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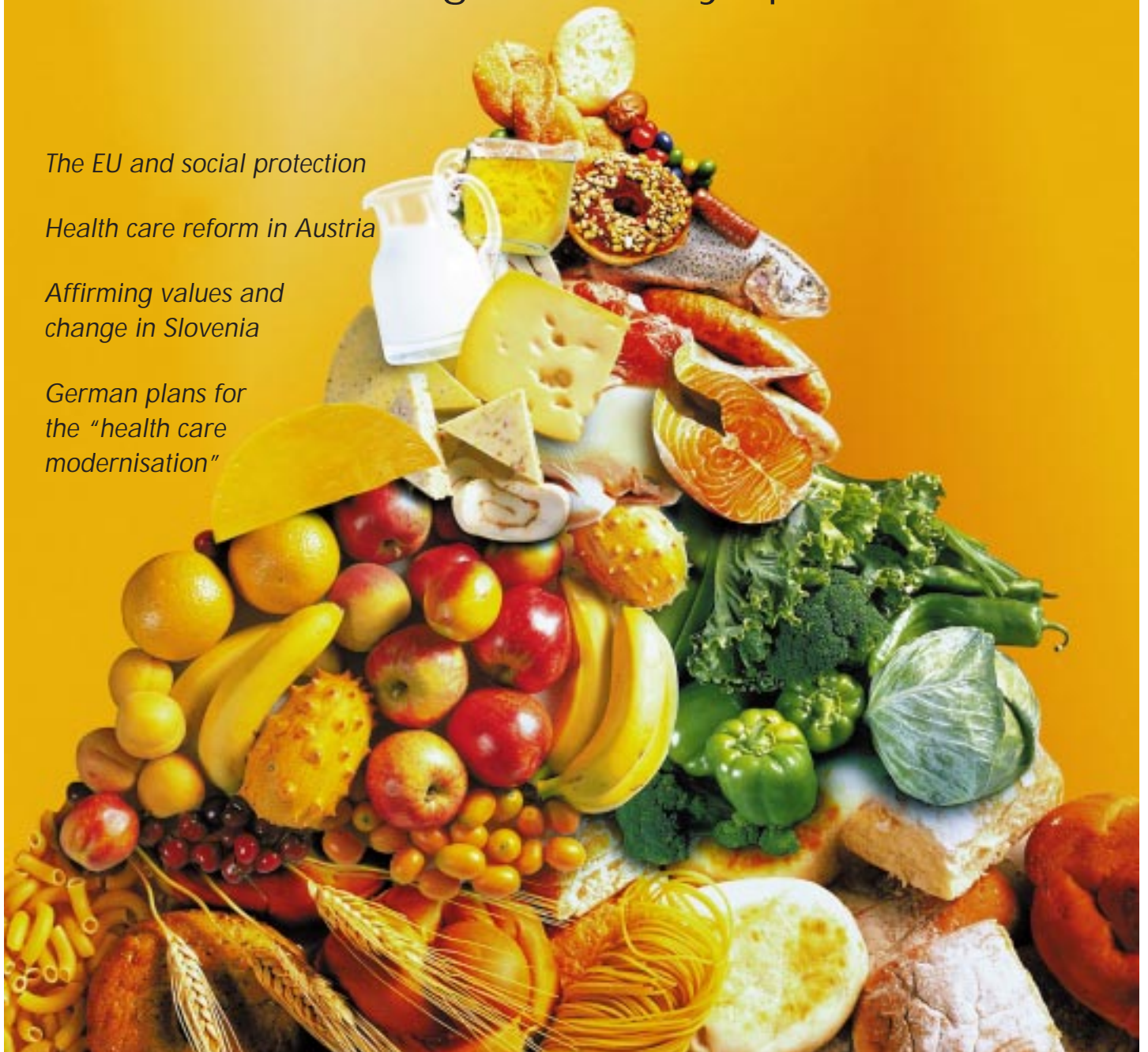
EU Action: tackling the obesity epidemic

The EU and social protection

Health care reform in Austria

*Affirming values and
change in Slovenia*

*German plans for
the "health care
modernisation"*



Greek Presidency: Interview with Costas Stefanis,
Minister of Health and Welfare, Greece

COMMENT

In this issue we are delighted to feature an interview with the Minister of Health and Welfare in Greece, Costas Stefanis, who discusses the priorities for health in Europe under the Greek Presidency and also those issues of great importance for the Greek health care system. In his interview one issue to which the Minister draws attention is the need to undertake measures to tackle the stigma and social exclusion that people with mental health problems have to endure right across Europe. With this in mind the Greek Presidency held a conference on stigma and mental illness in Athens in March with the subtitle 'Facing up to the challenges of social inclusion and equity', with a view to introducing this issue to the Council of Ministers at their meeting in June. I was fortunate enough to have attended this important conference, in which not only was the prominent role that Professor Stefanis played throughout the event there for all to see, but also the very positive and active contributions made by two European Commission DGs Health and Consumer Protection, and Employment and Social Affairs, alongside the ever strong commitment and contribution of the World Health Organisation.

Stigma of course is associated with many conditions whose symptoms are difficult to hide, and obesity is another issue that not only can have severe consequences for health and quality of life, but also carries with it a high degree of social stigma. Commissioner David Byrne, writing in this issue, outlines actions that he believes that the EU should be doing to counter what he describes as the 'obesity epidemic'. He recognises that the real challenge lies in the implementation of effective strategies, and believes this is an area where the EU 'needs to pool its intellectual resources'. Indeed, under the current Public Health Action Programme, funding will be provided for the creation of networks to pool resources and improve monitoring and analysis of EU-wide data. The importance of improving nutrition labelling so that it better informs consumers is also noted as a key issue. Geof and Mike Rayner in their article on this issue emphasise the important socio-economic consequences of obesity not only within health care systems but also more widely across society. They refer to the situation in the United States where the propensity for the consumption of fast food has been a major factor in the increase in obesity, and note urgent calls for action to tackle the problem early on within schools, and also by reforming advertising protocols. Like the Commissioner they too call for pan-European collaboration, recognising the major gaps particularly in estimating the economic costs and consequences of being overweight or obese. It is to be hoped that the Public Health Action Programme will go some way towards plugging this gap.

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Published by LSE Health and Social Care, EuroHealthNet, and the European Observatory on Health Care Systems, with the financial support of Merck & Co and the European Observatory on Health Care Systems. News section compiled by EuroHealthNet, EHMA and HDA.

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

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

The European Observatory on Health Care Systems is a partnership between the WHO Regional Office for Europe, the governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine.

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Design and Production: Westminster European,
email: westminster.european@btinternet.com

Printing: Seven Corners Press Ltd

ISSN 1356-1030

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Interview

with Costas Stefanis Minister of Health and Welfare, Greece

“More emphasis should be given to the elderly, people with disabilities and migrants in the priorities of the EU”

What will be the priorities in the area of health and welfare under the Greek Presidency?

The Ministry's programme during the Greek Presidency of the European Union essentially has two parts. The first aspect will look at the Community legislative frameworks in the area of health care. The second part of the programme consists of several events that the Ministry has organised, such as conferences, committee meetings, and the convening of expert working groups (which will include high-level officials from member states) that will take place during the six month period. The purpose of these meetings is to explore and promote public health issues.

The main objective of these events is to enhance cooperation between member states in various areas of public health and to achieve a fruitful dialogue on the future of health services in a unified Europe. We also hope that they will shed light on those aspects of public health that could be included in community policies.

In terms of priorities during the Greek Presidency, the Ministry of Health and Welfare will focus on the following issues:

1. Revision of EU pharmaceutical legislation.
2. Proposing a Directive on safety standards for tissues and cells.
3. Proposing a Recommendation on the early detection and prevention of cancer.

More specifically, the revision of the

European Union's pharmaceutical legislation includes proposals for the adoption of a Regulation and two Directives which will update Community pharmaceutical legislation regulating the marketing authorisation process of proprietary pharmaceuticals for human and veterinary use.

The proposal for a Directive on safety standards of tissues and cells aims to set high quality and safety standards for the donation, procurement, testing, processing, storage and distribution of human tissues and cells. The Ministry's aim is for the Health Council to adopt, in June 2003, a common position on the Directive, which we consider to be extremely important for the protection of public health.

The Recommendation on the early detection and prevention of cancer has been included amongst the Ministry's priorities as it can contribute to the fight against the disease, which is one of the two leading causes of death worldwide.

In addition to the three priorities just outlined, the Ministry will pursue an initiative to introduce the issue of Stigma and Mental illness to the Council. The Ministry, as well as the World Health Organisation (WHO), consider the issue of stigma to have serious consequences for mental health. Thus, it is important to raise awareness as part of the effort to introduce appropriate measures to reduce the consequences of stigmatisation. Ministers from both the EU and accession countries, as well as representatives from Eastern Europe, the Balkans, WHO, and the European Parliament, among others,

have been invited to attend a Conference on Stigma and Mental illness (see below).

There are, of course, other issues under discussion in the Council; indicatively, the WHO Framework Convention on Tobacco Control, and the proposal for a Directive on pharmaceuticals of herbal origin. These will also be promoted during the six months of the Greek Presidency.

As mentioned earlier, the second part of Presidency programme consists of several events; and these include five Conferences on the following themes:

- Mental illness and Stigma in Europe (with Ministerial participation).
- European Union Enlargement: Health and Health Care – Prospects and Challenges.
- Access and Quality of Health Care in the European Union: Improving Patient Experience and Expectations.
- Disabilities and the Media.
- Towards an Effective Policy on Drugs: Policy Choices, Evidence Based and Day to Day Practice.

In addition to the aforementioned events, and taking into account that 2003 is dedicated to people with disabilities, a solemn event took place on 26 January in Athens attended by EU Ministers, Commission representatives and other officials.

What do you consider to be the key issues and priorities for health care systems across the European Union?

The major health challenge, which is common to most EU member states, is the protection and the improvement of population health. Furthermore, more emphasis should be given to the elderly, people with disabilities and migrants. However, health and long term care expenditures steadily increase as individuals and society become richer and more educated. The reasons behind this trend are not very clear and are likely to include a mix of demand and supply side factors. These factors, to some extent, are connected to demographic ageing, education, income and citizens' expectations, but also to developments in biomedical technology. EU member states, faced with budget limitations, strive to reconcile 'conflicting' objectives: containing costs while improving coverage, choice, quality and access to health services. Therefore, it is important to improve efficiency in the financing and delivery of health services.

BRIEF BIOGRAPHY

Costantinos Stefanis has had a distinguished clinical and academic career. He was Professor and Chairman at the Department of Psychiatry of the Athens University Medical School from 1970 to 1996, and President of the World Psychiatric Association between 1983 and 1990. He has written 19 books, published more than 400 papers in scientific journals and been honoured by numerous international academic and clinical bodies. In 1996 he became a member of the Greek Parliament and chaired the Parliamentary Committee on Drug Abuse and Drug Dependence, and has been Minister of Health and Welfare in Greece since June 2002.

Some other highlights from his CV are listed below

Academic and Clinical Positions in Greece

- Member of the Academy of Athens
- Chairman of the Section of Psychiatry, Neurology and Social Psychiatry of the Athens University Medical School (1983–1986 and 1991–1996)
- Founder and Director of the University Mental Health Research Institute (1989–May 2002)
- Vice President of the National Research Council of the Ministry of Industry, Research and Technology
- Vice President of the Biomedical Research Centre of the Academy of Athens

Professional and Scientific Societies

- Chairman of the World Psychiatric Association Scientific Section on Alcohol and Drug Addiction (1986–present)
- Head of the WHO Collaborating Centre for Research and Training in Mental Health (since 1973).
- Head of the WHO Collaborating Centre for Psychopharmacology.
- Chairman (since 1993) of the International Committee for the Prevention and Treatment of Depression (PTD).
- Member of the Task Force on the "European Decade of Brain Research"

What proposals might you bring forward to promote improved mental health across Europe?

Awareness of the importance of mental health has continued to increase recently, notably through the World Health Report 2001, Mental Health: New Understanding, New Hope. Mental health problems have a substantial health impact; in Europe alone, they account for 20% of all disability adjusted life years, and 43% of all years lived with a disability. Individuals with mental health problems may be vulnerable to stigmatisation and social exclusion, they may find it difficult to obtain and maintain both housing and employment, and may be more likely to come into contact with criminal justice systems. While access to mental health care services in the European Union is good by international standards, there remain substantial variations in structures for the promotion of good mental health, and in the provision and delivery of mental health care services.

Perhaps most importantly, action can be taken at a European level to promote awareness and understanding of mental health. This may help create an impetus for

“The EU could play a leading role in helping to build up local capacity in mental health policy and service development in central and eastern Europe”

“Through the implementation of the Social and Welfare Care Act, the Greek government is attempting to join health care services with social and welfare protection.”

a change in attitudes, and in the long term help to alleviate the level of stigma and social exclusion that can hamper individuals in all aspects of daily life. Action might also be taken to further build up and share knowledge on effective interventions in different European settings, and in particular consider their broad socioeconomic impact not only on the health care sector, but also elsewhere such as in social care, education and employment.

The imminent expansion of the EU in 2004, to take on board many countries in Central and Eastern Europe, presents additional challenges for policy makers and service providers alike, at both national and European levels. Many of these nations have initiated a rapid de-institutionalisation policy over the last decade, but resource constraints and other structural issues have meant that community based support is often sparse and where it does exist, it is in need of improvement. The EU could play a leading role in helping to build up local capacity in terms both of mental health policy and service development, perhaps by facilitating and supporting training schemes and placements elsewhere in Europe. In the interim period, EU sponsored experts might also help guide the continuing process of de-institutionalisation, and assist in helping to ensure in the transition period that sufficient resources are available for community based support. An additional consequence of this process may also be to help to improve the implementation of reforms in mental health legislation, which are intended to eliminate any worries over human rights abuses associated with mental health care in these countries.

What are the current priorities for the health care system in Greece?

The most recent attempts for the reform of the Greek National Health Service began two years ago and the development and implementation of these measures is still in progress. The reform is based on two main Health Acts. The main objectives of the first Health Act (2889/2001) was to decentralise and develop the health care system at the regional level and to establish new managerial structures within public hospitals. The second Act on Welfare (June 2002) aims to join health care services with social and welfare protection under one administration at the regional level.

With 2889/2001, seventeen Regional Health Authorities (PeSY's) have been introduced, their aim being to provide comprehensive health services, including

disease prevention and health promotion. Each PeSY is a public entity, managed by a nine member board, chaired by a President-Executive Director appointed by the Minister of Health subject to parliamentary approval. PeSY board responsibilities include services planning and coordination, financial control and quality supervision of all health care services in a region. Hospitals and rural health care centres are directly affiliated with the Regional Health Authorities, which now have the responsibility to plan and manage their area-oriented care services. Previously, all these responsibilities rested directly with the Ministry of Health.

Additionally, new hospital managers have been appointed to all 130 NHS hospitals. Hospital managers are appointed for a five year term by independent committees, which assess candidates' managerial expertise and knowledge of the health care system. Performance contracts are now agreed with the PeSY Executive Director. Assessment is based on both quantitative and qualitative indicators. This is expected to improve the administration of public hospitals. A recent legislative measure is in the making, aimed at improving and extending some of the 2889 law articles. One of its core elements is a shift of administrative responsibilities from the regional to hospital authorities.

A further Act, which addresses social and welfare care was recently passed by Parliament (20 January 2002). With this new legislation, Greece is complying with the statement endorsed by the Council of EU Ministers (2000/c/8/05) that 'everyone should be in a position to benefit from systems to promote health care, to treat illness, and to provide care and rehabilitation for those who need it'. Through the implementation of the Social and Welfare Care Act, the Greek government is attempting to join health care services with social and welfare protection. The Regional Health Authorities have committed themselves to coordinating high quality health care with the social welfare system. This newly established system enhances cooperation between different parts of the traditional and centralised system and the new regional health authorities which are able to plan according to local needs and to treat patients on an equity basis, that is, not withstanding differences in income, age or type of disease.

Since the reform and modernisation of the Greek NHS is a constant process, the Ministry will continue to pursue many

other measures aimed at improving access and the quality of services. The measures set as priorities include:

The improvement of services provided in the country's hospitals with a capacity of over 200 beds through the creation of independent emergency departments. It is expected that in the next six months in Athens and in Salonika, independent emergency units will be functioning with permanent specialised care staff, and updated facilities and equipment.

Equal access to hospital services for all chronically ill people who seek help and advice, even during the afternoon and evening. A co-payment system has been established for patients admitted out-of-hours.

The improvement of home care at the community level. European and national funds have been allocated to the municipalities to organise domiciliary care teams providing home and nursing care at the local level.

The improvement of mental health care services. The Greek government has implemented community-based structures in order to deinstitutionalise chronic patients.

The improvement of the quality of care at primary care health centres, developing flexible health promotion programmes, disseminating practice guidelines and improving the interface with secondary care.

The development of highly specialised health care at university and other regional hospitals and fostering medical research, with funds that can be allocated by the Regional Health Authorities.

The establishment of an electronic network at the regional level, and provision of specific software for all primary and secondary care units to monitor and assess the health care needs of the population.

The development of training programmes specifically designed for care providers working in primary and secondary care services. These programmes will cover several aspects of health and illness, including health economics, health policy, quality of care, quality of performance and health administration.

The reduction of inequalities in health provision for minorities and refugees, ensuring common access to primary and secondary care services.

Further information on selected activities of the Ministry of Health and Welfare

Athens, March 2003

High Level EU Conference: "Towards an effective policy on drugs: scientific evidence, day to day practice and policy choices." Overcoming obstacles for the implementation of evidence based drug policies and interventions.

The objectives of the conference were to formulate proposals for the interaction of science, policy and practice, as well as to contribute towards further implementation of the EU Action Plan (2000–2004) taking into account its mid term assessment and to consider guidelines for the Action Plan at the end of 2004. Subjects discussed included demand reduction: from prevention to rehabilitation, the judicial system, and law enforcement.

Patras, May 4–6

Congress: "Access and Quality of Health Care in the European Union: Improving Patient Experience and Expectations. *

A high level forum of experts discussed methodological approaches, sharing best practice for policy development and cooperation among EU member states. Analysis focussed on different perspectives on equity and access by different stakeholders, interactions with social care, and the impact of patient mobility on health care system development and evaluation.

Athens, May 15–17

Conference: European Union Enlargement, Health and Health Care – Prospects and Challenges*

The aim of this conference is to offer a platform to discuss and debate issues concerning the development and planning of health policies in view of the challenges set by enlargement. The agenda of the conference includes issues such as the public health policies of the EU, activities of the European Commission related to enlargement in Member States and Candidate Countries, reform of candidate country health systems, internal health markets, and the mobility of health professionals and health goods.

Athens, June 13–14

Congress: Media and Disability. *

This congress is organised in cooperation with the National Confederation of Disabled People, in the European Year of People with Disabilities. It aims to increase disability awareness among the media and promote exchanges of best practice between disability NGOs and mainstream media. It will focus mainly on disability portrayal in the European media and advertising, particularly on news, fiction series, as well as employment and accessibility of the disabled in the media.

* Co-financed by the European Commission

Mental Illness and Stigma in Europe:

Reflections on an Athens conference under the Greek Presidency



David McDaid

“The conference examined the state of the art vis a vis mental illness and stigma”

Conference objectives

“Mental Illness and Stigma in Europe. Facing up to the Challenges of Social Inclusion and Equity”, a closed conference with ministerial participation, organised by the Greek Ministry of Health and Welfare, in association with the European Commission and the World Health Organisation took place in Athens from 27–29 March. As well as Ministers of Health, representatives of the European Commission and WHO, participants included representatives of the World Psychiatric Association, European experts, and representatives of organisations active in mental health.

The conference was held within the context of the Greek Presidency of the European Union, continuing a series of international actions by Greece in the field of mental health. These include the 1st and 2nd WHO Athens meetings for the countries of South and South East Europe, Greece’s participation as the main donor and partner in the SEE Mental Health Project of the Initiative for Social Cohesion of the Stability Pact, as well as its involvement in the Global Programme Against Stigma because of schizophrenia, initiated by the World Psychiatric Association.

It also followed on from the Athens Declaration on Mental Health and Man Made Disasters, Stigma and Community Care reached in June 2001. The declaration signed by mental health professionals linked to national governments and members of national health organisations of south and south eastern Europe called upon governments, the European Union, the World Health Organisation, professional organisations and non governmental organisations to “implement programmes aimed at reducing stigma and discrimina-

tion; and to uphold the principle of equity in mental health policies, programmes and services; and to accelerate the transfer of mental health care into the community.” It also called for stakeholders to ‘pursue vigorously and systematically the process of destigmatisation and the development of community mental health services that will lead to the guarantee of patient’s civil rights to the appropriate mental health services, as well as to education, housing and employment, so that their reintegration into society is based on solidarity, humanity and pragmatic grounds.”

A natural progression from this declaration, the aims of this conference were to examine the state of the art vis-à-vis mental illness and stigma in Europe, to reach concrete conclusions, and to define proposals, applicable at a practical level, in order to forward them for adoption by the Council of Ministers for ‘Employment, Social Policy, Health and Consumer Affairs’, so that a balanced and realistic proposal of measures for the whole European Region could be achieved. Greek Minister of Health Costas Stefanis, was prominent in the active role he played in all aspects of the conference.

Conference context: the wide consequences of mental illness

Mental health problems, account for 20% of all disability adjusted life years, and 43% of all years lived with a disability in the WHO European Region.¹ However the impact of mental illness is profound having consequences far beyond health, for instance affecting employment, housing, social relationships, contact with criminal justice systems etc. Furthermore the utilisation of services by people with mental health problems is low, even when these services are widely available. The stigmatisation of mental illness and the associated shame and social exclusion are key factors contributing to these broader consequences, and distinguish mental health problems from most somatic health problems.

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The importance of these wider consequences of poor mental health was widely recognised during the ministerial session at the conference. The observations of Tim O'Malley, Irish Member of Parliament, and Minister of State at the Department of Health and Children with responsibility for mental health were indicative of the constructive attitude adopted by all during these discussions.² O'Malley noted that "increasingly, mental health is being recognised as a major challenge facing health services in the twenty first century."

He commented that "We are all aware that good mental health is an integral component of general health and well-being which allows a person to realise his or her abilities. With a balanced mental disposition, one is more effective in coping with the stresses of life, can work productively and fruitfully and is better able to make a positive contribution to his or her community. Thankfully, society now recognises more fully the burden that mental illness places on sufferers and their families. In Ireland, people with a mental illness were excluded, for many years, from full participation in community life as a result of widespread stigmatisation of mental illness."

