-dense and micronutrient poor foods? What would be the alternatives to be considered if self-regulation fails?
- How can consumers best be enabled to make informed choices and take effective action? Which should be the key messages to give to consumers, how and by whom should they be delivered?
- What is good practice for improving the nutritional value of school meals and for fostering healthy dietary choices at schools, especially as regards the excessive intake of energy-dense snacks and sugar-sweetened soft drinks?
- In which ways can public policies contribute to ensure that physical activity be 'built into' daily routines?
- How can dietary guidelines be communicated to consumers and in which ways could nutrient profile scoring systems contribute to such developments?

The public consultation will run until 15 March 2006, and a report summarising the contributions will be published on the Commission's website by June 2006.

*For more information, see:*  
[http://europa.eu.int/comm/health/ph\\_determinants/life\\_style/nutrition/nutrition\\_en.htm](http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/nutrition_en.htm)

### **EC commits funds to prevent avian influenza**

Health officials and disease experts from 90 countries gathered in Beijing in a bid to raise €1.9 billion at an international donors conference on human and avian influenza. For its part, the European Commission pledged €80 million in aid grants from the Commission's External Relations budget and the European Development Fund, and committed €20 million to research funds for avian influenza from the 6th Research Framework Programme, bringing the total European Commission contribution to €100 million. European governments have until 7 February to send their national surveillance plans to the Commission.

Speaking at the conference on the amount of money raised Commissioner Kyprianou said: "This is a significant achievement we all can be proud of. We have surpassed expectations by considerably exceeding the estimated overall financing gap of around \$1.2 billion, 1 billion of which is in grants. For its part, the European Commission has played a central role both as a co-

host of this conference, and with a total pledge of €100 million (\$122 million). Taken together with the €114 million (\$140 m) pledged by the EU Member States, the EU has in total pledged around €214 million (\$260 m)."

Of the €80 million pledged by the European Commission to third countries, €30 million is destined for Asia, €5 million for Central Asia, €5 million for the EU's Eastern European neighbouring countries, €10 million for North Africa and the Middle East, and €30 million is earmarked for the African, Caribbean and Pacific Countries, subject to approval by the ACP countries. With the €20 million of research funds earmarked from the 6th Research Framework Programme, this brings the total European Commission pledge to €100 million. Separately, the European Commission is preparing to bring forward urgently €4 million in pre-accession aid to Turkey foreseen for 2007 to tackle avian influenza.

*More information on the EU's response to avian flu is available at*  
[http://europa.eu.int/comm/world/avian\\_influenza/index.htm](http://europa.eu.int/comm/world/avian_influenza/index.htm)

### **Seventh Framework Programme**

The European Commission has set out the details of its proposal for a new Seventh Framework Programme to fund research and development from 2007 to 2013. Four specific programmes have been proposed by the Commission:

*Cooperation programme* – designed to gain leadership in key scientific and technological areas by supporting cooperation between universities, industry, research centres and public authorities across the European Union as well as the rest of the world.

*Ideas programme* – to establish a European Research Council, a pan-European mechanism to support the truly creative scientists, engineers and scholars.

*People programme* – to strengthen human resources available to science and research across Europe, both

qualitatively and quantitatively.

*Capacities programme* – to enhance research and innovation capacity throughout Europe.

These themes will be discussed with the European Parliament, with a first reading anticipated in March 2006, before being decided by the Council. Commenting on the Seventh Framework Programme, Janez Potočnik, European Commissioner for Science and Research said “What is important now is to allocate sufficient funds to allow this project to achieve its objective of greater competitiveness for Europe and a better quality of life for its citizens.”

Rules for participation in the various schemes have now been published. These are aimed at making the programme more accessible and straightforward for their users.

