EUROHEALTH

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7th European Public Health Conference

› **Reducing inequalities in health and health care**

- Learning how to mind the gap
- Glasgow Declaration
- Migrant & ethnic minority populations
- Health information

- Public health monitoring & reporting
- Developing public health workforce
- Learning from each other
- Building sustainable & resilient health systems

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Editorial: Health inequalities are unnecessary and unjust

Inequalities in health exist both within and between countries. They are both unnecessary and unjust. They also create a great cost to societies, not only through the direct costs of providing health care for those with avoidable illness but also the costs of reduced participation in the workforce and lower productivity. In November 2014, these issues were brought to the fore when Glasgow hosted the 7th European Public Health Conference with the theme "Mind the Gap: Reducing Inequalities in Health and Health Care". It was fitting for such a conference to be held in Glasgow given that the World Health Organization report of the Commission on Social Determinants of Health had contrasted the very low life expectancy in one part of the city (Calton – 54 years) with that in a more affluent area nearby (Lenzie North – 82 years). Even more shocking, it showed that life expectancy in Calton lagged behind the average experience of some low income countries (India – 62 years, Philippines – 64 years).

The conference, organised by the European Public Health Association and the UK's Society for Social Medicine, provided an opportunity for researchers, practitioners and policy-makers to exchange opinions and examples of best practice, to improve our understanding of the nature, extent and causes of inequalities and to share ideas and experiences regarding the means to reduce inequalities. This issue of Eurohealth highlights some of the main contributions to the conference and provides a timely update of current knowledge and areas for action in Europe.

Mackenbach opens the **Observer** section and talks of the shift in research on inequalities, moving from a focus on description to explanation and on to intervention. Both the increase in knowledge as to what works to reduce inequalities, made possible in part by concerted action by the European Commission, and the evidence that some inequalities in health are starting to decrease are to be welcomed. This research has informed the Glasgow Declaration: a call for "all hands on deck" to reduce health inequalities, suggesting that this is not just a problem for the public health community but one for the wider all of society. Buissonniere and Cohen

then show how Roma communities have taken the lead in initiatives to improve the health of their communities, so that they have not only reduced the health gap with non-Roma communities but also contributed to improving the health of the overall population. These examples, whereby Roma have increased social accountability, improved access to health care, and challenged beliefs about the place of Roma within the public health system, illustrate how empowered communities can bring about change. This section also contains a description of a meeting that examined the adaptation of interventions designed to improve the conditions of migrant and ethnic minority populations, drawing on nine invited presentations and summarising the lessons learned for intervention research.

In the **Eurohealth International** section, Ruland and colleagues discuss the potential contribution of behaviour-centred design to improved health promotion and infectious disease control. They go on to highlight the need for more and better formative research, particularly in response to emerging diseases.

Evidence-informed policy-making (including policy to reduce inequalities) is dependent on high quality information

systems. Rosenkötter and van Bon-Martens discuss the state of national health information systems throughout Europe in a time of austerity and, in particular, focus on the need for much better data on morbidity from specific diseases and external causes. Maeckelberghe and McKee argue in favour of "progressive universalism" – public health policy directed at improving the health of all but with increased emphasis placed on improving the health of those in greatest need, thereby reducing health inequalities. They provide many examples of the successes that can be achieved when necessary governmental regulation is accompanied by measures empowering individuals and communities and an increase in the accountability of policy-makers. The World Health Organization has recognised the need to develop the public health workforce, and Bjegovic-Mikanovic and colleagues describe the current state of education and training across Europe concluding with specific recommendations to policy-makers and Schools of Public Health.

In the **Systems and Policies** section Hansen and colleagues describe the development of a European Research Area network in health services and systems research. This network will concentrate on the transferability of successful health care models from one country to another, identifying the necessary preconditions for successful transfer of policies or the arrangement of services. Ricciardi concludes this issue by providing a summary of some of the lessons learned at the conference. Bringing together over 1500 participants from so many countries undoubtedly provided a learning opportunity for all constituents of the public health community – researchers, practitioners and policy-makers. The Glasgow Declaration is a part of making sure that reducing health inequalities remains high on the agenda of the EU and all Member States.

Alastair H Leyland, Walter Ricciardi, Martin McKee and Dineke Zeegers Paget

HEALTH INEQUALITIES:
LEARNING HOW TO "MIND THE GAP"

By: Johan P. Mackenbach

Summary: Recent years have seen progress on tackling inequalities in health between socioeconomic groups in Europe on two fronts: several studies exploiting natural policy experiments have generated new knowledge on the effectiveness of interventions and policies to reduce health inequalities; and trend data on health inequalities show that some inequalities, particularly absolute inequalities in mortality among men, are becoming smaller instead of larger. Nevertheless, health inequalities remain unacceptably large, and it will require "all hands on deck" to close the health inequalities gap.

Keywords: *Health Inequalities, Natural Policy Experiments, Trends, Research*

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Introduction

"Minding the gap" in health between socioeconomic groups in our societies is one of the main challenges for public health throughout Europe,[1] and the European Public Health conference in Glasgow has shown that we are making progress – slowly, too slowly perhaps, but steadily.

There is progress on two fronts. First, there is progress in knowing what to do to reduce health inequalities. Thanks to serious investments in cutting-edge research by the European Commission (EC), lots of new knowledge on the effectiveness of interventions and policies to reduce health inequalities has recently been generated. Second, evidence is emerging that some inequalities in health are becoming smaller instead of larger. Although this narrowing of health inequalities is somewhat dependent on the perspective chosen, and largely limited to men, it is encouraging news that lends support to the idea that health inequalities are indeed remediable.

Progress in knowing what to do

Gradually, research on health inequalities in Europe has moved from description to explanation (in the 1990s) and then from explanation to intervention (in the 2000s).[2] Whereas research efforts in the 1990s were largely focused on finding out what the determinants of health inequalities are, recent years have seen a surge of studies looking at the impact of interventions and policies to reduce health inequalities. This was also evident at the Glasgow conference where four large projects funded by the ECs Seventh Framework Programme for Research presented their main results.

Evaluating interventions and policies to reduce health inequalities is far from easy. Randomised Controlled Trials, the "gold standard" for evaluation in the health care field, are generally unsuitable for evaluating the large-scale and complex interventions and policies that are needed for achieving population-level effects. The four EC-funded projects have therefore tried to exploit "natural policy

experiments", in which interventions and policies happened to have been implemented in one setting and not in another, allowing comparisons to be made. These four projects are known under the following acronyms: DEMETRIQ (www.demetriq.eu), DRIVERS (www.health-gradient.eu), SILNE (www.silne.ensp.org), and SOPHIE (www.sophie-project.eu).

> " health inequalities are indeed remediable

The results cover a wide range of policy areas, and only a few examples can be mentioned here. The introduction of a national minimum wage in the United Kingdom in 1999 not only reduced financial strain among its recipients, but also reduced depressive complaints among people on low incomes, and may therefore have contributed to a reduction of inequalities in mental health.[3] Urban renewal projects in disadvantaged neighbourhoods in municipalities in Catalonia (Spain) had a positive effect on self-rated health, and reduced inequalities in poor self-rated health.[4] Well-developed labour market integration policies which aim to re-integrate individuals in case of disability, are related to lower levels of stressful work at the national level in Europe, and may therefore contribute to reducing inequalities in stress-related health problems.[5]

One general finding of these four projects is that it is often easier to find natural policy experiments that made matters worse, rather than ones that improved the situation and had the potential to narrow health inequalities. Such "negative" results have been found, for example, in the areas of tobacco and alcohol control. Tightening of tobacco control policies in the Netherlands in 2003 led to a widening of inequalities in adolescent smoking.[6] Finland experienced a large reduction in alcohol prices in 2004 due to the lowering of alcohol taxes by about one-third, and the abolition of duty-free allowances for

travellers from the European Union. As a result, alcohol-related hospitalisations and mortality rose, particularly in low income groups.[7]

While these results clearly illustrate that the evidence base is slowly growing, there is an urgent need to continue research into what works to reduce health inequalities. Europe, with its variations in policy, offers excellent opportunities for generating more evidence, and the EC would do well to allocate funds from the Horizon 2020 programme to support further work in this area.

Progress in actually reducing health inequalities

There is also some progress in actually reducing health inequalities, but in order to see it one must first carefully define what "progress" means. Let's look at a numerical example. Suppose that in country X the mortality rate declines from 100 to 50 among the rich, and from 200 to 120 among the poor. While the decline in mortality will be seen as progress by everyone, the resulting change in magnitude of inequalities between rich and poor will not. Some will see a deterioration of health inequalities, because the Rate Ratio has increased from 2.0 (200/100) to 2.4 (120/50). Others will see progress, because the Rate Difference has fallen from 100 (200–100) to 70 (120–50).

Such opposing trends for relative and absolute inequalities are quite common, as recent studies of trends in inequalities in mortality have shown (**see Figure 1**). Trends have been very unfavourable in Hungary, Lithuania and Estonia, where mortality has increased among the low educated, and declined or remained stable among the high educated, and both relative and absolute inequalities in mortality have risen dramatically.[6]

However, trends have been much more favourable in Western Europe, where mortality has declined among both the low and high educated, albeit at different speeds. Whereas relative inequalities in mortality have nearly uniformly gone up, absolute inequalities have not, particularly among men. Due to greater absolute

declines among lower educated men, Rate Differences of mortality have gone down among men in Finland, Sweden, Norway, England & Wales, France, Switzerland, Spain and Italy (Figure 1b), and among women in Sweden, Norway, France, Switzerland, and Italy (Figure 1d). Rate Ratios, on the other hand, have gone up in almost all countries (Figures 1a and 1c).[8]

How to choose between these two perspectives? Embedded in quantitative measures of relative and absolute inequalities are value judgements.[9] Regretting the rise of Rate Ratios despite declining Rate Differences implies a strictly egalitarian position, in which what matters is equality in itself, independent of other considerations such as the absolute rates of mortality for each group. Welcoming the decline of Rate Differences despite rising Rate Ratios implies the pragmatic view that absolute rates matter most for people in lower socioeconomic groups, and that a smaller absolute mortality excess is thus to be preferred even if it goes together with a larger relative mortality excess, as in many European countries over the past decades.

In my view, there is a strong case to be made for the 'Realpolitik' of aiming to reduce absolute inequalities in mortality. In a context of rapidly declining mortality rates, it is extremely difficult to reduce relative inequalities in mortality. This is not only suggested by the near-absence of empirically observed reductions of relative inequalities (**see Figure 1**), but can also be underpinned by theoretical reasons. To achieve a reduction of relative inequalities in mortality one would need to create greater reach and/or greater effectiveness of interventions and policies among people with a lower socioeconomic position, and therefore spend considerably larger efforts on people with a lower socioeconomic position. While this is not impossible, it would necessitate a massive shift of resources that has so far not been politically feasible.[10]

Conclusions

In conclusion, there is progress, both in "knowing what to do" and in actually reducing health inequalities, but these two forms of progress probably have

Figure 1: Changes in educational inequalities in mortality between the 1990s and 2000s, by country/region and sex

a. Relative inequalities, men
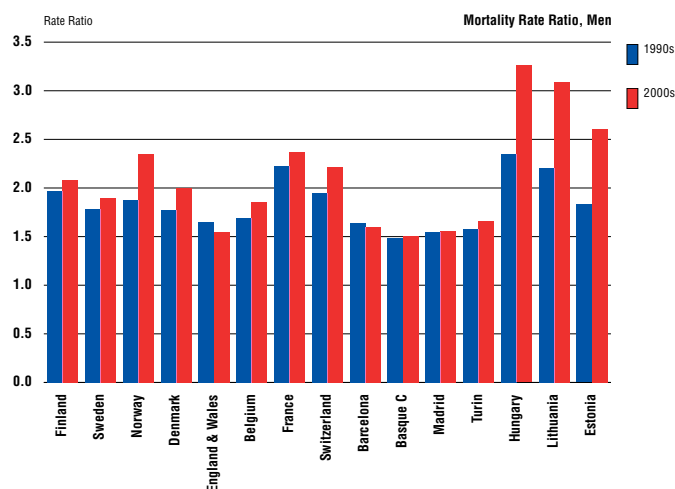
b. Absolute inequalities, men
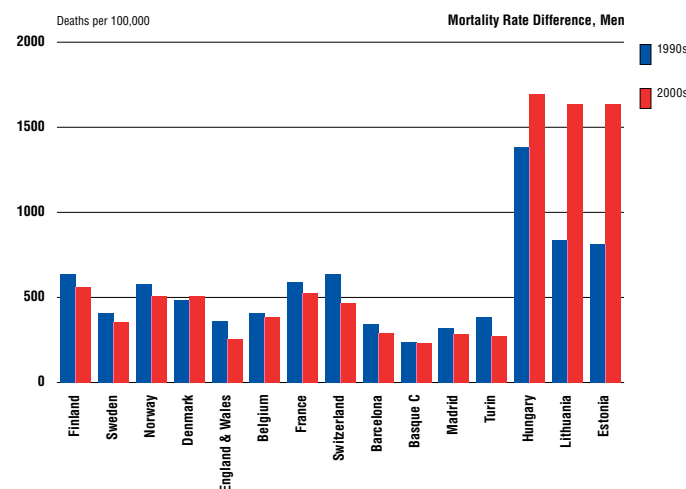
c. Relative inequalities, women
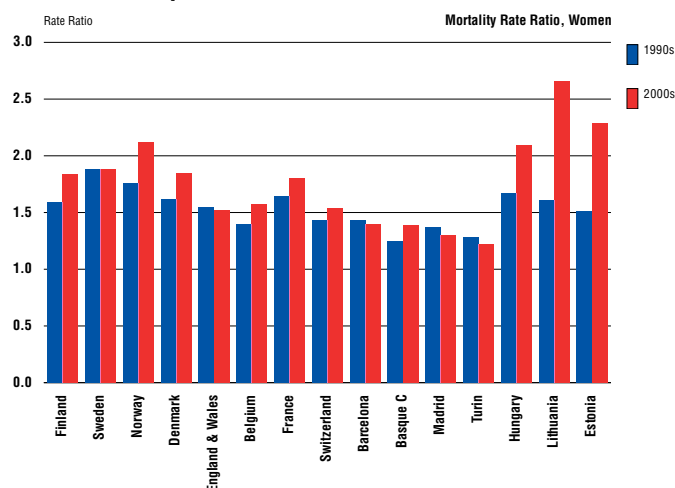
d. Absolute inequalities, women
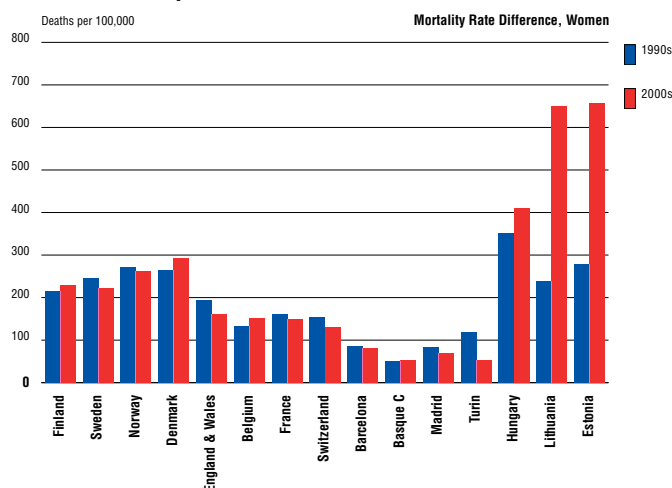
Rate Ratios and Rate Differences calculated from age-standardised all-cause mortality rates of those with no, primary or lower secondary education versus those with tertiary education.