He also emphasised the role that mental health promotion can play in tackling stigma. "The promotion of positive mental health will contribute significantly to combating the ignorance and stigma, which often surrounds mental illness. Better understanding of mental illness encourages people to access professional help sooner rather than later and this facilitates early recovery. Eventually, with time and education, the stigma may fade further away, allowing sufferers and their families to participate fully in society in every way."

Components of the burden of illness

One of the parallel sessions focused on looking at components of the burden of illness. Lorenza Magliano from the University of Naples discussed how stigma can contribute to both the objective and subjective burden placed on informal family caregivers. She in particular emphasised the importance of providing support including respite care in order to help alleviate some of this burden.

David McDaid from the London School of Economics discussed different aspects of the economic burden of stigma. He emphasised that there are many facets all of which are inextricably linked. These include mor-

tality and morbidity associated with illness, the rate of utilisation of health, social care and other services, the impact on employment prospects and overall productivity within society, and impact on families and society as a whole in particular through a loss of social capital and community cohesion.

In building an economic framework he drew on four dimensions of stigma defined recently:³ interpersonal interaction, public images of mental illness, structural discrimination, and access to social roles. If stigma impacts on interpersonal interactions it can for instance lead to a reduction in social capital, by which subsequent labelling or fear of labelling contributes to a reluctance of individuals to come into contact with service providers, raising major equity concerns. Public images of mental illness can lead to stereotyping of individuals creating barriers to employment and housing, a loss of freedoms and choice, and an increased association of mental health problems with the criminal justice system.

Structural discrimination manifests itself in insufficient legal protection or enforcement of legal protection for instance on rights over treatment, a level playing field for employment, educational opportunities, and welfare entitlements. Structural discrimination can also mean that when de-institutionalisation has taken place insufficient funds have been provided for community based services to support individuals. The impact on social roles as a result of stigma may for instance have a negative impact on familial relationships, and also lead to increased caring responsibilities for other family members.

In the same session, Clemens Huitink from the Dutch Association for Mental Health, examined the burden of illness from the service users perspective. He importantly noted that the term burden itself may not be helpful in discussions as it can reinforce negative images of mental illness; furthermore he reminded delegates that while there is a general totally complete public misperception that a large proportion of people with mental health problems are a danger to society, in fact there is little awareness that these individuals have a much greater risk of themselves being the victims of physical abuse.

Other plenary and parallel sessions focused on a number of key issues such as populations and transition, developing strategies for action, social inclusion and equity, community care (including presentations

"Stigma has many facets, inextricably linked, impacting on all aspects of life."

“The media play a critical role in shaping attitudes towards mental health problems”

on how services have changed in Greece in the last decade), improving employment, the importance of the media and increasing user involvement in both service development and in anti stigmatisation initiatives. Key conclusions drawn from each working group will be used to prepare a document for further consideration, ultimately by the Council of Ministers.

Improving links with the media

One important aspect of the conference was the emphasis it placed on improving links with the media to try and promote a more balanced view of mental health issues. The media plays a critical role in helping to shape attitudes towards mental illness, and has long been argued to socially reinforce stigma.⁴ Negative stereotypes of people with mental health problems continue to be depicted on television and at the cinema e.g. the recent depiction of schizophrenia in the film *Me, Myself and Irene*. Children are exposed at an early age to television programmes with ‘crazy, loony’ characters, stereotypical, blatantly negative and served as objects of amusement, derision or fear.⁵ Such presentations help contribute towards the prejudice and discrimination experienced by people with mental health problems in all aspects of life. At the extreme end this can have also have consequences for their civil liberties, particularly if the media sensationalise and erroneously report violent incidents involving people with mental health problems.

One good example of how the media can impact on individual attitudes was observed by chance in West Germany. Surveys conducted just prior to and following attacks by individuals with reported severe mental health disorders on two high profile politicians found that the population wished to increase markedly their distance from individuals with schizophrenia following these incidents.⁶ However, media coverage rarely provides balanced information on the risks associated with mental health problems. Despite coverage in the British press, and calls for increased use of secure institutional care very few people with mental health problems represent a danger to others; it was estimated that approximately 40 murder convictions in England and Wales in 1997 were for people with schizophrenia, (only 10% of the total murder rates); out of a total population of around 12,000–13,000 people with schizophrenia living in the community. Furthermore between 1957 and 1995, no increase in murder rates attributable to

mental illness has been observed in England, and in recent years rates have actually fallen.⁷ Thus the emphasis of delegates at the Athens conference on building links with the media (print and broadcast) to help provide expert advice on how stories are presented, and how individuals with mental health problems are portrayed, was particularly welcome.

Conclusions

This conference provided an invaluable opportunity and far too rare opportunity to place a particular focus on the wide consequences that social exclusion and stigmatisation have on people with mental health problems, and on the whole of society. In this respect the participation in addition to the World Health Organisation, of both DG Health and Consumer Protection and DG Employment and Social Affairs was particularly welcome, given that actions to tackle stigma need to take place on many different fronts. The European Commission can play a role both in helping to coordinate the collection of data on both the socioeconomic consequences of stigma, and effective interventions to tackle this, but also in helping to ensure that people with mental health problems are treated on an equitable basis and do not suffer discrimination across all aspects of life including employment and education opportunities.

These consequences affect all of us. At present only limited information is available on the economic costs of stigma and social exclusion, but studies have shown that the costs of not intervening may be very high. One recent study which followed up a group of children in London with or without conduct disorder from the age of 10 until 28, found that the financial costs for children with conduct disorder were approximately ten times greater than those for the control group. The overwhelming majority of these costs were not incurred within the health and social care system but within the criminal justice system, and the authors argued that early use of low cost interventions for these children might have preventing some of these higher costs later in life.⁸

While the conference demonstrated the ever increasing recognition of the need to tackle stigma and promote social inclusion, the key to achieving this is through effective implementation of policies, changing attitudes and practice. In delivering his keynote closing speech “Mental Illness and Stigma in Europe: Facing up to the Challenges of Social Inclusion and Equity.

Where do we go from here?" Professor Norman Sartorius of the University of Geneva urged delegates to strive towards ensuring that anti stigma initiatives do not simply become a focus of attention for short time specific campaigns, but instead become a continuous aspect of activities, as the need to tackle all aspects of stigma is a permanent long term requirement for all societies. This aspect is critical. Overcoming the political and practical obstacles to the implementation of long term strategies to alleviate stigma, helping to build social inclusion and thus social cohesion is a challenge which all of Europe must face up to. Events such as this Athens conference can play an important role in informing this process.

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"Tackling stigma is a permanent requirement for societies"

CONFERENCE ANNOUNCEMENT: MENTAL HEALTH IN EUROPE – NEW CHALLENGES, NEW OPPORTUNITIES

9–11 October 2003, Bilbao, Spain

The overall goal of this conference is to analyse the challenges and opportunities for promoting mental health within the European Union in its current situation, including the forthcoming enlargement of the Union. A special focus will be four areas which are particularly important regarding mental health in this context:

- the economic and social impact of mental ill-health;
- the impact of transitions (both on societal and individual level) on mental health;
- establishment of a supportive infrastructure, including relevant information system, needed for promotion of mental health and prevention of common mental disorders; and
- prevention of premature mortality (especially suicide), including prevention of abuse problems.

The expected outcome of the conference

will be conclusions and concrete recommendations in these fields for both the European Union and the existing and future Member States.

The conference is jointly organised by the DG Health and Consumer Protection, the Finnish National Research and Development Centre for Welfare and Health, the Department of Health of the Basque Government, the University of Deusto and the European Regional Office of the WHO.

Participants will include representatives from the European Commission and European Parliament, WHO and other international organisations, European health ministries, civil society organisations, as well as experts, researchers and professionals in the field of mental health promotion and prevention of mental health problems.

Further information is available from mhconference@soc.deusto.es

The EU and social protection.

An intervention to European Convention Working Group XI, "Social Europe"



**Frank
Vandebroucke**

Before elaborating on a number of specific proposals aimed at bringing about a clear balance between the principles of the single market and the principles pursued by national welfare states, I should like by way of an introduction to outline the content of a study I conducted during the summer of 2002 at the request of the Max-Planck-Institut für Gesellschaftsforschung in Cologne.¹ My inquiry into the role the EU should play in the field of social protection started from an empirical question: what role does the EU play in the development of social protection?

My discussion of the EU's role in social policy will not be exhaustive. I will concentrate mainly on the development of social protection, thus not going into employment policy and related issues. Nor will I relate the discussion on social protection to the discussion on how Member States can maintain the necessary funding for social programmes in a context of 'tax competition', nor to the debate on the future of the structural funds. This is not to say that these discussions are not important, quite the contrary. However, my aim here is to examine the impact of the EU on the typical work of a national minister who is responsible for social protection (including health care), and what kind of EU such a minister would like to see develop now, and after the Convention.

The facts point to two conclusions. First, Member States have lost more control over national welfare policies in the face of pressures from integrated markets than the EU has *de facto* gained in transferred authority, substantial though the latter may be. Thus, there is a growing gap in our steering capacity with regard to welfare policy. This is problematic, since the combination of diminished Member State autonomy and authority and continued weakness in developing responses at EU level may restrict both the scope and the pressure for innovative social investment, which is needed

everywhere given the common challenges created by the dynamics of demographic ageing. The problem will be exacerbated by EU enlargement because the requirement for unanimity in the Council for important areas of social policy entails the risk of paralysis of decision-making in the social field, and because enlargement will bring about dramatic increases in economic and social heterogeneity among EU Member States.

The facts point also to a second conclusion. In a context of increased mobility, not just of workers and capital, but also of service organisations (more particularly in the field of health care), care providers and patients, the present Treaty constellation might prioritise two polarised trajectories, as Leibfried and Pierson fear:² core welfare state components (redistribution, pay-as-you-go,...) would remain 'intervention-free', to the extent that they are 'pure' welfare; but the more that these functions are provided by market-based services, the more the welfare state (in whole or in parts) would tilt towards the sphere of 'economic action' from the point of view of the EU institutions, thus becoming subject to single market principles and market regimes. Thereby the welfare state could gradually be submerged into a single European 'security' market, that is, a single market for personal protection and insurance instruments. Yet, although it would be unfair to blame 'Europe' for some of the difficulties facing national social policy makers if they choose to rely more on market or quasi-market mechanisms in their welfare provision, the Treaty provides no robust guarantee against such a polarised development.

However, the answer to this problem is not an additional transfer of national competencies to the EU, nor the imposition of uniformity, let alone harmonisation for the sake of harmonisation.

Although I think that the concept of 'a European social model' not only reflects an important reality which should be specified by means of common objectives, I also

This text is based on a speech given to the European Convention Working Group XI, "Social Europe" at an expert hearing on 21st January 2003.

See also "News from the European Convention" item on page 40 of this issue.

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think national diversity with regard to social protection systems cannot be treated as illegitimate. On the contrary, diversity is itself part of the legitimating structure of beliefs and practices supporting the multi-level European polity. Although there is a proper role for EU legislation in the social domain, social protection policy is and should primarily remain the responsibility of municipalities, regions and nation states. Nevertheless, Europe should enable the Member States to develop active welfare states and encourage intelligent social investment, by indicating broad objectives, both where employment and social protection are concerned. Cross-border mobility should create additional opportunities for intelligent welfare solutions, rather than make welfare policies more difficult to sustain.

Social protection policy, so conceived, has gained some momentum with the Lisbon Summit. Yet, this progress remains politically and institutionally fragile. Moreover, the answers to important questions (such as the proper organisation of patient mobility) remain open, as the Treaty lacks an explicit balance between the principles of the single market and the principles pursued by national welfare states. The efficiency of decision-making in the field of social protection can also be improved. Therefore, I set out in the paper prepared for the Max-Planck-Institut, six proposals.

I shall begin by reviewing these briefly, and then looking in more detail at some of the specific proposals which, to my mind, are indispensable in creating a clear balance between the principles of the single market and the principles pursued by national welfare states.

In short, the following actions seem to me indispensable:

First, to include the Charter of Fundamental Rights into the constitutional Treaty.

Second, to express clearly the idea that the social dimension is integral to the Union, it is crucial to reformulate the general principles of the European Community, as laid down in Articles 2 and 3 of the Treaty, to anchor a commitment to social protection to the new Treaty. Since this principle would have a 'horizontal' nature, all actions undertaken by the Union would have to take it into account.

Third, we need a legal basis for the open method of coordination as it is to be applied in the field of social protection and

social inclusion. This legal basis should guarantee the transfer of the results of the open method of coordination in the social domain to the economic and budgetary policy coordination on the level of the Broad Economic Policy Guidelines.

Fourth, enlargement demands that we increase the efficiency of decision-making with regard to the social provisions of the Treaty.

Fifth, social partners should be able to decide for themselves which issues relating to employment they want to negotiate. All European collective agreements could be declared legally binding by qualified majority voting.

Finally, it would seem advisable to ensure that agreements concluded by means of collective bargaining between the social partners on basis of social solidarity should enjoy a particular legal status, recognised by the Treaty. It would seem equally appropriate to specify in the Treaty the concept of "service of general economic interest".

Here I shall confine myself to three crucial proposals:

- Inclusion in the future constitutional Treaty of a horizontal clause on social values, which includes, among others, a commitment to social protection.
- Strengthening the social provisions in the Treaty.
- Enshrining the open method of coordination in the constitutional Treaty.

Inclusion in the future constitutional Treaty of a horizontal clause on social values

The part of the existing EC Treaty relating to principles (Part One) contains two so-called "horizontal" clauses intended to ensure that certain fundamental values are taken into consideration in the formulation and implementation of European Union policies and activities. The first appears in Article 3(2) of the EC Treaty, which stipulates that: "In all the activities referred to in this Article, the Community shall aim to eliminate inequalities, and to promote equality, between men and women". The second is in Article 6 of the EC Treaty, which states that: "Environmental protection requirements must be integrated into the definition and implementation of the Community policies and activities referred to in Article 3, in particular with a view to promoting sustainable development".

"There is a growing gap in our capacity to steer welfare policy"

“The welfare state could gradually be submerged into a single European market for personal protection and insurance instruments”

So as to express clearly the idea that the social dimension in a broad sense is an integral part of European Union policy, the cross-cutting clause of a social nature, currently contained in Article 3(2) of the EC Treaty, could be amended as follows and inserted in Article 3 of the preliminary draft constitutional Treaty drawn up by the Praesidium of the European Convention (this article should be entitled “Objectives and Principles for Union activities”).

“In all the activities falling within its competence, the Union shall aim to eliminate inequalities and promote equality, between men and women, and shall take into account the requirements related to achieving full employment and a high level of protection of human health, education and training, and to guarantee social protection and services of general interest which are accessible, financially viable, of high quality and organised on the basis of solidarity.”

The key advantage of this reworded clause is to place the values and objectives enshrined in it on the same footing as other values and objectives, most notably economic ones, which guide the building of Europe, in particular the internal market and competition. It also ensures that these social values and objectives are taken into consideration both in the formulation and implementation of European Union policies and activities, and in the enforcement and interpretation of Community law by national and Community judges. In other words, it is a matter of striking a fair balance (weighting) between economic and social objectives. This should be done in step with recent developments in case law at the European Court of Justice (ECJ), which believes that for overriding reasons of general interest it is necessary to maintain the financial equilibrium of social protection systems in each Member State, coupled with the organisation of a well regulated, high-quality medical and hospital service that is accessible to all.³

The added value of such a clause can be illustrated by four specific examples.

Supplementary activities of sickness insurance funds

In certain Member States, sickness insurance funds are key players in healthcare systems. In a number of markets, the sickness insurance funds responsible for operating statutory sickness-invalidity insurance schemes are embarking on supplementary activities (offering supplementary hospitalisation insurance or providing supplementary benefits for the disabled, for

example) without being subject to the legislation applying to private providers (legislation on business practices, rules on prudential control, etc.), sometimes by relying on compulsory contributions from members. Some private insurance providers wonder to what extent their activities are subject to the classic rules on competition.

The horizontal clause proposed above would consolidate the idea that, provided these sickness insurance funds embody a legally defined “social solidarity” mechanism, the activities they engage in, over and above their task of managing social security, would not be constrained by the rules on competition. This point could moreover usefully be made in the part of the future constitutional Treaty dealing with competition rules.

It goes without saying that one has to avert the risk of improper recourse to the notion of “social solidarity”. It is necessary to devise criteria for this purpose, most notably through ECJ case law, backed up by the so-called “horizontal clause”.

Supplementary sectoral pension schemes

In the context of pension reform, the national public authorities across Europe are considering ways of creating more democratic access to what it has been agreed to call the “second pillar” (supplementary occupational pension schemes) and to develop solidarity mechanisms within this pillar. In some Member States, the social partners are being encouraged by the government to conclude collective labour agreements with a view to establishing compulsory supplementary pension schemes in given sectors (sectoral pension schemes). The aim is both to make the second pillar accessible to categories of workers who are normally excluded from this level of social protection (older workers, blue-collar workers, etc.) and, thanks to a broadening of the contributor base, to introduce several elements of solidarity (the supplementary pension continues to accumulate despite temporary suspensions of contributions resulting for example from a worker’s prolonged illness).

On the basis of the horizontal clause proposed above, and in the light of recent ECJ case law concerning the Dutch system of compulsory affiliation to sectoral pension schemes,⁴ one might suggest inserting a provision into the present Article 81 of the EC Treaty, which will undoubtedly be placed in the part of the future constitutional Treaty relating to Union policies, stipulating that

"Agreements concluded in the context of collective bargaining between management and labour in pursuit of social policy objectives shall not fall within the scope of Article 81(1) EC".

Similarly, in this same part of the future Treaty, one might see fit to reflect the broad interpretation given by the ECJ, in the above-mentioned context, to the notion of "services of general economic interest", in the meaning of existing Article 86(2) of the EC Treaty.⁵ This provision could be amended as follows:

"Undertakings entrusted with the operation of services of general economic interest or with a mission of general social interest...".

Alternatively, the existing Article 86(2) of the EC Treaty could be amended as follows: "Undertakings entrusted with the operation of services of general economic or social interest...". Another solution may be to delete the term "economic", so that the existing Article 86(2) of the EC Treaty would read: "Undertakings entrusted with the operation of services of general interest...".

Such adjustments, in the constitutional Treaty, would send out a strong signal that, in the context of free market competition, the European Union wishes to preserve the particular nature of agreements or mechanisms predicated on social policy considerations. There is a clear link between these considerations and my proposal regarding the financing of services of general interest, which is my third illustration of the potential added value of the "horizontal clause."

Financing services of general interest

Services of general interest are a key component in the European model of society, whose role is consolidated by Article 16 of the EC Treaty, inserted by the Amsterdam Treaty, and by Article 36 of the Charter of Fundamental Rights of the European Union, proclaimed in Nice in December 2000.

Whether it be entrusted to a public or a private company, the management of a service of general economic interest inevitably engenders additional costs related to the obligation to conduct unprofitable operations with a view to ensuring continuity and universality of service (for instance, the obligation to make local mail deliveries even in the most distant regions, or the obligation to connect small, remote communities to the telephone, electricity and gas networks). In order to safeguard the

financial equilibrium of companies providing such services and, hence, universal and continued provision of these services, their additional costs are often offset by governments through direct funding (subsidies) or indirect funding (tax benefits). Such compensatory measures are sometimes criticised as running counter to competition rules, especially when the company concerned also performs activities unrelated to its public service mission. On the basis of the above-mentioned cross-cutting clause, and in keeping with recent ECJ case law,⁶ it could be stipulated, in the part of the future constitutional Treaty concerning State aid, that:

"Benefits granted by a public authority to a company entrusted with the operation of services of general interest shall not constitute State aid unless those benefits exceed the additional costs borne by that company in ensuring the continuity and universality of the service".

Financing of sectoral training activities

Arrangements are being put in place in some markets, in the context of collective labour agreements negotiated at sectoral level, to establish training programmes for workers that are funded from employer and employee contributions and operated exclusively by social partners (private funding and operation). Such arrangements are geared to establishing a form of social solidarity in the operation and financing of sectoral vocational training activities. On the basis of the cross-cutting clause, a provision could perhaps be inserted into the rules laid down by the future constitutional Treaty on State aid, stipulating that:

"Provided that the public authorities are in no way involved in their funding or operation, vocational training programmes established by a collective labour agreement concluded between the social partners and based on a social solidarity mechanism shall not fall within the scope of the rules on State aid, even where it is extended to all sectors by an act of the public authorities".

The importance of such a clause can be illustrated by looking at ongoing discussion between the European Commission and Belgium where the social partners conclude sectoral agreements on the constitution of training funds. The social partners have a free hand in deciding how much of the total wage bill is allocated to these funds and how the resources are spent (e.g. in support of training initiatives.) The funds are therefore not public funds, for the money does not originate from the

***"National diversity
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State and the social partners manage the resources independently. Furthermore, the funds do not “favour” any particular company, since the companies collect the money themselves. Despite this, because the Belgian government “declares these agreements to be generally binding,” the Commission describes them as “State support” and places them under the same strict supervision as economic support. It goes without saying that such an interpretation does nothing to promote training and education, despite the fact that these measures are fully in line with European wishes.

Strengthening the social provisions of the Treaty

My second proposal deals with the social provisions of the Treaty, which can be found, at present, in Articles 136 and 137, as well as in the technical coordination of social security systems. The new formulations of the social provisions since Amsterdam allow us to conclude that the social objectives of the Union are being accepted as independent objectives, despite the fact that the central place of the subsidiarity principle still holds, meaning that social policy is still primarily a matter for Member States, as should be the case. The scope of these articles is in my view sufficiently large. However, we have to change the decision-making procedure applicable to the social provisions of the Treaty, some of which are still governed by the rule of unanimity in the Council. The perspective of enlargement calls for the generalisation of qualified majority voting also in this area.

I am aware that some (current and future) Member States fear the shift to qualified majority voting (QMV) on all social provisions as an attempt to oblige them to give up their competitive advantages in social terms, which they sometimes see as compensation for geographical and capital investment disadvantages. I would like to allay these fears by mentioning three factors. My first argument is substantive: we should not forget that cumulative scientific evidence has further corroborated, since the Dutch Presidency in 1992, that social protection is a productive factor and not an impediment to competitiveness. My second argument is institutional: even if we were finally able to abandon the unanimity rule for decision-making on social policy at the next Intergovernmental Conference, it is clear that a broad coalition of the accession countries, possibly supported by one or two of the current Member States, could

easily, and rightly, block decision-making in this respect. Rightly, indeed, since we would be making a bad start with the unification of Europe if the Union were immediately to twist the arms of the accession countries. Thirdly, and finally, I believe we can attach the necessary conditions to ensure that such an extension of QMV will not impose unacceptably high burdens on the Member States. The conditions that have already been agreed upon in Article 137 of the Treaty and which refer, amongst others, to minimum requirements and unnecessary administrative and financial constraints, can serve as a source of inspiration.