*Further information on the FP7 Programme can be found*  
[http://europa.eu.int/comm/research/future/index\\_en.cfm](http://europa.eu.int/comm/research/future/index_en.cfm)

### **The health programme of the Austrian presidency**

The Austrian Minister for Health and Women, Maria-Rauch Kallat presented the health programme of the Austrian presidency to the European Parliament Committee on Environment, Public Health and Food Safety. Mrs Kallat presented a long list of work areas including:

- Finding agreement on the joint Health and Consumer Protection Programme.
- Health threats (such as bird flu and HIV/Aids in neighbouring countries).
- Working towards the adoption of the proposed directive on paediatric medicine.
- Working towards the adoption of the food additive and nutritional claim on food products directives.
- Reviewing legislation on medicine and exploring alternative medicines.
- Working on a EU alcohol strategy.
- Working on a EU strategy for

sustainable development and its mainstreaming in all policies.

- Injuries and infection prevention.
- Promoting e-health for patients and health care structures.

The two thematic priorities of the Austrian Presidency will be women’s health and diabetes type II. In the field of women’s health, Austria will focus primarily on cardiovascular diseases, lung cancer, osteoporosis, endometriosis and depression and will ask the Commission to present a report on the health status of women in the enlarged EU Community by June 2006.

In the field of Diabetes type II, the presidency will organise a conference in Vienna on 15–16 February and the Council will make conclusions on the issue of obesity in March. At a conference on e-health in Malaga on 10–12 May, the Presidency will present a charter on health. This charter has been presented by Minister Rauch Kallat as progressive and innovative. The first EU conference on injury prevention and safety promotion will also be held in Vienna 25–27 June 2006.

*Further information is available on the Austrian Presidency’s website*  
[www.eu2006.at/en/index.html](http://www.eu2006.at/en/index.html)

### **Commission launches revision to the Medical Device Directives**

Medical devices have become an increasingly important health care area in relation to their impact on health and health care expenditure. The sector covers some 10,000 types of products, ranging from simple bandages and spectacles, through life maintaining implantable devices, equipment to screen and diagnose disease and health conditions, to the most sophisticated diagnostic imaging and minimal invasive surgery equipment. The public expects that these devices meet the highest safety standards.

On 22 December 2005, the European Commission proposed amendments to the current legislative framework. The proposal has been developed involving extensive

stakeholder consultation and has also been subject to public consultation. The most significant proposals concern conformity assessment, including design documentation and design review, clarification of the clinical evaluation requirements, post market surveillance, compliance of custom-made device manufacturers and the alignment of the original medical device directive 90/385/EEC.

Commission Vice President Günter Verheugen stated: “This is a good example of better regulation in this complex and highly diversified sector. We have listened to stakeholders and have clarified and simplified the current rules. At the same time we bring improved requirements for safety for the patients whilst continuing to provide a coherent legislative framework that fosters competitiveness.”

The proposal also brings increased transparency to the general public in relation to the approval of devices. It introduces the necessary regulatory clarification in order to continue the high level of protection of human health and support better implementation. It also foresees provisions necessary to regulate medical devices with an ancillary human tissue engineered product. This mirrors the proposed EU legislation on advanced therapies and fills a potential regulatory gap.

The proposal enjoys widespread support and it is anticipated, by authorities and industry alike, that its eventual adoption will see resurgence in this sector, both in terms of competitiveness and safety.

Moreover, the proposal fits neatly into the European Commission’s policy to maintain the high competitiveness of this sector. Indeed, a recent study commissioned by the European Commission has underlined again the importance of this sector which consists of some 7,000 business entities in Europe, employing upwards of 350,000 Europeans and which regularly records the highest production growth rates amongst all industry sectors in the EU.

The Commission proposal will now be forwarded to the European

Parliament and Council for co-decision.

*Additional information, including the text of the study and the Commission proposal, can be found at: [http://europa.eu.int/comm/enterprise/medical\\_devices/revision\\_mdd\\_en.htm](http://europa.eu.int/comm/enterprise/medical_devices/revision_mdd_en.htm)*

*Information on the proposal on Advanced Therapies can be found at: <http://pharmacos.eudra.org/F2/advtherapies/index.htm>*

## NEWS FROM THE EUROPEAN COURT OF JUSTICE

---

### ECJ rules on professional recognition of dentists in Austria

The European Court of Justice has ruled that individuals with non-university dental training of three years' duration are not entitled to engage in their occupation under the name of dental practitioner or dentist. The judgement (Case C-437/03) comes following an enforcement action brought by the Commission against Austria, for failure to comply with two Community Directives relating to the dental profession on the mutual recognition of diplomas (Recognition Directive) and the coordination of training required by the various Member States (Coordination Directive). The Directives were adopted with a view to facilitating the free movement of workers as well as freedom of establishment and freedom to provide services.