Source: [8]

little to do with each other. The decline of absolute inequalities in mortality seen in some countries was not due to the implementation of policies aiming to reduce health inequalities, but represents general progress in reducing mortality which was shared more or less equally between socioeconomic groups.

One example is the decline in mortality from cardiovascular disease which has been larger, in absolute terms, among the low than among the high educated in many Western European countries, probably as a result of advances in prevention and treatment of these conditions which have benefited all social strata.[9] Such benefits to lower socioeconomic groups do not come automatically but represent an

enormous achievement of many Western European countries, which would not have been possible without, some degree of equality of access to health care.

Nevertheless, much remains to be done, particularly if we aim at reducing relative inequalities in health. Health inequalities remain unacceptably large, both in absolute and relative terms, and while evidence on the (in)effectiveness of policies and interventions to reduce health inequalities is accumulating, the political will to implement these policies, and to allocate the resources necessary to achieve population-level effects is often lacking. As the Glasgow declaration rightly states, it is "all hands on deck" to close the health inequalities gap.

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Some tweets from the Conference #ephglasgow

Prof Whitehead: governments should invest in social protection over austerity measures that hit hard the more disadvantaged **#ephglasgow**

Access to care key in decreasing mortality among lower socio-economic groups **#ephglasgow**

#KarlEkdahl is warning that health politicians are not aware of lower access to **#healthcare** for vulnerable groups **#ephglasgow**

Marc Sprenger: "public health is a clockwork" – all measures should interlock **#ephglasgow #phealth**

Policies more effective than pills against non-communicable diseases **#ephglasgow #NCD**

For Johan Mackenbach major determinants for reducing health inequalities are smoking and alcohol related mortality **#ephglasgow**

Ricardo Baptista Leite: health in all policies is the Loch Ness monster of the EU **#ephglasgow**

Raj Bhopal: Need to integrate social determinants of health and ethnic disparities agendas. Will help improve health for all **#ephglasgow**

Simon Capewell: drug, alcohol and processed food/drink industries care about profit not **#publichealth #ephglasgow**

'ALL HANDS ON DECK' TO CLOSE THE HEALTH INEQUALITIES GAP

Introduction

Glasgow welcomed Europe and beyond to the 7th European Public Health (EPH) Conference between 19th and 22nd November 2014. Sixty-five countries were represented by over 1500 delegates, who gathered to discuss and debate the knowledge and practice of reducing health inequalities.

Over the course of the conference, which included seven plenary sessions, over 100 parallel sessions, about 300 posters and six films, delegates had the opportunity to share findings from research and experiences with innovation in all fields of public health and health services.

Researchers, educators, policy-makers, community representatives and health managers from Europe and beyond shared new information and insights from their experiences with interventions to reduce health inequalities, the theme of the conference, and developed a deeper understanding of the urgency to address this issue.

This Declaration summarises broad ranging discussions over the three days of the conference, drawing upon rapporteurs' notes across all the sessions.

The facts

Health inequalities exist not only between countries but also within countries. Health inequalities refer to differences in people's health and life chances. Health inequalities are strongly related to the conditions in which people live, such as their income, employment status or the area they reside in. In the UK, for example, those living in the richer areas will live, on average, seven years longer than those who live in poor and deprived areas. Priority areas in health inequalities are tobacco, alcohol, addictive drugs and poor diet.

While there are some welcome indications that inequalities have started to narrow in recent years, at least on an absolute scale, they are still unacceptably large.

The evidence presented at the EPH Conference in Glasgow was overwhelming:

- Health inequalities between countries amount to a gap of 8.9 years of life expectancy between Latvia (74.1 years in 2012) and Iceland (83.0 in 2012)

- Health inequalities within countries systematically favour the well off. In Glasgow, for examples, there is a nine-year gap in male life expectancy between neighbourhoods.

At the conference, several promising examples were presented, including:

- Involving peer groups (professional sports clubs willing to 'buy in' to health improvement programmes for their fans) has a positive effect on lifestyle changes

- Green spaces in urban environments have a positive effect on mental health

- Regulation by authorities having a positive impact on healthy choices (e.g. Danish fat tax and potential UK sugar tax)

- Organising better access to health care by making ethnic/migration status a routine part of policy.

Even though there have been successes, health inequalities are still unacceptably large. Recent trends, for example in cardiovascular disease mortality, suggest that reducing health inequalities is indeed feasible. National programmes in various European countries to tackle health inequalities have so far been only partly successful, and have shown that we need to re-think what is needed to measurably reduce health inequalities at the population level. The focus going forward should be on a reduction of absolute and relative health inequalities.

The solutions

Glasgow 2014 has made us aware that we not only have to 'mind the gap' in health inequalities, we need to go much further than that. It is ALL HANDS ON DECK! The whole public health community and the whole of society needs to get involved in reducing health inequalities.

We need to:

- Increase the available data and also studies on how to achieve population wide impact

- Translate research/evidence to policy consistently and at all levels

- Understand what works to reduce health inequalities, for whom, and why

- Ensure that policies are based on established models of good practice and evaluated both in terms of economic and health benefits

- Exchange best practice (international, national) to learn from each other

- Think outside the box: topics to be covered include poverty reduction, improving employment and working conditions, tobacco and alcohol control and urban renewal

- Foster public engagement and solidarity

- Increase personal engagement

- Develop the commitment of the public health community

- Obtain a commitment from the community

The next steps

At the 8th European Public Health Conference, in October 2015, in Milan, Italy, we will evaluate what processes have been put in place that can reduce health inequalities. We encourage researchers, governments, NGOs and funders to attend Milan 2015 and contribute towards this vision.

LEADERSHIP FROM WITHIN: **ROMA COMMUNITIES RESPONDING TO HEALTH INEQUALITY** IN EUROPE

By: Marine Buissonniere and Jonathan Cohen

Summary: The economic crisis disproportionately impacted on European Roma's access to health care, with health status deteriorating further. While state efforts have produced limited results to address social exclusion in health facing Roma, Roma communities themselves are leading on solutions that can lead to better health for Roma and beyond. Whether using social accountability methods to hold authorities to account for health-related commitments; working with paralegals to overcome obstacles to care; or changing the system from within by becoming medical professionals, Roma communities are challenging the prevailing narrative of Roma as burdens on – to become leaders of – Europe's health systems.

Keywords: Roma; Health Inequalities; Community; Accountability; Human Rights

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Introduction

Although health inequality in Europe is hardly a new phenomenon, the European economic crisis has fuelled an ideology of fiscal austerity,[1] which has disproportionately affected vulnerable populations.[2] [3] This has further widened the health gap between non-migrants[4] and migrants, ethnic minorities and the general population. Europe's Roma, marginalised long before the crisis, have not been spared. In its 2014 *Roma Health Report,*[5] the European Commission concluded that the economic crisis was disproportionately impacting Roma populations' access to health care, further pointing at indications that "*Roma health status ... is deteriorating further in a number of places as a result of cutbacks*".

Though health indicators pertaining to Roma remain few and piecemeal due to the lack of systematically disaggregated data by ethnicity, a review of the most recent available data continues to paint a picture of inequality and social exclusion in health. According to a study[6] conducted by the European Roma Rights Centre (ERRC), the average age at death of Roma and non-Roma in Romania was 52 and 68 years respectively in 2013. A staggering 32% of Romani women in Romania reported never having had a gynaecological examination, twice as high as in the general population. At the 7th European Public Health Conference (EPH) in November 2014, Dr Jean-Francois Corty, Director for domestic programmes at Médecins du Monde, reminded the audience that an average of 30–40% of

people in Roma settlements in France were vaccinated, with numbers dropping to as low as 10% in some areas.

" more rapidly translating evidence into implementation

Those statistics are only part of a continued story of marginalisation of Roma people, whose social exclusion and vulnerability to human rights abuses limit their access to care. Yet as shocking and unrelenting as these discrepancies are, they remain too often insufficient to move policy-makers to take action and to lead to tangible changes for Roma people. In contrast, it is more often Roma communities themselves that are devising and leading solutions that can and have led to better health and rights outcomes for Roma and beyond. The three case studies below illustrate how *the excluded help the excluded,* especially where duty bearers in government fail to apply official resources and policies to address the Roma health gap.

Holding authorities to account for their commitments

Accountability is increasingly recognised as a cornerstone of any successful health system. Throughout Europe, Roma communities have been on the cutting edge of community-driven inquiries, monitoring, applied budget work, and other forms of social accountability which contribute to holding local officials to their stated commitments in the health sector. An example comes from Bulgaria, where national legislation has been drawn up to address health inequalities, but actual implementation has been lagging behind and meaningful participation by Roma communities had not been prioritised. Complicating the situation, the devolution of health budgets had largely left the task of addressing health inequality to the discretion of local authorities, some of which lack commitment to their most vulnerable citizens.

In 2011, the Amalipe Center for Interethnic Dialogue and Tolerance (Amalipe) decided to put Roma at the heart of holding local authorities to account for the delivery of health services in Bulgaria – not just for Roma, but for the entire community. Following a model first proposed by Professor Abhijit Das of the Public Health Institute in India, Amalipe developed a system to enable communities to monitor health care services themselves, and to carry out their own inquiries into their health needs and how local services met (or failed to meet) them. Amalipe established local volunteer clubs, where young people, women and informal leaders came together with trained moderators from the community to discuss health issues. Together, they went on to conduct surveys, documenting the community's views and assessment of their access to primary health care, emergency and hospital medical care, as well as child and women's health care.

The findings were not unexpected, from an inability to afford medication to discrimination from medical staff. The surprising part is what happened next. The Amalipe project team shared their results with the wider community, municipalities, and responsible institutions, and because of the way the data were collected – by communities, within the view of local authorities, with planned follow up surveys every six months to assess progress – the impact was almost immediate. An action plan for addressing the harshest problems was designed and implemented. Amalipe's Teodora Krumova captured some of the results of these efforts in a poster she presented at the 7th EPH: between June 2012 and June 2014, the proportion of Roma women who could identify their local primary care physician jumped from 83% to 94%. Illegal payments within both general practice and hospital went down by almost 25%. Regular medical check-ups for children almost tripled. This resulted from a monitoring and accountability exercise, not from a programmatic intervention.

While public health tends to operate on a traditional policy cycle, whereby academically-produced evidence is translated for policy-makers and churned through a democratic process, community

monitoring offers a shortened and radically different process, whereby communities are able to immediately give feedback to implementers. The link between evidence and action is swifter and more direct. The leadership of the community and their direct engagement with local leaders has the effect of more rapidly translating evidence into implementation and palatable changes for communities.

Overcoming legal and administrative obstacles

Access to citizenship and documentation has long been recognised as a gateway to health care in many countries of Europe. The former Yugoslav Republic of Macedonia (FYROM) is a case in point, where in 2009, the law was amended to provide universal health insurance to its citizens. However, Roma who lived in slums or temporary dwellings in FYROM still found it difficult to access health care services, and they often lacked the documentation necessary to apply for health insurance benefits. In a study carried out in two Roma communities in 2011, the non-governmental organisation ESE (Association for Emancipation, Solidarity and Equality of Women) found that 76% of patients were unable to obtain the care they needed.[9]

The communities devised their own solution, which was not only about engaging doctors, nurses, or even Roma health mediators to address this gap, but also to work with paralegals, trained from within their own community. In four community-based organisations in the Roma communities of Shuto Orizari and Delcevo, ESE trained twelve community paralegals on human rights and the structure of FYROM's health care and judicial systems. The paralegals conduct door-to-door outreach, hold workshops with communities to inform them of their rights, and hold office-hours. They listen, offer advice, and when necessary, accompany clients to local authorities or clinics where they negotiate resolutions to disagreements, lodge complaints, or demand remedies for violations. They also help many Roma navigate administrative

hurdles to obtain personal identification documents, without which they cannot get health insurance.

Between January 2011 and July 2012, more than 587 people benefited directly from the paralegal services provided by these Roma community organisations, and the paralegals have also become a source of assistance for regional units of FYROM's Health Insurance Fund. By helping people secure their rights to identity documents, social security coverage and health insurance, paralegals are also contributing to addressing entrenched systemic biases, including denial of care to Roma or illegally charging for free services, which have reportedly decreased since Roma paralegals have begun operating.

Challenging the health system from within

Despite evidence to the contrary, the prevailing narrative about Roma health in Europe is that Roma pose a challenge to the public health system that burdens the non-Roma population.[10] Yet the increasing number of *Roma* doctors, nurses, and other medical professionals in the region pose a challenge to this narrative. The Roma Health Scholarship Programme (RHSP), launched by the Open Society Foundations and the Roma Education Fund in 2008, has contributed greatly to this positive trend. Since 2008, 1000 young Roma have enrolled in medical and nursing schools in Bulgaria, FYROM, Romania, and Serbia with scholarship support from RHSP. When the programme was started, one could count on one's hands the number of self-identified Roma medical professionals in these four countries. The scholarship recipients, who identify as Roma, are not only changing the system from within as an integral part of the next generation of doctors and nurses in their countries, but they also are contributing to public health research and knowledge writ large.

Pepa Karadzhova, a student at the Medical University of Pleven in Bulgaria, is one of the Roma scholars who participated in panels or presented posters at the 7th EPH. A conference veteran, Pepa chose to present an analysis of the impact of prematurity on demand for infant health and social services. After her presentation,

she pointedly said: "*For the past two years, I have presented posters on Roma issues. This year, I wanted to present something for the entire community.*" She is not alone: when floods hit Serbia in the summer of 2014, amongst the first respondents were Roma medical students, who were met with surprise by non-Roma local residents; and in a powerful and humorous video,[11] scholarship recipients in Romania challenged Bucharest residents' view that Roma are only beneficiaries and beggars rather than providers and leaders of health interventions. Pepa and her fellow health scholars represent a powerful new generation of professionals, who are demonstrating to their own community that despite internalised views to the contrary, one of their own can aspire to a medical profession. They are also highlighting to their fellow students that a Roma can be a successful student, to their professors and mentors that a Roma can be a doctor, and to their patients – and ultimately, society – that Roma are part of improving health for all.

"paralegals help many Roma navigate administrative hurdles

Recommendations

These three cases illustrate that supporting communities to lead and participate in human rights-based solutions that improve their health, opens up a different path–one that could possibly take us out of the infertile circle of undetectable investments and imperceptible results that has come to characterise Roma health in Europe. They also illustrate that new thinking and imagination are needed to address intractable problems such as the gap between policy and implementation, the social determinants of health, and the prejudicial beliefs about ethnic minorities – and that this new

thinking and imagination comes from within communities themselves. Three recommendations flow from these cases:

- It is time to add new approaches to the seminal and successful Roma Health Mediator model, which too often continues to be presented as the only best practice in this field of Roma health. The European Commission and its Member States are uniquely placed to encourage the dissemination, scale-up and funding of promising health inclusion practices, of the kind presented above – community inquiry and monitoring, paralegals, and scholarships.