Finally, I find it inconceivable that the decision-making process with regard to one of the fundamental pillars of European integration, namely the free movement of persons, should be brought to a complete halt. I believe that this alone constitutes a convincing argument in favour of applying QMV to the technical coordination of social security systems (Regulation 1408/71).

Anchoring the open method of coordination on social policy to the EU’s architecture

My third point relates to enshrining the open method of coordination in the constitutional Treaty. A potential weakness of open coordination as it has developed today, is that this kind of intergovernmental collaboration tends to be highly dependent on the coincidental political constellation of the moment. Given that the open method of coordination is not part of the formal *acquis* we need to think of ways of ensuring that this soft *acquis* remains valid after enlargement. This ‘soft’ *acquis* means that, potentially at least, the Ministers of Social Affairs have a say in the broad outlines of European policy.

The enlargement of the EU to 25 Member States will certainly make the processes of ‘peer review’ and evaluation in the open method of coordination more complicated. Practical feasibility will require simplification (and maybe a revision of the frequency) and possibly integration of the various processes. I will not elaborate upon this, since my concern here is with the legal entrenchment of the open method of coordination in the field of social protection.

Given the ambition to establish a coherent and transparent new Treaty, it seems logical to argue, within the Convention, for the inclusion of the open method of coordina-

tion as one of the general instruments of the Union. This could be done in the planned article of the constitutional Treaty that would describe all the Union's instruments. This general article would give a description of the basic features of the open method of coordination. Such a 'generic' article could even encompass the processes of policy coordination which are already established in the actual Treaty, such as the employment process (art. 128). The specific application of the open method of coordination to employment could then be developed in more detail in the employment chapter of the Treaty, and the specific application to social protection and social inclusion could be developed in the social provisions of the Treaty, etc. I do believe this twofold anchorage to the constitutional Treaty to be necessary.

What form might such a 'generic article' and a 'specific article' in the field of social protection take?

Proposal for a generic article in the basic Treaty

As far as the 'generic article' is concerned, I envisage two possibilities. The first is that the generic article is a reflection of what the Member States regard as the fundamental characteristics of open coordination. These fundamental characteristics relate to the goal of open coordination (enabling European Union Member States to compare their practices and learn from one another), as the tools to be used in making this process effective (common objectives, indicators, national reports). I therefore fully endorse the text submitted by the Belgian Minister for Foreign Affairs and Vice-Prime Minister, Mr Louis Michel to the Convention Working Group on a Social Europe, which specifies that the open method of coordination could be defined as:

"Consisting for Member States, at their own initiative or that of the Commission, with due respect for national and regional diversity, in setting joint objectives and indicators on a given topic, and, on the basis of national reports, enabling these States to improve their knowledge, develop exchanges of information, experience and practice, and, in accordance with the objectives set, to promote innovative approaches likely to result where appropriate in guidelines, recommendations or other forms of European legislation."⁷

Another possibility would be to provide a mere 'anchor point' in the article of the draft constitutional Treaty describing all

the instruments of the Union. In this regard I would refer to Article 83 of the "Principles" part of the PENELOPE document put forward by the European Commission, in which the open method of coordination is introduced in a specific provision on recommendations reading as follows:⁸

1. "A Recommendation shall give those to whom it is addressed guidance to be followed to attain a given result. It shall not produce binding legal effects, unless the Constitution provides otherwise.

2. A Recommendation may be directed to encouraging a dynamic coordination method between the Member States in specific areas covered by different Union policies and action."

Proposal for a specific article in the 'Political' part of the Treaty

This specific legal basis should build on the learning process which we are currently experiencing in the social field, and more particularly in respect of social inclusion and pensions. This constitutional provision, which is probably best placed in the part of the future constitutional Treaty relating to policies of the Union, should meet the following requirements:

- Make it clear that open coordination applies to two specific subject matters in the broad social policy field: the modernisation of social protection and the promotion of social inclusion (to signal that we do not want open coordination to replace 'hard EU law', in those domains where a 'hard law' approach is indicated).
- Make it unambiguously clear that open coordination on subject matters will not depend on political goodwill, but be stated as an obligation by the Treaty (hence the expression "shall").
- Give an active role to the Commission, yet taking into account the prominent and positive role played by the Social Protection Committee in shaping the social ministers' common political identity over the past two years.
- Define the role of the European Parliament, and of the social partners (called 'management and labour' in the Treaty's jargon).
- Provide for the possibility, yet not the obligation, of developing guidelines (it seems easier, at this stage, to envisage the development of guidelines with regard to social inclusion, than with regard to a

"it seems logical to argue for the inclusion of the open method of coordination as one of the general instruments of the Union."

Box 1

TEXT PROPOSAL

Anchoring the open method of coordination with regard to social protection and inclusion to the Treaty

In the fields referred to in Articles 137, paragraph 1, (j) and (k), (*)

the Council,

on the basis of the conclusions of the European Council,

pursuant to a consensus between the Member States, on a proposal from the Commission, which takes into account the opinion of the Social Protection Committee, and after consulting the European Parliament, management and labour, and the Social Protection Committee,

shall

- adopt a set of commonly agreed objectives and commonly agreed indicators,
- if appropriate, draw up guidelines which the Member States shall take into account in their policy,
- adopt reports on the implementation of this co-operation process.

The result of this process shall be incorporated into the Broad Economic Policy Guidelines.

(*) reference is to the Treaty establishing the European Community as amended by the Treaty of Nice)

A Social Protection Committee with advisory status shall be established to promote cooperation on social protection policies between Member States and with the Commission. The composition and tasks of the committee are set out in Additional Act No 4.

Box 2

CHAPTER 3 - SOCIAL PROTECTION

Article III – 42

The Union and the Member States shall work towards developing a coordinated strategy for social protection with a view to achieving the objectives set out in Article 19 of the Constitution.

Member States, having regard to national practices related to the responsibilities of management and labour, shall regard the modernisation of systems of social protection as a matter of common concern and shall coordinate their action in this respect within the Council. That coordination shall not affect the prerogative of the Member States to define the fundamental principles of their system of social protection.

Article III – 43

1. The European Council shall each year consider the social protection situation and adopt conclusions on the basis of a joint report by the Council and the Commission.
2. On the basis of the conclusions of the European Council, the Council, acting on a proposal from the Commission and after consulting the European Parliament, shall adopt common objectives and, where appropriate, draw up in the form of recommendations, guidelines on the modernisation of systems of social protection which the Member States shall take into account in their policies.
3. Each Member State shall provide the Commission with a periodic report on the principal measures it has taken to implement the modernisation of its system of social protection in the light of the objectives and, where appropriate, guidelines for the modernisation of systems of social protection.

On the basis of those reports, the European Parliament and the Council shall periodically carry out an examination of the implementation of the modernisation of systems of social protection of the Member States.

Article III - 44

A Social Protection Committee with advisory status shall be established to promote cooperation on social protection policies between Member States and with the Commission. The composition and tasks of the committee are set out in Additional Act No 4.

highly sensitive area such as pensions).

- Require the incorporation of the results of the process into the Broad Economic Policy Guidelines (I use the expression ‘Broad Economic Policy Guidelines’, referring to the Treaty as it stands today; maybe the Convention will opt for a broader concept, such as ‘Broad Economic and Employment Guidelines’).

In the aforementioned Max Plank lecture I took these criteria as my starting point and developed the following proposal (Box 1).

The European Commission has also developed an interesting proposal in this connection in the PENELOPE document. It can be found more particularly in Articles 42, 43 and 44 of Chapter 3 on Social Protection (Box 2).

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The EU and the obesity epidemic

David Byrne is EU Commissioner for Health and Consumer Protection

Obesity is the major emerging threat to public health in Europe. The International Obesity Task Force estimates that between 2% and 8% of total healthcare costs in Western countries are already attributable to obesity.¹ Obesity related illnesses range from non-fatal, but debilitating, complaints like respiratory difficulties and musculo-skeletal problems, to life threatening conditions such as diabetes, gallbladder disease, hypertension, stroke, heart disease and cancer. If the obesity rate amongst European children continues to rise, the consequences are potentially catastrophic. Average EU life expectancy could fall, while healthcare spending may go through the roof.

Areas for Community action

What should the EU be doing about this epidemic? In my view, there are three main areas for Community action:

1. Supporting the identification and development of effective strategies.
2. Providing EU-wide data and analysis.
3. Ensuring EU food labelling law plays a positive role.

The case for fighting the obesity epidemic is overwhelming, devising a plan of attack is more difficult. Most in the public health community share a common analysis of the root cause of the epidemic: a population eating an increasingly high-energy diet but living a sedentary, low energy, lifestyle. Opinions though diverge on why this trend has occurred, and how best to address it. Health officials around Europe, and,

indeed internationally, have tried various strategies for countering obesity, but their impact has usually been very limited. In my opinion, obesity is an issue on which the EU needs to pool its intellectual resources.

Addressing obesity is a priority of the EU's Public Health Action Programme for 2003–2008. The programme will fund an EU wide Nutrition and Physical Activity network to facilitate collaboration on obesity prevention strategies. It will also improve monitoring and analysis of EU wide data on the obesity epidemic and fund innovative obesity prevention projects. All this work will build on the results of previous EU public health programmes: in particular, the Eurodiet project, the EPIC project on cancer and nutrition and the EU supported Masters University degree course in public health nutrition.

By harnessing policy analysis and experience Europe-wide the EU can play a crucial role in developing effective strategies against obesity. The EU's role in implementing these strategies though will be limited. Health education and health promotion, likely to be key elements of any strategy, are primarily the responsibility of national public health authorities. The EU can support, advise and even help coordinate the national authorities but, aside from issues of subsidiarity, its public health programme simply does not have sufficient budget to finance major health promotion campaigns. One area, however, where the EU will have a central role to play is in respect to the rules concerning food labelling.

“Addressing obesity is a priority of the EU's Public Health Action Programme”

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To improve nutrition labelling

The Commission is reviewing the EU's rules on nutrition labelling. Currently such labelling is only obligatory where a nutrition claim is made. Feedback from consumers indicates that the format and information contained is often difficult to understand. We are examining whether labelling rules can be developed that better address consumers' information needs and also help promote a healthy diet.

The Commission will soon be proposing a EU Regulation for health and nutrition claims on food. This will define a list of authorised claims together with conditions for their use. It will define criteria for using terms such as "high fibre", "low-fat" or "sugar-free". For example, "high fibre" would only be permitted where the fibre content exceeded a certain pre-determined threshold. Claims that are misleading due

to the way they are expressed would also be addressed: "90% fat-free" might imply a low-fat content to the consumer whereas "10% fat" may have less marketing appeal but is more straightforward and comprehensible.

These initiatives on labelling should make it easier for Europeans to understand the role of individual foods in a balanced diet. This in turn, I hope, will encourage citizens to make healthy choices. Promoting healthier diets and more active lifestyles amongst Europe's citizens is one of the toughest public health challenges of our era. These issues are now firmly on the EU policy agenda. Nonetheless, beating the obesity epidemic will require governments and stakeholders at all levels, local, national, European, and international, to work together. Even more difficult, it will require individual citizens to change their behaviour.

Fat is an economic issue!

Combating chronic diseases in Europe



Geof Rayner

Europeans are getting fatter, we are eating the wrong mix of foods and we are becoming less physically active. These observed trends have been linked to the rise in chronic diseases, with potentially severe consequences. While the indications are strong, more research is needed to guide politicians and policy makers, not only to spell out the health and economic costs but also to define effective intervention strategies and promote investment in health promotion. We have to act now.

Economic change can have a powerful impact on health, not always for the better; witness the dramatic impact of the economic collapse of the former Soviet Union. Equally, the burden of disease has important implications for economic performance and inequality: HIV/AIDS in

Africa, has reduced regional GDP by as much as 30%, while the costs of new variant Cruetzfeldt Jakobs Disease (linked to BSE or mad cow disease) in Europe, are approaching €40 billion. Sudden Acute Respiratory Syndrome (SARS), though still limited in its significance compared to the big killers, has greatly damaged trade, investment, and tourism in south east Asia and Canada.

The Burden of NCDs

With over 30 new infectious diseases emerging over the past 30 years, the case for better surveillance and investment in health protection has been powerfully made.¹ What though of the burden of less pin-pointable, less headline-grabbing 'non-communicable diseases' (NCDs), often



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termed 'lifestyle diseases' or, inaccurately, 'diseases of affluence'? In terms of morbidity rather than mortality these chronic diseases occupy a growing burden of disease worldwide. In 2001, they accounted for approximately 60% of the 56.5 million total deaths and 46% of the global burden of disease, increasing to 57% by 2020.² Chronic diseases are usually associated with older age groups, but with almost half of total chronic disease deaths due to cardiovascular disease (CVD), and the incidence of diabetes increasing dramatically in some countries, these problems are also starting to appear in the young.³ Worldwide, attention is focusing on the most visible sign of this problem, obesity, though the related health problems go far beyond this. What is clear is the perception of obesity and excessive weight as problems of appearance impedes their far more important health consequences.

Many in public health are beginning to ponder these big questions. How might these disease trends affect Europe and what are their economic costs, either to the health care system or to the broader economy? What is the impact of these diseases on household incomes or on health inequalities? Perhaps the most important question of all is what can be done to stem the mounting tide of NCDs? To answer these questions, research is required across academic disciplines. The traditional approach adopted in health economics, focussing narrowly on medical care, has failed to address these public health concerns sufficiently. Such research can have an important role in guiding politicians and policy makers, but the evidence should also help to direct the media away from its pre-occupation with 'medical breakthroughs' or personal manifestations of disease and treatment, storylines which invariably direct public attention away from a population perspective and analysis of upstream causation.

Obesity in the US

If the significance of obesity and being overweight has not dawned upon many European leaders, it has done so in the US. In June 2002, President Bush, announced the revival of the President's Council on Physical Fitness, and emphasised the importance of 30 minutes of daily physical activity for adults (60 minutes for children), and the value of 'five a day' consumption of fruit and vegetables. Certainly, evidence from the US provides a warning to Europe, not just because of the implications for

health and financial costs, but also because of the clear identification of causes. As one WHO expert group has noted: "In many countries, perhaps most typified by the US, changes in family eating patterns and the consumption of fast foods, pre-prepared meals and carbonated drinks, have taken place over the past 30 years. Likewise, the amount of physical activity has been greatly reduced, both at home and in school, as well as by increasing use of mechanised transport."⁴

Such changes have been immense in the US. Food companies seemingly defined a new food culture as early as the 1950s. Per annum it is estimated that \$4.5 billion is spent by the food industry on advertising and \$50 million on lobbying in Washington.⁵ Around 90 % of US children between 3 and 9 visit a hamburger restaurant monthly. Average portions in hamburger chains have doubled in 30 years, with a similar trend in the consumption of sweetened carbonated drinks. Schools appear to have a particular problem, as children have been 'trained' to consume fast food and reject vegetables. The US Surgeon General reports that school foods have the highest saturated fat density of all food outlets.⁶

Catastrophic consequences

If the health consequences are already serious, they are set to become catastrophic. Current estimates are that more than 60 million Americans have one or more types of CVD. According to the US Surgeon General, approximately 300,000 deaths a year are associated with obesity and being overweight (compared with more than 400,000 deaths a year associated with cigarette smoking). Furthermore recent government projections estimate that health care spending in the United States will reach \$2.8 trillion in 2011, up from \$1.3 trillion in 2000, and health care spending is expected to reach 17 % of GDP by 2011, up from 13.2 % in 2000.⁷ (Bear in mind that approximately 41 million Americans in 2001, 14.6% of the population, were without health insurance for some of this year.) Expenditure on prevention in the US is a tiny fraction of the amount spent on medical care. According to official assessments, CVD accounts for approximately 61 % of all health care spending. The total direct and indirect costs attributed to being overweight and obesity are smaller, amounting to around \$117 billion in 2000, or 10 % of total health care costs.⁶

We believe the last assessment may be an

"Evidence from the US provides a warning to Europe"

“Better information based on solid collaboration focusing on macro economic issues is needed”

underestimate. One recent study comparing the treatment costs of obesity with those for smoking and alcohol has suggested that obesity is associated with a 36 % increase in inpatient and outpatient spending and a 77 % increase in the use of medications, compared with 21% and 28% increases respectively for current smokers, and smaller increases related to alcohol.⁸ Demand for medical treatment for obesity is rising. In 1998, there were some 400,000 liposuction procedures in the US. Over 100,000 Americans per year, and the numbers are rising rapidly, now receive gastric bypass surgery, the ‘last ditch’ technique for saving lives and tackling the symptoms of morbid obesity, such as diabetes.⁹ Needless to say, the total costs of surgery, ranging from \$17,000 to \$45,000 per operation, are considerable.

The situation in Europe

How do these trends correspond with the situation in Europe? From data collected for the recent World Health Report, we estimate that around 8% of deaths and disability are attributable to being overweight or obese, only slightly less than the 12% attributed to smoking. How much does this cost and, more importantly, could it be avoided? Cost of illness studies are generally done by those with a vested interest in a particular disease, such as pharmaceutical companies and health charities, and there are no standardised ways of carrying out such analyses. So the short answer is that we have very little information to go on. We urgently need the European

Commission, or another international body, to commission a study looking at all diseases and all the main causes of ill health in a comparable way. At the moment it is only possible to make provisional estimates of attributable costs.

What is known, however insufficient, is worrying. It has been estimated that each year approximately €74 billion is spent on treating CVD in the EU and about another €106 billion a year are incurred in indirect costs due to the lost production of goods and services.¹⁰ WHO estimates that between one quarter and one half of CVD is attributable to being overweight or obese, and as about two thirds of death and disability from being overweight or obese are related to CVD this suggests total costs to European society of between €70 and €135 billion a year. In comparison the total budget for the Common Agriculture Policy (CAP) is approximately €40 billion a year.

Working out how much things cost is, of course, only half the battle. The next stage is to work out how much cost could be avoided, and indeed who would save the money. Here the ground is even shakier. What seems clear is that we need society-wide changes to deal with the problems of obesity. Dietary survey data show that adult intake of fruit and vegetables is less than 400g per day in 20 of the 25 countries for which data are available. WHO recommends that fat intake should be less than 30% of total energy, but survey data show that 21 out of 26 countries fail to meet this goal. There are paradoxes too that confuse the picture. For example, in Spain the proportion of children aged 6–7 who are overweight is higher than the US, while adolescent excessive weight levels are among the highest in the world. Nevertheless, CVD related mortality is lower, similar to that in Italy and France, while the cancer mortality rate is even lower.

The UK has the unenviable position of setting the trend for population weight increase in Europe. (See Table) The National Audit Office estimated that obesity accounted for 18 million days of sickness absence and 30,000 premature deaths in 1998. Treating obesity costs the NHS at least £500 million a year. The wider costs to the economy in lower productivity and lost output could be a further £2 billion each year. On average, it noted, each person whose death could be attributed to obesity lost nine years of life.¹¹ These figures were picked up in the UK Treasury’s assessment of health spending, which prompted its

Table
PREVALENCE OF OBESITY (BODY MASS INDEX \geq 30) IN A SELECTION OF EUROPEAN COUNTRIES

	% Men with BMI \geq30	% Women with BMI \geq30
England	17.0	20.0
France	9.6	10.5
Scotland	15.9	17.3
Germany	17.2	19.3
Italy	6.5	6.3
Finland	19.0	19.0
Sweden	10.0	11.9
Belgium	12.1	18.4
Netherlands	8.4	9.3
Denmark	10.0	9.0
Spain	11.5	15.2
Czech Republic	16.3	20.2
Russia	10.8	27.9

Table compiled by the International Obesity Task Force 1999.

author, Derek Wanless, to call for a 'fully engaged' health strategy,¹²

Tackling obesity

So much for the worries, what can be done about them? In the UK a variety of actions are being pursued including support of 'five a day' type schemes promoting fruit and vegetables, as well as putting fruit directly into the hands of school children. Local action plans are recommended and a physical activity strategy is promised. Industry is also concerned, for instance, one of the world's largest chocolate confectioners, is sponsoring a scheme in which purchasers can trade in vouchers for sports equipment. Although sports bodies have been enthusiastic, the Department of Health and the Food Standards Agency have been noticeably cool. Others have suggested that different factors are influencing industry participation in health promotion initiatives, such as a growing awareness of the threat posed by the tide of anti-obesity litigation in the US.¹³

It is the growing size of the problem, and the growing tensions over the role of the food sector, which have prompted the UK Parliament's Health Select Committee to look at the issue from May 2003. The UK Public Health Association and the Faculty of Public Health Medicine have argued that the problems of being overweight or obese are world-wide, and require a pan-European approach, ranging from reform of the CAP to promoting new approaches to health protection (see ukpha.org.uk). Consideration should be given to the taxation of processed foods and drinks with high fat, high salt and high sugar content, and a hypothecated tax could contribute towards the costs of 'National Fruit in Schools' schemes and support further initiatives, particularly focussed on poorer communities.

They recommend a review of restrictions on food advertisements, proposing a ban on all that are targeted at programmes watched by children under ten. All school-based commercial promotion of foods should be ended and schools encouraged to adopt food policies, which for, example, end the link between income generation and the operation of school snack shops. Price differentiation they suggest should be introduced in schools to encourage the consumption of a healthier range of foods. They also recommend a society-wide approach, promoting urban planning, transportation and building design to give priority to the safety and transit of pedes-

trians and safe bicycle use, with policy innovations ranging from congestion charging to reduced speed limits in urban areas.

However, much stands in the way of such proposals being implemented, ranging from industry pressure to organisational and political inertia. What is now needed, urgently, is better information for the public, based on solid collaborative research focusing on macro-economic issues. Several organisations in the UK have called for collaboration along the lines of the Cochrane Collaboration in evidence-based medicine [see www.cochrane.org] to secure a set of principles for researchers to work together. While the case for undertaking the work on a UK basis is strong, the case for doing it on a Europe-wide basis, involving the European Commission, is compelling.