The European Commission claimed that Austria had infringed the provisions of the Directives on two grounds, firstly the 'Coordination Directive' (Council Directive 78/687/EEC) provides that dentists must complete a five-year full time dentistry course at university. However, the 'Recognition Directive' (Council Directive 78/686/EEC) provides for an exception (in order to take into account the situation in Italy, Spain and Austria) whereby those having undertaken medical training in a university can also avail themselves of the title of dentist. Austria's national

legislation still allowed for individuals with non-university training to present themselves as dentists. The Court therefore concluded that Austria had failed to fulfil its obligations under Community law.

The European Commission had also claimed that Austria had failed to comply with the Directives by not requiring doctors specialising in dental, oral and facial surgery to use the title 'Dental practitioner'. However, the Court rejected this complaint on the grounds that the Commission had failed to show that this might lead to a genuine risk of confusion between specialists in dental surgery and other doctors; moreover a requirement for doctors to give up their professional title in favour of the title of 'Dental practitioner' would effectively oblige them to hold themselves out to patients as dentists without indicating their skills as a physician, which would be harmful to the pursuit of their profession; finally the possibility for them to continue to use the title 'Doctor specialising in dental, oral and facial surgery' appeared to be justified on the grounds of transparency, enabling patients to distinguish between the two professions.

### ECJ rules on the protection of workers from exposure to carcinogens

The European Court of Justice has stated that Austria failed to protect workers by not adopting the necessary legislation to fully implement the Council Directive on the protection of workers from the risks related to exposure to carcinogens at work and extending it to mutagens (1999/38/EC). The action (Case C-378/04) was brought before the Court by the European Commission.

The Austrian government argued that the Directive had been subsumed into national law at federal level within the time limit prescribed. However, since the Directive had not been subsumed by all of the Länder, the Court found that the measures required to ensure the incorporation of the Directive into national law had not been adopted.

## NEWS FROM AROUND EUROPE

---

### Climate change and human health

Growing evidence shows that climate change and variability is affecting health now. The 890 million inhabitants of the European Region are exposed to rising temperatures, changes in precipitation pattern and increases in the severity and frequency of extreme weather events, particularly heatwaves, droughts and intense rainfall. Southern Europe is likely to become drier in the future, while the climate in northern Europe is expected to be warmer and wetter. Climate change and variability are affecting health in a variety of ways. Some of these changes find countries unprepared. Weak health system preparedness contributed to the more than 35,000 excess deaths in western Europe alone in the 2003 heat-wave. This means that climate change affects all countries, irrespective of their socioeconomic development.

At the United Nations summit on climate change that took place in Montreal in December, the WHO Regional Office for Europe launched a new report, *Climate Change and Adaptation Strategies for Human Health* (cCASHh). The report illustrates how across Europe people and systems can adapt to new climate-related threats and how public health interventions can best curb the negative effects on health now. It identifies concrete action that the health sector can take, in collaboration with other sectors, as a prerequisite for effective policy-making on health and the climate. This includes creating early warning systems for heat-waves and floods, strengthening disease surveillance and systematically collecting health, meteorological, environmental and socioeconomic data at the local, regional and national levels, and with adequate time scales.

"If the health sector is to exercise its stewardship," suggests Dr Roberto Bertollini, Director of the Special Programme on Health and Environment of the WHO Regional Office for Europe, "it will have to work with other sectors, such as energy, transport, industry and



agriculture, to advocate 'healthy' mitigation measures. It will have to inform the public and keep people aware of how to avoid the risks of food-, vector- and rodent-borne diseases and allergic disorders. It will have to learn to collaborate with climatologists and land-use and urban planners, to prepare communities and cities for the growing risks posed by climate change."