- Communities should be an integral part of the design and implementation of Decade Action Plans and current National Roma Integration Strategies. The European Commission and the Member States should support the establishment of mechanisms for community feedback on the accessibility, affordability, quality and appropriateness of the health and care services provided to them. In addition to their views of the problem, they should seek communities' recommendations for solutions, so that the community's feedback can be incorporated into the development and improvement of subsequent health strategies and services.

- As noted at the outset of this article, it will remain a struggle to monitor the success or failure of policies targeting Roma without ethnically disaggregated health data. Such data lay a foundation of accountability and can support community-led efforts by showing whether progress has been made in terms of health outcomes. Roma communities can also assist and advise in designing methods of data collection that respect privacy and human rights. The European Centre for Disease Prevention and Control, European Commission, and World Health Organization should encourage European countries to collect disaggregated data through exchange of good practices, dissemination of information on relevant data protection

rules (i.e., EU Directive 95/46/EC on data protection), and support for pilot projects that can serve as models.

- It is bad enough that we have allowed the European economic crisis to increase health inequalities among Roma and other vulnerable groups. The real mistake would be to fail to harness the imagination and energy of communities in leading solutions to these problems – for the benefit not just of Roma, but for everyone.

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Assessing chronic disease management in European health systems

Edited by: E Nolte, C Knai & RB Saltman.

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The rising burden of chronic illness, in particular the rapid increase in the number of people with multiple health problems, is a challenge to health systems globally. Associated premature mortality and reduced physical functioning, along with higher use of health services and related costs, are among the key concerns faced by policy-makers and practitioners.

There is a clear need to redesign delivery systems in order to better meet the needs created by chronic conditions, moving from the traditional, acute and episodic model of care to one that better coordinates professionals and institutions and actively engages service users and their carers. Many countries

have begun this process but it has been difficult to reach conclusions about the best approach to take: care models are highly context-dependent and scientifically rigorous evaluations have been lacking.

Assessing chronic disease management in European health systems explores some of the key issues, ranging from interpreting the evidence base to assessing the policy context for, and approaches to, chronic disease management across Europe. Drawing on twelve detailed country reports (available in a second, online volume), the study provides insights into the range of care models and the people involved in delivering these; payment mechanisms and service user access; and challenges faced by countries in the implementation and evaluation of these novel approaches.

This book builds on the findings of the DISMEVAL project (Developing and validating DISease Management EVALuation methods for European health care systems), led by RAND Europe and funded under the European Union's (EU) Seventh Framework Programme (FP7) (Agreement no. 223277).

Adaptation of health promotion and disease prevention interventions for migrant & ethnic minority populations: policy, practice and research

Pre-conference summary report by: Erika Marek, Allan Krasnik and Raj Bhopal

The meeting was held in Glasgow on 19–20 November, 2014 as a preconference event within the annual European Public Health Conference, organized by the European Public Health Association (EUPHA). The meeting enjoyed the participation of more than 60 health care professionals from 22 countries. Three EUPHA Sections planned this joint preconference meeting: the Migrant and Ethnic Minority Health Section led, in partnership with the sections for Chronic Diseases and Health Promotion. The meeting was organized in collaboration with the Scottish Health Migration and Ethnicity Research Strategy Steering Group, West of Scotland Health and Ethnicity, and Edinburgh Ethnicity and Health Research Group. It was financially supported by the EUPHA Migrant and Ethnic Health Section and NHS Health Scotland.

The meeting had two major goals. Firstly, in the tradition of past Migrant and Ethnic Health Section pre-conferences, with reference to the theme of the meeting, to provide an overview of national policy on migration, ethnicity and health in the host nation (Scotland) and secondly, to share experience on the pre-conference theme, with the intention of furthering a common agenda across European countries and EUPHA sections.

During the first day's presentations the participants were provided with detailed overviews of the current state of migration, ethnicity and health in Scotland, concerning the recent changes in ethnic health policies, improvements in service delivery, current research strategies and ongoing research, and also of the state and challenges of the availability of health data in relation to migration and ethnicity.

As *'Adaptation of health promotion and disease prevention interventions for migrant & ethnic minority populations'* was in the main focus of the meeting, during these two days nine invited presenters shared the experiences of different national and international research projects and interventions with special reference to the pre-conference theme i.e. how these health promotion interventions may be adapted for migrant and ethnic minority populations, and what obstacles and challenges such adaptations may face. These shared experiences encouraged the participants of the meeting into joint thinking and discussions and by the end of the second day some thought-provoking lessons and conclusions were defined:

- There is a strong need for common, international definitions of the main concepts regarding ethnicity and migrants, as well as methodologies such as patient-centered care, health inequality impact assessment etc.

- The terminology of adaptation of interventions needs further development and refinement in order to establish common grounds for discussions and actions. This includes agreements on a clear typology for relevant adaptation approaches and the main elements involved.

- It is important to document which kinds of adaptations contribute to the effectiveness of health promotion among migrants and ethnic minorities e.g. whether interventions are related to surface versus deep structures, targeting individuals versus communities, focusing on commonalities across groups versus specificities within groups, and on observable behaviours versus cultural values etc. This will also provide an opportunity for learning in order to increase the general quality of programmes for health promotion and prevention in the entire population.

- Ineffective programmes should not be adapted. Interventions which are not proven to be effective in the first place are not likely to be successful among migrants and ethnic minorities after adaptation either. More research is needed to study the contribution of specific cultural adaptations to interventions that are known to be effective and to find out which components of the programs are the most important for effectiveness.

- It is crucial to include cultural and broader diversity competencies in the training of medical and health promotion staff, and to ensure the development of relevant training curricula. Interventions should be adapted as much as possible to the existing working method of health care providers in order to provide diversity-appropriate care in multi-ethnic practice.

- The efforts to develop well adapted health promoting programmes should be building on partnership between government agencies, public and private institutions and organisations aiming to promote equity and justice at international, national and local levels.

Information on these sessions are available from: http://ephconference.org/conference-glasgow-2014-149

LEARNING FROM EACH OTHER: WHERE **HEALTH PROMOTION MEETS INFECTIOUS DISEASES**

By: Erik C. Ruland, Irina Dinca, Valerie Curtis, Margaret M. Barry, Karl Ekdahl and Aura Timen

Summary: Communicable disease control can benefit from the transfer of knowledge on health promotion. Behaviour change interventions are more effective if they incorporate recent insights on formative research and emotional drivers. By mapping current health communication activities in Europe, a range of perceived needs and a wealth of opportunities emerged. Furthermore, successful interventions in non-communicable disease have shown that political commitment is essential to develop public health policies. In order to get these policies adopted, health professionals need to develop vision, strategy and effective action. As public health budgets are limited 'smart collaboration initiatives' are needed to drive capacity development.

Keywords: Infectious Disease Control, Health Behaviour, Emotional Drivers, Health Promotion, Public Health Policies

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Introduction

In order to achieve behaviour change that prevents the acquisition and further spread of infectious disease, one should look at opportunities to improve health promotion and health communication. Taking the perspective of professionals in infectious disease control, this article examines: a new approach in behaviour change; improving health communication for communicable diseases in the European Union (EU); and the observation that policies are more powerful than pills*.

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*   These topics were presented at the 7th European Public Health (EPH) Conference by Dr. Valerie Curtis, Professor Margaret Barry and Professor Simon Capewell, respectively.

A new approach: Behaviour-Centred Design

Human behaviour is one of the major factors that underlie the emergence and spread of infectious pathogens and as such, represents a key target for developing strategies to combat diseases.[1] Many programmes on infectious disease control involve behaviour change interventions and employ a variety of theoretical models. These tend to focus on rational drivers of behaviour, beliefs and social influences. By contrast, the innovative Behaviour-Centred Design (BCD) approach seeks powerful emotional levers to change behaviour.[2][3]

BCD draws on a classification of fifteen basic motives for human behaviour derived from evolutionary and environmental psychology and neuroscience (**see Figure 1**). It also seeks to understand how routine and habitual behaviour is embedded in the social and physical settings in which it takes place. Having developed a theory of change for target behaviours, the BCD then uses commercial creative processes to develop innovative interventions. Key lessons are that practitioners need to better understand behaviour through formative research, to use the tools of marketing to optimise interventions and above all, to ensure that interventions are new, creative and surprising, otherwise behaviour will not change.

> ❝ ensure that interventions are new, creative and surprising

Figure 1 shows the fifteen human motives. One or several of these can provide the motives for a change in behaviour. For example, formative research for the SuperAmma-project in India identified that key drivers of handwashing with soap (HWWS) in rural mothers were likely to be: disgust of contaminated hands, affiliation (the desire to adhere to local norms of behaviour) and nurture, where mothers cared about instilling good manners in their children.[3] Working with a local creative agency, the intervention team designed an intervention that used a highly emotional cartoon film, skits about disgusting hands and pledges made in public places.[5] A randomised controlled trial of the intervention showed much better results than similar interventions based only on education about handwashing (**see Figure 2**).[3]

BCD has been used to change a variety of behaviours, including handwashing, in several countries, food hygiene in Nepal, exercise in Ireland and nutrition practices in Indonesia. It is also being used to improve environmental sanitation in Vietnam and for diarrhoeal disease

control in Zambia. Experience has shown that many of the drivers of disease-related behaviour are not, in fact, health-related and that these drivers are often universal, hence applicable to many different populations. Rather than emphasising the negative effects of becoming infected with an infectious agent and the risk of complications, it emphasises the emotional benefits of behaviour.

Improving health communication for communicable diseases

From the new insights formulated in relation to behaviour change interventions, it is a logical step to the more general question: how can the experiences in health communication and health promotion be captured and transferred to communicable diseases?

A consortium of universities from Ireland, Scotland and Spain addressed this question in the Translating Health Communication Project, which ran from 2009-2012. This programme conducted a series of evidence reviews in key areas, mapped current use of health communication activities in the EU/EEA countries, identified perceived needs among key stakeholders, and consolidated the findings in a SWOC-analysis (strengths, weakness, opportunities, challenges).[6]

The study identified a number of key strengths and gaps in the current European evidence base for health communication and communicable diseases. A major strength identified is that during the past decades, a body of knowledge concerning theoretical models and concepts has emerged, including health literacy, health advocacy and promotion of immunisation uptake and behaviour change.

Nevertheless, the level of use of health communication varies considerably between disease groups and between countries, with activities in the areas of HIV/AIDS and vaccine preventable diseases tending to be more sophisticated than influenza and non-HIV / -STIs (Sexually Transmitted Infections). There is still limited consensus about concepts related to social marketing, health information-seeking, risk communication, campaign evaluation, trust and reputation

Figure 1: A new model for determinants of human behaviour: classifying emotional drivers, based on the evolution of the human brain
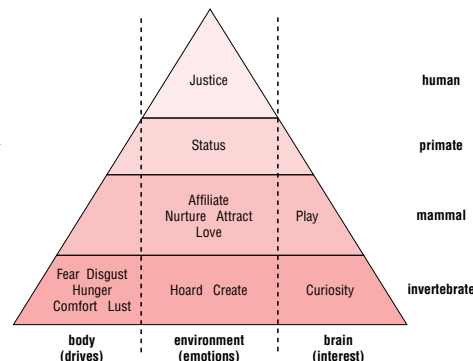
Source: [4]

management. Furthermore, the specific needs of disadvantaged and hard-to-reach populations are poorly represented in current research.

Enhanced collaboration and building communities of practice around professional networks are needed among those working in the area of health communication and communicable diseases in the region. A shared online interactive health communication resource/platform for the prevention and control of communicable diseases could function as a facilitator of this collaboration. Furthermore, attention should go to the use of new media and investments in formative research and audience segmentation. Keys to success remain the existence of dedicated national budgets and plans and enhancement of education, training and research in health communication.

Consequently, crucial recommendations for capacity development at different levels are required. At the organisational level, health communication should be incorporated into planning and implementation of all public health policies; capacity would be improved by enhanced collaboration between health promotion and health communication. Within Public Health Authorities or Ministries of Health, clear lines of responsibility for communication should be developed, and future communication should include a focus on reducing disparities and inequities. Concerning

Figure 2: Results of the SuperAmma evaluation study
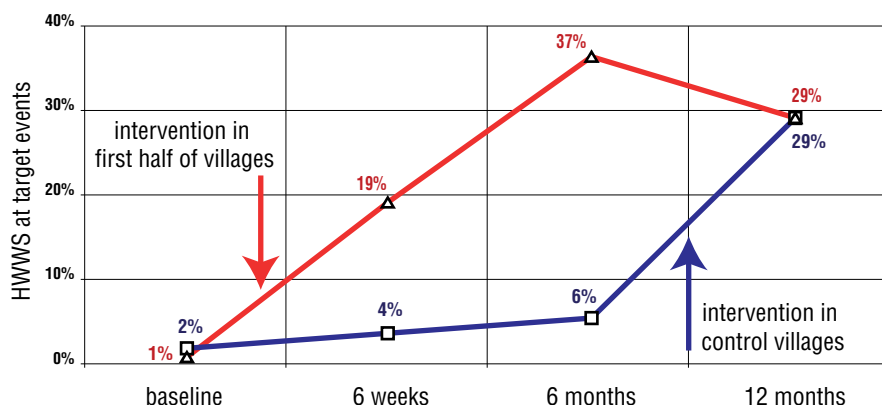
financial resources, dedicated budgets and a greater use of evaluation, including cost-effectiveness, would equip policymakers with the relevant evidence.

Concerning practice and research, a greater synergy needs to be fostered to facilitate transnational and transdisciplinary approaches, which could potentially limit costs. Scientists and practitioners should utilise more citizen-centred approaches to promote social dialogue and help build public trust.

investments in formative research and audience segmentation

Thirdly, at the knowledge management level it is recommended to focus efforts on strengthening the evidence base through conducting systematic evaluation studies that will help identify key indicators of success and best practices, and optimise the transferability of knowledge from non-communicable diseases to communicable diseases. A prerequisite for all this is health communication workforce capacity development, including the articulation of core competencies–the necessary

knowledge, skills and abilities in translating policy, theory and research into effective action.

Policies are more powerful than pills

Starting off from the impressive *Global Burden of Disease study,* Simon Capewell demonstrates that poor diet is accountable for more than 40% of the burden of non-communicable diseases, more than smoking, alcohol and physical inactivity put together.[7] Looking at the fall of death rates due to coronary heart disease in Western countries over the past decades it is arguable that one third is attributable to better treatment, and two thirds to public health policies that improve risk factors in the population at large. 'Downstream' prevention activities targeting individuals consistently achieve a smaller public health impact than 'upstream' policies such as regulation or taxes. Population-wide prevention policies prove to be much more powerful, but implementing them is opposed by vested interests of major global companies. The reality for food is that ten worldwide corporations control almost anything we buy in our supermarkets. Capewell cites Moodie in *The Lancet* [8]: "These corporations all behave the same: to maximise profit for their shareholders they put public health aspects at the bottom of their priority lists and undermine effective public health policies and programmes". What can be done about this?

