

eurohealth

David Byrne,
European
Commissioner for
Health and
Consumer Protection



Portuguese
Presidency of the
European Union –
Priorities for Health
*Minister Manuela
Arcanjo*

P r e f a c e

An increasingly important aspect of policy making within the European Union is the role of sub-national institutions in the policy process. Nowhere is this more the case than in the United Kingdom, where the devolution process is creating new centres of decision making in the health policy field. This issue of *eurohealth* includes an article by the new Scottish Minister for Health and Community Care on the aims of the current Executive in health policy and service delivery.

The changing institutional structures in Northern Ireland, as well as the evolving political climate there, are the focus of several articles. In particular, they discuss the new opportunities for cooperation between the North and South of Ireland in providing health services for the populations in the border areas. This is an important step for all Member States, as an example of inter-institutional cooperation being used pragmatically to deliver healthcare to their populations in the most efficient and effective manner. The difficulties of promoting health policy, or any policy, in a party system defined by sectarianism are also discussed. The successful formation of the Northern Irish Executive since the writing of these articles has, however, led to greater optimism in this respect.

In the context of the current high profile of food safety issues in the EU, several articles discuss the development of policy in this field. In particular, Tim Lang sets out the complexities inherent in developing EU food policy and the problems likely to be encountered by a European Food Agency. Jeanette Longfield, meanwhile, focuses on the Common Agricultural Policy (CAP), and explains the Sisyphean task facing those attempting its reform to take account of diet and public health, as well as environmental factors in the production of Europe's food. Nils Rosdahl concludes this section with a look at the food control system in Denmark and its implications for public health.

David Byrne, the new Commissioner for Health and Consumer Protection, sets out his view of how the policy of the new Directorate General will proceed over the coming years, and how it will respond to the broader public health provision accorded the Community in the Amsterdam Treaty. The Portuguese Minister of Health, Maneula Arcanjo, summarises the tasks of the current Portuguese presidency, and details the official programme for the coming six months. John Bowis addresses the issue of mental health in Europe and the opportunities for progress in this area within the provisions of Amsterdam.

In short, we again have a *eurohealth* packed with informative and informed debate about many aspects of public health. It is a debate that will continue, in the new atmosphere of accountability surrounding Europe's institutions, as the provisions of Amsterdam are seen to require action to make sure that health really is taken into account across the policy spectrum.

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Would the Commissioner for health please stand up?

Paul Belcher

Senior Editorial Adviser, eurohealth

A casual observer of EU affairs since the new European Commission took office last year might be forgiven for thinking that David Byrne has swapped his appointed role as Health and Consumer Protection Commissioner to become 'Commissioner for Food Safety', as he now appears typecast by the European media. Whether this is a result of the need to deal with recent food related scandals, or evidence of a longer-term policy shift away from the broader EU health agenda, is now a serious cause for concern.

To be fair, few could have predicted the whirlwind of food scandals that engulfed the new Commissioner as soon as he took office. The European Parliament must also accept its share of the blame for reinforcing the current high political profile of food safety, by failing to raise wider health policy issues during its questioning of Mr Byrne in the hearings held prior to his appointment – apart from the notable few such as John Bowis MEP, former UK Health Minister, who also writes in this issue of *eurohealth*.

Food safety is, of course, a major public health issue. However, the Commission should not lose sight of the fact that this is one part of a much wider EU Treaty obligation to ensure a high level of human health protection and integrate health considerations into all EU policy areas. The high political priority given by the new Commission to press ahead with the White Paper on Food Safety and create a European Food Authority stands in contrast to the absence of proposals, now long overdue, to implement Article 152 on Public Health.

Readers will recall that in April 1998 the Commission published its ideas on the way forward for EU public health activities. There followed a

process of consultation with the other EU institutions and interested parties, which was finalised before the previous Commission left office, and it demonstrated overwhelming support for the Commission's general approach to future policy. However, we are still awaiting the second stage of the process and the publication of concrete policy proposals.

As the Commissioner points out in this issue of *eurohealth*, the resignation of the last Commission was a reason for the initial delay. However, there is now palpable annoyance among some Member State administrations, particularly EU Presidency countries, as well as other interested groups who were involved in the consultation process in 1998–99, that proposals have still not been put forward. Now, as Mr Byrne notes, the delay has led to the inevitable discussion of 'interim measures' to keep afloat those health programmes which are coming to an end. Even these interim measures, which have yet to be decided, may themselves have to pass through a lengthy process of agreement and, as a result, there is great uncertainty over the future of some of the valuable projects and health networks funded by the programmes.

The Commissioner announces in this issue of *eurohealth* that his package of proposals can be expected sometime in the next six months during the Portuguese Presidency of the European Union. But why will it have taken so long to deliver these health proposals and are there any conclusions to be learned from this for the future? For many, the Commission resignation last year and the subsequent focus on food safety scandals are not valid excuses for the lack of activity on wider health policy development. It may have more to do with political pri-

ority setting within the new Commission. Indeed, the demonstration of how political will and concrete action can be employed in the field of food safety stands in contrast to the infrequent and vague policy statements on the future direction of EU health policy – let alone the complete absence of any detailed policy proposals. Some observers suggest that the reason may lie in the failure of the much heralded joining together of Consumer Policy (previously DGXXIV) and Public Health (previously DGV) within the Commission. There are reports that far from being a marriage made in heaven, this has been a bed of nails from day one and that the partners are barely on speaking terms. As a consequence, have wider health interests been marginalised by food and consumer concerns within the new Directorate-General for Health and Consumer Protection?

Encouragingly, Mr Byrne has already stated publicly that wider health issues do need greater attention. At a conference on 'Building Healthier Hearts' held in Dublin on 5th November last year, he recognised that much of his time was indeed being taken-up with food safety issues. He said that while they are important, "they should not serve to distract our attention from wider health issues". The Commissioner will find much support for these sentiments among the wider European health policy community. However, the time has now come for words to be translated into concrete action by ensuring the timely publication of visionary health policy proposals that interpret Article 152 to the full and maximise the 'added value' which the EU can make to national efforts to *improve* and not just protect public health.

A health strategy for the new millennium

Manuela Arcanjo

Minister of Health of Portugal

During first the six months of the year 2000, the Portuguese presidency of the European Union will play an important role in the area of public health.

First of all, we are making all efforts to ensure the continuity of proposals launched under the previous Finnish presidency. These will certainly contribute to the implementation of a global strategy for health for the fifteen countries that constitute the Union.

Since becoming Minister of Health in Portugal eight weeks ago, I have been conscious of the importance of this presidency for Health in the European Union. Working towards that objective, we have decided to organise initiatives that will be developed in the forthcoming six months. I am completely confident that they will all be highly beneficial for the successful exercise of my mandate, as they will be for all of my fellow Ministers of Health in the other fourteen Member States.

The recent changes to the Treaty of the European Union have been of great value, first by establishing a Community public health competence (Treaty of Maastricht), and then by introducing a clearer legal basis for the action of the Community in terms of health policy (Treaty of Amsterdam). These changes make the horizontal character of the Community health policy mandatory, implying the need to consider the protection of public health in all EU policies.

As such, the Portuguese Presidency will focus on food safety, starting as determined in Helsinki, with the work on the White Paper on Food and Safety, to be presented by the Commission, aiming to reach the highest possible level of health pro-



“The Portuguese Presidency wishes to accomplish every task at its hand. I hope ... that it will result in a real improvement in health in the European Union. This is our commitment.”

tection for consumers of Europe's food.

To complete the ‘farm to table’ approach, a major programme of legislative reforms has to be undertaken, as well as ensuring the horizontal nature of health across policy areas. In the Feira Council, a report including the combined work and discussions in Health, Agriculture, Internal Market and Consumers Councils will be presented.

Tobacco, will also be a major theme, and we will approach the Members States in relation to the proposal presented by the Commission.

The work that the Portuguese Presidency will continue include the questions related to microbial resis-

tance; the excessive use of antibiotics and its consequences; and the effort to ensure a better quality and safety of blood, improving control and handling procedures.

Included in the official programme of the Portuguese Presidency, two conferences will be organised, focusing on Public Health. The first, “Health determinants in the European Union”, will take place in Évora, between 15th and 17th of March. This conference intends to give adequate visibility in the European agenda to this subject. All the existing information and data will be analysed and answers will be formulated to the problems detected at this level.

The second conference, “Medicines and Public Health”, will take place on 11th and 12th of April in Lisbon. Matters such as the impact of the use of medicines in the context of public health and health systems, under the Treaty of Amsterdam, will be discussed, contributing to debate about the role of the European Union in this field.

Finally, we hope, with the cooperation of the European Commission, to organise an expert meeting, in Oporto, to begin a political debate about the quality and security of organs and fabrics of human origin for transplantation. We hope that this initiative will lead to a proposal for a Community Directive that deals with these issues.

To finish, I would like to summarise our objectives in a simple way: The Portuguese Presidency wishes to accomplish every task at its hand. I hope that this will give us something to cheer, and that it will result in a real improvement in health in the European Union. This is our commitment.

The European Community's future strategy in the field of public health



David Byrne, European Commissioner of Health and Consumer Protection, here elaborates on his and the Commission's role in public health, and the priorities for building on the work of the previous Commission and developing future policy in its public health strategy.

From the outset, the new Commission has put health high on its agenda. For the first time a health portfolio has been created. A new Directorate General has been established bringing together public health, consumer protection, animal and plant health, inspection and scientific advice. This significant development responds to the new health provisions contained in the Amsterdam Treaty, which widen the scope of Community action in this area.

The Community's current public health actions are based on the strategy set out in the Commission's framework for action in the field of public health, published in November 1993. In this context, eight action programmes were introduced and are in the process of implementation. Other activities undertaken included a strategy and measures on tobacco and smoking; a strategy and a Council recommendation on blood safety; the organisation and coordination of surveillance

and control of communicable diseases at Community level and regular reporting on health status and on the integration of health requirements in other policies.

A new strategy

Following the conclusion of the Amsterdam Treaty, which strengthened the health provisions of the EC Treaty, and with the prospect of

future enlargement, a stock-taking exercise concerning the objectives and administration of the programmes and the overall coherence of policy took place, involving stakeholders inside and outside the Commission. There was consensus towards developing a new policy which ought to be highly effective, well-structured, in tune with the strategic needs of the Member States and flexible enough to respond to new developments. The new policy had also to address the issue of limited resources and the heavy administration burden posed by the current action programmes.

The Commission's communication of April 1998 on the development of public health policy set out the results of the review and suggested a number of priorities and options for the future. It proposed a broader, coherent approach to tackling health issues at Community level, involving:

- one overall public health pro-

gramme with actions in several key fields: health information, rapid response and tackling health determinants, which should pay due attention to issues related to enlargement and to the interaction with other health-related policies;

- large-scale, sustainable actions, involving all Member States, which would have a strong link to policy development and, eventually, the preparation of legislation;
- taking full advantage of the range of legislative possibilities offered by the Treaty.

The Communication stimulated a wide debate on how the Community's public health policy should develop. For example, the German Presidency organised a major conference (in Potsdam, January 1999); the European Parliament commissioned an expert study and held a public hearing (in Brussels, October 1998); and many NGOs, professional organisations and other bodies wrote to the Commission giving their views, or organised events at which the communication and the future of health policy in the EC was discussed. The overwhelming majority of opinions and comments received, and in particular those of the Parliament, the Council and the other Community institutions, indicated support for the Commission's ideas and approach as set out in the Communication.

The resignation of the Commission in March 1999 has inevitably delayed the process of developing specific proposals. However, it is clear that developing new proposals for action in public health based on Article 152 of the Treaty, and a general communication on the Community's health

strategy, are priorities for the new Commission. While these would reflect the debate on the Community's future policy in this field launched by the Commission's communication, they must also take account of the recent developments concerning the place and weight accorded to health in the new Commission and in public perception, as well as the lessons learnt from recent health-related crises.

A communication on health strategy

Although the details of the communication have yet to be confirmed, my intention is that it would have a number of aims. First, to describe major trends and developments in health. Then to set out the legal basis for the Community's actions related to health, and to describe the various Community policies that relate to health and how they relate to each other and fit into an overall framework. In addition, it would also show how the new public health programme and the various legal measures to be taken under Article 152 relate to these other policies.

The goal will be to address the implications of Article 3(p) of the EC Treaty according to which the Community's overall objective is to raise the standard of living and working conditions by making a contribution to the attainment of a high level of health protection.

A new programme

In addition to the communication, I also intend to submit a proposal for a decision by the European Parliament and the Council adopting a programme of action in the field of public health. This programme will build upon the orientations of the April 1998 communication and the resolutions of the Community institutions, notably the Council and the European Parliament.

Without prejudging the outcome of the current process of consideration, I am convinced that a major emphasis of the new programme should be on improving health-related information. This will enhance the ability of the Member States and of the Commission to design and implement effective health policies and

will assist Member States in making their health systems perform better and to cope with change. Activities would build upon actions undertaken under the current health monitoring programme, such as identification and establishment of health indicators, the interchange of data between administrations and the analysis and evaluation of health interventions.

The programme would also have to take on board the need to address health determinants. Health determinants can be linked to behaviour, genetic predisposition, environment, and socioeconomic conditions (including health care interventions). In practice, only some determinants can be addressed at Community level: examples include tobacco, alcohol, drug dependence, food and nutrition, environment and pollutants, working conditions, education, and social protection. Effective strategies and measures in relation to key determinants will be needed, as well as the creation of links with other health related Community policies such as research, taxation, social security, environmental policy, transport safety, educational programmes, and so on.

The third priority area mentioned by the 1998 communication involved the creation of a Community surveillance, early warning, and rapid reaction capability for health. The network on surveillance and control of communicable diseases could serve as the fundamental element in developing an overall alert and response platform. Such a mechanism would have to link and establish effective coordination with other alert mechanisms at Community level.

The new programme would also have to explore and to exploit the possibilities of cooperation which are now visible as a result of the creation of the health and consumer protection portfolio. There might well be advantage in maximising synergy between these areas by putting forward some specific proposals complementing consumer health protection, starting with nutrition and extending to alcohol and other risk factors.

Some interim measures

The first four of the existing action programmes (health promotion, cancer, AIDS and other communicable diseases, and drugs) will be expiring by the end of 2000. Since the procedure for adopting the decision on a new public health programme is likely to take a considerable amount of time, the proposal cannot be expected to be adopted before these programmes come to an end. Therefore, there may be difficulties in pursuing actions that have proved their worth. A solution to this problem would be to extend the action programmes until the new public health programme comes into effect.

A closer look at health impact

A great number of Community policies have an impact on the health of Community citizens, and on Member States' health systems. Take, for example, legislation on pharmaceuticals or medical devices, the recognition of diplomas of health professionals, or, more generally, environment and transport policies. It is crucial to ensure that health issues are given due weight in the development and implementation of Community policies and actions. The links between these policy responsibilities and public health within the Commission have to be strengthened. In my opinion, this means that we need to review and to strengthen – where appropriate – the mechanisms we have established within the Commission to implement the Treaty requirement on ensuring a high level of health protection across Community policies.

Conclusions

The development of the Community's new public health strategy has now come to a decisive stage. I intend to present my package of proposals under the Portuguese Presidency, i.e. in the first half of 2000. I am of course aware of the fact that the delays we have encountered have led to some concerns. But I have made it clear that for me it is important to take the time needed to devise a well-balanced and structured strategy. Only in this way will we be able to address properly and effectively today's and tomorrow's public health challenges.

After Tampere – Mental health in Europe



John Bowis MEP

“In the words of the National Lottery advertisers, ‘It could be You’ – or me, or my wife or son or daughter or a close friend - and it almost certainly will be one of those.”

“The Council of the European Union ... Recognises that mental health is an indivisible part of health ... Invites the Member States to develop and implement action to promote mental health and prevent mental illness ... Invites the Commission to consider ... the need to draw up a proposal for a Council Recommendation on the promotion of mental health.” This extract from the unanimously adopted Resolution of the Health Council meeting of 18th November in Brussels shows just how far we have come since the Treaty of Amsterdam gave the European Union competence for health promotion; since the Finnish Government decided to make mental health a priority for their 1999 Presidency; and since the Conference in Tampere, Finland on the Promotion of Mental Health and Social Inclusion, on 10th to 13th October, 1999. This brought together the Council, Parliament and Commission, together with Finnish NGOs, the WHO and representatives of mental health practitioners, planners, service users and families came together from 10th to 13th October in Tampere, Finland for the first EU Conference on the Promotion of Mental Health and Social Inclusion.

I was privileged to represent the European Parliament and speak in the opening session alongside the Health Council’s Finnish President, Eva Biaudet and EU Health Commissioner David Byrne. Eva Biaudet and I both challenged the Commissioner to put mental health firmly and highly on his agenda and pledged our support for him if he were to do so.

A growing burden

We know, from a great deal of research but notably from the trio of reports from the World Bank, WHO and Harvard University in 1993, 1995 and 1996, that mental disorder is the fastest growing cause of disability and of the global burden of disease. We know too that five of the ten leading causes of disability are psychiatric and that the burden is set to rise from the current 10.5% to some 15% by 2020, at which point it will overtake cardiovascular

disease. In Britain we know that we lose more people through suicide than we do through road accidents, that we lose some 92 million working days a year from mental illness and that the direct health, social care and benefit cost to the nation is about £20 billion, before you take account of the cost to individuals of lost earnings and to the country of lost wealth creation.

To me, even more important are the statistics that show just how many of us are mentally ill at any one time (one in seven), how many will be during our lives (one in three) and the fact that one in three of us who visit our GP have some form of psychosocial disorder but only one in six of us has that diagnosed. In the words of the National Lottery advertisers, ‘It could be You’ – or me, or my wife or son or daughter or a close friend - and it almost certainly will be one of those. And, if it is, then shouldn’t we all want there to be in place a caring, humane, close-to-home facility, where we can be restored to health or, if that is not possible, then that we will be cared for with love and with dignity and without stigma. That must be our driving emotion and also our cool logic in pressing forward the need for mental health to be promoted as an integral part of EU policy.

The opportunities of Amsterdam

The Treaty of Amsterdam takes us forward in two ways: it gives a real jurisdiction for mental health promotion and education and illness prevention; it also provides for all EU policies to take account of their effect on health, including of course mental health. We should therefore be able to look forward to the development and implementation of some form of health impact assessment, to go alongside the small firm, employment and environment impact assessments that are supposedly in place already. I say ‘supposedly’ because my experience of Europe’s institutions is that they are quick – well fairly quick – to pass regulations and directives but abysmally slow in ensuring they are implemented – and even slower in doing something about it.

There is also a degree of sensitivity to be overcome where any EU action on health is concerned. In this area it is Germany, I am told, who is the strongest upholder of the principle of subsidiarity. The Treaties, we are firmly told, do not cover health, which is entirely a matter for member states. And that is true – well fairly true. In fact public health has been a competence of the EU for some time and so has health and safety at work and so, following a recent judgement, has the right of European citizens to benefit from health provision in whichever member state they find themselves. But the actual system of health service provision is and remains entirely a matter for each country and its government and parliament.

Amsterdam does not give the EU power to direct health across the Union, but it does encourage it to research and share best practice, to promote education on steps to good health and away from poor health. So it will be right for the Commission to enable member states and the Parliament to find a range of good practice in prevention, promotion and provision but not to go the next step and say what each country must provide. It will therefore have to be done by example and by showing what works. The exact border between health provision and health promotion is a little blurred; for example when one is in the area of post-treatment care and rehabilitation and measures to prevent relapse, clearly the two are interdependent.

The Tampere Conference

Tampere was an excellent coming together of practical experience and academic thought. We started from the quartet of base points

- acknowledging the social and economic causes of mental ill health as well as the physical and neurological ones
- accepting that many if not most mental health problems can be cured or stabilised
- welcoming recently published evidence that health promotion works and that many mental disorders can be prevented
- realising that we have a long way to go in developing acceptable outcome and cost effectiveness measurements and indicators, without which it is difficult to convince finance ministers and budget committees of the wisdom of investing in health promotion

There were three areas that the conference felt merited priority action: children and

“Amsterdam does not give the EU power to direct health across the Union, but it does encourage it to research and share best practice, to promote education on steps to good health and away from poor health.”

young people, the workplace and elderly people.

Changes in society have made the world a less secure and stable place for many children. Families break up; parenting skills are no longer handed down the generations; the parent’s job and housing mobility removes children from the wider family circle; crime, delinquency, truancy and unemployment inhabit too many estates. It is hardly surprising that child behavioural and psychiatric problems multiply.

At work, firms that take a health at work policy as a matter of course, look bemused when you ask to see their mental health at work policy. People with a problem conceal it, lest it should undermine their job or chance of promotion. Employees, who are caring for a disabled relative, struggle to cope with both and end up coping with neither, for the lack of a flexible policy for carers at work. And when the temporary or permanent end of work comes, through redundancy or retirement, nobody helps the person prepare for the suddenness of the change or to make best use of the new availability of time; and we wonder why people become depressed.

The lengthening of our life years is a bonus but also a challenge. Many of us will become not ill but frail of body or mind. We have a remarkable generation of 80 and 90 year olds, particularly women, who found and took positions of responsibility during the war. There is perhaps a lesson in this that a sense of purpose and of being needed and valued in our later years is good for our mental and physical wellbeing. Again social and economic factors are as important to a solution as medicines and medical science.

So the lesson of Tampere is a hopeful one, even an exciting one, but one that tells us Tampere alone is not enough. The Finns deserve enormous praise for firing the starting gun but the race is now on. The Council resolution took this on the first lap; Parliament and Commission must now follow, as must the Portuguese Presidency; and above all a budget line must be established. The race is a marathon, not a sprint; but at least we are all now up and running.

“firms that take a health at work policy as a matter of course, look bemused when you ask to see their mental health at work policy.”

Health policy in the EU

A basic guide

Graham Chambers

This is my second attempt¹ to take you through the labyrinth of the European Union's modus operandi and lead you out at the other side, compos mentis. Both our tasks are simplified because of the most recent changes to the ways in which the EU works, the Treaties of Maastricht in 1992 and Amsterdam in 1998. The fallout from the 1999 'implosion' of the Santer Commission and nomination of the Prodi Commission resulted in considerable changes in the Commission and in its relations with the Parliament.

"There are fears that consumer protection will predominate over health policy in the new department, given the current preoccupation with food hygiene and the almost theological arguments over the safety of British beef."

