

eurohealth

Focus on Norway



Interview with
Dagfinn Høybråten,
Norwegian Minister of
of Health

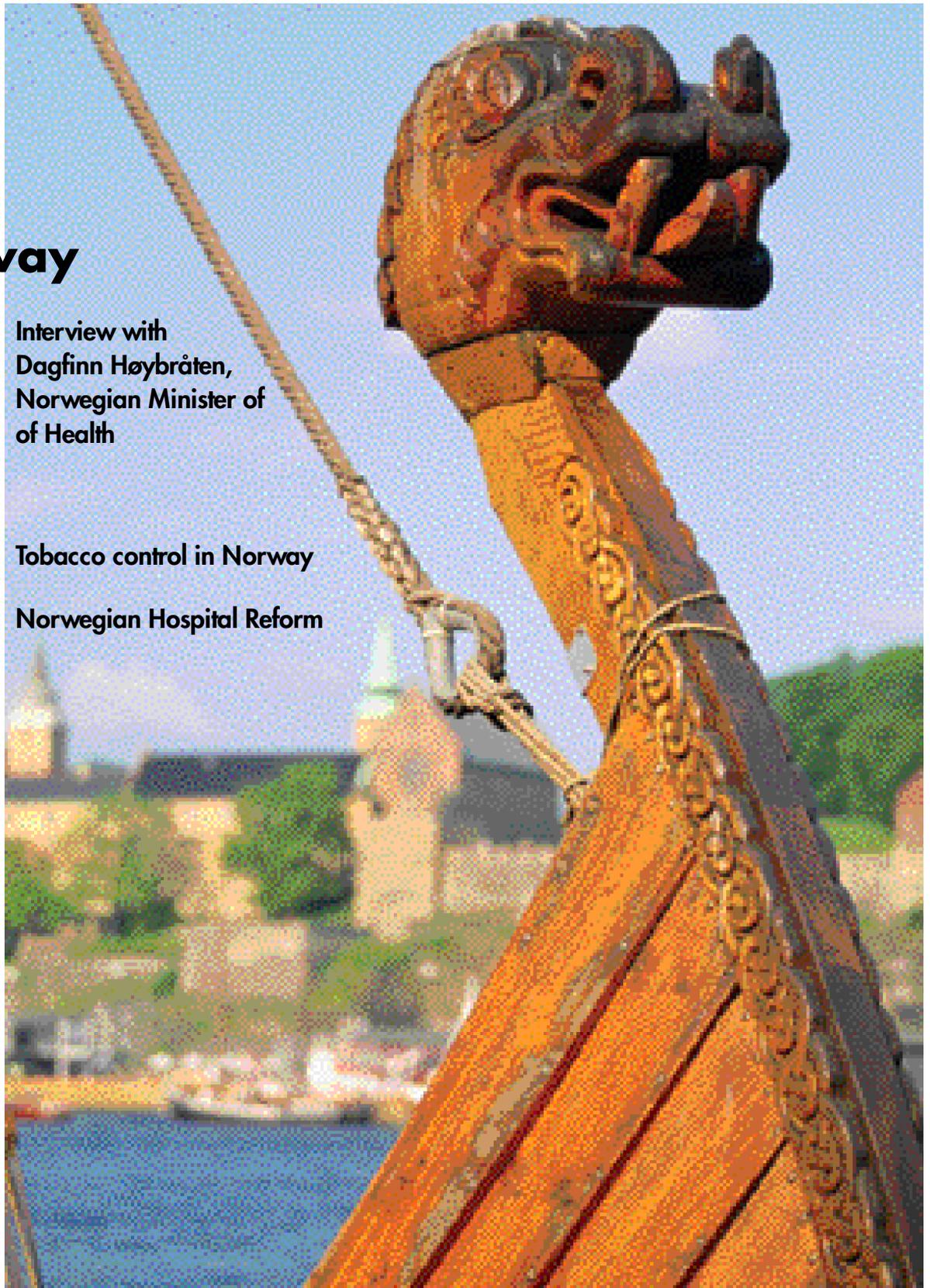
Tobacco control in Norway

Norwegian Hospital Reform

Tribute to
Hans Stein

From
health targets to
health targeting

The state of
men's health
in Europe



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C O M M E N T

Building Bridges, Meeting Challenges

Eurohealth continually seeks to build bridges between the myriad worlds of policy making and practice, tackling topical issues in innovative and informative ways. Thus we are particularly fortunate in this issue to feature not only an interview with the Norwegian Minister of Health, Dagfinn Høybråten, but also accompanying articles on Norwegian approaches to health care reform and tobacco control. While Norway has a long and proud tradition of delivering high quality health and social care services, time does not stand still, and a series of reforms to improve the performance of the system further are underway, providing experience that may help others rise to meet their own challenges elsewhere in Europe. *Eurohealth* in this issue also has the honour of being able to pay its own small tribute to Dr Hans Stein who has and continues to be a stalwart champion of European health policy and who here outlines his vision for the future.

It is with pleasure that we also offer a warm welcome to readers from the *European Health Forum Gastein*. The Forum has long served as a vehicle for building bridges, linking scientific rigour to the realities of an ever changing European policy environment. This year's Forum, entitled *Health and Wealth: Economic and Social Dimensions of Health*, focuses in depth on several key issues: the wider macroeconomic aspects of health; reflecting on issues and lessons from a broad range of experiences, including the findings of the WHO Commission on Macroeconomics and Health; and the application of macroeconomic theory and policy across Europe.

Other key issues raised include challenges in the enlarged Europe, pharmaceutical policy and healthy ageing. This latter issue well illustrates the macro-economic nature of health. Too often it is assumed that there is a simple correlation between ageing and health and social care expenditures. The relationship between health and ageing is of course much more complex, and far from being pessimistic the key goal should be to examine ways to promote healthy ageing and look towards developing more flexible and less ageist labour markets. Coverage of these topics at the Forum will appear in a future issue of *Eurohealth*.

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Is health in the European Convention?

An historic moment was reached on 18 July when the President of the European Convention, former French President M. Giscard d'Estaing, officially handed over the draft EU Constitution to Sr. Berlusconi, the current chair of the European Council. This event marked a significant point along an often-tortuous road to developing a new Constitution for the European Union.

Background

The Convention on the Future of Europe was set up following the 2001 December summit of European leaders. Its original mandate was to hold discussions on how the various Treaties on which the EU is based could be consolidated into a single text. The key players in the Convention debate are as follows.

15 representatives of the Heads of State or Government of the Member States (one from each Member State),

13 representatives of the Heads of State or Government of the new Member States set to join the EU in 2004 (1 per State), in addition to representatives from the other three accession candidate countries, Bulgaria, Romania and Turkey.

30 representatives of the national parliaments of the Member States (two from each Member State),

26 representatives of the national parliaments of the candidate States (two from each candidate State),

16 members of the European Parliament,

2 representatives of the European Commission.

As well as consolidating existing Treaties, the draft Constitution makes explicit the

values and goals that guide the European Union, defines citizens' rights and duties, and clarifies the powers of the Member States and the EU and the relationships between them. The weighty text covers all aspects of European Union activities and the following observations tease out those parts of the text that are of particular relevance to health. The full text is available at the Convention website.¹

Health as an 'objective' of the EU

Against the background of an international debate characterised by calls to shift measurement of the progress of nations beyond the conventional measures of wealth to include health, as well as evidence of the fundamental linkage between the two, illustrated by the recent Commission on Macroeconomics and Health, there were numerous calls from health NGOs and professional associations (notably coordinated by the European Public Health Alliance) for health to figure prominently in the Constitution. However the draft text fails to mention health explicitly in Article 3, which lists the objectives of the European Union, instead concentrating on issues such as the creation of the EU Single Market, sustainable development, and environmental protection.

Calls for health to be mentioned explicitly were motivated by concerns that the existing commitment to build a social Europe should be made more concrete, with health as a social objective being equivalent and not subordinate to the economic goals of European integration. However, while health is not included in Article 3, other wider EU objectives are stated which could be interpreted as having health implications. These include promoting well-being, social justice and protection, the eradication of poverty and protection of human rights and, as in the past, offer scope for creative interpretation by those seeking to ensure that progress in social and economic policies go hand in hand.