“Children have been ‘trained’ to consume fast food and reject vegetables”

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German plans for “health care modernisation”



Reinhard Busse



Markus Wörz

“It is more than likely that this year Germany’s SHI will experience the largest changes in decades”

The German Federal Ministry of Health and Social Security declared that 2003 would be the year in which to modernise the 120-year old Statutory Health Insurance (SHI) system. Indeed the SHI, funded equally through contributions by employees and employers, is confronted by mounting problems. On one hand, the revenue base is shrinking because of economic and demographic changes with persisting high rates of unemployment and increasing numbers of pensioners. On the other, the statutory sickness funds expenditure is rising, especially for pharmaceuticals. The funds made deficits of circa €3 billion in both 2001 and 2002, and as they are not allowed to incur long-term debts they were forced to raise contribution rates. The average contribution rate has increased quite steeply from 13.6% of gross earnings in 2001 to 14.3% two years later. The last such increase (from 12.4% to 13.2% between 1991 and 1993) was followed by the Health Care Structure Act, the greatest reform act of the 1990s.

Already in just three months following re-election of the government in September 2002, two reform bills were introduced containing ad hoc austerity measures to reduce expenditure. However, the government also consented in its coalition agreement in October 2002, containing the government’s plans for the legislative period 2002–2006, to strive for more structural changes (compare measures in these bills with the contents of the coalition agreement¹). The Federal Minister for Health and Social Security, Ulla Schmidt, announced in February 2003 that an all encompassing bill, the “Health Care Modernisation Act”, would be presented in

May. According to the current schedule, this reform package will be considered in the Federal Assembly (lower house of parliament) in June and in the Federal Council, representing the 16 states, in September. It is anticipated to come into force in January 2004. A preliminary version of the reform bill already in circulation, not only contains measures to improve efficiency and therefore save money, but also takes up ideas from the coalition agreement.

Proposed reforms

Central elements include strengthening the role of patients, increasing their participation rights and introducing a patients’ representative at the federal level who will have the right to participate (but not vote) in the most important institutions within the German-style of delegated decision-making, for example, the Federal Committee of Physicians and Sickness Funds. A ‘German Centre for Quality in Medicine’, modelled upon the National Institute of Clinical Excellence in England is proposed. Amongst other tasks the centre would commission health technology assessments, make recommendations on the inclusion of technologies in the benefit catalogue of the SHI (the Federal Committee would still make the decision), develop guidelines for certain illnesses, and provide information to patients on new scientific knowledge.

Fourth hurdle for pharmaceuticals

However possibly it’s greatest role will be in the area of pharmaceuticals, as market access and pricing will be re-organised. The centre would classify new pharmaceuticals according to their degree of innovation and effectiveness (i.e. operate a fourth hurdle) and undertake cost-effectiveness analyses with comparative pharmaceuticals (except for break-through drugs). If effectiveness is

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superior to existing drugs, producers will be asked to negotiate prices with sickness funds taking the comparative cost-effectiveness into account. If these negotiations are not successful, the drugs would be covered but liable to an additional co-payment. If effectiveness is equal to products already on the market, the new product would be immediately classified into the reference price system, i.e. a patent would no longer secure a reference-price free marketing period. In addition, the market for pharmaceuticals will be "liberalised", e.g. e-commerce would be allowed, over the counter drugs would no longer be charged uniform prices, and pharmacists would be allowed to operate more than one pharmacy.

Organisational reforms

Organisational reforms of sickness funds and regional physicians' associations are also proposed. The government would facilitate the merger of sickness funds, enable funds to move association, and prohibit new sickness funds until 2007 (when the risk structure compensation mechanism would be based on morbidity criteria). Smaller regional physicians' associations would be reorganised into larger units and, importantly employ full-time managers instead of the current boards of practising physicians (mandatory for sickness funds, since 1993).

The relationships between the payers (sickness funds) and the providers would be totally re-organised. Currently, the ambulatory sector is strictly separated from the in-patient sector, with collective contracts between sickness funds and physicians' associations in the former and sickness funds and hospitals in the latter. In future, there shall be four different 'sectors': family medicine (including gynaecologists and ophthalmologists), specialist ambulatory care, in-patient care, and integrated care. The current system of collective contracts shall be only retained for the family medicine sector, thus retaining the access of patients to all general practitioners but diminishing the role of physicians' associations. The reimbursement mechanism for family physicians would be changed to a system of capitation fees instead of fee for service.

Specialised ambulatory care will see the greatest changes: Sickness funds will have the right of selective contracting in an area which will not only include specialists in private practice but also hospitals, initially at least for "highly specialised" services. Thus sickness funds would no longer be

obliged to contract with all accredited providers but instead selectively choose, with the underlying assumption that this will enable them to offer an improved level of quality, albeit trading-off against access. Reimbursement would be based either on fees for a group of services or on case fees, similar to in-patient medicine.

For in-patient care, sickness funds shall no longer be obliged to contract with all hospitals listed in so-called hospital plans after 2007. The obligation for collective contracting would remain in force however, thus sickness funds must agree on which hospitals to contract or de-contract with. It should be noted that the reimbursement of in-patient services, recently changed to diagnosis related groups (DRGs) will not be affected by this act.^{2,3}

The fourth "sector", integrated care, is legally not new, being introduced through the 2000 SHI Reform Act. However the obligation of framework contracts between the Federal Associations of Sickness Funds and the Federal Association of SHI Physicians has, regardless of the difficulty in calculating the necessary adjustment in ambulatory budgets, effectively prevented any real implementation. The bill eliminates these obstacles and allows greater flexibility.

Probably a side show (but ideologically important) is the introduction of the right to establish so-called health centres, i.e. multidisciplinary institutions providing ambulatory care. These health centres can offer services in family medicine, specialist ambulatory care and integrated care. Until now, only a few health centres exist as successors of the German Democratic Republic 'polyclinics'.

Rebuilding the welfare state: future direction of health care policy

In a long awaited policy statement in March Chancellor Schröder spoke on rebuilding the welfare state to face the challenge of globalisation and unemployment, and in doing so the future direction of health care policy and reform was further outlined. As the constitution gives the Chancellor the right to decide upon the fundamental direction of policy, it is likely that these measures will also be added to the reform bill. Schröder stated that cost increasing monopoly structures must be abolished, mentioning explicitly the regional physicians' associations with their current monopoly on ambulatory care. Referring to the approximate 350 sickness

"A 'German Centre for Quality in Medicine', modelled upon NICE is proposed"

“Market access and pricing of pharmaceuticals will be reorganised and a fourth hurdle of cost effectiveness introduced.”

funds, he stated that such high numbers cannot be maintained, hinting at measures to force in particular the approximate 280 company sickness funds to merge. He also announced that there has to be a revision of the SHI benefit catalogue and that there have to be exclusions, most notably:

- To exclude sick pay from the SHI benefit catalogue (currently wages are paid for the first six weeks of illness, and afterwards sick pay is paid by the statutory sickness funds for a maximum of 78 weeks), thus shifting the sole responsibility to employees.
- To introduce a fee of €10 for physician visits, with some exceptions (chronic illness, low income, children).
- To finance benefits not considered as insurance (for example, maternity benefits) via taxation.

The Chancellor announced that with these changes it would be possible to decrease the average contribution rate to SHI below 13% of gross earnings. What he did not say, however, is that this calculation only refers to joint funding, or more precisely that the employers' share would really drop (from 7.15% to circa 6.45%) while the employees' share would increase, from 7.15% to circa 7.25%, half of 12.9% plus around 0.8% to cover sick pay. Nor did he mention that a mandatory sick pay contribution for all SHI insured is legally questionable as this would require that pensioners for example contribute to a benefit that they are not entitled to receive.

The Chancellor's policy statement reinforced some aspects of proposed reforms, but also introduced new elements, most importantly the announcement regarding benefits. This is not surprising, because the policy statement was expected to be a blood, sweat and tears speech, to convince the public that sacrifices are necessary to overcome present economic problems. However, the speech has made the possibility of benefit cuts a much more concrete possibility, previously, several other options had been raised. The exclusion of adult dental care, or at least of denture and operative procedures, was the proposal voiced most often. This sector is quite large in Germany, and exclusion would be relatively clear-cut. Schröder acknowledged this idea but rejected it on the grounds that one should not judge the social status of individuals by the state of their teeth. As this was known before hand, the exclusion of private accidents was on the agenda from

the beginning of 2003, voiced by the health minister and the Advisory Council to the Concerted Action in Health Care. Again Schröder rejected this idea, due in part to the difficulties in delineating private accidents from "illness", but also because of vocal lobbying by football clubs and questionable signals for household accidents, especially by mothers caring for children.

Rürup Commission

Politicians have also put great hopes in the so called Rürup Commission, named after its chairman, economics professor, member of the Social Democratic Party (SPD) and long-time economic advisor to the government, Bert Rürup. This commission, composed of academics as well as representatives of employers, trade unions and other groups, is charged with the task of developing reform proposals for the sustainable financing of the social insurance system including SHI. Rürup himself spoils the search for consensus behind closed doors, when he announced that he favoured a system of community-rated per-capita premiums as used in Switzerland. Under such a system, the employers would add their current contribution share to wages and employees would have to pay a fixed amount per person (including their dependents); the poor would receive a subsidy paid from taxes.

In the sub-group on SHI, Karl Lauterbach, a physician and professor of health economics, member of the Advisory Council and the SPD and a close friend of the minister, quickly became his main opponent. Lauterbach suggested that both the SHI membership and funding basis should be broadened making it mandatory for the entire population, including non-waged income and increasing the contribution limit by one third. This threat to the entire private health care industry was quickly refuted by the Chancellor. Given such large differences, the consensus of Rürup's sub-commission on SHI, reached on April 9, was unsurprisingly luke-warm and boring: exclusion of sick pay, a fee of €15 per physician visit, higher co-payments for certain services and goods, and tax-funding of maternity benefits.

Next steps

The draft bill will now be finalised by May; in particular it is necessary to include proposed benefit cuts and funding measures. The planned timetable calls for a final vote in the Federal Assembly by July. While trade unions and some individuals from the

trade union wing of the SPD have signalled their resistance to benefit cuts, this will not endanger the reform. Vociferous lobbying by physicians' representatives and the pharmaceutical industry could be more dangerous. Their opposition especially to the Quality Centre is echoed by the opposing Christian Democrats who condemn it as "state medicine", although they agree with other components of the reform bill. The consent of the opposition Christian Democrats is important for the SPD-Green government because for the law to be passed it needs the approval of the Federal Council, where the states governed by the Christian Democrats are in the majority. If all goes according to schedule, the Health Care Modernisation Act will be on the Federal Council's agenda in September.

How the reform package will look there-

after remains speculative at this time, but it is more than likely that this year Germany's SHI will experience the largest changes in decades, at least bypassing the current 'record holder', the Health Care Structure Act.

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"The Chancellor's speech has made the possibility of benefit cuts a much more concrete possibility."

Health policy in Austria after the November 2002 election



Maria Hofmarcher

"The current programme contains a mix of measures, mainly to secure revenues for sickness funds but also to re-structure the pooling of resources and purchasing."

Compulsory health insurance contributions, benefits in kind, selective contracting in primary care, unrestricted access to public hospitals including outpatient departments, and provider reimbursement are the core features of the Austrian health care system. Public bodies, non-profit organisations, for-profit organisations, and individual health care providers deliver health care services.

Contrary to other countries with social health insurance systems, Austria's approach to improve allocative efficiency in the health sector in recent decades has been the introduction of a comprehensive performance related payment scheme in inpa-

tient care accompanied by a form of global budgeting for inpatient care. The main objective of the Austrian reorganisation of service delivery and payment in inpatient care was to reduce hospital cost growth and to shift some provision of services to the primary care sector. These objectives have not yet been met, as hospital cost growth seems to have gained momentum again and, more importantly, allocative efficiency has not yet visibly improved.¹ According to official statistics, health care spending in Austria amounted to 7.3% of GDP in 2001, similar to the United Kingdom and Czech Republic. However, Austria is not yet calculating health expenditures according to OECD standards, and additionally, as a consequence of exploiting EU-calculation methods since 1997, health expenditures are currently under estimated by at least €4 billion.

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“Introducing user charges in primary care may increase the pressure on hospital outpatient departments.”

Recent developments

As laid out in a 1999 policy paper,³ the coalition government of the People's Party (ÖVP) and the Freedom Party (FPÖ) agreed to increase co-insurance to a general level of 20% for all enrollees regardless of their sickness fund. After a short heated public debate this plan was ruled out of the political agenda. However, in April 2001 the coalition government introduced a user fee for outpatient care to redirect patient flows to the primary care sector. This was accompanied by a complicated variety of exemptions, and in November 2002, these were expanded further, and took effect retrospectively from April 2002. Of approximately 6 million outpatients treated, 48% were exempted from the charge after its introduction in 2001; 12% exceeded the annual ceiling.⁴ Furthermore only 3 to 8 percent of outpatient care cases are thought to have been billed, and there has been public encouragement for patients to withhold payments and/or go to court. Administration of co-payments should be carried out by social insurance institutions, but it is doubtful whether receipts from co-payments cover administration costs. Financing approximately 80% of public expenditure on health, the sickness funds' deficit in 2003 is predicted to amount to €350 million, and expected to increase further to €900 million by 2005.⁵

Against this background, compounded by the severe floods in summer 2002 and the postponement of tax reforms, forcing government members of the FPÖ to resign from office, a general election took place in November. The ÖVP won the highest number of votes and were invited to form a new government. After three months a coalition government was formed consisting again of the ÖVP and the FPÖ, commonly known as Schüssel II.

The health chapter in “Schüssel II”

Whereas the 1999 government policy paper dedicated one page of the health chapter (“Programme for better health”) to principal policy goals, the 2003 to 2006 programme chapter (“Health and care”) contains just one paragraph on principal policy goals:⁶

- Maintenance and improvement of the health system based on solidarity.
- Provision of high quality medical care regardless of income.
- Promotion of patient/provider relations by strengthening patient rights, sharing responsibilities, and increased patient

participation.

- Implementation of quality assurance for all levels of care.
- Maintenance of financial sustainability via increased efficiency and economic viability.

The current programme contains a mix of measures, mainly to secure revenues for sickness funds but also to re-structure both the pooling of resources and purchasing. Other reform ideas include measures to control spending on pharmaceuticals, capacity planning including the re-organisation of non-medical human resource education, information technology harmonisation across sickness funds including the introduction of an e-card, and several measures to make health promotion and prevention more attractive. In this paper the focus is on the rather innovative reforms addressing financial sustainability and institutional structures.

User fees and fund contribution rates

To deal with the current and predicted deficit of sickness funds the programme foresees the introduction of socially adjusted user fees with simultaneous abolition of charges for health insurance vouchers (“Krankenscheingebühr”) and outpatient care (“Ambulanzgebühr”). Secondly there will be equalisation and adjustment of health insurance contribution rates on three levels. Firstly 7.3% for blue and white-collar workers (current rates: blue 7.6% white 6.9%), essentially increasing total contribution revenue and generating about €90 million annually. Secondly 0.1 % for leisure time accidents, applied to all insured persons, generating approximately €116 million annually. Thirdly an increase in the pensioners' contribution rate of 0.25% annually from the current rate of 3.75% until a level of 4.75% is reached, generating €600 million by 2006.

The main goal of contribution adjustments is to increase revenues, and the harmonisation of rates between blue and white-collar workers is certainly overdue. The main clientele of the ÖVP, civil servants are not though included in this harmonisation. The increased rate of pensioners' contributions can be seen as a step towards risk-adjusted contributions, which have no tradition in the Austrian health care system. The proposed leisure insurance scheme seems to be an improvement on previous ideas, which usually contained incentives against healthy life styles (sports) and did not cover household accidents.

While the revenue generating part of measures for financial sustainability are detailed, neither the amount nor the type of user charge to be introduced is obvious. In particular, the programme states that sickness funds are entitled to collect socially adjusted user fees. Reinforcing and stimulating the ongoing public debates about user charges, the opposition parties vehemently resist the idea of co-payments on equity grounds. Unsurprisingly, the Austrian Medical Association (AMA) has called for a working group to be set up including members of social health insurance funds, the AMA and hospitals. While the executive management of the Federation of Austrian Social Security Institutions supports user fees, some regional health insurance funds are heavily opposed. Interestingly though, there is hardly any public discussion about raising sickness fund contribution rates. As the programme was launched only very recently, discussion and the public pressure may in future switch from user charges to contribution rates.

The possible new user fee scheme will replace the health insurance voucher (€47 million) and outpatient care charges (€29million). During the last legislative period, a tendency to weaken the position of sickness funds could already be observed. Enabling regional sickness funds to design their own user fee scheme, rather than adopt a universal scheme, seems to further weaken those funds, as user fees are highly unpopular. At the same time, regional sickness funds for the first time can influence their revenues to some degree, albeit through an unpopular measure chosen in a time of existing deficits. The weakening of the social health insurance position may be accelerated given that administrative costs are frozen at their 1999 levels, and sickness funds are not yet ready to manage patient billing.

Restructuring pooling and purchasing

To restructure the current mechanism of pooling and purchasing the programme intends to:

- Merge regional private employees sickness funds with the general occupational accident insurance fund while having regional funds deliver benefits in kind.
- Reorganise the management structure of regional health insurance funds.
- Create a holding centre (all insurance funds including pension funds) for health promotion and prevention.

- Merge private employees' social health insurance funds in each state after harmonising contribution rates, physician fees and benefits.

These policy ideas have and will generate further contentious debate. For instance, compared to regional private employees sickness funds, the general occupational accident insurance fund generates a surplus. Once regionally integrated funds exist, this may lead to a proliferation of experts needed to administer accident insurance, something that is rather centralised at the moment; with the creation of the holding centre this tendency may be lessened. However as the administration costs of sickness funds are low it can be assumed that increasing efficiency is not the principle goal.

With respect to the idea of introducing regional purchasing funds, one state already launched the idea of a state led purchasing fund to improve the continuity of care some time ago. In particular, the aim was to close the gap between inpatient care and outpatient care provided externally. Project orientated implementation is planned, for example, with pre- and post-hospitalisation management. Another state has also adopted this approach, but intends to create a purchasing fund within more radical reform, which may for example involve integrating all funds and purchasing providers for all levels of care.

Even though these initiatives deserve attention both from an economic perspective and with respect to the necessary effort to integrate service provision, the organisation of the management boards of these purchasing funds remains rather ambiguous. In fact, the idea in the pioneering state has been to share responsibility equally in management boards between the state government and sickness funds. However, this even division of responsibilities is likely to enhance obstacles that federalism in the Austrian health sector, particularly for inpatient care, has contributed towards. Ensuring that sickness fund representation is equivalent to their share of public expenditure on health (about 80%) seems necessary to ensure that health policy remains a national issue and prevails over individual state led interests.

Missing points

Health policy reform measures as addressed in the current government programme are embedded in internationally observed efforts to minimise "policy

“The health chapter fails to target improvements in population health”

failures" in the health sector. The health chapter fails to take a European dimension of health policy development into account⁷ and even more importantly, it fails to target improvements in population health, even though the health planning paragraph among other things aims at formulating Austrian-wide health goals.

To develop a needs-based health policy seems important, as the health status of Austrians is not favourable. Whereas age-standardised mortality is declining relative to the EU and was just below the average rate in 2000, deaths due to suicide and cirrhosis of the liver strikingly exceed the EU-average. Mortality due to circulatory coronary diseases and accidents are also above average, although cancer deaths are below this average since the mid 1990s.⁸ Furthermore raising the health status of older Austrians must become a political goal, particularly as life expectancy for this group is rising quickly, not least because of successful efforts to stem premature mortality. Compared to other EU members Austrians up to 35 years enjoy the best health, but for those over 75 health is significantly less satisfactory.⁹ Moreover a recent survey¹⁰ indicates that health status

is highly associated with attained educational levels for both sexes: the higher the educational level the better or the less worse people feel.

The planned introduction of user fees in primary care not only has to take into account possible adverse effects on health status, it also has to focus on the incentives they are likely to create. The Austrian health system has traditionally been hospital-centred, and the introduction of diagnosis related group payments for hospitals also caused an "asymmetrical structural shock" as the primary care sector and the hospitals' outpatient departments, which play a key role in emergency care and are also very popular with patients, have been integrated inadequately to date. Budgeting of social health insurance expenditure on inpatient care creates a built-in incentive for sickness funds to benefit from shifting patient flows to the inpatient sector. Preliminary evidence suggests that the introduction of an outpatient co-payment rate in 2001 has not yet steered demand towards primary care providers. On the contrary looking at the development of caseloads in different settings, the growth rate of the number of inpatient stays still exceeds that for cases in extramural settings. In fact, introducing user charges in primary care may even increase the pressure on hospital outpatient departments. To absorb patient flows, a higher number of physicians under contract with social health insurance are desirable and the development of group practices has to be promoted. Working hours should be made more flexible and the remuneration of general practitioners and specialists adjusted to provide incentives for tailoring practice hours, promoting weekend services and home visits. Although recently introduced, the creation of group practices appears to have been hindered by disincentives within current regulations.

If regional purchasing funds are to be effective purchasers of health services, it is necessary to promote stronger involvement of (regional) social health insurers in their boards. The federal government could reinforce the social health insurers' role within individual purchasing funds. There is a common understanding across all parties and stakeholders about the necessity to promote supply chain integration and thus enhance allocative efficiency. Integration of inpatient and outpatient service provision and financing is a must, but as yet it is loosely addressed in current policy proposals.

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Health care reform in Austria



Alfred Gusenbauer

“financial consolidation should not be based on cutting benefits or increasing cost sharing, but on productivity gains and quality improvements.”

Austria has been shaping up well over the past decades and has become one of the most affluent countries in the world, with low unemployment figures, strong economic growth and stable prices. A substantial share of these positive developments can be attributed to our social security system. The Austrian health care system is a fundamental pillar of this social security.

It has been demonstrated that there is a relationship between health, income and social status. Therefore, I think it is very important to make quite clear that health care is a matter of public rather than private concern. It is the duty of the public health care system to improve the chance of staying healthy and also ensuring receipt of adequate treatment without delay in the case of illness. Problem-oriented prophylaxis and health promotion, differentiated according to target groups, is our approach to reach this goal. Therefore, ensuring fair, equal access to basic health care and first-rate medicine for all is important.

Financing health care

In Austria, the principle of solidarity in financing through contributions and taxes is applied. Half of health expenditure (approximately €16.5 billion) is funded through social security contributions, a further 22% from federal, provincial and local government budgets, and no less than 28% through out-of-pocket payments. Private health expenditure is primarily comprised of patient co-payments (totalling approximately €1 billion for prescription charges, health insurance certificates, hospital charges, out-patient clinic

charges, contributions for medical aids, dentistry, etc.), private supplementary health insurance (approximately €1 billion), self-medication (€222 million) and alternative medicine.