The UN conference in Montreal adopted more than 40 decisions at what the acting head of the UN Climate Change Secretariat Richard Kinley described as "one of the most productive UN Climate Change Conferences ever".

*Information on the conclusions of the UN conference is available at [www.montreal2005.gc.ca](http://www.montreal2005.gc.ca) while information on the WHO Regional Office for Europe's work on climate change and health is available at [www.euro.who.int/globalchange](http://www.euro.who.int/globalchange)*

### **New health insurance system comes into effect in the Netherlands**

From January 2006, a new insurance system for curative healthcare came into force in the Netherlands. Under the new Health Insurance Act (Zorgverzekeringswet), all residents of the Netherlands are obliged to take out health insurance.

The new system is a private health insurance subject to social conditions. The system is operated by private health insurance companies; the insurers are obliged to accept every resident in their area of activity. A system of risk equalisation enables the acceptance obligation and prevents direct or indirect risk selection. The insured pay a nominal premium to the health insurer. Everyone with the same policy pays the same insurance premium. The Health Insurance Act also provides for an income-related contribution to be paid by the insured. Employers contribute by making a compulsory payment towards the income-related insurance contribution of their employees.

The new health insurance covers a standard package of essential health-

care. The package provides essential curative care tested against the criteria of demonstrable efficacy, cost effectiveness and the need for collective financing. Prior to 2006, there were two types of health insurance: obligatory and voluntary. Employees, people entitled to a social benefit and the self-employed people with incomes up to a maximum level were compulsorily insured under the Social Health Insurance Act (Ziekenfondswet). Individuals with higher incomes could choose to opt out of this system and either take out private health insurance or even remain uninsured.

*More information on the new system is available at [www.minvws.nl/en/themes/health-insurance-system/default.asp](http://www.minvws.nl/en/themes/health-insurance-system/default.asp)*

### **Belgium: national health survey results published**

Belgium has carried out its third national health survey since 1997 covering almost 12,500 respondents. The survey indicates that the overall health status of the population has been relatively stable since 1997. 23% of respondents complain about their health while 13% report suffering from mental health problems. Smoking is on the decrease, especially among the young, but on the other hand it appears that people above 65 consume too many medications. One worrying result of the survey is the emergence of a trend since 2001 suggesting that the less well-off tend to postpone medical visits because of cost, with more than 15% of those interviewed in Wallonia and Brussels delaying contact with the health system.

*The report is available in French and Dutch at [www.iph.fgov.be/epidemiolo/epien/index.htm](http://www.iph.fgov.be/epidemiolo/epien/index.htm)*

### **Latest Nordic social welfare and health statistics focus on children**

The annual publication of the two Nordic committees dealing with statistics on health and social welfare, Nomesko and Nososko, in 2005 focused on children and young

people. Few of the overall trends are encouraging, but they help social policy makers better target child and youth welfare needs.

Overall trends show that in Finland fewer underweight infants are born each year compared to other Nordic countries, Finnish children smoke the most but Danish children use the most drugs and alcohol. The numbers of children in care have increased. Sweden has the lowest mortality rate among 1–17 year olds, 13 per 100,000, while in Finland the figure is 18 per 100,000. Traffic accident deaths and suicides are highest in Finland. Diabetes has increased among the young everywhere, with Finland facing the most cases. Asthma and allergies have also become more common in each country, and more 15–19 year olds than earlier require treatment for mental health problems.

*Further information at [www.stm.fi/Resource.pbx/publishing/documents/5493/index.htm](http://www.stm.fi/Resource.pbx/publishing/documents/5493/index.htm)*

### **The Netherlands: report on the state of health in 2005**

This report published by the Healthcare Inspectorate (IGZ) assesses the health care system's effectiveness in addressing population health issues. It concludes that both the health system and the quality of services provided at the municipal level (which has gained increasing responsibility for health) have improved considerably over the past ten years. The report also concludes, however, that there is still too little focus on preventative care and on tackling emerging health problems. These problems include the growing number of overweight people, the increasing risk of large scale epidemics, psychosocial problems amongst the young and the need to provide basic care to uninsured and undocumented migrants. The report does however suggest that the current structure of the health care system should be capable of tackling such problems.