Two types of EU health powers

The draft Constitution divides EU health powers into 'common safety concerns in public health matters' and 'protection and improvement of human health'.

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The first area is defined as a 'shared competence' between the EU and Member States (Article 13) and provides the possibility of enacting binding EU legislation. It is seen as a response to increasing health threats from communicable diseases and bioterrorism.

The second part is considered an area of 'supporting competence' (Article 16) which rules out any European legislation that could harmonise national laws and regulations.

Describing this split to the European Parliament on May 6, the European Commissioner for Justice and Home Affairs, Antonio Vitorino, said that actions supporting Member States' health services would fall under this weaker 'supporting competence'.

Many health observers have reservations about splitting EU health policy into these two different areas of shared and supportive competencies. There is some confusion as to how "common safety concerns in public health matters" and "protection and improvement of human health" can actually be differentiated in practice. There is a danger that, as with the European Union's earlier efforts to legislate in the area of public health, these words will give rise to an industry of commentators seeking to interpret what the legislators actually meant, rather like those visiting the oracle at Delphi, when it is not at all clear that the legislators have any idea what they mean.

Rights to healthcare

For the first time in a European Treaty, 'healthcare' is explicitly mentioned. The Charter of Fundamental Rights, adopted in December 2000, has been fully incorporated in Part II of the Treaty. Article II-35 states that:

"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities."

The right to healthcare has been carefully worded to ensure that Member States, not the European Union, determine how their citizens access healthcare within their own territories. Yet, once again, this leaves many issues unresolved, in particular those facing patients and health professionals who cross borders and who experience

quite different "national laws and practices" that in effect block the ability to move freely. It is difficult to avoid the conclusion that the drafters of this article have been unaware of the unfolding events in the European Court of Justice in recent years.

In addition, the Charter includes other rights that have health implications. These include the 'right to life' (Article II-1) and the 'Right to the integrity of the person' (Article II-3) which impacts on medical research:

Right to the integrity of the person

Everyone has the right to respect for his or her physical and mental integrity.

In the fields of medicine and biology, the following must be respected in particular:

the free and informed consent of the person concerned, according to the procedures laid down by law,

the prohibition of eugenic practices, in particular those aiming at the selection of persons,

the prohibition on making the human body and its parts as such a source of financial gain,

the prohibition of the reproductive cloning of human beings.

While these provisions may, superficially, seem sensible and in accordance with accepted practice, once again there is a risk that careless drafting may create future problems. For example, at present, in several Member States, there are real concerns about the way in which restrictive requirements on informed consent may block necessary research using health data (for example, in cancer registries) or stored samples (such as blood taken for routine testing) where it is necessary to investigate a hypothesis that was not anticipated when the data or samples were collected, and so the individual was unable to give precise consent for the particular analysis involved. There are many examples of major advances that would have been impossible if such restrictions had existed in the past. Furthermore, the ability to opt out renders cancer registries, a key tool in monitoring progress in public health, unrepresentative and so almost useless. Consequently, there is a strong argument that this Article should contain some attempt to balance the right to consent with the benefit that society as a whole will gain from the ability to undertake population-based monitoring and research where they cause no harm to the participating individual.

"the Convention debate threw into stark relief the absence of consensus about what constitutes public health"

“There are plenty of reasons for the IGC to revise this Article”

Rewording of Article 152

Until now, explicit mention of health in the EU Treaties has centred on Article 152, which outlines EU powers in “Public Health”. There is no specific Article on “healthcare” as national powers in this area are guarded jealously by the Member States.

The draft Constitution includes an amended version of Article 152, which is now renumbered Article 179. At first sight it appears little different from the previous text, with its many limitations and uncertainties, but several observations can be made.

First, some observers note that the scope for EU action could yet be widened depending on the final definition of “common safety concerns” in paragraph 4. A previous version of the draft, which remained intact until an 11th hour amendment, did not limit action merely to blood, organs, and veterinary and phytosanitary measures. Other than simply reproducing what was in Article 152, the arguments for adopting these criteria are far from clear and certainly do not take into account to the growing literature on, for example, international cooperation in the production

of global public goods for health. The rather tortuous language, with its inclusions and exclusions, contrasts with the much simpler, and arguably more effective, wording of Articles on issues such as the environment.

Second, in response to requests made by many members of the Convention, the so-called ‘open method of coordination’ has been acknowledged, in all but name, for use in a number of areas including health and social policy. This method of working seeks to encourage Member States to coordinate their actions voluntarily, without using EU legislation, such as Directives and Regulations. In the field of health, Article 179 applies this to ‘initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation’.

Finally, the revised text maintains the accepted principle that “European Union action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care.”

ARTICLE 179 (EX ARTICLE 152) PUBLIC HEALTH

A high level of human health protection shall be ensured in the definition and implementation of all the Union’s policies and activities.

Action by the Union, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Union shall complement the Member States’ action in reducing drugs-related health damage, including information and prevention.

2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action.

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any use-

ful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. A European law or framework law shall contribute to the achievement of the objectives referred to in this Article by establishing the following measures in order to meet common safety concerns:

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) measures in the veterinary and phytosanitary fields which have as their

direct objective the protection of public health;

European laws or framework laws shall be adopted after consultation of the Committee of the Regions and the Economic and Social Committee.

5. European laws or framework laws may also establish incentive measures designed to protect and improve human health and to combat the major cross-border health scourges, excluding any harmonisation of the laws and regulations of the Member States. It shall be adopted after consultation of the Committee of the Regions and the Economic and Social Committee.

6. For the purposes set out in this Article, the Council of Ministers, on a proposal from the Commission, may also adopt recommendations.

7. Union action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

Did the Convention deliver on public health?

Promisingly, all the signs were present for a new political approach to health at EU level. Many health commentators had been calling for a reform of the EU competence in health for years. This revision of the Treaty, the last foreseen for some time, was an excellent opportunity to get the text right. Despite the careful drafting of Article 152 in Amsterdam to ring-fence national healthcare systems from EU interference, the recent cascade of case judgements from the European Court of Justice had made it abundantly clear to all concerned, both in the Commission and Member States, that EU policy in areas such as the internal market has an impact on healthcare. A committed Commissioner campaigned on the slogan that he had more powers to protect animal welfare than to protect human health.

For many in the health community the goal is the integration of 'a high level of human health' in Article I-3, (EU Objectives) in combination with a robust public health Article that is inclusive and not simply an exclusive list of potential EU legislation. This combination would enable the Union, through unanimous decisions of Member States, to take actions – including legislation – in order to fulfil these overall objectives.

The end result is mixed. The Open Method of Coordination forges a new role for the Union in terms of developing indicators and exchanging best practice. But EU legislation is excluded except for existing issues such as blood and human tissues. In this context EU Member States may unilaterally go further than the EU standard. The Article confers the EU only with the job of supporting Member States, and not even coordination of national policies, a role reserved for governments alone in 'liaison' with the Commission.

The Convention debate threw into stark relief the absence of consensus across Europe about what constitutes 'public health', with interventions ranging from the dangers of biological and chemical contaminants and communicable diseases to dire warnings about 'creeping competence' over hospitals by a power-mad Brussels bureaucracy. Advocacy by health organisations about the major health threats in Europe (cardiovascular disease, obesity, cancer and mental health problems) all of which are non-communicable, largely preventable and require a concerted interna-

tional approach were overshadowed and ignored. The Health Ministries, whose participation in the High-Level Reflection Process on Patient Mobility and Healthcare has underlined the added value of European collaboration, were absent from the Convention process, which was largely undertaken by Foreign Ministries. Once again the Treaty text on health was drafted without sufficient consultation or involvement of relevant actors.

