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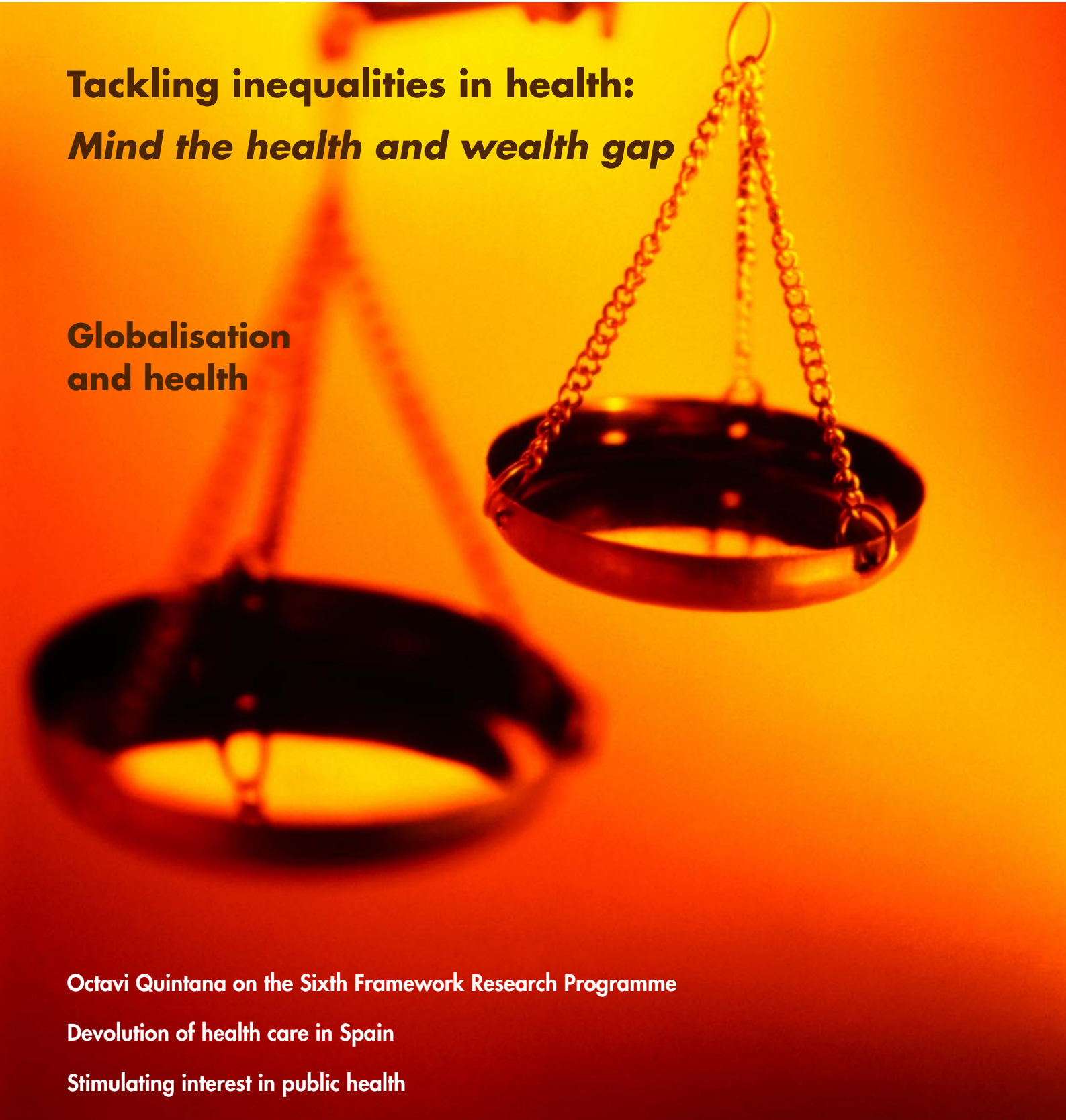
**Tackling inequalities in health:
*Mind the health and wealth gap***

**Globalisation
and health**

Octavi Quintana on the Sixth Framework Research Programme

Devolution of health care in Spain

Stimulating interest in public health



COMMENT

Tackling inequalities in health: a global challenge

Regardless of healthcare system, some degree of inequality in health outcomes is inevitable; this reflects informed individual choice, for instance on lifestyle and diet. Many inequalities in health however are not a consequence of free choice. Final outcomes, as well as access to and utilisation of health promotion and health care interventions will be influenced by factors beyond individual control. For instance individuals may be genetically predisposed to disease, they may live in abject poverty, have little education, be unemployed or suffer from social exclusion. They may have to contend with environmental hazards, such as industrial pollution. Many of these factors are external to health care systems. If governments' desire to promote policies to tackle health inequalities and promote health, this is unlikely to be achieved through investment in health care systems alone. A 'joined up' approach integrated with other agencies such as those responsible for employment, social security, environment or education at local and national levels is required. Evidence of some recent and on-going cross sector initiatives in Europe is provided in this issue.

While such approaches, taking account of evidence on effectiveness and costs may help reduce some health inequalities within countries, these problems are also in part a consequence of global actions, requiring global solutions. Globalisation has witnessed increased movement of labour and goods both within and between nations (including illicit activities), widespread international travel heightening the risk from communicable disease, and more recently the threat of global bio-terrorism. The growth in world trade in the last fifty years, while leading to phenomenal economic development, some contend is heavily slanted in favour of major trading nations in the developed world. Income and health inequalities between the developed and developing world continue to grow.

World Trade Organisation initiatives to promote free trade may increase economic prosperity. Such prosperity it is argued has a beneficial impact on health and the development of health care systems. Others dispute this, claiming that trade exploits the developing world, and can even have a harmful effect on health. They suggest that the health consequences of globalisation need to be taken much more seriously, and that international bodies require an even more coordinated approach to address health aspects of globalisation. Some of these issues on health and globalisation are discussed in this issue.

One way of building on existing joint initiatives in setting common standards and developing strategies for tackling global problems, would be greater facilitation by international agencies of the exchange of knowledge on innovations and experience across countries. The links between economic development and health need to be strengthened. The WHO Commission on Macroeconomics in Health recently estimated that carefully targeted investment in health in developing countries of \$66 billion per annum by 2015 could save more than 8 million lives and produce substantially greater economic benefits of \$360 billion per year by 2020. In Europe the newly launched Sixth Framework Research Programme recognises the importance of developing networks for knowledge exchange in public health across Europe. Our challenge is to create global networks to address the interface between sustainable economic development and health.

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*Interview with Paul Belcher,
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Congratulations on your new post. Could you describe your areas of responsibility in the European Commission's Directorate-General for Research?

My responsibility is to manage and promote the creation of the European Research Area, in life science concerning medical and health research. Specifically this means the implementation of the new 6th Framework Programme for research, technological development and demonstration activities (FP6). The services under my responsibility will work to establish Priority 1 as a reality, that is advanced genomics and applications for health, combating major diseases including cancer and poverty-linked disease. The Framework programme states that the objective in the medical field is to develop improved patient-oriented strategies for the prevention and management of disease and for living and ageing healthily. This work also includes the Article 169 initiative to bring about a national and European programme for clinical trials in poverty-related diseases. I also have responsibilities for elements of the Framework Programme, such as policy-oriented research and coordination activities, as well as the continued implementation of the fifth Framework Programme (FP5), which is in its last six months.

With the launch of the new Sixth Framework Research Programme you have arrived at an exciting time of change. Could you outline the health aspects of the new programme?

There are four main areas of major relevance to health research in FP6. These include Priority Theme 1: genomes and biotechnology for health where a budget of €2.2 billion is anticipated. This priority has been devel-

oped to respond to the new and unprecedented opportunities offered by the sequencing of the human genome both to improve human health and also to stimulate industrial economic activity. Genomic research relevant for human health will be supported, as will mechanisms to accelerate the transfer of results from basic research to the bedside.

A second area is the fifth theme: food quality and safety with a budget of €685 million. This is aimed at ensuring the health and well-being of citizens through a better understanding of the influence of environmental factors and diet on health. This end-user approach is reflected in seven research objectives including: epidemiology of food-related diseases and allergies, impact of food on health, 'traceability' along the production chain, detection, control and safe production methods, as well as the impact of animal feed on human health.

An eighth theme focuses on supporting policies and anticipating the EU's scientific and technological needs, this sets the context for the EC's public health policy. It concentrates on the development of strategic positions on the cutting edge of knowledge, anticipating major issues facing European society including public health.

Lastly under the heading 'Strengthening the foundations of the European Research Area' support for the coordination of activities is provided. One area covered is health where related activities will be implemented, for instance through coordination of research and comparative studies, the development of European databases and interdisciplinary networks, the exchange of clinical practice and coordination of clinical trials.

There appears to be a greater focus on clinical, biomedical research priorities rather than on policy-related research compared with the previous programme. What future is there for 'public health and health services' research in FP6 as we appear to have lost the FP5's specific focus on these areas?

I believe the focus has not been lost but rather has become more intense. In order to move towards the creation of a European Research Area, initial analysis indicated that critical mass needs to be created in terms of financial, material and human resources, that flexibility of human resources and mobility of researchers, engineers and technicians has to be tackled, while improving the general working and research environment in order to attract scientists. The result therefore is a concentration of research efforts on selected priority fields.

This principle is a major new policy direction, requiring a difficult policy choice largely avoided in previous framework programmes, with the inevitable result that the research effort was spread too widely and too thinly. Concentration is essential to achieve added value in European research integrating national potential and achieving the critical mass required by scientific and technological progress in a global world. Public health is not lost, one of the essential aims under Priority 1 is the translation of new knowledge into applications that improve clinical practice and public health. Surely health services' research will play a part but probably within the framework of a much larger patient-oriented strategy than in previous programmes.

The section on policy-oriented research will also offer opportunities for public health and health services' research especially in the context of efficient health care systems. Health care systems of all member states are under increasing pressure to cope with population demands. An ageing population, technological innovation and greater patient expectations are likely to continue to exert pressures on social welfare systems, and health systems in particular, over coming years. This is a priority policy area for the European Community.

The new research programme aims to contribute to the implementation of other EU policies including the new EU health programme. How will research priorities be decided?

The section on supporting policies will play a major role in the development of the European Research Area since policy-orientated research will help to create a more efficient environment for policy research. It provides policy actors throughout the EU with a facility to access relevant Community research. It makes the link between research and policy stronger, more responsive and more coherent. It also opens opportunities for research support in a wider range of policy areas. Public health can be found in the strand on "providing health, security and opportunity to the people of Europe". This section must of course support the new EU health programme, calls for proposals must complement work envisaged by DG Health and Consumer Protection and where relevant by DG Employment. This is why there has been, and will continue to be, close collaboration between our services.

Just to mention some of the topics under this section, one finds health determinants, the provision of high quality and sustainable health care services and pension systems (particularly in the context of ageing and demographic change), public health issues including epidemiology contributing to disease prevention, responding to emerging rare and communicable diseases, allergies, procedures for secure blood and organ donation and non-animal testing methods, and quality of life issues relating to handicapped/disabled people (including equal access facilities)

In the past some have criticised the evaluation process for research proposals as being weighted towards scientific rather than policy relevant criteria? Do you think this is still the case?

First of all, we must not forget that we are talking about running a science programme and only the best scientific proposals are selected. In FP6, the philosophy and principles of evaluation will not change. However, a new element has been introduced, a specific budget has been earmarked for EC policies within the 'eight priorities' to

address policy relevant questions, and DG Research will assist in this process. Furthermore, scientific criteria will remain the most important element in the selection process.

You have received many thousands of responses to your call for 'expressions of interest' earlier this year. These will play an important role in deciding what research activities are actually carried out when funding comes on stream. Given the quite overwhelming response, how will you evaluate these 'expressions of interest'?

Indeed we have been hard at work evaluating the 3,000 plus expressions, an exercise allowing a bottom-up approach within the context of FP6. We are very pleased by the response and some very interesting ideas and areas have emerged. It is certainly a way forward for future evaluations. We have chosen to engage in a peer review of proposals and process, and as in the past, this has borne fruit, allowing us to identify cutting-edge research topics. We hope to publish the results early in the autumn.

There has been criticism of the dissemination of outcomes of previous programmes, particularly to potential users beyond the scientific community. How can that be improved?

One of the objectives of creating the European Research Area will be the development of a dialogue between science and society. This is a prerequisite for good performance of the sciences and building trust with society. Dissemination has an important role to play here, and is reflected in the criteria against which proposals for integrated projects and networks of excellence, for example, will be evaluated. We have just published an impact assessment of the BIOMED 2 programme under FP4 and these types of exercises will continue, but research of course takes time to mature. A separate but related challenge is to take these results and feed them into other on-going processes, such as policy-making. I hope that our Forum on 'Public Health Research and European Community Policies' at the European Health Forum Gastein, in September this year, will raise some interesting discussions and ideas.

Would it not be interesting to set up a 'public health research' task force in

FP6 to promote and coordinate and integrate public health aspects within DG Research and also with other policy directorates and external agencies?

This is an interesting idea, reflecting the way in which public health permeates various themes under the new Framework programme. Coordination is undoubtedly necessary, and to a large extent work to establish Priorities 1, 5 and 8 as realities will reflect this concern.

What input will DG Health and Consumer Protection have in writing the work programme for priorities 1 and 8?

All participating policy DGs will have equal input to the elaboration of the work programme, for both priorities 1 and 8. However the process is somewhat different for each. The call for expressions of interest affects only Priority 1, this will to a great extent determine the way forward in the theme. The distillation process for policy-oriented research started over a year ago, and the Commission in November 2001 presented an amended proposal concerning FP6, incorporating policy priorities. I must say that we enjoy good working relationships with our colleagues in DG Health and Consumer Protection.

What is your vision for the future of public health and health services research at EU level?

Public health is an area of major concern for all European citizens. The issue occurs ever more frequently and is increasingly evident on the political agenda. Many Directorates are involved, for example: Health and Consumer Protection, Employment, Environment, Enterprise, Information society, Internal Market, even the Joint Research Centre covers public health activities. Then we have agencies such as EMEA European Agency for the Evaluation of Medicinal Products and the EMCDDA European Monitoring Centre for Drugs and Drug Addiction covering public health. My vision is that these activities should be carefully coordinated and that all these initiatives should be complementary. DG Research should be providing the policy DGs with elements for questions and issues that they encounter while dealing with public health matters.

Mind the health and wealth gap



Clive Needle

“Surely it is the duty of policy makers to prioritise actions to address greatest need and promote quality of life?”

European governments will no longer meet in a single Health Council. Bureaucracy streamlining means that a new combined council for Employment, Social Policy, Health and Consumer Affairs will be established. Is this just administrative shifting of deck chairs or politically significant? Some will argue that this means a reduction of the EU health policy element just as it becoming important, taking us back to the bad old days when health was subservient to employment policies. Others will contend that a new opportunity has been created to prioritise an aspect of public health that has so far been largely neglected by European policy makers: the health equity gap.

Eurostat reports that health is of increasing importance to social and economic development and of prime concern to most Europeans.¹ We are living longer in good health and differences in life expectancy *between* member states are fairly small. Yet *within* states differences in life expectancy and health status are quite substantial. Only 72% of people in low-income groups are satisfied with their health compared to over 90% in the highest income groups. The links between health status and factors such as income, education and employment are well documented. Women tend to live longer but the evidence suggests that their quality of life is generally poorer, particularly in those extra years. By 2004 there will be ten new member states, it would be a mistake to treat them homogeneously, but life expectancy remains lower and health status is more affected by national spending on health care than in western counterparts.

As the EU and member states grope uncertainly towards dealing with market realities in health care systems, *Eurostat* states:

- “Health is created, by and large, outside the healthcare sector in settings of everyday life. The ways in which policies in other areas are organised have a profound effect on the health of populations.
- The healthcare sector often pays for

mistakes being made in other policy areas. Healthy longevity requires a life-long process of maximising opportunities for economic, physical, social and mental well-being.

- Health promotion and primary health-care are the most cost efficient health interventions and with the best population health gains.
- Health promotion offers a comprehensive approach, ranging from the personal responsibility to make the healthy choice, to public policy options which support the healthy choices and environments.”

Indeed, not conference rhetoric, but backed up by statistical evidence from various sources. So will the EU turn evidence into policy and into practice?

Commission action

On examination of the Commission website (www.europa.eu.int) for information on social inclusion, DG Social Affairs and Employment pages contain Community Action Programmes to combat social exclusion and discrimination, European Council objectives and decisions, joint reports, common indicators and National Action Plans against poverty and social exclusion. The European Foundation for Living and Working Conditions is well established and active. Splendid, but where is the health community contribution? Certainly, contained within actions are health related projects, but there is relatively little evidence yet of input or definition. Whenever I ask health policy, research or care organisations how they contributed to the consultation required within National Action Plans, I receive quizzical responses. This tallies with work on links between health status, poverty and social exclusion, where the health/exclusion interaction is comparatively less developed.

The website for Health and Consumer Protection is being revamped, but it is striking how little interaction there is with a field that *Eurostat* reports to be a major determinant of health, and how thin and vertical are the contents. That is less the fault of unevenly resourced Commission services, than the realities of political priorities and legacy of dubious legal bases. Perhaps key figures do not want EU action to help those who may need it most? I recall a (former) senior health official saying that in his home country “peasants” enjoy the best health as they eat little but fresh food, the main problems concern the well-off!

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Perhaps measures to address health inequalities should be left to national health systems? Certainly it was the most controversial aspect of my report on the future of EU public health policies.² Some argued that I wanted to make all hospitals provide the same. I do not, but in a modern Europe, where the health of millions is affected by EU decisions, whether travelling across borders or set in communities, surely it is the duty of policy makers to prioritise actions to address greatest need and promote quality of life?