The European Union does not have a 'government' made up of Members of the European Parliament. Rather, there is an institutional triangle in which (very approximately), the Commission proposes, and Council and the Parliament scrutinise and jointly legislate.

The relative weight of the three main players changes and there is a permanent institutional 'tension' between them. There is a fourth player in the centre of the triangle The Court of Justice, which is the guardian and ultimate interpreter and arbiter of the Treaties.

There are other EU Institutions. The Court of Auditors scrutinises EU expenditure. The Economic and Social Committee and the new 'Committee of the Regions' (which has a health mandate) are consultative bodies, without legislative power. The three principal players are:

The European Commission

Headed by a 'college' of 20 Commissioners, including President Romano Prodi, the Commission is charged with implementing the Treaties. This means running detailed policy, where it exists (e.g. the CAP) or developing policy, where the Treaties grant the power to do so (e.g. the Single Market.)

The Commission employs about 20,000 in Brussels and in Luxembourg. It is divided into departments headed by a Director General. Each Commissioner is responsible for one or more departments.

Health was previously one directorate within the Directorate General (DG) for

Employment and Social Affairs as a result of its historical development from health and safety measures in the European Coal and Steel Treaty and Euratom, which were the forerunners of the Common Market (EEC) and the European Union.

Consumer protection questions were originally handled by a unit within DGXI (Environment) and then by a separate, so-called 'horizontal' unit outside of any DG. This lasted until a new DG (XXIV) was created in 1993. The BSE crisis, which revealed many inadequacies in the Commission's structure, triggered large-scale reforms in which health was amalgamated with DGXXIV in a new Health and Consumer Protection Department. The numbering of DGs having been dropped in favour of departmental names.

There are fears that consumer protection will predominate over health policy in the new department, given the current preoccupation with food hygiene and the almost theological arguments over the safety of British beef.

The Council of Ministers

The composition of the Council of Ministers varies according to the policy area. The Health Council is composed of national ministers of health or their equivalents. As well as the permanent Council secretariat in Brussels, all Member States have permanent representations in Brussels, which regularly meet outside of ministerial meetings.

The European Parliament

The Parliament is the only directly elected European body. It was created as a counterweight to institutional power at a European level. Its Members were initially appointed by Member States from their own Parliaments, but direct elections had always been envisaged and in 1979 the first elections took place (the first elections to an international parliament ever).

Parliament now comprises 626 Members, the number from each Member State is calculated in weighted proportion to its population, but the members sit according to political affiliation and not nationality. They belong to 'political groups', which range from nascent European political parties, at one extreme, to loose 'technical coordination' groups of small parties at the other.

Parliament's Secretariat employs about 4000, divided into seven Directorates General. The total includes the Political

1. The first article 'Inside the Labyrinth' appeared in *eurohealth*, September 1996.

Group staffs and the Members' assistants.

Parliament's role is to scrutinise the executive (Commission and Council) and it does this through its Committees, each of which covers a policy area. Health comes under the powerful Committee on Environment, Consumer Protection and Health, currently chaired by Dr. Caroline Jackson, a British Conservative MEP.

At various times, usually after the elections, when Committee Chairmanships are divided up between the political groups, a separate committee for health has been suggested. This seems attractive on the surface, but the fact is that health probably does a lot better with the weight and power of the Environment Committee around it.

One result of Parliament's increased power is that it is heavily lobbied, as indeed is the Commission. An entire industry has grown up in Brussels as a result. Often called the 'Eurosphere', it comprises a huge range of special interest groups, consultancies, lobbyists, lawyers and much increased local and regional representation since the establishment of the Committee of the Regions.

Health has its lobbyists too, although they tend to be less well funded than, for example, the tobacco lobby. As well as interacting with the EP Committee responsible, lobby organisations interact with individual members of Parliament and in the case of health with various intergroups, the most prominent of which has been the 'Health Forum Intergroup' in the Parliament.

Intergroups are a parliamentary phenomenon worth explaining. They are groupings of Members with particular interests. In themselves, they are not official organs of Parliament but they are in the main sponsored by the various Political Groups. They can complement the work of Committees by providing a useful forum for discussion of issues at a prelegislative stage.

The legislative procedure

The Commission (often egged on by Parliament and sometimes by one or more Member States) brings forth a legislative proposal, prepared in the appropriate Directorate General, often by fewer people than you might think, although the Commission consults widely with a range of bodies, including the Economic and Social Committee and the Committee of the Regions.

The proposal is sent to Parliament and to

the Council at the same time. In Parliament, it goes to the appropriate 'lead' Committee, and to one or more other Committees for Opinion. The Committees (which usually have between 20 and 50 Members) are structured to reflect the overall political balance in Parliament. A 'rapporteur' is appointed to shepherd the proposal through the Committee. What emerges after voting then goes to Plenary. The version that results from the Plenary vote is Parliament's official Opinion.

For a long time, Parliament's powers were impressive on paper, but difficult to use in practice. Although it could reject the entire EC budget, it had no power to change large parts of it and although it could vote to 'dismiss' the Commissioners, it had no say in who would replace them. In addition, Parliament was only 'consulted', which meant that its Opinion could be ignored.

The direct elections of 1979 gave Parliament legitimacy. By the beginning of the 1980's, the EC had run out of steam. Too much necessary legislation to create the 'Single Market' was stuck in the machine because of the need to obtain unanimity in the Council. Difficult enough with 6 Member States, it became impossible with 12 and later 15. The 'Single Act' amendment to the Treaties in 1987 was followed by the (Maastricht) Treaty of 1992. The effect was to put the EC (now EU) back on the rails to greater integration by completing the Single Market and creating new or enlarged policy areas, one of which was health.

The 'quid pro quo' was increased power to Parliament, to counteract the so-called 'democratic deficit'. From being more or less a consultative organ, Parliament obtained a second reading and a variety of conciliation procedures giving it the power of co-decision with the Council in many areas, including health. In addition, it obtained the power to 'vet' the appointment of Commissioners, ratify EU Treaties with third parties and advance its agenda in a number of other subtle and not so subtle ways.

Health policy

The earlier treaties contained few provisions of direct relevance to health, mainly in health and safety at work. However, other policies including agriculture, freedom of movement, research programmes, internal market provisions for medicinal products, mutual recognition of medical qualifications, free movement of services

"How does the 'white rabbit' of health survive in the jungle of savage beasts such as agriculture and industry?"

and environmental and transport measures have a considerable impact on the health of the public.

The Maastricht Treaty article 129 gave a specific legal basis and competence in the field of public health, though subject to conditions of subsidiarity. It stated that:

“the EU shall contribute towards ensuring a high level of human health protection by encouraging cooperation between member states and, if necessary, lending support to their action. Action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education. Health protection requirements shall form a constituent part of ... other policies.”

The Treaty of Amsterdam, introduced on May 1st 1999, whilst not introducing an EU health policy, nonetheless takes a number of steps in that direction. Article 3(p) sets out an overall objective “to raise the standard of living and working conditions by ... contributing to ... a high level of health protection.” Article 153, replacing art. 129, stipulates: “a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.”

These provisions are very important because they clearly put an obligation on the Commission and on member states to ensure that all other policy initiatives, be they in the environmental, transport, agriculture or any other field, ensure a high level of human health protection.

We still have a long way to go in ensuring that health considerations form a significant part of other policies and indeed the burning question is, given the Treaty provisions, how do we ensure that human health protection is not only ‘taken into account’, but forms the basis of policy initiatives in other areas.

Given the vested interests and consequent lobbying in areas such as trade and commerce, agriculture and transport, it is perhaps unsurprising that, so far, efforts to stop CAP tobacco subsidies, ban all tobacco advertising, and reduce traffic pollution have so far been of limited success. How does the ‘white rabbit’ of health survive in the jungle of savage beasts such as agriculture and industry?

One answer is through the European Parliament, which though lobbied hard by the ‘savage beasts’ is also highly sensitive to

the concerns of its electorate. There is no doubt that the public is becoming much more sensitised to questions of health. This is partly due to the success of EU economies, which has resulted in the population living better and for longer than ever before, raising questions of lifestyle, susceptibility to illness and the quality of health care. No less important is the question of how increasingly expensive health care is to be paid for in the future. Health is advancing rapidly up the political agenda, aided by various scandals concerned with health, AIDS infected blood, salmonella or dioxin in chickens, BSE in beef etc.

No one wants health services to be run from Brussels and this is not on the agenda. Nonetheless meetings at all levels between those concerned with health issues in the EU are bound to result at the very least in exchange of information and best practice. Current policy emphasises the need for action at EU level to bring ‘added value’ and the Finnish Presidency of 1999 strongly emphasised cooperation in the field of mental health.

All EU member states face the same problems in health and there is much to be learned from shared information and experience. In addition, free movement of people covers not only tourists but also professionals in the health field and free movement of goods and services covers pharmaceuticals and indeed provision of health care (as the Kohll-Decker and other cases before the Court of Justice have shown). Despite all the talk of subsidiarity, the international nature of health policy is making itself increasingly apparent. In future, pan-European, or at least trans-border, health insurance organisations are by no means unthinkable, although the thorny question of how these could relate to and interact with Beveridge-type national health service systems remains to be addressed.

The European Parliament has shown its determination not to let health policy be sacrificed on the altar of subsidiarity, as was once suggested. Most member states realise that so many aspects of health policy are not limited by national boundaries. Woolly as Article 153 is, and hedged about with subsidiarity clauses, its very vagueness can be regarded as advantageous to the development of an EU health policy that complements and does not replace national health policies. To accommodate future developments, health policy in the EU may well turn out to be of the ‘variable geometry’ kind.

“Despite all the talk of subsidiarity, the international nature of health policy is making itself increasingly apparent. In the future panEuropean health insurance organisations are by no means unthinkable”

Health policy in Northern Ireland:

What can we expect after devolution?



Martin McKee

For over thirty years Northern Ireland has seldom been out of the news because of the relentless toll of violent deaths, with over 3,200 people losing their lives since 'The Troubles' began in 1968. The formal cessation of violence by the main paramilitary groups, prior to the signing of the Good Friday Agreement last year, has reduced the annual toll of politically motivated murders to an all time low, even if it has not completely eliminated them. While each of these deaths has been an individual tragedy for the friends and family of the victim, what has received much less attention over this period is the vastly greater toll of premature death from causes such as heart disease, cancers, and accidents.¹ Each year, about 3,000 people, nearly as many as have died in the thirty years of 'The Troubles', die before the age

"The Northern Ireland diet, symbolised by the 'Ulster fry', is notoriously bad, levels of obesity are increasing, and rates of smoking among women are remaining stubbornly high. From a global health perspective, it is these premature deaths that any future government of Northern Ireland must tackle."

of 75 from heart disease or stroke. Death rates from heart disease are among the highest in the European Union, exceeded only by the Republic of Ireland, and life expectancy at birth is more than a year less than that for the United Kingdom as a whole. The Northern Ireland diet, symbolised by the 'Ulster fry', is notoriously bad, levels of obesity are increasing, and rates of smoking among women are remaining stubbornly high. From a global health perspective, it is these premature deaths that any future government of Northern Ireland must tackle.

Towards a government for Ulster?

If agreement between the Northern Ireland political parties can be reached, an achievement that, at the time of writing, is looking less and less certain, such a government could soon be in place. A Northern Ireland assembly, operating under a complex set of rules to ensure that any measure has cross-community support, has already been elected. If the politicians can agree on issues such as decommissioning of paramilitary weapons, an executive will be established, with members drawn from the province's elected politicians and with responsibility devolved from the United Kingdom parliament for a wide range of areas, including health. If this happens, what policies can we expect from the assembly and executive on the health of the people of Northern Ireland?

Positions of the parties

This article examines the stated policies on health of each of the leading political parties. (As many readers may be unfamiliar with these parties some key points are presented in Table 1). In most cases the information was extracted from their manifestos for the assembly elections or from specific policy statements obtained from their web sites. Gathering the information was a somewhat depressing experience as the web sites tended to be dominated by discussions on matters that were clearly much more important to the politicians, most notably the contentious topic of parades. The significance of this issue may be lost on those readers not from Ireland but an explanation would go well beyond the scope of this article and would certainly offend one side or other.

The Social Democratic and Labour Party (SDLP) and Sinn Fein, neither of whose web sites contained information on health policy, were contacted for more information but only the former replied, also noting that its web site would soon be improved.

Table 1
NORTHERN IRELAND POLITICAL PARTIES — KEY POINTS
 (number of seats in Assembly in brackets)

UNIONIST

Ulster Unionist Party (28)

Largest unionist party.
 Led by David Trimble.
 Accepts Good Friday Agreement.
 Blocking formation of executive because of failure of IRA to decommission weapons.

Democratic Unionist Party (20)

Second largest unionist party, led by Ian Paisley.
 Rejects Good Friday Agreement as too conciliatory to nationalists.

Popular Unionist Party (2).

Small party with historic links to Protestant paramilitaries but now pursuing essentially socialist programme and promoting reconciliation.

In addition, three members elected as independents have formed the **United Unionist Assembly Party** and the **United Kingdom Unionist Party**, elected with five seats, has split into two smaller parties.

NATIONALIST

Social Democratic and Labour Party (24)

Largest nationalist party, long associated with constitutional nationalism.
 Led by John Hume.

Sinn Fein (18)

Led by Gerry Adams.
 Historically linked to the paramilitary Irish Republican Army (IRA).
 Unionist concerns about continuing links to IRA have blocked progress on formation of executive.

CROSS-COMMUNITY

Alliance Party (6).

Draws support from both religious groupings.
 Led by Sean Neeson (a psychiatrist).
 Linked to UK Liberal Democrats.

Women’s Coalition (2)

Draws support from both religious groupings.
 Explicit rejection of failure of male dominated parties to achieve solution to Northern Ireland’s problems.

The information obtained varied greatly in extent and nature. The Democratic Unionist Party (DUP) simply stated that it was “committed to looking after your interests in a caring health service, responsive to local needs. We are pledged to provide health care free for all.”² In contrast, the Ulster Unionist Party (UUP) presented a detailed paper from its health committee that addressed a wide range of issues relating to the health service.³ Their report was unusual in that, for many issues, it spelt out the pros and cons of different approaches and recognised the need for both further research and for trade-offs between competing objectives. This may reflect the fact that their health spokesperson has been a

long serving member of the health committee in the House of Commons, the lower house of the UK parliament.

Few parties had clearly identified health, as opposed to health care, policies although many had policies that would be of significant importance for population health under other headings, such as education, rural affairs, or community development. For example, the Women’s Coalition argued for an integrated transport policy and the eradication of poverty.⁴ The Alliance Party proposed a series of specific policies designed to help the disabled.⁵

There was almost no explicit consideration of health inequalities, an exception being the SDLP manifesto, which noted the importance of addressing the broader determinants of health, such as poverty, education and housing, although it offered little specific guidance about what it would do. In contrast, the UUP policy focused much more on improving health through health education. To the extent that inequalities were considered, they were largely in relation to access to health care, either due to geography (UUP, SDLP) or between patients of fundholding and non-fundholding practices (Alliance).

Lack of a European perspective

Also missing was any discussion of health policy and Europe or how the health of the people of Northern Ireland compares with that of the rest of the Union, suggesting that the province’s poor position may not be widely recognised. The failure of Northern Ireland politicians to engage in European affairs has been noted elsewhere⁶ and is symbolised, uniquely in the United Kingdom, by the election of MEPs who believe they can combine their work in Strasbourg with membership of the United Kingdom parliament and, in one case, with the additional duties of membership of the Northern Ireland Assembly.

Policies concentrated largely on health care. A universal finding was a concern about the amount of bureaucracy in the health service, with widespread calls for reductions in the numbers of health boards and rationalisation of provider trusts.

Another issue achieving almost universal agreement was that the level of health care funding was inadequate. This would, however, be contentious in a United Kingdom wide context, in which English regions are increasingly questioning the arrangements whereby Northern Ireland and Scotland have historically, spent somewhat more on

health care than the rest of the United Kingdom. Successive governments have justified this on account of their more dispersed populations and higher levels of deprivation and ill health. There were few concrete suggestions to tackle the perceived lack of funding. The Alliance Party advocated hypothecated alcohol and tobacco taxation but the Assembly will not have tax raising powers.

Although the distribution of hospital services has received enormous media attention in Northern Ireland as a result of policies by the (non-elected) health boards to rationalise services, this issue was barely mentioned. An exception was the UUP health committee report which noted that it was "difficult to argue against the case for rationalisation of specialist services", although it also argued for development of complementary local services and good transport provision.

Several parties had identified issues of particular concern to them, such as the quality of care in facilities providing long term care for the elderly (UUP), clinical research training (UUP), general practice fundholding (Alliance), and responsiveness of services to local communities (Popular Unionist Party),⁷ although few of these issues had been developed into explicit policies.

A formidable task ahead

If the new system of devolved government works as planned, the executive and the assembly will face a formidable task if they are to develop policies that will address the health needs of their population. It would, however, be wrong to assume that there is a health policy vacuum in Northern Ireland. Since 1974 Northern Ireland government departments, while headed by ministers appointed from within the United Kingdom government, have developed a range of innovative policies, reflecting local circumstances. Bodies such as the Northern Ireland Health Promotion Agency and the Cancer Registry have been established. The Department of Health and Social Services has developed a regional health strategy,⁸ similar to the English Health of the Nation and Our Healthier Nation strategies, in which a series of key areas are identified (Table 2) and targets for health improvement are set. They have also undertaken a series of seminars for Assembly Members to raise their awareness of the health challenges facing Northern Ireland. Unfortunately, the almost exclusive focus on constitutional

and security issues seems to have prevented the Northern Ireland political parties from taking fully on board what has already been done and what more is needed to bring the health of their population closer to that of the rest of Europe.

As many politicians in central and eastern Europe have learned, the move from political opposition to government is far from easy. It would seem that, at least in health policy, Northern Ireland's politicians still have some way to go.

Table 2

KEY AREAS IN THE EXISTING NORTHERN IRELAND HEALTH STRATEGY

Family and child health and welfare
Physical and sensory disability
Learning disability
Mental health
Circulatory diseases
Cancers
Other non-communicable diseases

Post script

Just as this edition was going to press, agreement was reached among the political parties to form an executive. Sinn Fein nominated Bairbre de Brun as Minister of Health and this was accepted by the Assembly.

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The health of the public in Northern Ireland



Etta Campbell

“it is the differences that exist in life expectancy within Northern Ireland that currently cause the deepest concern and call for concerted and sustained action”

The people of Northern Ireland are healthier than they have ever been and on a global scale they are healthier than many other populations. However, in comparison with other European countries our health could be much improved and within the Northern Ireland population there are significant inequalities in health.¹

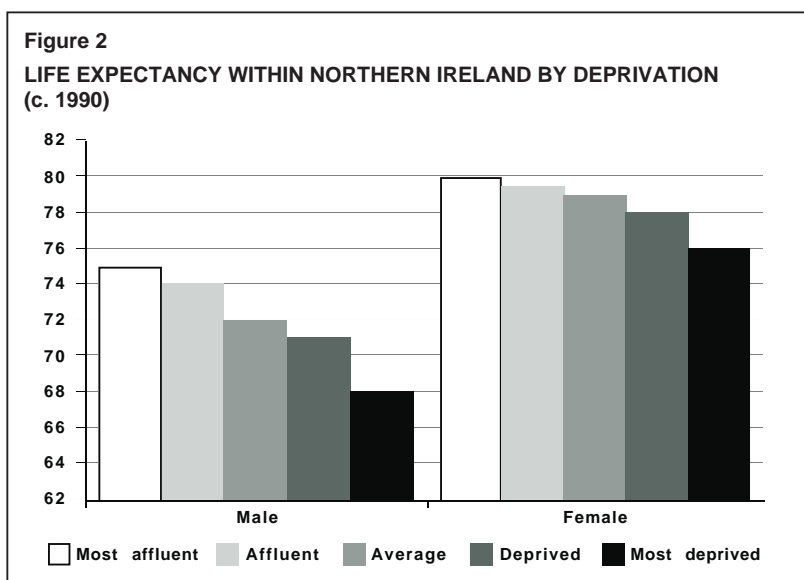
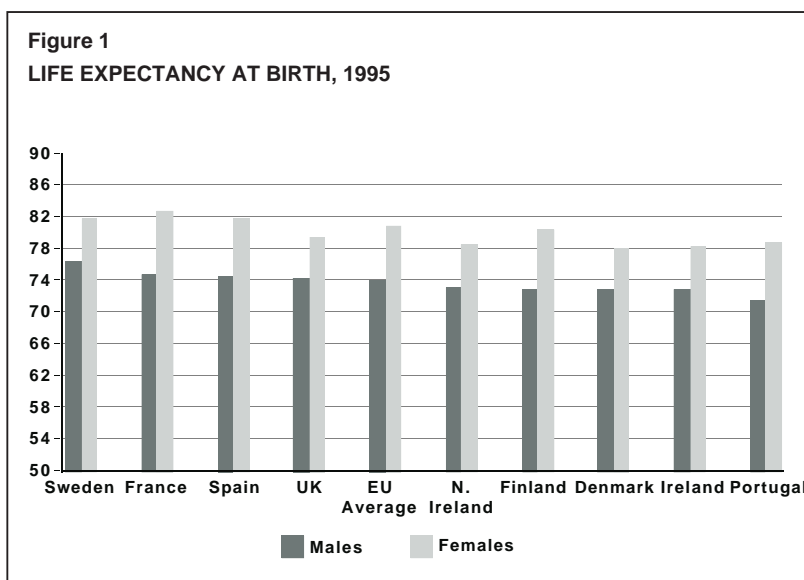
Comparisons within Europe show that Northern Ireland is not faring as well as other countries. The life expectancy of males at birth in Sweden for example is about three years better than Northern Ireland. In France women can expect to live almost five years longer than women in Northern Ireland (see Figure 1). These differences pose interesting hypotheses for epidemiologists and set challenging objectives for policy makers. Many life years could be gained if we could fully explain these differences.

Inequalities in health

However, it is the differences that exist in life expectancy within Northern Ireland that currently cause the deepest concern and call for concerted and sustained action. People who live in affluent areas have a much better life expectancy than those who live in the most deprived areas (see Figure 2). If these inequalities could be addressed, approximately 2,000 lives could be saved each year. Inequalities in health can be depicted in almost every health index which is available to us. Infant mortality rates are 50% higher in the most deprived group compared to the least deprived. These differences are carried through into childhood with higher rates of death due to accidents. Children living in areas of greatest deprivation are 15 times more likely than the most affluent to die as a result of a house fire and seven times more likely to die as a result of being hit by a vehicle.