Next steps

With the Convention's task complete, work on the draft Constitution now shifts to Member State representatives within the 'Intergovernmental Conference' (IGC) which may be concluded before the end of the Italian EU Presidency on 31 December 2003. Further changes to the draft text are inevitable, particularly on Article 179. In the final moments of the Convention, the UK government reserved the right to revisit Article 179, the Dutch called for the inclusion of nutrition and food safety into the Article, France requested a specific reference to an EU role in facilitating cross-border patient mobility and Germany raised the need for a rapid response to health threats. Scandinavian concerns were also tabled about the importance of regulating the sale and marketing of tobacco and alcohol. So there are plenty of reasons for the IGC to revise this Article in spite of the warning from Convention President Giscard d'Estaing against reopening negotiations, saying that it was "a finished product".

"The Treaty text was drafted without sufficient consultation or involvement of relevant actors"

REFERENCE

1. Draft text of the Convention can be accessed at the Convention website:
<http://european-convention.eu.int/bienvenue.asp?lang=EN&Content=>

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**European Centre on Health of Societies in Transition
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Dagfinn Høybråten, Norwegian Minister of Health speaks to Eurohealth

Interview by David McDaid,
Editor

"My philosophy is to find those approaches that are successful; find out why they are; find out if they are relevant, and strive to build on their success"

What have been the principal successes in the system and what are the challenges ahead over the next few years?

I think that if you look at the Norwegian health care system one of the characteristics is that we traditionally have had a fairly strong primary health care sector. The philosophy behind our primary health care sector is that should be the first meeting point for the population, it should be a gateway into the health system, with the primary care doctor acting as the primary gatekeeper. A few years ago however we had an emerging crisis in the primary health care system resulting from a lack of primary care doctors, mainly due to a poor distribution of the existing supply of doctors. Most newly qualified doctors were attracted to other areas of health rather than primary care, hospitals for instance took more than their fair share, but it is also true to say that we did not train a sufficient number of doctors.

An initiative was undertaken to reorganise the whole private practitioner system, into more of a family doctor system, akin to the one operating in Denmark for several years. This coupled with initiatives we took to increase the capacity for the education and training of new doctors, and also regulate the distribution of new doctors helped us manage to avoid the worst of this

emerging crisis. We now have much better facilities for primary health care doctors. We still have problems in some remote areas and districts, but overall the situation has drastically improved in the last four or five years.

I think this is also due to the general practitioners reform that was introduced and implemented in mid 2001, which means that practically all Norwegians are now listed with their own doctor. So far I think we can say that this has been a success not only in terms of the coverage of doctors geographically, but also in terms of improving their relationship with patients.

What incentives have you used to influence the geographical distribution of primary care doctors?

We certainly have provided financial incentives to help ease the burden on sole practitioners, as well as improve and encourage participation in educational programmes. A central element of the general practitioners reform was an improved financial package for doctors, which is of course also important in building capacity. What we have also done is to train more doctors, but in doing so have placed a cap on the number of doctors that hospitals can recruit, so that we indirectly have forced more doctors into primary health care. This was done by law and has been accepted by the professional doctors association. It also has been

politically acceptable, and I think it has proven to be a good way this time to for us to implement such reforms. I am not saying it could be done anywhere at any time but for us it has worked.

Are you training doctors here in Norway or sending more abroad?

For a time we had an increase in the number of students trained abroad, but our main focus has been to increase the capacity here in Norway. We have been able to recruit doctors from other countries, where they have a surplus, but always in cooperation with the authorities in that country, for example, in Sweden, Denmark and Germany we have recruited quite a few doctors. Now this is changing and I foresee more Norwegians working abroad in future.

What other challenges have you met in addition to that for primary care?

Although it is too early to judge the success of the results of hospital reform, so far we have focused on waiting lists and waiting times. There has been a clear and strong decrease in waiting times and waiting lists, this in Norway like in many countries is a key focus, influencing how the population perceives the health system.

The whole reform process is of course still in an implementation phase, but I see that it is producing good results when it comes to restructuring the whole of the service, compared to the way in which decisions were made under the previous local authority political machine. Now with five large regional areas, instead of 19, there is more flexibility to change the division of labour between hospitals. This together with changes that have been made to strengthen patient rights, for instance so that they have the right to choose a hospital on a national basis, and the use of a financial system where money follows the patient has triggered both an increase in and better use of capacity.

What I think will be an important challenge in the future will be the issue of health system costs and the ability to prioritise treatments. This is important because the financial system will probably never be perfect, and because it is difficult to fine-tune a plan to meet all needs. Being able to switch resources from areas where we can see overcapacity to other areas of need is going to be a real challenge. Another important issue is how to integrate primary health care and specialist health care and I see this as a key area for the next generation of health reforms in this country.

Can this reorganisation you mention with five regional authorities be characterised as a step towards recentralisation?

Recentralisation is a too much of a simplification of the situation, what we have done actually is to empower the whole system with differing responsibilities at different levels. In fact it can actually be characterised as a decentralisation, transferring power to the hospitals, but at the same time there is now a stronger level of coordination, with clearer lines of responsibility.

Before the reform we had 19 regional authorities, politically chosen, and fully elected. They were owners who in one sense were too far away from the daily running of the hospitals to intervene in a positive way, while at the same time being too close to the hospitals so they did interfere in the day to day running of the hospitals, even in their organisational structures. This was a very dangerous combination of being both too close and too far away at the same time; so what I think was a critical success factor of the reforms was our ability to build up the leadership capacity within the hospitals, giving them real powers, so that they were not simply caretakers of practical matters, which had been the traditional role for hospital directors. This new structure has reduced somewhat irrational political interference.

Following on from the issue of costs, how can you deal with the situation in Norway as in other countries, where policies may imply increased costs within health care system, but the benefits are in fact realised in other sectors of society. Furthermore how can you coordinate activities with other government departments?

This is a challenge in Norway, but in the last 10 years there has been a consensus around the necessity to increase capacity and put more resources into healthcare. That's one of the reasons we were able to introduce a Diagnosis Related Group (DRG) based system where money followed the patients. I think there is a wide consensus in this country, and in others, that more resources need to go into health. This doesn't of course negate the importance of costs, but rather increases this challenge. There is always a possibility of not having a strong enough focus on costs, but we try to ensure that we take the necessary steps, for instance we now set annual

"There has been a clear and strong decrease in hospital waiting times and waiting lists, following reform"

targets on efficiency and productivity within hospitals, which are then followed up.

I am very occupied with primary health promotion and preventative health care, but of course making a case to convince my colleagues that it is cost effective to put money into this area is not always easy. It might be said from a strict economic focus that it is not very cost effective if people live for a long time, because when they stop producing they tend to be a source of expenditure for many public services. So from my perspective although we need to have an economic focus, this needs to be supplemented by other perspectives in order to support health initiatives and health policies.

A new white paper has recently been published in Norway. In terms of promoting public health what do you see as the key issues?

What we have done, on the same basis as that adopted in the WHO 2002 report, is try to assess the risk factors for poor health and illness in this country. The results in fact are very much like those for any other Western society, our main risk factors are tobacco, alcohol, drug addiction, and obesity linked to nutritional issues.

We have subsequently sought to focus our policies on these risk factors albeit recognising that there are other areas which are also important. However, in order to see results, we have to use this risk assessment approach and then focus our policy and our resources accordingly.

Tobacco

I think we have tightened our tobacco policy quite substantially with new legislation banning all smoking in public places including restaurants and bars, which can be a great recruitment area for new smokers. This law was passed by a large majority in Parliament and comes into effect next year. We have also run tough campaigns, last winter we adopted an Australian approach which was reported to have generated 96% awareness. 100,000 people quit smoking as a result of the campaign, which is tremendous in a country of just 4.5 million people. We will follow this up with a new campaign this autumn, and will also make smoking cessation programmes more widely available.

Encouraging lifestyle changes

We have also introduced a 'green prescription' scheme in addition to the standard blue prescriptions reimbursed by the social

security system. A key issue has always been the list of reimbursable medications, and what we are now seeing is a greater number of pharmaceuticals on the market which are directed more towards prevention.