Although health policy makers tend to dwell on the restrictions of Article 152 of the Treaty, others look at the ambitions of Article 2: "to promote economic and social progress ... and to achieve balanced and sustainable development ... through the strengthening of economic and social cohesion."³

Work on health at EU level must be of benefit to all 370 million citizens. Nevertheless it is contrary to the fundamental objectives of the social and economic entity that has become the rapidly enlarging EU, that the health and life expectancy of a diner in one of the many elegant restaurants in Brussels, Luxembourg or Strasbourg is likely to be hugely better than the person serving or washing the plates. Much more needs to be done as a new EU Health Action Programme begins in 2003.

Initiatives across Europe

A two-year EU wide project, coordinated via the European Network of Health Promotion Agencies (ENHPA), to examine how health promotion can address health inequalities, came to a useful conclusion earlier this year, following meetings to agree recommendations in the European Parliament and with Ministers.⁴

To follow up, seminars have been held in Prague and Budapest to share and apply learning to EU candidate countries. Attention should also be paid to separate and successive EC funded work, lead by Professor Mackenbach, which will contribute to the general body of evidence, in particular to the field of women and tobacco.⁵

The Portuguese Ministry of Health contributed greatly to the ENHPA project and sets out here its perspectives on national activities. Portugal has made highly visible use of significant regional and social funding from EU programmes, including initiatives for health. EU funding has generally been well applied by regional and local

authorities, but it has been less well integrated with health communities because of subsidiarity misunderstandings. Not so in Wales where the European dimension is integrated with national initiatives in interesting ways, as the article by the Minister for Health and Social Services in the Welsh Assembly Government explains.

In England the national prioritisation of work to address health inequalities is highlighted by the Health Development Agency, amid rumours of the possible establishment of a new national centre to specialise in equity policies. Finally, as part of the Danish Presidency, a European Conference on social inequalities in health in children and young people will take place in Copenhagen in December. The organisers describe their objectives and how the conference builds on previous work.

Conclusion

So does that suggest national interest, commitment and some appreciation of the potential EU dimension? The imperative now transfers firmly to the Commission. There are relevant actions concerning indicators, impact assessments, and social and economic determinants contained within provisions of the new programme. There are encouraging indications of stronger partnerships than hitherto between relevant Commissioners and the World Health Organisation. The European Commission multi stakeholder Health Policy Forum is poised to study the link between health and social policies. There is a new dynamic to inter service coordination across policy sectors. Yet it is difficult to be convinced that tackling the health aspects of social inequalities will be given sufficient priority to make a real difference: one that would do much to improve how the EU is perceived.

Do we need more studies or more practical interventions? Probably both. Do we know which interventions work? Not sufficiently. Have needs and benefits been communicated well? I suggest not, proactive articulation of the case by health professionals to policy makers will be necessary to increase priority.

When politicians sit in their big new Councils, usually they will not be health experts. They have political priorities that may well conflict with the needs of huge numbers of European citizens, who fall into the health and wealth gap in the single market. It is a challenge for the health community to ensure that effective policies and programmes are put on to Council agendas.

"It is a challenge for the health community to ensure that effective policies and programmes are put on to Council agendas."

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Europe supports health promotion as a method to tackle social inequalities in health



Catherine Ancion

“It is essential to develop more effective strategies to enable disadvantaged groups to have a better control over their health behaviour and other determinants that influence their health.”

Despite the existence of a well-developed healthcare system in the EU, its population continues to be affected by social inequalities in health, morbidity and mortality. This has led to increasing policy attention at regional, national and European levels. Although social inequalities in health can, to some extent, be addressed through improved curative healthcare, reducing them also requires the use of health promotion strategies specifically targeted at the socioeconomically disadvantaged. Research has revealed that traditional health education messages tend to be ineffective among the socially disadvantaged, whose daily confrontation with a harsh socioeconomic reality often leads them to give a lower priority to their personal health. For this reason, it is essential to develop more effective strategies to enable disadvantaged groups to have a better control over their health behaviour and other determinants that influence their health.

In order to explore these strategies, the Flemish Institute for Health Promotion

(VIG) coordinated a two-year research project in collaboration with the European Network of Health Promotion Agencies (ENHPA). The purpose of this project, which involved the participation of experts from 13 EU countries and Norway, was to examine the availability and extent of information with regard to social inequalities in the different European countries, develop policies and health promotion strategies for the reduction of inequalities in health, and reach a consensus and better communication at a European level.

Methods

To reach these objectives, a twofold approach was used. To assess the availability and extent of information related to social inequalities in health within Europe, a systematic literature review of health monitoring systems and indicators in EU member countries was performed, using Nutbeam’s health promotion outcome model¹ (see Figure 1).

Figure 1
OUTCOME MODEL FOR HEALTH PROMOTION

Health and social outcomes	Mortality and morbidity (e.g., chronic disease, perceived health)			DISTAL
Intermediate health outcomes	Healthy lifestyles (e.g. smoking and dietary habits)	Effective health services (e.g. access to and use of services)	Healthy environments (e.g. housing, working conditions)	
Health promotion outcomes	Health literacy (e.g. knowledge, attitudes, skills)	Social mobilisation (e.g. community development)	Healthy public policy and organisational practice	
Health promotion	Health Education	Facilitation	Advocacy	

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Source: Nutbeam D, 1998.¹

Various information sources were consulted, including information from Ministries of Health and Social Affairs, National Institutes for Statistics, reports and other information from National Institutes for Public Health or Health Promotion, review studies from the European Working Group on Socio-Economic Inequalities in Health, and references from studies in the international literature. The latter were identified using the Health-Promis database of the Health Promotion Information Centre at the Health Development Agency (HDA), using the following key words:

- Socioeconomic status OR inequality.
- Health OR mortality OR morbidity.
- Cohort studies.
- NOT United States.
- NOT Canada.

Additionally, use was made of the OECD Health Database, as well as the European Health and Safety Database (HASTE) developed by the European Foundation for the Improvement of Living and Working Conditions.

The second stage of the project focused on the practice of tackling health inequalities through health promotion and furthering the policy environment. National coordinators and experts were selected in each member country to collect data and supply information, in the form of a national report, on policies, strategies and the practice of tackling health inequalities within the context of health promotion (see Figure 2). Reports were received from Austria, Belgium, Denmark, Finland, Germany, Greece, Ireland, Italy, the Netherlands, Norway, Portugal, Spain, Sweden and the United Kingdom. France, Iceland and Luxembourg were not able to allocate sufficient resources to produce a report within the timeframe of the project.

Findings

A total of 67 policies and 60 interventions were described in these national reports. Using these national contributions, VIG issued a research report *The Role of Health Promotion in Tackling Inequalities in Health*.² Two initial drafts of this report were distributed to national coordinators and experts in June and August 2001. Their comments and corrections were included in the final version of the research report, published to coincide with an expert seminar on the *Role of Health Promotion in Tackling Inequalities in Health*, held on September 28–29, 2001 at the European

“There is a growing tendency within governments towards joined up policy making in areas which have traditionally been determined independently, such as education, employment, housing, and health.”

Parliament in Brussels. During this expert meeting, specialists refined the recommendations of the research report and reduced their number to eight. These eight consensus-based recommendations focused on:

1. *Identification and promotion of national and regional health targets focussing on health inequalities.* Defining national health inequality targets requires reliable data and evidence that go beyond mortality and morbidity statistics, and which are concerned with determinants of health. For governments, health inequality targets not only provide a clear framework for relating health inequalities to the overall aims of health services. They also serve as a symbolic statement of support to the active reduction of health inequalities.

2. *Integration of health factors into other policy areas and the importance of cross-sectoral policies.* Since social inequality in health is such a complex problem, involving the entire domestic and professional environment of the socially disadvantaged, health promotion workers need to cooperate with partners from other professions and sectors. Likewise, there is a growing tendency within governments towards joined up policy making in areas which

Figure 2
KEY STEPS IN THE PROJECT

Phase 1 (July 1999–December 1999)
Selection and appointment of key informants (national coordinators)
Agreement of theoretical basis and definitions
Design and agreement of proforma/questionnaire and analytical framework
Data collection – construction of national reports (including consultation of experts)
Phase 2
Report assessment and follow up further information
Analysis
Report – findings, conclusions and recommendations

“cooperation at the European level should be encouraged to enhance the comparability of data on health inequalities and to develop guidelines for data collection.”

have traditionally been determined independently, such as education, employment, housing, well-being and health.

3. *Recognition and encouragement of the community development approach as a way of tackling social inequalities in health.* Working at the local or neighbourhood level often has more immediate effects than working at regional or national level. It also lends itself much better to the formation of cross-sectoral networks, which are vital if health issues are to be tackled across other closely related policy fields, such as housing, transport, leisure, education or the environment. Besides this geographic focus, a community approach based on participation and involvement is well suited to serving the needs of a particular type of vulnerable group, through a closer and better understanding of these needs.

4. *Reduction of barriers that prevent effective utilisation of healthcare and prevention services by socially disadvantaged and vulnerable groups.* Accessing healthcare and prevention services can be very difficult for certain groups in society because of language or cultural barriers, or due to legal or financial problems. Solutions include the use of cultural interpreters/advocates, the training of ‘peers’ within the same community or the establishment of outreach services.

5. *Importance of good monitoring systems and indicators to measure health inequalities.* More specifically, there should be more data uncovering the determinants of health (behaviour), such as structural factors and health literacy, rather than just mortality and morbidity. This information should be gathered according to social class, gender, ethnicity, etc. Cooperation at the European level should be encouraged to enhance the comparability of data on health inequalities and to develop guidelines for data collection.

6. *Use of health inequality impact assessments as an effective means of tackling*

health inequalities. The European Centre for Health Policy (ECHP) has defined health impact assessment as “a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.”³ This last element is of crucial importance for tackling health inequalities: it must ensure that an assessment is not only made of the aggregate impact of the assessed policy on the health of a population, but also on the distribution of the impact within the population, in terms of gender, age, ethnic background and socioeconomic status.

7. *Allocation of sufficient financial resources and training for the evaluation of health promotion initiatives/policies focused on the reduction of social inequalities in health.* Without the information which evaluation provides, it is difficult for project approaches to be replicated, or for practitioners and policy-makers to learn from a project’s successes, or failures.

8. *Creation and encouragement of opportunities to disseminate models of good practice.* For example, by creating a database for interventions that have successfully reduced health inequalities.

The above-mentioned recommendations were used in an awareness campaign to promote the issue of inequalities in health, in EU member states and at a high political level. Eight recommendations were presented to the Health Ministers of the European Union in November 2001, during the European Health Council. A round table conference on the issue of inequalities in health took place in Brussels in December 2001, in the presence of the federal and regional health ministers of Belgium, as well as Commissioner Byrne and high-level representatives from EU and accession countries. This conference recognised that social inequalities in health were a political priority at European, national and regional levels. Congratulating the Flemish Institute for Health Promotion on its research, policy-makers recognised the importance of health promotion as a method to reduce social inequalities in health. The Danes also promised to take up the issue of social inequality in health during their EU presidency in 2002.

Further information on the project *The Role of Health Promotion in Tackling Inequalities in Health* can be obtained at www.eurohealthnet.org and clicking on the link for Inequalities in Health.

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National perspectives on health inequalities in England



Yve Buckland

“The NHS Plan contained a commitment to reinforce local action by setting the first ever national health inequalities targets.”

The change of government in the UK in 1997 brought an immediate shift in public health policy in England – from a focus solely on individuals and their lifestyle choices towards a focus on the broader determinants of health and health inequalities (see Box 1). Emblematic of this shift were the creation for the first time of the post of Minister for Public Health with responsibility ‘for attacking the root causes of ill health’,¹ and the establishment of an independent inquiry to report on the state of the evidence on inequalities in health.²

Target setting

The national public health strategy for England, *Saving Lives: Our Healthier Nation*,³ made reducing health inequalities one of the twin aims of public health policy, alongside improving the health status of the population as a whole. It set national ten-year targets for cancer, coronary heart disease and stroke, accidents and mental health, but declined to set national health inequalities targets, preferring instead to give local agencies the responsibility for jointly setting local inequalities targets.

The following year saw a change in political sentiment in favour of national targets so that the plan for modernising the national health service in England, the NHS Plan,⁴ contained a commitment to reinforce local action by setting the first ever national health inequalities targets. The purpose of these targets was to help ‘narrow the health gap in childhood and throughout life between socioeconomic groups and between the most deprived areas and the rest of the country’.

The Department of Health set up a number of taskforces to oversee implementation of the various aspects of the NHS Plan. One of these was the Inequalities and Public Health Taskforce and a key task was to lead the development work on national targets. After much debate about technical issues, these were published in February 2001, as follows:

Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole.



Nick Doyle

Box 1

DETERMINANTS OF HEALTH AND HEALTH INEQUALITIES

Fixed	Social & economic	Environment	Lifestyle	Access to services
Genes	Poverty	Air quality	Diet	Education
Sex	Employment	Housing	Physical activity	NHS
Ageing	Social exclusion	Water quality	Smoking	Social services
		Social environment	Transport	Leisure
			Alcohol	
			Sexual behaviour	
			Drugs	

Source: Department of Health, 1998

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Starting with health authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

These 'headline' targets are part of a suite of targets which also include national targets on reducing teenage pregnancies, smoking and, most ambitiously, ending child poverty:

By achieving agreed local conception reduction targets, to reduce the national under 18 conception rate by 15% by 2004 and 50% by 2010, while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter.

To reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010.

To make substantial progress towards the eradication of child poverty by reducing the number of children living in child poverty by a quarter by 2004.

“There is a strong cross-government interest in tackling social exclusion, of which inequalities in health are an important dimension.”

A consultation document⁵ on a 'delivery plan' for meeting the targets has proposed that the priorities for action should be: promoting health in pregnancy and early childhood, promoting opportunity for children and young people, strengthening disadvantaged communities, improving primary care services, and tackling the wider determinants of health.

The implication of these priorities is that government departments other than the department of health, and national, regional and local organisations other than the health agencies, particularly local authorities, must play a crucial part in meeting the health inequalities targets.

Towards an inter-sectoral approach

What are the prospects for an inter-sectoral approach to public health? Fortunately, there are some favourable trends. For example, there is a drive to make all government policy more 'joined up' and partnership-based. Also, there is a strong cross-government interest in tackling social exclusion, of which inequalities in health

are an important dimension. These themes of 'joined up thinking', partnership and social exclusion have been reflected in some innovative structural changes and initiatives.

At national level, the UK Treasury has imposed a more corporate approach on policy making. Individual government departments must now show how their spending plans help achieve overarching policy goals on abolishing child poverty, providing educational opportunity for all, increasing employment opportunity for all, raising prosperity, and delivering strong and dependable public services, all of which are of great public health significance.

A particular benefit of the Treasury approach has been the way it has focused attention on 'cross-cutting' issues, and there has been a cross-cutting spending review on health inequalities, led by the Treasury. Its effect should be to ensure that mainstream funding for public services, such as housing and early years provision, is 'bent' in such a way as to contribute towards the targets on health inequalities

Also at national level, there have been innovative attempts within central government to achieve better coordination of policies. The Social Exclusion Unit has been highly influential in developing cross-cutting strategies to tackle problems arising from social exclusion. The national strategy for neighbourhood renewal is the most significant of these,⁶ and can almost be viewed as an action plan on health determinants in England's most deprived areas, particularly as there are targets for the public sector in those areas covering housing, the environment, employment, education and crime, as well as health inequalities.

Additionally, there have been a number of centrally inspired but locally based programmes (though also complaints from locally agencies about 'initiative overload'). Among the most successful have been Sure Start and health action zones (HAZs). Sure Start (www.surestart.gov.uk) aims to improve the health and well being of families and children before and after birth, so that children can flourish when they go to school. The government sees it as the cornerstone of its policies on child poverty and social exclusion.

HAZs (www.haznet.org.uk) are partnerships between the NHS, local authorities, community groups and the voluntary and business sectors aimed at tackling health inequalities and modernising services through local innovation. There are 26

HAZs in England of varying sizes and covering over 13 million people. Although they will be winding down in the next year or so, HAZs are providing valuable learning about partnership working and integrated approaches to tackling health inequalities.

At a local level, new partnership bodies called local strategic partnerships (LSPs), are beginning to coordinate local planning by bringing together different parts of the public sector as well as the private, business, community and voluntary sectors. A core task of LSPs is to prepare and implement the community strategy for the area, i.e. the plan for promoting the economic, social, and environmental well-being of the community.

Local authorities have a leading role in LSPs but health agencies must play a full part, particularly primary care trusts, the new local health agencies responsible both for commissioning health care services and for public health. As enhancing community well-being and reducing health inequalities are intimately related tasks, the future should see increasing integration of the primary care trust's local strategic plan for health and health improvement the community strategy.⁷

Finally, the regional level of government is growing in significance: first as an administrative tier that ensures coordination of policies and initiatives coming down from central government; second, as a provider of developmental support for LSPs engaged in neighbourhood renewal in the most deprived areas; and third, as a focus for strategic planning concerned with economic, social and environmental regeneration. In the years ahead it may also be a new level of democratic governance.⁸

Conclusion

There are reasons to be optimistic about the chances of making an impact on health inequalities. There is high-level political support, there are targets to aim at, and a cross-sectoral infrastructure is beginning to emerge. However, there are also worries that perennial concerns about the performance of health care services will again distract policy makers from public health issues.

Furthermore, there are deficiencies in the public health system. For example, the *Saving Lives* strategy noted that the quality of public health practice was patchy. A particular concern was the lack of robust evidence to guide strategic planning, choice

of interventions, and as the basis for setting standards. It was for this reason that it announced the establishment of the Health Development Agency (HDA), with the dual task of identifying what works to improve people's health and reduce health inequalities, and supporting policy makers and practitioners in putting evidence into practice (see www.hda-online.org.uk/).

"A cross-cutting spending review on health inequalities, led by the Treasury, is almost complete."

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Approaches to address health inequalities in Portugal



Manuela Cabral



Pedro Ribeiro da Silva

“Cultural differences are an extremely important aspect of health promotion interventions.”

In Portugal, social policies related to disadvantaged people have improved dramatically over the last twelve years, both in quantitative and qualitative terms. One relevant reason for this improvement has been the inter and cross-sectoral approach adopted at all levels, from governmental policies right through to local interventions. Inter-sectoral work involves partnerships between health, social welfare, education, employment, housing, transport, and justice agencies as well as local municipality authorities and different non governmental organisations (NGOs).