Dutch Minister of Public Health, Well-being and Sport, Hans Hoogervorst, noted that future health policy will focus on stimulat-



ing further implementation and improving effectiveness at the municipal level, while strengthening the national level's ability to provide guidance and play a coordinating role. An emphasis will also be placed on addressing the weaknesses highlighted by the report and on improving the quality of municipal health policy.

*More information in English can be founds at [www.minvws.nl/en](http://www.minvws.nl/en)*

### **Ireland: Report of the expert group on mental health policy**

Mary Harney, Tánaiste (Deputy Prime Minister) and Minister for Health and Children and Tim O'Malley, Minister of State at the Department of Health and Children, on 24 January 2006 launched 'A Vision for Change', a new national policy framework for mental health services.

The report, which was developed by the Expert Group on Mental Health Policy, is the first comprehensive review of mental health policy since Planning for the Future was published in 1984. The Expert Group, appointed by Minister O'Malley in August 2003, was chaired by Professor Joyce O'Connor, President of the National College of Ireland, and consisted of 18 widely experienced people drawn from a range of backgrounds within the mental health services. The report outlines an exciting vision of the future for mental health services in Ireland and sets out a framework for action to achieve it over the next 7–10 years.

It proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. A person-centred treatment approach which addresses each of these elements through an integrated care plan, reflecting best practice, and most importantly evolved and agreed with both service users and their carers is recommended. "This comprehensive mental health policy framework outlines a set of values and principles that will guide both

Government and service providers as we proceed to develop and put in place a modern high-quality mental health service for our citizens" the Tánaiste said.

Substantial additional funding will be required to finance the implementation of this policy document. The report estimates that an additional €21m per annum is needed over the next seven to ten years for additional 1,800 staff. The Tánaiste has confirmed an additional allocation of €25m in the 2006 budget to the Health Service Executive for mental health services. The report also estimates that nearly €800 million in capital expenditure is required.

The report was preceded by a nationwide consultation process drawing on the experience, perspectives and ideas of key stakeholders, interested agencies and concerned individuals. "The necessity of involving service users and their carers in all aspects of service delivery was a key message and this is the foundation on which 'A Vision for Change' was built" said Minister O'Malley.

'A Vision for Change' makes clear recommendations on how the mental health services should be managed and organised in the future. These recommendations include the establishment of a National Mental Health Service Directorate and the reorganisation of the current Mental Health Catchment Areas. It also recommends the closure of all the remaining mental hospitals and the re-investment of resources realised as a consequence in the mental health services.

The closure of large mental hospitals and the move to modern units attached to general hospitals, together with the expansion of community services, has been Government policy since the publication of Planning for the Future in 1984. A number of the large mental hospitals around the country have already closed completely. The re-organisation of services which these closures entailed resulted in more community facilities, new acute psychiatric units in some cases and an overall improvement for service users, their families and carers. The remaining

hospitals, of which there are 15 in all, cater in the main for long-stay patients, many of whom are over 65 years of age.

*The report can be viewed at [www.dohc.ie/publications/pdf/vision\\_for\\_change.pdf](http://www.dohc.ie/publications/pdf/vision_for_change.pdf)*

### **Finland: Finnish EU presidency will seek closer cooperation on drugs**

A main theme Finland intends to pursue during its stint in the EU presidency, in the second half of 2006, is to intensify cooperation with the Union's eastern neighbours – Russia, Belarus, Ukraine and Moldova. This will focus especially on drug prevention, tighter border policing to stop drug trafficking and cooperation between police and social and health authorities on drug problems. A specific goal during the presidency will be to get acceptance of the EU Council's resolution on police and social and healthcare collaboration on the treatment of drug users. During the Finnish presidency an 'expert conference' will be held in Turku on disease prevention in intravenous drug use. Towards the end of the year the EU Commission will also hold a conference on drugs for non-governmental organisations. The basis for the conference will be the Green Paper handled in the EU's Horizontal Drugs Group during the Finnish presidency.