The majority of government expenditure on health (approximately €4 billion) is used to fund public hospitals. In the year 2000, public and private health expenditure was €16.5 billion, or approximately 8.2% of Austria's gross domestic product (GDP). With this rate of health expenditure, Austria is in the medium range of affluent western countries, with the highest expenditures in Europe being in Germany, Switzerland and France. In absolute terms, per capita health expenditure in the USA amounted to approximately €4,500 in 1999, just under €3,000 in Switzerland, €2,500 in Germany, just over €2,000 in Austria, and approximately €1,500 in the UK. On an international level, Austrian health expenditure has kept within bounds, and no unusual growth rates have been recorded in recent decades. However in all affluent societies with growing prosperity, expenditure on health has been increasing at a disproportionately rapid pace.

In the World Health Report 2000,¹ the WHO conducted an indexed assessment of the health care systems of 191 countries. The assessment included elements such as life expectancy, fairness in financing, patient orientation and expenditure on health. Austria is rated ninth in this assessment. The central performance indicator is health system responsiveness to the population.

Furthermore, the European Commission conducted a public opinion poll on satisfaction with medical care in EU countries,

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“Health care must become more patient and service-oriented”

and reported that 35% of Austrians feel they are “served very well”, while another 35% feel they are “served well” by the health system. With an approval rate of over 70%, Austria ranks second only behind Finland (78%), compared with an average rating in the EU of circa 40%.

The financial situation of the health insurance funds

The financial status of the health insurance funds is decisive to the overall well-being of the public health system. Deficits in the health insurance funds ranged between €150 and €250 million or approximately 2.5% of annual income between 1999 to 2002. There are three reasons for this stable deficit. First, contributions paid by the insured have been increasing at a slower pace than the gross domestic product. Second, drug costs have been increasing rapidly, and lastly legal measures have placed a heavy financial strain on the health insurance funds.

Sustainability

The touchstones of our health care system are its sustainability, investment in innovation and the further development of the public health care system. I believe that a future-oriented health care policy must not be content with protecting what has been achieved, but must instead meet new challenges. Therefore, financial consolidation should not be based on cutting benefits or increasing cost sharing, but on productivity gains and quality improvements. Reform of the health care system means not only solving pending funding problems but also adapting benefits to the needs of tomorrow. In particular:

- Due to the increasing number of older people, health benefits will need to be utilised to a greater extent.
- Progress in medical engineering has led to new and better diagnostic and therapeutic procedures, which need to be financed and made accessible to everyone.
- Health care must increasingly focus on prophylaxis, especially with regard to new endemic diseases (for example, disorders of the locomotor system, metabolic disorders, diabetes).
- Gaps in health care need to be closed, for example in the areas of paediatric rehabilitation, dentistry, psychotherapy covered by the health insurance fund, and in palliative care.

Approaches to reform

Secure and sustainable financing

Equal contributions – equal benefits: In Austria, the different contribution and benefit laws involve a number of injustices. These injustices and inequalities must be eliminated step by step. Initial steps have been taken, including the approximation of contribution rates paid by workers and salaried employees as well as those paid by the self-employed. At the same time the benefits should also be harmonised in a fair manner.

Acceptance of a health component in tobacco duty: In Europe, we have been observing a tendency to use revenue from taxes levied on harmful behaviour to finance health care services. I think we should seriously consider this possibility in Austria as well.

A programme of action against unrecorded employment and employers’ failure to pay contributions: Our public health care system can only be fully financed if all participants pay their contributions. Loss of income caused by unrecorded employment and failure to pay contributions must be prevented, if only for reasons of fairness.

Transparency in financing: In Austria, the health insurance institutions pay ‘external’ benefits such as labour market-related benefits and family benefits (for example, maternity benefit). These benefits must be refunded to the health insurance institutions so that they can wholly recover these costs.

Moving to a broader base for the assessment of contribution rates: Since labour’s share of national income has been decreasing in all industrialised countries, contribution receipts must be linked to the growth of the Austrian economy. As an alternative to the current strategy of financing health insurance benefits out of the sum total of wages and salaries paid, output-oriented elements must also be included in determining contribution rates.

Reforming expenditure

Drug expenditure has been increasing: In the framework of a programme of action, the margins of wholesalers and pharmacists should be reduced to EU levels, and we should also begin implementing a restructuring and supplementation programme on the channels of distribution. Furthermore the prescription of generic drugs should be promoted.

Higher quality, better services

In addition to the quantitative availability of health care services, the quality of their structure, process and outcome is important to the public. To me, quality in the health care system means internal quality assurance and external quality control. So we must give a fresh impetus to the course that has been adopted with high-quality projects in hospitals. Also for physician services, binding instruments and strategies of internal quality assurance and external quality control should be created. To ensure high quality in the health care system, the training of personnel is of special importance. Health care job profiles must be adapted to meet constantly changing tasks, and professionals should be trained within modular learning programmes to be more transparent.

Improving the organisation of health and social services

All well-founded analyses show that problems frequently occur where the health care system and the social services meet and interact, which frustrates optimal health care provision both in organisational and economic terms. Therefore, regional networking of health and social services is required to ensure a continuous chain of care (discharge management, case management, etc.).

Differing financing competencies in passing from one form of care to another should not affect patients or diminish the quality of benefits received. In this respect, the rapid establishment of a safe, standardised health data network with many participants is especially important (health telematics). It will improve the quality of health care and at the same time help to avoid multiple evaluation and multiple treatment, thus increasing the system's efficiency.

Goals in health care

Our guidelines and goals are to ensure fair access to health care. The goals of health policy in the years to come must be defined in qualitatively and quantitatively measurable targets to ensure that all players in the health care system proceed in a single-minded and coordinated manner. In particular, I would like to emphasise the importance of a coordinated approach to cardiovascular disease, cancer, mental health/mental disorders, diabetes, disorders of the locomotor system, allergies, dementia, geriatric care/hospices, health promotion, and moving towards a "healthy society"

Health care must become more patient and service-oriented. My suggestion is to develop the field offices of health insurance institutions into a network of service centres.

Patients should be able to get in touch with the health insurance funds 24 hours a day. Advice and support via the internet and telephone call centres should be offered. Also, the approval of drugs or therapeutic appliances by the health insurer's chief physician should be more patient-friendly. Attending physicians should cooperate directly with health insurance institutions.

More rights for patients

The goal is to protect patients' privacy and independence. It seems important to me that patients no longer be considered objects of treatment. There should be nationwide, uniform patients' rights. The right to know one's state of health, the purpose and type of treatment, the consequences, the risks, and possible alternative therapies should be defined, as should the right to obtain a second medical evaluation and the right to take a look at one's clinical history. A revision of medical liability is required for treatment-induced injuries. Rather than the individual physician, hospital or other persons, an insurance company should provide comprehensive cover for this risk in the community.

Summary

As one of the most affluent countries in the world, Austria should be able to afford a high-quality health care system in future. I also think that the importance of health policy will continue to increase and focus on topics like justice, productivity, high quality and health care system organisation. An adequately performing health system needs the cooperation between all professional groups involved, the social insurance institutions, the health service providers, and politicians. It is very important to me to offer all players in the health care system a genuine partnership for the public's well-being, and I am sure that such cooperation is possible and in the public interest.

"The goals of health policy in the years to come must be defined in qualitatively and quantitatively measurable targets"

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Affirming values and promoting change: Health reform in Slovenia in 2003

“Reform needs to be seen as a continual process of sustainable development, rather than a periodic exercise in response to crises.”



Dušan Keber

The challenges for health care

Several factors are contributing to the increased pressure on health services across the world. They include new drugs and technologies that are more effective and often more expensive, increased survival rates and a consequent growth in the number of patients with chronic health conditions, social development (including citizen empowerment), greater access to information that enhances awareness of needs, and a growth in expectations for care. In total, citizens expect innovative programmes, ever greater choice, better responsiveness from service providers and personal participation in health care activities to which they are entitled.

Slovenia is experiencing all of these factors.¹ Its demographic trends are particularly worrying. The proportion of elderly citizens is increasing, and health care costs for the elderly are almost five times greater than costs during earlier periods of life. At the same time the number of newborn children almost halved in the last fifteen years, which will lead to a smaller proportion of the population being of working age in the near future. We must respond to these challenges.

Principles of reform

Health care reforms are either under way or being planned in almost every country, and Slovenia has recently embarked on a significant program of reform. Health reforms launched by modern social states over the past decade have taken almost identical values and principles as their starting point.²⁻⁵ First, they focus on the interests of the citizen, and the success of service providers is judged on the basis of how well they respond to citizens' needs. Second, they emphasise the importance of

equal access for all citizens to health care, regardless of financial status, and equity in service provision, whereby the same high quality health care is provided to everyone with the same health care needs.

Third, almost all countries reforming their systems emphasise that the financing of health care should be a public sector responsibility, and should be based on the principles of solidarity and sustainability regardless of whether the money is raised via taxes, social security payments or a combination of both.^{6,7} However, there is also a general acceptance of the potential value of involving both public and private health care providers, and most countries support their mutual co-existence in accordance with specific societal goals.

Financing and social solidarity

Solidarity in funding and equity of access are values that form the main pillars of the health care system in every social state. They are so important to the vast majority of citizens that when countries have chosen to institute reforms in quite the opposite direction, they have avoided speaking openly about their intentions.

Slovenia went through such an experience. During the reforms of the early 1990s that reduced public health care funding, there was almost no warning that solidarity would be prejudiced, but that was precisely what happened. The introduction of substantial co-payments for most health care services diminished solidarity in funding by transferring the burden onto economically weaker sections of society. The inevitable but unsatisfactory remedy was the introduction of voluntary health insurance, mainly to cover co-payments. The term 'voluntary' was somewhat inappropriate in these circumstances, because no citizen who wanted to avoid bankruptcy arising from a serious illness could escape it.

Furthermore, Slovenia's voluntary health insurance had a single premium rate so that individuals with the lowest levels of income paid an annual amount for health insurance for their family (including compulsory coverage) almost twice their monthly wage.

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In contrast, those with the highest income contributed less than one month's income. This inadequate degree of progressivity in financing has led us down a cul-de-sac: the system is still under-funded, but increasing the financial burden would mean the poorest citizens resigning en masse from voluntary insurance, thus drastically reducing their chances of benefiting from the entitlements they have under compulsory insurance.

The main elements of current reforms

The first goal of the current reform program is to rectify the insurance system by reclassifying entitlements that have proven beneficial for health and health treatment entirely within compulsory insurance. This includes modifying the range of services covered and adding more detail and specificity. If co-payments remain for some health services, they will be limited according to individual income in order to maintain the principle of solidarity.

Thus co-payments will no longer force most citizens to take out additional insurance, and there will be opportunities for new types of schemes primarily aimed at wealthier citizens. They will include, for example, faster access to health services for which there is a waiting period in the public system. It must immediately be added that this would not mean jumping the queue ahead of people that have compulsory insurance only, because voluntary insurance will have to cover the entire cost of services offered. In other words, everybody will benefit from this kind of insurance, as it will cut waiting lists in the public system.

This policy restores the principle of solidarity, but does not resolve the problem of under funding. To be honest, we do not need reforms to increase funding but rather social consensus on how much we can afford to spend on health care, given the current level of productivity. At the moment we cannot say whether funding will be increased in the near future, especially as considerable resistance to these initiatives has come from our principal social partners, such as employers and trade unions. Without doubt, continuing with the current level of funding, which is already inadequate for citizens' needs, would mean the further dilution of entitlements and a widening of the gap between Slovenia and more developed countries. Additional sources of funding to be considered now include increased social security contributions combined with permanent tax inflows into health budgets following

the pension budget model, a higher base for contributions from the self-employed, other forms of insurance for higher risk categories, and combinations of all the above.

A second target of reform is the lack of transparency in service provider payments that, by ignoring cost differences across case types, have led to surpluses for some care providers and losses for others. The recent payment method based on days of hospital stay created perverse incentives for care providers that have resulted in unnecessary admissions to hospital, unnecessary referrals to specialists, and a reluctance to promote more efficient and appropriate forms of treatment in outpatient clinics, doctors' surgeries, and at home.

The principal element of the payment model can be based on the standard costs of efficient treatment for high-volume case types, taking into account notions of evidence-based health care defined in clinical guidelines and operationalised as clinical pathways. Thus the idea of focusing on the citizen and not the service provider will also be extended to the financial sphere. The policy of having the money follow the patient rather than responding to the needs of health institutions will improve access to health entitlements and increase equality among citizens that need to claim those entitlements.

Taking a long-term view of reform

In the past, reform has often been spasmodic and seldom based on a shared long-term vision. We are doing our best to resolve this problem. One aspect of this is the revision of health laws and secondary legislation. Another involves changing perceptions of the nature of the reform process. In particular, it needs to be seen by everyone to be a continual process of sustainable development, rather than a periodic exercise in response to crises. It must also be seen as a process that involves holistic thinking. For example, there is no sense in thinking about financial reform without reflecting on the inseparable links between financing, resource allocation, clinical practice, and the health status of the citizen. In short, we must see reform in the same way as continuous quality improvement in care delivery: involving everyone, goal-oriented, and having daily implications for evaluation and improvement.

Overcoming poor organisational cultures

Areas that will be affected include the operation, management and administration of

“Continuing with the current level of funding, would mean a widening of the gap between Slovenia and more developed countries.”

“Co-payments will no longer force most citizens to take out additional insurance”

the health care system. Slovenia still makes use of management methods inherited from the former Yugoslavia with all their weaknesses: irrational expenditure of public funds; poor and inflexible organisational structures; authoritarian leadership instead of leading through shared learning; emphasising the needs of the care provider rather than users; semi-corrupt relations in the field of purchasing medications, equipment etc; and finally, rejecting urgently needed changes.

Furthermore, the system has many ineffective processes of governance, including weaknesses among management boards of the various care provider institutions. The development of administrative and management functions should be based on the efficient use of assets, the integration and development of quality and efficiency indicators to measure operation and administration, the introduction of efficient operational tools, and consistently taking responsibility for operations and professional development.

Public health

Another area of reform is public health. In Slovenia we still distinguish between the health of the individual and public health. The individual is rightly at the centre of curative medicine, but a collection of actions carried out at the individual level is not enough to ensure an efficient, fair and effective health care system. We must look beyond the individual to consider the population as a whole. If not, the health system cannot properly prepare for future changes. Individual treatment of disease, though vital, is not enough. However, we have in fact given too little attention to population health, and associated public health interventions. In part, this has been a consequence of the power of personal health care service providers, especially of diagnostic and therapeutic interventions, to divert resources to their uses.

Our current view is that public health care is nothing less than a duty for almost of sectors of government. However, this does not imply greater state involvement in medicine and health, quite the contrary. The government's responsibility is primarily to ensure that the community at large is sufficiently well informed and motivated to take on greater responsibilities for their own health.

An updated national health care programme is therefore being prepared that will give greater emphasis to public health than has been the case to date. It will contain a

comprehensive strategy for protecting and improving health and reducing differences in health. In addition, the programme will contain a number of policies on national nutrition, legal and illicit drugs, promoting physical activity, protecting mental health, and on improving and protecting health in the workplace. The goal is to provide our citizens with sufficient knowledge and values from an early stage to enable them to enjoy a healthy way of life.

Outcome measurement

If implementation of these policies is to be successful, we will need a more effective process of monitoring and evaluation. This must include more than the measures on which we have relied in the past which have focussed mainly on inputs and outputs. In particular, we must become better at the routine measurement of health status for population sub-groups, the ultimate measure of performance. We must also pay more attention to consumer satisfaction, by informing our citizens about what they have a right to expect and how to indicate the degree to which this was actually provided.

Thus the reform process must be systematic and its outcomes systemic. This is why the citizen must be at the centre. The insurer worries more about income and expenditure than health outcomes, whereas the surgeon often sees only a successful operation but not errors in the total process of care. The citizen, however, has the opportunity to see everything if given the chance.

Summary

The guiding principles of reform and evolutionary efforts in health policy in the near future will be increased solidarity, increased responsiveness to the needs of citizens, increased responsibility of all users and health care providers, the fair and efficient allocation of funds, increased access to health services for all citizens, improved protection of patients' rights, permanent growth in the quality of health services and increased participation of citizens in decision-making processes.

The primary responsibility for health care will in the future remain within the public sector, indeed it will be one of its most important functions, and funding will remain predominantly public. However, on the condition that the government health network is preserved and consolidated, we will continue to enable various forms of private provision of health services.

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Mental health promotion and prevention of mental health disorders

Highly needed but realistic?



Anke Bramesfeld



Matthias Wismar

Mental Health is increasingly recognised as a subject of public health concern. Particularly the widely distributed “common mental diseases” such as depression, and anxiety are of rising relevance in the industrialised nations. The Global Burden of Disease for psychiatric disorders is expected to rise from 10.5% in 1990 to 15.5% by 2020.¹ They can be a substantial economic burden because of high prevalence, early onset in life and their chronic nature. Mental health disorders are the main reason for early retirement due to disability in the EU.² They carry an increased risk for premature mortality, not only through suicide and accidents but also due to a higher co-prevalence with somatic disorders, and can impact across generations. Children of people with mental health disorders may have fewer chances for development and may be at greater risk of developing a disorder themselves.³

The high prevalence and the impact that mental health problems have on national economies as well as the suffering they cause to individuals and families has led to calls for initiatives for prevention and promotion in the field of mental health. Today there is evidence that mental health and wellbeing is of central significance when trying to improve the general health status of societies.⁴ Nations that aim to develop their human, economic and social potentials recognise increasingly the necessity of a coherent policy in the field of mental health.⁵ To develop such a policy and programmes a comprehensive approach is needed because:

- Mental disorders are multi-causal. There is no single risk factor for mental health disorders that could be subject to primary preventive measures.
- Mental health disorders develop continuously. Disorder related disabilities can

occur alongside psychological symptoms, and it is difficult to draw a line between symptoms that requires intervention and those that do not. Depression below the threshold of internationally clinical diagnosis, can because of its wide distribution lead to more disability than clinically significant depression.

- Mental health disorders concern many sectors of society. Measures for promotion and prevention in the field of mental health should thus be implemented in various settings and policy fields, like education, family affairs, legal system, housing and health service provision.

Multiple evidence for promotion and prevention initiatives in the field of mental health is available today. This includes media campaigns, mental health education programmes for professionals, parenting skills programmes, problem solving and support programmes for the unemployed, support for long-term carers etc. However and despite its public health relevance, programmes in this field are not widely established yet. When searching the internationally available literature and the internet for adult-related comprehensive programmes in promotion and prevention in the field of mental health only four programmes were found:

1. The *EU Framework for Promoting Mental Health in Europe*.²
2. The English programme *Saving Lives: Our Healthier Nation* subsequently succeeded by the *National Service Frameworks for Mental Health*.⁶
3. The Australian *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*.⁷
4. The Health Target Programme of the Canadian State Québec, *The Policy on Health and Well Being* sets a framework for further research and engagement also on programmes for mental health promotion.⁸ While this programme dates from 1992 and has to be understood as a first initiative in the direction of mental health promotion,

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Table 1
Synopsis of public health programmes for promotion and prevention in the field of mental health

Targets	<ul style="list-style-type: none"> • Promotion of mental health in the population • Reduce stigma of mental disease (not included in the Québec programme)
Target groups	<ul style="list-style-type: none"> • All adults • Adults in particular challenging situations, such as unemployment • Caring relatives • People with substance abuse (EU and English programme) • Ethnic minorities (Australian, English, Québec programme)
Main foci	<p>These are functions of the Targets and Target groups and involve:</p> <ul style="list-style-type: none"> • Creating work conditions that promote mental health • Fight stigma and exclusion • Improve mental health literacy • Measures to raise resilience of mentally vulnerable groups • Measures to reduce risk factors
Protagonists	<ul style="list-style-type: none"> • Organs and protagonists in the health care system • Employees and their corporations • Politicians • Users (English and EU programme)
Setting	<ul style="list-style-type: none"> • Work place • Schools (for younger adults)
Outcome indicators	<ul style="list-style-type: none"> • Indicators for mental health of a population
Evidence	<ul style="list-style-type: none"> • Available to all programmes

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Canada is about to develop a *National Plan for Promoting Mental Health*.⁹

These four programmes differ in their degree of concreteness: the English and Australian programmes could be said to be rather close to implementation whereas the EU and Québec approaches are more at the stage of concepts and frameworks. However all four programmes have common contents (Table 1) that could be understood as essential for programmes of promotion and prevention in the field of mental health.

Although all programmes try to be based on a broad basis of scientific evidence, some uncertainties remain in this fairly new field. For instance where will there be synergy between the sectors in which mental health promotion will take place, or between mental health promotion and health promotion in general? How will programmes in the field be implemented, financed and coordinated?

Thus when developing national programmes in mental health promotion and prevention three factors should be considered. First, the multi-causal and multi-sectoral character of mental health disorders implies that a programme should involve all concerned players. It moreover can be used as a platform for ongoing activities in the field. Second, experiences from other national programmes should be utilised. Finally, local experience should be utilised and integrated, in Germany this would for example include experience from the German health target programme¹⁰ or the Nürnberg municipality based programme for early intervention and prevention of suicide.¹¹

One positive effect can already be expected from mental health being subject to official national health policy and publicity campaigns. Public opinion on mental health and mental health disorders would be influenced, and ease help seeking for the individuals concerned as well as influence positively social acceptance and support.

When using the available evidence from international and national projects on mental health promotion and prevention of mental health disorders as well as from comparable initiatives in other health fields the implantation of public health oriented national programmes on promotion and prevention in the field of mental health seems to be feasible and realistic. Looking at the public health consequences of mental disorders, the time seems to be more than ripe for such initiatives.

The nature of health choices; the need for a judgement framework



*Douglas
McCulloch*

“As a society, we cannot avoid health valuation, but we may value different health needs more or less well.”

The exercise of judgement is intrinsic to the nature of health choices. When resources available are insufficient to meet all the needs presented, the allocation of those resources must leave some of these needs unmet. The intended resource allocation is therefore an expression of values, in that the needs of those who are treated have been valued more highly than those who are not. If we allow resources to be allocated by market forces, or by bureaucratic competition between physicians or managers, the resulting choices will impose values on the sick, regardless of considerations of equity or efficiency.

It follows that, as a society, we cannot avoid health valuation, but we may value different health needs more or less well. A discussion of one approach the QALY (Quality Adjusted Life Year), probably the most important method yet devised for valuing health, illustrates the nature of health choice, and shows the importance of judgement.