In recent years many policies, regional measures and local interventions were implemented taking into account the needs of deprived populations vulnerable to social exclusion: low income families, at risk children, older people with no family support, disabled people, drug addicts, sex workers, homeless people, ethnic minorities including gypsies, Africans from Portuguese speaking countries, other immigrants and illegal residents.

Some examples of the main social policies, measures and interventions carried out include:

- Guaranteed minimum income.
- A network for combating poverty.
- An integrated program to support older people.
- A project promoting micro-enterprise (this policy measure was set up especially to tackle long term unemployment

problems faced by relocated disadvantaged populations).

- Projects to eliminate the exploitation of child labour, prevention of school dropouts and failure.
- Protection of disadvantaged and disabled children.
- Rehabilitation of people with disabilities.
- Social support and continuity of health care to dependent people.
- Accommodation and resettlement programs for deprived populations.
- Basic education programmes for travelling gypsies.
- Special professional training programs for ethnic minorities, immigrants, prisoners and the long-term unemployed.

A governmental institution was established for immigrant and ethnic minority groups, not only implementing measures to legalise their stay in Portugal but also guaranteeing them various rights: both to vote and be elected in local elections, to have access to school and professional training, to gather with their families, to take up employment, to have access to social protection, and live in decent surroundings.

The municipalities of Lisbon and Oporto, where most homeless people live, are continuously monitoring this group: collecting information on numbers, gender, and ways of living. They have created organisations in partnership with NGOs in order to provide shelter, food and washing facilities, the intention being to support individuals so that they may be fully integrated in society, with both employment and a social life. Drug addicts and people with HIV/AIDS have also been the object of governmental measures delivered by public

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institutions, municipalities and NGO's. They provide health care and some social support, (namely shelter, food and personal hygiene facilities) as well as rehabilitation and social integration programmes.

Gypsies

Gypsies, a minority group in Portugal, have access to some programs sensitive to their nomadic tradition, which involve members of their community as cultural mediators. Programmes for instance provide education, professional training and accommodation, in order to promote settlement and integration. These interventions are particularly important because cultural traditions and a high rate of illiteracy make engagement on health and social care issues difficult. Programmes are culturally specific, with teachers specially trained in gypsy history and custom. Gypsies acting as cultural mediators support schoolwork and serve as intermediaries between their own people, and other groups in society which are providing support. Goals include increasing awareness about health care needs, which in turn will increase uptake of vaccination programmes, as well as providing maternity and child health promotion/ health care services. Activities to combat racism complement this policy, racism prevention programmes are based upon the dissemination of information about customs and traditions, throughout municipalities where gypsies most commonly live.

Male and female prostitutes

There are several projects engaged with this population, but the Espaço Pessoa project is special. Taking into account the link between prostitution and social exclusion, this meeting and support centre for male/female prostitutes in Oporto city is really innovative and emerges as an attempt to address special needs, and improve living standards. The centre is not only concerned with sexually transmitted diseases and condom distribution, but principally adopts a psychosocial approach, improving self-esteem, and providing psychological and emotional support.

These prostitutes come from troubled low-income families in the lowest strata in society. They have poor educational attainment, illiteracy is high, and few have professional skills. Long-term unemployment, substance abuse and delinquent/illegal activities, act as a serious hindrance to attempts to improve their living conditions. The centre promotes their

empowerment, helping them take ownership and control of their daily lives. All key social and cultural partners are involved, addressing simultaneously various specific bio-medical, psychosocial and cultural needs. Training is provided in several different skills (literacy, computing etc), for use in different settings and contexts that provide an option for an alternative occupation in future, if they so choose. The centre also provides a breathing space to alleviate prostitutes' isolation and loneliness, allowing them to grow socially, culturally and in citizenship in a progressive and supported environment.

An intervention targeting legal and illegal immigrants

The *Quinta do Mocho* project in Lisbon is a good example of an intervention targeted towards legal and illegal immigrants. The majority of this group come from African countries (Angola, Cape-Verde Islands, Guinéa, San Tomé), fleeing from war, hunger and poverty in their countries. Again they are subject to a high rate of illiteracy, problems with housing and crime, are often unemployed or in poor, temporary jobs. Their children are victims of violence and sexual abuse, are not vaccinated, have a high dropout rate from school and suffer from nutritional problems. Adults may choose not to use health and community resources, for instance women wish to be self-sufficient and do not have assisted pregnancies.

This is a very complex group of problems, but the involvement of the target group in the development of the project since the beginning has been very important. They remain a key partner in developing action strategies, which are frequently amended as a result of their contributions. The training and role of *Health Promotion Peers* and *Health Cultural Mediators* had an outstanding and positive impact on the development of the project. All the strategic actions respect the culture and tradition of these populations. A final but crucial aspect was the acceptance and adaptation of health care professionals to the cultural differences and patterns of this population.

Conclusion

The Europe wide project coordinated by Flemish Institute of Health Promotion, *Tackling Inequalities in Health* is in our opinion very important, for several reasons. Research shows that in every European country there is a health gap between the

“Research shows that in every European country there is a health gap between the top and bottom social classes”

top and bottom social classes, and that this gap in life expectancy, for example, which could be five to ten years, is not decreasing but widening every year. An EU project is an excellent way to spread information on examples of best practice. In every country there are good health promotion projects, which help to tackle inequalities in health. Dissemination of this data is very useful for everyone working in the field nationally, or at local level. This information exchange helps facilitate partnerships and the implementation of a common policy acceptable for all EU countries.

Cultural differences are an extremely important aspect of health promotion interventions, directly related to human behaviour. This project provides data on the dissimilarity of cultural approaches between EU Members. This is fundamental when working together, to build a new and

stronger Europe, to facilitate communication and promote ways of dealing with problems, while decreasing ethnocentric views.

This project provides good tools to improve our knowledge of some of the causes of inequalities in health in the EU. It also informs on how to overcome obstacles that affect the health of disadvantaged people. Consensus is required between researchers to achieve a cross-sectoral approach and policy. This includes consideration of other political areas related to the determinants of health and well being, in both the strategy and fieldwork of *Tackling Inequalities in Health*. Finally we applaud the excellent coordination role of the Flemish Institute of Health Promotion in this project and the strong team spirit of expert members of the European Network of Health Promotion Agencies.

The Inequalities in Health Fund: *Helping disadvantaged communities*



Jane Hutt

“Action to promote healthy lifestyles is important but as an integrated part of wider action to tackle people’s social and economic circumstances and the conditions in which they live.”

While life expectancy in Wales is rising, health is not evenly distributed across the population. The lives of people in some of Wales’ most deprived communities are nearly five years shorter than those in its most affluent areas. This is unacceptable and is why reducing inequalities in health is one of the Assembly Government’s priorities.

Given that inequalities in health are the result of several interrelated factors, action is needed on two fronts. First, to address factors over which individuals can exert some control, for example, lifestyle choices and risks people take with their health. Second, to address factors that are beyond

individuals’ direct control, for example, social and economic factors. The Assembly Government’s approach encompasses both. Action to promote healthy lifestyles is important but as an integrated part of wider action to tackle people’s social and economic circumstances and the conditions in which they live.

We have in place a range of actions to address inequalities including healthy schools initiatives, health alliances and community food projects. Action on health also features in the work of other policy areas including, for example, the Assembly’s flagship community regeneration initiative *Communities First*, our National Economic Development Strategy and the European Union supported Objective 1 Programme.

Jane Hutt is Minister for Health and Social Services, Welsh Assembly Government, Wales, UK.

The Inequalities in Health Fund

While these initiatives and many others help to address inequalities in health, our *Inequalities in Health Fund* may be of wider interest given that inequalities in health are highlighted in the European Union's new Public Health Programme.

I am pleased to say that the idea received support across the political spectrum. I launched the Fund last year with a budget of £17 million (approximately €24 million) over three years. The Fund's purpose is to stimulate and support new local action to tackle inequalities in health and the factors that cause it, including inequities in access to health services.

Of the total budget, £14 million has been targeted at coronary heart disease as Wales' biggest health priority while £1 million per year has been allocated to specific action to reduce inequalities in dental and oral health.

Design

Given the Fund's purpose, and partnership working as a key principle, the core criteria for projects were:

- The involvement of primary health teams to enhance and expand their role in preventing ill health and in addressing inequalities in health.
- Action that reinforced partnership and joint working between organisations in the health, local government and/or voluntary sectors.
- Targeted action to help deprived communities and/or disadvantaged groups within the population.
- Action that helps to address inequalities in health and the factors that cause it, action that contributes to the National Service Framework for Coronary Heart Disease, and action that is consistent with the evidence base.
- Sound project design, with costs normally in the region of £50,000 – £100,000 (per project/year).

Recognising the need for a sustained effort, the Fund's design allowed projects of up to three years duration. While partnership was an important element, any organisation from the health, local government or voluntary sectors could lead a project.

Project selection

A streamlined application process was designed to minimise the work involved in submitting bids while at the same time pro-

viding sufficient information for the assessment of proposals. The aim was to avoid the process becoming a test of an organisation's bidding ability instead of its ideas to improve people's health in deprived communities.

The response was very encouraging in terms of both the number of proposals received – 112 – and their quality. It demonstrated the commitment that exists throughout Wales to joint action to address inequalities in health and to reduce heart disease.

“The Fund has achieved its aim of stimulating and supporting new local action”

All proposals were assessed against the criteria by at least two people and ranked accordingly. An Advisory Group of officials and representatives of health, local government and voluntary sectors was established. The group considered the results of the assessment process and recommended projects for support. I was pleased to announce a first tranche of 54 projects in July 2001 and a second tranche of 13 projects in January this year.

Interim evaluation

Given that the majority of projects (91%) are of three years duration, their impact will take time to appear. Our interim evaluation therefore focuses on an assessment of the portfolio of projects supported against the criteria set for the Fund. The data was collected from the administrative records of projects.

The Fund has achieved its aim of stimulating and supporting new local action. It is currently supporting 67 projects, which is well in excess of the original target of 20–30 projects. All projects are operational although some have experienced delays due to recruitment difficulties.

All projects have primary care involvement through individual practices or via Local Health Groups. Ninety-six per cent of projects involve Local Health Groups, which places the Fund's projects at the heart of the new Local Health Boards currently being established in Wales. This will help to ensure that preventing ill health and

Table 1
INEQUALITIES IN HEALTH FUND PROJECTS
 (by contribution to Standards of the National Service Framework for Coronary Heart Disease)

		% of projects (n=67)
Standard 1	Action to decrease risk factors for CHD	61
Standard 2	Primary care action to identify those at risk for assessment/treatment	55
Standard 3	High quality care for everyone with an acute episode of CHD	13
Standard 4	Identification and treatment of those with heart failure	3
Standard 5	Identification and treatment of those with arterial fibrillation	--

tackling inequalities in health sits alongside effective and efficient health services as an equal priority.

Partnership is a strength of projects. At the time of approval, local authorities were partners in 52% of projects and voluntary sector organisations in 37%. NHS Trusts (hospitals) were partners in 82% of projects, which is helpful to developing their role in their local community. It is expected that partnership working will increase further as projects develop and as links are made with wider community development action. Local Health Alliances with their multi-agency participation are partners in 40% of projects.

The National Service Framework for Coronary Heart Disease is an evidence-based plan of action to tackle coronary heart disease in Wales. Table 1 summarises its main components and illustrates the way that projects supported by the Fund are contributing to its implementation.

Some projects are contributing to more than one Standard by, for example, combining screening with wider action in the community to help people to improve their health. It is anticipated that this will increase further as projects develop.

Most of the projects (55%) fall within the £50,000 – £100,000 range (full year cost) while the remainder are split between

grants of less than £50,000 (21%) and those of more than £100,000 (24%). One aim of the Fund was to support action that meets locally identified needs and the funding criterion was applied flexibly in response to this.

Anecdotal evidence suggests the Fund is having a positive impact on the morale of staff involved in projects through a clear focus on practical, positive, action that helps people to improve their health.

There is considerable coherence between the Fund and the *Communities First* initiative and my officials are taking a proactive approach to ensure links are made between the two sets of projects. This will reinforce our integrated approach to programmes.

Future development

Heart disease builds up over time. Unfortunately, this can lead many people to ignore the risks to their health or at least set them aside. The Fund's projects are reaching into the community and are helping to improve access to health services and raising the profile of preventing ill health.

The evaluation of action is important and project leaders are required to build it into their projects to demonstrate effectiveness. Arrangements have been made for projects to be able to access advice and guidance on evaluation to assist them, and this support is being taken up. Arrangements for the overall evaluation of the Fund over the three-year programme are also in hand.

I have visited several projects and while it is early days, I must say that the action is very encouraging. The need for the *Inequalities in Health Fund* has been reinforced by the recommendations of our NHS Resource Allocation Review.¹ We will continue to develop its use as a discrete source of support for targeted action as part of wider action to tackle inequalities in health through health services and through joint work across policy areas.

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Copenhagen follows up lead on equity for young people



Hanne Nielsen

Danish initiatives

The EU Public Health Action Programme has given priority to addressing health inequalities. The Belgian Presidency placed social inequalities in health, and the role of health promotion in tackling this issue, on its official public health programme, and organised a Round Table Conference in December 2001. A number of policy recommendations and ways to carry these forward in policy-making and practice at global, European, national, regional and local levels were discussed.

The Danish Presidency has also placed the reduction of social inequalities in health on the agenda, both as a continuation of the efforts at EU level and also work begun in Denmark some years ago. In September 2000 the Danish Minister for Health and the Mayor for Health in Copenhagen hosted a conference on Social Inequalities in Health. One of the visible results of the conference was *The Copenhagen Declaration on Reducing Social Inequalities in Health* passed on the last day of the conference. Conference delegates also decided to organise both a national and European follow-up.

A national follow-up took place in March 2002. It consisted of a two day coach trip by participants from most Danish counties. A number of cities were visited, from Aarhus to Copenhagen, in order to learn more about how to tackle problems related to social inequalities in health. Participants had great experience and knowledge from their daily work in prevention and health promotion. The purpose was mainly professional development and exchange of new ideas. Individuals working on local and regional projects were both the organisers and the expert speakers for the tour. This 'conference-on-wheels', was a great success. Another event will take place in Spring 2003. A small report, including a short description of about 20 projects was recently published. It will be translated into English.

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International Conference

A conference will take place in Copenhagen, December 9–10, 2002 under the Danish EU Presidency. Entitled *Reducing Social Inequalities in Health among Children and Young People*, it is organised by the Ministry of the Interior and Health and Copenhagen Health Administration. The conference will be of specific interest to those working in the field of health promotion, as well as to planners, decision makers and politicians throughout Europe. Conference goals are consistent with the Copenhagen Declaration, which among other things states:

“Environmental and emotional factors in childhood and adolescence, including conditions of physical development and experience of caring, understanding and respect, are critical determinants of health that influence people’s ability to cope and to change their living conditions as adults.

Policies to promote equity in health should give high priority to providing equal opportunity and protecting against adverse environmental exposure early in life, for both moral and health reasons. Measures to support families and good parenting should be linked with measures to support the local community as a whole.”

The conference provides an opportunity to bring forward existing documentation on social inequalities in health among young people. It will focus on policies and best practice to reduce these inequalities, in order to diffuse this knowledge to other countries and settings. Prior to the conference, a research seminar, organised by the Institute of Public Health at Copenhagen University, in cooperation with the Danish National Institute of Public Health, will focus on the following questions:

- Are there social inequalities in health among adolescents?
- Are there social inequalities in health behaviour among adolescents?
- Which national and regional/local characteristics are important to health and health behaviour in adolescence?

Findings will also be presented at the conference. The preliminary programme includes keynote speeches by Lars Lokke Rasmussen, Minister for the Interior and Health; Inger Marie Bruun Viero, Mayor of Health for Copenhagen; and Commissioner David Byrne. More information about the conference is available at www.inequalities-copenhagen.dk.



Globalisation and health: An introduction

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The Health Development Agency for England (HDA) as a national public health body has an interest in the impact of globalisation on health. Like many of our peers we are also struggling to understand not only what the health impacts are, but also exactly what is meant by globalisation. Globalisation is a term frequently used, but seldom understood, whose health impacts are a matter of study and debate. Before asking whether it is good or bad for health, perhaps we need to come to some common understanding of the term's 21st century meaning and prominence in the current public health debate.

Since the 17th century trading days, at times there have been open markets and significant movements of goods and people between countries. While globalisation, as experienced now, is associated with freedom of movement, this is clearly not the whole story. Many in the health field see these freedoms as a benefit, but globalisation also suggests something threatening to others. The nature of the threat is often ill defined, felt rather than known, but felt strongly enough to engender demonstration and conflict, requiring democratically elected leaders to be separated from their people by fences and armed guards. This street rage is in part due to a sense that we are dealing with something not entirely understood. Moreover, there is a perception of disempowerment; an inability to find legitimate routes to influence those with power making decisions affecting lives in direct and often unwanted ways. This occurs when communities believe that international bodies

such as the World Trade Organization (WTO) and the International Monetary Fund can override national democratic processes.

Why is this of importance to public health? When discussing health impacts of globalisation, it is often assumed that these will all be negative, concentrated on specific health care policy, agreements and legislation. Attention is often focused on questions such as: Will we be able to prevent imports of goods that have the potential to harm the health of the population (such as asbestos)? Will we have to open our National Health Service provision to foreign competition? What is the impact on low-income countries of patents protecting pharmaceutical products?

These issues are clearly related to health and need to be kept under the watchful eye of public health professionals. Health is not just about absence of disease; the broader issue of the location of power in and outside the framework of civil society is crucial. Health promotion literature demonstrates that the amount of control we feel we have over our lives is a key factor in determining health. The sense that democracy is not working, that we have no voice in shaping the world we live in, is likely to have a negative impact upon health and well being. Additionally, many other important determinants of health lie outside the health sector control; issues such as employment, education, transport and the environment are of the greatest importance. A narrow health focus will not provide a true understanding of the health impacts of globalisation.