Inequalities in health are very much in evidence right through into adulthood. Significant differences in health exist between Northern Ireland’s electoral wards. Poverty and social exclusion rob a significant proportion of our people of their full potential for health and in turn place a huge demand on our health services.

Cardiovascular disease, including coronary heart disease and stroke, is the single



biggest killer in Northern Ireland.² One in three men and one in four women die from coronary heart disease.

Although deaths from heart disease have been falling since the early 1980s, Northern Ireland lags behind other countries in Europe where the death rates are dramatically lower (see Figure 3). With an ageing population we can expect heart disease to remain a major problem for some considerable time. In addition more people than ever are now surviving their first heart attack and are living with heart disease. The incidence of chronic heart disease such as heart failure and atrial fibrillation is increasing.

Breast cancer is the most common cause of death from cancer among women in Northern Ireland.³ The death rate from breast cancer in Northern Ireland is one of the highest in Europe. Provisional figures from the Cancer Registry suggest that at long last the death rates from breast cancer may be falling.

Northern Ireland has one of the highest rates of colorectal cancer in Western Europe with about 600 new cases every year. The number of colorectal cancers is falling among women but not men. Diet must remain a priority if any reduction in colorectal cancer is to be realised. On average, people in Northern Ireland eat fewer than three portions of fruit and vegetables each day, much less than the current recommendation of five portions.

Mental illness is one of the most common forms of ill health in Northern Ireland. It is responsible for enormous costs to the individual and to society. Many working days are lost as a consequence of mental illness. Using the General Health Questionnaire the Northern Ireland population is at an increased risk of mental illness when compared to other UK regions.⁴

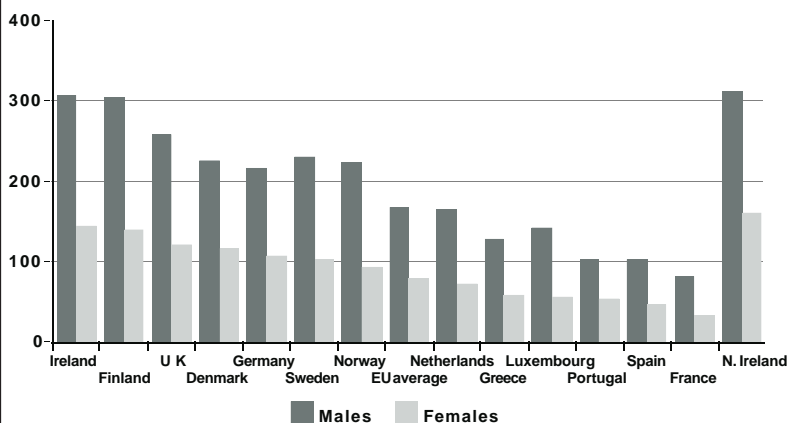
Risk factors for ill-health

Smoking is a common risk factor for many of the major diseases. Whilst there has been some reduction in the numbers of people who smoke the number of smokers in the population is still high at 28%.

These trends in disease and the risk factors for disease suggest that heart disease, stroke, cancer and diabetes will remain as major causes of premature death and morbidity well into the next century. The distribution of the risk factors for these diseases across the social divide within our society suggest that the inequalities in

Figure 3

ISCHAEMIC HEART DISEASE: AGE STANDARDISED DEATH RATES PER 100,000, ALL AGES, 1995



Notes:

Age standardised death rates (SDR) were calculated by using the direct method and the European standard population.

Ischaemic heart disease (IHD) refers to ICD 9 codes 410—414.

Ranked by female SDR in descending order

Source: WHO (Europe)

NI rates derived from RGO (NI) mortality statistics and RGO (NI) population estimates.

health will remain and grow even wider in the foreseeable future even if concerted action is taken now.

Signs for hope

Faced with these figures it would be all too easy to give in to despair. However there are some signs of hope. Since 1986 the Regional Strategy⁵ for the Department of Health and Social Services in Northern Ireland has been based on the principles of Health for All. Whilst this strategy did not have the impact that we might wish, it did introduce a new language into policy development and programme implementation within health and social services. In the past, Government in Northern Ireland has introduced the principle of 'Targeting Social Need' across all Government Department. Within the past two years the interest paid to tackling social inequalities within the UK Government has given an added focus on these issues. Importantly the 'Surestart' programme of pre-school support and education may in the long-term bring benefits if outcomes match the famous US Study, Headstart.

At the moment we are all waiting to see if devolution will bring the opportunity for better health. The new Assembly will inevitably have its attention held by the 'local hospitals' debate and the inevitable

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“the Public Health body ... will require leadership ... leadership that has been won by those who can persuade, influence, manage, but most of all inspire.”

health service funding issues that distract all Governments. There will be an urgent need to ensure that attention is drawn to the wider agenda of public health.

The development of public health policies needs to be based on the best evidence. Expert help needs to be given in terms of skills, knowledge, and insight to inform that process. In turn Government must be open enough to be informed. Public health experts need to build the evidence-base and develop a credible corporate voice with which to inform.

To be truly effective the Public Health body needs to be inclusive and multidisciplinary and non-elitist.

In addition, it will require leadership – leadership that is gained not by dint of position within an organisation or by acad-

emic qualifications, but leadership that has been won by those who can persuade, influence, manage, but most of all inspire. Collaboration in public health is the only way forward. A team approach is needed.

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‘Cooperation and Working Together’



Tom Frawley

Improving the health of the border populations in Ireland

Background to the initiative

In July 1992 the North Eastern and North Western Health Boards in the Republic of Ireland and the Southern and Western Health and Social Services Boards in Northern Ireland entered into a formal agreement, known as the Ballyconnell Agreement, to cooperate in improving the health and social well-being of their resident populations. These four Boards cover the whole of the land boundary between the Republic of Ireland and the United Kingdom and between them they comprise a population of one million people.

With the reforms of Health and Social Services in Northern Ireland, the membership of Cooperation and Working Together (CAWT) was enlarged to include Foyle Health and Social Services Trust, the Sperrin Lakeland Health and Social Care Trust, Altnagelvin Trust, Armagh and Dungannon HSS Trust, Newry and Mourne HSS Trust, Craigavon Area Hospital Group Trust and Craigavon and

Banbridge Community HSS Trust.

CAWT Boards/Trusts share common demographic features and common problems in terms of rural isolation, infrastructure, population trends and unemployment. There is constant cross border traffic, and there are examples of services provided in a consumer's natural hinterland that are provided by the neighbouring Member State on an agency basis.

The primary objectives of CAWT were identified as the improvement of health and social well being of CAWT's resident populations by:

- The exploitation of opportunities for cooperation in the planning and provision of services;
- The involvement of other public sector bodies in joint initiatives where appropriate;
- The exploitation of all opportunities for joint working or sharing of resources



Eithne O'Sullivan

where these would be of mutual advantage;

- Assisting border areas in overcoming the special development problems arising from their relative isolation.

Official endorsement for the CAWT process has been given at a national level by both ministers of health and by the departments of health in Northern Ireland and the Republic of Ireland.

Areas of cooperation

CAWT has sponsored joint working across a range of service areas. These include acute services, primary care, accident and pre hospital care, learning disability, family and child care, mental health, health promotion and public health. CAWT has been operating a two track approach, concentrating on operational (across the fence, good neighbour) cooperation in the provision of services to the local resident populations, and in addition developing, with the assistance of funds from the EU Special Support Programme for Peace and Reconciliation, foundation projects for the further enhancement and longer term development of key service areas. CAWT has, in addition, developed a Secretariat to support and enhance ongoing cooperation and to develop a strategic direction for its future. In 1997 it published its Strategic Plan for the period 1997–2001 and is at present developing a CAWT web page for wider dissemination of its work and experience to date.

Achievements

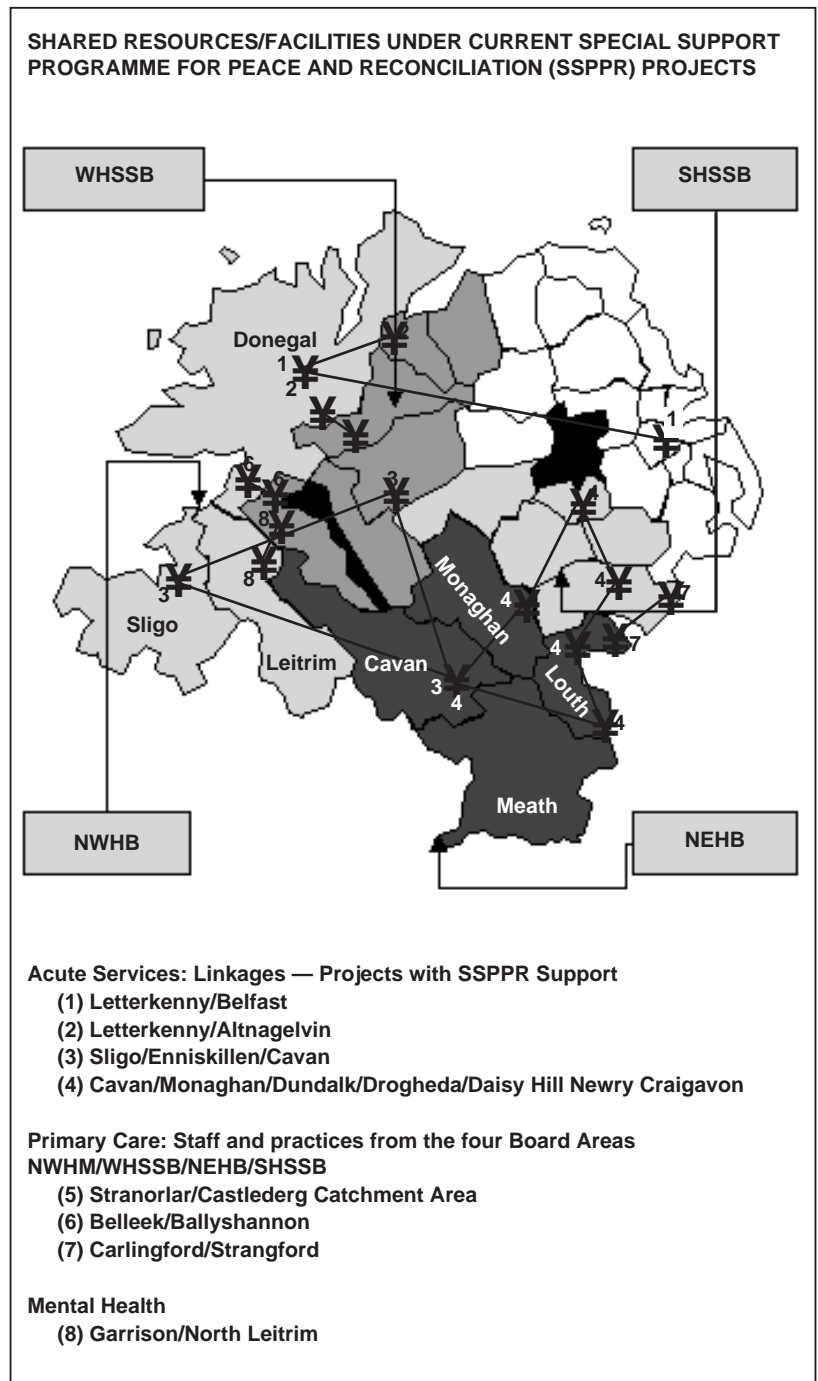
Outlined below are key elements of the programme of work currently underway across a range of service areas.

Acute services

Projects have now been undertaken between all of the centres providing acute services along the border:

- (1) Craigavon/Drogheda/Dundalk/Monaghan/Cavan/Daisy Hill.
- (2) Letterkenny/Altnagelvin.
- (3) Enniskillen/Sligo/Cavan.
- (4) An acute services project is being developed between Letterkenny General Hospital and a tertiary service at Belfast City Hospital.

In the cases of (1) and (4), joint service provisions have been developed or are being developed in specified service areas. In the case of the Craigavon et al project, shared dermatology and teleradiology services have been developed. Cancer services are



being developed in the case of (4), that is, between Letterkenny and Belfast. Projects between Letterkenny/Altnagelvin and Enniskillen/Sligo/Cavan are still at an early stage and are focusing on the identification of potential areas for enhanced service cooperation and provision.

These projects are particularly timely within the context of the present review of acute services in Northern Ireland, and the strategic objective of the Health Boards in the Republic of Ireland to extend the range of acute services available in their areas.

Within the area of public health and health promotion, CAWT has undertaken a breast

cancer audit across the four Board areas. It is anticipated that this audit will last a total of three years and will have strategic significance in the context of future planning for breast cancer services.

Primary care

Primary care cooperation across the border has been developed in the following areas:

- Joint practice organisation.
- Joint service developments.
- Community pharmacy.
- Clinical practice.
- Facilities development, i.e. cross border joint resource centres.
- Initial work in the area of cross border health actions zones.

Work undertaken within practice organisation has recently been nominated for a major UK award in primary care practices, i.e. the Primary Care Management Award 1999.

“The future for cross border cooperation between Member States within the context of wider European policy is crucial for the development of the Union in a way that is relevant and important for ordinary people.”

The work underway within the primary care project has particular strategic importance in the context of the primary care groups envisaged in the reorganised Northern Ireland health services outlined in ‘Fit for the Future’. It also dovetails with the blueprint for the development of general practice in the Republic of Ireland and the strategic approach being followed by all the Boards for the development of primary care services.

Ambulance services

The work undertaken within the joint ambulance training and developments project began between the Northern Ireland Ambulance Service and the NEHB initially, with the NWHB joining later in the project. This project focused on operational improvements between the ambulance services north and south of the border. In this regard it concentrated on the development of joint training packages, the piloting of a Geographic Information System (GIS), the development of a joint

communication system, and the testing of all of the above developments within the context of a cross border major incident exercise in May 1999.

This project has also had particular strategic importance because of the current Review of the Northern Ireland Ambulance Services and the recent Review of the Republic of Ireland Ambulance Services. It also has relevance for the current Review of Acute Services, and importantly in relation to the identification of cross border accident and emergency services as an area for development within the context of the Good Friday Agreement.

Cooperation between specific social care groups

Projects to enhance operational good practice within the areas of family and child care, learning disability and mental health have been undertaken in a number of areas. These include the following:

1. Family and child care:
 - Improved accident prevention strategies for children;
 - Protection of disabled children;
 - Improved parenting skills on a cross border, cross community basis;
 - Prototyping and Evaluation of youth intervention strategies;
 - Drug awareness training.
2. Learning disability:
 - Piloting evaluation of different types of flexi care working schemes in marginalised areas;
 - Development of protocols and training for the protection of vulnerable adults within care settings.
3. Mental health:
 - Development of a cross border resource centre;
 - Community based research into suicide prevention strategies;
 - Development and piloting of cross border training for mental health staff in cognitive therapy, and piloting supported employment model of training for those with mental health problems.

Health promotion and public health

A range of health promotion strategies has been carried out under the auspices of CAWT since 1992. These include major health promotion activities in the areas of childhood accident prevention, drug awareness strategies, smoking cessation strategies, mental health promotion, suicide pre-

ventative strategies, examinations of compliance by elderly persons in use of medication.

A programme of achievement

Since its inception CAWT has been successful in a programme of real achievement:

1. Beginning the process of strategic, epidemiological and operational planning for a transborder region.
2. Establishing formalised cross border cooperation within the health and social care sectors in the border region.
3. Improving service for the CAWT population.
4. In achieving operational cooperation across the range of areas outlined above, there have been significant improvements in service cooperation, and the development of new and innovative approaches to common issues and problems. In addition there has been a pilot provision of new localised services on a cross border basis for resident populations who heretofore would have been required to travel to the main centres of Dublin and Belfast for such services.
5. Working in collaboration with other agencies and bodies to establish the special needs of the population in the border region.
6. Placing health sector coordination on the agenda with both Departments north and south.

Current opportunities in a changing political environment

CAWT will continue to build on operational cooperation and to enhance service provision to its client population by means of strategic partnerships and alliances. Difficulties posed by back to back planning at national policy-making level and the very different natures of employment, namely in relation to terms and conditions, registration etc., are seen as positive challenges which, in cooperation with national and European bodies, can be overcome in an innovative and energetic way by CAWT and other cross border public bodies.

The re-introduction of an executive into Northern Ireland and its potential for making its own stand-alone legislation and policies provide a major opportunity for coordination of policy making on the island. If supported by both UK and Irish governments and with a focus on joint cooperation, much of this new legislation

and policy could significantly impact on the problems in the border region, in particular on the difficulties created by the different funding and management systems in the two jurisdictions. The fact that cooperation between the ministers of health in both Northern Ireland and the Republic of Ireland over a number of years is well established is a firm foundation for future development.

“In achieving operational cooperation ... there have been significant improvements in service cooperation, and the development of new and innovative approaches to common issues and problems.”

Future Developments

The Good Friday Agreement recognises certain areas of cooperation in health as being worthy of future development. These are:

1. Accident and Emergency Services.
2. Cancer Services.

With the groundwork undertaken by CAWT, opportunities exist for a more organisational approach to planning for health and social services in the border region. To date much of the work undertaken by CAWT has been funded through European funds. It is anticipated that national governments will recognise:

- The special needs of the border region;
- The need to border proof their national policies;
- The need to focus in a special way on encouraging and promoting cross border cooperation in key public service areas within the border region, which has a dispersed, isolated and marginalised population.

In simple terms CAWT has proven that practical cooperation across the border can enhance service provision, create economies of scale and enhance peace and reconciliation through collaborative working. The future for cross border cooperation between Member States within the context of wider European policy is crucial for the development of the Union in a way that is relevant and important for ordinary people. Continued and coordinated European, national and local commitment to the needs of this border region can only produce increasingly significant and longer term benefits for the population.

Health care across borders:

The scope for North-South cooperation in hospital services



Dorothy McKee

“formal contact between official bodies in Northern Ireland and the Republic has been extremely limited and, at least in Northern Ireland, highly contentious”

Shared problems but individual solutions

The Good Friday Agreement and the constitutional changes that have arisen from it offer scope for a reassessment of the provision of acute health care in Northern Ireland. Provision of hospital services in its border regions has long been contentious with the current pattern based largely on historical factors. Health authorities, in this rural region with its very low population density, have sought, since at least the mid 1960s, to concentrate facilities on fewer sites. It has, however, been difficult to introduce change in the face of widespread public and professional opposition, based largely on concerns about poor transport links.

Although the border areas of both Northern Ireland and the Republic of Ireland face the same problems, proposed solutions have been limited to only one country. A common response, based on cross-border cooperation, has received no serious consideration. This is especially surprising in view of both the long tradition of free movement across the border – facilitated by the existence, since Irish independence in 1921, of a common travel area within which passports are not required – and, until relatively recently, the use of a common currency. Furthermore, the medical professions in the two countries have strong links. The Irish Royal Colleges, which predate independence, draw members from both parts of the island.

On the other hand, formal contact between official bodies in Northern Ireland and the Republic has been extremely limited and, at least in Northern Ireland, highly contentious, extending only to matters such as fisheries and the cross-border rail link. In addition, cooperation on health care has been complicated by different financing and delivery systems.

The political settlement in Northern Ireland has been accompanied by a growing recognition, on both sides of the border, that cooperation can bring important benefits. This process is being encouraged by substantial funds, in particular from the two governments and the European Union.

Most readers of Eurohealth will be familiar with the provisions for free movement of patients within the European Union so these will not be repeated here. In addition, however, the UK and the Republic of Ireland have a separate agreement enabling each other's citizens to obtain care in the other state without requiring an E111 form.

In 1992, health boards on either side of the border, signed an agreement (the Ballyconnell Agreement) to “improve the health and social well being of the resident populations and to exploit opportunities for cooperation, joint working and sharing of resources”. This led to the establishment of Cooperation and Working Together for Health Gain and Social Well Being in Border Areas (CAWT), which has developed work in areas such as mental health, prevention of childhood accidents, drug education and information technology. In addition, the border health boards are sharing experiences in primary care, supported by funds linked to the Northern Ireland peace process.

The Good Friday Agreement, ratified by referendum in May 1998, provides for a North/South Ministerial Council, “to develop consultation, cooperation and action within the island of Ireland –including through implementation on an all-island and cross-border basis, on matters of mutual interest within the competence of the Administrations, North and South.”* This has included social security and social welfare. ‘Health’ seems to have been something of an afterthought, specifying inclusion of “accident and emergency services and other related cross border issues”. It seems likely, however, that emerging cross-border structures will ultimately provide a basis for cooperation on other health-related issues,¹ building on recent developments

* Agreement reached in multi-party negotiations. See <http://www.nio.gov.uk/agreement.htm>

in cross-border cooperation on communicable disease control and cancer registration, although much will depend on the attitude of a Northern Ireland executive.

The scope for cross-border cooperation

Although the purchaser-provider split in Northern Ireland enabled health boards and trusts to agree contracts with bodies in the Republic, this has had little practical effect. Some outpatient services are provided in Derry and Omagh, in Northern Ireland, for residents of the Republic and health boards in both countries have purchased some elective procedures, such as cardiac bypasses and orthopaedic procedures, from each other.

Nevertheless, there is likely to be an underestimate of the scale of cross-border flows, as there is no effective system to measure them. There is, however, a widespread impression that patients from Donegal, in the Republic of Ireland travel to Derry, in Northern Ireland – many may use addresses of friends or relatives there when doing so.

Last year I examined perceptions of cross-border care in a survey of managers and general practitioners in a border area of Northern Ireland, supplemented by information from government bodies and health boards in both countries.² Respondents saw cross border flows as predominantly into Northern Ireland. Few general practitioners were aware of proposals to increase cross border cooperation in health care, although most saw advantages outweighing disadvantages, citing benefits such as shorter waiting lists, easier access, and better services. Another perceived benefit was the ability to support local hospitals that are currently not viable but which could become so if they served both sides of the border.

Those in hospitals saw similar benefits, in particular the ability to concentrate provision while maintaining access, and several argued that greater cooperation in health care would bring benefits for the political process, reducing mutual suspicions and fears.

According to general practitioners, disadvantages included potential incompatibility of payment systems, currency transactions, administrative costs and competition between the various towns to maintain services. A concern, voiced by some in hospitals, was how to ensure quality in another country.