However, lifestyle changes can both be a better and much cheaper way to improve health. The green prescription scheme is designed to encourage doctors to prescribe programmes for lifestyle change before prescribing drugs, where of course this is an appropriate medical option. Patients may be introduced to a programme to which they are expected to adhere, this is then followed up by their physician.

We already have smoking cessation programmes running, and now are introducing similar programmes for diabetics and people with high blood pressure. Such schemes provide a day-to-day routine concerning such factors as diet and exercise. This has been piloted in some communities and we are now expanding it nationwide. Doctors will also receive a greater reimbursement from social security, as a carrot to encourage them to use green prescriptions.

Alcohol abuse

To tackle alcohol our plan is focusing on the heaviest abusers and also on prevention initiatives regarding young people, so as to reduce the likelihood of them misusing alcohol in the future.

Drug addiction

We are also now in the process now of restructuring the whole treatment sector for drug addicts, this will probably be integrated into the health system, while at the same time we are promoting local 'come as you are' health clinics in the municipalities, for addicts and their families to obtain help for all sorts of basic help and advice. A past problem for drug addicts and their families is that when they have come into contact with formal health services, they have felt that the system has been incompetent and discriminating against them in many ways. We wish to change this through the reforms currently being debated in Parliament, and further actions will probably be agreed in the autumn.

Mental health

I should also say that one of the major areas for change and strengthening within the health system that has been a priority for me as long as I have been a minister is mental health. This also has a lot in

"an important future challenge will be the issue of health system costs and the ability to prioritise treatments"

common with drug addiction, as more and more people have a dual diagnosis. We can see in this country the results of mental illness continuing to be stigmatised and not talked about. It was this way with cancer fifty years ago, but this is now widely talked about. What we need to do is break this kind of barrier, because this silence had really contributed to the very low priority in the past given to mental health care when it comes to resources skills, research, and organisation of the whole system of treatment.

In 1996 we undertook an assessment of the whole system with very depressing results. It was concluded that the whole system didn't work; individuals did not get the treatment they needed; staff did not feel they got the job done; there was a lack of capacity and competence in the system; and a lack of a system wide perspective, with links to other support and treatment services.

In response to this we introduced an eight-year plan to build up the level of resources and restructure the system. Historically in Norway we had succeeded in closing down all the large asylums and the old fashioned psychiatric institutions, but had failed to build up community based alternatives. We are now aiming to build up district mental health centres and build up the support system in the municipalities, and as a result of this more of those people who otherwise would present at overloaded hospital departments can be helped locally. We are in the middle of the eight-year plan now, and it's a very challenging and complicated reform, but we now are beginning to see the results of having better capacity, and furthermore waiting times are decreasing.

I think the main challenge remains changing the way of thinking of people in the system from an 'old fashioned' approach to psychiatry to a new community based service approach. The challenge is increasing because more people have mental health problems. Changing public attitudes towards mental illness is an important part of the plan; the idea is to channel quite a lot of resources towards public information campaigns for the general public, and also targeted at young people through schools etc.

We want to make mental health problems something that we can talk about. Of course our own Prime Minister took sickness leave some years ago because of depression; he spoke quite openly about this and I believe that more people now in

the public arena are also coming forward and speaking about their experiences. This is a very important part of changing attitudes.

We are also trying to build up patients' organisations and family associations, and we are providing quite substantial sums of money to strengthen them not only to be stronger competitors with the hospitals and other service providers, but also to be stronger voices in the public arena. We know that when you suffer from a mental health problem the first thing that needs to be done is to help fight for individual patient rights; there has historically been no strong advocacy movement in this country to do this; strengthening patients organisations will also help build this capacity.

What can be done at a European level to promote mental health and health more generally?

Well I think, and this is why I believe in the work of organisations like the European Observatory on Health Care Systems, that anything that can promote the exchange of relevant information about what works and what does not, what are the successes and failures and what can we learn from them, all of these types of exchange are important in health care. So much of society's resources are channelled into the health sector that we need to learn from each other. When we were devising the mental health plan in Norway we went abroad to learn from other experiences. We found in Italy a mental health sector that had gone far in the direction of community based services and we learnt a lot at the time and are still learning from them.

When we planned and implemented our general practitioner reform we went to Denmark and to the UK to learn. The Danish model is very much the model we have implemented here. I cannot though say the same things about hospital reform, this is very much a Norwegian product and we have been travelling in a different direction. Perhaps though others can learn from us, we have had individuals coming here to ask us why we have done what we have done, and again I think that this kind of exchange of information and interaction is so important because we cannot afford to repeat mistakes over and over again in different countries; but neither can we afford not to learn from all the successes in other countries. My philosophy is to find those approaches that are successful; find out why they are; find out if they are relevant, and strive to build on their success.

"making a case to convince my colleagues that health promotion and prevention is cost effective is not always easy"

"Mental health has been a priority for me for as long as I have been a minister"

How do the hospital reforms link with the primary sector reforms?

What we have done is to reform the primary sector through the general practitioner reform, while also reorganising the secondary care sector and taking over their ownership. What now is the challenge is to see a better integration of the two. We do want to maintain the traditional Norwegian value of primary health care being on the front line acting as the principal gatekeeper, this is very important. I do not envy countries where individuals can go directly to hospital sector, but we still need better integration as we see that hospitals are becoming more and more efficient, and thus patients are discharged earlier and earlier. Our municipalities may feel that they get much of the burden of care. Although in some cases the system is working very well, this is too much dependent on the people involved, we need a system that in a better way approaches patients in a holistic manner, not seeing the individual as either a municipal or state responsibility.

I am now planning to appoint a Commission to look over this crossroads in the system and consider how we can improve its organisation. This does not necessarily mean that the state should take over the responsibility for primary health care, this is not necessarily the solution to the problem, but I believe that strong integration will be in the next phase of health reforms in this country over the next five years. I cannot describe any solutions yet, but I am very aware of the problems and recognise that they need to be handled, and I believe that having laid down foundation stones in primary health care and in specialist health care, we are in a position to meet this challenge.

International cooperation is important if measures to reduce use of tobacco are to be successful. What role has Norway played in this process, and can you comment on the World Health Assembly's adoption of the framework convention on tobacco control?

Norway was one of the first countries to ratify the convention. We have tried from day one to support Dr Brundtland in her efforts to support this convention, and we have had people working very actively in the negotiations. Of course what is needed first of all is to get enough countries to ratify the convention, but I don't think this will be a problem. An important question

of course will be what the United States actually does, we will have to wait and see. Prior to the World Health Assembly this was very uncertain, but at the convention they did declare that they would sign. I think that the main effect of this convention will be to put tobacco control on the agenda in countries where this issues traditional has been of low importance. It can be a challenge from the international community towards those countries yet to sign up. Of course it depends on how international organisations and the UN are able to follow up progress, and also on how prominent countries are able to keep the process living. This is certainly something we will strive to do.

Can the EU do more in this respect?

Definitely but I think the process with the tobacco directive shows that it is possible within the EU which is diverse, and will become more diverse, still to make progress. I think though it is still too weak and a shame that they support the production of tobacco, but at least it is an issue, at least they have an aspiration to phase it out. Furthermore we have seen a new directive that even has challenged us, we have had to change some of our regulations. So we are not totally better than the EU in every area! We have now introduced a new labelling system for tobacco products as a result of the EU. This wouldn't have been done if it hadn't been for the EU. I am not all critical, but I think they have been too slow. Norway being an outsider will certainly continue to play such a role as we can, as we have done in previous negotiations.

Norway has had a strong commitment to poverty reduction and improving health globally. What role is Norway currently playing in global health initiatives?