It is worth remembering that impacts do not necessarily have to be negative, aspects of globalisation may have a public health enhancing impact. Nations aspire to join the WTO expecting economic benefits. A view subscribed to not only by international organisations, but also by public health professionals suggests that national economic growth will automatically lead to improved population health. Certainly economic growth generally leads to expansion of the health care sector. It is also true that population health in high-income countries is generally better than in low-income countries. However, once basic needs are met, increased wealth does not necessarily help close the health gap between the richest and poorest in society, in some cases, health inequalities can increase. A very evident health gap exists not only between Europe and low-income countries such as those in Africa, but also across Europe, where there is an east/west divide.

If we accept that there are economic benefits to countries from international trade agreements, the question must be whether benefits will reach those who most need them, or whether there is potential for an increase in health inequalities within and between countries?

Phenomena covered by globalisation are too complex and dynamic for easy judgements on whether they are good or bad for health. Public health professionals will require a high degree of sophistication to pull factors likely to impact upon health out of the globalisation bag. This is essential, not only to develop understanding of what the real issues are, but also to identify meaningful actions to take in order to advocate for a reduction in aspects that are harmful to health and an increase in those which can offer positive health benefits. The HDA has approached authors who can help us better understand some of the issues. We hope that this will be the start of a meaningful debate and will help to take our thinking forward.

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Health services in a globalising world



Rudolf Adlung

“A day will come when the only fields of battle will be markets opening up to trade and minds opening up to ideas. A day will come when the bullets and the bombs will be replaced by votes, by the universal suffrage of the peoples”

Victor Hugo, World Peace Conference, 1848, Paris

Globalisation is one of the great buzz-words of our time. It has very many facets, cultural, social and economic, and may convey an array of meanings, expectations and, not least, concerns. There are few Ministers, whether responsible for finance, industry, culture or health, who would not currently use globalisation as the *leitmotiv* of a speech or article. Ministers for finance or industry might want to stress fiscal constraints and the need for wage discipline perceived to arise from international market integration and capital mobility. By contrast, their colleagues for culture or health might call for more funds to support the arts or to launch information campaigns (AIDS etc) in order to cope with the challenge of globalisation. There seem to be few policy messages that could not be linked to, or blamed on, globalisation. Globalisation, it is often implied, is *the* defining feature of modern life, all embracing, unstoppable and, possibly, inescapable.

Globalisation is not new ...

Economic historians paint a slightly different picture, putting modern developments in a broader context. A recent essay by Borchardt points to various periods of economic globalisation in history, including the creation of a “medieval world economy”.¹ Driven mainly by technical and/or institutional innovation, early attempts eventually collapsed. As a likely explanation, Borchardt refers in particular to the tensions generated by the re-distribution of political and economic status, and the absence of sufficient compensation. Similarly, one study of nineteenth century globalisation traces very profound changes in economic integration – in terms of trade expansion, international financial flows, and migration, on both sides of, and across

the Atlantic.² The prime momentum apparently came from falling transport costs, due to the introduction of railways and steamships and complementary public investment, coupled with a favourable policy environment.

The distributional implications of economic globalisation, including changing land prices and real wages, caused a political and economic backlash, even before the First World War and the Great Depression took their toll. Nationalism triumphed, in politics, economics and beyond. Victor Hugo’s vision proved elusive for at least two more generations.

... but the vision has come in new guises

Like its nineteenth-century predecessor, modern globalisation seems to be driven mainly by technical innovation, in this case new communication technologies, and policy reforms. The latter included not only the creation of open, market-based systems in many countries, but also of common international institutions, most notably in the form of the IMF, World Bank, and GATT/WTO. The underlying intention is to ensure transparency, consistency and predictability in international economic policies and to prevent sudden reversals or slippages.

There may also be additional protection against the resurgence of economic nationalism and isolationism. First, the role of individual channels through which globalisation proceeds, labour and product market integration, investment and information flows, seems to have changed. While many nineteenth century economies experienced rapid trade expansion and large-scale migration, not least across the North

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“International market integration helps to spur economic development. The ensuing increase in disposable income, in turn, enables better working conditions, education, nutrition, and access to medical care.”

Atlantic, the main driving force today is the combination of trade and foreign investment. Growing equity and production links across national frontiers and between continents, and the emergence of truly multinational companies, are among the hallmarks of modern-day economies. While possibly posing new challenges for policy cooperation, including “non-trade” areas such as competition, the multinationals tend to foster commonalities of interest between home and host countries.

Second, trade relations no longer focus on goods alone, but increasingly cover intangible products (software, design, education, insurance, medical and legal advice) and information flows. The latter cannot easily be subjected to conventional border controls, regardless of government intentions. Viewed from that angle, modern products and markets are more immune from protectionist interference.

Third, while the empirical evidence of the past two or three decades points to a powerful impact of globalisation on economic growth, it has not apparently come at the expense of increased inequality in per-capita incomes. Developing countries that have opened up to trade over the past two decades have grown much faster than rich countries and the non-globalisers, but have not experienced any significant increases in income disparities.³ Thus, all population groups seem to have participated in overall economic expansion.

A note of caution may be necessary, however. While these findings may sound reassuring from a social policy (and health!) perspective, they do not necessarily imply that social acceptance of globalisation, in its various facets, is more deeply rooted today than a century ago. For example, there are understandable sensitivities against the emergence of what could be considered a uniform world culture and the attendant loss of national identity. Many resent the global village and are not prepared to swap their native habitat.

From a purely economic perspective, it would be naïve to infer that globalisation (i.e. openness to international trade, investment, expertise, etc.) is painless for all participants at all times. Even if the relative position of large income groups has not changed significantly over a reference period, this does not imply that there have been, and that there will be, no adjustment costs. Like a century ago, there are always beneficiaries of the status quo who wish to defend their professional, social and/or

economic position. Tellingly, among the main opponents against nineteenth century globalisation in Germany were large-scale grain producers, affected by cheaper Ukrainian and American imports, rather than the underprivileged working class. The latter were even compelled to foot part of the protectionists’ bill, in the form of higher food prices.

Globalisation may have a direct impact on public health ...

The links between economic globalisation, development, and health are multifaceted. For instance, using strong empirical evidence, many have stressed that international market integration helps to spur economic development. The ensuing increase in disposable income, in turn, enables better working conditions, education, nutrition, and access to medical care. These factors are directly related, in a clearly supportive way, to a country’s health status. Additionally, there is a positive link between health and labour productivity and, further, between labour productivity, growth, and development. While it is true that trade, and especially migration, also pose health risks, this does not appear to be a compelling counter-argument. People have moved throughout history and continue to do so, sometimes even more intensively and violently, in periods of economic disintegration.

The strongest line of causation seems to run from trade and investment expansion to development, and from development to health. What factors could otherwise explain the strong health-indicator improvements in Hong Kong, South Korea and Singapore (e.g. infant mortality), compared with neighbouring, less internationally integrated countries?^{3,4} Is there any evidence of exogenous changes that, first, might have helped to enhance the three globalisers’ health situation and, next, pushed them onto a higher and steeper growth path? Concerning the perceived link between mobility and health risks, it is worth noting that, although Hong Kong and Singapore are among the world’s busiest travel hubs, they apparently found it possible to contain such risks.

This is not to suggest that economic globalisation necessarily translates into better life and health conditions or, even more daringly, that people in richer countries are necessarily healthier and live longer. Of course, social, cultural and institutional differences matter, impinging on lifestyle, diet, public sector involvement, etc, but so

do many other factors, including income distribution. Countries where large population groups live below the poverty line are likely to fare worse in terms of health, education etc. than comparable countries with more equal income distribution. Globalisation offers opportunities for health and social policies and makes better care affordable; it does not, however, substitute for responsible and prudent governance and institution building.

... but not necessarily on public health systems

Health-sector institutions differ widely between otherwise comparable countries, including EU countries. Public health systems, based on government-owned and -operated facilities (for example, Spain, UK), coexist with various types of mixed systems made up of public, other non-commercial, and private suppliers. Whatever the system, however, there have been discussions in virtually all EU countries about changes needed to ensure quality, curb waste, contain costs, reduce waiting lists, etc. While globalisation may have exposed weaknesses in current systems, it has not affected governments' scope for health sector policies or policy reform.

Unlike its predecessors, modern globalisation proceeds within a framework of international agreements and institutions, such as the WTO. WTO governments are committed to applying trade measures – tariffs on goods, restrictions on foreign services, etc. – only within pre-defined limits, regardless of how they feel about other members' policies. This is particularly important for small and poorer trading nations, who would suffer most from exposure to unconstrained economic clout, and has possibly been the strongest incentive for ever more countries joining the WTO. Potentially relevant for service-related policies, in any sector, is the 1995 General Agreement on Trade in Services (GATS).

WTO rules are potentially relevant for all services ...

The GATS provides the WTO's 140-odd members with a legally enforceable, common set of rules. These are possibly more flexible than those contained in any other WTO Agreement, including the GATS' counterpart in merchandise trade, the 1947 General Agreement on Tariffs and Trade (GATT). Neither affects members' freedom to organise their public sector as they see fit; rather, they protect national policy decisions from international encroachment.

The main elements of GATS are firstly, that it applies only to *commercial* services and/or services supplied in *competition*. This exempts core areas of governmental competence, in most countries possibly including primary and secondary education or even medical care, from trade disciplines. It would not be possible, in new rounds of negotiations or otherwise, to require a member to reconsider institutional arrangements in such sectors, let alone to open them to commercial investors.

Second, even if a service is covered by GATS, this does not imply acceptance of private participation. Members are obliged to open their markets and to extend national treatment to foreigners only in sectors they have chosen to include in their country-specific Schedules of Commitments, and only to the extent that no qualifications have been inserted. In other words, if a country decided to schedule medical or hospital services, which is the case for slightly more than one third of members, it might attach various limitations reserving the right, for example, to limit foreign equity participation, cap the total number of hospital beds or doctors, or exclude foreign-owned facilities from subsidies. Countries are thus able to adjust their commitments to all sorts of national policy objectives or constraints. There is one minimum obligation, however, that applies across all services covered by the Agreement. Regardless of whether a Member permits or restricts access to any such sector, the relevant conditions must not discriminate between services and service suppliers from other WTO Members (most-favoured-nation principle).

Third, the GATS does not affect a government's right to impose licensing or qualification requirements or standards that may be needed to ensure *national* quality objectives. Nor does it compromise members' rights to regulate markets for social and other policy purposes. Any allegations that the Agreement could undermine universal service obligations are thus completely unfounded, even in fully liberalised systems.⁵ Private hospital and other health-service suppliers can be subjected to all types of universal services, (free treatment of needy patients, obligation to invest in rural facilities, training requirements exceeding own demand for staff) or obliged to source universal service funds. If such requirements were to be imposed only on foreign suppliers, and if the country decided to include the sector in its schedule, a limitation would need to be attached.

“[the GATS does not affect countries] freedom to organise their public sectors as they see fit; rather, it protects national policy decisions from international encroachment.”

... and may help to promote basic policy objectives

Globalisation, in the form of increased mobility and enhanced information, may prompt more governments to consider the case for domestic regulatory adjustment. Economic growth has enabled large segments of the population not only to compare their supply situation with that in other countries, but to act accordingly and, if need be, move abroad. It would be hard to prevent dissatisfied consumers (patients) from such movement, or qualified domestic staff (nurses and doctors) from following. Mobility, i.e. the right to vote by feet, and access to information are inalienable entitlements in an open society.

Mobility tends to be selective, however. The affluent and well-educated are usually over-represented compared to

those remaining behind. The ensuing distributional implications, for example, better medical care for patients who can afford to escape waiting lists by travelling abroad, might prove difficult to reconcile with basic equity objectives. On the other hand, accepting commercial providers within a country may carry similar risks. In the absence of proper regulation and enforcement, a dual system could emerge: wealthy patients and qualified staff might shun public hospitals in favour of better equipped and more pleasant private facilities. The resource and equity implications do not seem to differ at first glance. However, since the investment is in the country, it is easier to use domestic regulation to pursue the public interest.

Whatever a government's decision, it could be accommodated under the GATS.

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Public health after globalisation: *Injecting health into the post-Washington consensus*



Geof Rayner



Tim Lang

"Too often public health voices engage globalisation with an upbeat optimistic tone, which belies the worrying evidence."

In recent times, the public health movement has veered between awe at the power of globalisation (as though it is a homogeneous entity and process) and the academic response of monitoring its impact (as though epidemiology alone, amounts to a public health position!). In our view, it is time that proponents of public health took a new, tough stance on globalisation – tough in the sense of knowing where they stand. Globalisation is, of course, immensely complex, but our concern here is to encourage the public health movement to question two specific arguments about globalisation and health.

Firstly, it has mostly adopted an argument that globalisation generates wealth enabling societies to invest in healthcare. Too often

public health voices engage globalisation with an upbeat optimistic tone, which belies the worrying evidence. In fact the modern era of globalisation has unleashed astonishing wealth for some while confining others. These gross inequalities are themselves factors in determining ill health.

Secondly, it is unacceptable that health is marginalised from discussion of globalisation. In our view, health is a, if not the, key to showing how a narrow definition of globalisation on economic growth is symptomatic of a partisan approach to public policy in which public health is seen as a luxury of the rich. Why is it that after the decade of water, there is no end in sight for world water shortages? Why are there still 800 million people suffering chronic

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malnutrition? Why are so many countries crippled by debt? These are health questions, not just economic ones.

Globalisation, old and new

Globalisation is, of course, nothing new. This is but the latest era of globalisation, characterised by greater global reach and pace, and by the sheer power of economic forces. Goods and ideas may have circulated the globe for millennia before, but in the last half century the scale and focus has been awesome.

The debate around globalisation mirrors the magnitude of the topic. Researchers and commentators are now demanding a front row seat on the affairs of international institutions like the World Bank, the International Monetary Fund (IMF) and the World Trade Organisation (WTO) or are issuing books and papers charting global trends in economics, culture, and everyday life.

To the chagrin of those who think globalisation a wholly new historical event, we have been here before, not only in terms of analysis of the phenomenon, (which existed in a fully fledged state in the late nineteenth century), but also its advocacy and disparagement. If today the study of globalisation occupies at least one academic department in every noteworthy university, 150 years ago much of the debate could be encapsulated in the writings of Marx and Engels.

The *Communist Manifesto*, implicitly drawing upon the work of outstanding British political economists, Adam Smith and David Ricardo, was both pro-globalisation and also a critique. “*The need of a constantly expanding market for its products chases the bourgeoisie over the entire surface of the globe. It must nestle everywhere, settle everywhere, establish connections everywhere.*”¹ They considered capitalism a progressive force, releasing new productive forces and breaking down the backwardness and oppression of tradition.

Rapid communications are said to be a defining feature of modern globalisation but Marx and Engels had already spoken of the ‘connectedness’ of the new industrial system, the “*immensely facilitated means of communication*”; a diffusion of ideas and commodities which produced “*a world in its own image*” among the developing states. Nevertheless, despite this power for good, Marx and Engels thought capitalism to be self-destructive and ultimately doomed through internal contradictions,

principally the capacity of the system to overproduce in conditions of a narrow base of ownership and massive inequality.

Given the acuity of this analysis why did their diagnosis of breakdown and prognosis of socialism turn out so far from what was to occur? One of the reasons, among many, is that the globalisation process they described came to a halt with the First World War. Class loyalties did not cement as anticipated. The working class slaughtered each other in a triumph of nationalism, laying down political divisions between East and West that dominated the 20th century. A second reason is that the economic and social crises which did occur, for instance the 1930s depression, resulted in new counterbalancing mechanisms within major states.

Furthermore, capitalism splintered into various different forms, American (or latterly Anglo-American), European, Japanese and most recently Chinese, this latest being an accommodation between capitalism and communism. If states at the periphery resembled Marxist depictions of industrialising Britain, a revised hegemonic system was put in place to contain the spread of discontent. To be fair, as early as the 1880s Engels, in observing the success of British public health measures, said that the British elite had looked into the abyss and pulled back.² The middle classes, not just the elite, realised that investment in the public health was self-interest. Public health measures were key components in the foundation of European Welfare-Keynesian and regulatory state action.

Globalisation advocates today also draw their inspiration from the same economic theorists who influenced Marx: Adam Smith, for analysis and advocacy of free markets, and David Ricardo for his doctrine of comparative advantage. While these writers viewed circumstances flexibly, over time the advocacy of free markets, privatisation and deregulation became the formulaic answer to the question of tackling economic growth, poverty and economic relations between states. This became known, even to insiders within these organisations, as the ‘Washington Consensus’. This might be seen as the final point of destination for free trade philosophy, in some respects a revival of British attempts to secure fully open markets at the height of its empire. This was mercantilism rather than ‘pure’ free trade, a doctrine defining geographical and political limits to the exchange of goods.

“It is unacceptable that health is marginalised from discussion of globalisation”

“A tough line on funding international public health action is required.”

According to Pfaff this version of globalisation, an “*aggressive program for the imposition of Western norms of national economic management, economic deregulation and market opening, and facilitating takeovers of indigenous industries and agriculture by multinational companies*”, was “launched by the Clinton administration during its first term”.³ Seen as an American-led enterprise, as with the British, it bears the hallmark of an attempt of a major power to stamp its authority on the rest of the world. This point requires amplification, as it is key for the public health.

If the current phase of globalisation begins with the conclusion of the Second World War, then it did so under an American, rather than a British hegemony while its progress was hindered by a world divided into two ideologically opposed camps. The policy forerunner to today’s globalisation theories emerged in the 1950s, Rostow’s ‘stages of growth’ theory.⁴ Similar to modern day advocates of globalisation, the theory stated that the developing world was in the process of economic change and would inevitably pass through a five stage transition from an agricultural society to an industrial society (‘mass consumption’), providing, that is, the alternative, communism (‘the disease of transition’), did not take root.