Few saw any obstacles but, of those who did, the main one was political resistance to any kind of cross-border cooperation. A few were concerned that some patients might be reluctant to cross the border, that administrative costs would be high, and that the flow would mainly be from South to North. Some also questioned whether health boards would really be willing to pay for services elsewhere that were available in their own country. However, many saw important new opportunities for improving cross-border cooperation, such as sharing ambulance services, out of hours cover for primary care, and better access to specialised tertiary facilities. A common view was summarised by one general practitioner who said, “until border issues are dealt with, acute services will never make sense”. This view seems to be gaining support, with a senior nurse from Northern Ireland writing that “successive government reviews and proposals have been based on deliberations within the context of Northern Ireland only, and ignores the reality concerning duplication of acute services” along the border.³

In August 1998, following a bomb in the town of Omagh that killed 29 people and injured over 100, health care facilities on both sides of the border worked together in a new, and very visible, cooperative spirit. Many saw the emerging cross-community spirit of cooperation creating a new political context in which collaboration would be much less contentious. Despite this, subsequent proposals for acute services in the west of Northern Ireland are based on patient flows within Northern Ireland and fail to take account of the cross-border perspective.⁴

The structures that have emerged from the political settlement in Northern Ireland now provide a basis for much closer cross-border cooperation in the field of health care. The low density, highly dispersed population on both sides of the border creates major challenges for those providing hospital services. While greater cooperation will not be a panacea, it can bring real benefits to those living in both countries. This issue was long considered too politically sensitive to discuss openly and those activities undertaken together were not widely known. Results of my survey show that there is no serious opposition to greater cooperation from either health professionals or managers. Of course, the true test will be whether it is acceptable to all shades of political opinion in this divided region.

“Many saw the emerging cross-community spirit of cooperation creating a new political context in which collaboration would be much less contentious.”

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The health impact of European single market legislation

Since its early years, one of the main aims of the European Community has been to develop a unified internal market. The final step was the completion of the single market on 1st January 1993. The legislation that paved the way for that was the Single European Act of 1986. The principal aim of the Act was to facilitate the free movement of goods and services, and of people (labour). It also contained many other provisions that were

considered relevant in this context.

From the point of view of health, the most important was article 100a, guaranteeing a 'high level of health protection'.



Mike Joffe



Sofie De Broe

Commission project

The European Commission funded a short project, which ended in early 1999, with the aim of investigating the possible health impact of internal market legislation. This was carried out in the Department of Epidemiology and Public Health, Imperial College, London, in collaboration with the European Public Health Alliance.

Its objectives were:

- i to investigate the health impact of EC policies that are relevant to the free movement of goods;
- ii to develop the methodology of health impact assessment in this context;
- iii to establish a European network of relevant expertise.

The specific areas of work were pharmaceutical products, medical devices, dangerous substances and preparations, foodstuffs and fiscal policy. The European legislation in each of these areas was taken as the starting point for the work. In a project lasting 15 months and covering such a broad range, it was necessary to rely on a critical review of existing evidence, rather than on original evaluative research.

The effects of market forces

The basic concept underlying the project was that the health impact of internal market policies would depend on the minimum standard that each European Directive is

intended to establish. The reason for this is that market forces can have a 'levelling down' effect: suppose food hygiene standards were originally higher in one Member State than in others. This is likely to be accompanied by higher costs. The consequences of liberalising trade in such circumstances are that domestic production will be replaced by cheaper imports with lower standards for consumers, and that the producers in that Member State will be penalised. There will also be negative implications for the balance of trade. The setting of a 'floor' would prevent this happening, and the specification of a high level of health protection was intended to ensure additionally that standards would rise in those Member States that had hitherto had a lower level of health protection.

The project proposal put forward the hypothesis that after the coming into being of the internal market on 1st January 1993, standards had both risen, and become more uniform (except in those cases where national derogations have been agreed).

In preparation for the completion of the single market, a great deal of work was carried out, coordinated by the Commission. Much of this was motivated by considerations of health. For the purpose of this project, ideally one would like to have been able to assess whether the resulting degree of regulation was too low from a health protection point of view, or possibly higher than could be justified by the evidence – as may be true of certain drinking water standards, which are outside the scope of this project. However, it has become clear that the evidence rarely exists on which such a judgement could be made. Little material has been published in peer-reviewed journals, and while more information was available in the 'grey' literature, we found that this is an under-researched area. It is unclear why this is the case.

A public seminar for the project took place during October 1998 in Brussels. Approximately 50 people registered, from the European Commission and other EU institutions, statutory bodies in Member States, industry, academia and the NGO sector. The seminar brought together con-

tributions from three of the five topic areas, fiscal policy, foodstuffs and pharmaceuticals, thus introducing a comparative element into the debate.

The comparative dimension

One of the advantages of carrying out a project in several topic areas at once is the comparative dimension. For example, the EU approach in certain instances has been to develop a positive list, such as that for dangerous substances, and also of permitted food additives with indications of permitted uses and maximum concentrations. On the other hand, in the case of food hygiene a more elaborate system of Hazard Analysis Critical Control Point (HACCP) has been introduced with the aim of improving the way food is handled throughout the food chain. DG XI is trying to introduce ways of moving towards a more sustainable use of plant protection products (pesticides used in agriculture): to ensure that smaller quantities are used, of less toxic compounds.

There are differences too in post-marketing surveillance. The Directive on medical devices, which has recently been enacted as Member State legislation, introduced surveillance into this area, whereas in many, probably most, Member States, no such requirement existed. In contrast, the pharmaceutical area has been well regulated in this respect for decades.

Other themes that could be used to compare the different topic areas include packaging, labelling, claims and advertising.

Finally, a major consideration is the size of the health problems involved in the different areas. This would have to take into account the seriousness of the problem as well as numbers. It seems reasonable that priorities should be set according to a 'proportionality' rule: that the intensity of health protection should be proportional to the size of the potential health gain.

Methodology: a model to assist in assessing health impact

During the course of the project, a model was developed to relate pre-existing risks to policy interventions. This is depicted in the diagram to the right.

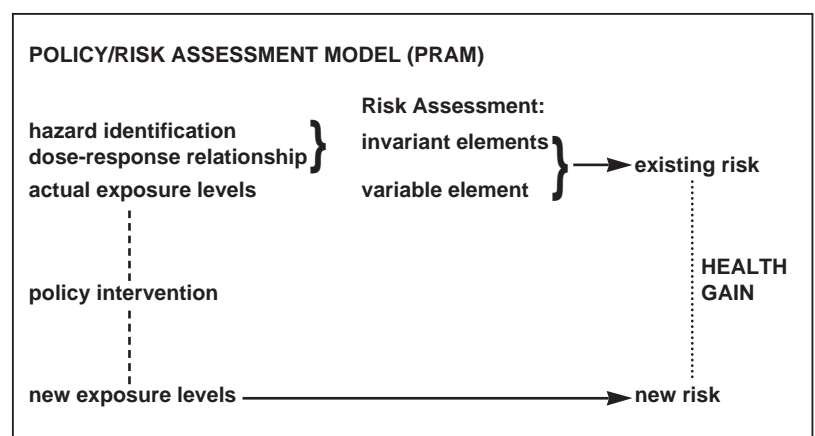
It was found that different areas of work had different points of entry. For example, with a well researched major health risk like asbestos, the starting point would be its well understood dangers, corresponding to the invariant elements of risk assessment. This is the 'research driven' approach. To

complete all stages of the model, reliable data on actual exposure levels in all the Member States would be needed. Unfortunately, this was not possible for asbestos, so that the potential health gain from tighter controls could not be rigorously quantified.

Another possibility in trying to assess the effectiveness of EU legislation would be to start from the legislation itself, for example, particular food additives for which the legal status had changed as a result, and then to relate this to scientific evidence and try and assess the likely health impact. This is the 'intervention driven' approach. In attempting this, however, it transpired that disputes over particular items tended to relate to different trade-offs made by different Member States, which in turn tend to be rooted mainly in their differing levels of prosperity and their cultural traditions.

"In preparation for the completion of the single market, a great deal of work was carried out... Much of this was motivated by considerations of health".

A third approach would be a situation in which an increased risk is directly inferred from a knowledge of incidents that have occurred, and in which the EU has intervened to protect health. This is the 'incident driven' approach. An example of this is a type of decorative lamp with a coloured oil that appealed to children. The health problem was serious, as children drinking the oil developed inhalation pneumonia with fatal or long-term consequences (see below). It was possible to document the fall in cases following the European Directive that addressed the problem. The following articles analyse particular topic areas in more detail.



The regulation of pharmaceutical products

The analysis in this area draws heavily on work presented at the seminar that was held in the course of the project.^{1,2}

“it is unclear whether standards are likely to rise or fall in the future as a result of harmonisation.”

The road to harmonisation

The background to the EU-level system is that the regulation of pharmaceuticals has a long history, and was already well developed in the Member States before effective harmonisation took place. Thus, apart from the possible economic advantages of an enlarged single market, the EU system could benefit public health by providing a higher quality of regulation than would otherwise continue to be provided at Member State level, in accordance with Article 100a of the Single European Act that specified ‘a high level of health protection’. However, it is also possible that a harmonisation process could lead to a reduction in standards, rather than a rise.

The European Community’s first Directive on medical products regulation (EEC/65/65) was published in 1965. Common standards for specific toxicological and pharmacological tests were subsequently issued in 1975, when the Committee for Proprietary Medicinal Products (CPMP) was set up to provide expert scientific advice. At the same time, a Community-wide mutual recognition system (the CPMP procedure) was introduced. This was not completely successful in achieving harmonisation, especially because Member States frequently tended to seek arbitration, and it was replaced in 1985 by the multi-state procedure. A concertation procedure was also introduced for biotechnology and ‘high technology’ products in 1987.

A major change occurred on 1st January 1995, when CPMP opinions became binding on the Member States. At the same time, the European Medicines Evaluation Agency (EMA) was established to administer the new procedures, with expert advice from the CPMP. The process of harmonisation has thereby been greatly strengthened. A further major change occurred in January 1998, when national authorisation routes effectively ended.

The current situation

The situation now is that the regulatory authorities are still based at national level, and that they compete for regulatory work

and the fees from industry that support it; the expectation is that only about five of them will survive, which has implications for the future of the European toxicological science base. There is also a requirement for rapid evaluation: a strict time frame (typically 210 days) may be all that is available to review an application that runs to thousands of pages and that took the company many months to compile, and it is difficult to maintain high quality in these circumstances.

This and other features of the system mean that the industry and the agencies have a relation of cooperation rather than the opposition that is traditionally associated with the regulatory process. This situation is evaluated differently by different participants (apart from in the industry where it is uniformly welcomed), and places a heavy responsibility on the peer review process. While it is generally agreed that the scientific standard is high, it is unclear whether standards are likely to rise or fall in the future as a result of harmonisation.

Two other issues deserve to be highlighted. First, there is widely agreed to be excessive secrecy, which is usually justified in terms of the need to maintain commercial confidentiality. If the latter is indeed necessary, it is unclear why the public and the regulators should be expected to trust pharmaceutical companies that apparently cannot trust each other.

Secondly, the EU regulatory system pays no attention to the question of need: perhaps three drugs each year have something substantially new to offer, whereas a large number of apparently new products are merely versions of already available drugs. Not only are these rarely advantageous therapeutically; the proliferation of ‘me-too’ versions has sometimes resulted in the belated discovery that they caused problems, as was the case with bromfenac and mibefradil. There is now a case for moving from an essentially economic system of product regulation towards a system that has the rational use of pharmaceutical agents as its basic aim, as occurs in certain non-EU countries (2). This would mean reconsidering the position of the regulatory system within the Commission: pharmaceuticals are currently the responsibility of DG III (Industry), but health could be given a larger role.

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Regulating the market in medical devices

Unlike pharmaceuticals, the market in medical devices has been largely unregulated in most Member States. As this very broad and heterogeneous term embraces implantable items such as heart valves and artificial hip joints, as well as a wide variety of non-implantable equipment including such vital items as cardiac defibrillators, this is somewhat surprising.

A haphazard system

At best the system has been haphazard, either treating devices as pharmaceutical products, or covering some categories but not others, for example contact lenses but not intra-ocular lenses, or condoms but not intra-uterine contraceptive devices.

The situation has therefore arisen that a large number of essentially similar products exist, but some of them are inferior in design and/or manufacture. There has been no requirement to record which product is used, for example, for insertion of an artificial joint, and no follow up of adverse incidents. There have been examples of medical devices that have caused harm to patients, which in some cases have been serious, including the Shiley heart valve. A recent example was a type of artificial hip in the UK which was discovered to deteriorate over time, and required a large number of people (many of them elderly) to undergo replacement of the joint; the product had no advantage over the standard type of hip prosthesis (hundreds of different types exist). It also proved difficult to discover who had received this particular implant so that they could be contacted about the need for further surgery.

Towards effective regulation

In 1993, a Directive concerning medical devices (93/42/EEC) was agreed, and this came into force in all the Member States in 1998. Its main provisions are the requirement for all medical devices to carry the CE mark, and provision for post-marketing vigilance. Eligibility for a CE mark depends on safety, effectiveness, absence of side effects and satisfactory performance in use, as well as on manufacturing quality. The vigilance procedure should make it possible to have earlier warning of adverse events. However, there is a problem in linking the data on individual patients, because of data protection legislation. It seems strange that protecting the identity of patients is legally regarded as having priority over protecting their health.

Many devices have already been removed from the market, and progressive raising of standards in this area is likely to result from the Directive. The resulting benefit of this legislative initiative may be quite large, but this cannot be quantified, as the data on previous harm from medical devices is inadequate - another consequence of the previously anarchic situation. In addition, although there is a literature on aspects of medical devices, for example from a legal viewpoint, no work appears to have been done that could be used to assess the public health impact of changes in legislation and practice. This is an area that requires further research.

Dangerous substances and preparations

Chemicals have been regulated since the 1960s, both at national and European Community level. As with pharmaceuticals, Member States would have developed a comparable although more fragmented system if there had been nothing at European level. Therefore to evaluate the effect of the single market would ideally imply a comparison between the existing EU system and what might have existed without it, if this were possible. Inevitably, more prosperous countries tend to favour greater restrictions than poorer countries.

Assessing the regulation in place

In practice, serious health consequences that are known to result from exposure to dangerous chemicals are uncommon, apart from a few specific instances, notably asbestos. This could be because the regulatory system is functioning effectively, because there is limited potential for most chemicals to cause serious illness at exposure levels that actually occur and/or because there is under-recognition of such effects.

The regulatory method used is risk assessment, and a great deal of attention has been paid to the methodology; however, it is an

“risk assessment ... is an expensive and laborious process”

expensive and laborious process. The system is not only concerned with the question of approval, but also with such things as labelling, packaging etc. Labelling has been harmonised, and includes symbols of danger, risk phrases and safety phrases.

The system is very complex, and will not be described in detail here. A distinction is made between substances that already existed in 1981 and are listed in the EINECS inventory (there are approximately 100,000 of these), and new substances of which there are typically several hundred introduced each decade. To prioritise within the ‘existing’ substances, the production level is used, e.g. above 1000 tonnes annually (2000 substances). A second type of distinction is between types of product, for example plant protection products (PPP - pesticides used in agriculture), biocides (other uses of pesticides), detergents, explosives, etc. There can be differences in the way these are handled, such as in the case of PPP because of the possibility of residues in food. A third distinction is in the type of toxicity: whether the hazard affects human health or some aspect of the environment. In the former case, a particular group is known as CMR, because they are carcinogenic, mutagenic and/or harmful to reproduction; these have been withdrawn from the market.

The difficulty of banning substances

One consequence of banning is that it is possible for a useful substance to be withdrawn despite absence of an actual risk. This could occur if the potential level of exposure to, for example, a teratogen would have been so low that no harm would have resulted. The converse situation occurs with chemicals that have been approved: there has traditionally been no way of influencing their usage. DG XI has initiated an attempt to encourage sustainable use of PPP, which includes the reduction of quantities used, and substitution of safer products for less safe ones.

The main aim of the regulatory system is to prevent episodes of adverse outcomes occurring. Nevertheless, it is occasionally possible to identify an instance where intervention has made a difference. In early 1997, Germany and Austria reported approximately 1000 cases of children being poisoned by drinking coloured oil from decorative oil lamps. One died, and many had serious respiratory problems that could be long lasting. It is thought that in the EU as a whole, four times that number were affected. The Commission introduced an urgent Directive to ban the use of coloured oil in the lamps, together with other measures, to prevent further cases of poisoning.

Foodstuffs: harmonising a diverse policy area

Within the overall area of foodstuffs, there are three major branches to consider: additives, hygiene and nutrition.

“Member States are sometimes accused of using food hygiene as an excuse to exclude imports when the true motivation is economic”

Additives

Concerning additives, the first Directive in 1962 consisted of an indicative list. The recent trend has been to develop a positive list, which contains every permitted substance, together with the foods in which it can be used, and in what quantities given the amount that is typically consumed. This is now essentially complete.

It is generally thought that the level of protection has been unchanged or increased in most Member States, except that those countries that have traditionally been the most restrictive have had to accept a slightly longer list. It is impossible to say definitively what is the ‘best’ level of protection, for two reasons: (a) because this judgement would involve a trade-off between the ben-

efits of restricting a possibly harmful substance against the benefits of its use, and this is inevitably indeterminate given that they are not measured using a common metric; (b) the evidence to make these judgements is in any case typically incomplete.

There have been trends in certain substances as scientific evidence has changed, for example boric acid has now been restricted to sturgeons’ eggs. The bacteriocide nisin has been phased out, but is still permitted in mascarpone after six people died of botulism. Member States can also apply for specified traditional foods to contain particular substances that would otherwise not be allowed. In addition, a few disagreements remain over specific compounds: for example, Denmark has been against the use of nitrates, and the use of

azo colours has been contested by Sweden and Finland.

A controversial area is so-called technological justification, which signifies whether or not a substance is needed. This criterion is potentially subject to disagreement between individuals and between Member States. For example, colourants are typically less favoured in the Nordic countries where people are used to paler (un-dyed) food. Clearly a judgement of this type is different when the additive is used for an essentially cosmetic purpose rather than for health protection, as the mascarpone example illustrates.

Food hygiene

Food hygiene has played a prominent role in European affairs in recent years, and continues to do so. Earlier plans aimed at comprehensive deregulation were reversed, and the Commission was re-structured: DG XXIV (consumer affairs) was given responsibilities that had previously belonged to DG III (industry) and DG VI (agriculture), as they were considered to require more orientation towards consumers rather than producers.

Hygiene is clearly important in relation to trade in foodstuffs: producers in Member States with traditionally high standards, and therefore relatively high costs, complain that they are subject to unfair competition from inferior produce at lower prices. Conversely, Member States are sometimes accused of using food hygiene as an excuse to exclude imports when the true motivation is economic. Within a single market, it should be possible to solve this two-sided problem by bringing the standards closer together.

The European Union has approached this task by adopting a comprehensive regulatory regime: a good infrastructure and good hygiene practices throughout the food chain, underpinned by HACCP (Hazard Analysis Critical Control Point). The principle underlying HACCP is that for each type of product, the entire food chain should be analysed to see at which points problems could arise, and then systems are adopted both to minimise their occurrence and to monitor the situation so that early warning is obtained. There is general agreement that this is an improvement on previous methods. The intention has been not only to make standards more similar for trade purposes, but also to improve food hygiene throughout the EU. Prior to this, scant attention was given to public health; a generally clean environment was required,

but this took no account of the real problems, which are more concerned with faecal contamination, temperature, and so on.

Food hygiene is an area where it is difficult to get the balance right. It is important to avoid excessive regulation where the risk is low, for example in the case of cheese made from unpasteurised milk. More generally, food hygiene measures have developed in a way that favours large, vertically integrated companies. Such measures are a potential threat to small and medium sized enterprises that are so important to the food sector, especially in their role in maintaining traditional and regional specialities.

Nutrition

Nutrition is represented in several EU Directives, including infant formulae and follow-on formulae, foodstuffs for particular nutritional uses and nutrition labelling. In general, the view is taken that the consumer can and should decide on dietary composition. This has led DG III to strongly oppose the idea that fiscal policy could be used to discriminate in favour of foods that are more beneficial to health: a proposal from Finland that a sugar-free chewing gum should be favoured was rejected, although apparently other sections of the Commission were willing to consider the idea.

Nutrition labelling, allowing the consumer to have access to the information to make informed decisions, is compulsory only when a health claim is made. This implies that the less beneficial (or most harmful) foods are the least likely to have information about nutrition on the label. In addition, it is unclear to what extent potential buyers can understand the type of labelling that is specified, especially if their level of education is relatively low.

More fundamentally, however, labelling may have less effect on behaviour than other factors, notably price and availability, especially among those sections of the population who have relatively few resources. The pattern of nutritional intake is immensely important to the health of the population: for example, an increase in fruit and vegetable consumption could help to prevent many common cancers as well as coronary heart disease. While the Single European Act may not have been a suitable legal basis for policy initiatives in this area, the health compliance clauses of the Maastricht and Amsterdam Treaties open the way to this possibility, in their insistence that all EU policies should ensure health protection.

“labelling may have less effect on behaviour than other factors, notably price and availability”

The health dimension of fiscal policy instruments

The EU has weaker legal powers in the area of fiscal policy than in the other four areas, limited principally to exhortation and monitoring. In the late 1980s, the Community encouraged an increase in the level of taxation (excise duties) on cigarettes, especially in the hitherto low tax Member States of southern Europe.

Member State actions

To assess the effects of this, Member States' data for the years 1988–97 (provided by DG XXI) were examined. It was clear that the low tax countries had greatly increased the level of excise duty: in Greece it rose six-fold, in Spain and Portugal it trebled, while in Italy and France it merely doubled. On the other hand, most of the high tax countries had rather stable levels, although there are some exceptions to this, notably the UK.

A tax rise is not the same as a price rise: for example, if tax forms half of the price, and it is then doubled, the overall price rise will be 50%. This assumes that the tax rise is passed on to consumers. If this does not happen, the manufacturer loses the corresponding amount of profit.

The effects of tax increases

It is well established that a higher price leads to a fall in consumption. The economics literature suggests that for each 1% rise in price, consumption will fall by 0.3 to 0.6%, partly from quitting and partly from cutting down. In addition, one would expect fewer new smokers to be recruited during childhood.