The QALY approach defined

One definition of the QALY is the following:¹

We can define the full range of health states that describe patients before and after all the interventions between which resources are to be allocated. These states can be valued on a cardinal scale, from zero (death) to unity (full health). If H1 and H2, and S1 and S2, respectively, are the average health state values and expected years of survival before and after a particular intervention, then the value in QALYs of the intervention is: $(H2 \times S2) - (H1 \times S1)$.

It can be shown that allocating resources towards low (marginal) cost per (marginal) QALY, and away from high cost per QALY treatment options will maximise the health impact of the activities funded by the budget, measured in QALYs per unit of expenditure. Applying the approach requires judgement; this is best illustrated by issues examined under reliability, survival estimation and the research of Erik Nord.²

Reliability

QALY measures are not reliable in the same sense as an instrument for measuring, say, temperature, or the concentration of white blood cells. The nature of health state value judgements remains relatively unexplored (though see Nord's work, outlined below).

Suppose a set of health states is valued by a very large sample of the UK population, say 10%, in which all of the age, sex, and disease groups are carefully represented. The valuations found would be representative of the values of the population at the time of the sample, but would they be reliable? Individuals can change their minds; health state valuations record the outcomes, on one or more occasions, of individuals' judgement processes. This process abstracts from many judgmental issues (such as equity).

It is important to remember that scarcity requires health valuation; this problem of reliability will apply to all health valuation methods, and if we wish to allocate health sector resources in an acceptable fashion, some method will have to be used. The same applies to the achievement of validity; since there is no gold standard health state measure, the most one can say is that a set of values have been established in a

This article is based on the author's recent book, "Valuing Health in Practice", published by Ashgate, January, 2003

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“The process of reaching a judgement needs to be discussed, and if possible made explicit.”

rigorous and (as far as possible) scientific process, with each part of the process explicitly defined and followed. Supposing that the science was impeccable, the problem of justifying the valuation process remains; a method for deriving values cannot be justified objectively. However some method has to be used, if values are to be obtained, in response to the need for justifying a resource allocation.

Survival estimation

The measurement of health impacts in terms of QALYs requires a figure for survival, estimated in years. Generally speaking, we have to rely on estimates based on evidence from the trials carried out during the development and testing of a procedure or a drug. Judging the survival impact of an intervention in a particular region is however not just a matter of statistical analysis. Trial evidence is regarded as unrepresentative, because of the need to isolate the effect of the procedure on patient health, and because of differences between the best practice of research centres, and routine practice. These factors compound the difficulties of judging what survival impacts will be for a particular population. A QALY-based allocation of resources cannot avoid relying on (non-scientific) judgements of survival impacts of interventions.

Nord’s research

Nord’s approach² examines the judgement of health states by representative samples of the population. The main concerns can be illustrated by using a table to represent hypothetical average QALY gains, for three patient groups, A, B, and C (see Table).

If only one group can get treatment, and if all three treatments cost the same, then the QALY approach means that group C should be treated. This conclusion runs counter to the view that those worse off deserve treatment more (the “rule of rescue”, most prominently discussed by Rawls³). On this view, group A should be treated, and Nord notes that government commissions in Norway, the Netherlands, New Zealand, and Sweden have concluded

that severity of illness continues to be the most important basis for prioritisation, though effectiveness also has to be taken into account. Evidence in support of the importance of severity to the population at large is reported from the United States, Norway, England, Spain, and Australia. While this cannot be assumed to be a universal value judgement, it at least gives grounds for caution before assuming that the minimisation of the cost per QALY is a universally acceptable healthcare objective.

Conclusion

The QALY approach can certainly measure health impacts, and enable the comparison of drugs and procedures, to determine which offers the best value for money. However, in any particular context, the meaning and relevance of QALY values can be called into question. If its assumptions are not adequately understood, QALY data may hide important dimensions of a healthcare management decision. The process of reaching a judgement needs to be discussed, and if possible made explicit, because of the several important points at which judgement issues become important. The judging of the value of health states is only one of these.

It seems to follow that health prioritisation should occur within a framework that takes judgement into account explicitly. Programme Budgeting and Marginal Analysis (PBMA) is the formal expression of choice-making in the health sector, which permits judgement to be included.⁴ While problems of conflicts of interest may be unavoidable, PBMA does offer a route for the clarification of health sector choices, permitting issues of judgement to receive consideration.

HYPOTHETICAL QALY GAINS

Patient Group	Initial health state	Health state after treatment	Gain
A	0.2	0.5	0.3
B	0.4	0.7	0.3
C	0.4	1.0	0.6

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NHS Direct Online
www.nhsdirect.nhs.uk

NHS Direct Online provides high quality health information and advice for the people of England. Using the website individuals can access a wide range of information, including a health encyclopaedia, self help guide providing information on common symptoms, as well as a database of local NHS services. The service is also supported by a 24 hour telephone nurse advice and information helpline.

Canadian Health Network
www.canadian-health-network.ca

The Canadian Health Network is a national, non profit health information service. It's goal is "to help Canadians find the information they're looking for on how to stay healthy and prevent disease". The network of health information providers includes Health Canada and national and provincial/territorial non-profit organisations, as well as universities, hospitals, libraries and community organisations. There are links to more than 12,000 English and French Canadian web-based resources. These are checked to ensure that they are timely, accurate, and relevant. Detailed information on 26 health topics and specific population groups is available, as well as information on broad health issues, including the prevention of violence, environmental health and occupational safety. Regular features also include news items, topical health issues and contributions from guest contributors. The website is available in both French and English.

The National Institute for Clinical Excellence (NICE)
www.nice.org.uk

NICE, a special health authority in England and Wales is intended to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current "best practice". Guidance covers health technologies, including pharmaceuticals, medical technologies, diagnostic techniques, procedures and clinical management of specific conditions.

The website provides a wealth of information including completed and on-going technology appraisals, board reports, and the recently established NICE Citizen's Council. This council consists of 30 independent Councillors drawn from all walks of life, intended to bring the views of the general public to NICE decision making on guidance for treatment and care. The website also provides an opportunity for anyone both in England and Wales and also internationally to provide comments related to particular appraisals. The website is available in both English and Welsh.

European Foundation for the Improvement of Living and Working Conditions
www.eurofound.ie

The Foundation is a European Agency, one of the first to be established to work in specialised areas of EU policy. Specifically, it was set up by the European Council to contribute to the planning and design of better living and working conditions in Europe. The Foundation carries out research and development projects, to provide data and analysis for informing and supporting the formulation of EU policy on working and living conditions. As part of its research base, the Foundation maintains a number of key monitoring tools, and is currently implementing a strategy to monitor the living conditions and quality of life across 28 countries in Europe.

The Living Conditions Unit's current research areas include: organisation of time over working life, social and economic integration of people with chronic illness or disability, household services, including the employment in care of children and older people living at home, and social and economic impacts of migration and mobility. A wide range of publications can also be downloaded from the website, which is available in both English and French

Mental Health Europe
www.mhe-sme.org

Mental Health Europe is a non governmental organisation committed to the promotion of positive mental health, the prevention of mental distress, the improvement of care, advocacy and the protection of human rights. Information on publications as well as completed and on-going European projects are available. The website is available in both English and French.

The European Convention
<http://european-convention.eu.int>

The European Convention under the chairmanship of Valerie Giscard d'Estaing is currently finalising proposals on how Europe's institutional and political framework can be adapted and modernised to cope with enlargement and the changing nature of the EU. A wide range of documentation is available including proceedings of plenary sessions and of 11 working groups including 'Social Europe'. Upon conclusion, anticipated later this year, the Convention will submit its proposals to the European Council, in which the Heads of State or Government of the Member States regularly come together for discussions. The subsequent Intergovernmental Conference will work on that basis. The website is available in all official EU languages.



NEW PUBLICATIONS

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

Health Inequalities. Evidence, Policy and Implementation. Proceedings from a Meeting of the Health Equity Network

Edited by Adam Oliver and Mark Exworthy

2002. The Nuffield Trust. 60 pages

ISBN 1-902089-82-0

£10.00 Paperback Report.

Freely downloadable at www.nuffieldtrust.org.uk/bookstore

This meeting of the Health Equity Network focused on the extent to which health inequalities policies have or should be influenced by evidence on the effectiveness of interventions. Rudolf Klein in the concluding article observes that policy making about health inequalities can take place "in a fog of disagreement about goals, controversy about causes and uncertainty compounded by ignorance about means." The proceedings in particular examine how different governments have responded to reports on health inequalities, the availability of evidence on both the effectiveness and cost effectiveness of interventions, and the challenges in implementation.

Contents: The Black Report: interpreting history (Virginia Berridge); The Acheson Report: the aftermath (Mark Exworthy); Evaluating the evidence on measures to reduce inequalities in health (Sally MacIntyre); Practical issues in translating evidence into policy and practice (Marie Armitage, Sue Povall); Implementing policies to tackle health inequalities at local level (David Evans); Tackling health inequalities in the UK: what is the Government doing (Don Nutbeam); Joining up the big windows and little windows of implementation (Martin Powell); Commentary: making policy in a fog (Rudolf Klein).

Health Care Priority Setting: Implications for Health Inequalities. Proceedings from a Meeting of the Health Equity Network

Edited by Adam Oliver

2002. The Nuffield Trust. 67 pages

ISBN 1-902089-84-7

£10.00 Paperback Report.

Freely downloadable at www.nuffieldtrust.org.uk/bookstore

This collection of papers from a Health Equity Network seminar reflect on the priority setting processes in the UK and elsewhere in Europe following the establishment in England and Wales of the National Institute of Clinical Excellence. Undoubtedly NICE has raised awareness of the explicit rationing of health care services on the grounds of clinical and cost effectiveness. In his introduction to the proceedings Oliver notes that while much criticism of the concept of rationing is unjustified, the methods used in both clinical and cost effectiveness for priority setting may be largely concerned with improvements in total health rather than on the distribution of health gain across society. Addressing the issue of the geographical distribution of access to health care services, he notes, also remains a challenge. These issues are explored in this volume from the perspectives of economics, ethics, politics and public health.

Contents: NICE (and the NHS) – quo vadis? (Jack Dowie, Karl Claxton, Mark Sculpher, Mike Drummond); A prescription for injustice: A case against the use of normative approaches to address equity versus efficiency tradeoffs in healthcare (Franco Sassi); Fairness in health: What the public thinks (Paul Dolan); NICE or nasty? Threats to justice from an emphasis on effectiveness (Alastair Campbell); Implications of priority settings on health inequalities: Does NICE help at local level (Sian Griffiths); Finnish strategies to reduce socioeconomic inequalities in health (Marita Sihito); Policies for health equity: An ethical and epidemiological framework and targets for a new health policy in Sweden (Finn Diderichsen). Commentaries by Jack Dowie, Peter Littlejohns, Adam Oliver and Alan Williams are also featured.

Welfare Policy from Below. Struggles Against Social Exclusion in Europe

Edited by Heinz Steinert and Arno Pilgrim

2003. Ashgate. Hardback. 304 pages

ISBN 0-7546-3063-3

£45.00

Future European systems of social security and welfare are examined in this book, which concentrates on how such systems can be adapted to tackle the problems caused by social exclusion. As well as providing a theoretical perspective the book draws on empirical studies in eight European cities. Studies featured focus on a range of problems of exclusion (e.g. poverty, housing, work, neighbourhood, position of family, women, migrants) in the context of different European welfare regimes, identifying and assessing the coping strategies and resources needed. Reviewing the book Professor Loïc Wacquant, from the University of California, at Berkeley commented that the book 'enriches our understanding of the dynamics and experience of social inequality and marginality today, and will be of particular interest to all those, scholars, policy makers and citizens, concerned with building a genuine social Europe.'

Contents include: Cultures of welfare and exclusion; Limits of market society: European perspectives; Participation and social exclusion; Understanding situations of social exclusion; The welfare-work-family mix: the usefulness and widespread absence of community; Housing problems; Legal exclusion and social exclusion: 'legal' and 'illegal' migrants; Welfare policies as a resource management; Policy implications.

MEPS VOTE AGAINST CLONING AND RESEARCH USING EMBRYONIC STEMS CELLS

A report calling for restrictions on research using embryonic stem cells and a total ban on human cloning for reproductive purposes was approved by an overwhelming majority of MEPs on 10 April.

Over 80 amendments were made to a Commission proposal on setting standards of quality and safety for the donation, procurement, testing, processing, storage and distribution of human tissues and cells. These included proposals that donation of tissues and cell transplantation should be voluntary and unpaid, that EU wide rules should be laid

down to ensure traceability, and that the scope of the Commission's proposal should be further clarified. In particular, MEPs sought to address the ethical issues surrounding stem cell research and cloning, and thus text was added to the proposal, outlawing research on reproductive human cloning.

The vote by MEPs comes in the

same week as the publication of a report by the Commission, exploring the scientific, ethical and legal implications of funding science in this field under the Sixth Framework Programme (FP6) It also reviews the current state of legislation in various EU Member States and the governance of human stem cell research under FP6.

For further information, please: www2.europarl.eu.int/omk/sipade2?PUBREF=-//EP//TEXT+PRESS+DN-20030410-1+0+DOC+XML+V0//EN&L=EN&LEVEL=2&NAV=X&LSTDOC=N#SECTION1

The Commission Report is available at http://europa.eu.int/comm/research/press/2003/pdf/sec2003-441report_en.pdf

COMMISSION PROPOSES NEW HEALTH INSURANCE CARD

On 21 February 2003, the Commission revealed its proposal on the European Health Insurance Card. According to the proposal, the new card will, as of 1 June 2004, replace all paper forms that are currently needed for health treatment when in other Member States.

The card will be introduced in three stages; first, it will replace the existing E111 form for short stays (such as holidays). It will then render obsolete all other health forms used for temporary stays, such as those used by employees, students and job seekers. Finally, the health card will become an electronic 'smart card', readable by computers. The new health card will allow patients to be reimbursed more quickly by their own social security systems and gradually offer more advantages for EU citizens, such as the right to all necessary care in the host Member States, which has already been agreed at the political level between the Member States.

More information is available at www.europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=MEMO/03/390/RAPID&lg=EN

NEWS FROM THE EUROPEAN CONVENTION

The final report of working group XI on Social Europe can be viewed on line at <http://register.consilium.eu.int/pdf/en/03/cv00/CV00516-re01en03.pdf>

A corrigendum to this report is available on line at <http://register.consilium.eu.int/pdf/en/03/cv00/CV00516-re01co01en03.pdf>

Among their conclusions the group recommended that Article 3 of the Constitutional Treaty include the promotion of:

- full employment;
- social justice;
- social peace;
- sustainable development;
- economic, social and territorial cohesion;
- social market economy;
- quality of work;
- lifelong learning;
- social inclusion;
- a high degree of social protection;
- equality between men and women;
- children's rights;
- non-discrimination on the basis of racial or ethnic origin, religious or sexual orientation, disability and age;
- a high level of public health and efficient; and

- high quality social services and services of general interest.

The working group also came to the general conclusion that the existing competencies of the EU were sufficient in the social field, although they suggested that they may require further clarification, and that action at a European level should concentrate on issues related to the functioning of the single market and issues with a significant cross border impact. They did though recommend that specific extensions to the competence of public health should be considered in order to provide a sufficient legal basis for EU action on communicable diseases in a multi-state emergency, grave cross border emergencies, bioterrorism and WHO agreements.

The text of the Draft Constitution has now also been published. This can be downloaded via <http://european-convention.eu.int>

CONFERENCE
ANNOUNCEMENT:
6TH EUROPEAN HEALTH
FORUM GASTEIN 2003

The 6th meeting of the European Health Forum Gastein will take place in Gastein, Austria from 1 to 4 October. The Forum will once again be a focus for high level discussions amongst key decision makers and experts in European health policy. The overarching theme this year is "Health and Wealth. Economic and Social Dimensions of Health". Parallel Forum sessions will again include a session organised by the European Commission on 'Health Challenges in an Enlarged Europe' while the European Observatory on Health Care Systems is organising a session entitled 'Pharmaceutical Policies in Europe'. There are two other parallel sessions: Macro-Economics and the Health Sector; and Healthy Ageing: the Challenge for Society. There will also be a range of special interest sessions on a variety of topics throughout the conference.

Further information is available at www.ehfg.org or by contacting info@ehfg.org
Tel: + 43 (6432) 3393 270;
Fax: +43 (6432) 3393 271

LACK OF PROGRESS IN FIGHT
AGAINST POVERTY DISEASES

On 26 February the European Commission published a report on the progress made in the implementation of its Programme for Action on HIV/AIDS, malaria and tuberculosis.

The report finds that despite the efforts made in the target areas, progress has been limited. It therefore recommends a continued joint effort in the areas of health, education, trade and research, as well as an increased spending on social structures, as an important determinant of the effectiveness of these efforts.

Further information: www.europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=IP/03/282/0/RAPID&lg=EN

EU ENLARGEMENT COUNTRIES JOIN EMEA AS OBSERVERS

The ten accession candidate countries expected to join the European Union in May 2004 began working with the European Medicines Evaluation Agency (EMEA) on 1 April 2003 as observers on the Agency's scientific committees and working parties.

The national competent authorities responsible for medicines for human and veterinary use in the accession countries were invited in January 2003 by Thomas Lönnngren, EMEA Executive Director, in consultation with the European Commission.

This invitation ahead of accession builds on the successful preparatory training and exchange programme (Pan-European Regulatory Forum or 'PERF') that the Agency has led since 1999.

Welcoming this new phase of co-operation between the Agency, current EU Member States and the ten countries, Thomas Lönnngren said, "One of the Agency's priorities is the successful integration of the new Member States into the

operation of the European regulatory system and maintenance of our rhythm of work with no significant slow down in the centralised procedure. I am confident that this period ahead of accession will ensure a smooth transition."

As part of the ongoing preparations for accession, the EMEA has also put in place a programme of benchmarking visits to the national authorities of the accession countries, including Bulgaria and Romania. The visits are intended to enhance the implementation of an integrated quality management system to ensure good regulatory practices in the EU and provide targeted audit training for participating quality professionals in the EU and accession country agencies.

OVERVIEW OF DRUG RELATED
EXPENDITURE IN THE EU

On April 1, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) presented a new study on public spending to counter drug abuse. It provides a first overview of drug-related public expenditure in EU countries during the last decade (1990-2000).

The report notes that public expenditure on drugs within the different EU countries is an important indicator for assessing government commitment to tackling the drugs problem. However, the study finds that each Member State devotes a fraction of its budget to facing the negative consequences of drug consumption and to combat trafficking and related crimes.

Further information: www.emcdda.org/policy_law/national/strategies/public_expenditure.shtml

BLOOD SAFETY DIRECTIVE
ENTERS FORCE

A new EU directive setting EU-wide quality and safety standards for the collection, testing, processing, storage and distribution of human blood and blood components entered into force following its publication in the EC Official Journal on 8 February.

The measures put in place comprehensive and legally binding standards for blood and blood products from donor to patient and for related medical applications. They aim to prevent blood contamination scandals similar to those that have occurred in some EU countries in the past.

This is the first time that the new EU competence in public health policy making, introduced in the Amsterdam Treaty, has been used to bring forward legislation. The deadline for the transposition of the directive into national law by EU Member States is 8 February 2005.

NEW COURT RULING ON MEDICAL TREATMENT ABROAD

On 25 February, the European Court of Justice (ECJ) issued a judgement (Case C-326/00) stating that a Member State may not subject payment of the medical expenses of a pensioner who has visited another Member State either to prior authorisation or to the proviso that the illness suffered appears suddenly. The court report of the case is reproduced below:

Pensioner Mr Vasileio Ioannidis resides in Greece and receives his pension there. During a visit to Germany, he had to be admitted to hospital urgently because of angina pectoris. He travelled with a valid E111 (for temporary visits), issued from his sickness fund IKA, and requested that a German sickness fund pay the costs of hospital treatment directly and then arrange for reimbursement by IKA, as provided for by EU Regulation No 1408/71. However, the German sickness fund asked IKA to issue a Form E112, which is the form required where an insured person wishes to obtain authorisation to go to another Member State to receive medical treatment.

IKA then refused to fund the expenditure in question, on the grounds that Mr Ioannidis was suffering from a chronic illness and that the deterioration in his state of health had not been sudden. Greek legislation requires, in order for ex post facto authorisation of reimbursement of medical expenses incurred by a pen-

sioner abroad to be possible, that the illness be manifested suddenly during the stay and that treatment is immediately necessary.

When the complaint brought by Mr Ioannidis was upheld, IKA took action in the Greek courts. The court in turn put questions to the ECJ on the compatibility of Greek legislation with Community Law. The ECJ noted, first, that it is for the national court to establish whether treatment provided to the person concerned was planned in advance and whether his stay in another Member State was planned for medical purposes. In this case Regulation No 1408/71 imposes a system of prior authorisation (Form E112) for the direct funding of benefits in kind by the institution of the Member State in which the treatment is provided. In the present case, it appears that the national court considered that this was not the case.

The ECJ then observed that, as regards the funding of medical treatment which became necessary during

a stay in a Member State other than the State in which the insured person resides, Regulation No 1408/71 laid down differences between the status of pensioners and of workers. According to the Court, the aim pursued by the Community legislature appears to have been, in particular, to promote effective mobility of pensioners, taking into account their increased vulnerability and dependence in matters of health. Thus the Community rules do not make the funding of treatment provided to a pensioner during a stay in another Member State subject to the proviso (which applies to workers) that their condition necessitates immediate treatment during their visit.

Therefore, the entitlement to benefits in kind guaranteed to pensioners by Regulation No 1408/71 must not be limited solely to cases where the treatment appears necessary as a result of a sudden illness. In particular, the mere fact that the pensioner suffers from a chronic illness, which is already known before his stay, cannot prevent him from enjoying the benefits of treatment necessitated by his changing state of health during his visit. The ECJ pointed out, moreover, that the principle applicable to guaranteed funding of medical expenses of pensioners in another Member State is that of reimbursement of costs to the institution of the place of stay by the institution of the place of residence.

The ECJ ruled, however, that if the institution of the place of stay has wrongly refused to fund the benefits and the institution of the place of residence has not contributed as it must do to facilitate such funding, the insured person is entitled to obtain reimbursement directly from the institution of place of residence. Furthermore, this reimbursement may not be subject to any authorisation procedure or requirement that illness occurred suddenly.