Subsequently, fierce ideological collisions between east and west have diminished while development economists have rejected linear models of transition for more differentiated types. This fact, together with the Welfare-Keynesianism of the times and the marginalisation of neo-classical economics, was hardly conducive to the liberal-economic themes underscoring contemporary globalisation. This is not to say the pressure for more open markets was not present at the time, rather that the ideological conditions were not available to solidify a trend. Under the 1947 General Agreement on Tariffs and Trade (GATT), the encouragement of economic transactions occurred by means of a “substantial reduction of tariffs and other barriers to trade”, having the purpose and effect of “raising standards of living”. The World Bank and IMF were seen as benign institutions, and terms like privatisation did not exist while the regulatory state was still in ascendance.

Globalisation has taken on a new shape since its first appearance, including the relative rise in manufacturing exports by

developing countries alongside a significant trade in capital goods. Multinational enterprises have also played a larger part, and the shape of investment has differed considerably, with a shift away from transport and government sectors to banking and industry.

The globalisation debate has been far wider than new economic structures or additions, covering issues such as the reduced power of nation states, the impact of digital technologies, the question of whether globalisation equates with Americanisation, the impact of IMF-inspired Structural Adjustment Policies (now rebranded ‘development policy support lending’ in order to boost exports and reduce indebtedness in developing countries), alongside public health and environmental debates on disease, links with global warming, deforestation, etc. The breadth of issues suggested to be explained by globalisation, stretch onward, perhaps too far from what always was an imprecise notion.

The debate usually focuses on whether globalisation is a good or bad thing. Pro-globalists are typified as supporters of neo-liberal theories of trade (Washington Consensus supporters); anti-globalisers, are a varied band ranging from those who oppose global capitalism per se, to those who support protectionism for reasons of environmental sustainability. International bodies such as the World Bank, IMF or WTO, have strongly asserted that the opening up of markets, deregulation or privatisation are pathways to economic growth, which itself is the sure route to poverty alleviation. Meanwhile, critics argue that the GATT and WTO are merely new projects for ‘rigging the rules’.⁵

One analysis prepared for the IMF is that the developing world can be divided into a globalising group of countries that have seen rapid increases in trade and foreign investment over the last two decades, well above the rates for rich countries, and a ‘non-globalising’ group that trades even less of its income today than it did twenty years ago. Openness to foreign trade and investment (along with complementary reforms) explains the faster growth of the globalisers. It asserts that globalisation has not resulted in higher inequality within economies. Where shifts in inequality have occurred they stem more from domestic education, taxes, and social policies. Generally higher growth rates in globalising developing countries have translated into higher incomes for the poor.⁶

Those who challenge this view interpret the same evidence quite differently. Galbraith argued that world growth rates were systematically higher under the structured international financial regime of Bretton Woods from 1945 to 1971 than in the era of deregulation after 1980. Furthermore, analysis of economic data suggests that forces of globalisation, including high global interest rates, debt crises, and shock liberalisations, are associated with rising inequality in pay structures.⁷ One group stated that out of eighty-nine countries, 77% saw their per capita rate of growth fall by at least five percentage points in 1980–2000 compared with 1960–1980. Only 14 countries, 13%, saw their per capita rate of growth rise by that much from (1960–1980) to (1980–2000). While US economic dominance might suggest benefits accruing to the US workforce, the median real wage remained about the same as a quarter century before, meaning a considerable widening of income disparities.⁸ This implies that increases in trade are linked to lower growth and rising inequality, both in developed and undeveloped countries.

The most vocal element of the debate between globalisers and their adversaries, was represented by the dispute between Joseph Stiglitz, former chief economist to the World Bank, and the International Monetary Fund. Stiglitz's charge was not against globalisation as such, but against what he regarded as IMF's slavish imposition of 'text book' liberalisation of capital markets. This was "*the single ingredient most responsible for the global financial prices which caused such havoc in S.E. Asia and Korea, Indonesia, Thailand and elsewhere around the world.*"⁹

The implication, perhaps, is that despite the suggested close equation between economic growth and globalisation, the reverse may be true. While there is little argument that the level of trade has increased, most has been between countries on a more secure path of growth, exporting industrial products, while for those countries dependent upon primary commodities, such as agriculture or mining, growth went into reverse as these products were oversupplied, leading to tumbling basic commodity prices. While the stock market boomed and technological progress was rapid, the claim that economic growth was associated with open markets on the American (or Anglo-Saxon) model had considerable force. In the wake of the US stock market collapse post 2001, it ceases to convince. While the

growth underpinning globalisation was already shaky, it now appears unbelievable.

Where does this leave public health? The liberal welfare model under which health-care receives investment generated by growth is now shaky. Healthcare has always had a greater pull on finance ministers' attentions than prevention. Public health proponents now need to return to core principles. Prevention has to be the priority. There is an urgent agenda ranging from climate change to the wastefulness of consumerism. It has long been recognised that while the consumer boom of the North has suited the affluent, a huge slice of humanity has been excluded. What is now apparent is that the model of affluence rolled out over the last half century is both bad for health and unsustainable. The evidence that (ill)health is socially determined now means Ministers of Health have to stand up to their finance, trade and economic ministry colleagues. A new approach to health is called for.

The challenge to the UN 'family'

Firstly the simmering discontent between various international 'arms' of global governance must be dealt with. Health has been a source of some contention between the UN agencies charged with promoting public health, notably WHO but arguably FAO and the United Nation's Children's Fund (UNICEF), and the stronger economic agencies, notably the IMF and World Bank. Gradually, in recent years, the World Bank in particular has entered the health arena. This has been resented by some, indeed the Bank has on occasions taken a strict approach to public health, but this is changing towards a more progressive position, notably on tobacco and food/ agriculture. Over the years, the World Bank has been subject to campaigns for closure because of its stance on developing country debt, among other matters. Some critics forget that, however flawed, the World Bank, IMF, etc. are public organisations, which although not immediately apparent from their behaviour, are enterprises in global governance.

All these international bodies urgently need to regain public credibility. Taking public health seriously could be one way of doing this. The primary intent, therefore, is to get health on the agenda of major international entities within the UN system, through the introduction of matters like global governance, gathering and sharing knowledge, development of country-based action, key targets for areas, such as tobacco, alcohol

and illicit drugs, influencing trade agreements to promote equity, actions to improve global disease surveillance and the promotion of actions around both communicable and non-communicable diseases, especially those having an impact on the poor.

A tough line on funding international public health action is required. UN bodies, starved of funds are pressurised to take funds from unacceptable sources under duress. This has meant the UN mingling with globalising forces directly. In 1999, the United Nations Development Programme (UNDP) announced the Sustainable Development Facility (GSDF) a partnership with around 15 corporations. The GSDF was one of many partnerships with the private sector pursued by the UN and many of its agencies under the umbrella of the "Global Compact." The GSDF was to include major chemical, mining, energy and pharmaceutical companies. Participating companies paid \$50,000 each to underwrite costs. Activists questioned whether sponsorship of the programme promised to brighten corporate image more than serving the needs of the world's poor. Over 100 organisations signed a letter to the head of UNDP calling for GSDF to be abandoned, as indeed happened in June 2000.

In July 2002, UNICEF and a worldwide hamburger restaurant chain, announced plans for a joint fundraising initiative, 'World Children's Day'. The partnership has been criticised by some who feel that financial assistance to combat communicable disease is seen as tradable against non-communicable disease, such as obesity and type 2 diabetes. Thus in seeking such links agencies risk being seen in alliance with corporations whose commitment to either sustainable development or children's health may be perceived as being superficial or at worse part on an exercise in brand management.

The challenge to Europe

Globalisation, whatever version subscribed to, reminds us that public health is no respecter of national boundaries. Yet within the EU, health is still primarily a member state responsibility. The much-vaunted Article 152 of the Amsterdam Treaty is more celebrated in principle than in practice. The Common Agricultural Policy (CAP) which accounts for nearly half of the entire EU budget has never been properly audited for health. The recently announced Fischler reforms might make

important steps in the direction of conservation, the shift from commodity support (pillar one) to rural development and agri-environment schemes (pillar two) funding, but health is not mentioned. Yet CAP funds a huge production of dairy fats, distorts production and distribution of fruit and vegetables, and also constrains market access from the developing world.

Ironically, the prime driver for CAP reform is not so much a desire to tackle intensive agriculture's environmental problems, but to address the political challenge of EU enlargement. CAP's current expenditure system is simply unsustainable if ten poorer countries join the EU. Reform also addresses USA and Cairns Group inspired challenges to EU subsidies through the GATT system.

Why is public health so inactive at the European level? We believe that there is a huge health agenda requiring urgent policy attention. Taking food policy, the EU went into crisis, as did many member states, over the comparatively rare health problem of BSE. A new programme of health-driven work has emerged and a new European Food Safety Authority is being created. Yet this health focus has been remarkably narrow, centring on food safety and food contamination, when the evidence is that non-communicable diseases such as heart disease and cancers are far more significant. These diseases go to the heart of modern life. EU public health policy has been reluctant to criticise let alone tackle these, which is symptomatic, we suggest, of policy inactivity before globalisation.

Conclusion

The so-called Washington Consensus – the alliance between the World Bank, International Monetary Fund, and US Treasury, has dominated public policy for too long with its mix of support for open markets, de-regulation and privatisation. For public health advocates, there is now a great opportunity to return to basics, one in which the aspirations of earlier times are re-engaged, such as the Alma Ata Declaration and Ottawa Charter. This requires some critical distance from the love affair with globalisation, and demands that the public health movement becomes more involved in defining a new meaning for public health, which overcomes the disciplinary separation from economics. Health has to be central to economics not something which is bolted on or which is paid for by surpluses generated in an anti-health manner.

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Globalisation: *An Idiots Guide*



Julius Weinberg

“To what extent are the relationships between objectives to further trade and public health in conflict?”

Globalisation means different things to different people. It describes a process whereby companies have become involved in markets around the world, and where there is concern that they can, by shifting capital between markets, leave individual companies powerless. It describes the fate of poor traditional producers whose livelihood may be undermined by a technological advance in a wealthy country many miles away. However it also describes the increasing interconnectedness of countries and peoples, clearly better than isolation and ignorance. The mantra of globalisation has been local good, global bad, but this analysis is simplistic. This article describes some of the key international agencies involved in ‘Globalisation’ and indicates where their activities impact on health.

Establishing International Agencies and Agreements

The possibility of interactions between commerce and health has been recognised for many centuries. One of the few evidence based health care interventions was quarantine, a restraint on trade. Attempts to regulate the international response to infectious disease were one of the drivers for international collaboration in health. Since the first International Sanitary Conference in 1856, balancing the interests of trade with disease control has proved problematic. International Health Regulations explicitly state that any measure taken should be the appropriate minimum for disease control, with the least possible disruption of trade.

As trade and travel between countries has increased, and problems associated with infectious disease diminished, issues have become more complex. Concern now includes the internationalisation of non-infectious disease threats to health including food, tobacco, pesticides, and genetical-

ly modified crops as well as the response to threats, such as trade in pharmaceuticals and health related services. The essence of conflict revolves around the principle that local authorities should be enabled to take appropriate measures to control threats to health. There should be minimal impediments to trade, with common regulation of standards.

The International Monetary Fund (IMF) and the International Bank for Reconstruction and Development (IBRD or World Bank) are UN specialised agencies, established as part of the international infrastructure at the end of World War Two. Besides strengthening a particular economic model, it was hoped that creating stability in international monetary affairs and facilitating the expansion of world trade would reduce the possibility of future wars. Members of the World Bank are also required to be in the IMF. The World Bank was responsible for long-term financing for nations in need, while the IMF’s mission was to monitor exchange rates, provide short-term financing for balance of payments problems, provide a forum for discussion of international monetary concerns, and give technical assistance to member countries.

Negotiations also began in 1946 to reduce tariffs, and dismantle protectionist measures in place since the 1930s, thus boosting trade. Negotiations resulted in 45,000 tariff concessions affecting \$10 billion, one-fifth of world trade. Agreements on tariffs and provisional acceptance of rules concerning employment, commodity agreements, business practices, international investment and services defined the 1948 General Agreement on Trade and Tariffs (GATT).

Major changes in international trade liberalisation have occurred through multilateral trade negotiations, or ‘trade rounds’, the Uruguay Round being the latest and most extensive. Trade rounds offer a package approach; negotiations address a wide range of issues. It is claimed this is advanta-

geous, making concessions easier in a package also containing benefits. Less powerful participants have a greater chance of influence than if bilateral negotiations dominated. Fundamental reform of world trade sectors appeared more feasible within the context of a global package. Although trade rounds have concentrated on reducing tariffs other issues such as the GATT Anti-Dumping Agreement were negotiated.

“The essence of conflict revolves around the principle that local authorities should be enabled to take appropriate measures to control threats to health.”

GATT helped spur high rates of world trade growth seen in the 1950s and 1960s. However the economic recessions of the 1970s and early 1980s, lead to governments seeking bilateral trade agreements, using subsidies to protect indigenous industries and farming. This and the rapid development of international trade in services (not covered by GATT rules) and other factors convinced GATT members that a new effort to reinforce and extend the multilateral system should be attempted. That effort comprised the Uruguay Round, covering all aspects of trade policy, including trade in services and intellectual property. This resulted in establishment of the World Trade Organization (WTO) in 1994.

WTO replaced GATT and is very different. The WTO is a permanent institution with its own secretariat, and unlike GATT, commitments to WTO are full and permanent. It covers trade in goods and services (GATS) and trade-related aspects of intellectual property (TRIPS). A dispute settlement system is provided, designed to eliminate world trade blockages. Tribunals comprising three trade experts rule on disputes. However the criteria for choosing panellists has been criticised as ensuring that they favour current trade rules. Normally to qualify for a tribunal an individual must have worked at GATT or WTO or represented a country there.

WTO has provisions concerning domestic public health, food safety, consumer, worker and environmental protection policies. Agreement constrains members to “ensure the conformity of its laws, regulations and

administrative procedures with its obligations as provided in the annexed Agreements.” WTO members constrain their ability to act under the agreement. Provisions assert that “*domestic health, safety, and environmental policies must be designed in the “least trade restrictive” manner and national laws and standards should be standardized internationally, to maximize economic efficiency in cross-border trade.*” Standards providing more protection to consumers, public health, local communities or the environment can be challenged as unfair trade barriers.

Global standard setting

The WTO has provision for *global standard setting*, in international standard-setting institutions, as well as *equivalency agreements*. Specific global standards are set by organisations such as the International Organization for Standardisation (ISO) and the Codex Alimentarius Commission (Codex). Regulatory systems and standards in countries can be declared ‘*equivalent*’ to domestic regulatory systems. Once a foreign system is declared equivalent, it must be treated as domestic. Mutual Recognition Agreement (MRA) is a reciprocal agreement between nations, allowing a country to rely on another’s verification that a product meets required standards.

Codex was established by WHO and the U.N. Food and Agriculture Organisation in 1962. It is a voluntary standard-setting body, facilitating international trade of food and agriculture products. Codex comprises government representatives, with active and formal assistance from official industry advisors, serving as members of country delegations. One 1993 study reported that over eighty per cent of non-governmental participants on delegations to Codex committees represent industry, while only one per cent represented public interest organisations.

The ISO in Geneva is a private, industry standard-setting body, recognised by WTO as the international standards body for all non-food products. From the 1950s ISO began to standardise sizes for consumer products (i.e. batteries). ISO’s areas of interest have expanded and now include standards for environmental products, eco-labels, and humane fur trapping standards; it is now developing standards of management practices.

General Agreement on Trade and Services

Since the 1999 Seattle meeting on international trade rules, talks have begun to

strengthen one of 28 agreements overseen by the WTO, the General Agreement on Trade in Services, (GATS). This covers sectors like banking, construction, education, insurance, retail, telecommunications, tourism, health or waste disposal. Via GATS, private companies can insist on being allowed to enter the market for publicly funded services. In OECD countries public expenditure on health services and education accounts for 13% of GDP. Much of this goes to public or voluntary bodies but could go to for-profit groups. By 1998, 59 countries had one or more aspects of professional (medical, dental, veterinary, nursing, midwifery, physiotherapy) services or health-related and social services (including hospitals) under GATS. 39 countries had agreed to open up hospital services to foreign suppliers. Seventy-six countries have made financial services sector commitments, (including health insurance).

The US Coalition of Services Industries have stated that *"We believe we can make much progress in the [GATS] negotiations to allow the opportunity for US businesses to expand into foreign health care markets ... Historically, health care services in many foreign countries have largely been the responsibility of the public sector. This public ownership of health care has made it difficult for US private-sector health care providers to market in foreign countries."*

TRIPS

TRIPS covers a wide range of subjects, including copyright and trademarks as well as patents. A patent on a pharmaceutical product can cover products, or a manufacturing process if novel. Patents reward inventors and enable research costs to be recovered. Upon patent expiry, other companies can make the product. Generics are often cheaper, as they do not have to cover research costs, furthermore competition lowers price. TRIPS standardises the use of patents, all WTO members have to grant twenty year patents. Previously some countries used shorter periods, permitting earlier production of generics. All countries, including those without previous patent procedures, will be expected to implement the provisions of TRIPS.

There is concern that attempts to balance public health interests with those of innovation are tilted towards the pharmaceutical industry, and without access to generics new drugs will remain too expensive for poor countries. Generics manufacturers in developing countries will also be adversely

affected. TRIPS allows for action to be taken against countries with inadequate patent laws.

Some safeguards exist within TRIPS to protect public health interests. Governments can justify compulsory licensing; including undefined "national emergencies". Under TRIPS, products made using compulsory licences should be "predominantly for the domestic market", but countries may not have capacity and wish to use compulsory licenses for import. Parallel imports are also allowed, however there is concern that this might lead to re-export of cheaper products.

"Via GATS, private companies can insist on being allowed to enter the market for publicly funded services."

Key Issues

If trade/investment liberalisation generally improved goals of human development, and lead to fairer distribution of goods, it is likely that it would be widely supported. Economic liberalisation enthusiasts claim that open markets are a necessary condition for this. However empirical evidence is doubtful, some would claim that poorer economies suffer under trade liberalisation. There are concerns that increased liberalisation, in particular the move for liberalisation of services (health, education) under the GATS process, may increase their privatisation, decreasing access.