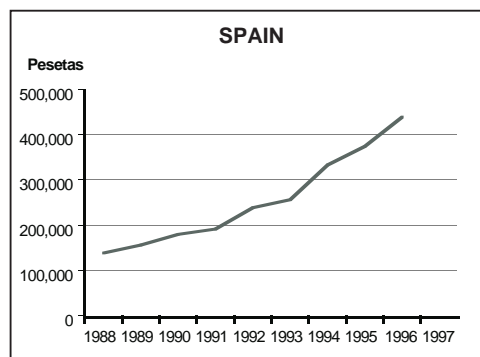
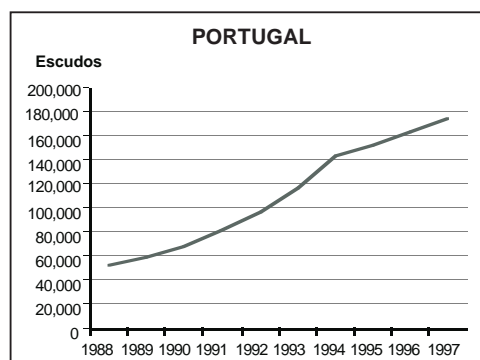
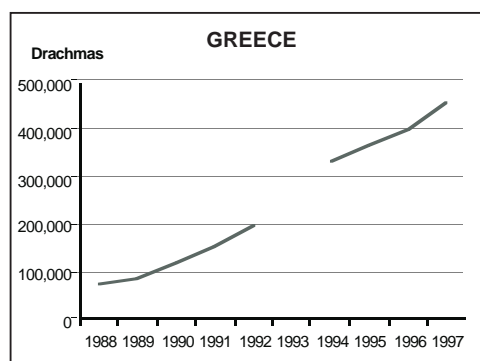
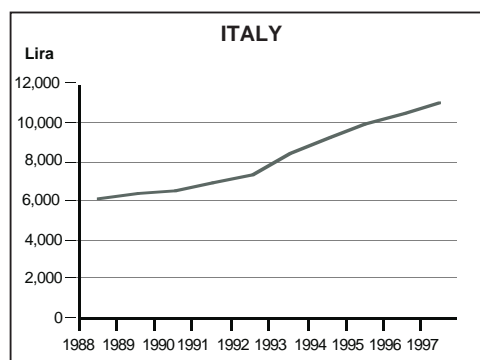
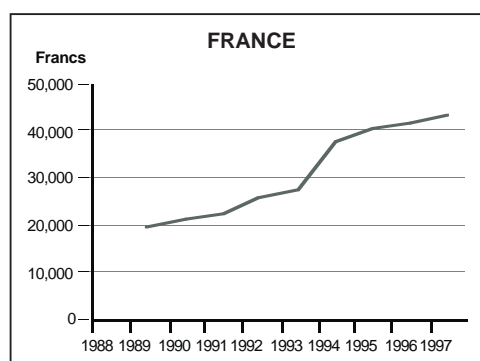
Assuming that these figures apply without modification in all Member States, it is possible to estimate the effects of a price rise on cigarette consumption. For example, consider a population of 35 million adults of whom 28% are current smokers: thus, there are 9.8 million smokers (these figures approximately represent the situation in the United Kingdom). If there were a five percent increase in the price, adjusted for inflation, approximately 1% of smokers would give up smoking, meaning that almost 100,000 people would become ex-smokers. A comparable magnitude of reduction in consumption would be seen from cutting down, and a further fall from non-recruitment. The benefit to health is thus likely to be large from a price rise of this magnitude, after a lag corresponding to the latent period of the various diseases.

Other consequences

Apart from the health gain and the benefit to the exchequer, three other consequences need to be borne in mind, and these are less welcome. First, there is an adverse effect on equity, since increases in price disproportionately affect people who are unable to quit, and these tend to be people who are on low incomes or who are disadvantaged in other ways. Secondly, excise duties have not been raised on other forms of tobacco, which is likely to lead smokers to switch from manufactured to hand rolled cigarettes which are more harmful. Thirdly, the tobacco industry is responding to the loss of its market in the developed world by expanding sales in developing countries.

Overall, the findings in the area of fiscal policy support the hypothesis that was originally proposed for this project as a whole, that (a) standards have risen, and (b) they have become more uniform. The term 'standards' here needs to be understood as 'those conditions which most effectively promote health', and therefore corresponds to a high price of tobacco in this instance.

Tobacco excise duty in some Member States where an appreciable increase has occurred (not adjusted for inflation)



Where is European food policy going?

Tim Lang, Professor of Food Policy at Thames Valley University, wonders if the proposed European Food Agency will clarify or add further confusion to EU food and public health policy.



With astonishing speed, a new map of European food policy is emerging in which food safety now rates as high a political profile as the farm politics of the Common Agricultural Policy (CAP). Besides staring in wonderment as this new terrain is altered as the volcanic eruptions over consumer safety lead to food wars within the EU and between the EU and particularly the USA, there is also an urgent need to subject this new map to proper public policy analysis. What are its new fault-lines? Where will the next eruptions come? Who, if anyone, is in control? Is the political process in charge of public policy? Will the new food agencies at EU and member state level pacify or exacerbate public concerns about food safety?

The European Union is being drawn inexorably into food policy without having any clear overall official policy. As with so many areas, the EU has bolted new initiatives on to the core that is, and is likely to remain, the Common Agricultural Policy (CAP). The reaction in 1996 to the BSE crisis was supposedly going to change this emphasis but in reality it has not. Within days of his appointment, Commissioner David Byrne promised a new European Food Agency and in December 1999, in response to a request by the then Director General of DGXXIV, three academics produced an outline of what a European Food and Public Health Authority could look like.¹ This January the EFA was announced but in a weaker form than the Professors proposed. It will be part of the EC, not free-standing. Excellent though this might be, it is unclear whether such a body could resolve the tensions already manifest within EU food policy and institutions. A number of fissures are key.

Producer versus consumer interests

The first is the tension between consumer and producer interests. Although political rhetoric now gives primacy to consumers, producer interests still carry the legacy of a munificent past. Despite supposed subsidy reductions negotiated in 1994 under the last

Uruguay Round of the General Agreement on Tariffs and Trade (GATT), the reality is still that about half of all EU expenditure is on farm support. Anti-CAP Member States such as the UK love to portray CAP as the promoter of inefficient farming. The reality is more complex. Born out of a very real experience of hunger and of food chaos in World War II, the CAP set out to bring stability and to ensure that Europeans never suffered hunger again.

Who today remembers that the Netherlands suffered a famine in 1944? Or that the UK's war-time reliance on US lend-lease to feed itself nearly brought it to its knees after the war ended, when the tap of Uncle Sam's food beneficence was (understandably) turned off in the late 1940s to give priority to feeding Germany and to keep it from falling to the USSR? Critics argue that the past rationale for CAP is irrelevant today. But it would be a foolish politician who allowed Europe to stop feeding itself and to put its currencies and affluent consumers onto the roller-coaster of world commodity markets.

The political challenge for CAP negotiations today is not so much whether there is a CAP but what the expenditure is for? The EU is breaking its own commitment to scrutinise all policies for health by ignoring the health impact of CAP.² One might have thought that the neo-liberal policy agenda would have latched on to this opportunity to tame CAP. It has for years sought the nirvana of dismantling all subsidies. Neo-liberals like to portray CAP as a trough filled endlessly by conned consumers who as a result pay too much for their food, but the reality is again more complex. Although producer subsidies are high in the EU, as the OECD constantly shows, the price farmers get for their products is a small, and for some commodities a decreasing, proportion of end consumer prices. The food supply chain is lengthening all the time. This means that even when food is cheap, many costs are externalised. Who pays for food poisoning or pollution of land and waterways? A team led by Prof Jules Pretty at Essex University has now calculated for the UK alone, extra environmental costs amount to £208 per hectare.³ This did not include diet-related costs such as for heart disease or diabetes. The former, for example, costs an annual £10 billion in the UK. For EU policy-makers, the lesson is clear. To assess the full costs of EU food

“The EU is breaking its own commitment to scrutinise all policies for health by ignoring the health impact of CAP”

policy we need more accurate and comprehensive studies.

The new importance of food quality

The second fissure in modern EU food policy links directly from this issue of cost. If CAP was set up to (re)build quantity, now its challenge is quality. Since the early 1980s, a wave of scandals has made consumers sceptical about the commitment of industry to quality. Europe's food processors and retailers have been driven by other drivers such as building brands, searching for new products, beating competitors, squeezing primary producers. This, ironically, has generated an opportunity that politicians have so far not grasped. Consumers are sending consistent messages that they want changes in HOW food is produced. So far, the mass market has been dominated by intensive production, but now different messages are coming.

“Consumers are sending consistent messages that they want changes in HOW food is produced. So far, the mass market has been dominated by intensive production, but now different messages are coming.”

Euromonitor polls, let alone the public mood since the 1996 BSE crisis, show that since the late 1980s Europeans have been prepared to fund farm support but not at any price. They want farming to change, to be more environmentally sound, and now, above all, they want the food supply to be safe. They are right. The safety scandals that used to be associated with the British are now seen to be more systemic. France has been found to have been feeding sewage to animals, and Belgium to have released excessive dioxin in meats. Everywhere there is unease, if not fury, at perceived big business backing for genetic modification (GM) foods but support for the EC to hold firm before a US inspired assault via the World Trade Organisation. Big business is now backing away from GM under consumer pressure. No wonder food safety is now such a priority for the Commission. Intensive farming, not just national incompetence or ministries overzealous in their support for insensitive farmers, is under scrutiny.

The European Parliament, just as much as national Parliaments, has seized the opportunity to admonish and curtail excesses of EC farm support programmes. The humiliation of former President Santer following the publication of the damning European Parliament report on the handling of the BSE crisis in 1996 was a defining moment. Many at the time expressed a more cynical view that M Santer's Japanese-style self-criticism was merely playing to the gallery.⁴ It was a clever smokescreen, they argued, to disguise a desire to return to 'business as usual'. That may have been so, but by com-

ing out into the open, the EP-EC tensions over handling of food policy meant that when further scandals happened – a likelihood as certain as night following day – the EC would be on the defensive again.

Hence the alacrity with which David Byrne, Ireland's EC Commissioner for Public Health and Consumer Affairs stepped into his job with promises to make food safety his primary concern. I have little doubt that Mr Byrne means what he says but can he deliver without setting longer-term goals? The short answer is 'no'. He is setting out on the false premise that better controls and management of microbiological contamination is all that EU food policy needs to clean up the food system. This is wrong. The problems are more deep-seated and will take decades to sort out. Sweden, for instance, which had a cataclysmic outbreak of food poisoning in 1952, killing 100 people, set up a programme to eradicate salmonella from its poultry flock. This took decades. In Britain, for instance, which had its salmonella-in-eggs scandal in late 1988, a period when over one in three carcasses sold to the public were contaminated, companies privately admit that they still cannot eradicate contamination. Rates are dropping but to achieve low counts, let alone zero, will take years.

The broader issues of food policy

This brings us to the major fault-line in modern EU food policy. While political priority is given to food safety, a real food policy – one the consumer can trust – would be like a good chair, built on four legs: safety, nutrition, environment and social justice. In practice, the approach to safety is crisis management rather than systemic. The approach to nutrition is next to non-existent, bar a reliance upon labelling (which has little proven impact on improving food-related ill-health unless accompanied by a battery of measures – precisely what the EU currently refuses to implement.) The approach to the wider environment is marginalised to the edges of agricultural policy through measures such as the agri-environment programme. Social justice through food policy barely registers. Any social audit of EU food would have to conclude that there is little concern from public policy makers for feeding low-income consumers – unless they are to get US-style hand-outs of surplus commodities through the Surplus Food Disposal Scheme, which systematically ignores the major potential gain of such schemes, namely to give poor people good fruit and

vegetables. This, as a Swedish National Institute of Public Health report has pointed out, is a scandal within such a rich agri-food zone as Europe.⁵

Even if the current concern for food safety were – wrongly – the sole concern for the EU, there would still be one thorny final problem. Which state level is to have responsibility for safety – EC or Member States? This policy hot potato has been served up by the row between the UK and France over beef. The handling of this ‘food war’ bodes ill for the role of national food agencies. France’s new Food Safety Agency, set up in the wake of a national outcry about contaminated blood samples, made a pronouncement that it wanted British beef kept out. Its credibility for putting consumer safety was on the line. The UK, whose Food Standards Agency has only just received legal approval and will not come into existence formally until autumn 2000, received advice from its embryonic agency (mostly drawn from the old Ministry of Agriculture) that the changes made to UK beef slaughtering now meant British beef was safe. Scientists separated by a narrow strip of water apparently came to different conclusions.

The EC meanwhile had been patiently taking the UK through a number of safety procedural hoops begun back in 1996 when the cases of new variant Creutzfeldt Jakob’s Disease (CJD) were confirmed. At stake here is a tussle over subsidiarity and the legacy of the 1987 Single European Act. The SEA had swept away national food laws in return for harmonising EU rules to allow speedier passage of goods (including food) throughout the Community. Critics at the time feared that public health was being put second to the trade imperative. So it is ironic that 13 years later, the EC is being forced by public pressure, now on the global stage, to resist the USA trying to force its version of the biotechnology revolution through the WTO disputes system. Oh what irony!

What direction policy now?

Against this structural analysis of the real challenge facing EU food policy, what is the current thinking of Commissioner Byrne? My understanding is that the White Paper will establish a new European Food Agency but whether this has a narrow food safety focus or a wider public health role, including nutrition as the three Professors’ report recommended, remains to be seen. The credibility of EU public health policy hangs on whether the focus is narrowly

microbiological or is comprehensive. Although food safety has recently demanded the most time of politicians, for the EU to have a mature and sensible food policy, it will require equal policy weight to be given to nutrition, environmental health and social justice, as well as safety. The focus in the White Paper is likely still to be upon consumer information, which bucks the challenge by putting the onus on consumers to protect themselves. Everyone agrees that Europe should have good labelling, but information is not the only plank of a food policy. There is also the question of what sort of information and labelling we should get. Will a label on, for example, a chicken give lots of information about the brand and price or will it say something like this: ‘This chicken is likely to contain pathogens. Please handle and cook it well. If you don’t, you are likely to get food poisoning and we will blame you. It’s your choice not our responsibility.’

The White Paper emphasises a Rapid Alert System to facilitate information flow in crises between member states. The idea for a RAS was developed by the former nuclear energy division in the old DGXI. Like other measures in the White Paper, the goal is to modernise and simplify. In the 84 proposals, legislation is to be simplified, and there will be a new focus of clarifying sources of scientific advice, which can be circulated faster. Centralisation and harmonising member state controls are to go hand in hand. Other measures are to include the production of a positive list of ingredients for animal foods; safeguard clauses in legislation; maximum limits for contaminants; improvement of controls for GMOs; better nutritional monitoring and data; and simplification of food safety rules.

All of this makes sense but it is above all one feature that characterises the real, as opposed to rhetorical flavour, of the new Commission’s food policy. Consolidation and harmonisation make some sense, but setting up the EFA carries considerable political dangers. It both plays to the gallery – the EC is seen to be more consumer-friendly – and delivers what Europe’s powerful and rich food industry long has wanted, one voice for it to deal with rather than 15 fissiparous, divergent countries. As we have already seen with the UK–French tension over BSE, food policy is a minefield. Whether the EFA can reduce rather than add to difficulties remains to be seen. The White Paper makes it clear that power is to reside with the EC. I see trouble ahead.

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Sustain, the alliance for better food and farming

The labour of Sisyphus

According to legend, Sisyphus, one of the Titans, was condemned forever to push a boulder up a hill. The boulder repeatedly rolled back to the bottom.



Jeanette Longfield

Talk to anyone engaged in trying to reform the Common Agricultural Policy (CAP) and they will tell you that Sisyphus had it easy. Despite years of patient research and determined lobbying, the CAP seems as resistant as ever to attempts to change it into an environmentally sustainable system that produces wholesome food and creates high quality jobs while respecting the rights of other living creatures. Today, the CAP remains a juggernaut, piled with mountains of produce for which there is no market, under the wheels of which jobs are destroyed, the environment is damaged and animals suffer.

Admittedly, part of the problem has been – and will continue to be – the fact that the patient and determined lobbyists are often lobbying against each other, allowing politicians to ignore proposals or ‘cherry pick’ policies that, outside the framework for which they were devised, work less well or not at all. Another is the sheer scale and complexity of the many policies that make up the CAP. It seems appropriate, somehow, that the CAP should attract legends of its own (for example, that only three people have ever understood the CAP: one has died, one has forgotten, and the one that still understands it has gone mad).

Arguably, though, the most fundamental obstacle is that the CAP was designed to solve a problem that we no longer face in Europe – lack of food. Shaped as it was by post-World War II shortages, the CAP has been spectacularly successful in solving that problem, but the costs have been high. This article will focus on just one of these: diet-related diseases.

Food and health

Despite popular belief that experts on food and health are in a state of perpetual disagreement, the consensus has been growing

for 30 years or more that diets high in fat, sugar and salt, and low in fibre, vitamins and minerals increase the risks of developing cardiovascular disease, a range of cancers, and a number of other fatal or debilitating conditions. This agreement is only now coming to be recognised formally by the EU policy making process, with a group of experts convened by the Health and Consumer Protection Directorate currently developing food based dietary guidelines.

The phrase ‘food-based dietary guidelines’ may not be the most elegant in the language, but it is critical to avoiding the ‘nanny state’ accusations that are routinely hurled at any agency trying to improve public health by shifting the balance of the food supply. In practice it means that a dietary guideline of, say, a maximum of 30% of the total energy in the diet from fat, can be met by choosing from a very wide range of foods. In Northern Europe, it is likely that much of this fat will come from dairy and meat products, whereas in Southern Europe a higher proportion will be made up of olive and other vegetable oils. Similarly, a dietary guideline to increase the proportion of complex carbohydrates in the diet will encourage some people to eat more potatoes, others bread, while some will opt for rice and others pasta.

In other words, people’s physiological requirement for particular nutrients generally does not vary, but our way of meeting those needs can do, and is fulfilled by a huge range of foods. Thus food-based dietary guidelines that apply across the EU are emphatically not a way of ‘Brussels bureaucrats’ telling us what to eat.

Vested interests

Doubtless this is a distinction that will be lost on leader writers in the popular press. They will be aided and abetted in fuelling popular prejudices by powerful sectors of the food and agribusiness industries that are unable or unwilling to diversify out of

“Today, the CAP remains a juggernaut, piled with mountains of produce for which there is no market, under the wheels of which jobs are destroyed, the environment is damaged and animals suffer”

the food sectors that should shrink, and into the food sectors that should grow, according to food-based dietary guidelines. And make no mistake, a CAP based on such guidelines would be radically reshaped and require some serious investment to ease the process of diversification.

Working on the 1997 CAP budget, fully one-third of the ECU 41,438 million was spent on meat and dairy products. Arable crops (excluding several that are listed separately) consume an even larger slice, at around 40% of the budget. Much of this will support cereal production that, on the face of it, seems positive, since we should be eating far more cereal-based products, particularly in their whole, unrefined form. But, since it has been estimated that over a half of cereal production is destined to be eaten by animals, a large proportion of this expenditure should be allocated to meat and dairy production, bringing total CAP expenditure in this area to over half the total. This is without allocating any of the substantial funds spent on product promotion, anti-fraud policies and accompanying measures.

Contrast this with the derisory amounts spent on fruit and vegetables. In the same year this amounted to ECU 1,661 million or four per cent of the CAP budget; slightly less than was spent on the sugar regime. The situation is even worse than the figures suggest since most of the money is spent on destroying fresh produce to keep it off the market and avoid prices falling. Stable prices, while good for growers, are less good for low income families who, in the UK at least, seem to be consuming smaller and smaller proportions of these health enhancing foods.

What now?

It doesn't have to be like this. The Amsterdam Treaty clearly gives the EU the power to take action that "...shall be directed towards improving public health, preventing human illness and diseases..." Shifting cash into promoting sustainable production and increased consumption of fruit and vegetables would have the following advantages:

Health

Eating at least five portions of vegetables and fruit could help prevent cardiovascular diseases and several types of cancer, still the EU's major killers.

A reduction in incorrect use or over-use of pesticides used in horticulture would diminish the health risk to farm-workers

applying them and to those, particularly children, consuming pesticide residues.

Environment

A wide range of sustainably produced horticultural products could create diverse wildlife habitats, improve soil fertility and reduce agri-chemical pollution.

Fresh produce consumed close to the area of production could reduce energy use and pollution linked to processing, packaging, transport and storage.

Employment

For all EU citizens to consume a healthy amount of fruit and vegetables each day, production within the EU would have to increase. Even if prices fall, farm incomes should rise because of increased sales.

"the consensus has been growing for 30 years or more that diets high in fat, sugar and salt, and low in fibre, vitamins and minerals increase the risks of developing cardiovascular disease, a range of cancers, and a number of other fatal or debilitating conditions"

Horticulture is understood to be more labour intensive than other parts of agriculture so, provided good working conditions can be established and maintained, it would offer good employment opportunities.

Development

Since it would be neither possible nor desirable to produce all our vegetable and fruit requirements within the EU, increased consumption could offer opportunities to increase the export earnings of countries in the Southern Hemisphere. Sustainable production methods would reduce the occupational risks to farm workers in the South, who are currently at highest risk from global pesticide use.

A number of policy instruments already exist that would begin the shift in the desired direction, including:

- free distribution, rather than destruction, of all temporary surpluses (fresh, frozen or minimally processed)
- changes in quality standards to reduce the proportion of edible produce removed from the market
- funding for conversion to and maintenance of

“the derisory amounts spent on fruit and vegetables ... is spent on destroying fresh produce to keep it off the market and avoid prices falling.”

- nance of environmentally sustainable production methods, in urban as well as rural areas
- ending payments for grubbing up orchards
- support (funding and training) for marketing schemes (including promotion of regional specialities)
- local or regional support for a wide range of retail outlets for vegetables and fruit (to reduce reliance on supermarkets)
- major media campaigns, supported by local activities, to provide the skills and confidence for people to incorporate vegetables and fruit into their daily diet
- shifting subsidy away from some types of crops (tobacco and sugar beet are obvious candidates) to support sustainable production of vegetables and fruit

Fruit and vegetables are not a major or complex part of the CAP compared to other sectors. Changes in this sector would not, therefore, have an immediately profound or far-reaching impact, particularly if the amounts spent, directly and indirectly, on supporting meat and dairy production were left untouched. However, given the size of the alliance of different interests that could be constructed around this positive agenda, the chances of success are – arguably – reasonable. It might be one small stone that we manage to push to the top of the hill without it rolling back down again.