### **UK: Meeting on attracting investment to develop new medicines**

On 9 February 2006 a high level group bringing together government ministers and top-level representatives of the pharmaceutical industry, met in London to discuss how the UK can continue to be a leader in attracting investment to develop new medicines. The Ministerial Industry Strategy Group (MISG) discussed the progress made by the Long Term Leadership Strategy, which aims to ensure that the UK remains an attractive option for the pharmaceutical industry, and agree how they might build on progress so far.

The meeting coincides with the publication of The Department of

Health and Association of British Pharmaceutical Industry (ABPI) Pharmaceutical Industry Competitiveness Task Force (PICTF) Competitiveness & Performance Indicators for 2005, which help in monitoring the competitiveness of the UK relative to 12 other countries as a location for the pharmaceutical industry.

Jane Kennedy, Minister for Health and co-chair of MISG said “the Government wants the UK to maintain its position as a leading country for the pharmaceutical industry to develop medicines. We see from the Taskforce indicators that the UK attracts 9% of world pharmaceutical industry research and development expenditure while it has less than 4% of the global market for medicines. We want to improve even further on this. The Strategy has delivered real improvements to date, but I would now want it to increase this momentum so that when MISG next meet in November we have concrete proposals that will maintain the UK’s leading position as leaders in developing new medicine.”

John Patterson, of AstraZeneca, said: “Historically the industry has invested strongly in the UK, and a quarter of the world’s top 100 medicines were developed in British laboratories. This joint initiative is very timely, since global competition for research, development and manufacturing are all intensifying and the UK needs to continue to develop positive reasons to do business here. We are therefore very committed to the success of this exercise, for the benefit of UK patients and of the economy.”

The MISG welcomed the achievements of the Strategy and endorsed the recommendations for the next stage of the work that look at:

- Improving the rate at which effective new treatments are made available to NHS patients.
- Facilitating joint working between the NHS and the pharmaceutical industry for the benefit of patients.
- Building on the high level pharmaceutical meeting held under the UK Presidency of the

EU in December 2005, and developing proposals to assist the aims of the European Commission’s Pharmaceutical Forum to make Europe a more attractive location for pharmaceutical companies to invest.

- Considering new methods for safe introduction of medicines and ensuring the safety of medicines that are already licensed, whilst maintaining patient access to innovative medicines.

*More information on the Ministerial Industry Strategy Group can be found at*

[www.db.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/IndustryBranch/fs/en](http://www.db.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/IndustryBranch/fs/en)

### **Keynote speech on health policy and health economics in Germany**

German Health Minister Ulla Schmidt delivered a keynote speech at the conference, ‘The American Model and Europe: Past–Present–Future’, organised by the Friedrich Ebert Foundation, Washington, DC, on 27 January 2006. In a wide ranging speech the Minister stated her desire to see Germany move towards a mandatory system of health insurance. One first step towards this is the decision of the new Federal Government that no one may lose their insurance coverage. Individuals who have lost their coverage because they were unable to pay their premiums, are to be given a right to reinstatement.

She also discussed the challenge of containing the rising costs of health care expenditure and the future funding of the system, believing that “it is indeed, possible to manage trends in health care expenditure and to guarantee high quality health care for all at affordable prices. The prerequisite, however, is that policymakers do not allow their good intentions to be co-opted by lobbyists”

She touched on current discussions on how insurance contributions should be funded in future. At present health insurance contributions are charged solely on earned income (or replacement such as pensions), other sources of income are not

taken into account. She noted a difference in perspective between the two partners in the coalition government on this issue, “while the Christian Democrats wish to replace the income-dependent contribution with a standard premium (supplemented by state subsidies for low-wage earners), at least for those persons covered by the statutory health insurance, we Social Democrats want to maintain income-related contributions. But we want all citizens to pay contributions and contributions to be paid from all kinds of income.” Both major parties agree that reforms are necessary to stabilise health care financing, ensure that burdens are shared and reduce labour costs to boost the competitiveness of the economy.