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EUROPEAN COMMISSION AND THE WHO DISCUSS JOINT STRATEGIES TO TACKLE GLOBAL HEALTH ISSUES

European Commissioners and high-level representatives from the World Health Organisation (WHO) have reiterated their commitment to strengthening and increasing collaboration in the field of public health.

During a series of high level consultations on 6 May, Commissioners Busquin (research), Lamy (trade), Byrne (health and consumer protection), Wallström (environment) and the head of Nielson's cabinet (development) met with WHO representatives to discuss a variety of health related issues where joint strategies are essential. These included disease control with particular regard to severe acute respiratory syndrome (SARS); the framework convention on tobacco control (FCTC); public awareness of diet and physical activity for risk

reduction; the environmental impact on health; cooperation in developing countries and global health research.

On the subject of enhancing EU and WHO collaboration in the field of research, the director general of WHO, Gro Harlem Brundtland, and Commissioner Busquin, agreed that both communities must participate actively in one another's respective policy, advisory and technical consultations. In addition to open consultation, they suggested that the EU and WHO could also organise joint meetings to discuss areas of mutual interest. Both said that they look forward to reading the forthcoming world health report on health research, and participating in the ministerial meeting on global health research, scheduled for Mexico, November 2004.

UK: PARLIAMENTARY COMMITTEE REPORT ON PROPOSED FOUNDATION HOSPITALS PUBLISHED

The House of Commons (Lower House) of the United Kingdom Parliament's select committee on health published a report on 6 May examining the possible introduction of what are called foundation hospitals in England. These hospitals if introduced would have a high degree of independence and autonomy and would for instance be able to make their own local agreements on personnel. David Hinchcliffe MP chair of the committee, acknowledged that the issue was complex but stated that "we have not had any evidence during the course of this inquiry to reassure us that the introduction of Foundation Trusts will not entrench inequalities still further." He also was worried by the emphasis on acute care, rather than on primary care and community based alternatives.

The Committee report examines two key issues: will the proposed changes bring about improvements for patients who are treated by Foundation hospitals? Secondly what implications will the proposed

changes have for patients being treated in the rest of the NHS? Exploring the potential impact of these proposals on the rest of the NHS, the report concludes that as the proposals stand, they pose a threat to the equity of service provision, one of the founding principles of the NHS. The report argues that the introduction of Foundation Trusts, has the potential, in some areas at least, to lead to wage inflation and aggressive poaching of staff

The report recommends that if these proposals go ahead, Foundation status should be piloted with all trusts in a given geographical area, to help to evaluate how the system would operate in the long term. If these reforms are introduced, steps will need to be taken to prevent the introduction of Foundation Trusts from undoing the recent shift in emphasis from secondary to primary care, and stronger safeguards will be needed to ensure continued co-operation between the primary and secondary care sectors

The full text of the report is available at www.parliament.the-stationery-office.co.uk/pa/cm200203/cmselect/cmhealth/395/395.pdf

ECONOMIC AND FINANCIAL MARKET CONSEQUENCES OF AGEING POPULATIONS

A new European Economy Economic Paper by Kieran McMorrow and Werner Roger published in April aims to quantify and analyse the nature, extent and geographical reach of the "real" economy and budgetary aspects of ageing populations as well as providing an initial assessment of the financial market implications of this phenomenon. The implications of ageing populations over the coming decades at the global level will be significant in terms not only of a slowdown in the growth rate of output and living standards but also with regard to fiscal and financial market trends.

The paper is available at http://europa.eu.int/comm/economy_finance/publications/economic_papers/economicpapers182_en.htm

UK OFT REPORT:

Private dentistry market must work better

A recent report by the Office of Fair Trading 'The Private Dentistry Market in the UK' concludes that consumers require better information on prices and treatments in order to improve competition and promote choice. The UK market for private dentistry is expanding rapidly, growing by around 50% between 1997 and 2001 and is currently valued at over £1 billion. Approximately seven million people regularly receive private dental treatment. The study also recommends better and more effective self-regulation of the market through improved monitoring and enforcement of standards promoted in professional guidance and the implementation of comprehensive complaints procedures

The full report can be downloaded via www.of.gov.uk/News/Press+releases/2003/PN+29-03.htm

€81 MILLION EARMARKED FOR SOCIOECONOMIC RESEARCH

€81 million has been targeted by DG Research to fund 89 new projects, representing what they claim are the biggest ever socioeconomic research networks in the world. The research findings will reveal current social trends and challenges across Europe, and be used to develop measures to improve people's quality of life across and beyond the EU.

Funded projects have been grouped into key issues and policy fields including 'societal and individual well-being and policies for quality of life and social cohesion.' These cover issues such as overcoming barriers and seizing opportunities for active ageing policies in Europe; the impact

of changing social structures on stress and quality of life; conflict between family life and quality of life, and understanding homeless populations. An important part of building the European Research Area in this field is the creation of 'infrastructures' available to all researchers.

A new initiative is the European Social Survey, which will address, amongst other things, inclusion and exclusion, well-being, health and security. The survey will provide a fully documented and easily accessible set of data to scholars, policy analysts, journalists, politicians and the public at large.

Additional information is available on: www.cordis.lu/improving/socio-economic.home.htm, and www.cordis.lu/citizens

News in Brief

Disability rights in Europe: from theory to practice

The UK Disability Rights Commission in partnership with the Department of Law and the Centre for Disability Studies at the University of Leeds are organising a conference to celebrate European Year of Disabled People at the University of Leeds on 25–26 September 2003. The conference will examine the range of legal strategies which have been adopted internationally to counter discrimination against disabled people and facilitate their inclusion into mainstream society.

The conference aims to bring together scholars, policy-makers, lawyers and others to share insights and develop a greater understanding of the issues involved. It is hoped that the conference will also lead to the creation of a network of interested parties who will develop close links for ongoing work.

For more information visit the conference web site: www.disability-europe.info/lawconference

Germany and Poland to cooperate on neurological research

The German and Polish governments are to fund joint neurological and neuropsychiatric research with around €3 million over the next three years. Work will begin in June and it is hoped that the research will provide new insights into Parkinson's disease, Alzheimer's, epilepsy and multiple sclerosis. The two governments are also hoping that the collaboration will lead to the establishment of new links between German and Polish researchers. The creation of such networks is also intended as a contribution towards the creation of a European Research Area.

For further information, please contact: The project coordinator for Germany. Tel: +49 228 3821 249. Fax: +49 228 3821 257

Council of Europe Conference Report on Access to Social Rights

The Council of Europe has published documents from its key conference on Access to Social Rights held in November 2002 in Malta.

Further information at www.coe.int/socialcohesion

Report of the Greek Presidency on the High Level Conference on Drugs

A report on this conference that took place on the 6–7 March, and which aimed to bring together the different opinions concerning drug policy in the EU in order to develop a more effective European policy, has now been published.

The conference report and the speech of Greek Foreign Minister, George Papandreou, entitled "Towards an effective drug policy: Scientific documentation, everyday action and political choices" are available at www.eu2003.gr/en/articles/2003/3/26/2351/ and www.eu2003.gr/en/articles/2003/3/6/2179/

'Widening the Europe of Health'

Commissioner Byrne addressed a conference of the Irish Nurses Organisation in Dublin on 4 April. In his speech the Commissioner spoke about recent developments in the fields of nutrition, enlargement and the mobility of health professionals.

Full text of the speech available at www.europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=SPEECH/03/183/0/RAPID&lg=EN&display=

Commission appeal on cancer

As cancer is the cause of around one death in four in Europe, the European Commission launched an appeal on 8 May to Member States to implement effective screening programmes for breast, colon and cervical cancer. Commissioner Byrne stressed that many thousands of cancer deaths could be avoided each year if best practice in early detection was applied in all Member

States. The proposal calls for mammography screening for breast cancer in women aged 50–69; faecal occult blood screening for colorectal cancer in men and women aged 50–74; and pap smear screening for cervical abnormalities, starting between the ages of 20 and 30.

The full text of the proposal can be viewed at http://europa.eu.int/comm/health/ph_determinants/genetics/keydo_genetics_en.htm

Commission reviews proposal on herbal medicines

The Commission adopted an amended proposal on April 9 for a Directive on traditional herbal medicinal products, extending the simplified registration procedure to medicinal products containing non-herbal ingredients. The legislation anticipates that new pre-clinical and clinical trials will not be required if there is sufficient knowledge about a specific product.

The amended proposal is available at: http://pharmacos.eudra.org/F2/pharmacos/docs/Doc2003/COMM_

EU funded research into tuberculosis

To mark World Tuberculosis Day on March 24, the European Commission highlighted its research contribution to meet this global health challenge. €28 million has been invested in TB drug and vaccine research over the last four years under the Fifth Framework Programme for research and development and "significantly more" will be committed during the course of the Sixth Framework Programme.

A fact sheet on EU funded TB research is available at <http://europa.eu.int/comm/research/press/2003/pr2403en.html>

EuroHealthNet, EHMA and HDA can be contacted at the following addresses:

EuroHealthNet EuroHealthNet
6 Philippe Le Bon, Brussels Tel: 00.322.235.0326
Fax: 00.322.235.0339 Email: i.stegeman@ehnpa.org

European Health Management Association



European Health Management Association
4 Rue de la Science, Brussels 1000
Email: Pbelcher@ehma.org

NHS Health Development Agency

Health Development Agency
Holborn Gate, 330 High Holborn, London WC1V 7BA
Email: maggie.davies@hda-online.org.uk

Programme

Organiser: International Forum Gastein
Co-organisers: Federal Ministry for Health and Women
EU Committee of the Regions
Austrian Broadcasting Corporation

With the support of and in collaboration with:
European Commission, DG Health and Consumer Protection
European Observatory on Health Care Systems
Land Salzburg
World Bank
World Health Organization, Regional Office for Europe



www.ehfg.org

1st – 4th October 2003 in Bad Gastein, Salzburg, Austria

Health & Wealth

economic and social dimensions of health

*Health challenges in an enlarged Europe • Pharmaceutical Policy in Europe •
Macro-economics and the health sector • Healthy aging: The challenge for society*

Health & Wealth

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Wednesday, October 1st, 2003

13:30 - 14:30	Plenary Session I	Plenarsitzung I
14:30 - 17:30	Parallel Forum Sessions AI + All	Parallel Foren AI + All
18:00 - 20:15	Plenary Session II	Plenarsitzung II
20:45	"come together" evening	gemeinsamer Abend

Thursday, October 2nd, 2003

9:00 - 12:00	Parallel Forum Sessions AI + All cont.	Fortsetzung Parallel Foren AI + All
12:15 - 13:45	Special Interest Sessions: Lunch Sessions	
14:00 - 18:00	Parallel Forum Sessions BI + BII	Parallel Foren BI + BII
18:15 - 19:45	Special Interest Sessions: Workshops	
20:45	Theme evening	Themenabend

Friday, October 3rd, 2003

9:00 - 11:00	Parallel Forum Sessions BI + BII cont.	Fortsetzung Parallel Foren BI + BII
11:15 - 13:30	Plenary Session III	Plenarsitzung III
13:30 - 14:30	Reception hosted by: David Byrne, Member of the European Commission, Health and Consumer Protection	Empfang , Gastgeber David Byrne Mitglied der Europäischen Kommission, Gesundheit und Verbraucherschutz
15:00 - 18:00	Special Interest Sessions: Workshops	
18:15 - 19:15	Plenary Session IV	Plenarsitzung IV
20:00	Informal Conclusion Evening	Informeller Abschlussabend

Saturday, October 4th, 2003

9:00 - 13:00	Special Interest Sessions: Workshops	
9:00 - 18:00	Social Programme	Rahmenprogramm
19:00	President's Evening	Präsidentenabend

Interpretation Services

During Opening and Closing Ceremonies as well as Plenary sessions simultaneous interpretation will be available in English, French and German. Interpretation in English, French and German is available for Parallel Forum AI, and BII.

Simultanübersetzung

Eröffnungs- und Schlußzeremonien sowie Plenarsitzungen werden simultan in Deutsch, Englisch und Französisch übersetzt. Simultanübersetzung in Englisch, Französisch und Deutsch wird für Parallel Forum AI, BII angeboten.

Co-Organisers



Sponsors



Wednesday, October 1st 2003, 13:30 - 14:30 and 18:00 - 20:15

Opening	I	Eröffnung
Representative of the Government of the Province of Salzburg (A)	M. Rauch-Kallat , Minister for Health and Women (A) J. Olekas , Minister of Health (LIT) (tbc) (tba)	Vertreter der Salzburger Landesregierung
Health as economic and social factor	II	Gesundheit als Wirtschafts- und Sozialfaktor
Making the links between macro-economics and health	J. Sachs , Columbia University (US)	Die Verbindung zwischen Makro-Ökonomie und Gesundheit
Securing our future health	A. Maynard , University of York (UK) (tbc)	Die Zukunft unserer Gesundheit sichern
Health as a criterion, consequence, cause and casualty of economic and social development within Europe (presentation and discussion)	D. Wanless , Advisor, UK Treasury (UK) M. McKee , London School of Hygiene and Tropical Medicine (UK) A. Fidler , Health Sector Manager, World Bank B. Merkel , Head of Unit, European Commission P. Wold-Olsen , President, EMEA, Merck & Co. (tbc) D. Yach , Executive Director, WHO key note speaker(s) from above	Gesundheit als Massstab, Voraussetzung, Ergebnis und ‚Opfer‘ wirtschaftlicher und sozialer Entwicklung in Europa (Präsentation und Diskussion)
M. Danzon , Regional Director, WHO (tbc)		

Friday, October 3rd 2003, 11:15 - 13:30 and 18:15 - 19:15

The social character of health in Europe	III	Der soziale Charakter der Gesundheitsversorgung in Europa
What defines the European "health and social model"	E. Mossialos , London School of Economics (UK)	Was ist das europäische Gesundheits- und Sozialmodell
Social and health policy in European integration	U. Schmidt , Minister of Health (D) F. Vandenbroucke , Minister for Social Affairs and Pensions (B) (tbc), Moderator: A. Macara , CPME A. Gustav , Vice-President, Commission G. Katiforis , MEP, (GR) (tbc) E. Mossialos , LSE (UK) Civil Society representative (tba)	Sozial- und Gesundheits-politik in der europäischen Integration
Discussion – The application to European Integration and the EU treaty reform process		Diskussion: Die Anwendung im Rahmen der europäischen Integration und EU Vertragsreform
R. Waneck , State Secretary for Health, (A) D. Byrne , European Commissioner for Health and Consumer Protection		
Conclusions	IV	Schlussfolgerungen
Presentation and discussion of results of Parallel Forum Sessions	(tba)	Präsentation und Diskussion der Ergebnisse der Parallel Foren
Representative of the Government of the Province of Salzburg (A)		Vertreter der Salzburger Landesregierung

Parallel Forum Sessions

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Wednesday, October 1st, 14:30 - 17:30 and Thursday, October 2nd, 9:00 - 12:00

Parallel Forum AI

Health challenges in an enlarged Europe

Hosted by the European Commission, organised in co-operation with GVG



EUROPEAN COMMISSION

Herausforderungen im Gesundheitswesen in einem erweiterten Europa

Gastgeber: Europäische Kommission, organisiert in Zusammenarbeit mit GVG



Chair: **Z. Jakab**, Permanent Secretary of State, Ministry of Health, Social and Family Affairs (HU)
Co-Chair: **J. Bowis**, Member of the European Parliament
Rapporteur: **N. Azzopardi-Muscat**, Ministry of Health (MT)

Health Challenges in an enlarged Europe:
Welcome and introduction to the Forum

Investing in population health

Introduction

Instruments and best-practice: investing in a "healthy population"

Results of the implementation of the public health strategy in Estonia

Health inequalities: underlying factors and different ways of addressing them across Europe

Health at the work place: European Network for Workplace Health Promotion

The role of patients in public health and health services

The enlarged health care market

Case studies:

Free movement of health professionals – learning from current experience

Human resource planning: Lithuanian physicians in the process of accession

Regional co-operation in health care services

Attracting investment of capital in accession countries

Discussion: An emerging care market - how to address the challenges on the different levels of action?

Interpretation available in English, German and French

M. Hübel, European Commission

Z. Jakab, Ministry of Health (HU)

B. Pettersson, Deputy Director-General, National Institute of Public Health (SE)

A. Aaviksoo, Head, Public Health Department, Ministry of Social Affairs (EE)

H. Graham, Lancaster University (UK)

G. Breucker, Federal Association of Company Health Insurance Funds (BKK) (D)

R. Elgie, President, European Patients' Forum

J. Bowis, Senior Employment Adviser, on b. Standing Committee of Nurses of the EU

V. Lewis, senior employment adviser, Royal College of Nursing (UK)

Z. Padaiga, Vice-Rector, Kaunas University (LT)

L. Bertinato, Department of Health and Social Services, Veneto Region (IT)
D. Paica, Regional Authority of Timisoara (RO)

S. Achner, Rhön Klinikum AG (D)

Chair: **J. Bowis**, MEP

B. Nielsen, Committee of the Regions

Z. Jakab, Ministry of Health (HU)

M. Hübel, European Commission

S. Wright, European Investment Bank

M. Rosenmöller, on b. EU Health Policy Forum

Herausforderungen im Gesundheitswesen in einem erweiterten Europa: Einleitung

Investitionen in die Gesundheit der Bevölkerung

Einleitung

Instrumente und "best-practice". Beispiele Investitionen in eine "gesunde Bevölkerung"

Ergebnisse der Einführung der öffentlichen Gesundheitsstrategie in Estland

Ungleiche Gesundheitschancen: zugrundeliegende Faktoren und unterschiedliche Lösungsansätze in Europa

Gesundheit am Arbeitsplatz: Europäisches Netzwerk zur Förderung der Gesundheit am Arbeitsplatz

Die Rolle der Patienten im Gesundheitswesen

Der erweiterte Binnenmarkt für Gesundheitsleistungen

Fallbeispiele:

Freizügigkeit von Angehörigen aus Berufen des Gesundheitswesens

Personalplanung: Litauische Ärzte im Beitrittsprozess

Grenzüberschreitende regionale Kooperationen im Gesundheitswesen

Grenzüberschreitende Kapitalinvestitionen im Gesundheitswesen

Diskussion: Ein entstehender Gesundheitsmarkt - wie begegnen wir den Herausforderungen auf den verschiedenen Aktionsebenen?

Simultanübersetzung in Englisch, Deutsch und Französisch

Wednesday, October 1st, 14:30 - 17:30 and Thursday, October 2nd, 9:00 - 12:00

Parallel Forum All

Pharmaceutical policies in Europe

Pharma-Politik in Europa

organised by: European Observatory on Health Care Systems



Governing pharmaceutical markets in Europe

New pharmaceutical legislation - providing the framework for a competitive pharmaceutical industry to the benefit of the patient

Improving the competitiveness of European pharmaceutical industry
tba

Paying for pharmaceuticals

The macro-economic role of the pharmaceutical industry

Responses

Parallel Workshop A: Innovation and access to medicines

New medicines: What are the public health dimensions of pharmaceutical legislation?

Innovation and diffusion of new medicines in Europe: The industry's perspective

New medicines and their added therapeutic value

The patient perspective

Responses

Parallel Workshop B: Doctor - patient relationships and health communication

Key statement of stakeholders and discussion

Chair: **E. Mossialos**, European Observatory on Health Care System, LSE Health and Social Care (UK)
Rapporteur: **D. Taylor**, Prof. of Pharmaceutical Policy, University of London (UK)

P. Weissenberg, Director, European Commission

K.P. de Joncheere, Regional Adviser, WHO - Euro

W. Clement, Research Institute for Pharmacoeconomics (A)

T. Palu, World Bank Patients, (tba)
Member State representative, (tba)

Chair: **I. Read**, European Parliament (tbc)
Rapporteur: **R. Busse**, Technical University Berlin and European Observatory on Health Care Systems (tbc)

B. Merkel, Head of Unit, European Commission

J.L. Sturchio, Executive Director Public Affairs, Human Health Europe, Merck & Co (USA) (tbs)

S. Garattini, Istituto Mario Negri, and Committee for Proprietary Medicinal Products, EMEA

(tba)

L. Tiddens-Engwirda, Secretary General, Standing Committee of European Doctors
P. Bundgaard, President, Pharmaceutical Group of the European Union (tbc)
Representative of Insurance industry (tba)

Chair: **M. Defever**, University of Leuven (B)
Rapporteur: **D. Taylor**, Prof. of pharmaceutical policy, London (UK)

A. Maynard, University of York (UK) (tbc)
A. Macara, CPME
and other stakeholders: Doctors, Industry, Pharmacists, Patients, European Commission

Ordnungspolitische Steuerung pharmazeutischer Märkte in Europa

Neue Pharma-Gesetzgebung – Den Rahmen für eine wettbewerbsfähige Pharmaindustrie zum Wohle des Patienten sichern

Verbesserung der Wettbewerbsfähigkeit der Pharmazeutischen Industrie in Europa

Die Finanzierung von Arzneimitteln

Die Gesamtwirtschaftliche Rolle der Pharmaindustrie

Reaktionen

Parallel Workshop A: Innovation und Zugang zu Arzneimitteln

Neue Arzneimittel: Was sind die (öffentlichen) Gesundheitsdimensionen der Pharma-Gesetzgebung?

Innovation und Verbreitung neuer Arzneimitteln in Europa: Die Perspektive der Industrie

Neue Arzneimittel und deren zusätzlicher therapeutischer Nutzen

Die Perspektive der Patienten

Reaktionen

Parallel Workshop B: Arzt – Patienten Beziehungen und Gesundheitskommunikation

Stellungnahmen der Akteure und Diskussion

Programme organiser: Elias Mossialos, European Observatory on Health Care System, LSE Health and Social Care (UK)

Working language will be English

Thursday, October 2nd, 14:00 - 18:00 and Friday, October 3rd, 9:00 - 11:00

Parallel Forum BI

A macro-economic view of the health sector

Eine makroökonomische Betrachtung des Gesundheitssektors

Chair: **W. Neudeck**, Diplomatic Academy (A)
 Rapporteur: **M. Rosenmöller**, IESE Business School (E)

The health sector as an engine for growth in GDP and employment

An analysis of the health care sector from an aggregate point of view shows its contribution to economic growth in interrelation with other sectors of the economy, emphasising its impact on employment. How do these structures compare between selected countries and how will the health sector change, particularly in terms of public and private provision of services?

Health as an economic sector – a comparison of selected EU-Member States

Future of the health sector – forecasting demand for health services

Starting from the consequences of demographic developments for the demand for health care a variety of macro-economic models has been developed and empirically estimated. What are the demand projections resulting from these analyses?