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Public health and food safety: the case of Salmonella in Denmark¹



Nils Rosdahl

The main concern of food control is safeguarding of human health dealing with a range of chemical and biological factors. This article addresses primarily Salmonella, but the considerations are relevant to other infectious agents.

The development in Denmark has features comparable to those in other European countries, but there are also unique elements. Denmark has experienced significant changes in the food control system over recent decades, some with potential public health implications.

The size of the problem

The true incidence of salmonella infections is not known in any country. Several countries have figures for microbiologically confirmed cases, but they probably need to be multiplied by at least a factor ten to give the real incidence.

In 1992, we conducted two telephone interviews asking representative samples of approximately 1,500 Danes about experi-

ence of ‘stomach trouble’ during the preceding three months. Only a limited number of these incidents are related to foods and even fewer to salmonella. The adult respondents recorded a total of 927 incidents of ‘stomach trouble’ over the combined six months period and for the approximately 750 children in the households 688 incidents. We calculated that ‘stomach trouble’ in the 5.2 million Danish population are responsible for at least 800,000 annual contacts to the health services, usually telephone consultations to the patients’ own general practitioner.² These figures are significantly higher than those reported in a recent British multi-practice study.³

Figure 1 shows microbiologically confirmed cases in Denmark over time. In 1980, 823 cases were recorded rising to 3,460 in 1988, followed by a decline, which in the early 1990s was followed by an increase to 4,276 cases in 1994. From 1996 to 1997, an increase of more than 50% resulted in a new record of 5,049 cases. In

1998, the number decreased by 30% and this trend continued in the first part of 1999. Microbiologically confirmed cases of *Campylobacter* infections are still increasing. In Norway with a population similar to Denmark and in Sweden with a 60% larger population, recorded cases in 1997 were only one fifth of those in Denmark. There might be differences in criteria for performing stool examinations in various countries and there have undoubtedly been changes over time.

As is seen in Figure 2, *Salmonella* Enteritidis has for most of the time been the predominant serotype, but *S. Typhimurium* dominated from 1987 to 1990. The changes between serotypes are linked with the food origin of the bacteria.

In the past 15 years Denmark has had three major sources of *Salmonella* infections.⁴ From 1984 to 1988 the main culprit was chicken, followed by pork around 1991 to 1994, while in the second half of the 1990s it is eggs. The estimated sources of human salmonellosis in Denmark in 1995 were eggs with 40–50%, poultry with 15–20%, pork with 10–15% and travel abroad with 10–20%.⁴ Beef and other sources only constituted minor proportions.

The multiresistant *S. Typhimurium* DT104 constituted 6.1% of all *S. Typhimurium* isolates from humans both in 1995 and 1997.

Organisation of the Danish food control

Denmark has a long tradition of state-organised control of foods for export, organised through the Ministry of Agriculture. Control of domestically consumed foods was a local government responsibility administered through Ministry of the Interior legislation. In the 1960s, an Institute of Foods was developed, which due to its administrative duties was renamed the National Food Agency.

In 1972, a Ministry of the Environment was created, of which the National Food Agency became a part. When a Ministry of Health was established in 1987, the National Food Agency was moved to that ministry.

However, the Ministry of Agriculture retained responsibility through its Veterinary Directorate for animal infections and parts of microbiological control of foods. Consequently, local government food control units were professionally accountable both to the Veterinary

Directorate and the National Food Agency.

In 1995, a report from the Academy of Technical Sciences⁵ recommended unification of the state food control system under a slogan similar to the British 'from plough to plate'.

In a 1996 government reshuffle, the present Ministry of Foods, Agriculture and Fisheries was born. The National Food Agency was merged with the Veterinary Directorate into the Danish Veterinary and Food Administration. The Danish Parliament in 1998 passed a bill consolidating existing food laws into one common food law. According to the law, local government food control units are being transferred to the state and reduced in number.

'The Salmonella crisis'

Denmark experienced an increase in human infections caused by *Salmonella* from 1985. No single factor can be held responsible. Increased centralisation both in the production sector and in the slaughtering industry has without doubt played a signif-

Figure 1 Confirmed cases of *Salmonella* and *Campylobacter* in Denmark

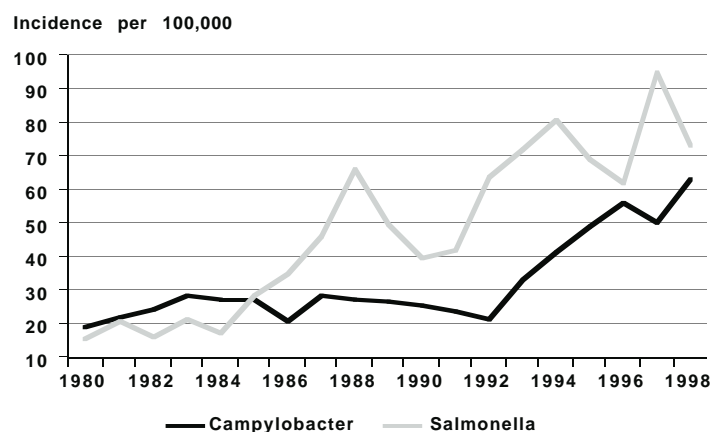
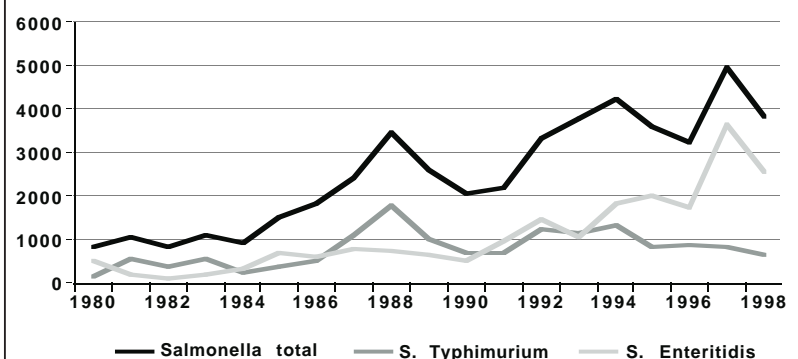


Figure 2 Predominance of *Salmonella* serotypes in Denmark



“the Ministry of Agriculture retained responsibility through its Veterinary Directorate for animal infections and parts of microbiological control of foods.”

ificant role. Spread of Salmonella within flocks in chicken farms and in pig raising ‘factories’ has been seen repeatedly. Centralisation of fast food production has also been responsible. The involved industries were slow to recognise publicly these factors and to take appropriate action. For quite a time, the authorities and industries tended to place the responsibility for the increase in human cases on the lack of consumers to adhere to the so-called good old housekeeping practices.

In the early 1990s, it became apparent that something had to be done. In 1993, the Danish Zoonosis Centre at the Danish Veterinary Laboratory was established. It was to follow the development by collecting and collating data from all sources, establishing excellent working relations with the national institute for human microbiology, Statens Serum Institut. In the following years, state financed action plans were developed, aiming at expanding the monitoring system at all levels of the food chain and subsequently imposing certain measures on the industry.

Monitoring schemes carry out some two million investigations annually. The system is based on regular controls of broiler flocks as well routine sampling after slaughter. Egg production is primarily controlled through routine monitoring by serological and microbiological analysis of flocks of layers. If *S. Typhimurium* or *S.*

Enteritidis are detected in a flock, production is terminated and the flock destroyed. Eggs are not systematically monitored for Salmonella. Screening including 14,800 eggs in 1995 showed one in 1,000 eggs contaminated with Salmonella. In 1998 this figure decreased by a factor of ten. The control of pigs and pork is based on continuous monitoring of all breeding and multiplier pig herds and all herds producing more than 100 pigs annually for slaughter, combined with control after slaughter. Beef is controlled after slaughter and a random sampling in 1996 showed 0.7% positive samples.

An independent expert review concluded in 1997, that the control programme with regard to pigs and pork has substantially reduced the level of Salmonella in pork products and the incidence of human infections related to the consumption of pork.⁶ A revised plan from 1997 concerning egg production has been followed by a reduced incidence of human *S. Enteritidis* infections.

Conclusions

Human salmonellosis in Denmark increased for ten years before serious attempts were taken to control the ‘epidemic’.

The food industries were late in recognising their responsibility – and obvious self-interests – in providing safe food products. The National food control authorities were slow to initiate measures to safeguard animal products from microbiological contamination.

Monitoring the industry helped identify the major trouble areas, but the initial action plans tended to focus on partial solutions, and the Salmonella problem moved from one food sector to another.

Denmark has, however, reacted to the problems, which is unfortunately not the case in some other countries. Recent developments look positive, but fluctuations have occurred earlier, and *Campylobacter* infections are still increasing

Health services have a responsibility to provide information on the relationship between disease and environmental factors, including microbiological, and public health authorities and should present the data on the magnitude of such problems. Salmonella infections in Denmark continue to cause 3–4,000 hospital admissions and some 30 deaths annually, and in persons without predisposing illness.⁷

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Targets for health: shifting the debate

September 23 and 24, Paris

An international policy conference sponsored by the European Public Health Association, the European Healthcare Management Association and Merck Sharp & Dohme



Morton Warner

After more than 20 years in which European states have, to different degrees, introduced health targets, much has been learned. A total of 17 of 32 countries in the WHO European region had targets in 1989. Now 27 of 51 countries use them. This wide spread of experience ensured a sharp interchange of ideas in Paris in September, as 200 politicians, doctors, nurses and other healthcare professionals and policy makers shared their experiences.

Merely setting a specific, time-related goal for reduction in disease and death can be powerfully beneficial. But things are seldom as simple as they appear. Delegates concluded that target-setting can be ineffective or may even exert untoward effects. And the public must be involved.

Winning public support

Jean-Pierre Poullier, a WHO adviser, singled out Sweden for making an 'enormous and unique' effort to consult the public. But "it is a very difficult exercise to get informed consent to targets," he said.

Lena Rydin-Hansson, from Ostergotland in Sweden, explained how it can be done. All political parties were consulted in formulating outcome-related targets for the county in 1990 and 1995. These included lifestyle goals and accident prevention. Health experts, lay people and non-governmental organisations were invited to contribute. Public meetings were held and the county's 400,000 silent majority was reached through surveys, and the strategy was supported by media campaigns. Rydin-Hansson conceded that the Swedish tradition of voluntarism helped inject the strong

element of democratic support into the scheme.

By contrast, England pursued a top-down approach in its 1992 Health of the Nation programme. David Hunter, from the Nuffield Institute of Health in Leeds, gave this as a reason for overall failure, which went deeper than simply missing the targets. Failure to win public support could negate targeting. In the successor document, "Saving Lives: Our Healthier Nation", the Chief Medical Officer gives his top ten

"Failure to win public support could negate targeting ... they are about not eating fatty food, not smoking, not sunning yourself in the park. It is all about not doing things ... That will be the downfall of targets."

tips. "If you look at them they are about not eating fatty food, not smoking, not sunning yourself in the park. It is all about *not* doing things. Negative approaches and blaming individuals is no way to enlist public support. That will be the downfall of targets". Naomi Fulop, from the London School of

Hygiene and Tropical Medicine went further: "if you are trying to motivate people, this is a real challenge and one which authorities in England have not addressed". The other danger is "that the targets involve non-medical agencies but they are being monitored through the health service".

Accountability can also be vital to the success of hitting health targets, but targets are usually set way into the future. By then the politician or planner who conceived it is probably sitting at another desk, or retired. As Dr Anna Ritsatakis, of the WHO European Centre for Health Policy put it: "Politicians like to be seen as visionary, but targets can be so distant, it is difficult to get them involved."

But as Dr Birgit Wehrauch, head of health protection for North Rhine Westphalia, stated: "The process of introducing targets can be as important as the targets themselves. Target

setting sets people thinking and encourages compromise between rival interest groups".

Calcification through targeting

Taken too far, targets threaten to become a bureaucratic game, more a test of massaging statistics than improving health. In the UK, where

health service managers are judged by several hundred performance indicators, there is a potential for calcification, with 41 indicators and 200 public sector agreements.

David Hunter added: "It is easy to have too many outcome-orientated targets and for managers to manipulate the data to give the Government what they want, even if the reality is that it creates all kinds of other distortions in the system locally."

Does targeting work?

Several delegates were even sceptical about putting too much value on targets at all. Nick Bosanquet, from Imperial College, London, commented that target setting is "a fairly harmless activity by middle level bureaucrats in international agencies." But he added later that they are still a good idea, provided they were limited in number. Smoking and traffic accidents are good target areas.

"It is easy to have too many outcome-orientated targets and for managers to manipulate the data to give the Government what they want, even if the reality is that it creates all kinds of other distortions in the system locally."

The Danish answer

Denmark provides a startling example of what can happen if you institute good healthcare but fail to set long-term health goals and monitor effectiveness. Allan Krasnik, of the University of Copenhagen, recounted how his country had been seen as a model in health terms. So deep-rooted was the feeling that WHO public health initiatives were deemed relevant only to "Africans and nurses – certainly not for medical interventions in our part of the world".

Self-satisfaction, he said, was rudely shattered in 1993 when Danes realised that they were not among the world leaders in health, having dropped from fifth to seventeenth place in the OECD league of life expectancy, with 6,000 excess deaths a year.

The poorest health record is in the capital, said Ib Haurum, of the City of Copenhagen Health Administration. In an example of how local health drives can be put into effect, he said the city instituted public health initiatives in schools and the workplace, and support services for alcoholics were set up. The plan was based on the WHO European Healthy City Project and was refined to reflect local public opinion as to target choice. Five-year targets were set in 1994 and have now been met. Health indicators are beginning to improve, although Copenhagen remains behind other cities in Europe. Public enthusiasm is encouraging health planners to set new targets.

North Rhine Westphalia: linking to the insurance model

Germany is often seen as having a model dominated by health insurance funds, financing acute care at the expense of health promotion;

and this was the case until recently, but in some of the Länder this is changing.

Giving details of introducing targets in the North Rhine Westphalia in 1995, Dr Weihrauch said they had come about through a conference initiated four years earlier. The meeting drew in state and local politicians, health professionals, health insurers, welfare organisations and others. Greater rationality in healthcare, more transparency for patients, and better evaluation of treatments is the result – as well as closer cooperation between professional groups.

Devolved in Spain

Spain has autonomous, regionally run health services, but these are required by federal law to have 'integrated' health services and tar-

gets. Some regions have set 100 targets, the average is 45. Juan Cabases, an economist from Navarra, pointed to the Basque Country as one of the most advanced regions in targeting. Services are organised on internal market lines, with providers and purchasers of healthcare. Targeting is effective because purchasers take it into account when they draw up contracts. This helps to ensure they are hit – a model borrowed from earlier developments in Wales. Other lessons are that 'health' targets should be backed by 'healthcare' targets: and progress should be assessed on quality as well as quantity.

It was argued by one delegate that the Spanish model, where money follows the target, is a form of rationing in a cash-limited system. Non-targeted conditions will get less. But this also can be used as a way of sparking public interest, which can be crucial to the whole exercise.

Where should the targeting drive come from?

Targets need to be realistic and distinguish between those that are high and low level. In Poland, a high level target might be cutting blood cholesterol levels in the population and, by contrast, seeing that stroke patients are properly diagnosed is a low-level target about which doctors and managers should liaise.

Distinguishing between types of target is also important because of accountability. There have been cases in which health authorities have been charged with reducing accidents. Hardly appropriate!

Ultimately though, the meeting concluded different rationales are at play when it comes to targeting – the political and the technical. It is the combining of these that gives rise to a process of health targeting, at the end of which there is the requirement for decision-making about the allocation of resources. This is a political act, and politicians are confronted by the realities of scarcity and the difficult requirement that they might have to be explicit about both prioritisation and rationing.

The uninsured and the US presidential election

The United States is the only industrialised country that fails to provide for universal health care coverage for its citizens. In his first term, President Clinton attempted to introduce wide ranging health care reform but failed. Health care reform has, however, been placed on the political agenda again, primarily by potential Democrat candidates for the 2000 presidential campaign. This paper examines the arguments for and against the different proposals and, drawing on the experience of the Clinton reforms, discusses their feasibility in a changing context in America. Bradley's proposals are most developed and would achieve the widest coverage, but would be most expensive. Gore's proposals are more limited and less detailed. Among Republican potential candidates, health care reform has a low priority.



Elias Mossialos



Martin McKee



Alexandra Pitman

The United States is the only major industrialised country that has failed to provide basic health care cover for all its citizens. Indeed, between 1989 and 1997 the number of Americans with no health insurance cover increased by over 10 million, to an estimated 45 million.¹ By the time of the 2000 presidential election it is likely to have increased by a further 500,000.

Traditionally, those without cover were the most disadvantaged, in particular the poor, the unemployed, and non-whites. These groups have continued to be affected, and the largest absolute increases in the uninsured have been among black and Hispanic populations and those in poor or middle income families. However, since the early 1990s they have increasingly been joined by others who, in previous years, might not have considered themselves to be at risk of losing cover. Downsizing by employers has created a large pool of people in their late 50s and early 60s who, while no longer employed, are too young for Medicare cover.² Many small employers do not offer health insurance cover, so that 80% of the uninsured are now actually in employment or in families of someone who is.³ Indeed, some of the increases in the numbers of uninsured have been in north-eastern states that have achieved greatest economic growth. Although cross-sectional studies will capture many people who are experiencing a short period of uninsurance, with one in four Americans uninsured for at least one spell in a two year period, there remains a large number of people whose

chance of coverage continually recedes.

The fate of those who experience a period of unemployment is especially difficult. This includes growing numbers of people who are falling victim to an increasingly 'flexible' economy. A third of respondents in a 1996 New York Times survey said either they or a household member had experienced redundancy in the previous 15 years, whilst three-quarters reported that they or someone close to them had done so. Despite the 1986 COBRA legislation, subsequently extended by the Kennedy-Kassebaum legislation, which requires employers to provide access to their group insurance scheme (if they have one) for up to eighteen months after redundancy, albeit at the individual's expense, few unemployed people could keep up payments. Furthermore, after this period they must purchase individual plans that are much more expensive, prohibitively so if there is any evidence of a pre-existing condition, as premiums are risk-related.⁴

A further concern is the adverse effects of this system on children, up to 11 million of whom are uninsured,⁵ accounting for up to 30% of children in low income families in some states.⁶ 1997 legislation making available \$24 billion over five years to expand health insurance for children has had limited impact, with less than 25% of the funds available being used. Adolescents and especially those in disadvantaged families are especially vulnerable.⁷ However, even children and young people with nominal cover are falling foul of tighter eligibility rules,

“Downsizing by employers has created a large pool of people in their late 50s and early 60s who, while no longer employed, are too young for Medicare cover.”

with growing evidence that they are facing obstacles to uptake of services.⁸ These failings are attracting growing public attention, with the American Academy of Paediatricians launching its own proposals for universal child coverage.

Although it may be argued that the system does ultimately provide some forms of acute care for the uninsured, this care is often of poor quality and typically is received late in the course of the disease, when complications are more likely.⁹ It is also increasingly difficult to find as providers are forced to eliminate internal cross-subsidies between different categories of patients. Furthermore, while the uninsured might receive treatment in emergencies, they are substantially less likely to receive preventive services despite their greater need.¹⁰

At state level, some legislatures have attempted local solutions, such as expansion of Medicaid and various insurance reforms (such as low-cost plans, subsidies, risk pooling, open enrolment, continuity of coverage requirements, and community ratings). However few have succeeded in increasing health insurance coverage and those that have worked have achieved only limited impacts.¹¹

In these circumstances, in which those on middle incomes are increasingly insecure, there is a high level of support for change.¹² Despite the failure of President Clinton's 1994 proposals, a majority of voters nonetheless favour covering the currently uninsured and particularly children and those with low incomes. This is reflected in the decisions of both leading Democratic candidates, Gore and Bradley, to make access to health care a central issue of their campaigns. In this paper we examine the various plans, asking whether they have any greater chance of success than the failed Clinton plan. In particular, will they resonate with the American electorate, especially given that many of those most disadvantaged by the existing system either do not have a vote, being children, or are among the approximately 50% of adults who, while eligible, choose not to vote?

The Clinton reforms – why they failed

Clinton's health initiative to provide health insurance for all Americans was sent to Congress in 1994 as an effort to provide 'universal coverage', following promises made during his bid for the presidency in 1992. He ran on a strong programme to develop comprehensive health reform, which contrasted strongly with Bush's laissez-faire attitude. Health care reform had been seen as a way of winning middle-class votes from the Republicans. The plan seemed to be a compromise between marketists and medicalists, falling between market tendencies and governmental involvement in health care.¹³ It was designed to produce 'competition within a set national budget' and relied on five basic elements:

- the creation of 'regional health alliances' to organise and regulate the regional health insurance market;
- quality and regulatory standards for health insurers and managed-care plans, determining the price at which products could be sold through the health alliances, which products each health plan must include, and the level of

deductible and co-payments to be charged;

- employers were to make premium payments to the alliances on behalf of their employees, with the promise of federal subsidies for the smallest companies (employers of low wage earners);
- consumer choice for health plans on the basis of price to encourage cost-containment;
- regulation of the rate at which alliance premiums could rise, with a national cap forming the budget under which competition would operate.

The plan is said to have failed for a number of reasons. These include lack of coalition building or attempts to achieve public support, unanticipated crises both at home and abroad that distracted government attention from reform, a loss of presidential credibility as control of congress appeared to slip away, pressures from small businesses (many of which felt threatened by the reform), and aggressive lobbying by the health care industry, particularly medium and small insurance companies which would have been forced out of business by the legislation.

Although many in the industry did favour the reforms in principle, they were unwilling to make any form of sacrifice themselves, either in terms of profits or disrupted regimes and they spent in excess of \$100 million to raise public doubts.

The healthcare industry was supported by anti-government conservatives working through a network of organisations and the media (including the influential Christian Coalition, and the National Federation of Independent Businesses). These groups were highly effective in spreading the message that acceptance of the Clinton plan would lead to a 'welfare state' with health care rationing. The media seized on this, with *Readers' Digest*, *Policy Review* and talk radio shows portraying the Clinton plan as a bureaucratic takeover which would increase costs and tax many jobs and businesses out of existence.