It is right to say that Norway has a long tradition of focusing on development aid and cooperation and our ambition is to increase the amount of resources devoted to this area. The two main targets of our activities in the future will be health and education. These are two key areas for eradicating poverty. Norway has been blessed with oil in the North Sea (as has the UK) and I see no meaning for this generation to be blessed with such vast resources if we are not able to use some of them to bless others. The potential given to us by Nature and our rather uncontroversial position on the international scene,

provides us with the possibility of serving poorer parts of the globe, and we certainly want to do this in the health area. Therefore we are supporting the poverty profile of WHO and other UN organisations, we are significant contributors to this, and you'll find Norway high on all these lists, that's our ambition. Within the health sector Norway can also contribute more skilled workers than previously, as I said earlier we have had a phase where we had local scarcity but in the future I believe we will see more Norwegians go abroad and serve as doctors, nurses and so on. This will be a very good development if it happens, because they will eventually come back home as better doctors and nurses, and they will have done something that makes a difference in the world in the meantime. We can also help in the development of infrastructure and in providing assistance on specific problems, for instance in the area of HIV/AIDS Norway has been successful, and it is our obligation to share our experiences when we see how this disease is tearing Africa apart.

How can the EU, WHO and other international bodies work together more effectively? What role can Norway play?

This is a very wide-ranging question. I feel that there should be a better division of labour between these organisations. I think that every organisation has an ambition to make a difference in different fields, but if this process were better coordinated existing resources could be used more efficiently. Everyone does not need to do everything and I think coordination on a leadership level would improve things. I believe that there will be an increasing need for international cooperation in the area of health, the SARS epidemic is just a sign of the times that we are moving into. I should, say though that WHO did a marvellous job on SARS and has really stood up and was counted for good management when it was needed. However I think for instance in the work on structural reforms, organisation, health economics and so on we have potential in Europe to use our resources better.

"I am planning to appoint a Commission to look at the integration of primary and secondary care"

Tobacco Control in Norway



Rita Lindbak



Bjørn Inge Larsen

About 7,500 people in Norway die each year because of smoking related diseases. A further 350–550 lives are lost annually due to passive smoking. Cardiovascular diseases are the greatest cause of increased mortality among smokers, while lung cancer is probably the illness most people relate to smoking. Twenty-five years ago four times as many men in Norway developed lung cancer compared to women. Today they are only twice as many.¹ Among the population under the age of 50, the risk of developing lung cancer is actually the same regardless of gender. This development is closely related to the changes in the prevalence of smoking in Norway in recent decades. The Cancer Registry of Norway has projected that the cancer incidence among women will double by 2020.²

Tobacco use

In the early 1970s, 51 percent of men smoked daily compared to 32 percent of women (aged 16–74). In 2002, these figures were 29 and 30 percent respectively. Many men have quit smoking, while the lack of change among women is mostly due to elder non-smoking women being 'squeezed out' of the statistics by younger women who smoke as much as men of the same age.³

Tobacco use has been monitored by the Norwegian health authorities since 1973. Young people smoke far less now than in the 1970s, but there has been no significant decrease during the last two decades. Furthermore since the 1970s, there has practically been no difference in smoking

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prevalence rates between boys and girls aged between 16–24 years old. It seems that girls start smoking at a slightly earlier age than boys, but that boys soon catch up. In recent years there has also been a rise in the use of ‘snus’ (oral tobacco), particularly among young men. A low level of education is the most important explanatory factor for the prediction of smoking prevalence rates. The difference in smoking behaviour between the low and well educated is increasing, emphasising social inequality also as a health issue.

The early years

Since 1970, the Norwegian government has had an active governmental tobacco control programme. Tobacco control is mainly a public responsibility, but the authorities enjoy highly developed cooperation with non-governmental organisations, trade unions and organisations of health providers. Although the Norwegian authorities have focused on a comprehensive plan for tobacco control, what has perhaps gained the most international interest, both previously and recently, is restrictive national tobacco control legislation. These restrictive measures have perhaps also represented Norway’s most significant success in tobacco control. Further information on the early years of tobacco control in Norway can be found in the recent publication of Dr Kjell Bjartveit.⁴

Pioneering advertising ban

Norway was among the first countries to introduce a total ban on tobacco advertising and promotion, including all indirect advertising and has therefore played a pioneering role. The law was enacted in 1975 and attracted much attention from abroad, both from organisations representing health interests, from other governments, and not least from the tobacco industry. Loopholes are sometimes unavoidable, and after seeing the tobacco industry try to circumvent the ban in a variety of ways, the government introduced amendments to the Tobacco Act, with the intention of counteracting all these attempts by the industry. These new amendments were passed in 1996.

Age limit and health warnings

Even though the advertising ban attracted the most attention internationally, the first Tobacco Act contained provisions banning the sale or procurement of tobacco products to children under 16, and strengthened compulsory health warnings. At the time Norwegian health warning labels were at

the cutting edge internationally, containing a specific and detailed text. Since 1975, the Tobacco Act has however been revised several times. Among other things, the prohibition on sales to minors has been extended to those aged under 18 years of age.

Though not part of the European Union, Norway is, because of the European Economic Area (EEA) Agreement, bound by law to enact legal provisions to fulfil the requirements of Community legislation. Directive 2001/37/EC concerning the manufacture, sale and presentation of tobacco products has therefore been implemented in national legislation. Among other things, one of the provisions requires that manufacturers and importers submit a list of ingredients as well as a list of the reasons for their inclusion. The list must additionally include the ingredients’ function and category. This list is to be made public as well as reported to the respective EU/EEA authorities. ‘Light’ and ‘mild’ and similar descriptions are to be banned from 1 January 2004 and health warnings must cover between 30 and 40 per cent of the surfaces of tobacco product packaging. Warnings including pictures showing the adverse health effects of tobacco are being considered and may be introduced at some future point.

Ban on new tobacco products

In 1989, the Ministry of Health introduced regulations that prohibit the introduction and sale of new products that contain nicotine and tobacco, thus excluding the introduction for instance of confectionery containing nicotine or other ‘unnatural’ ingredients. The motive for this was the concern that the use of such products might lead to nicotine addiction, and later to tobacco use. This provision is unique in tobacco control measures. Another exceptional provision concerns banning the sale of toys and sweets shaped like tobacco products. This is to deter children and young people from associating the use of tobacco with something tasty and pleasurable.

Passive smoking

In 1988, an amendment to the Tobacco Act was adopted. The provision ensured smoke free indoor environments in public areas and transportation as well as within work premises. This was a reaction to an increased awareness of the adverse health effects of passive smoking. The provisions were far-reaching, but restaurants and bars were exempt from these provisions. Regulations stipulated that smoking be

“Norway was among the first countries to introduce a total ban on tobacco advertising and promotion”

allowed in only two thirds of the space within premises from 1993 and only half from 1998. In 1996, schools for pupils up to 15 years were made entirely smoke free, both indoors and outdoors.

In November 2002, the government proposed a white paper to amend the Tobacco Act to deal with smoke free restaurants, pubs and bars.⁵ So far, employees in this industry have been the only ones without satisfactory protection from the health hazards of passive smoking. On 8 April 2003, the bill was passed by an overwhelming majority and will enter into law from June 1 2004.

Even though ensuring all employees' equal protection in their working environments has been the main motive behind this proposal, it is important to note that other factors have also been influential. The most obvious is the protection of customers, but also the new law will remove an important arena where many teenagers start smoking. Smoke free environments are not only a protection from passive smoking; they could constitute a key element in reducing smoking prevalence among young people. Parliament members stressed this point in particular during the debate.

One successful criterion for this progressive legislation is the fact that the influential labour trade unions not only gave their full support, but also campaigned actively for the legislation to be passed. Another was the decision of the Supreme Court ruling in favour of a plaintiff who sued for damages due to illness caused by exposure to passive smoking in a bar. The new act is an illustration that legislation enacted at an opportune time can become a powerful public health tool.

Taxation

Price and tax measures have long been considered an effective means of reducing tobacco consumption by various segments of the population, in particular among the young. Tobacco taxes were initially viewed by successive Norwegian governments as a means of raising general national revenues, and it was only more recently that taxes have been justified on health grounds. Norway is renowned for its high tobacco prices, but it should be added that consumer prices are in any case high in the country.