First of all we can be inspired by the successes of the past: sanitation, slavery abolition, immunisation, road safety, smoke free legislation, etc. The lessons

learned in all these struggles were the same; they consecutively developed three key elements: *vision, strategy* and *effective action*. An essential part of strategy is, for instance, to connect the issue to people's everyday lives; clear evidence and striking actions that capture the public's attention are needed to withstand authorities and vested interests. Based on these elements the path of effective implementation of public health policies can be described in seven steps, summarised in the verb '**support**'. First, **s**cientific evidence emerges and professional **u**nderstanding spreads; consequently, **p**rofessionals accept the paradigm shift. Fourthly, the **p**ublic and politicians become aware, and gradually supportive. The hard part being that **o**pposition of vested interest is fierce and is only slowly surmounted; not by voluntary agreements or partnerships. At a decisive moment **r**egulation is introduced, often strengthened by **t**axation, and the new paradigm becomes institutionalised, anchored in social norms.

"The conclusion is that politics are inevitable, you either get involved or you watch things fail to happen. So today's challenges in both infectious diseases and non-communicable diseases resemble the past – they're substantial, but they can be overcome if we work together."[7]

Discussion

What can we learn from each other? The recommendations of the European Centre for Disease Prevention and Control technical report offer a roadmap, which needs a driving force. The reality is that budgets are not bound to increase; therefore, smarter collaboration will have to fuel progress. One way to do so might be the development of Academic Collaborative Centres for Public Health.

In the Netherlands, a nationwide policy to develop these collaborative centres has been put in place since 2004, based on a long-term partnership between community health services and a university. The main purpose of these academic collaborative centres is to improve the knowledge transfer between practitioners, policy makers, researchers and the education sector. The ultimate goal is to improve public health policies

Figure 3: Map of Academic Collaborative Centres for Public Health in the Netherlands

Academic Collaborative Centres Public Health

AMSTERDAM
Sarphati Initiative
- Epidemiology
- Infectious Diseases
- Provinces of North Holland and Flevoland

G4-USER
- Public Mental Health Care
- Large cities of Amsterdam, The Hague, Rotterdam and Utrecht

Youth Health Care North Holland (JGZ NH)
- Youth Health Care
- Province of North Holland

TILBURG
Brabant
- Health Promotion
- Epidemiology
- Youth Health Care
- Public Mental Health
- Province of North Brabant

WAGENINGEN
AGORA
- Health promotion
- Epidemiology
- Northern and eastern parts of the province of Gelderland

ARNHEM
Environment & Health
- Environmental Health
- National

NIJMEGEN
AMPHI
- Health Promotion / Local Health Policies
- Infectious Diseases
- Provinces of Brabant and Gelderland

MAASTRICHT
Limburg
- Health Promotion
- Epidemiology
- Youth Health Care
- Infectious Diseases
- Province of South Limburg

ROTTERDAM
CEPHIR
- Health Promotion
- Epidemiology
- Infectious Diseases
- Youth Health Care
- The greater Rotterdam area, the southern part of the province of South Holland, and the province of Zeeland

LEIDEN
Northern South Holland (NZH)
- Health Promotion
- Infectious Diseases
- Youth Health Care
- Public Mental Health
- Northern part of the Province of South Holland

LEEUWARDEN
North Netherlands
- Population shrinkage
- Provinces of Friesland, Groningen and Drenthe

ZonMw

Source: [9]

at the local level.[9] So far, this policy has been successful and generated a substantial output in PhDs, policy advice and health promotion interventions, overarching health communication, health promotion and communicable disease control, and contributing to reduction of inequities.[9][10] Within a period of ten years, eleven academic workplaces emerged (**see Figure 3**). The question is whether such initiatives might be (or already have been) implemented in other European countries as well and what their significance is in the light of the broader European context. Considering the fact that EUPHA aims to bring together practice, policy and

research, it might provide the platform for further studies aiming to identify and promote 'smart collaboration initiatives'.

Conclusions

The 7th EPH conference yielded valuable lessons to be applied in communicable disease control. The first lesson is the need for more and better formative research. Although there is comprehensive experience with formative research in public health, formative research in the context of emerging diseases and crises is very challenging to conduct. Nevertheless, in these particular contexts

it is essential that such studies take place in order to formulate the best approach to behaviour change.

key elements: vision, strategy and effective action

Historically, in the communicable disease areas, activities are organised around networks of medical professionals, policy-makers and citizens/target groups. The performance of interventions targeting these networks might be quite variable, and lessons learned are not consequently implemented. There is a strong need for leadership from the public health community to address opportunities, promote successful interventions, and collaborate closely with policy-makers. The public health leadership should aim to translate best practices of comprehensive approaches to other complex health issues, like the example of tobacco control policies, into the communicable disease area.

Last but not least, there is a need to think 'out of the box' and bring more innovation in the actions undertaken to prevent and control infectious diseases.

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PUBLIC HEALTH MONITORING AND REPORTING:
MAINTAINING AND IMPROVING THE EVIDENCE-BASE

By: Nicole Rosenkötter and Marja van Bon-Martens

Summary: It is undisputed that reliable and comprehensive health information is needed to support evidence-informed policy-making. This article gives an overview of the drivers and actions that aim to improve the health information infrastructure in Europe. In addition to outlining the status quo of international infrastructure development, this article highlights existing gaps in monitoring health inequalities and in data sources for monitoring morbidity. A sustainable health information infrastructure in Europe, a feasible legal framework, as well as opportunities for good-practice exchange, would help to overcome information gaps and improve the possibilities for evidence-informed decision making.

Keywords: Public Health Monitoring and Reporting, Health Information System, Health Inequalities, Morbidity Statistics

Introduction

Information on the frequency and distribution of disease, populations' health behaviour, health care utilisation patterns, and other determinants are, amongst others, a prerequisite for evidence-informed (health) policy-making at local, regional, national and international levels. A well-functioning health information system, including reliable and comprehensive data collection mechanisms and routine monitoring and reporting activities, is regarded as a core capacity for generating evidence-informed (health) policies.[1] Such a health information system can be understood as an infrastructure that allows professionals and lay people to use, interpret, and share information and to transform it into knowledge.[2] It enables decision making

by the relevant stakeholders and policy-makers with regard to the extent and the design of required actions.

> *enhanced possibilities to monitor health inequalities are needed*

The relevance and availability of health information, especially for monitoring health inequalities, was a common issue in multiple sessions and plenaries of the 2014 European Public Health (EPH) Conference. Additional data sources and enhanced possibilities to monitor the development of health inequalities are needed to strengthen the evidence base for health policy-making in Europe. Moreover, stakeholders from policy, public administration and the scientific community discussed the current status and further steps for the development of a European Union (EU)/European health information infrastructure and how the financial crisis and related austerity measures imposed threats, but also opportunities, for national health information systems.

A European health information system–the status quo

Since the 1990s, the European Commission (EC) has been actively stimulating the development of an EU public health monitoring and reporting system with a multitude of EU-funded projects, networks and Joint Actions. The definition of a common indicator set (ECHI – European Community Health Indicators) and the development of a common health information survey template are just two examples of these achievements; albeit a comprehensive health information infrastructure and well-established governance mechanisms on the EU-level are still missing.[3]

In addition to the EC, which has a legal mandate for health at the EU-level, there are two other important stakeholders in the field. The World Health Organization Regional Office for Europe (WHO/EURO) and the Organisation for Economic Co-operation and Development (OECD) are running well-established databases and reporting systems. All three entities have intensified collaboration in recent years, e.g. by a common reporting system (System of Health Accounts), joint data collection for non-monetary health care statistics, with the OECD and EC writing joint health reports for the EU (*Health at a Glance* series). The organisations expressed their intent for improved coordination and to work towards a single, integrated European Health information system.[4]

Despite high interest for the development of a health information system in Europe, the implementation of necessary actions can be slow and laborious.[5] At the EU-level the actions gained momentum after the publication of the final evaluation report of the ECHI[3] and the Council Conclusions on the "Reflection process on modern, responsive and sustainable health systems" in 2013. The Council called upon Member States to *"cooperate with a view to establishing a sustainable and integrated EU health information system, built on what has been already achieved through different groups and projects, such as ECHI-ECHIM projects, exploring in particular the potential of a comprehensive European health information research infrastructure consortium (ERIC) as a tool."*.[6]

In response to this request, a call to analyse the potential of an ERIC for an EU health information system was part of the 2014 call for proposals under the third EU public health programme (2014–2020). A group of former EU health information project leaders handed in a proposal that was accepted for funding. This project will function as a so-called bridge project towards a future ERIC and offers new perspectives with regard to the realisation of an EU-level health information system.

This new momentum for health information at the EU-level can also be explained by the relevance of data-driven health system performance assessments, one of the fields of action which Jean-Claude Juncker, President of the EC, recommended to the new Health Commissioner, Vytenis Andriukaitis. Moreover, country-specific recommendations for economic reforms that are formulated by the EC within the European Semester cycle are increasingly targeting health care systems of EU Member States. So far, the recommendations are mainly based on economic indicators, but the inclusion of social and health indicators is increasingly requested.[7]

In parallel to these developments, WHO/EURO started a Health Information Initiative,[8] that can be regarded as instrumental for the development of a single European health information system for the European region.[4] The WHO European region comprises a total of 53 Member States, including all 28 EU Member States. In 2013, all 53 WHO/EURO Member States agreed on a set of indicators for monitoring WHO/EUROs *Health 2020* policy: this indicator set includes twenty core indicators and seventeen additional indicators for monitoring the *Health 2020* targets.[9] WHO/EURO presents these indicators in the Health Information and Evidence Portal (http://portal.euro.who.int/en/portal/); about half of the indicators are also part of the 88 indicators in the EC's ECHI list.

This rough overview of international activities in the European region shows that currently a lot is going on. Due to different mandates, liabilities and responsibilities, there are parallel, as well as joint developments, that could potentially result in a comprehensive and useful European health information infrastructure that supports evidence-informed decision making at the international, but also national and subnational, levels.

National health information systems – subject to austerity measures?

Austerity measures introduced in the aftermath of the financial crisis had the potential to hit health information infrastructures with the consequence that

less accurate, timely and comprehensive health information is available and less adequate health policy responses are formulated. However, budget constraints can also give a jump start for long needed health information system reforms that, if wisely conceived, can result in a system that works more efficiently and produces information of higher quality.

A qualitative survey conducted in 2009/2010 among European experts in infectious disease control identified potential threats for infectious disease surveillance systems.[9] They anticipated that financial and human resources for infectious disease surveillance might decrease in response to the financial crisis, which would impact on the timeliness and accuracy of the data. There was also a fear that the implementation of new programmes is likely to be stopped or postponed,[10] and some reported that nationwide surveillance programmes were already downscaled. In addition, less developed public health surveillance systems, like those on mental health, could be under threat. Mental health disorders are among the main causes for disease burden in Europe. However, resources allocated for data collection and the representation of mental health in health information systems is often underdeveloped and might be threatened when health information systems are downscaled without taking the main drivers of disease into account.[11]

Two examples highlight some of the challenges and opportunities. Due to a lack of a central health information system in Greece, public health experts experienced difficulties in monitoring the potential impacts on health, health care and related health determinants while austerity measures were being introduced. In cooperation with WHO/EURO, Greek politicians and other stakeholders have worked on a solution for implementing and maintaining a sustainable national health information system and for defining an interim indicator database that derived information from secondary data sources. During workshops and country visits, indicators as well as relevant stakeholders for system development could be identified

but resource allocation for infrastructure development remained challenging despite political support.

The need to redesign parts of health information systems might also create opportunities. In the Netherlands, it was intended to harmonise different lifestyle surveys and consolidate them into one single lifestyle monitor.[12] Before these harmonisation efforts occurred, different stakeholders – all financed by the Dutch Ministry of Health – organised surveys on sometimes overlapping themes with different methodological approaches, resulting in diverging national figures on the same topic. Coordinated by the Dutch Institute for Public Health and the Environment (RIVM), a new survey scheme was established, resulting in the development of additional survey modules and single annual basic figures for each theme. Even though this initiative was not financially motivated, the Dutch experience suggests that the reorganisation of data collection routines within a health information system can lead to improved data quality and better resource utilisation.

Availability of health information – areas of concern

It is widely acknowledged that health, health-related behaviour and utilisation of health care are determined by a wide set of determinants, in particular social determinants. Information about the development of socio-economically driven health inequalities are therefore of the utmost importance for integrated health policy-making. However, the linkage of health and socio-economic data, which would be necessary for routine monitoring and reporting activities, poses problems for many European countries and regions and underlines the need for good practice exchange among practitioners. Until now, the evidence base was often derived from research projects, countries with routinely developed possibilities for data linkages, or health interview surveys. A routinely performed, comprehensive, and European-wide monitoring of social inequalities in health remains difficult. The future possibilities for analysing and monitoring social inequalities in health are also touched by the debates on a new EU General Data Protection Regulation.

The public health community urges stakeholders involved in the legislative procedure to formulate a supportive legal framework for population-based research and public health monitoring.

Another information gap for public health monitoring and reporting is routinely available disease-specific morbidity statistics from which incidence and prevalence rates could be derived. Decision makers in Europe need morbidity data in order to appropriately assess their health systems, allocate resources, and identify the health needs of an ageing population, increasing life expectancy, changing lifestyles, and new treatment possibilities. However, in contrast to the widely available mortality statistics, which highlight the causes of death, information about lifetime disease burdens is scarce. For EU-wide analyses only self-reported information from surveys, selected disease registries (e.g. cancer), notifiable disease surveillance systems (e.g. infectious diseases), or scientific studies can be used. Therefore, Eurostat has started to develop a short list of public health relevant diseases and external causes of morbidity for which data should be routinely available.

> EU morbidity statistics will be output-driven and not source-oriented

A pilot study in sixteen EU Member States tested data collection, respective guidelines, and methodological approaches. The most important difference between the envisaged EU morbidity statistics compared to usual statistics was that Member States were asked to deliver the best national estimate for the requested diseases, which means that the EU morbidity statistics will be output-driven and not source-oriented. Potential sources from which morbidity statistics can be

derived are disease-specific registries, hospital data, data from ambulatory health care providers, and health insurance funds, or a combination of data sources. The latter also requires possibilities for data linkage. Even though the pilot study revealed several caveats with regard to data sources, data collection, definitions, methodology, and comparability at the EU-level, the practice exchange was important and the results of this exercise were regarded as promising for further development and implementation of diagnosis-specific morbidity statistics.[13]

Conclusion

Although the development of a sustainable health information infrastructure in Europe has not been among the top policy priorities in the past years, this narrative seems to have changed. Discussion has increased on the relevance of health information infrastructure and steps to develop it further. This is probably driven by new health information needs in order to develop country-specific recommendations within the European Semester cycle at the EU-level and to monitor WHO/EUROs *Health 2020* policy in the WHO European Region.