A number of questions need to be answered. To what extent are the relationships between objectives to further trade and public health in conflict? Does trade liberalisation improve health and reduce inequalities in health? What are the respective rights, responsibilities and capacities of the private and public sector? Should international standards serve as a ceiling or as a floor that all countries must meet? What assessments have we of the efficacy of service liberalisation? Finally how do we strike a balance between the need to provide incentives for innovation and the need to enable all people to benefit from innovation?

This article is based upon a talk previously given at the European Health Policy Forum 2001.

European Union foreign and health policy



Graham Lister

“There are increasingly important links between global health and foreign policy in relation to: human security, economic development and global citizenship.”

In April this year an international conference at Ditchley Park, supported by The Nuffield Trust and RAND, discussed the relationship between foreign policy and health. It concluded that there are increasingly important links between global health and foreign policy in relation to: human security, economic development and global citizenship. One of the actions identified as a result of the conference was to promote further research into, and support for, policies at European Union level directed towards global health as a foreign policy issue. This paper sets out some of the thinking behind this conclusion as a starting point for discussion with researchers and policy analysts. Conference papers can be found at www.ukglobalhealth.org.

Growing links between foreign policy and health

The traditional view of foreign policy, as exemplified during the cold war era, was narrowly focussed on national security and national interests. The main concern was with the balance of power and the creation of military and political alliances to protect national self-interests in competition with those of other states. This so-called ‘Realist’ perspective is still apparent in much of the debate on foreign policy.¹

Over time the focus of foreign policy expanded to include trade, aid, and human rights. Investment in health was an element of aid, but less than 10% of the total. Health was also a basic human right, as defined in the UN Universal Declaration of Human Rights, but in practice health was not prominent on the foreign policy agenda unless health services were abused, as for example, the detention of dissidents as

psychiatric cases. Health was a subject for monitoring, advice and support orchestrated by the WHO, but was not central to foreign policy.

The fall of the Berlin Wall in 1989 was a milestone in the redefinition and expansion of national foreign policy. As international trade became more important to prosperity and power, rising from 4% to 10% of World GNP from 1955 to 1989 and then accelerating to double again by 2001, it became more central to foreign policy. It also became apparent that in trade, as in other areas of foreign policy, collective power and action were crucial to the common interests of states.

The ‘Neo-liberal’ perspective, which emerged, no longer saw foreign policy as a zero-sum game. States had to cooperate to create open markets for trade and investment, which was seen as mutually beneficial. The ‘Washington consensus’ can be seen as agreement between rich countries and trading blocks to replace national market controls with international agreements to open trade in industrial products and privatised services, but not agriculture, while protecting intellectual property rights. The rules of globalisation are clearly stacked against the poorest countries.²

By 2001 trade and foreign direct investment accounted for seven times the level of aid flows to poor countries; official aid consistently fell as a proportion of GNP, until 2001/2. Non-government organisations became more important both in the channelling of aid and as agencies for the delivery of services.

For these reasons multi-national companies and NGOs became important to foreign policy. “Foreign policy today is no longer the property of chancelleries and diplomats. The world’s great trading firms and great civil society movements make foreign policy too.”³ Policy issues relating to

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health and trade are addressed at international levels through the WTO and WHO, which increasingly seek to engage with the private sector and civil society.

Security remained at the heart of foreign policy but was now defined more broadly thus 'food security', 'water security' and 'economic security' have all been promoted. 'Human security'⁴ was redefined to encompass a wide full range of threats to safety and well-being, including health threats to individuals and communities.

Attitudes towards health investment as an aspect of foreign policy changed because:

- Infectious diseases and abuse of anti microbial agents are no longer issues confined to poor countries, the extent and speed of international travel is such that new and re-emergent diseases (30 in the last 20 years) now threaten every country.
- The scale and extent of the HIV/AIDS pandemic clearly required major international effort and investment, raising the political stakes so that heads of state must engage with the issue.
- While health investment used to be seen as a drain on economic development, the experience of the 'tiger' economies shows that longer, healthier productive lives are essential to economic growth.

In the US, influential reports by the Institutes of Medicine (1997), Council on Foreign Relations (2001), National Security Council (2001) argued that health should be an important factor in American foreign policy, because of the threat to the human security of Americans.

The HIV/AIDS pandemic was discussed at the Davos World Economic Forum, at the UN Security Council and at G7/8 meetings. This was followed in 2001 with the announcement by Kofi Annan of the establishment of a Global Health Fund to address the problems of HIV/AIDS, Malaria and TB, this was originally projected to raise some \$7-10 billion per year but so far has reached only a quarter of this in total.

The latest estimate from the Commission on Macro Economics and Health is that some \$29 billion per year will be required from donor countries to address basic health needs in poor countries by 2007, and that this will need to be matched by efforts of poor countries both to invest \$37 billion more in health and to improve the efficiency and targeting of health expenditure. The

report notes that poor countries can achieve economic benefits from investment in health from the reduction in productive years lost to disability and death of up to six times the level of investment.

The events of September 11th underlined a further link between foreign policy and health. Terrorism is not directly caused by poverty, ill health or lack of education. But these underlying inequities feed resentment and despair and are linked to the development of failed states and failed cities, in which civil order breaks down and illicit activities and terrorist groups flourish. This demands the reaffirmation of basic health, education and civil protection as human rights of citizenship together with concerted action to ensure that these services reach every part of our global community. Health can be a bridge to peace both in conflict situations and in reinforcing civil society to avoid the emergence of failed states or cities.

The evolution of European foreign policy

The evolution of European foreign policy exemplifies the slow shift from 'realist' to 'neo-liberal' approaches and hence from state centred foreign and health policies to a realisation of the need for collective agreement and action.

European foreign and security policy has been a contentious issue since the signing of the European Defence Community agreement, and its failure three years later in 1954. It proved impossible to move from a general agreement on defence, to agreement on common military actions or other aspects of foreign policy. This may be ascribed to the general weakness of the emerging European Union as a political entity and its inability, at the time, to "assert its identity in the international scene" as proposed by the Treaty on European Union. This weakness was exposed by the EU's inability to respond to the Soviet invasion of Afghanistan or the Islamic revolution in Iran.

Progress in achieving practical cooperation on foreign policy was marked by the adoption of the London Report in 1981. This required member states to consult each other and the European Commission on foreign policy issues of mutual concern. But this was still a difficult area, as demonstrated by the inability of the EU to take timely, concerted action in response to the disintegration of the former Yugoslavia.

Gradually the political processes of the EU

"Poor countries can achieve economic benefits from investment in health from the reduction in productive years lost to disability and death of up to six times the level of investment."

“[In low income countries] the economic benefits from the reduction in productive years lost to disability and death are estimated to be up to six times the level of [necessary] investment.”

have matured. The debate between ‘federalists’, arguing for cooperation between autonomous states and ‘functionalists’, arguing for transfer of certain powers to a European level, has largely been resolved. While there remain differences of emphasis, there is a general appreciation that national governments need to be supplemented by European institutions with responsibility for those areas in which joint action is more effective.

The 1997 Treaty of Amsterdam provided a further stimulus to the extension of foreign policy by creating the decision making and funding mechanisms for pursuing common strategies in relation to foreign policy objectives. The treaty designates the Secretary General of the European Council as the “high representative for common foreign and security policy” and established a policy planning and early warning unit in the General Secretariat of the Council.

The EU now has the capability to define and express common foreign and security policy, but it is more difficult to ascertain what the current common foreign policy is. EU foreign policy objectives have been summarised as:

- Safeguarding the common values, fundamental interests and independence of the Union.
- Strengthening the security of the Union and its Member States in all ways.
- Preserve peace and strengthening international security.
- Promote international cooperation.
- Developing and consolidating democracy, the rule of law, and respect for human rights and fundamental freedoms.

If this seems rather a general statement it should be noted that UK foreign policy has recently been summed up in four words “prevent conflicts – promote well-being”.³

The emergence of EU health policy

By contrast to foreign and security issues, health appears to have crept almost unnoticed onto the agenda of the European Union. The 1987 Single European Act may be said to have provided the basis for the development of European cooperation in public health surveillance, development of European standards for health information and the Europe Against Cancer and Europe Against AIDS programmes. In fact cooperation in these spheres and wider

inter ministerial, professional and NGO collaboration in health predates this. Similarly while the 1992 Maastricht Treaty, gave explicit recognition to the importance of public health protection measures including the strengthening of European health surveillance networks in relation to communicable diseases, some of these networks were already established. Echoes of the debate between federalists and functionalists can be seen in discussions as to whether to strengthen public health collaboration by creating networks of national centres or by establishing single supranational centres of excellence. Agreement was finally reached in 1998 to adopt a network approach and to strengthen early warning and rapid reaction systems.⁵

The 1997 Treaty of Amsterdam, both reinforced the provisions of Maastricht and promoted a wider perspective on the determinants of health by stressing that a “high level of health protection shall be ensured in the definition and implementation of all Community policies and activities.” This initiative should provide the basis for the application of health impact assessment to EU policies, as developed for example through the Verona Initiative, promoted by the WHO Regional Office for Europe. However, it has proved difficult to make progress in this area, there were delays in applying health impact assessment to past EU policies, in identifying EU policy proposals with potentially important health impacts and in promoting the practical implementation of health impact assessment at national level. The treaty also led to the establishment of the European Health Forum bringing together health professionals with an interest in public health (but strangely omitting patient groups).

It should be noted that the powers and actions of the EU relate to public health and exclude reference to health delivery systems, since this is an issue for member states. However, this does not mean that health systems are unaffected. A review of the implications of EU action for health and health systems⁶ showed that, while explicit European Union health policies had limited impact, there were many consequences arising from aspects of EU trade, competition and labour policies, including the working hours directive and, in parallel, the case law developed by the European Court of Justice had very significant implications.

This may have been in part because it was only in 1999 that the Directorate General

for Health and Consumer Affairs was established, bringing together EU responsibilities for public health. For this reason it is difficult to discern a EU health policy before this date. Current European public health policy is aimed at:

- Improving information on health for all levels of society.
- Setting up a rapid reaction mechanism to respond to the major health threats.
- Tackling health determinants, particularly by addressing harmful factors related to lifestyle.

A European Union strategy for global health

The relatively late development of explicit foreign and health policy perspectives within the EU does not mean that such issues were not important. The agenda of the EU includes many topics, which might naturally be thought to occupy the 'policy space' between health and foreign policy, for example:

- Trade policies have recognised the importance of ensuring the safety of food products and controlling the health impact of trade in products such as tobacco, blood and anti-microbials.
- Development assistance policies focus on the impact of trade and particularly agricultural trade on development, but the debate has also widened to include issues concerning health and safety, environmental standards, child labour and the development of civil society.
- Humanitarian aid programmes have focussed on emergency assistance, food and refugee support, of which health is an element.
- Enlargement of the EU raises issues relating to public health, the movement of health professionals within Europe, phyto-sanitary controls, occupational health and safety and health consumer protection.
- Security discussions have recently focussed on the prevention of bioterrorism.

There are of course tensions and inconsistencies between aspects of EU policy, for example, while promoting free trade to support development of poor countries the Common Agriculture Policy also offers EU farmers the highest level of agricultural subsidies in the world. Subsidies available to tobacco growers are greater than the

total EU budget directed towards health protection.

We believe it would be helpful and timely to develop a European Union strategy for global health, bringing together foreign and health policy perspectives. In the first place it would be helpful to see the development of a 'pathfinder' strategy; a set of proposals exploring the potential for strategy in this field and identifying research, development and political hurdles that would need to be addressed in a full strategy.

This could be supported by examination of the current impact of EU policies and actions on health and foreign policy objectives. It might be helpful to attempt to discern broad impacts arising from policies such as enlargement or the Common Agriculture Policy and to promote case studies to examine the health and foreign policy impacts of EU actions in relation to a specific poor country or accession candidate. At the same time we hope to stimulate debate within EU member countries to develop their own strategies for global health and to examine how action by government, the health industry and NGOs can contribute to global health and human security. We hope to proceed with such programmes in the UK and the Netherlands over the next year. This will in turn identify common policies and actions that might be taken forward in discussions at EU level. We welcome comments and suggestions for taking forward this initiative.

“It would be helpful and timely to develop a European Union strategy for global health, bringing together foreign and health policy perspectives”

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Health care shortages:

Where globalisation, nurses and migration meet



Frits Tjadens

“The drain of health workers from poorer countries can be a severe blow to their health care systems”

Europe is ageing rapidly, affecting health care for patients as well as care providers. During the recent economic boom several EU countries were unable to meet the demand for health care personnel, and now that the economic tide has turned, it will prove even more difficult to provide health care. Although structural shortages may decrease due to the cyclical nature of the nursing labour market, as soon as economies flourish once more, nations will again face the full force of personnel problems. How should countries deal with structural health care personnel shortages when populations are ageing? How do they deal with it? This article explores whether cross border movements by patients and health workers provide possible answers.

The immediate reaction to health care shortages is care rationing. This results in waiting lists and major economic and ethical questions concerning the distribution and allocation of care. Countries such as Norway, the UK and the Netherlands all have waiting lists, leading to further questions about the management and funding of health care, subsequent political debate, and possible ‘unorthodox’ cross border approaches.

Cross-border care

One ‘unorthodox’ possibility is to ‘export patients’. The European Court of Justice, in the Smits-Peerbooms cases, ruled that waiting lists are a legitimate reason for patients to seek treatment abroad. In the Netherlands, health care insurers were urged to be more creative in shortening waiting lists by contracting cross border care. Generally a number of factors contribute to mobility of health care utilisation in the EU:

- Individuals can seek treatment abroad of their own accord, be sent abroad by their health care payer, follow the physician (who, for various reasons, may be able to perform his duties abroad more effectively), or be sent abroad on medical grounds.
- Cross-border workers and border inhabitants.

- Retired expatriates requiring care in country of residence.
- People abroad on holiday or business.

Although data are scarce, incomplete and unreliable, nevertheless, there appears to be an upward trend in cross-border patient flows: increasing from 0.17% of European public health expenditure in 1989 to 0.5% by 1997.¹ Subsequently personnel shortages have increased and European Court judgements made. In-depth analyses of mobility flows are needed, as they may have consequences for systems, care providers and patients. Nickless,² for example, states ‘the Kohll and Decker decisions have enabled patients to make uninformed decisions about medical treatment in other Member States.... By making an uninformed decision to receive lower quality care, patients could be putting their health at risk without knowing it’. However one study reported that only a minority of German patients on holiday abroad experienced problems: (5% quality, 6% access and 13% language barriers).³ One question is whether these figures are similar for all categories of patients or just those on holiday, who may be more compliant and grateful given their sudden need? Furthermore is patient assessment similar to expert assessment?

Labour migration: universal motives and consequences

The second approach is to ‘import’ health workers. In a study commissioned by WHO Pacific Region on the migration of skilled health personnel (nurses, pharmacists, doctors) from small Pacific Island countries (PIC) such as Fiji, Palau, Samoa, Tonga and Vanuatu, many reasons were given why professionals leave the health care sector and migrate for instance to Australia and New Zealand. These include low remuneration, inflexible hours, heavy workload, lack of continuing education, limited training facilities, poor career development, poor working environment, resource shortages, and patient demands and complaints.⁴ At a recent presentation, strikingly these motivations turned out to be identical in the EU. Reasons for leaving

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the profession in the Pacific and in western Europe are similar. This raises fundamental questions about the long-term sustainability of health care, which need to be addressed. If answers could be found, they would not only support the sustainability of health care systems, but would reduce migratory flows as well.

From low to high: migration world wide

From Table 1, excluding nursing data from the Netherlands, which includes non-active and part-time working nurses, the richer countries have more health workers. The drain of health workers from poorer countries can be a severe blow to their health care systems, not in the least because it puts additional strain on fragile education systems. In the Pacific, Australia, New Zealand, and, to a lesser extent, Fiji are major recruiters. When the UK recruits from Australia, as in 1998–99 (see Table 2), the result is globalisation in action, where Australia becomes a transit country, just like Fiji and South Africa. Countries can be both importers and exporters of nurses at the same time. Not only do nurses migrate from one country to another, leaving gaps to be filled perhaps by a colleague from abroad, but sometimes they also ‘hop’ countries.

International recruitment in Europe

International recruitment occurs all over Europe. With the exception of the UK which recruits globally, this has involved relatively small numbers of individuals usually from neighbouring countries. This will probably increase as personnel shortages become more structural and pressing, draining resources in source countries and even increasing exploitation of workers. Hence WHO, trade unions, and professional associations not only speak out against recruitment abroad, but also propose more ethical practices.

Ethical recruitment: some experiences

Comparing figures and populations, Dutch imports would have to increase by 2,900% in order to reach the UK level. The UK has been increasingly active on the global market, unlike the Netherlands. Both countries recruit from their former colonies, as well as the Philippines.

In the Netherlands recruitment abroad invariably leads to parliamentary debate. The Dutch Minister of Health advised that recruitment in South Africa and Surinam be halted, following worries about draining

Table 1
SKILLED HEALTH WORKERS IN PACIFIC ISLAND COUNTRIES AND SELECTED OECD-COUNTRIES

	Doctors (per 10,000 population)	Nurses	Population (million)	Year of data
Fiji	3.57	19.35	0.84	1998
Palau	11.04	14.40	0.02	1998
Samoa	3.36	14.87	0.17	1998
Tonga	4.99	22.34	0.10	2000
Vanuatu*		26.00	0.20	1997
UK**	18.41	42.50	58.9	2000
The Netherlands***	18.12	130.50	15.8	2000/June 2001
Australia	26.00	82.00	18.76	2000
New Zealand*	22.60	84.50	3.81	1999

Source: WHO, Pacific Region.

* New Zealand and Vanuatu: nurses including midwives.

** UK: statistics exclude Northern Ireland; NHS-staff only; nurses include midwives and health visitors.

Source: www.statistics.gov.uk/statbase/Expodata/Spreadsheets/D5035.xls.