Cessation activities

Norwegian tobacco control policy has a focus on cessation, but perhaps not as

much as in many other European countries. Since 1996, a quitline (Røyketelefonen) has been many smokers' best friend. During its first years of operation it was merely a service where people called in and sought advice or information. The quitline then went from using just a passive but also including an active approach. Smokers who are ready to set a date for quitting can now be phoned back at regular intervals over a one year period. Cooperation and exchange of information with other quitlines, mainly in Europe, has been essential.

The moderate involvement of health professionals is a challenge for Norwegian cessation work. This is now improving, not least because of continuously improved cooperation between the health authorities and the associations for health providers. Doctors are urged to initiate more 'minimal interventions' by talking about smoking and health at each consultation. They receive a set monetary fee for each consultation and new guidelines have been prepared in order to better equip healthcare professionals to talk to and treat patients who smoke. In 2003, the Norwegian government also made Nicotine Replacement Therapy (NRT) more accessible by allowing sales through ordinary stores and not only in pharmacies. Health authorities have also trained leaders for smoking cessation courses.

Prevention programmes

A central component in the youth prevention strategy is the three-year school based programme for teenagers between 13 and 15 years of age – BE smoke FREE. The idea is to show pupils what it means to be free and independent and responsible for their own choices. The long-term health damage caused by tobacco is only a moderate focus of the strategy. The programme has been used since 1997 and now more than 60 per cent of all pupils at secondary school participate, and evaluation has been positive good.⁶ There is also a programme for older youths, which has not been as successful and is being revised based on initial evaluation. Another aspect of adolescent smoking prevention is the introduction of smoke free outdoor environments at upper secondary schools. An action plan has been prepared and has been implemented in several counties.

Community-based initiatives

Since 1997, a national cancer plan has allocated resources for community-based tobacco control strategies. The 19 counties in Norway each appointed one person to

“An ambitious goal to halve the proportion of young smokers within five years has been set”

“Since 1997, a national cancer plan has allocated resources for community-based tobacco control strategies”

be in charge of initiating and implementing tobacco control measures, among other health prevention measures. The purpose of the system is to stress the regional perspective of national strategies. A previous lack of local perspective in the tobacco control policy in Norway might be one of the reasons that Norwegian smokers are still numerous, in spite of the health authorities implementing many well-documented measures.

Information and education

So far, Norway has had few large-scale media campaigns, but has concentrated on smaller campaigns at certain times of the year, such as New Year (resolutions), International Women’s Day and World No Tobacco Day. Some campaigns were carried out in the early days in the 1970s, but since then few resources have been allocated to tobacco control throughout the 1980s and until the mid-1990s. Media campaigns are expensive, and it was impossible to prioritise a massive media strategy, although reports from other countries show that they should be part of a comprehensive tobacco control strategy.

In February 2002, the Minister of Health set an ambitious goal whereby within five years the proportion of young smokers was to be halved. As a result, the Directorate for Health and Social Affairs was given the task of suggesting a strategy to meet this goal. A report concluded that mass media campaigns are an effective means that have not yet been properly explored.⁷ This element within initiatives can provide an additional impetus in an otherwise comprehensive tobacco control programme. The Directorate was then granted NOK 10 million (about £1.2 million) to initiate this campaign. This was the first step in a five-year strategy, and comprised an extensive campaign, launched in newspapers and on television and radio, with large and explicit pictures of the damage caused by tobacco smoking, adapted from a widely used Australian campaign.⁸ The first results from the evaluation show positive effects on smoking behaviour, but they are not significant due to inadequate sample sizes. However, other surveys point in the same direction, including a drop in the sales of tobacco products. It seems that the campaign has had a short-term effect.⁹

Challenges for tobacco control

Looking at the achievements in Norwegian tobacco control during the last three decades it is surprising that the prevalence

of smoking has remained quite high. A few factors have been pointed out, such as fewer resources in the 1980s than before and a previous absence of a local perspective, which for instance was a distinction between Norway and Sweden, but the entire story has yet to be told. However, there are several short and long-term challenges that Norway faces. These include improving cessation assistance, increasing the involvement of healthcare professionals, reducing social inequalities, reducing the availability and consumption of tobacco by children and obtaining more information on the use of snus (oral tobacco).

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Aspects of Norwegian hospital reforms



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In recent years hospital policy has played a major role in the Norwegian public debate on health care. This is quite natural, not only are hospitals a key component of the health care system, they often play a key role in the local community, and they are a major and growing component of the public sector in Norway. This compels any discussion of hospital management to pay special attention to two distinct areas. The first involves striking a balance between changes in medical technology and treatment, the current set of common diseases, and indeed, population expectations. The second is concerned with the appropriate monitoring and evaluation of the efficiency by which inputs are utilised in hospitals.

As in many other European countries, the running costs of Norwegian hospitals rose steadily over the last decade. It was felt however that the simultaneous expansion and improvement in hospital services could not fully account for all of this increase, leading to a major effort to ascertain the cost effectiveness of hospital management. This process has had an important bearing on the shape of current hospital reforms.

The cornerstone of Norwegian health policy has been, and remains providing publicly owned and financed hospital care. More generally this public responsibility for hospital services remains an integral part of the health policy in all the Scandinavian countries. However the recent transfer to the central government of responsibility for all Norwegian hospitals represents a radical break with a tradition going back over more than 30 years, where hospitals were owned and managed by the 19 county councils. The Hospital Act of January 1970 charged the counties, each

with an average population of 240,000, with the responsibility for institutional health services. This came to an end in the spring of 2000, when Parliament approved a proposal to initiate a state takeover of all publicly owned hospitals, which were then defined as state health enterprises.

The challenge of cost management

Managing service costs remains an ever-present challenge in the health sector. The figures in Table 1 on hospital running costs appear to correspond with three phases in the growth of hospital services.

The first phase illustrates the tremendous rise in real expenditure in the 1970s. During that time, a significant proportion of Norwegian hospital services were established. The second phase between 1980 and 1995, shows a steady but small rise in expenditure. The third phase began in 1995 with expenditures rising on average by 5.2% annually. Some believed this rise in expenditure simply reflected the increased allocation of funds to hospitals. This view became increasingly untenable however, since many hospitals still ran into deficit even when allocated more and more funds. Soon it became clear that inept cost management was an important factor in accounting for these rising costs. This increase in expenditure was though accompanied by a specific expansion of hospital services. The introduction of a capitation fee based on the concept of a Diagnosis Related Groups (DRG) Scheme provided incentives for hospitals to maintain a steady through-flow of patients. It probably also served as an aid to cost management.

Pressure on the labour market

Some may argue that in any case Norway could afford these high increases in its health budget, as revenues from petroleum exports have contributed to a steady rise in Norwegian Gross Domestic Product. However, one cannot overlook the negative effects any financial imprudence within the health sector can have on the national economy. Hospital services are known to be rather labour intensive, and personnel costs account for about 70% of hospital budgets. So far the demand for personnel has been met through a judicious combination of adjusting the relevant training and education capacity, and secondly by

Table 1
Running costs in Norwegian somatic hospitals (fixed prices)

Period	Average growth per year
1970 - 1980	14.0%
1980 - 1990	1.0%
1990 - 1995	1.5%
1995 - 2000	5.2%

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“Managing service costs remains an ever-present challenge in the health sector”

recruiting skilled personnel from abroad.

Factors influencing cost management

While the increase in expenditures over the period 1995 to 2000 can principally be explained by a growing political consensus on the need to allocate more resources to health care, there is nevertheless some evidence that this increase in expenditure has also resulted in part from continuing weak cost management in many hospitals. Substantial deficits were incurred in this period, and additional funds had to be provided during the year in order to maintain a high level of services.

Another issue is how the financing system has indirectly influenced cost management. A new payment system using capitation fees was introduced in 1997, providing hospitals with an incentive to increase the volume of patients treated, knowing that this would increase the level of resources that they would receive. This probably to some extent discouraged hospitals from targeting their resources to unproductive activities, and indeed they managed to expand their activities substantially over this period. The fact that many hospitals ran up large deficits indicates a lack of the necessary tools or knowledge to manage costs as activity increased. In our opinion too much attention was focussed simply on increasing revenue through treating more patients without giving sufficient attention to the management of costs.