In order to further develop available information for evidence-informed decision making, public health monitoring and reporting practitioners in Europe need a sustainable health information infrastructure and a feasible legal framework, as well as possibilities for good-practice exchange on how to monitor morbidity and health inequalities.

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CHANGING YOUR HEALTH BEHAVIOUR: REGULATE OR NOT?

By: Els Maeckelberghe and Martin McKee

Summary: The overwhelming message of the EPH-conference is that taking health inequalities seriously demands a portfolio of approaches. Regulating health behaviour is neither a choice for liberalism (self-regulation) nor for paternalism (interventionism). Regulation and fiscal policies are essential but they must be accompanied by measures to empower people and to hold accountable those (policy-makers at local, national and European levels) who may make populations vulnerable. These policy-makers would have benefited greatly from listening to the discussions among public health researchers at the EPH in Glasgow. It is now our task to take these messages to them.

Keywords: Health Behaviour, Self-regulation, Interventionism, Vulnerability, Accountability

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Introduction

"Glasgow: Aye, it's a dump. It's like dirty. You've got like, they want to build railways and all that, it's like what about the graffiti, what about other stuff, like the young people?"[1] Three young mothers (they hate the term 'teen mum') know what would allow them to live good lives: an environment in which they and their fellow citizens can thrive. Having become mothers at fifteen or sixteen years of age makes them think about what kind of world they want to live in and what conditions they need to raise their child. They do not need that much: a park in which to play with their child, the support that will allow them to finish school, and a world that does not look down on them.

The impressive short film in which they appeared was shown in the session 'Understanding Health Inequalities in Glasgow'. It gets straight to the heart of what the 2014 European Public Health (EPH) Conference was about: 'reducing inequalities in health and health care'. These young mums challenge the public health community to deliver on the social determinants of health that they keep talking about, inviting them to create a healthy environment (a park), provide empowerment and literacy (support to finish school), and recognition as contributors to society ("do not demean us").

Many debates about what constitutes 'healthy behaviour' and how it can be promoted tend to descend to a clash between those who argue for state intervention, through regulations and taxes, and those who believe that individuals must take responsibility for their own actions. Fortunately, discussions at the EPH conference in Glasgow took on a more nuanced view that tried to respond to the agenda that the young mums had set out. As Marx noted, people make choices, but not always in circumstances of their own choosing.[2]

Regulating health behaviour: framing the question

The more traditional debates about health behaviour as mentioned above often veer, as Greek mythology would put it, between the Scylla and Charybdis of liberalism (self-regulation) and paternalism (interventionism); in other words these debates can be caught between two equally unpleasant alternatives. From a liberal perspective, people should be free to make their own choices and this should be done without external guidance. From this perspective, public information campaigns (such as marking so-called healthy foods with clover leaves) are a subtle way of regulating and disciplining individual behaviour. The true liberal fears that individuals will no longer have control over their own bodies. Such a liberal individual believes the state should do no more than give them the freedom to make their own choices, even if this means "being free to be foolish".[3] Government policies should be limited to fostering opportunities to be a free, sovereign individual. However, in such circumstances, where the state retreats, too often a vacuum is created that is filled by others, especially, large private corporations whose products may undermine public health.[4]

What is overlooked, from this liberal perspective, is how vulnerable groups may not be able to achieve sovereignty over their mind and body because of circumstances they cannot alter. Poor people often buy less healthy food than the well off. It is not simply that they choose freely to do so. It is more often that the healthy alternatives are unavailable in the shops in their neighbourhoods, and even if they were they would often be unable to afford them. Perhaps there are healthier alternatives available that would require longer preparation, but they cannot spare the time as they wrestle with several low paid insecure jobs and a lack of help in looking after their children. Placing cheap, energy dense junk food in a microwave is not a lifestyle choice, it is a survival strategy.

A paternalistic approach supports interventions in people's lives when these promote wellbeing, as this is viewed as giving them real freedom. Urging

people to exercise thirty minutes a day because it keeps you fit is not sufficient. From a strong paternalistic perspective, it could be argued that elevators should be made inaccessible for all except, of course, those who need them because of impaired mobility. The theory behind this paternalistic intervention is that running up and down the stairs is part and parcel of a healthy lifestyle, and being healthy makes people happy. People supposedly only realise their lack of real happiness after having been forced into adopting a healthy lifestyle. A weak paternalistic strategy would not prohibit able-bodied people from using elevators but would discourage them strongly by positioning the elevators in remote places, far away from the main entrance of buildings. From this perspective, the citizen is supposed to trust the state to know what is best and to provide the necessary means to promote people's well-being. The obvious objection against paternalistic interventions is that it is an unacceptable interference in people's lives. The paternalist must be able to provide a convincing and reasonable answer as to why he might restrict the freedom of individuals to do as they wish.

> *facilitating a society that protects and promotes health*

Taylor and Hawley have proposed a third way, that is an attempt at changing people's behaviour without this being an infringement on their liberty: "the state can help to empower people to assume greater responsibility for their own health and thus to rely less upon the input of the state".[5] The state, and other parties that can influence people, must provide the necessary conditions for individuals to make the choices that allow them to live a healthy life. The main objective here is giving citizens the opportunities to be responsible, healthy citizens.

Thus, the question is no longer *'changing your health behaviour: should we regulate*

or not' but *'how can we provide the necessary conditions for citizens to enable them to make the healthy choice?'* The responsibility then shifts from individuals who should change their behaviours (often a difficult thing to do) to governments and others, such as corporations, to create a healthy environment. This is at the heart of the public health tradition that starts from the notion of social justice: to protect the health of whole populations and to draw special attention to the weaker members of societies,[6][7] called "progressive universalism". This is a tradition that is not preoccupied with individual moral agency but with facilitating a society that protects and promotes health and takes a stance on behalf of the disadvantaged.

Regulating a healthy environment

In the opening plenary, Johan Mackenbach reminded those present in Glasgow that:

"Risk factor data also clearly demonstrate the avoidability of health inequalities – studies show that if we would be able to eliminate inequalities in the prevalence of risk factors like smoking, lack of physical exercise, or low income, health inequalities would be markedly reduced in many European countries. The next important question therefore is: what is an effective strategy to reduce health inequalities? On this point, unfortunately, the evidence is rather sobering: national programs in various European countries to tackle health inequalities have so far been only partly successful, and have shown that we need to re-think what is needed to measurably reduce health inequalities at the population level. I will argue that key elements are a focus on quantitatively important determinants and an ability to achieve population-wide impact – and that acquiring a democratic mandate for the massive shifts in resource distribution that this requires will prove to be a major hurdle."

Enabling citizens to make healthy choices demands a visionary, evidence based approach from policy makers.

"Health inequalities are a persistent problem in European countries. Although health in Europe was improved in recent decades, inequalities in health have also widened. 'Health inequalities' refer to differences in people's health

and life chances. Health inequalities are strongly related to the conditions in which people live, such as income or the area they reside in. Health inequalities exist not only between countries but also within countries. Crucially, they are still increasing in many places. The evidence presented at the EPH was overwhelming!" (Walter Ricciardi, summarising the conference; see article in this issue).

Such a visionary approach seeks to improve everyone's health but recognises that those who are disadvantaged need particular attention, to overcome the factors that mitigate especially against them making healthy choices.

This demands a vision that is driven by the core values of fairness and empowerment, whereby everyone, no matter how prosperous or disadvantaged, is equally able to access the resources necessary for a healthy life. While stressing a universal approach, this also demands that the most vulnerable are reached out to, as otherwise there is a danger of widening the existing inequalities even further.

The philosopher Robert Goodin labelled this approach the vulnerability principle: "Moral agents acquire special responsibilities to protect the interests of others to the extent that those others are especially vulnerable or in some way dependent on their choices and actions".[8] The vulnerability relationship reads as follows: 'A is vulnerable to B because of C with respect to D'. For the young mothers in the film this translates to: the young mums (A) are vulnerable to not achieving a healthy lifestyle for their child (B) because of the lack of investments of the local authorities (C) with regard to urban development (D). Investments in roads rather than parks, where children can get fresh air and run around, makes these young families vulnerable, with restricted opportunities to incorporate 'exercise for their children' into their daily routines. The vulnerability principle specifies who has what responsibilities. Thus, it is the local authorities' planning decisions that make the young mothers vulnerable. Even if these young women wanted to change their behaviour and go out for walks more often, city planners have created hurdles by not investing in a safe park. It is their responsibility to remedy that situation.

The EPH conference provided ample evidence of successful policies and interventions that had turned the vulnerability principle on its head. Programmes that engage local communities stimulate co-creation of responsible healthy citizens. For instance, the conference workshop on Community-based Nutrition Programmes (organised by the EUPHA section on Food and Nutrition) highlighted that such nutrition programmes can achieve this through:

1) a participatory approach to food-based health promotion and to perspectives on the creation of consistent foodscapes across the community, engaging schools, retailers and media,

2) a community based social marketing intervention promoting healthy eating and activity behaviours of elementary and middle school children and their parents,

3) a strengthening of the evidence base concerning the effects of sugar-enriched drinks on the health of children, and the development of associated health advocacy activities, and

4) cross-sectoral approach on strengthening local food supply chains between kindergartens, schools and other public institutions and local producers. (quotes from the workshop)

This evidence, however, often might not be very pleasing to the ears of policy-makers of the liberal, self-regulating persuasion as it argues strongly that responsibility for changing behaviour cannot be placed solely on the individual.

These issues were developed further in the round table on "Health promotion in small communities: why, how and by whom?" (organised by the EUPHA sections on Child and Adolescent Public Health and on Ethics in Public Health, along with the Norwegian Research Centre for Health Promotion and Resources HiST-NTNU). This session examined policy processes at central, county and municipality levels. Those present showed how close cooperation between the different scientific disciplines, policy-makers, decision-makers and local authorities can generate imaginative and innovative ideas. New forms of knowledge-sharing and collaboration in the field of public health,

regionally and locally, as well as new methods for converting knowledge into practice, were presented. It was clear that communication and collaboration among key stakeholders involved in evidence-based practice like research, policy, and practice, can lead to much more evidence- based policy making to reduce individual vulnerability.

Changing your health behavior: regulate responsibilities

The overwhelming message of the EPH-conference is that when you *mind the gap* (the EPH conference slogan) and take health inequalities seriously, a portfolio of approaches is needed. Regulation and fiscal policies are essential but they must be accompanied by measures to empower people and to hold accountable those (the policy-makers at local, national and European levels) who make populations vulnerable. These policy-makers would have benefited greatly from listening to the discussions among public health researchers at the EPH in Glasgow. It is now our task to take these messages to them.

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DEVELOPING THE PUBLIC HEALTH WORKFORCE

By: Vesna Bjegovic-Mikanovic, Anders Foldspang, Elke Jakubowski, Jacqueline Müller-Nordhorn, Robert Otok and Louise Stjernberg

Summary: The development of the public health workforce is a cornerstone in WHO's Action Plan for Strengthening Public Health Services and Capacities. Public health education shall combine Essential Public Health Operations – surveillance; monitoring; health protection and promotion; disease prevention; service delivery; communication and research – with the competences needed within: public health methods; population health and its social, economic and environmental determinants; and man-made systems and interventions to improve population health. An authorised public health profession founded on graduation from comprehensive public health education is needed. The capacity and standards of Schools of Public Health should accordingly be continuously developed.

Keywords: Public Health Workforce, Essential Public Health Operations, Public Health Competences, Public Health Education, Public Health Training, Public Health Professionalisation

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Population health challenges and the European Action Plan

Inequity in levels of living plays a dominant role in creating ill-health in Europe.[1] In accordance with the *Health 2020* strategy, social and economic determinants, such as education, employment, and income, should be addressed, e.g. through "upstream" approaches. Fiscal policies should be reconsidered, as they provide us with good measures to influence behaviour through prices and taxation. Public health needs much higher and more stable funding, and resources should be used more effectively in building capacities to sustain population health improvement. This all requires new public health policies with the systematic development and sustainment of a highly professional public health

workforce and strong, comprehensive and coherent public health institutions, brought forward by systematic methods for population health challenge identification and systems planning, implementation, resource allocation, follow-up and evaluation in defined populations and population groups.

The European Action Plan for Strengthening Public Health Services and Capacity emphasises action as indicated by the Essential Public Health Operations (EPHOs).[2] The Plan provides practical solutions, such as how to extend the reach of community care by involving public health services to carry out screening, counselling, population empowerment and health education services.

Across Europe we observe an underuse of designated public health institutions to tackle the increased burden of non-communicable diseases. This is partly due to a mismatch between professional skills and competences and our contemporary health challenges. Moreover, systematic overviews of existing public health services are lacking across Europe, and the WHO Regional Office for Europe thus has started mapping such services and systems based on the list of EPHOs.[3]

Developing the public health workforce

Education and training play crucial roles in developments towards increased equity in health. The Association of Schools of Public Health in the European Region (ASPHER) is the key independent European organisation dedicated to strengthening the role of public health by improving education and training of public health professionals for practice and research.

Despite the fact that the continued development of the public health workforce is a cornerstone of public health strategies, we have not been able to identify systematic methods implemented in European countries for estimating human capacity needs in public health or for the assessment of relevant educational capacity in public health. Consequently, ASPHER has started the development of principles for public health planning, linking population health challenges with the EPHOs and the competences needed.[4]

Major challenges include: shaping an authorised public health profession, as a central element in the public health workforce; and a comprehensive and coherent public health service system.[4] Today, there are a large number of programmes focusing on separate aspects of public health and, concurrently, the number of vocations covering selected parts of public health is also high.[5] All in all, this creates doubt about what the public health discipline really is, and where decision-makers can turn to get advice. Moreover, as an authorised profession is lacking, in contrast to medical doctors, nurses and other health professionals,

public health as a discipline is invisible in official statistics – a poor situation in the quest for necessary resources.

Public health is mature for professionalisation and has a long history of professional education, training and research. Shaping a public health profession simply would be following the principles of development within other health disciplines, e.g. medicine, nursing and midwifery. A unified profession should be defined based on comprehensive public health education programmes, offering the ability to perform all EPHOs[2] (**see Table 1**) as well as the core competences of the European list endorsed by WHO member states in 2012[6] (**see Table 2**), so that professionals can analyse population health challenges; set targets for population groups; identify, select and implement evidence-based and ethically acceptable interventions; and follow-up results.

The comprehensive basic education of public health professionals will form a natural foundation for specialisation and continuing professional development (CPD). Schools of Public Health will play a key role, and the public health workforce will, besides public health professionals, include health professionals doing part-time, selected tasks in public health, and all others, for example, including high-level decision-makers, as well as the police officer on the street and the teacher in the classroom.[4] Other important community-oriented activities should also be developed by the Schools of Public Health, such as functioning as local and national centres for knowledge brokering.