*** The Netherlands: doctors in curative sector only (2000).

Source: NIVEL, PRISMANT & OSA: *Rapportage Arbeidsmarkt Zorg en Welzijn 2001*, p.67. Registered nurses only (June 2001). Same source, *Bijlagen*, p. 93).

resources. Debate on the Philippines also focused on the supposed shortages in nursing staff. Parliament also discussed the Dutch Development Ministries refusal to cooperate with the Philippines because of their national debt, and bad relationship with the IMF. However, the Philippines deliberately train nurses for export and do have an infrastructure in place to receive financial compensation for training, factors ignored in the debate. Labour is one of the few natural resources and export goods in the Philippines.

Table 2
INTERNATIONAL NURSING RECRUITMENT BY THE UK AND THE NETHERLANDS

Source countries	Work permit applications in the UK		First work permits granted in 2001	
	1998–99 ⁵	2001 ⁶	UK*	Netherlands ⁷
Australia	1,771	601	277	
South-Africa	1,114	2,514	1,163	35
Philippines	972	10,050	7,422	39
Nigeria	920	1,100	354	
India		2,612	1,759	
Zimbabwe		1,801	261	
Ghana		493	147	
Trinidad & Tobago		357	43	
Surinam				25
Indonesia				10
Other		3,525	1,336	5
Total	4,777	23,063	12,726	114

* up to 17/12/2001.

Subsequent policy guidelines announced that recruitment ought to take place in the Netherlands first, in the EU/EEA second, and only then in the rest of the world, with a preference for pre-accession states, such as Poland. Recruitment abroad also should be restricted to countries with a plentiful supply. This led to debate on whether this would seriously hinder nurses moving abroad, if they wish to do so, or whether it would only mean that they will not travel to the Netherlands, but elsewhere, instead.

The Netherlands considers from an economic perspective its position in the international market, and ethically the consequences of external recruitment. The UK went further developing guidelines on ethical recruitment from abroad. Interestingly this begins with a statement that one can learn from foreign experience. As yet this notion has not reached the Netherlands, hence differences in perceptions on recruitment between the UK and the Netherlands. Another difference is language, the UK has a huge recruitment backyard, as English is the lingua franca of the western world. Dutch recruiters have thus far tried to recruit in countries where people speak some form of Dutch (Surinam, South Africa), and by a selection system that includes language courses. Nevertheless it is clear that the competitiveness of the Netherlands is not good in an increasingly global labour market.

Economy and ethics: questions for the near future

There are a number of questions relevant for all EU countries facing health care labour shortages now or in the future. How should small countries act in an increasingly global labour market for health care personnel, and how can we deal with third-country workers who then decide to try their luck in other EU countries? If countries need to 'import', can this be turned around into a win-win situation for all parties involved and if so, will rich countries inevitably win more often than the poor, or is a more equitable distribution possible? How does this relate to country-hopping by health workers?

How should EU countries act, will they end up as competitors, colleagues or in coalition? They need to deal with issues concerning basic human rights for workers, voters that want adequate health care and an end to immigration at the same time, ethical and practical questions surrounding operating theatres, health care employers

facing staffing shortages, and unclear migration processes.

If they decide to recruit from abroad, whom do they hire and how do they deal with the consequences? Do they hire young flexible nurses or only the experienced, people without children to minimise homesickness, or those with children to maximise economic profit of wages for the source country? Should they only accept unemployed nurses to reduce the strain of systems?

If EU countries decide to collaborate and adopt identical ethical stances, will this limit their recruitment area, leading to fishing in the same pond, and thus to even harder competition?

What would this imply for a small country like the Netherlands, with its language disadvantage? Should it consider a unique selling proposition to compensate for this, and if so what should it be?

Could processes lead to a scenario where larger member states (with language advantages) recruit abroad, smaller member states 'export' patients, and accession states become suppliers of skilled health workers? What are the effects of migratory flows on the quality of care? Finally to what extent is language still a crucial variable, given that societies have become increasingly multicultural?

Epilogue

Mobility within the EU will have an increasing impact on health care systems. In fact, it might lead to an increasing internationalisation of systems. For employers, non EU countries are certainly not the first place to look for personnel, as indicated by a Dutch survey earlier this year. But when all is said and done, that is what they will do. More and more EU countries face severe staffing problems in their health care systems, not only including nursing and medical staff but also less qualified care personnel. No solutions have yet been found for this problem. There is a need for EU-wide monitoring and evaluation of innovative initiatives to balance supply and demand, including cross border mobility of both health care workers and patients. The Social Protection Committee, in its thinking about its Open Method of Coordination on health care and care for the elderly, proposes a focus on accessibility, quality and financial viability. All three issues are heavily influenced by the availability of skilled workers, but no mention has been made of this.

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Devolution of health care in Spain to the regions becomes reality



Guillem Lopez-Casasnovas

Even the most optimistic observer did not believe that the Conservatives would decentralise health service management to all Spain's Autonomous Communities (AC). Nevertheless, the government surprised everyone in July 2001 by agreeing new fiscal arrangements with ACs (some under socialist control), including the devolution of health care responsibility.

It came as a surprise

The speed and comprehensiveness of the transfer came as a surprise. First, because some had argued; including trade unions, that previous decentralisation in seven regions (60% of overall expenditure) had eroded social cohesion. Second, the opposition party was divided, representing on one hand a regional partisan view, and on the other, an alternative government keen not to weaken central control. Third, some areas lacked detailed agreements, notably on finance (for example, on costing services and redistribution parameters), and on basic central regulation of health planning and coordination. The latter is not trivial as ten ACs have populations under two million.

Why then has this happened? One political interpretation is that politicians believe public health care is unmanageable (for example, complaints, demands for extra resources, resistance to administrative change etc) and decentralisation is therefore the first step towards privatisation. Additionally, by limiting central commitments the Government may protect its own purse, leaving the regions facing the political consequences.

However the Conservatives are involved in a number of ACs, Madrid, Galicia, Castilla – Leon and Cantabria, and there is only anecdotal evidence suggesting they favour privatisation of provision and funding. Alternative arrangements may have looked extremely complex. For example, organising health care for 40% of the population, with high disparities between centrally managed regions (because of the generous treatment of Madrid AC) under consortia agreements; with regulated cross boundary flows and other mechanisms appeared complicated. Additionally, there were

expectations by partisan politicians that transferring health responsibilities would change the political balance both between Nationalist/Socialist and Conservative administrations, and also in Conservative areas of influence. If not already begun, decentralisation would not have started now, but given its progress, any return back to centralisation appears worse than further devolution. Extending devolution is also a way of weakening the search for differential power positions by more nationalistic ACs (Catalonia, Basque country and Navarre) in favour of so called 'café para todos' (coffee for all).

The new fiscal agreement

Some key features of the new arrangements are summarised:

1. Regional health care finance is now included in general financial AC agreements. Previously it was decided by separate negotiation between the national and corresponding regional Ministers of Health. Given that health care budgets accounted for 40% of regional expenses, negotiation could seriously affect regional finance. Now it will not be determined by political bargaining between central and regional Departments of Health, but firstly by finance ministers initially, and secondly, by regional ministers within each AC. Regional parliaments will now have a more decisive say on health policy.
2. There is a minimum level of health expenditure. This may be based on (i) expenditure at time of transfer or (ii) share of overall central expenditure weighted by population (75%), age (24.5%) and 'insularity factor' (0.5%) (Balearic and Canary Islands only). If the former is greater, the central government is committed for three years only to maintain expenditure

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increased by nominal GDP growth and at factor costs. However, above the basic level, each AC in future can use its own funds discretionally to increase expenditure.

3. From 2002, funds to finance all AC services (including health) now come from a share of taxes collected regionally: income tax (33%), VAT (35%), petrol, tobacco and alcohol taxes (40%), and 100% of minor taxes (for example, car registration, energy tax, inheritance, property transfer, gambling). Initially, everything, including the central transfer equalisation, will be computed to guarantee that all basic needs (health, and education – in per capita terms) will be covered. This applies also to some pre-set increases over time. If revenue sharing capability increases, e.g. if regional consumption indicators increase in percentage terms, or if a surcharge on income tax is applied (+/- 20%), no restrictions will apply to this additional revenue.

4. To preserve cohesion, and avoid 'excessive' deviation in per capita health spending, central transfers will help those AC that have increases in public health coverage (for example, legal immigration) three points above the Spanish average. Additionally, all AC will have to finance at least some of the increase in basic health care. No maximum level is defined, a variable average according to the effectiveness of regional revenue raising capacity may result. Increases in funding, may arise from the possibility of setting a petrol tax on consumers (as a surcharge) just to finance health care. This is not a real earmarked tax, but a way to build a more politically acceptable tax. The Central Administration has already approved a central tax on petrol to finance planned health expenditure. AC strongly complain that this makes it more difficult to impose their own taxes as stated in fiscal agreements. At any rate Madrid has recently created the surcharge for the fiscal year 2003.

5. A Cohesion Fund from the central budget will allocate resources to compensate for cross boundary flows of patients amongst regions. The central state plans to create a homogeneous information system with DRG type billing, subject to negotiation with regional health authorities. Some regions seem prepared to coordinate themselves to avoid central intervention, for example, in the extended central (Madrid and both Castillas) health region. Caveats exist on compensation for new central regulations or pricing policies that affect regional expenditure, for example,

reimbursement of new drugs and new technologies. Without compensation, regional acceptance is less likely.

6. A defined basic entitlement package will become a necessity if patients are not to exploit differences. Diversity should not be a cause for concern, (so legal precedent suggests) provided the basic minimum package is covered, and additions financed by regional sources. Handling other variations in policy, such as for drugs, may not be straightforward. Regions will not negotiate drug prices, but may well influence the prescribing habits of professionals, posing new challenges to drug company marketing departments.

The future: fewer geographical equity taboos and more fiscal accountability

Integration of health care within the general financing system for all AC indefinitely should end a very contentious political process. The present system has promoted little consensus among health authorities, the only common interest being their demand for more resources from central government. There have been endless disputes on the share of funds allocated between ACs, consequently all health problems are blamed on a lack of resources, with little discussion of new evidence-based policies.

Now, complaints about central under funding of regional health care will have to cease. This is appropriate because, despite common perception, Spain is not an unequal country in terms of health delivery and finance. This is borne out by a recent study that evaluated the impact of regional health policies since the first health transfers to Catalonia in 1981.¹ Indeed the coefficient of variation in regional health care finance per capita is one of the lowest in systems for which territorial health care expenditure may be identified. Contrastingly, France and England are among countries with the most uneven distribution of health care resources. This is probably because their health regions are geographical artefacts, with no parallel in regional government. Therefore, differences are not readily translated into the political arena, as in Spain or Italy, and central governments are under little political pressure to justify variations.

Additionally, differences observed between Spanish regions relate to relatively few programs that have little practical relevance to health status. For example, Andalusia

finances certain low therapeutic value drugs, which are excluded in most regions. Only a few regions will finance sex change operations or the 'morning after' contraceptive pill. These differences should cause few equity concerns, as they reflect different political views on public preferences. Such interventions should be self-funded, as there seems little basis for inter-regional transfers to support them. Indeed, where conducted, regional opinion polls seem to favour keeping such decisions close to citizenry affected.

Having said this, we should also recognise that we know relatively little about health differences deriving from variations in quality of care or clinical practice. Probably there is no fundamental regional pattern to such disparities. The main equity concern probably relates to intra-regional differences rather than inter-regional differences. Those who have spoken loudest against the dangers of inter-territorial inequities have not usually made as much effort to redress imbalances between local areas within regions.

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Stimulating interest in European public health



Owen Metcalfe

“Improved collection and dissemination of health information and knowledge is of vital importance”

The relationship between individual states and the European Union is brought into sharp focus with current moves towards greater integration and enlargement. Historically the economy and security have been to the fore in debates but after the Maastricht and Amsterdam treaties were adopted, the EU was awarded specific jurisdiction in the field of public health. There is a new Directorate General for Health and Consumer Protection and there will be an “increasing involvement of European Union institutions in health policy including direct involvement on public health and health protection”.¹

There is also an aspiration that the Commission has a stance on the overall approach to health across different policy areas. The aim is to ensure that the impact of a public health programme is reinforced by policies and actions in areas having an effect on health and health systems. As part of this changing landscape the Commission prepared a health strategy document and proposal for a programme of community action in the field of public health. This article provides an overview of reactions and details a process used on the island of Ireland to explore implications of this programme.

There had been a general perception that those in the Republic were more informed about European developments than their Northern counterparts. In Northern Ireland many involved in public health thought EU health developments had not made a significant impact. The newly

established Institute of Public Health in Ireland was seen as ideally placed to explore the implications of the new EU programme for all on the island.

Responding to feedback obtained from this and many other responses throughout Europe, the Commission produced an amended proposal. At their June 2001 meeting the Health Council reached political agreement on a common position for a programme of community action in public health. The programme budget is currently €280m.

Initial reaction to the EU Programme

The initial proposed health strategy received a broad welcome from member states, the European Parliament, and many other stakeholders. The European Public Health Alliance (EPHA) stated that “*the Commission’s health strategy document and action programme provides a solid framework for EU health policy*”² The Catalan Health Minister, said that “*the new health strategy represents a qualitative leap in European health policy and points very clearly to an increasingly important role for health in the construction of the European Union*”.³ Dr. Tapani Piha called the proposal “*very interesting and profound, and the first overall approach to health across different policy areas in the community*”⁴ The Institute of Public Health in Ireland’s Director said “*the new EU Programme offers us a wonderful opportunity to take action together to tackle the causes of ill health*”,⁵ while the

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“Increased interest and commitment could be achieved with the establishment of designated international and European portfolios within public health organisations.”

European Network of Health Promotion Agencies (ENHPA) welcomed *“the emphasis and importance given to a more strategic approach to the impact on health of other EU policies and the broader content of health within EU policies”*.⁶

Although the proposal was welcomed as a deepening and focusing of the Community’s approach to public health many commentators had concerns. The ENHPA felt that the budget was not adequate, and as the programme would only fund 50% of project costs, many innovative organisations would not participate. Funding is small compared to other issues such as EU subsidies on tobacco. The EPHA commented generally that many strategic questions and operational issues remained unresolved.⁷

One innovative feature of the programme is the establishment of a forum to promote wide consultation and participation. It is difficult though to see how representation can be achieved in the forum, the diversity of interests in public health will make consensus often impossible. Thus despite this innovation, the overall impression is

that the proposed programme is cautious, seeking to consolidate previously successful areas.

The Irish response

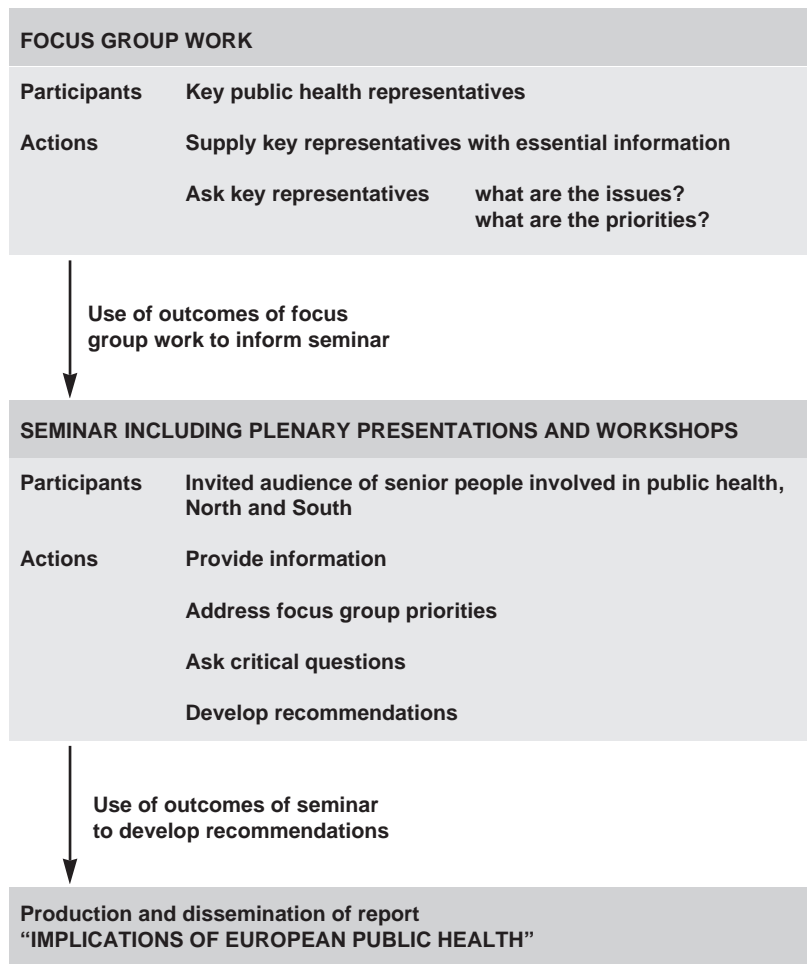
Apathy had previously caused one commentator to state, *“it is striking to note how little attention has been paid by public health professionals to debates on public health.”*⁸ Thus the Institute wished to ensure that the public health community were not ignorant or apathetic to this important European development. Debate about the programme was stimulated with the aim of developing clear recommendations and actions that would, firstly allow for a strengthening of links for public health on the whole island and with the rest of the EU, and secondly maximise the potential for public health development offered by the programme.

A combination of focus group work, didactic information sessions and workshops were used to arrive at agreed recommendations on how to move forward and maximise the potential of public health. (See Figure 1). Focus group methodology allowed the identification of key issues without requiring a large group of participants. Focus groups consisted of senior management from public health, health promotion and community development. After reading the proposed EU Programme and discussing crucial priority areas in public health, this group identified four key areas to be addressed to strengthen public health links within Ireland and with the rest of Europe:

- Improving the collection and dissemination of health information and knowledge in Ireland, North and South and in Europe.
- Strategic development of public health policy in Ireland, North and South and in Europe.
- Clarifying and defining responsibilities, roles and structures in Ireland and Europe.
- Integrating health into other policy areas in Ireland and in Europe.