Clinton's reforms were also intro-

duced at arguably the worst possible time. The president faced the legacy of 12 years of Republican rule that had created a massive federal budget deficit and an accentuation of the traditional climate of distrust of the role of government in American life. The policy was constrained by the perceived need to avoid words such as 'tax' or 'government'. In this climate, critics of the federal government found it easy to accuse the plan of hurting small businesses, individuals and health providers as well as warning of rising taxes and the destruction of choice. Ultimately some used the health plan as a convenient opportunity to pursue their attacks on the institutions of government.

Although the Clinton plan would ultimately have offered coverage to millions of uninsured Americans and promised new security to those already insured, it also entailed many new regulations that would challenge insurance companies, health care providers, employers and state governments. While explicit opposition concentrated on criticism of the bureaucracy involved rather than admitting to pure self-interest, in reality many were convinced that the plan would bring few benefits except to the currently uninsured. The proposals were defeated in Congress in 1994 and not resurrected.

We now turn to the proposals by the leading Democratic candidates, Bill Bradley and Al Gore.

Bradley's proposals

Bradley plans to offer health coverage to lower income adults and children, either by expanding access to the Federal Government employees' health insurance scheme for its employees or by providing subsidies for private health insurance. He claims that his plan is an improvement on Clinton's because it is simpler, requires less bureaucracy, and gives people greater say over their insurance plans.

The plan is based on an extensive programme of tax credits designed to improve access to health care by providing funds to cover insurance to those on low incomes as well as the self-employed and those

employed in small businesses.¹⁴ Adults in a family of four earning less than \$16,400 and those currently enrolled in Medicaid will receive an annual tax rebate of \$1,800 which can be used to contribute to a health insurance premium (although this will leave a considerable out-of-pocket payment and leave coverage unaffordable for many). In addition, there will be a sliding scale of tax credits for those making up to \$32,800 a year.

The plan places a particular emphasis on children, seeking to provide cover for all under age 18 from birth.¹⁵ This will be achieved by means of refundable tax credits equal to the value of complete insurance coverage for children in families with less than \$32,800 in annual income, with smaller subsidies for families earning up to \$49,200. Both adult and child premiums are deductible from federal income tax, even by the self employed.

The estimated cost of \$55 million will be provided from the projected surplus arising from the 1997 Balanced Budget Act as well as from efficiency savings due to reductions in unnecessary medical procedures and administration.

Bradley has anticipated many of the possible criticisms, drawing extensively on the lessons of the Clinton plan. Clinton's vision of regional health alliances was criticised for creating more bureaucracy, and Bradley has refused to follow suit. Following another lesson from the past he will allow consumers to rely on existing private or Government insurance plans, allaying the fears about loss of choice that had plagued Clinton. Indeed, by opening access to the Federal Employees Health Benefits Programme (FEHBP), which covers government workers and their dependents and which offers generous benefits, he can be considered to have enhanced choice. Bradley's plan has been described as "less extensive and regimented than Clinton's complicated proposal" and it is clearly designed to appeal to middle class voters in that it plans to reduce health care costs for people in higher income brackets by excluding all health insurance premiums from

"Although the Clinton plan would ultimately have offered coverage to millions of uninsured Americans ... it also entailed many new regulations that would challenge insurance companies, health care providers, employers and state governments."

income tax. Indeed, while attracting some criticism from liberals for failing to offer universal coverage, he has attracted praise from moderate Republicans for the use of tax credits.¹⁶

Despite attracting support from moderates of both parties, some have voiced concern about its ability to cover the uninsured and support the growing cost of Medicare should there be an economic downturn. Others have argued that it will be difficult to set fair premiums for new entrants to the FEHBP without raising costs for existing members. A third criticism reflects its potential success as, it is argued, it may stimulate small businesses to cease their existing schemes and leave employees to enrol in the new scheme, thus transferring costs to the federal government.¹⁷

Gore's proposals

Gore's proposal is more modest than Bradley's. It proposes extending coverage to all children and about a third of the adults currently uninsured. He guarantees that under his plan every child in the nation would have access to affordable healthcare by 2005. He proposes a step-by-step approach to changing managed care,

“At first sight Bradley’s plan seems to reach many more people than Gore’s...it may be that the scale of Bradley’s proposed premium subsidies for the uninsured are insufficient to provide adequate health care benefits, or that those subsidies may contribute to rising costs in healthcare.”

expanding existing structures like the Children’s Health Insurance Programme and Medicaid to cover more families and individuals. As yet Gore has not announced how he plans to finance the proposal, an omission underlined by Bradley, but claims that it should not involve a tax increase. The key attraction of this plan to the American public is its provision for small businesses to come together to negotiate lower rates for their workers’ coverage and in providing a 25% tax benefits for the health insurance policies they offer.¹⁸ Small businesses proved to be a powerful lobbying force in the debate about the Clinton plan.

The incremental nature of the plan has attracted favourable comment, with some arguing that the boldness of Clinton’s plan contributed to its failure.¹⁹ On the other hand, Gore’s proposals are seen by some as over cautious, with some commentators calculating that a more ambitious plan would yield considerable economies of scale.²

Recently Gore has seized on a comment by Bradley that he felt so strongly about health care reform that he would even be prepared to raise taxes. Bradley has stressed that

he does not see such a move being necessary but it is now clear that Gore is seeking to make health care reform a major issue in differentiating the two Democrat contenders.²¹

The Republicans’ plans

In contrast to the two leading Democrat contenders, Republican hopefuls have had little to say on health care reform. We have been unable to find any reference to proposals by George W Bush. John McCain has been slightly more active but proposals have been limited. He has argued for federal support for health care provided to illegal immigrants that is currently funded by states, no doubt reflecting the high cost to states bordering Mexico, such as Arizona, which Senator McCain represents.²² He has also supported extension of a programme that tackles the shortage of health facilities in rural areas.²³ Finally, drawing on his personal experiences after adopting a Bangladeshi child with a severe cleft palate, he has put forward a bill that would prevent Health Maintenance Organisations from refusing to fund reconstructive surgery on children with severe deformities, as is increasing the case in the US.²⁴

Some clues about a possible Republican approach emerge from ideas pursued by the present House Republican leaders who, in September 1999 passed their own health plan, subsequently vetoed by the President. This would have been much less wide ranging than that put forward by Bradley or even by Gore. It envisaged tax breaks for people buying health coverage as well as a provision to allow opting out of the current health insurance market to buy medical savings accounts, which are savings plans with no risk pooling that produce high risks for the insured.²⁵

This is opposed by many Democrats on the grounds that it transfers an undue element of risk to the individual. The legislation would also give small businesses the option to buy health insurance under federal rather than state regulation, exempting them from state mandates that larger self-insuring companies now avoid.²⁶

A changed context?

In the aftermath of Clinton’s attempts to reform healthcare, candidates in the 1996 Presidential campaign, such as Bob Dole, repeatedly reminded the electorate of the plan’s failure, and criticised the involvement of the First Lady. However Clinton comfortably won his second term in office and did not seem to be damaged by the health reforms. Indeed a pre-election poll showed that 58% of Americans thought they would have been better off had the plan been passed.²⁷ So have things changed?

In 1993 America was in recession. This was an inopportune time to effect major social change. Yet following the 1994 elections, incoming Republicans also attempted to reform health care, planning to cut spending on Medicare and Medicaid so as to eliminate the federal budget deficit while reducing taxes. This also met with public opposition, in part because of its adverse impact on the elderly.

Major change has now been tried by both parties and has failed at both attempts. Instead, there seems more enthusiasm for incremental changes, some of which have been passed, such as the Kennedy-Kassebaum health legislation which requires employers to continue coverage for employees who switch jobs or become unemployed, without regard to ‘pre-existing’ medical conditions.²⁸

The nature of the public debate may also have shifted. Health Maintenance Organisations may have dampened spiralling increases in healthcare costs. However they have raised concerns about the quality of healthcare, a new issue for politicians to address.

One key factor may not have changed. The political composition of Congress is likely to remain hostile to expanded coverage. The Democrats seem unlikely to regain control of Congress in the immediate future and, since 1994 some moderate Republicans have been replaced by conservatives while divisions have appeared amongst Democrats, with some in favour of introducing market forces, and oth-

ers committed to universal coverage using existing programmes.

The challenge ahead

Presidential candidates seeking change must address the needs of the bottom three fifths of the income distribution who face real insecurity from the threat of illness with no money for essential care. However they face a major challenge from powerful anti-government forces.

At first sight Bradley's plan seems to reach many more people than Gore's and it also seems to have attracted considerable support or, at least, limited opposition, although this may change as Gore increasingly attacks it. There are, however, many details yet to be clarified. It may be that the scale of Bradley's proposed premium subsidies for the uninsured are insufficient to provide adequate health care benefits, or that those subsidies may contribute to rising costs in healthcare.

A key question will be how many of the uninsured actually assert their democratic right to vote. Voter participation has declined significantly in recent decades, and is particularly marked amongst lower income Americans. In the 1989 Congressional elections health care (specifically Medicare reform, the uninsured and managed care reform) were perceived as important issues at the polls, but not the most important ones. It is notable however that those who voted for Democratic candidates ranked health care higher than did those who voted for Republican candidates. In a contradictory fashion voters seemed to view health reform as a priority for the next Congress rather than as a voting issue in the election of the time. Whilst voters seem keen for health care reform (particularly of Medicare and managed care) they appear to be less affected in their choice of candidate at the polling station. This may be because although the majority believes that radical health care reform is needed, no-one can agree on how it can best be done.

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Health of the nation

The new Minister for Health and Community Care in Scotland reflects on the opportunities created by the Scottish Parliament and Executive for improving the health of the Scottish people. She sets out the aims of the current Executive and the policy programme planned to achieve them.



Susan Deacon

Good health is the most precious individual possession. Sadly, too many Scots are deprived of this. Now, as a nation, we have the unparalleled opportunity offered by the new Scottish Parliament to rid Scotland of its reputation as the 'sick man of Europe'.

Scotland now has its first democratically elected Parliament in over 300 years. A Scottish Parliament promises to deliver a better quality of life and better opportunities for the people of Scotland.

In July 1999 I became the first Scottish Minister for Health and Community Care. Immediately obvious was the fact that nowhere can the Scottish Parliament better demonstrate a capacity to make a real improvement to the lives of those we represent than in the fight to improve the health of the people of Scotland.

The Scottish Parliament offers scope for distinctive Scottish solutions and flexibility to concentrate resources and coordinate efforts to the best effect. The health programme, which has since been set out, recognises the necessity of tackling the root causes of ill-health and their links with poverty.

Recognising the problem

Much of Scotland's ill health is preventable. Yet, previous Governments chose to ignore the most telling cause of poor health: poverty. Times have changed. It is no longer acceptable to attempt to address the symptoms of ill health, without diagnosing the causes and then prescribing the cure.

"public health has been designated a crosscutting issue by the Scottish Cabinet ... the National Health Service in Scotland does not carry a health improvement monopoly. Ministerial colleagues in Education, Enterprise and Justice all have a part to play."

Public health is central to the Scottish Executive's priorities and there is now a commitment to tackle the years of neglect, which have seen the health of our poorest people get worse and inequality flourish.

Improving public health for this Executive is not just a necessary task. It is a conviction, an imperative.

Statistics that show 400,000 people in Scotland on income support, 27,000 houses classified as below tolerable standard, and over 530,000 houses affected by dampness and condensation, demand action. These statistics translate into ill health. Health is worst where people are poorest. Where deprivation is greatest, adults die prematurely, the rate of teenage pregnancies is highest and children have the poorest oral health.

The Scottish Executive will not tolerate this situation in the future. Health inequalities are an intolerable blight on the modern, equal Scotland that the Scottish Executive is determined to achieve.

Scotland is now getting workable strategies that strike at the heart of the problem and provide solutions and that will deliver long-term success. These are substantial measures, which make the best use of what we have got, and bring every potential contributor together in an all-out offensive to improve the health of Scots.

A foundation to this is the White Paper 'Towards a Healthier Scotland', published in February 1999. It was fully endorsed by the Scottish Parliament in the following September, and is a watershed in the history of public health in Scotland.

Reflecting the complexities of ill-health

This document demolished once and for all the argument that poverty, unemployment, environment and social exclusion had no impact on health. Instead it proposed a concerted, three pronged approach – tackling life circumstances, encouraging healthier lifestyles, and homing in on particular topics such as coronary heart disease, children's health and teenage pregnancies. Underpinning all this was an assault on health inequalities. The White Paper is the platform on which the Scottish Health Programme will build.

To achieve a healthier Scotland we need to be bold, imaginative and brave, and practical as well, catching the tide of change within society.

Public health is defined as “the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society”. The “organised efforts of society” are particularly important. Individual responsibility is right and it is essential; but to reach their full potential, individuals need the organised support of the society around them.

This might mean good quality education, a warm and comfortable house, a safe environment, the feeling and reality of being part of a community – to feel included. That is what the Scottish Executive is all about. Better schools and housing, a cleaner environment, safer communities, social inclusion, higher employment and worthwhile jobs.

Identifying solutions

A new childcare strategy; helping parents into work or training. The new community schools programme assisting pupils to increase their educational achievement through the integrated provision of services, including health and social work. The ‘Warm Deal’ for the elderly ... all of these are the essential ingredients of a long-term solution, creating the conditions in which good health can flourish. Transforming, slowly but surely, life circumstances, hitherto the harbinger of sickness and disease, into a catalyst for better health.

In relation to lifestyle, a determined drive against smoking is being mounted. We are totally committed to an advertising ban. We will give practical help as well for those who want to give up but have difficulty in doing so, especially the disadvantaged, by providing funding specifically for smoking cessation, and for the provision of initial free supplies of nicotine replacement therapy for the less well off.

Drug misuse commands the headlines, and for good reason. The collective will and resources of the Scottish Executive are being brought to bear in confronting this pernicious modern scourge. Tackling drugs misuse is a priority that requires crosscutting action across traditional departmental and organisational boundaries. Alcohol misuse is another feature. We are working on a national Alcohol Strategy to ensure effective coordinated action across Scotland.

Diet too remains a real concern in Scotland. The appointment, in the near future of a national diet coordinator is a vital step in the drive to accelerate, yet further, the implementation of the Scottish Diet Action Plan. The Plan provides the comprehensive framework within which we are working to tackle our dietary problems. Low-income communities experience the worst health of all the population, and their diets are a particular priority. The Scottish Community Diet Project and an increasing number of Community Food Initiatives, are making a particular, and major, beneficial impact on the diet, and health, of many Scots.

“The Scottish Parliament offers scope for distinctive Scottish solutions and flexibility to concentrate resources and coordinate efforts to the best effect ... we have the unparalleled opportunity ... to rid Scotland of its reputation as the ‘sick man of Europe’.”

The challenge is to ensure that all these welcome, health-enhancing measures are brought together in a coherent way, which ensures maximum health gain. That is why public health has been designated a cross-cutting issue by the Scottish Cabinet. Implicit in that is recognition that the National Health Service in Scotland does not carry a health improvement monopoly. Ministerial colleagues in Education, Enterprise and Justice all have a part to play.

That, too, is equally true in the front line. Local authorities, schools, voluntary organisations, as well as the NHS, have a crucial role to play in health improvement. The key is maximising their contribution. I am setting up structures that bring together representatives from the key sectors with an interest in health to monitor, support and push forward the implementation of the White Paper.

Programmes of action

There are two particular, medium-term, public health priorities. The first is to improve child health and the other is to tackle teenage pregnancies and sexual health. It is increasingly clear that improving the health of mothers and children lays the basis for better health in later life. Maternal health, breastfeeding, maternal and early childhood nutrition, parental

“previous Governments chose to ignore the most telling cause of poor health: poverty.”

lifestyles, the home environment, parenting skills and child care, have a profound impact on patterns of health and disease in later life. Cancer, stroke and heart disease rates, as well as mental health are all affected by childhood health.

Four health demonstration projects announced in the White Paper – backed by £15 million of new resources – will all be under way by spring 2000. They should help make considerable inroads into reducing health inequalities and provide test-beds for bringing together the principles set out in the White Paper, building on best practice from UK and abroad, developing new approaches and providing scope for innovation and new thinking.

‘Starting Well’ will focus on the promotion of health and protection from harm in the period leading up to birth and throughout the first five years of childhood.

‘Healthy Respect’ will foster responsible sexual behaviour on the part of Scotland’s young people with emphasis on the avoidance of unwanted teenage pregnancies and sexually transmitted diseases.

‘The Heart of Scotland’ will focus on the prevention of heart disease, recognising that many of the measures likely to be used

(for example, healthy diet, exercise and avoidance of tobacco) will help reduce the incidence of cancers and strokes.

‘The Cancer Challenge’ will add a screening programme for the early detection of colorectal cancer to existing screening programmes (for breast and cervical cancer) and take forward the new measures to combat the cancer-promoting effects of tobacco smoking.

Fluoridating the water supply is also back on the agenda. It is a controversial issue that needs to be tackled in order to bring lasting improvements to child dental health, especially those who are disadvantaged. We await the conclusions of a current review of the safety of fluoridation. The Scottish public will be fully engaged and informed in the debate on this important issue.

We have an unprecedented opportunity to create a healthier Scotland and to drive down health inequalities. All the necessary ingredients are there. A new Parliament. An energetic and committed Executive. I want a committed public health workforce – ministers included – empowered, resourced and energised in order to claim a new future for our people – a prosperous and healthy Scotland.

How a new English health agency can benefit European health development

“While the new H.D.A. is being born in England, to play a full role it is essential that it grows up in Europe.”



Clive Needle

Forget the *Millennium Bug*. Is *Millennium Fever* (MF) treatable as a communicable disease? Politicians display the worst symptoms – an inability to pen an article without standing on the threshold of a new age – but it does seem rife throughout much of the media, commerce, sport, and also European health policy? Well, M.F. does have an inevitable dynamic and a heady mix of desirable and dangerous elements, so there are some parallels.

Donald Reid’s welcome for the bright new English Millennium baby, the Health Development Agency (*eurohealth* 5:3), avoided such clichés but posed some perti-

nent questions about what will be a demanding infancy. However, although he didn’t mention that M word, he excluded the E word too. While the new H.D.A. is being *born* in England, to play a full role it is essential that it *grows up* in Europe. Let me explain why.

The role of parliament

During the coming year alone, health related issues will play a hugely significant role in EU development. Come with me amongst the ‘chattering glasses’ of the European Parliament to visit its newly reformed committees that scrutinise every matter affecting 400 million citizens:

Stop first at the traditional home of health, the Committee on Environment, Public

Health and Consumer Policy. In the Autumn edition of *eurohealth* its new Chair, Dr. Caroline Jackson, reminded us of the range of issues before it. Very soon it will consider the urgently needed new health framework and a new Directive on blood, as well as the massive high profile body of work on food and consumer safety. Given the parliament's power of co-decision, there will be some big tests of MEPs' priorities on integration, inequalities, impact assessments and interpretation of the Amsterdam Treaty as well as budgets, and some fascinating tests of their readiness to distinguish between populist single issue campaigns and evidence based horizontal measures. Clearly information sources will be crucial.

But we have little time to pause, for in the sixteen other committees decisions are being taken affecting health back home. The question is whether the *politicians* understand that they are affecting health; and how are they coordinating their work? The background is the imminent enlargement of the EU, with the myriad of health problems and opportunities that are belatedly being addressed, from capacity to culture to cross border freedoms. The *acquis communautaire* may be modest – but the opportunities and challenges are huge, and largely under emphasised until recently.

The EU's existing Internal Market is also creating responsibilities as well as rights. European judges already have before them several key tests of those new boundaries that could impact on services and products in the health sector; an eye-opening seminar run by EHMA in Brussels in November demonstrated how far reaching those rulings could become. So are the MEPs in the Economic, Legal Affairs or Citizen's Rights Committees consulting with patients and health professionals, or just governments?

New technologies are revolutionising potential diagnoses, treatments and prevention; the ways in which health products are being traded is changing beyond recognition. So what is the health basis for decisions in the Media or Industry committees? How are health inequalities tackled in the Social Affairs, Equal Opportunities or Regional Policy Committees? When the glaring nonsense persists of a pittance spent to fight cancer against a fortune ploughed into tobacco, where is the coherence between the Agriculture, Budgetary and Environment Committees? How will the 1999 ministerial declaration on health,

transport and environment be driven on? Where the EU is a lifeline for seventy of the poorest countries in the world, how are Europeans ensuring health gets the priority it deserves in Trade and Development too?

That poses enough questions to demonstrate how the decisions being taken now in the name of the new century will be having a lasting effect on health as a whole, not the narrow interest implied by the old 'public health' attribute. The 'public' should be more to the fore in the decision making process. Dr Jackson did not mention that every European can scrutinise the work of parliamentarians without traipsing to Brussels or Strasbourg. Agendas, minutes, many speeches, voting records and documents can all be accessed via www.europarl.eu.int/, and every MEP has email provided in his or her office. Health professionals should keep in touch.

MEPs are, of course, just one inexpert access point into the European decision making process. But in seeking to inform them, how much does the world outside know? I have been impressed to discover how many exciting international health developments and projects exist, but alarmed at how little appreciation the majority of national and local health professionals have of them, and therefore how much their value is diminished.

Independent agencies and bodies

The useful news briefing in Autumn *eurohealth* was largely provided by your editors and the Network of Health Promoting Agencies (ENHPA), one of a handful of invaluable organisations, like the European Health Management Association (EHMA) or the European Public Health Alliance (EPHA), who graft from Brussels to inform and influence health development across the continent. Ironically ENHPA was partly created by support from a body that ended with the century, the UK Health Education Authority, and one that had to change to survive, the European Commission. So there is good work at EU level, but is it getting national support in the UK? Let us look at three pieces of evidence readily to hand, from the UK *Health Service Journal* of 25th November:

- A survey of Primary Care Groups identifies clinical governance, prescribing, IT and commissioning as priorities. Health improvement does not feature in the report.
- One year after the Acheson Report, a

“When the glaring nonsense persists of a pittance spent to fight cancer against a fortune ploughed into tobacco, where is the coherence between the Agriculture, Budgetary and Environment Committees?”

“Although the health of the continent’s citizens may never have been better as a whole, the potential threats are clear and exacerbated by isolationism or restriction of debate to narrow regimes.”

review praises forthright government economic actions, but fears health inequalities may worsen with relative poverty increasing and growing regional imbalances.

- The renowned Professor David Hunter bemoans the rarity of UK health services seeking to learn from abroad. He calls for a new way of “capturing knowledge gained across healthcare systems and using it to inform policy changes in various countries” rather than “needlessly reinventing the wheel.”