Demand for health services – forecasts on the basis of econometric models

Technical progress in health care – both a blessing and a curse?

How successful have been attempts to measure the productivity of the health care sector? Does technical progress lead to an improvement of the quality of service? Does technical progress decrease or does it rather increase cost? Some general considerations and specific examples will be put up for discussion.

Relating microeconomic efficiency in health services and programs to macro level productivity in the health care sector: the challenge finding common product definitions, measurement tools and information standards in the EU context.

People will live longer but how to guarantee them a good quality of life in their 90's and 100's? Interactions between aging and technical progress

Health services as investment – raising productivity and improving the quality of life

Health care should also be seen as an input into the production process raising the productivity of the work force (also improving the quality of life). The topics range from prevention to life styles!

R. Buchegger, Johannes-Kepler-University (A)

M. Riedel, Institute of Advanced Studies (A)

A. Maeda, IBRD/World Bank

R. Elgie, European Patients' Forum

G. Becker-Neetz, Federal Ministry of Health (D)
M. Chawla, World Bank

Programme organiser: R. Buchegger,
 Johannes-Kepler-University Linz (A)
Working language will be English

Der Gesundheitssektor als Wachstumsfaktor für BIP und Beschäftigung

Eine Analyse des Gesundheitssektors aus makro-ökonomischer Sicht beleuchtet dessen Beitrag zum Wirtschaftswachstum im Zusammenwirken mit anderen Sektoren der Wirtschaft, wobei die Beschäftigungswirkungen besonders beachtet werden. Was zeigt ein Vergleich dieser Strukturen zwischen ausgewählten Ländern und wie wird sich der Gesundheitssektor verändern, vor allem hinsichtlich der öffentlichen und privaten Bereitstellung von Gesundheitsdienstleistungen?

Gesundheit als Wirtschaftssektor - ein Vergleich ausgewählter EU-Mitgliedsstaaten

Die Zukunft des Gesundheitssektors – Prognose der Nachfrage nach Gesundheitsdiensten

Ausgehend von den Folgen der demographischen Entwicklungen für die Nachfrage nach Gesundheitsversorgung wurde eine Vielfalt makro-ökonomischer Modelle entwickelt und empirisch implementiert. Welche Nachfrageprognosen erbrachten diese Analysen?

Nachfrage nach Gesundheitsleistungen - Prognosen auf Basis ökonomischer Modelle

Technischer Fortschritt im Gesundheitswesen – Fluch und Segen?

Wie erfolgreich waren die Versuche der Produktivitätsmessung im Gesundheitswesen? Wird technischer Fortschritt die Qualität der Dienstleistungen verbessern? Wirkt technischer Fortschritt eher kostensenkend oder kostensteigernd? Die Herausforderung der Bereitstellung von hochtechnologischen (und kostenintensiven) Behandlungsmethoden für die Älteren.

Die Beziehung zwischen mikro-ökonomischer Effizienz von Gesundheitsleistungen und -programmen und Produktivität auf der Makro-Ebene. Die Herausforderung der Identifizierung gemeinsamer Produktdefinitionen, Messinstrumente und Informationsstandards im EU Kontext.

Menschen werden länger leben, aber wie garantieren wir eine gute Lebensqualität in den "90er und 100ern"? Wechselbeziehungen zwischen Altern und technischem Fortschritt

Gesundheitsdienstleistung als Investition – Steigerung der Produktivität und Verbesserung der Lebensqualität

Gesundheitsversorgung kann auch als Input in den Produktionsprozess betrachtet werden, der zu einer Erhöhung der Arbeitsproduktivität (und auch Verbesserung der Lebensqualität) führt. Die Themen reichen von Prävention bis zum Lebensstil!

Thursday, October 2nd, 14:00 - 18:00 and Friday, October 3rd, 9:00 - 11:00

Parallel Forum BII

**Healthy Ageing.
Citizens Needs and Expectations
The Challenge for Society**

**Gesundes Altern:
Bedarf und Erwartungen der Bürger
Die Herausforderung für die Gesellschaft**

sponsored by Merck, Sharp & Dohme¹

Chair: **S. Greengross**, House of Lords (UK)
Rapporteur: **P. Berman**, European Health Management Association

The rise of life expectancy in the last 50 years, the expected continuing demographic changes in the coming decades, the improvement of living conditions and the health status of the elderly are some of the biggest achievements of modern society. These achievements however have raised the expectations of citizens as they grow older. Combined with fast developing new technologies and treatments, these trends are creating new challenges to society. The aim of this Forum is to examine how these challenges can be met, especially at the European level.

Der Anstieg der Lebenserwartung in den letzten 50 Jahren, die erwarteten fortgesetzten demographischen Änderungen in den nächsten Jahrzehnten, die Verbesserung der Lebensbedingungen und des Gesundheitszustands der Älteren ist eine der größten Errungenschaften der modernen Gesellschaft. Diese Erfolge haben die Erwartungen der älter werdenden Bürger gesteigert. Verbunden mit der schnell ansteigenden Entwicklung neuer Technologien und Behandlungsmöglichkeiten haben diese Trends zu neuen Herausforderungen an die Gesellschaft geführt. Ziel dieses Forums ist es, zu untersuchen, wie diesen Herausforderungen insbesondere auf der Europäischen Ebene begegnet werden kann.

Ageing – the Implications and Challenges
Health, Ageing and Retirement in Europe

Ageing well
The Citizens Perspective

The Medical Perspective

The Response of Society and Social Systems
Demographic Uncertainty and the Sustainability of Social Welfare Systems

Integrated Care for Older People: Management and Policy Issues

Europe Addresses the Challenges – Mutual Learning/Exchange of Experiences - Support for National Strategies

Discussion: Potential and Limitations of European Cooperation

Interpretation available in English, German and French

A. Börsch-Supan, University Mannheim (D)

P. Maguire, European Institute for Women's Health (IRL)

P. Barry, Merck Institute of Aging & Health (USA)

J. Lassila, ETLA (FIN)

H. Nies, NZW/Care (NL)

A. Silvo, European Commission

Chair: **H. Stein**

Z. Jakab, Secretary of State, Ministry of Health (HU)

N. Boyd, Department of Health (UK)

M. Schölkopf, German Hospital Association (D)

L. van Nistelrooij, Committee of the Regions

C. Attias-Donfut, CNAV (F)

R. Busse, Technical University Berlin (D)

A. Silvo, European Commission and others.

Älter Werden- Auswirkungen und Herausforderungen

Gesundheit, Altern und Rente in Europa

Gesundes Altern
Die Perspektive des Bürgers

Die Perspektive der Medizin

Die Antwort der Gesellschaft und der Sozialsysteme

Demographische Unsicherheiten und die langfristige Finanzierbarkeit der Sozialen Sicherheitssysteme

Integrierte Versorgung für ältere Bürger: Aufgaben für Management und Politik

Europa nimmt die Herausforderungen an - voneinander lernen - Erfahrungen austauschen - Unterstützung nationaler Strategien

Diskussion: Potential und Grenzen der europäischen Zusammenarbeit

Simultanübersetzung in Englisch, Deutsch und Französisch

Programme organiser: H. Stein, European Observatory on Health Care Systems-European Centre on Health Policy

¹ Merck Sharp and Dohme (MSD) are the international subsidiaries of Merck & Co., Inc., Whitehouse Station, New Jersey, USA.

MSD has a long-standing commitment to breakthrough research, and to being a reliable partner in the drive to improve health and health care in Europe. We feel that integrated approaches to health policy planning, which involve a broad range of stakeholders, especially informed patients, are necessary to achieving real improvements in healthcare quality.

Thursday, October 2nd, 2003 18:15 - 19:45

Safety and quality of human blood products and human plasma derivatives in an enlarged European Union

hosted by: Baxter



Chair: **J.-M. Vlassembrouck**, Vice President Global Industry Affairs (B)

The experience of an EU Member State:

R. Wanek, Secretary of State, Ministry for Health and Women (A)

The challenges faced by the new Member States of an enlarged European Union

Czech Republic

Representative of the Czech Ministry of Health (CZ)(tbc)

Hungary

Representative of the Hungarian Ministry of Health, Social and Family Affairs, Budapest-Hungary (HU) (tbc)

How can industry contribute ?

C. Waller, Executive Director, Plasma Protein Therapeutics Association (B)

The approach taken by a Central/Eastern European Blood Transfusion Organisation

Representative of the Polish Blood Transfusion Institution (PL)

How to meet patients needs in a Central/Eastern European Country - The situation in Romania

Representative of the Romanian Hemophilia Association (RO)

Trans-border healthcare provision across Europe

organised by EHTEL



Chair: **R.J. Richardson**, Chair UK eHealth Association and Chairman, eHealth Working Group - EHTEL

A strategic overview: the European Commission's perspective
J.-C. Healy, Head of Unit, European Commission (tbc)

A pan European health policy

M. Wismar, European Centre for Health Policy, World Health Organisation (tbc)

The patients views

A. Frithiof, Stockholm Rheumatism Association (SE) (tbc)

An overview of pan-European medical practice

O. Rienhoff, Georg-August-University Göttingen (D) (tbc)

The role of video conferencing

J.-F. Raffestin, Regional Vice-President, Business Development, PolyCom EMEA (F) (tbc)

An overview of technology: Infrastructures and solutions

D. Kitney, Chair of Biomedical Engineering, Imperial College and Chairman of ComMedica Ltd. (UK) (tbc)

Industry support for eHealth across Europe

T. Jones, Chief Medical Officer, Oracle Corporation (UK) (tbc)

Solving waiting lists in practice

O. Nordhus, Chairman, Nordhus Medical Group (tbc)

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Friday, October 3rd, 2003 15:00 - 18:00

Campaigning for health in the EU

hosted by: GPC International



Chair: **H. Stein**, European Observatory on Healthcare Systems and Former Head of EU Affairs, Ministry of Health (D)

Outlook for EU health policy development and the role of stakeholders

M. Hübel, European Commission

The role of patients in EU policy development

A. Broekhuizen, Vice Chair, European Patient Forum (tbc)

One Voice in 15 – soon 25! - The role of the Council of Ministers in the policy process

N. Boyd, Head of International, Department of Health, (UK)

Working for health in the European Parliament

J. Bowis, Member of the European Parliament

How to negotiate the political process

Issue case study: Health and the European Convention

T. Rose, Secretary General, European Public Health Alliance

Obstacles and opportunities for stakeholders - Discussion

Chair: **C. Wunnerlich**, Senior Vice President, GPC International

Programme co-ordinator:

P. Belcher, EU Adviser, Royal College of Physicians (England) and European Health Management Association

Patient-orientated quality management in healthcare

hosted by:

Deutsche Krankenversicherung AG (DKV)



Opening

D. Ziegenhagen, Deutsche Krankenversicherung (D)

Introduction: Patient-orientated quality management in healthcare – European dimensions

B. Kutryba, National Centre for Quality Assessment in Healthcare (PL) (tbc)

Scientific approach: Patient-orientation in outpatient oncologic healthcare: results of a recent study

T. Ruprecht, Picker Institut Deutschland (D)

Patient empowerment: the discrepancy between patients' rights and reality

P. Poletti, CEREF (I)

Practical approach: experiences of a patient (tba)

Practical approach: experiences in patient empowerment of DKV as a health insurance company

D. Ziegenhagen, Deutsche Krankenversicherung (D)

Conclusion

Saturday, October 4th, 2003 9:00 - 12:30

Health in a wider Europe: A look at the new EU neighbourhood European responses to new challenges

organised by the World Bank and the European Commission



Chair: tba, European Commission

Rapporteur: **M. Rosenmöller**, IESE Business School

Threats and preparedness: Evidence from the wider European neighbourhood

Preparing for guarding the new EU Border: Examples from Poland and Slovakia

M. Chawla, IBRD/World Bank

Health and health systems in the new neighbour countries: Examples from Ukraine

T. Palu, IBRD/World Bank

The Southern European neighbourhood: Realities in the Middle East and North Africa Region

A. Maeda, IBRD/World Bank

Looking across the Atlantic. Experiences from the US-Mexican border

A. Fidler, Sector Manager, HNP, IBRD/World Bank

Responses to new challenges

Quality of surveillance systems: Experiences from the US and Europe
D. Miller, CDC / World Bank (tbc)

Getting ready: The EU Networks of Communicable Diseases
tba, European Member State

A new European Health Strategy. Responding to new realities:
B. Merkel, Head of Unit, European Commission

Panel discussion

Günther Leiner

President, International Forum Gastein



In the past years we have succeeded in establishing a multiplicity of topics on the European health policy agenda. It makes me happy to see that a set of recommendations and ideas find access in the concrete work of decision makers. This year the congress focuses under the main topic "Health and Wealth" not only on the immediate aspects of health but at the same time addresses the social

and economic dimensions also. The constantly rising cost-containment discussion in health services make me anxious. Therefore it is a particular concern for me to raise awareness regarding our responsibility for older citizens in Europe at this years congress.

In den vergangenen Jahren ist es uns gelungen eine Vielzahl von Themen nachhaltig in der europäischen Gesundheitspolitik zu etablieren. Es freut mich zu sehen, dass eine Reihe von Empfehlungen und Ideen in der konkreten Arbeit der Entscheidungsträger wieder zu finden sind.

Der dies jährige Kongress widmet sich unter dem Oberthema "Gesundheit und Wohlstand" nicht nur dem reinen Gesundheitsaspekt sondern erinnert zugleich auch an die soziale und ökonomische Dimension. Sorge bereitet mir die stetig steigende Ökonomisierung des Gesundheitswesens. Deshalb ist es mir auch ein besonderes Anliegen beim diesjährigen Kongress an die Verantwortung gerade gegenüber unseren älteren Bürgern in Europa zu erinnern.

David Byrne

Member of the European Commission, Health and Consumer Protection



This year's European Health Forum Gastein brings together "Health and Wealth" - the social and economic aspects of health and health policy. The challenge to improve health status and the quality of health services while containing cost increases is very topical across Europe and is high on the European Union's health agenda. The EHFG will no doubt provide an important input into these discussions within countries and at European level.

Das diesjährige European Health Forum Gastein wird sich mit "Gesundheit und Wohlstand" - den sozialen und wirtschaftlichen Aspekten der Gesundheit und der Gesundheitspolitik - auseinandersetzen. Die Verbesserung des Gesundheitszustands der Bevölkerung und der Qualität der Gesundheitsdienstleistungen bei gleichzeitiger Kontrolle der Kostensteigerung ist ein brandaktuelles Thema in ganz Europa und steht ganz oben auf der Tagesordnung der Europäischen Union. Das EHFG wird zweifelsohne sowohl auf innerstaatlicher als auch auf europäischer Ebene einen wichtigen Beitrag zu dieser Debatte leisten.

Marc Danzon

Regional Director, World Health Organization



Since its foundation, the European Region of the WHO has included the countries of central and eastern Europe. Many of these countries are now candidate countries for the European Union. The enlargement of the EU constitutes a great opportunity to tackle health issues in the countries in question, but also in the other 15 countries which already are members of the EU. The WHO will continue to provide its support to all countries and maintain its strong partnership with the European Commission that it has been building day after day.

Seit ihrer Gründung hat die europäische Region der WHO die Mittel- und Osteuropäischen Staaten integriert. Viele dieser Länder sind heute Beitrittskandidaten zur Europäischen Union. Diese EU-Erweiterung stellt eine Chance dar, sich der Gesundheitsfragen sowohl in den betroffenen Ländern sowie in den jetzigen 15 EU-Ländern anzunehmen. Die WHO wird ihrerseits alle Länder, sowie die starke Partnerschaft zur Europäischen Kommission, die sie Tag für Tag aufgebaut hat, weiterhin unterstützen.

Caroline Jackson

Chair of the Committee on the Environment, Public Health and Consumer Policy, European Parliament



A high level of public health is an indicator of well being and prosperity. On the other hand, maintaining that level, let alone raising it, is not cheap. There is a constant demand for innovative ideas on how to provide, finance and organise health care services. I rely on the 6th European Health Forum Gastein not only to act as a forum for discussion on all health-related policy issues, but also to bring forward fresh proposals that can later be further developed, both at the European and the national level.

Ein hoher Gesundheitsstandard in der Bevölkerung gilt als Zeichen von Wohlstand. Andererseits ist die Aufrechterhaltung eines solchen Standards, geschweige denn seine Anhebung, mit hohen Kosten verbunden. Es existiert eine dauerhafte Nachfrage nach zukunftsweisenden Konzepten zur Bereitstellung, Finanzierung und Organisation von Gesundheitsdienstleistungen. Ich bin zuversichtlich, dass das 6. Europäische Gesundheitsforum Gastein nicht nur als Diskussionsplattform für alle Fragen der Gesundheitspolitik dienen wird, sondern auch neue Ansätze hervorbringen wird, die später sowohl auf europäischer als auch auf nationaler Ebene weiterentwickelt werden.

Maria Rauch-Kallat

Federal Minister for Health and Women



The organisation of a freely accessible, high quality health system at an affordable cost presents a permanent challenge for health policy. The possibility to use health services must be ensured regardless of the patients' individual financial situation. I welcome the initiative to focus on issues of health economics at this year's European Health Forum Gastein. So far the reactions have shown that this move was met with great interest. Hence, the foundation for a successful European Health Forum Gastein 2003 has already been laid. I am convinced that this year's event will once again bring together a large number of committed participants in the Gasteiner Tal.

Die Organisation eines frei zugänglichen, qualitativ höchstwertigen Gesundheitssystems zu finanzierbaren Kosten, ist eine permanente Herausforderung, der sich die Gesundheitspolitik zu stellen hat. Die Inanspruchnahme von Gesundheitsleistungen muss unabhängig von der individuellen materiellen Situation der Patientinnen und Patienten gewährleistet sein. Ich begrüße die Initiative, sich beim diesjährigen European Health Forum Gastein schwerpunktmäßig mit Fragen der Gesundheitsökonomie zu beschäftigen. Wie die ersten Reaktionen zeigen, stößt sie auf breites Interesse. Die Basis für ein erfolgreiches European Health Forum Gastein 2003 ist gelegt. Ich bin davon überzeugt, dass auch heuer wieder eine große Zahl engagierter Teilnehmerinnen und Teilnehmer ihren Weg ins Gasteiner Tal finden werden.

Reinhart Waneck

State Secretary, Federal Ministry for Health and Women



The challenge faced by organisers of annual conferences is to find the right mixture of continuity and new topics, and to maintain a high quality of presentations and speeches while offering a perfect organisation and a pleasant atmosphere. The European Health Forum Gastein has impressively succeeded in doing so for years.

Moreover, this annual event also reflects the excellent cooperation between the Austrian Health Ministry and the EU Commission and Commissioner David Byrne, and has become increasingly popular over the years, developing into one of the most important gatherings particularly in view of the enlargement of the European Union. By focusing on the "Social character of the health sector", the EHFG 2003 has once again chosen to deal with one of the most topical issues in the European health policy debate.

Die Herausforderung für Veranstalter jährlicher Konferenzen ist es, die richtige Mischung aus Kontinuität und neuen Themen zu finden, die hohe Qualität der Präsentationen und Vorträge sicherzustellen und gleichzeitig eine perfekte Organisation und ein angenehmes Ambiente zu bieten. Dem European Health Forum Gastein gelingt dies seit Jahren in eindrucksvoller Weise.

Darüber hinaus sind diese Veranstaltungen auch Ausdruck optimaler Zusammenarbeit zwischen dem österreichischen Gesundheitsressort und der EU-Kommission mit Kommissar David Byrne und erfreuen sich Jahr für Jahr zunehmender Beliebtheit und sind somit eine der bedeutendsten Veranstaltungen insbesondere in Hinblick auf EU-Erweiterung geworden. Mit dem Themenschwerpunkt "Sozialer Charakter des Gesundheitswesens" greift das EHFG 2003 wieder eines der aktuellsten Themen in der europäischen gesundheitspolitischen Diskussion auf.

Franz Schausberger

Governor, Land Salzburg



The repeated presence of high-ranking participants and speakers from 35 nations is a proof and a guarantee that even in the sixth year, the European Health Forum Gastein will be setting decisive trends in shaping European aspects of health policy. The development of a core competence in the health sector allows the Land of Salzburg and the Gasteinertal to assert themselves as a health region throughout Europe. Having a very long tradition and a cross-border importance in the health sector, Gastein was virtually predestined to hold this event.

Die alljährliche hochrangige internationale Besetzung der Tagung mit Teilnehmern aus über 35 Nationen ist Beweis und Garant dafür, dass das European Health Forum Gastein auch im sechsten Jahr seines Bestehens entscheidend bei der Gestaltung einer europäischen Gesundheitspolitik Akzente setzt. Durch die Entwicklung einer Kernkompetenz im Gesundheitsbereich kann sich das Land Salzburg und das Gasteinertal außerdem europaweit als Gesundheitsregion darstellen. Das Tal mit seiner langjährigen Tradition und grenzüberschreitenden Bedeutung im Gesundheitsbereich ist ja geradezu prädestiniert für diese Veranstaltung.

Gabi Burgstaller

Deputy-Governor, Member of the Government responsible for Health Affairs, Land Salzburg



This year's European Health Forum deals with "health as an economic and social factor" as a central question within the European Union. How will the political sphere deal in the next decade with the flood of costs in the health and social systems caused by the ageing of the population? Care can be currently financed, but there are specific measures to be undertaken to also ensure this high standard for the future, whereby the interests of individual patients are to be maintained. I wish the European Health Forum Gastein to again enjoy continued success.

Das diesjährige European Health Forum widmet sich mit dem Thema "Gesundheit als wirtschaftlicher und sozialer Faktor" einer zentralen Frage innerhalb der Europäischen Union. Wie geht die Politik mit den durch die Alterung der Bevölkerung entstehenden Kosten im Gesundheits- und Sozialwesen in den nächsten Jahrzehnten um? Derzeit ist die Versorgung noch finanzierbar, doch es sind unbedingt Maßnahmen vorzunehmen, die diesen hohen Standard auch für die Zukunft sichern, wobei die Interessen des einzelnen Patienten zu wahren sind. Ich wünsche dem European Health Forum in Gastein auch für heuer wieder gutes Gelingen!

Booking information

For your convenience, we will provide you with a variety of services. When booking the congress and your accommodation through the International Forum Gastein you ensure that all services we offer are included: direct shuttle service from Salzburg Airport (1h) or Schwarzach-St Veit / Bad Gastein railway stations; congress papers delivered to your hotel; participation in all EHFG sessions; Special Interest Sessions; social events for all participants and partners including the President's evening on Saturday.

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