The minister also spoke of cutting edge development of the infrastructure “for an electronic health card that is to be provided to all people in Germany as early as possible. This system will link 82 million insured, more than 100,000 office-based physicians, 22,000 pharmacies, 2,200 hospitals and roughly 300 private and statutory health insurers. Thanks to this card, every physician – anywhere in Germany – will have easy access to the health details of their patients and be able to avoid treatment errors.”

The Minister discussed reimbursement and coverage issues and highlighted the participation of patient and consumer organisations in the decision-making process. She stated that “this has considerably improved the transparency of and the culture surrounding the decision-making process. Informed patients who manage their own health are indispensable partners in a modern health care system.” She concluded by announcing that new proposals that will contribute to a more economical provision of drugs, liberalisation of medical professional activity and the organisation of the health care system, and a reorganisation of financing would be brought forward in the coming weeks and months.

*The full text of the Minister’s speech can be accessed at*  
[www.bmg.bund.de/cdn\\_041/nm\\_617014/EN/Health/health-policy,param=.html](http://www.bmg.bund.de/cdn_041/nm_617014/EN/Health/health-policy,param=.html)

## 2006: European Year of Worker's Mobility

2006 is 'European Year of Workers' Mobility'. Two key objectives are to raise awareness and exchange good practice on mobility and its benefits.

[http://europa.eu.int/comm/employment\\_social/workersmobility2006/index\\_en.htm](http://europa.eu.int/comm/employment_social/workersmobility2006/index_en.htm)

## New work for EU body

The European Foundation for the Improvement of Living and Working Conditions has announced its work programme for 2006. This focuses on job creation, mobility, better working conditions and work-life balance

More information at [www.eurofound.ie/press/releases/2006/060118.htm](http://www.eurofound.ie/press/releases/2006/060118.htm)

## EU Environment Agency report on Environment and Health

The European Environment Agency has recently published a new report on environment and health.

[http://reports.eea.eu.int/eea\\_report\\_2005\\_10/en](http://reports.eea.eu.int/eea_report_2005_10/en)

## Our health, our care, our say: A new direction for community services

A new White Paper published on January 30 2006 proposes to make NHS care in England more accessible by shifting services from hospitals into the community. The White Paper could see specialisms such as ear, nose and throat and dermatology carried out in new community hospitals and GP surgeries. The GP market could also be opened to the private and voluntary sector to help fill gaps in under-doctored areas. In total medical work worth £4 billion a year could be diverted from hospital outpatient departments in England into NHS and private units closer to people's homes.

The paper can be accessed at [www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf](http://www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf)

## What is the evidence on effectiveness of empowerment to improve health?

A new report from the Health Evidence Network authored by Nina Wallerstein from the University of New Mexico shows that empowering socially excluded populations is a viable strategy for improving health. While participatory processes make up the base of empowerment, strategies must also build community organisations' and individuals' capacity to participate in decision making and advocacy.

More information at [www.who.dk/eprise/main/WHO/Progs/HEN/Syntheses/empowerment/20060119\\_10](http://www.who.dk/eprise/main/WHO/Progs/HEN/Syntheses/empowerment/20060119_10)

## New EC Roma website

The European Commission has launched a new website dedicated to the Roma. It aims to provide information on the EU's activities in support of the Roma, gypsy and traveller communities across Europe. The site does not contain information on health but contains a section on how the EU intends to promote the social inclusion of the Roma population (via the European Social Fund, Equal Initiative, the Community Programme for Social Inclusion).

[http://europa.eu.int/comm/employment\\_social/fundamental\\_rights/roma/rfund/rempl\\_en.htm](http://europa.eu.int/comm/employment_social/fundamental_rights/roma/rfund/rempl_en.htm)

## A new framework for coordination of social protection and inclusion policies

The EC has launched a communication setting new objectives to the Open Method of Coordination on social protection and social inclusion. These new common objectives reflect the lesson from the analysis of the 2005 implementation National Action Plans (NAPs) for inclusion that inclusion objectives need to be mainstreamed into relevant public policies, including structural fund programmes and education and training policies. Specific objectives include provision of sustainable pen-

sions and ensuring access to high quality and sustainable health and long term care.