It seems there is scope for some health improvement.

Simultaneously, Tilman Togel, a German representative in the Committee of the Regions, a consultative body for EU regional and local governments, has produced a series of recommendations on how those bodies should play a greater role in developing European health policies. Other conferences talk of local government ‘seizing’ the new health agendas. Every day, printers chatter in regional offices across the continent as new links and programmes are formed.

Yet who decides which are the appropriate researchers, what are the reliable evidence bases, who forms the networks, which skills are exchanged, even who goes to the seminars? When the projects are underway, how are results evaluated, communicated and disseminated? Are valuable funds being properly used or just shared amongst cliques? Who advises government advisors and the health attaché network in Brussels? How accountable are all those scientific, technical and management committee representatives who determine the actual programmes? Would it not be better to ensure all that information is collated and easily accessible? Where better could a new agency start to provide a useful service?

The need for communication and coordination

The new Commissioner and Director General for Health and Consumer Policy have had an unenviable start, full of arguments over dioxins and beef. They deserve every encouragement and will need all possible support from the health community, not least to press on from principles to priorities, within an imaginative new framework that received a wide consensus of support when proposed in draft in 1998. That support has to be practical, and the best way to demonstrate the added value of international cooperation is to ensure accu-

rate information and communication for mutual benefit.

That is where the new UK Health Development Agency can ideally meet needs. As Donald Reid rightly pointed out, an initiative to provide a coordinated, evidence – led base for public health in England is welcome. That role is clearly separate from any delivery or programmes. It must be about communication, and coordination is vital. When I recently asked how a new English regional observatory might link into European networks, I was met with puzzled looks. That should not happen after years of discussion about EU health monitoring in the current framework.

There is terrific work on integrated health development policies underway across Europe, but it tends to be too fragmented and staccato. There are several sustainable urban networks but they are often seen as driven by competition for resources rather than collaboration for common good. All those initiatives exploding from newly devolved regional or national bodies (the splendid Welsh proposals on health impacts have just arrived as I write) need a spider sitting at the hub of the web, not to control, but to empower. The new Health Development Agency, working with others, can start to be that spider, coordinating in England and communicating beyond. It should not be spinning a web to suit any government alone, for it must merit a most non-arachnid confidence and trust from the communities with whom it seeks partnership. As new opportunities beckon and awareness increases, not least amongst patients and users, so do pressures to deliver, from leaders in the capital cities, in Brussels or Geneva, to the front line providers.

Time for a new politics

It is a most stimulating, fascinating, unprecedented time for international health development. That is why a year ago I urged MEPs, Ministers and Commissioners to set out a European Decade for Health. Although the health of the continent’s citizens may never have been better as a whole, the potential threats are clear and exacerbated by isolationism or restriction of debate to narrow regimes. Professor David Hunter concluded by urging “a new politics to confront the public policy challenges posed by globalisation ... combining vision with leadership.” That seems to me to be an antidote to Millennium Fever worth striving for.

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FOOD SAFETY AND THE WHITE PAPER ON FOOD

Revelations about food manufacturing practices, the recent dioxin and BSE crises, and uncertainty about the effects of hormone treated beef and genetically modified food have generated much public concern about the issue of food safety.

The Commission has presented a **White Paper on Food and Safety**, which includes an Action Plan that sets a clear timetable for action over the next three years, including options for the establishment of a **European Food and Public Health Authority**. All Commission proposals, including a fundamental review of food law, shall be put forward before the end of 2000. On this basis the EU will establish a coherent and up-to-date body of food legislation by 2002.

During the Food and Tobacco Federation Conference on the 19th November 1999, the EU's Health and Consumer Protection Commissioner, David Byrne elaborated upon the contents of the White Paper and its three aims.

The first aim of the White Paper is to modernise food safety legislation and to develop a single, coherent body of legislation that is flexible enough to respond to advancing scientific knowledge, new production techniques and the discovery of new health hazards.

The White Paper's second aim is to increase the capability of the EU's scientific advice system to respond rapidly and effectively to situations

concerning food safety. The EU has already reinforced the European Food and Veterinary Office (FVO), which has recently moved from Brussels to Dublin. The Commission will present options to further improve scientific advice at European level and a number of options concerning a European Food and Public Health Authority.

The report *A European Food and Public Health Authority: The future of scientific advice in the EU*, contains recommendations on the creation of a European Food and Public Health Authority (EFPHA). The report is available on: http://europa.eu.int/comm/dg24/health/sc/future/_food_en.html

The third aim of the White Paper is to reinforce food controls 'from stable to table'. Currently, food control is conducted at three different levels. Industry conducts its own checks. Member States have the responsibility to carry out controls at all levels of the food chain, and the Commission's Food and Veterinary Office (FVO) controls the performance of national authorities in Member States and third countries. The Commission believes that additional legislative proposals are needed to improve the functioning of the system. The Commission should, for example, be given more legal authority to control and inspect at all levels of the feed and food chain.

BST considered risk free

BST (Bovine Somatotrophin) is a hormone that increases milk production when injected into dairy cows. In the opinion of the European Medicines Evaluation Agency on Veterinary Products (CVMP), which has reviewed all the scientific data currently available, there are no public health grounds for establishing a Maximum Residue Limit for BST. The Commission therefore decided on December 8 that BST is risk free, having earlier adopted a proposal to ban the use and marketing of BST in the EU from January 2000.

Anglo-French Dispute on British Beef

The dispute between the UK and France arose because of French failure to lift the ban on British beef, despite the fact that EU veterinary experts pronounced that it is safe for human consumption. Germany has also refused to lift its ban, owing to obstruction in the Bundesrat by some Länder.

Exports of British beef were abruptly halted in March 1996 after UK scientists identified a potential link between BSE and CJD (new variant Creutzfeldt-Jakob disease), a disease that can be fatal to humans. This worldwide ban was lifted on August 1, 1999. France, however, informed the European Commission on October 1, 1999 that it would not lift its embargo on British beef, on the basis of advice from its recently established National Food Agency.

The EU's Scientific Steering Committee (SSC) evaluated the evidence presented by France and on October 29 concluded unanimously that there was no need to change their previous opinions on the safety of British beef. On November 16, The European Commission decided to initiate formal legal proceedings against France for not fulfilling its obligations under Commission Decisions 98/256/EC and 99/514/EC relating to the lifting of the embargo. David Byrne has called on the German government to act on its promise to lift the import ban on British beef.

SLUDGE

France's continued ban on British beef was made more politically sensitive by the disclosure of findings by the Commission's veterinary inspectors that some French animal feed manufacturers have been using treated sewage sludge, which might include human faeces, as a protein rich ingredient for meat meal.

The Commission's Food and Veterinary Office inspection was carried out from 19-20 August, in response to press reports on the use of sludge in animal feed. There have been similar allegations against feed manufacturers in other countries, including Belgium and the Netherlands.

Sewage sludge is included amongst the list of ingredients whose use in compound feedstuffs is prohibited by Commission Decision 91/516. The European Commission has brought forward legislative proposals that will prohibit the use of all residues obtained from wastewater processes in feed manufacture.

HEALTH COUNCIL MEETING

The Health Council, under the Finnish Presidency met on the 18th of November 1999.

Community Strategy in the Field of Public Health

Commissioner Byrne informed the Council about the proposal for an **Action Programme on Public Health**, which is currently being developed and about the **Fourth Report on the Integration of Health Protection Requirements in all Community Policies**, that was recently adopted. The Council welcomed the plans of the Commission for the Action Programme, which according to the Finnish Health Council President Eva Biaudet will represent a new qualitative step for public health in Europe. The Council noted the need for a wide cooperation in the sector and welcomed the Commissioner's idea of creating a European Health Forum. The Council acknowledged that, in order to achieve a high level of health protection in Europe, existing mechanisms had to be strengthened and new ones possibly created.

The Council adopted a Resolution on ensuring health protection in all Community policies and activities. The Resolution "reaffirms the previous invitations to the Commission regarding the protection of health in Community policies and activities". It invites the Commission to include in the Action Programme ideas on the elements and structures that should be introduced to ensure that all Community policies meet the obligation to protect public health. It also encourages the Commission to further develop a health impact assessment of Community policies

Antibiotic Resistance

The Council took note of the Commission's intervention and of the Presidency's intention for future action following a Resolution that was adopted on Antibiotic Resistance in June 1999. The Council's conclusions, which focus primarily on veterinary and feeding stuffs-related aspects of antibiotic resistance, were submitted to the Agriculture Council in December 1999.

and activities and to set up a network of experts to advance the use of methods, skills and common terminology applicable at Community level. In addition, the Resolution urges Member States to take health impact into account in all Community policies that they propose and implement, and to assess the health impact of Community policies and activities implemented at the national level.

An interim Report from the Commission to the European Council, the ECSC and the Committee of Regions on the implementation of the Commission's Action on the prevention of cancer, AIDS and certain communicable diseases and drug dependence within the Framework for Action in the field of public health (1996-2000) is available on: http://europa.eu.int/comm/dg24/health/ph/programmes/pr01_en.html

Tobacco Consumption

The Council heard a presentation by Commissioner Byrne on a proposal for a directive adopting measures regarding the manufacture, presentation and sale of tobacco products which aims at strengthening the existing directives concerning the labelling and content of tobacco products. The Council adopted Conclusions on the Commission's report on progress achieved in relation to public health protection from the harmful effects of tobacco consumption. During a policy debate on this issue Member States welcomed the Commission's proposal and outlined action that could be taken at Community level to support national efforts to combat tobacco consumption.

Health Issues beyond the Present Borders of the Union

In accordance with the conclusions adopted by the Council on 26 October 1999, the Council will evaluate, on a regular basis, the progress made in the aim to increase cooperation in the sphere of public health between applicant countries and EU Member States. The Council agreed on a negotiating position in relation to the Euro-Mediterranean Conference of Health Ministers that was held in Montpellier, 2-3 December 1999, in the framework of the Barcelona process. (See News in Brief)

Promotion of Mental Health

The Council adopted a Resolution on the promotion of mental health, one of the priorities of the Finnish Presidency.

The Resolution 'recognises that mental health is an indivisible part of health'. Amongst other things, it invites Member States to give due attention to mental health and to strengthen its promotion in their policies. The Commission should consider incorporating activities on the theme in the future Action Programme for public health and develop and implement a Community health monitoring system. It should consider producing a report on the issue and analyse the impact of Community activities on mental health. The Council also invites the Commission to consider, after consultation with the Member States, the need to draw up a proposal for a Council Recommendation on the promotion of mental health.

Pharmaceutical Dossiers

The Council took note of the progress achieved on the deliberations concerning a proposed **Directive on the implementation of good clinical practices in the conduct of clinical trials on medicinal products for human use**. It proposed an amendment to the **Directive concerning medical devices**, regarding medical devices incorporating stable derivatives of human blood or human plasma. Both proposals are based on Article 95 of the Amsterdam Treaty and are discussed in the framework of the Internal Market Council.

A NEW DIRECTORATE GENERAL ON "HEALTH AND CONSUMER PROTECTION"

Amongst the first series of reforms implemented by the Prodi Commission in the effort to "... re-engineer, adapt and improve the organisation to make it more efficient and more effective" has been the establishment of a new Directorate General (DG) for "Health and Consumer Protection". The Commission's Unit on Public Health, which previously fell under the Employment and Social Affairs Directorate, has been incorporated into this new DG.

The mission of the new Directorate General is to ensure a high level of protection of consumers' health, safety and economic interests as well as of public health at the level of the European Union. To this end, the DG has been organised into six Directorates: Consumer Policy, Scientific Health Opinions, Coordination of Horizontal Questions, Food and Veterinary Office, Public, Animal and Plant Health, and Public Health.

In the area of consumer safety and health the DG's main activities will be to propose and monitor legislation in the areas of veterinary, animal feed and phytosanitary matters. It will manage European scientific

committees concerned with consumer health and carry out inspections within the EU and outside, to ensure that rules of hygiene and food safety are respected throughout the food production process. The new DG will aim to protect consumer's economic interests by, amongst other things, proposing and monitoring legislation, reinforcing market transparency, and improving consumer confidence, especially through more complete and effective information and education. On Public Health, the new Directorate will assure a high level of human health protection in the development of all Community Policies, and take actions to improve public health in the European Union, to prevent human illness and diseases and to remove sources of danger to human health.

David Byrne, former Attorney General in Ireland, has been appointed Commissioner of the new DG. Mr. Robert John Coleman, a qualified lawyer who studied at Oxford University and in the United States and who previously headed the Transport Directorate-General, has been appointed the new Director-General.

For more information on the DG Health and Consumer Protection look at the website http://www.europa.eu.int/comm/dgs/health_consumer/index_en.htm

EU AND US LEADERS MEET TO DISCUSS TRADE ISSUES

During their meeting in October to discuss the agenda for World Trade talks, European Commission President Romano Prodi and US President Bill Clinton agreed to launch a dialogue between EU and US scientists in a bid to defuse damaging trade rows over food safety issues such as genetically modified foods.

The move aims to close the gap between the two scientific communities over controversial health issues and is designed as an interim measure until the EU sets up its own food and drugs agency. The leaders also discussed a new "Non-Hormone Treated Cattle" (NMTC) programme that was launched in the US in September 1999. The EU's Food and Veterinary Office will

review this new programme, and reassess the situation regarding exports of beef from the US. In view of the wish to stimulate 'trade creation' rather than 'trade distortion', the two parties are looking into compensatory measures to replace the retaliatory measures that the US imposed upon the EU over the latter's ban on hormone treated beef.

Further Commission Reform

Following the first series of changes, the Commission is now embarking on the creation of an overall reform programme.

The reform programme aims at introducing a culture of change within the Commission, to increase the institution's efficiency, accountability and transparency, and to foster the ethos of public service. The measures to achieve this will be set out in the Reform Strategy Programme that includes detailed plans for future change and a full timetable for implementation. This Programme will be published in February 2000. A new Task Force for Administrative Reform (TFAR) has been set up to steer the process.

For more information about Strategic Reform Issues, see the Communication by Commission Vice President Neil Kinnock on this subject, available on: http://www.europa.eu.int/comm/reform/index_en.htm.

Commission Communication on the Precautionary Principle

Before the end of the year, the Commission shall present to the Council and the European Parliament a Communication on the precautionary principle.

The Communication aims to determine the criteria and situations under which the precautionary principle should be applied. The idea behind the precautionary principle is that provisional safety measures should be taken when there are safety concerns and where scientific information is incomplete. Given the constantly advancing nature of science, scientific information is always incomplete. The Communication therefore tries to clarify how complete scientific knowledge must be, how much of a health concern there must be and in whose mind it must exist, before trade restrictive measures are introduced on the basis of the precautionary principle.

MENTAL HEALTH

A European Conference organised by the Finnish presidency on the Promotion of Mental Health and Social Inclusion was held from the 10-13 of October 1999 in Tampere, Finland.

In an address to the Conference, Commissioner David Byrne concurred with the conference statement that "there is no health without mental health" and discussed the role that the EU can play in making a real contribution to promoting improved mental health. All Community policies should be closely monitored for their potential contribution to mental health, in accordance with provisions of the Amsterdam Treaty.

Mr. Byrne stated that while mental health has not been given direct priority within the EU's current public health framework, it has received much emphasis under the Health Promotion Programme and the Health Monitoring Programme that fall under this framework. Under the Health Promotion Programme, for example, concrete priority has been given to mental health promotion for children up to 6 years of age. Under the Health Monitoring Programme, a European network of mental health promotion has been established to collect information about existing relevant databases, information systems and indicators

to give recommendations concerning data collection. A 'key concepts' project is addressing the need for clearer European definitions of mental health and for better indicators to measure the effects of mental health promotion and care. Comparable and reliable information will lead to the further development of mental health policies.

Mr. Byrne stated that the Commission is to present its recommendations on the promotion of mental health to the Council. He believes that mental health will have a significant place in the public health framework that will replace the existing framework after 2001. Preparations for this new framework are currently underway.

One of the issues discussed during the Conference were the effects of unemployment on mental health. According to Professor Augustin Ozamis from the Basque Health Service, unemployment clearly has various negative effects on mental health. He believes that the EU's employment policies should include a mental health component, and that Member States should cooperate to

develop common concepts and actions. Health service, education, employment policy and social welfare should all coordinate efforts at the regional level to design joint strategies for mental health promotion.

Another issue discussed during the Conference was the application of information and communication technology in the prevention of mental health. According to Teuvo Peltoniemi, Head of the Information Unit of the Finnish A-Clinic Foundation, telematic methods in substance abuse prevention have proved to be very advantageous and user-friendly. Mr. Henry Haglund, Head of Unit for the Information Society Promotion Office at the European Commission, presented a new programme by the Commission that opens possibilities for providing telematic services to all citizens.

For more information on the conference please contact: Professor Ville Lehtinen, STAKES, Finland e-mail ville.lehtinen@stakes.fi or look at the STAKES website <http://www.stakes.fi>

LIFE WEEK

The LIFE programme is a Community action devoted to supporting environmental protection in Europe and in bordering regions.

The programme supports environmental policy by funding innovative local initiatives, testing new ideas and techniques at grass root level, and providing good practices of sustainable development. LIFE "Week", held in Brussels 20-23 October, encouraged the dissemination of knowledge in environmental protection accumulated over seven

years through the LIFE programme.

Set up initially in 1992, the LIFE programme was extended for a second phase until the end of 1999. It is now about to enter its third phase and the LIFE III programme (2000-2004) is currently under discussion in the European Parliament and the Council of Ministers.

Global Assessment on Environmental Programme

On November 24, 1999 the European Commission adopted a Global Assessment on the overall results of the European Union's Fifth Environmental Action Programme. Serious environmental problems such as increasing amounts of waste, summer smog in cities, chemical dispersion into the environment, climate change and bio-diversity losses, remain in Europe and globally.

The Report will be available on the Environment DG's website: <http://europa.eu.int/comm/environment/newprg/index.htm>

CLIMATE CHANGE

The Environment Commissioner Margot Wallstrom launched an action programme in mid October to combat climate change, as part of her efforts to persuade EU governments to do more to cut greenhouse gas emissions.

The Commission released its annual ozone reports that give an overview of ozone pollution in the EU for 1998 and for the summer of 1999. The reports conclude that ozone pollution in the EU is still a threat to human health and vegetation.

The reports are available on: <http://europa.eu.int/comm/dg11/air/ozonerep.htm>

NEWS IN BRIEF

First Meeting of Euro-Mediterranean Health Ministers

The first meeting of 27 Euro-Mediterranean Health Ministers was held in Montpellier, France on the 2nd and 3rd of December, 1999. The Conference emphasised that health threats, such as communicable diseases, know no borders, and are therefore relevant to both the Northern and Southern dimension of the European Union. Vaccinations are cost-effective means to combat diseases. Equally important are measures outside the actual health sector, such as safe drinking water and safe food. The Euro-Mediterranean ministers adopted the first political declaration on future cooperation in the field of health.

High level Committee Meeting on Health

About thirty high-level civil servants working in the field of health in EU Member States met in Helsinki on 26-27th October to discuss the future of public health programmes in the EU and the impact of other EU policies on health. Representatives of applicant countries were invited to take part in the second day of the meeting, where they discussed their participation in activities relating to the EU's health policy.

EU ban on phthalates in childcare articles and toys

The European Commission will adopt proposals for an emergency ban on sales of some oral baby toys softened with chemicals believed to be toxic. Representatives on the Emergencies Committee set up under the General Product Safety Directive, composed of representatives of Member States, unanimously endorsed the Commission's draft decision (approved on 10 November) to ban certain oral baby toys made from polyvinyl chloride (PVC) that have been softened with phthalates. Tests have shown that babies may ingest quantities of two phthalates (DINP and DEHP) that

exceed the levels considered safe by scientists. The Decision marks the first time that the Commission has instigated an immediate ban under the General Product Safety Directive. The Decision will enter into force before the end of 1999. (1 December)

New Directive on the protection of workers at risk from explosive atmospheres

The European Parliament and the Council of Ministers have confirmed the full agreement on rules for the protection of workers at risk from explosive atmospheres. The successful result of this conciliation procedure is particularly noteworthy as it is the first legal act in the health and safety area to be adopted under the co-decision procedure as a result of entry into force of the Amsterdam Treaty. (1 December)

Labelling GMOs

EU governments backed the European Commission's proposal to require companies to provide information labels on foods if any ingredient in a product contains more than 1 percent of genetically modified soya and maize. Although the decision applies only to these two substances, it is likely to set a precedent for other substances. The proposal will probably be followed by a formal Commission proposal. Environmental Groups such as Greenpeace have argued that the threshold of 1 percent is too high and the proposals are likely to face opposition in the European Parliament

Conference on screening and early detection of Cancer

A European Conference on screening and early detection of cancer, sponsored by the "Europe Against Cancer" Programme and organised by the Austrian Cancer Society of Vienna, took place in Vienna on the 18-19th of November 1999. The ultimate goal of the Conference was to adopt European guidelines to implement cancer-screening programmes in such a way as to max-

imise resources available. Scientific participants at the Conference recommended that the best way to do this would be to offer healthy people only those screening tests that have proved to decrease the incidence of cancer. At present these methods are: pap smear screening for cervical abnormalities starting at the latest by age 30 and not before age 20, mammography screening for breast cancer in women aged 50-69, and faecal occult blood screening for colorectal cancer in men and women aged 50-69. The Commission services will examine, on the basis of these precise guidelines, a proposal for a Council recommendation on cancer screening in the EU.

The Commission adopts funding provisions for its annual animal disease eradication programme

In the year 2000, as in previous years, the European Union will co-finance programmes of the Member States aimed at the eradication of animal diseases and at the prevention of zoonoses. The diseases targeted by the programmes have implications for both human and animal health. The European Commission has adopted two decisions listing 41 programmes covering 14 diseases and qualifying for a 50% financial contribution from the EU.

Commission presents report on human exposure to dioxin

The Environment Commissioner Margot Wallstrom has presented a study on the most current dioxin exposure and health data in the EU, entitled "Compilation of EU Dioxin Exposure and Health Data". The report concludes that despite the fact that dioxin levels have been decreasing in recent years, in all countries for which data is available for the last 10-15 years the daily intake of dioxins and dioxin-like compounds remain above the recommended levels for some parts of the population. The study can be downloaded from the following website: <http://europa.eu.int/comm/environment/dioxin/index.htm>