The first Bologna Cycle: European public health bachelor programmes

Bachelor programmes in public health represent a relatively new phenomenon, indicating the integrity of public health as a discipline in its own right, e.g., not necessarily demanding a medical background. Moreover, in response to the increased demand from the public health labour market, over the last two decades a number of bachelor programmes have been developed across Europe. In 2011–12, 18 Schools of Public Health delivered 977 bachelor degrees, with a

median of 55 per institution.[7] By 2014, 25 of ASPHER member schools could report that they provided bachelor programmes.[8]

The expectations of present and potential employers of a public health workforce, however, are still largely unknown, and still relatively little is known about the academic structure of the programmes, and about labour market needs and the actual provision of bachelor degrees. The documentation of roles, practices and competences produced in bachelor programmes still appears to be unsystematic across Europe.[8]

In 2012, ASPHER's survey found that there was a need to: develop more bachelor programmes in English; develop more programmes offered within networks of educational institutions; increase student and teacher mobility; develop more distance learning; and also develop more specific topics within comprehensive public health programmes.[7]

The second Bologna Cycle: European public health Masters programmes

The second Bologna cycle – the Masters programmes – constitutes the classical domain of the European Schools of Public Health. The number of programmes has increased substantially over the years, and in 2012 there were more than 80 Masters programmes in European countries, 47 of them in the Bologna format.[9] The subjects most often offered were: epidemiology and statistics, health systems and management, and environmental/occupational exposure, while newer fields, like public health genomics, global health, and health economics, were more rare.

European Schools of Public Health are relatively small units with a median full time equivalent of 20 teaching staff members – a relatively restricted capacity. Moreover, nearly four-fifths of the Schools also deliver teaching in other health programmes. The 66 Schools participating in the 2012 survey (participation rate, 82.5%) produced 3035 graduates (previous year), where 1851 were Masters degrees and 1309 of these in the Bologna format.[7] The relatively low priority of teaching global health contrasts with the fact that a fifth of the total enrolment was made up

Table 1: Chapters of WHO Europe's Essential Public Health Operations

Chapter number and content/theme
1. Surveillance of population health and well-being
2. Monitoring and response to health hazards and emergencies
3. Health protection including environmental, occupational, food safety and others
4. Health promotion including action to address social determinants and health inequity
5. Disease prevention, including early detection of illness
6. Assuring governance for health and well-being
7. Assuring a sufficient and competent public health workforce
8. Assuring sustainable organisational structures and financing
9. Advocacy, communication and social mobilisation for health
10. Advancing public health research to inform policy and practice

Source: [3]

of international students, and this points to the need for more programmes aiming at global public health.

Originally, the classic Master of Public Health (MPH) was developed as an effective means to educate public health professionals based on a bachelor degree or a Masters degree within a health discipline. MPH programmes are now open to students without such backgrounds, and this naturally poses challenges to the classic MPH concept and its competency profile. Moreover, MPH programmes intended to follow bachelor programmes will have to take into consideration that bachelors in public health will already possess the competences provided by the classic MPH programme. Thus, there is a need to differentiate the MPH concept while ensuring the continued comprehensiveness of the combined (1 and 2) Bologna cycles in public health education.

The Third Bologna Cycle: European public health doctoral programmes

In 2012, 22 educational institutions enrolled 381 doctoral students (range, 3–80; median, 10 students).[7] During the preceding 12 months, 20 institutions graduated 207 students (success rate, 55.6%; range, 1–70; median, 6 graduates). The principles and organisation of doctoral programmes, however, vary considerably across European countries. To achieve uniform standards in the quality of doctoral programmes in Europe, ASPHER's Working Group on Doctoral

Programmes and Research Capacities has issued recommendations for PhD programmes in public health.[10]

In balance with the European Action Plan,[2] research training is an important component in the development of the public health workforce. It allows public health practitioners and decision-makers to base their recommendations and decisions on the knowledge of up-to-date, cost-effective and ethically responsible scientific evidence. Research in public health demands the application of the methods of all public health main disciplines, not least the methodological disciplines, e.g. epidemiology, statistics, and qualitative methods, besides more specific disciplines e.g., medicine, sociology, anthropology, psychology, nutrition, geography, organisational theory, leadership, economy, law, and ethics. Besides a comprehensive public health background (Bologna Cycles 1 and/or 2), it may require contributions from, and thus collaboration with, researchers from various disciplines and sub-disciplines – with all the challenges involved in inter-disciplinary teamwork, due to differences in terminology, methods used, varying approaches to publications.

Excellence in public health research will strengthen the role of public health in Europe and support funding. Within the health sciences, public health research is rather under-funded, lacking strategic systematics and, all in all, not complying with the need to develop sufficient cost-effective and ethically responsible

public health interventions. Public health needs to be competitive with regard to publications in high-impact journals and grant applications. This must be comparable with related disciplines such as biomedicine.

The creation of a European network in research training among ASPHER member schools is imminent, supported by other European public health associations.

The Bologna Cycles: Exit Competences

With regard to the exit competences for all three Bologna cycles, employers of the public health workforce from 30 European countries in ASPHER's survey stated a highly significant difference for all EPHOs, between the current competency profile of their employees and the required profile, whereas the schools' exit estimates were, on the average, in between.[11]

As the relatively small and often fragmented European Schools of Public Health often do not have the capacity to offer all relevant public health fields at the highest quality, a high degree of mobility of lecturers and students in collaborating networks will be essential, based on mutual acknowledgement of modules – an old ASPHER desideratum. Another supportive strategy will include the further development of distance learning and an increased use of social media, relating also to improved offers for CPD.[12] Blended learning, which combines in-classroom, problem-based learning, in-field and online-learning, probably will be the best option for the future development of education and training programmes in public health.

Public health graduation does, however, not ensure a sustainable level of income. Public health graduates and specialists in many European countries miss career pathways, and many face considerably low pay and reputation. Although in some countries of the European region, public health education is becoming progressively more inter-disciplinary, there is still a long way to go before public health education is, in general, strongly established based on modern public health concepts.

Table 2: Chapters of European Core Competences for Public Health Professionals and for MPH Education

Chapter content/theme
Methods in public health
Population health and its social and economic determinants
Population health and its material – physical, radiological, chemical and biological – environmental determinants
Health policy; economics; organisational theory and management*
Health promotion: health education, health protection and disease prevention
Ethics
* Including leadership

Source: [6]

Conclusion

The public health policy perspective:

Developing the public health workforce, including shaping the public health profession, is a cornerstone for strategically planned population health development in European countries; however, co-ordinated, systematic estimation of public health workforce needs and the resulting education and training needs appear missing or insufficient. Therefore European countries should strive to establish mechanisms to support rational assessment and planning of the development of their public health workforces, including shaping a public health profession with adequate authorisation in parallel with other health professions, and in balance with the development of their systems for public health services provision. This includes taking the responsibility for the health of local, regional and national populations. In this process, Schools of Public Health should be sustained to develop into strong centres for public health research, knowledge brokering and consultancy for decision makers and European countries should substantially increase their support to funding of public health research, including research conducted in relation to doctoral programmes.

The more specific educational and training perspective:

Schools of Public Health should organise into networks, so that complete rather than fragmented public health education and training can be offered at a relevant level of quality. Schools of Public Health must implement the use of information technology for teaching and research, as well as introducing new subjects, e.g. global public health. Furthermore, teacher and student mobility within Europe and interactions with other parts of the world are of utmost importance. Public health bachelor and doctoral programmes still lack the fundamental systematic identification and declaration of their competences, an EPHO profile, as part of the development of the public health professional profile. Research should be high on the agenda in education and training to support the development of more cost-effective and ethically responsible, evidence based types of public health intervention in the future.

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BUILDING SUSTAINABLE AND RESILIENT HEALTH CARE SYSTEMS: HOW ERA-NETS IN *HORIZON 2020* CAN HELP

By: Johan Hansen, Judith de Jong, Peter Groenewegen and Walter Ricciardi

Summary: Currently, a European Research Area network (ERA-NET) research programme – within *Horizon 2020* – is being developed in the area of health services and systems research. It focuses on two meta-questions 1) under what conditions can health care innovations be effectively transferred to other countries and 2) how can this enhance health systems performance? In terms of substantive topic areas, ERA-NET will focus on the organisation of services throughout the entire chain of care, ranging from public health and prevention to hospital and long-term care. This article identifies the programme's focus and how it can build on existing initiatives.

Keywords: Health Systems Research, Sustainability, Health Care Delivery, Transferability, ERA-NET, Horizon 2020

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ERA-NET as a tool to foster cross-country learning

In 2015, Europe is still struggling to find its way out of the economic and financial crisis. Consequently, resilience and sustainability will remain key priorities for European countries and their health care systems for years to come.[1] This continuing focus is in part reflected in the ambition of the European Commission's (EC) flagship programme for research and innovation, *Horizon 2020*,[2] which should contribute to boosting competitiveness and innovation to meet the (health care) demands of the European Union's (EU) ageing populations. Challenges such as the growing burden of chronic diseases, the declining workforce to provide for our

wealth and health, and increasing financial and political pressures call for innovative solutions on how to organise health care in an equitable and efficient manner.

Within *Horizon 2020* there is only limited room for fundamental research on the comparability between health systems as its focus is mostly on the implementation of (biomedical) innovations.[3] At the same time, there is a strong need for cross-border policy learning, in order to understand and value whether good practices and innovative solutions in health care delivery can be transferred from one country to the other. A European Research Area network (ERA-NET) can provide that opportunity, as it is

a tool within *Horizon 2020* to support more coordination and collaboration among countries. Through an ERA-NET, research funding bodies from inside and outside the EU can jointly set up calls for trans-national research and innovation in a joint research programme. Within selected areas with high European added value and relevance for *Horizon 2020,* these programmes can be topped up with additional funding from the EC.

> redesigning care models to face the common challenges of EU health systems

Currently, an ERA-NET is being developed, focusing on the conditions under which successful innovations in the organisation and provision of services can transfer from one health system to another. It deals with the interaction of, on the one hand, substantive priority areas, such as models of integrated care, and on the other hand, the meta-questions of transferability, absorptive capacity and the contribution of innovations to health system performance. Below, we will elaborate on both dimensions to clarify the exact focus of the ERA-NET and its linkage to existing initiatives.

Substantive questions: key priorities in European health systems

A key step in the development of any research programme is to determine the main priorities. The exact focus of this ERA-NET will depend on the priority areas in the countries that will join the ERA-NET. To provide a first indication of policy issues high on countries' agendas in Europe we looked at the reports produced as part of the European Semester. The European Semester is a yearly cycle of economic policy coordination, described in greater detail by Azzopardi Muscat et al.[4] We analysed the country

responses to the European Semester's Country Specific Recommendations (CSR's). In their responses, EU Member States describe what actions and/or health care reforms they have initiated or are contemplating in order to meet the requirements as set out by the European Council.

A word cloud of all texts relating to health care is shown in **Figure 1**. It shows that overarching system goals are important EU-wide, including how to safeguard accessibility and quality within the budget constraints that countries are facing. Many countries also place particular emphasis on equity, by protecting vulnerable groups, such as children, older people and those with mental health problems or Roma populations across Europe. In order to balance these goals, many countries are considering measures to achieve a better design of services throughout the entire chain of care, including public health and prevention. It implies, among others, strategies for strengthening community and primary care in relation to social care and prevention, redesigning hospital care and de-institutionalising long-term care with more care provided closer to home, thus also placing more emphasis on self-management of patients, new ways of linking health with social care and changing the role of regional or local government.[5] It is exactly these common priorities that will be explored by the funding bodies involved in setting up an ERA-NET.

Meta issues: performance enhancement, transferability and absorptive capacity

The similarity between countries, as highlighted in **Figure 1**, shows that there is great potential for countries to learn from each other's health systems and service provision. This is exemplified by the mission letter of EC President, Jean-Claude Juncker, to the Commissioner for Health and Food Safety, Vytenis P. Andriukaitis, asking him to focus during his mandate on developing expertise on performance assessments of health systems, thus building up country-specific and cross-country knowledge which can inform policies at national and European level.[6]

In this ERA-NET, the focus is not so much on comparing the level of performance of health systems, but mostly on the question of how the performance of the system as a whole or parts of it, such as hospitals or primary care centres, can be enhanced by learning from successful health care models in other countries. A key element for this is whether such models are transferable from one country to another. Often, this transferability is hampered by contextual differences in the political, cultural and institutional arrangements of health systems. This often makes direct copying of policy or services arrangements impossible. In addition to transferability, it is also important to address the absorptive capacity of recipient countries. Taking integrated care as an example, it is far more difficult to organise this effectively in a health care system in which most primary care physicians work in single-handed practices than in countries which mostly have larger multidisciplinary practices. The latter have far more opportunities to bring the right expertise together around specific patient groups.

Therefore, an international research programme should focus on the transferability of and absorptive capacity for innovative solutions in service provision. Under what circumstances and to what extent can a programme that is effective in one place transfer to another?[7] So far little is known about what works where, when and why. The proposed ERA-NET should help determine what the required preconditions are that make an innovation work, in order to accurately and appropriately predict how a proposed policy may work in a new setting.[8]

When identifying such lessons, we hardly need to start from scratch. In the past, many comparative studies have been conducted, e.g. by the European Observatory on Health Systems and Policies as well as others, which combined together, will provide an important starting point for this ERA-NET.[9] The programme should also provide room for methodological advancement for new calls of research, e.g. on how to deal with small-sample country comparisons, on comparing smaller and larger countries, or the regional health systems within those countries. Interestingly, as ERA-NETs can

Figure 1: Word Cloud of texts in country responses to Country Specific Recommendations within the European Semester, year 2014 (n=26 countries)*

Note: * Countries that provided a response report in English, either for 2014 or the latest available year

also involve regional authorities, they may use Europe's variation in health systems to its fullest, as a natural laboratory setting.[3]

Building up country-specific and cross-country knowledge: linkage to other EU-initiatives

Both at EU and national level, there is a clear window of opportunity for this type of research. It is not only illustrated by the above-mentioned mission letter to the Commissioner for Health and Food Safety, but also by the EC communication in 2014 on effective, accessible and resilient health systems.[10] An ERA-NET on health care models has the potential to contribute to this overarching goal, while providing added value to other EU-level and national level initiatives. To name a few examples:

• EU-level health information and knowledge systems, such as the HIS ERIC (Health Information System European Research Infrastructure Consortium), ensure the availability of comparative data for assessing performance, while an ERA-NET

provides the potential to use such data to identify innovations in the organisation and provision of services, including the conditions needed to transfer these.

• The Joint Action on Workforce can identify strategies to avoid future health care personnel shortages, while an ERA-NET can assess whether the organisational conditions are present to help transfer these strategies to other settings, e.g. in terms of the available recruitment mechanisms and division of tasks between health professionals.

• The Joint Programming Initiative 'More years, better lives' strengthens research collaboration in relation to demographic change and includes projects that investigate appropriate and effective models of care for people near the end of their lives. An ERA-NET can make use of these insights when evaluating the transferability of health care models for similar or different age and patient groups.

• The European Innovation Partnership on Active and Healthy Ageing showcases business models which may

contribute to better integrated care solutions, while an ERA-NET can determine whether the contribution to performance of these solutions depends on the division of responsibilities between care providers.