Flexible budgets?

Inadequate cost management was probably also influenced by the knowledge that additional financial support had been pro-

vided to hospitals over many years. As can be seen from Table 2 the consistent use of such supplementary funds effectively acted an indicator to hospitals that their budgets could be treated as being flexible.

The government usually outlines its budgetary plans for the following year every October. Table 2 illustrates the strong tendency by Parliament to vote initially for an increase in the level of funding over that outlined in the budget proposal (column two). On average this increase is 0.6%. Furthermore the table also provides quite strong evidence that supplementary funds also are made available during the operational year (column three). On average this increase is 5.6%.

Access to these supplementary funds may very well be necessary given current political goals. The interesting point to note here however are their unintended side effects, namely giving the hospital sector an impression that budgets can be flexible. The hospital reform process should aim for a better degree of cost management. A pre-requisite for this is a predictable and realistic budget process, a stronger process of costs management within hospitals should then follow.

The search for balance

Throughout the last three decades, every Norwegian government has championed a similar health policy with its emphasis on equity. However, in the late 1990s, hospital policy was gradually changed from a broadly planned and regulated system towards a system where incentives and some other competitive market elements were introduced. As noted earlier, these incentives took the form of hospital payments based on a DRG Scheme, and by 1997 were in use at every hospital. In 1998, Parliament in its effort to enhance patients' rights also empowered patients to choose the hospital where they would be treated. This introduced an element of free competition between hospitals. The challenge that Norwegian health policy makers face today is how to strike a balance between decentralised decision-making influenced by aspects of the free market, and a regulatory policy that guarantees equity. This challenge is shared by health authorities in many European countries.

The need for change

In the wake of these changes in hospital policy it became necessary to ascertain the organisational and management ability of hospitals and their capacity to deal with the

Table 2
Supplementary funds as share of governmental initial proposal

Year	Beginning of year	End of year
1990	0.0 %	6.3 %
1991	0.0 %	14.9 %
1992	6.5 %	8.1 %
1993	0.0 %	7.1 %
1994	-4.6 %	8.7 %
1995	0.7 %	-0.1 %
1996	4.4 %	4.5 %
1997	4.4 %	6.6 %
1998	0.4 %	4.5 %
1999	0.3 %	8.5 %
2000	1.5 %	4.5 %
2001	-0.6 %	4.1 %
Average	0.6 %	5.6 %

new arrangements. Even though the conditions under which hospitals operate have changed quite substantially, only minor amendments were undertaken in their organisation and managerial structures. In general the picture was one of minimal change, although in a few areas some hospitals were restructured as health enterprises. At the same time there had been a vigorous public debate on waiting times for specific procedures and treatments, which have varied according to patients' place of residence. Another issue of growing concern had been the detrimental effect that a large number of small hospitals may have had on the quality of services provided.

The hospital reform process

The previous system of hospital administration contained elements both of a decentralised and a centralised system. The latter involved local politicians entering into hospital management structures, something that they had no training or experience for. Moreover, they failed to take appropriate strategic decisions on the local hospital system, or introduce a rational division of labour among component units. Often such necessary changes were not compatible with local political interests. Furthermore, ownership of 80 hospitals serving a population of 4,500,000 people across 19 counties presented an excessively top-heavy administrative structure.

The recent hospital reforms divided the country into five health regions. Each region was responsible for its own regional health enterprise, which in turn owned the hospitals in that region. Every regional health enterprise has a statutory duty to provide equitable hospital services to those who live in its catchment area.

Subsequently a new Health Enterprise Act has now placed the sole responsibility for the delivery of holistic and specialised health care on the government, and in order to achieve this objective, the state has taken over the ownership of hospitals. Each hospital now is a discreet legal entity, with a board of management responsible for all activities. Thus, while the hospitals may be state owned, they actually remain decentralised and self governing. Each regional enterprise is set up with an executive board appointed by the Ministry of Health and managed by a chief executive officer. The same model also applies to individual health enterprises. Another important feature of these reforms has been to transfer to health enterprises full responsibility on the use of capital as well as other inputs.

The reforms have been criticised for being implemented too rapidly. It has been argued that both public consultation and parliamentary decisions relating to the reforms were conducted at a record-breaking pace. Another criticism has been that local democracy was weakened when local political bodies lost their influence over hospitals. This led to a strong demand for open public hospital board meetings, and these will now be introduced on January 1, 2004 by order of the Health Minister.

Achievements so far

At this stage it is too early to draw conclusions about the results of our hospital reforms, but as the new system beds in a few observations are worth noting. Firstly there seems to have been quite a substantial decrease in waiting times for a number of diagnoses. Although registration on waiting lists is of variable quality, it is reasonable to believe that real waiting times have come down. Secondly, it appears that financial management still remains a challenge. Thirdly, we observe the introduction of more clinicians into management structures together with the strengthening of unified leadership arrangements. This may explain the growing attention to quality issues by hospital management, and is probably also influenced by patients' right to choose between hospitals. Finally we see an increasing number of decisions made on structural questions by executive boards, however the results of their implementation remain to be seen.

Future challenges

We anticipate that the debate concerning the organisation of the hospital sector will not draw to a close because of this reform process. On the other hand, we think it is important to recognise that the new organisational arrangements need some time to settle properly before judging the results. These hospital reforms were a technical first step towards improving hospital management and introducing organisational change. These changes should in the longer run, in addition to better cost management, result both in more efficient services and more attention being given to quality of care.

Looking several years into the future there are still a number of problems to be resolved. Perhaps the most important of these will be how to support a seamless health service with incentives to encourage collaboration both horizontally and vertically across the different health organi-

“The challenge is to strike a balance between decentralised decision-making influenced by aspects of the free market and a regulatory policy guaranteeing equity.”

“it is reasonable to believe that real waiting times have come down”

On the road from Maastricht to a new Europe



Do we really know where we want to go and how to get there?

Hans Stein: A personal view of the history and future of EU health policy

Having been on the European health stage for more than 25 years, knowing many of the actors, I am thankful to *Eurohealth* for giving me this opportunity to point out future perspectives drawing on the experiences of the past. And of course I am also thankful to my many superiors, who gave me the sufficient freedom necessary to develop health as a new area of European integration and cooperation. I hope that I have never really misused this trust, at least it was always my intention to serve my country's as well as European interests, which I am sorry to say were not always identical. I have now stopped being an official actor, but I have not left the stage yet. I still hope that in an unofficial function I can contribute a little to creating a healthier European Union.

The following thoughts are not always identical with the official German view, just as in the past I believe that I was not always totally in line with, and sometimes a little ahead of formal positions. I have represented my country in all kinds of official Council and Commission groups, working parties, committees, and high-level groups as well as in informal and unofficial ones. Europe is really good in creating all kinds of new groupings, better even in giving them nice, often misleading names such as "friends of the presidency". This situation often leads to confusion, as a lack of transparency often makes it impossible to find out, who is responsible for what. I have the feeling that this is done on purpose,

because good new ideas can be better developed if the author remains unknown, just as non-papers can be more influential than official documents. This being the case, unofficial groups are often more productive than official ones, where words like "reserve" or worse even "scrutiny reserve" can kill any discussion, only topped by "I have to ask my capital", whose negative answer is often predictable.

Nevertheless even if the formal decisions are taken by the formal European institutions such as Council, Commission or European Parliament, Europe is shaped within these groups. They are mostly guided by the rules of 'Commitology', a science just as hard to understand as cricket is for the people of continental Europe. In these groups, especially in the informal ones, new ideas and initiatives can be produced and if needed compromise can be found. The process of reaching a formal decision then takes a long time, especially if co-decision between Council and European Parliament is involved, but the foundations are established in the groups.

It is a strange new but nice feeling for me, not to have to answer questions any more, as to what the German position is, being able to say what I think without having to ask others, such as superiors, other sections in the health ministry, other ministries especially those for Economy or Finance, the Parliament, the German States, the 'Länder' and especially the many stakeholders with their differing vested, mainly

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economic interests. All these different partners have their individual positions, which in most cases have little to do with Europe, which as a rule is looked at as an intruder disturbing established procedures and endangering well established claims and positions. To do them justice, at least in Germany it was not the government but institutions outside government, doctors, sickness insurance funds and of course industry, that discovered the potential Europe had for health and health policy.