A seminar was then held by the Institute; *European Public Health – The Irish Connection*. Over 100 individuals participated and were provided with information on the programme by Commissioner Byrne, as well as an assessment of programme contents by relevant experts. Seminar participants took part in separate workshops addressing the four themes previously identified by focus groups. Key

Figure 1
PROCESS USED TO DEVELOP RECOMMENDATIONS



recommendations and actions arising that would strengthen public health in Ireland and Europe in the four groups are summarised below. More detailed information is available elsewhere.⁹

To improve the collection and dissemination of health information and knowledge: conduct an information audit on the current availability of health information and data sets; additional data are required in areas where deficits exist, particularly for determinants of health and inequalities; standardisation is required of data collection, management, analysis and reporting procedures; information systems should incorporate components for analysis, reporting and communication of information.

For strategic development of public health policy in Ireland, North and South: public health must be defined on a multi-disciplinary and multi-sectoral basis; the consultation process in public health policy development is crucial; structures allowing for easy, effective communication to take place at local, regional, national and international level need to be established; structures and consultative processes need adequate financial and personnel resources; all health strategies and policies should have as a core aim the reduction of social and health inequalities.

To clarify and define responsibilities, roles and structures in Ireland and Europe: conduct an audit of roles, responsibilities and structures for public health; given health issues are not considered important by many outside the health sector, responsibilities must be allocated across Government departments, and commitment to the health agenda obtained at senior level; a health forum is a useful mechanism for achieving collaboration on health.

To integrate health into other policy areas in Ireland and Europe: a wider awareness of influences on health is important in promoting public health considerations; cross sectoral working is essential for effective public health; all relevant policies must be health proofed, health impact assessment is one tool for this; strategic and protected budgeting is critical in ensuring health integration into other policy areas; strong determined leadership is needed to secure political support for integration.

Conclusions

This process resulted in very clear recommendations about how this exciting development can be used to strengthen

public health in member states and at European level. The Institute is certain that if these recommendations are followed, the impact and effectiveness of the programme will be greatly enhanced. Prioritisation is difficult, but the Institute learnt that improved collection and dissemination of health information and knowledge, and the requirement for public health to tackle social and economic inequalities are of vital importance.

These recommendations can be addressed within the EU stated aspiration of improving health information, knowledge and addressing health determinants. The Institute believes that all its recommendations can be implemented, but sustained commitment will be necessary to achieve this. It calls on the Commission, the Council and Parliament to allocate sufficient resources to ensure implementation. The changes in the programme whereby 70% of project costs may be available, compared to 50% outlined initially are welcome, but the Institute remains very concerned that the Health Council meeting assigned only €280m to this programme.

It is also concerned that many in public health, not just in Ireland, but elsewhere, are unaware of and uninterested in European developments. This apathy is not good for public health. The proposed EU forum for health, if operated inclusively, can attract participation and interest from a wide range of stakeholders and assist in overcoming apathy and increasing interest. This increased interest and commitment could be achieved with the establishment of designated international and European portfolios within public health organisations. The recommendations highlight the necessity for increased contact and communication between public health organisations throughout Europe.

This programme has the potential to make a significant impact on public health in Europe. The degree to which member states engage with the programme will be critical to success. This is a two way process, progress in European public health will depend on member state and Commission commitment. Arrangements for the management and implementation of the programme are critical and must include appropriate member state representation. If the Commission addresses the recommendations outlined here, the Institute believes there are major opportunities for a bright future for European public health in the first decade of the century.

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EUROPEAN HEALTH FORUM DISCUSSES EU ENLARGEMENT AND RESEARCH

The European Health Policy Forum met in Brussels on June 20 to discuss Health and EU Enlargement and the new Sixth Framework Research Programme. Representatives of some 40 stakeholder groups were present.

Health and Enlargement

Dr Magdalene Rosenmoller presented the health service challenges of enlargement on behalf of the European Health Management Association (EHMA). She stressed that EU accession negotiations have not adequately addressed health systems. While negotiations have focused on implementing the very narrow public health dimension of EU legislation (the 'Acquis'), policies supporting health system development in accession states are fragmented.

Draft recommendations presented at the meeting called on the Directorate-General for Health to take the lead in launching a new joined up strategy or 'coordinating centre'. This would bring together all DGs to address pressing public health and health infrastructure deficiencies and provide a central information point for accession countries on all EU health related issues. Such a development would clearly require additional resources for the Public Health Directorate.

This call for a coordinating office providing information for accession countries was also echoed by Louise Sarch from the European Heart Network (EHN). She also highlighted the challenges of communicable disease (tuberculosis, hepatitis, HIV/AIDS, other sexually transmitted diseases and diphtheria), non-communicable disease (cardiovascular diseases, cancer and injuries) and the need to develop civil society and public health infrastructures.

EU Research

Following a presentation of the Sixth Framework Programme (FP6) by Octavi Quintana, the newly

appointed Director of 'Life Sciences: Research for Health', discussion highlighted the absence of ring fenced research funding to implement the policy priorities of DG Health's new EU public health programme and the lack of any defined focus for health services research within the new programme structure. However, Fernand Sauer, Director of the Commission's Public Health Directorate, expressed confidence that the new public health programme would benefit from greater resources available from FP6.

Further information on the meeting is available at: http://forum.europa.eu.int/Public/irc/sanco/ehf/library?l=/policy_2002_brussels

Future Priorities

In concluding discussions, speakers including Clive Needle of the European Network of Health Promotion Agencies (ENHPA) stressed that the role of the Forum must be to provide input into policy discussions at an early stage rather than simply reacting after the event. Pressing issues for future discussion include health aspects of the Intergovernmental Conference and Treaty reform, which will be taken up at the next meeting in November.

6TH RESEARCH FRAMEWORK PROGRAMME ADOPTED

On 15 May, the European Parliament approved the Commission's proposal for the new EU Research and Development Framework Programme (FP6). The Employment and Social Council formally adopted FP6 on June 3.

The new programme will run until 2006, with a budget of €17.5 billion, a 17% increase on FP5. This represents a substantial EU financial and policy effort to upgrade European scientific knowledge, quality and competitiveness. Some 34 amendments were made to the final text by Parliament on expenditure breakdown, reflecting Parliament's concern that emphasis be placed on tackling serious diseases such as cancer and those that affect children.

Amongst the priorities covered by FP6 are life sciences, genomics and biotechnology for health, information science technologies, new production processes and devices, food quality and safety, sustainable development, global change to

ecosystems, and citizens and governance. FP6 will also introduce new instruments, such as networks of excellence and integrated projects to help pool financial and intellectual resources,

The sensitive issue of ethics in the programme was not adopted, due to divisions between Member States. The Commission will append a declaration stating that it will not finance research programs involving genetic manipulation, human cloning or the creation of embryos for research purposes. The first call for proposals is expected in autumn 2002.

Further information is available at: http://europa.eu.int/comm/research/fp6/index_en.html

EU HEALTH COUNCIL: PATIENT MOBILITY AND HEALTH CARE DEVELOPMENT

Health Ministers met in the EU Health Council (27 June 2002) to agree a set of conclusions on patient mobility and health care developments in the EU. They also reviewed the current state of play of EU tobacco control, prevention of drug dependence, reform of EU pharmaceutical legislation, quality standards for human cells and tissues, and results of the G10 Medicines high-level group.

It was recognised that although there is a wide range of issues linked to patient mobility and health care in the European Internal Market, no forum exists for hosting these discussions. Therefore, EU Health Commissioner Byrne announced the establishment of a 'high-level process of reflection' to resolve this issue and take discussion forward.

The Council's Conclusions on Patient Mobility and Healthcare are reproduced below:

1. The Council and the representatives of the Member States meeting in the Council recognise that health care systems in the EU share common principles of solidarity, equity and universality, despite their diversity. They also recognise the emerging interaction between health systems within the EU particularly as a result of the free movement of citizens, and their desire to have access to high quality health services.

2. The Council recalls that according to Article 152 of the Treaty, Community action in the field of public health must fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. However, it recognises that other developments, such as those relating to the single market, have an impact on health systems. The Council is concerned that these should be consistent with the Member States' health policy objectives, and the common principles outlined above. It therefore considers that there is added value in examining certain health issues from a perspective that goes beyond national borders. In this context it welcomes the debate at the seminar of health ministers held in Malaga in February 2002 which sets out a number of priority issues for further cooperation and takes note of the expert discussions on this subject.

3. The Council takes note of the ongoing work on the future of

healthcare and care for the elderly being carried out by the Social Protection Committee and the Economic Policy Committee on the basis of the conclusions of successive European Councils. It also notes the work being undertaken on the reform and modernisation of Regulation 1408/71 which should provide a simplified framework to support, inter alia, patient mobility. It underlines the necessity to take health concerns and patients' interests fully into account in this process in which the delivery of care shall be another main concern together with the administrative issues. The relevant instances of the Community and its Member States should be fully involved regarding the implications of this process. In particular, the Ministers of Health should be fully involved in this process.

4. With regard to developing cross-border cooperation, the Council and Member States' representatives recognise that bilateral or regional arrangements, which respect the competence of Member States to organise their health care systems and which are in accordance with relevant Community legislation, can play an important role, and they underline the importance of sharing information about such initiatives. They emphasise that patient mobility, especially concerned with tourism or long-term residence abroad, presents particular challenges in terms of the need to exchange clinical and other information, in order to ensure proper follow-up and continuity of care. They recognise the importance of cooperation, inter alia, to examine the benefit of reference centres, in order to facilitate the most effective treatment for those diseases requiring specialist interventions.

5. The Council recognises that the new programme of Community action in the field of public health

together with, inter alia, the new research and telematics programmes provide a framework to pursue a number of issues in relation to mobility of patients, in particular aspects relating to information and exchanges of experience.

6. In the light of these considerations, the Council and Member States' representatives consider that there is a need to strengthen cooperation in order to promote the greatest opportunities for access to health care of high quality while maintaining the financial sustainability of healthcare systems in the EU. The imminent enlargement of the EU makes this even more imperative.

7. To this end the Council and the representatives of the Member States meeting in the Council:

– recognise that there would be value in the Commission pursuing in close cooperation with the Council and all the Member States – particularly health ministers and other key stakeholders – a high level process of reflection. This process should be closely coordinated with relevant work ongoing in different fora, including action already initiated in the context of the Lisbon process. This high-level process of reflection, about which they wish to be kept regularly informed, should aim at developing timely conclusions for possible further action.

– welcome the Commission's intention to take forward work in this field, inter alia by including relevant actions in its work plan for the programme of Community action in the field of public health.

8. The Council and Member States' representatives will return to this issue at the next meeting of the Health Council, taking into account the developments of the reflection process mentioned above.

A full report of the meeting is available at: http://europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=MEMO/02/1550|RAPID&lg=EN

EUROPEAN PARLIAMENT APPROVES 'FOOD HYGIENE PACKAGE'

On May 15 Parliament approved in a first reading (with many amendments) Commission proposals on a 'food hygiene package' originally adopted by the Commission in July 2000.

The package includes proposals on general food hygiene, hygiene of food of animal origin, and animal health rules. The new regulations will merge, harmonise and simplify complex hygiene requirements previously scattered over 17 directives. They require food operators to bear full responsibility for the safety of the food they produce, with the help of programmes of self-regulation and modern hazard control techniques. Legislation sets objectives, leaving national governments and businesses the flexibility

to decide what safety measures to take, rather than prescribing them in great detail. Amendments adopted by Parliament included making exceptions for traditional local specialties. The package will be discussed in the European Council and adopted through the co-decision procedure.

General information about the initiative is available at: www.europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=IP/02/719|0|RAPID&lg=EN

The Commission and WHO join forces to tackle health threats

Last year, WHO and the European Commission explored the possibility of establishing a new partnership and a framework for cooperation. Subsequently, a series of high-level consultations were held in Brussels in June to advance joint efforts to tackle health threats throughout the world. Public Health Commissioner Byrne, Trade Commissioner Lamy, Research Commissioner Busquin and Development Commissioner Nielson as well as senior officials from DG Environment and WHO Director General, Dr Gro Harlem Brundtland, discussed joint strategies to address a wide range of health related issues, including smoking, communicable diseases, health research, access to medicines, the environment and health, nutrition and food safety.

The meeting reviewed ongoing and successful cooperation between the EU and WHO on a variety of different initiatives, such as the Programme for Action on Communicable Diseases in Developing Countries and the development of new international public/private partnerships, such as the Global Fund, which has committed funds to more than 40 developing countries to fight AIDS, Tuberculosis and Malaria. They decided to work towards increasing the amount of Official Development Assistance (ODA) targeted towards health (currently at 7.4%) and agreed on major trade related issues to improve access to medicines. Future priority areas for cooperation include strengthening the existing partnership on tobacco issues and health information as well as exploring ways for cooperation in new areas such as health aspects of EU enlargement, the link between poverty and health, and child health.

The Commission Press Release is available at: www.europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=IP/02/830|0|RAPID&lg=EN

RESEARCH SHOWS THE LINK BETWEEN UNEMPLOYMENT AND HEALTH

A new study *Unemployment and Public Health*, led by Professor M Harvey Brenner from the Technical University, Berlin, and sponsored by the European Commission reports a direct link between ill health, life expectancy and long periods of unemployment. According to the study, those who work usually live longer and enjoy better health. Active labour market policies, which result in increased employment, improve the health of individuals.

The Interim Report is available at: www.europa.eu.int/comm/employment_social/news/2002/may/unempl_en.html

In addition, a new study by Anneke Goudswaard and Frank Andreis from the TNO Research Organisation prepared for the European Foundation for the Improvement of Living and Working Conditions indicates that temporary staff across the EU continue to experience poorer working conditions than their permanent colleagues. They perform less skilled jobs, receive lower incomes and have less access to training.

The report is available at: www.eurofound.ie/publications/file/EF0208EN.pdf

PARLIAMENT SUPPORTS COMMISSION PROPOSAL FOR AN AMENDMENT TO THE FOOD LABELLING DIRECTIVE

On June 12, the European Parliament approved a Commission proposal to amend the food-labelling Directive.

This is intended to ensure that all consumers are informed of the complete contents of foodstuffs, enabling consumers with allergies to identify any allergenic ingredients present. The proposal means that all ingredients added will have to be included on the label and will abolish the '25% rule' which is currently in place and holds that it is not obligatory to label components of compound ingredients that make up less than 25% of the final product. The proposal will also establish a list of ingredients liable to cause allergies, including alcoholic beverages if they contain an ingredient on the allergen list. The Council is expected to adopt a common position in November 2002.

News in Brief

Commission funded public health projects

The Commission has released further details of projects funded in 2001. These are available at:

AIDS

<http://europa.eu.int/comm/health/ph/programmes/aids/2001indx.htm>

Rare Diseases

http://europa.eu.int/comm/health/ph/programmes/rare/fundproj2001_list.htm

Health Monitoring

http://europa.eu.int/comm/health/ph/programmes/monitor/proj01indx_en.htm

Commission doubles research spending on pharmaceuticals

Speaking at the annual assembly of the European Federation of Pharmaceutical Industries Associations (EFPIA) in Bruges in June, Research Commissioner Busquin committed at least €2 billion to pharmaceutical research within the sixth framework programme, with a particular priority on genomics and biotechnology for health. This compares with €1 billion under the fifth framework. He called for greater research spending in future to improve the international competitiveness of the EU pharmaceutical industry.

Further information is available at: http://europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=IP/02/920|0|RAPID&lg=EN

Commission to invest in nanotechnology research

Machines no bigger than a molecule will one day surf our bloodstream, search and destroy infected tissue and heal our wounds. This is just one application of nanotechnology. On June 14, the EU Research Commissioner chaired an information day on *Nanotech New Frontiers* in Grenoble, France. Research is still in its infancy and will be more effective if coordinated and supported at EU level. The Commission will therefore allocate €700 million to research within the 6th Framework. More information on nanotechnologies is available at www.cordis.lu/nanotechnology

Initiative on access to drugs for low-income countries

The EU has unveiled a plan to ensure that low-income countries with no domestic drug production can obtain affordable supplies of essential medicines. The plan is set out in a communication to the Trade Related Intellectual Property Rights (TRIPS) Council at the World Trade Organisation in Geneva and follows on from a Declaration made in Doha last November on TRIPS and Public Health. The plan would enable a foreign supplier to fill orders on the basis of a compulsory licence to address the specific public health needs of another WTO member state.

The full text of the EU Communication to the TRIPS Council is available at:

<http://europa.eu.int/comm/trade/miti/intell/intel3.htm>

More information on access to essential medicines is available at: <http://europa.eu.int/comm/trade/csc/med.htm>

Directive on products used to test the safety of blood

The Commission has approved a new Directive that establishes EU wide technical specifications for products used to test the safety of blood and organ donations. These common technical specifications (CTS) replace existing national rules for products used to ascertain blood groups and test for infectious agents such as HIV and Hepatitis. Manufacturers are expected to comply with these specifications unless they have appropriate reasons for doing otherwise and can offer a solution that is at least equally safe.

European Health Insurance Card

The Employment and Social Policy Council (June 3, 2002) adopted a resolution giving further momentum to the implementation of the Commission's Action Plan for Skills and Mobility, including the upcoming European Health Insurance Card. The Council agreed on a proposal to step up protection of workers against the risks relating to asbestos exposure, and also approved the Community strategy on health and safety at work for the period 2002–2006.

Danish EU Presidency Priorities

In a speech to the European Parliament on July 3, Prime Minister, Anders Fogh outlined the priorities of the Danish Presidency. The programme will be based on the theme *One Europe* with the principle aim of completing enlargement negotiations in Copenhagen at the end of the year. The Danish EU Presidency website stresses continuity rather than bringing forward major new initiatives in the health field. "In the health field, it will be very important for the Danish Presidency to follow up the present debate on the future shape of European co-operation. Work on the proposed Directive on tobacco advertising and negotiations on the WHO international convention on tobacco control also constitute high-priority health issues. Considerable priority is attached lastly to pressing ahead with discussions on reform of EU pharmaceutical legislation."

Further information on the Danish EU Presidency programme is available at: www.eu2002.dk/programme/

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