Joining forces across all regions of Europe

The ERA-NET initiative is currently being developed by the Istituto Superiore di Sanità in Italy and The Netherlands Organisation for Health Research and Development (ZonMw), supported by an international scientific working group (see acknowledgements). In February 2015, plans were addressed at a meeting of *Horizon 2020*'s Programme Committee for Health. In March 2015, an invitational meeting will be held among interested parties, in order to refine their specific plans. Other national or regional level governmental and research funding institutes will be able to join the collaboration. To indicate their interest, they can contact the authors of this article. Joining forces across all of Europe's

regions should contribute to fostering long-term collaboration between countries, all with the same ambition to organise health care in a more sustainable manner.

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New HiT on Uzbekistan

By: M Ahmedov, R Azimov, Z Mutalova, S Huseynov, E Tsoyi, B Rechel

Copenhagen: WHO Regional Office for Europe

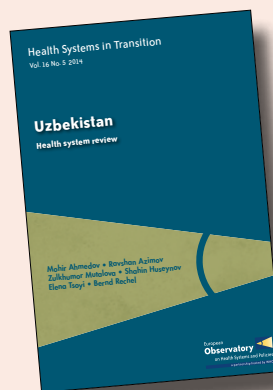**Number of pages:** 168, **ISSN:** 1817-6119

Freely available for download at: http://www.euro.who.int/__data/assets/pdf_file/0019/270370/Uzbekistan-HiT-web.pdf?ua=1

Since the country's independence in 1991, Uzbekistan has embarked on several major health reforms, which included changes to health financing and the primary health care system. The country has also retained some features of the Soviet period, as most health care providers are still publicly owned and administered and health workers are government employees.

Health expenditure is comparatively low when compared to the rest of the WHO European Region. The government has increased public expenditure on health in recent years, but private expenditure in the form of out-of-pocket payments remains substantial. The government has implemented a basic benefits package, but, for most people, this does not include secondary or tertiary care and outpatient pharmaceuticals.

This new health system review (HiT) on Uzbekistan examines the changes and reforms that have taken place and the challenges that still remain.

Health Systems in Transition
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Uzbekistan
Health system review

Mohir Ahmedov • Ravshan Azimov
Zulkhumor Mutalova • Shohin Husyynov
Elena Tsoyi • Bernd Rechel

European Observatory on Health Systems and Policies

LEAVING A LEGACY IN GLASGOW

By: Dineke Zeegers Paget

The European Public Health conferences have been organised for over 20 years now – first as the annual European Public Health Association (EUPHA) conference and, since 2009, as the European Public Health (EPH) Conference. The conference combines networking, knowledge exchange and capacity building between more than 1500 public health professionals worldwide and several international institutes and NGOs are partners in this venture. However, in the past, the Conference did not include activities aimed at the population of the city where the conference was being organised. That is, not until Glasgow in 2014. At the initiative of the Glasgow City Marketing Bureau (GCMB), EUPHA and the EPH Conference decided to get active for Glaswegians and organise, together with the GCMB and the University of Glasgow, some activities to leave a tangible and meaningful legacy in the city.

The format that was chosen was "coffee shops", in a location that was easily accessible to Glaswegians. EUPHA selected two topics and the EPH Conference team selected interesting abstracts with practical examples to be featured in the coffee shops. GCMB organised the advertising through their local network and in newspapers.

The coffee shops were organised at the winter garden of the People's Palace on 21 November 2014: the themes were 'Fight obesity – get active now!' and 'Your Health. Your Move.' As both coffee topics addressed being physically active, the moderators, organisers and presenters decided to lead by example and arrived at the venue on bikes, kindly provided by *People Make Glasgow* (http://peoplemakeglasgow.com). For us, it was a wonderful opportunity to enjoy Glasgow in beautiful weather during a wonderful cycling trip along the Clyde River.

The 'Fight obesity- get active now!' coffee shop was moderated by Christopher Birt, the President of the EUPHA section on Food and Nutrition. Ane Bonde, from Denmark, presented experiences with step counters used in mathematics classes in a primary school to make children investigate their daily step patterns and to reflect on how to become more physically active. One reaction from the audience was that step counters are getting outdated, since activity apps are widely available. Of course such apps may also be used for investigating your steps and reflecting on physical activity patterns. Modi Mwatsama, from the UK, made the case for a tax on sugary soft drinks to raise their price and change consumption from 'everyday' to 'occasional,' in order to lower sugar intakes. The audience asked about fruit juices which are high in sugar.

The 'Your health. Your move.' coffee shop was moderated by Nanette Mutrie from Edinburgh, Scotland. Susanne Jordan, from Germany, explained the difficulty in reaching the non-active population,

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as the 'get active now' programmes mostly encourage those who are already active. Cindy Gray, from the UK, showed that peer support, especially from other people you feel you have something in common with, can have a positive effect on getting active. She gave a demonstration of how this works in *Football Fans in Training,* a healthy lifestyle programme for overweight male football supporters. And a third speaker, Tom McBain, from the UK, presented an innovative active video gaming approach for encouraging hard-to-reach males to engage with a (no cheating possible) high-intensity, low-volume work-out.

Around 30 Glaswegians attended the coffee shops, where coffee was served along with fresh fruit (instead of biscuits). There was a lot of interaction with the audience: on healthy food and how to adapt your lifestyle to move more. On the question of how to get more active, one answer to a young mother was clear and practical: 'pushing your baby in a buggy is exercise, just take the long road home'.

Reflecting on this very positive experience of public engagement in Glasgow, the EPH Conference organisation has plans to continue this scheme at future conferences. We would like to thank Campbell Arnott and Evie Mauchan from GCMB for this initiative, Alastair Leyland from the University of Glasgow for pushing it, and the moderators and presenters for their wonderful collaboration.

New HiT on Iceland

Average life expectancy at birth is high in Iceland: 81.6 years for men and 84.3 for women in 2012. As measured in healthy life years (HLY), the health status of the Icelandic population is better than the European average.

The small, state-centred, publicly funded health system guarantees universal coverage with the state as payer and provider of most health care services. However, since 1990, the number and scope of private non-profit and for-profit providers has increased, especially through a rapid growth in private specialist care at the expense of more developed (and publicly provided) primary care services.

The high levels of health care resources and utilisation, in the context of an ageing population and other public health challenges (such as obesity), as well as the continued impact of the country's financial collapse in 2008, have been particularly challenging for the financial sustainability of the current system, which is increasingly shifting costs from public coverage to private households.

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Iceland
Health system review

Sigurbjörg Sigurgeirsdóttir •
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European Observatory
on Health Systems and Policies

The most important reform challenge is to change the pattern of health care utilisation, steering it away from the most expensive end of the health services spectrum towards more cost-efficient and effective alternatives. To a large degree, this will involve renewed attempts to prioritise primary care as the first port of call for patients, and possibly to introduce a gate-keeping function for GPs in order to moderate the use of specialist services.

EUROPE'S CHALLENGE IN
REDUCING HEALTH AND HEALTH CARE INEQUITIES

By: Walter Ricciardi

Summary: The European Public Health (EPH) Conference was about promoting excellence in public health in Europe. Europe is a tremendously rich place for health research and this conference was an opportunity to bring everyone up to the level of the best, as well as creating the opportunity for networking and bringing people together to exchange ideas on good practices and on further research and collaboration. Inspired by the exclamation "mind the gap", the conclusions of the 7th EPH Conference provided governments with real policy options to address the challenge of reducing inequalities in health and health care.

Keywords: *EPH Conference, Health Inequalities, Health Policy*

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Introduction

Health inequalities are a persistent problem in European countries. Although health in Europe has improved in recent decades, inequalities in health have also widened. 'Health inequalities' refer to the differences in people's health and life opportunities amongst different population groups, and are strongly related to the conditions in which people live, such as their income or the area in which they reside.

Health inequalities exist not only between countries but also within countries and, crucially, they are still increasing in many places. They represent a waste of human potential, as well as a huge potential economic loss–conservatively estimated at between 1.5% and 9.5% of GDP.[1]

Are we on track in tackling health inequalities in Europe?

Population health professionals, researchers and other stakeholders came together at the 7th European Public Health (EPH) Conference to discuss how health inequalities can be effectively reduced. The evidence presented at the conference was extensive.

Equity in health research and large scale interventions

Public health refers to all organised measures put in place to prevent disease, promote health and prolong life among the population as a whole. Modern public health has many successes to claim in terms of population-targeted interventions, whose merit is largely due to extensive underlying research. However, as pointed out by the *World Health Report 2013*,[2] research is not

a prerogative of some countries and persistent geographical inequalities exist also in research output and research capacity. For example, research output, estimated through the number of published papers per capita, varies greatly across regions, with countries from the Former Soviet Union among the worst performers, where coincidently, mortality has actually risen over the past few decades. To overcome these inequalities funders and governments could develop national health research strategies in order to identify research areas and priorities; make rational use of resources; and increase financial contributions to health research, for instance by also using innovative financing sources such as lottery revenues.

remarkably similar paths towards eventual success

Large scale interventions also comprise projects that improve factors such as accessibility, equipment, social integration and perception of security. Such interventions are effective in improving the health of the resident population. For example, the *Neighbourhoods Law,* implemented by the Government of Catalonia (Spain) between 2004 and 2011, led to large-scale urban renewal interventions across Catalonia. The results show that the health perceptions of both women and men improved in the neighbourhoods in which intervention programmes were developed within the framework of the Neighbourhoods Law.

Another inspiring project presented at the EPH conference is the *Demetriq Project* by the European Commission, aimed at developing, evaluating and refining methodologies for assessing the effects of social, economic and health policies on the pattern and magnitude of health inequalities. Examples of findings from the project include: policies that promote the financial security of individuals who

are worst off in society by increasing their employment chances, such that better job security reduces the adverse effects of recession; smart public investment in health and social protection can save up to €3 for every €1 spent; and fairer pay strategies reduce mental health inequalities. Governments possess real policy options to promote health equity, by prioritising social and labour policies that strengthen sustainable employment in national budgets.

Disease: old challenges, novel solutions

Some communicable diseases are chronic (HIV/AIDS, tuberculosis, etc.), meaning that their control is quite similar to that of non-communicable diseases (NCDs), yet at the same time, some NCDs are in part transmissible (e.g. some infectious agents can cause cancer). A better understanding of the relationship between infectious and chronic diseases can affect health across populations, creating opportunities to reduce the impact of chronic diseases by preventing or treating infections. It is necessary to also consider the potential benefits of minimising infections that increase the morbidity of pre-existing chronic conditions during the process of care. This is an important, cross-cutting clinical and public health issue and a tremendous opportunity to reduce long-term illness and disability by implementing new models of care, new treatment regimens and public health programmes that substantially reduce and even prevent chronic diseases and related conditions. Political will and health investments are needed at a global level.

In 2012, NCDs accounted for 38 million of 56 million total global deaths. Cardiovascular Disease (CVD), mainly heart disease and strokes, contributed 40% of all NCD deaths (17 million deaths each year, perhaps rising to 22 million deaths in 2030). The NCD burden of death and disability is immense, but most NCDs have only four major risk factors. Poor diet generates a bigger contribution (about 40%) than the combined effects of tobacco, alcohol and inactivity.[3] Population-wide policies are powerful, more powerful than pills. They have

prevented more CVD deaths than all medical and surgical interventions combined.

Safeguarding prevention policies

Prevention politics are challenging, not least because prevention policies tend to reflect political compromises. Quite often, scientific evidence risks being overcome by powerful vested interests: for example, the reality for food is that ten corporations control almost everything we buy. Unsurprisingly, these commercial companies prioritise profit, not public health.[4] They behave the same way, use the same marketing and lobbying strategies and often hold views that are contrary to the available scientific evidence. This phenomenon, known as denialism, is becoming more elaborate and widespread, and poses threats to public health.[5]

However, public health can celebrate a long tradition of successes, including safe drinking water, clean air, sanitation, seatbelts, immunisation, and smoke-free public spaces. These public health triumphs all demonstrate remarkably similar paths towards eventual success. They begin with scientific evidence, gain traction as public issues, then eventually overcome oppositional vested interests to become consolidated by regulation, legislation and fiscal policies. We might therefore learn useful lessons from the great public health pioneers who preceded us.

European Action Plan for Strengthening Public Health Capacity and Services

Health has improved markedly across the European Region, yet not sufficiently nor equally: the great progress of gaining five years of life expectancy is scarred by profound inequities in health that are striking and unacceptable. Inequities in health outcomes also persist within countries, even in those that are known to promote equity in governmental policies.

What can we do to steer towards more equity in health? There is much to be done. Much potential for improving health equity lies outside the health

sector. As suggested in *Health 2020,* the policy framework for the WHO European Region, more equitable health gains might result from making health a shared goal of governments and societies.

The contribution of the health sector is vital in supporting economic, labour, environmental and social policies that are conducive to health. To contribute to equitable health gain, the health sector needs to move away from merely reactive models of treating diseases. It requires more proactive approaches in tackling the root causes of disease through population health interventions. This requires strengthened public health capacity and services in all Member States. Public health is presently too weak and its potential far from realised. For this reason, the WHO Regional Committee for Europe (62nd session) adopted the *European Action Plan for Strengthening Public Health Capacities and Services* [6] as a main implementing pillar of *Health 2020*. It is a comprehensive statement of strategic actions necessary to support and develop modern public health practice.

Reaching the most at risk populations

There are significant disparities in terms of access to health care and health status among population groups across the European Union (EU). Socially disadvantaged and vulnerable groups are exposed to greater lifestyle and environmental health risks, and carry a higher burden of chronic disease and co-morbidities. Chronic diseases are responsible for 86% of all deaths in the region and are the main cause of disability and morbidity, costing more than €700 billion a year – a number destined to grow year after year. [6] At the same time, chronic diseases contribute to increasing socioeconomic inequalities, due to disability, loss of productivity, and risk of poverty.

There are still health systems within the EU that do not provide access to health insurance and necessary services to all on a universal basis, or that present forms of discrimination or prioritisation of patient groups according to reasons unrelated to health. Integration of care is an important approach to improve access

to high quality care for patients, including the most vulnerable ones. In order to provide integrated services there should be a learning culture and a readiness to provide care through joint collaborative forces and partnerships between health care professionals, service users and wider communities. The European Innovation Partnership on Active and Healthy Ageing (EIP-AHA) is an excellent example of the mobilisation of knowledge and of critical groups working together in partnerships in order to obtain integrated health care in Europe.

Empowered individuals and communities are also key drivers of the change and transformation in health and social care delivery. Advancing health equity implies the need to shift from the current bureaucratic management philosophy towards a true clinical citizen/patient centred approach that enables people to become healthier and more aware of the decision-making processes.

Improving health literacy – as well as Information Technology (IT) literacy – is a major factor in empowering citizens to take more responsibility for their own health, to obtain a greater level of choice, control and confidence in their care and well-being regardless of age, gender, and place of residence, and facilitate self-management. Furthermore, the use of technology in telehealth and telecare is playing a vital role in transforming the way health care is delivered to people and in organising health services in a more productive way.