More information at [http://europa.eu.int/comm/employment\\_social/emplweb/news/news\\_en.cfm?id=110](http://europa.eu.int/comm/employment_social/emplweb/news/news_en.cfm?id=110)

## Global plan to stop TB 2006 – 2015

The Global Plan to Stop TB 2006-2015, Actions for Life was launched at the World Economic Forum in Davos, Switzerland, on 27 January. "The burden of suffering and economic loss caused by tuberculosis is an affront to our conscience. TB is a curable and preventable disease. Urgent action is necessary to scale up our efforts to Stop TB", the Global Plan states. WHO Europe has declared a TB emergency in the Eastern part of the Region. Action is underway with discussion among Member States, donors and counterparts to set up resources and a timely intervention.

More information at [www.who.int/tb/en](http://www.who.int/tb/en)

## European Health Insurance Card now in force

Since 1 January 2006, the old E111 forms have been replaced by the new credit-card sized European Health Insurance Card. The card contains no medical information on the individual covered but will entitle the holder to free or reduced cost health treatment as if they were a resident of the country they are visiting. It does not apply if the main purpose of any trip is to seek medical attention.

[http://europa.eu.int/comm/employment\\_social/healthcard/index\\_en.htm](http://europa.eu.int/comm/employment_social/healthcard/index_en.htm)

## EuroHealthNet

6 Philippe Le Bon, Brussels.  
Tel: + 32 2 235 03 20.  
Fax: + 32 2 235 03 39  
Email: [l.coulet@eurohealthnet.org](mailto:l.coulet@eurohealthnet.org)





Rt Hon Patricia Hewitt, Secretary of State Department of Health, UK  
Mr Markos Kyprianou, EU Commissioner for Health and Consumer Protection  
Ms Rosie Winterton, Minister of State for Health Services, UK  
Mrs Maria Rauch-Kallat, Minister of Health, Austria  
Mr Hans Hoogervorst, Minister of Health, Welfare and Sport, Netherlands  
Mrs Ylva Johansson, Minister for Health and Elderly Care, Sweden  
Dr Pawel Szwed, Under Secretary of State, Ministry of Health, Poland  
Ms Liisa Hyssänen, Minister of Health and Social Services, Finland  
Dr Radosław Gajdarski, Minister of Health, Bulgaria  
Prof António Correia de Campos, Minister of Health, Portugal  
Mr Neven Ljubičić, Minister of Health and Social Welfare, Croatia  
Mr Rudy De Motte, Minister of Social Affairs, Public Health and the Environment, Belgium  
Mr Xavier Bertrand, Minister for Health and Solidarity, France  
Mr George Konstantopoulos, Deputy Minister, Health and Social Solidarity, Greece  
Dr Vlad Anton Iliescu, Secretary of State for European Integration, Romania  
Mr Andreas Gavrielides, Minister of Health, Cyprus  
Mr Peeter Laasik, Deputy Minister, Estonia  
Mr Andrej Bruščič, Minister of Health, Slovenia  
Dr Klaus Theo Schröder, State Secretary Federal Ministry of Health and Social Security, Germany  
Mrs Katerina Ciharová, Czech Republic  
Dr Alexandra Novotná, State Secretary of Health, Slovakia  
Mr Gábor Kapás, Deputy State Secretary for Health Policy, Hungary  
Dr Sabhattin Aydın, Deputy Under Secretary, Turkey  
Mrs Mary Harney, Minister for Health and Children, Ireland  
Mr Gundars Bērziņš, Minister for Health, Latvia  
Professor Zilvinas Padaiga, Minister of Health, Lithuania  
Mr Mars di Bartolomeo, Minister of Health and Social Security, Luxembourg  
Hon Francesco Storace, Minister of Health, Italy  
Mr Lars Løkke Rasmussen, Minister for the Interior and for Health, Denmark  
Ms Elena Salgado, Minister of Health and Consumer Affairs, Spain  
The Hon Dr Louis Deguara, Minister of Health and Elderly Care, Malta