Population-group challenges in public health

The European economic crisis has fuelled an ideology of fiscal austerity, which has contributed to the widening of health inequalities in the EU between migrants and non-migrants, and between ethnic minorities and the majority population. Migration is a high priority on the political and policy agenda of most Member States of the WHO European Region. The complexity of the issue poses challenges within and beyond the health sector, especially with regard to the health needs of undocumented migrants and of political asylum seekers. Migrants

often bear an unfair accumulation of disadvantages throughout life and migration can be in itself a determinant of inequities, unhealthy lifestyles, exposure to infections, limited access to care, social stigmatisation and of mental and physical health challenges. Furthermore, the adoption by some migrants of specific risky health behaviours that are characteristic of the receiving society, can ulteriorly contribute to the deterioration of health over time.

> "both political will and health investments are necessary

The Roma people are Europe's largest ethnic minority. Many Roma in the EU are victims of prejudice and of social exclusion and consequently face barriers in accessing good quality housing, health care and education.

A sixteen year difference in the age at death between the Roma population and the general population in Romania underlines the dramatic disparity in relation to health status and health outcomes; in Romania the average time between first diagnosis of a condition and death is 3.9 years in the Roma population, while it is 6.8 years in the general population. [8] The poor and unequal health outcomes of Europe's Roma population reflect the contemporary political and social trends on the continent.

Moreover, the lack of disaggregated data poses an obstacle to monitoring the success or failure of the policies targeted for the Roma population. Disaggregated data should be collected through the exchange of good practices, the dissemination of information regarding relevant data protection rules (i.e., EU Directive 95/46/EC on data protection) and the support of pilot projects that can serve as models. However, the real mistake would be to fail to harness the imagination

and energy of the communities in finding solutions to the above-mentioned problems. In fact, communities often know what works best for them. It would be a tragic failure of our system if we failed to capture and support these opportunities, not just for the benefit of the Roma but also for the whole population's health.

Conclusions

In conclusion, keeping health inequalities high on European and Member State agendas at a time of great economic strain will be no mean feat. This challenge needs to be met if both population health and social solidarity across Europe are to be protected.[9] In order for this to be done, both political will and health investments are necessary. The principal responsibility for action in addressing health inequalities rests with the Member States, but EU policies should also have a role in helping to overcome some of the current obstacles to action.

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International Award to Professor Martin McKee

Martin McKee, Professor of European Health Policy at the London School of Hygiene & Tropical Medicine, Research Director of the European Observatory on Health Systems and Policies and president-elect of the European Public Health Association has been awarded the *2015 Donabedian International Award*.

Each year the Avedis Donabedian Foundation honours leaders in the field of quality in health care, both individuals and institutions, which have made a substantial contribution to health care excellence.

The Foundation notes how Professor McKee has an impressive record in health systems analysis and evaluation, especially in drawing attention to the challenges that all countries in Europe face in integrating health and social care and the responses that will be needed in the future.

Professor McKee is a world leader in health systems and his leadership is evident in his crucial contributions that have provided new insights into the adverse health consequences of rapid social transition and his major research activities on the health effects of the financial crisis. His contributions on strategies for changing health care enlighten quality programmes all over the world, making him an outstanding leader and advocate for quality in health care.

Many congratulations to Martin!

NEW PUBLICATIONS

What do we know about the strengths and weakness of different policy mechanisms to influence health behaviour in the population?

By: D McDaid, A Oliver and S Merkur

Copenhagen: World Health Organization / European Observatory on Health Systems and Policies, 2014

Number of pages: 36; **ISSN:** 2077-1584, Policy Summary 15

Freely available for download at: http://www.euro.who.int/__data/assets/pdf_file/0003/270138/PS15-web.pdf?ua=1

With health care systems under increasing pressure the development of a well-defined and effective public health strategy has never been more important. Many health problems are potentially avoidable and governments have long had tools at their disposal to influence population health and change individual behaviours, directed both 'upstream' at some of the underlying causes of poor health, as well as at 'downstream' challenges when poor health behaviours are already manifest. But how effective are these different actions?

This policy summary briefly maps out what is known about some of these mechanisms, including approaches that have come to recent prominence from behavioural economics and psychology.

Combinations of taxation, legislation and health information remain the core components of any strategy to influence behavioural change. There remain many unanswered questions on how best to design new innovative interventions that can complement, and in some instances augment, these well-established mechanisms.

Contents: Background; Focus of the policy summary; What factors influence why people do or do not change their behaviour?; What mechanisms have been used to help influence health behaviours?; What do we know about the effectiveness and cost effectiveness of these mechanisms?; How can the evidence base, including different modes of implementation, be strengthened?; Conclusions and summary of key themes; References.
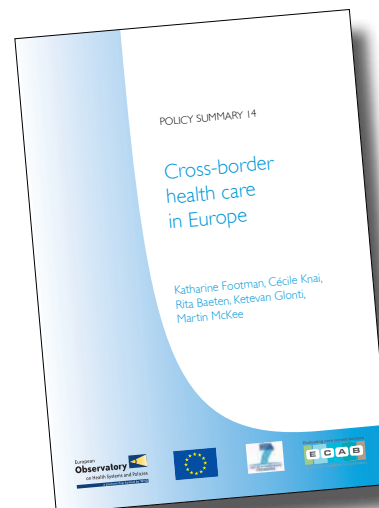
Cross-border health care in Europe

Edited by: K Footman, C Knai, R Baeten, K Glonti and M McKee

Copenhagen: World Health Organization / European Observatory on Health Systems and Policies, 2014

Number of pages: 41; **ISSN:** 2077-1584, Policy Summary 14

Freely available for download at: http://www.euro.who.int/__data/assets/pdf_file/0009/263538/Cross-border-health-care-in-Europe-Eng.pdf?ua=1

Patient mobility is high on the political agenda in the European Union, with increasing numbers of people crossing European borders. Issues relating to health professional mobility have received less attention, yet this is an important policy issue for the EU considering the scale of and reliance on professional mobility between countries, and existing variations in educational and professional standards.

How are health systems in Europe responding to patient and professional mobility, and what are the implications for access and quality of health services? Is greater coordination needed, or do calls for increasing integration reflect a political agenda for increasingly competitive markets in health care?

Recent legislative changes which clarify patient entitlements to cross-border care will have important impacts on national and EU-wide health policies. This policy summary provides a review of the current state of issues relating to cross-border health care in Europe. It combines a literature search with evidence gathered by the Evaluating Care Across Borders Project to provide an update on the 2005 'Policy Brief on Cross-Border Health Care in the European Union'.

Contents: Introduction; Who is moving?; Patients treated across the border; Professional mobility; The EU legal framework; EU mechanism to fund cross-border care; Organisation of cross-border care; Quality of cross-border care; Disease management; Continuity of care; Telemedicine across borders; Professional standards; Conclusions.

NEWS

International

Guntis Belēvičs: focus on healthy lifestyles, patient safety and quality

Writing in *The Parliament Magazine,* Latvia's health minister **Guntis Belēvičs** set out the Latvian Presidency's priorities for health. These include working towards agreement on new EU rules for medical devices and in-vitro diagnostic medical devices to help promote patient safety and quality care. Promoting healthy lifestyles, particularly for children and young people are another priority, with a focus on nutrition and physical activity. The Presidency will also host the first ministerial conference on tuberculosis and its multi-drug resistance on 31 March in Riga, while eHealth week in Riga in May will focus on ways to improve the uptake of eHealth and mHealth technologies by patients. The Presidency will also host a conference on deinstitutionalisation and the further development of social care policy in Europe on 15 June.

Minister Belēvičs' article in *The Parliament Magazine* can be read at: http://tinyurl.com/mz3l2b9

Transatlantic trade and investment partnership: extra safeguards promised

In an interview with *The Guardian* newspaper in the UK, Cecilia Malmström, the EU's trade commissioner, is stated to be planning to rework key areas of the Transatlantic Trade and Investment Partnership (TTIP) agreement to allay fears that US companies could use the deal to unfairly obtain health service contracts and undermine national health services. In the article Commissioner Malmström states that US multinationals must only have a "limited possibility" of winning compensation in behind-closed-doors investor to state dispute settlement (ISDS) procedures if governments cancel privatisations or award public contracts to in-house bids.

At a recent meeting at Europe House in London the Commissioner stated categorically that the UK's National Health Service will not be threatened by TTIP saying that it "will not hinder EU member states ability to run their public services… nothing will prevent outsourced services being brought back into public ownership."

The NHS Confederation's European Office has also produced a report on how the deal could impact on the NHS in the UK. One key worry concerns the ISDs procedures – the Confederation states that if American corporations challenge domestic health policy measures through ISDs arbitration procedures this could potentially result in "policy freeze" in the future, as UK governments might think twice about introducing new policy if they fear potential challenges. They point to recent experience with other international trade agreements noting that tobacco giant Philip Morris has now for several years been challenging the Australian Government on their introduction of cigarette plain packaging.

The Guardian article is available at: http://tinyurl.com/kjx23ll

The NHS Confederation briefing on TTIP is available at: http://tinyurl.com/kxy9jra

New EU report on antimicrobial agents and risk of antimicrobial resistance

Access to accurate data on the use of antimicrobials and the occurrence of antimicrobial resistance is an essential step to develop and monitor policies that minimise the development of resistance and keep antimicrobials effective for future generations. A new report concludes that the use of certain antimicrobials in animals and humans is associated with resistance to these antimicrobials in bacteria from animals and humans. There are also important differences in the consumption of antimicrobials in animals and in humans between European countries. These are just some of the findings of the first integrated analysis of data from humans, animals and food in Europe published jointly by the European Centre for Disease Prevention and Control (ECDC), the European Food Safety Authority (EFSA) and the European Medicines Agency (EMA).

The report combined data from five European monitoring networks that gather information from European Union Member States, as well as Iceland, Norway and Switzerland. The aim was to make better use of existing data and strengthen coordinated surveillance systems on antimicrobial consumption and antimicrobial resistance in human and veterinary medicine. It identifies data limitations that need to be addressed to aid in future analyses; these include additional data on antimicrobial consumption by animal species, data on antimicrobial consumption in hospitals in more European countries and monitoring of resistant bacteria in the normal flora from both healthy and diseased people.

The first in a series of planned reports that will look at data collected by various monitoring networks, the report will inform the European Commission's action plan against the rising threats from antimicrobial resistance.

The report is available at: http://tinyurl.com/ldk9uh8

Zsuzsanna Jakab appointed WHO Regional Director for Europe for second term

In January WHO's Executive Board, in its 136th session in Geneva, appointed Dr Zsuzsanna Jakab, WHO Regional Director for Europe, for a second term. This follows her nomination in September last year by the Regional Committee for Europe, which comprises the health ministers of the Region's 53 Member States. Dr Jakab started her new five-year term in February 2015. "In my second mandate, I will give priority to linking health to sustainable development in order to ensure greater equity in health in the European Region. It's not only about making health better; it's about ensuring more equitable and sustainable health for Europe," said Dr Jakab.

WHO launches tool to help countries reduce marketing of foods with too much fat, sugar and salt to children

Unhealthy diets are a leading factor affecting health and well-being in every European country; rising overweight and obesity among children are particular concerns. Affecting up to 27% of 13-year-olds and 33% of 11-year-olds, overweight risks becoming the new norm in the WHO European Region. Robust evidence points to a link between exposure to food marketing and unhealthy diets, while obesity in children and brand recognition starts in early childhood. Children who recognise multiple brands by the age of 4 years are more likely to eat unhealthily and be overweight.

Across the WHO European Region, children are still regularly exposed to marketing that promotes foods and drinks high in energy, saturated fats, trans-fatty acids, free sugars or salt. Despite progress in some countries, government action to restrict such marketing remains less than optimal. One of the reasons for this is the challenge of identifying foods whose marketing should be restricted. A first step in developing policies to restrict marketing to children is to establish the criteria that identify such foods and drinks. To meet this need, the WHO Regional Office for Europe has developed a nutrient profile model for countries to adapt and use to classify foods according to their nutritional composition. The model is largely based on Danish and Norwegian models which are used to restrict food marketing to children. Health authorities developed the Norwegian model, while the Danish model was developed by the Forum for Responsible Food Marketing Communication (a trade association) but endorsed for use by the Danish Government.

The model is available at: http://tinyurl.com/k2vpm2g

Country News

Ireland: strong new measures to tackle alcohol misuse planned

On 3 February the Irish Cabinet signed off on proposals to reduce alcohol consumption and tackle alcohol misuse which are intended to help Ireland cut alcohol consumption to the OECD average of 9.1 litres per person per annum by 2020 and reduce the harm associated with alcohol misuse. Minister for Health Leo Varadkar said the proposed Public Health (Alcohol) Bill 2015 is part of a suite of measures designed to reduce alcohol consumption and limit the damage to the nation's health, society and economy.

The proposed bill will include provisions to prevent the sale of very cheap alcohol, health labelling, as well as warnings on products including calorie counts. The minimum price will be set when the bill is published and will be at a level that the evidence shows will reduce the burden of harm from alcohol. The sale price of the alcohol product, in both the on-trade (e.g. pubs) and off trade (e.g. off-licenses and supermarkets) sectors, could not be below this minimum unit price.

New enforcement powers for environmental health officers to police and enforce the separation of alcohol within stores are planned. They will also be empowered to police minimum unit pricing, health labelling, marketing and advertising and other measures of the Bill.

New measures regarding marketing, advertising and sponsorship will be subject to a three year review to gauge their effectiveness. These will include restrictions on the advertising and marketing of alcohol from 2016 including a broadcast watershed on television and radio, with further restrictions due on cinema and outdoor advertising.· It will also be illegal to market or advertise alcohol in a manner that is appealing to children. There will also be legal regulation of sports sponsorship for the first time.

Ireland is no stranger to taking tough public health actions. On 3 March, following Australia, Ireland became only the second country to pass standardised packaging legislation which will remove all tobacco industry marketing from cigarette packets. The brand will be printed on the packet in a standardised font and colour. The size of the warning will also be doubled on the front of the packet (to 65% of the packet) and it will feature a graphic picture warning.

More information at: http://tinyurl.com/l6cbh9a

France: Sixth edition of health status of the population published

On February 12 the sixth edition of the health status of the French population was published by DREES (*Direction de la recherche, des études, de l'évaluation et des statistiques*) at the Ministry of Health. The report shows that the French are generally healthier than their European neighbours, but that they also face three major challenges. One challenge, paradoxically, is increasing life expectancy, as this inevitably means a need for care better tailored to the needs of an ageing population. With increased life expectancy comes an increase in the incidence of chronic disease, for instance there are now more than three million people in France living with diabetes. Another challenge is the persistence of social and health inequalities. One example highlighted in the report is that the children of executive level employees are ten times less likely than the children of blue collar workers to become obese. Moreover, life expectancy differences between senior managers and blue collar workers can be as much as ten years.

To meet these challenges the government plans to reform the health care system to put more focus on prevention and improve access to care as early as possible. A new health law will be discussed by the National Assembly in April. Among the proposed measures are better nutritional information on food packaging, combating underage drinking and potentially making public outdoor sporting venues smoke free.

The report on the health status of the population (French only) is available at: http://tinyurl.com/kfear8o

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- Discuss in a **critical manner the place and usefulness of integrated care** in a modern health and social care system

- Draw practical policy and implementation lessons to inform **better decision-making** on delivery system reform that will positively **impact the quality of care** given resource constraints.

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