When a long time before Maastricht in the early seventies of the last century I took my first tentative steps into Europe as a young government official there were only six Member States, and, more importantly, only four official languages. There was no Health article in the Treaty, indeed there was no Treaty. There was no Health Council, no Health Directorate in the Commission and of course no *Eurohealth*. At that time health as a topic for international cooperation was considered to belong to WHO, possibly the Council of Europe, but most certainly not to this slowly growing European Economic Community, a point of view that still exists, even if the Commission and WHO have exchanged letters about close cooperation.

It is worthwhile to note how WHO, especially WHO Europe, has reacted to the EU as a new actor in the field of European cooperation in health matters. First they oversaw it completely, then they neglected it, then they started looking for some kind of cooperation but I feel they have not yet found the correct formula. I once coined the phrase at a meeting in Copenhagen, that WHO had the brains and the Commission had the money, a sentence both institutions disliked very much. And of course I was completely wrong, WHO has some money and the Commission a lot of brains. With the enlargement of the European Union happening soon, increasing the number of Member States from 15 to 25 on 1 May 2004, it is high time for WHO Europe to define its new role in this changing Europe and to agree on appropriate structures of cooperation with the Commission. Friendly declarations of goodwill may be of value for speeches, but are not enough. Not to be misunderstood, I am convinced that WHO still has an important role to play, in Europe and world-wide (the WHO tobacco convention is an impressive example), but the existing administrative difficulties have to be sorted out on both sides to enable a meaningful co-existence as well as cooperation.

Many things have changed since then, not all of them an improvement. What has not changed are the fundamental critical national attitudes about Europe in general and especially about health as a European topic. With the new Member States especially from Northern Europe, and even beyond the continent, the Euro-sceptics have grown in number as well as in influence. I sometimes wonder whether the European Member States really want a European Health Policy let alone a common Health Strategy. Of course we have quite a large Public Health acquis, we have directives and a large number of resolutions, some of them quite progressive. But on the whole Member States are more in agreement as to what they do not want as to what they want. They want little or no influence by the Commission on the way they organise and run their health systems, despite the fact that they all have largely identical problems and similar solutions.

The Commission knowing and experiencing this in everyday life considers itself to be the only guardian of the treaty and of European solutions. It has as a very powerful weapon the "sole right of initiative" which is quite often used to block new initiatives, that were not born in Brussels or Luxembourg offices. This situation is not exactly helpful in developing partnerships, which have to be based on trust and common objectives.

The first steps into Europe

My views on European Health Policy were shaped by the orders given to me by my Secretary of State in the German Health Ministry in 1977, when I had to go to the very first meeting of a Council Health group as the German representative. The Belgian presidency at that time tried to establish a Health Council as a permanent formal Council configuration. I was told to stop this unnecessary and expensive nonsense once and for all. Of course I tried, I did my best, but it obviously was not good enough. I failed to convince the others. The Council took place, even without the EC having a formal health competence. They met as 'Council and the Ministers for Health meeting within the Council'. This name was important, because it meant they could discuss and decide any matter, for which they had national competence.

Germany's presidency followed that of Belgium. Of course we had a Health Council, which I had to prepare and organise. Its topics, health costs and prevention,

"What has not changed are the fundamental critical national attitudes about Europe in general and especially about health as a European topic."

“health policy is a political sector that more than others absorbs and reflects national developments, traditions and cultures”

could have well fitted into today’s agenda. Since then with some interruptions all presidencies have organised Health Councils. They were a regular feature until 2002 when they were merged by Summit orders into a combined ‘Employment, Social Policy, Health and Consumer Affairs Council’. This step has enlarged the scope and agenda. It remains to be seen whether Health is strong enough in political will and power to become an influential part of this new Council.

The personalities

It is one of the shortcomings of the present situation in the European Union, that we lack the personalities of the past, Guy Monnet, Robert Schumann, Konrad Adenauer, who not only had a European dream but who were willing and able to convert this dream into a reality even if it meant not exactly breaking but at least bending the rules. As far as health is concerned only a few names come into my mind, whose initiatives triggered the whole process: Halter, Tubiana, Veronesi, and time will tell whether the name Byrne should be added to this short list.

It was the Belgian Health State Secretary, Professor Halter, who created the very first Health Council in 1977, creating a situation that led to all further steps including the health articles in the treaties of Maastricht and Amsterdam. It was the French oncologist, Professor Tubiana, who convinced his patient and then President, Francois Mitterand, that the Heads of State should commit themselves to a ‘European Strategy against Cancer’. They did this in Rome in 1985. This led to the very first Public Health programme ‘Europe against Cancer’ based on Article 235, the catch-all phrase needing nothing but unanimity, because at that time there was no explicit Health article. It was this initiative that practically forced the Member States to add Health Article 129 into the Treaty of Maastricht in 1992.

It was the Italian scientist, Professor Veronesi, who as member of an expert-committee proposed to ban tobacco advertising and who later as the Italian Minister for Health contributed to establishing the need for a qualified majority for the directive in the Health Council. It seems quite significant that this most controversial and disputed, but nevertheless politically crucial decision of the Health Council was not based on the Health but the Internal Market Article. Furthermore it is interesting to note that

the three personalities I have mentioned were not born politicians but scientists.

Germany for explicable but not really understandable reasons opposed all these developments, especially the tobacco directive, arguing that the EU did not have the needed health competence. This put me into a very difficult, if not schizophrenic position, because my personal views were not in line with the official German view, a fact that did not remain a secret. Nevertheless of course I defended and fought for the official German position, unsuccessfully in the end.

The guiding principle for Member States

Different as Member States interests may be, one concern is shared by all. They want to retain their full and undiminished power in health matters. They are suspicious of any Commission interference. Their first commandment is written down in Article 152.4 of the Treaty of Amsterdam:

“Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care”.

And by “fully respecting” they understood “total abstention”, not exactly a good base for making progress. However they forgot that the Treaty has other articles beyond Public Health, namely on the Internal Market and on Competition, a fact they are being reminded of by the European Court of Justice with quite some conviction.

It is a peculiar and strange situation, that at a time when many Member States have a common currency, and others will soon follow, and when the Internal Market with its four freedoms has been established, they are rather reluctant to accept that their health system is also a part of this European Union, not some isolated island beyond all Community influence. This is surprising, because the health market is not only the biggest branch of the Internal Market, but also the Euro leads to more transparency in comparing costs and finally patients as well as health professionals have to be considered as individuals who also have the right of free movement. Somehow though European influence on health is considered problematic and dangerous to national interests.

It seems that health policy is a political sector that, more than others, absorbs and reflects national developments, traditions

and cultures. Health systems are seen as the results of decades of development and the rather individual response to a country's social situation and profile. The answers given long ago by Bismarck and Beveridge seem to be sacrosanct even if much has since changed.

Safeguarding the pluralism of national health systems in Europe is considered to be a value by itself, which has to be kept and safeguarded at all costs against influence from the outside, even if the problems faced everywhere are quite identical and the solutions at least similar. It is completely overlooked that the EU might be a good partner to overcome vested stakeholders interests, that otherwise would be nearly impossible. This explains the stakeholders position, but not that of the others.

This kind of thinking has not only determined the rather peculiar wording of the health articles in the Maastricht and Amsterdam treaties which concentrate more on what should not be done and are rather vague as to what could be done. It also influences Member States' reactions when the Commission puts a new proposals on the Council table. The first thought is not so much whether it is a good suggestion for improving health, but whether it is a threat to the undefined national interests to which the Commission is not entitled. It is this kind of attitude that is the biggest obstacle to the development of European health policy and strategy. It will not be easy to overcome, but there is no alternative. It has to be done and it can be done.

There are two steps. First, as subsidiarity is a basic European principle it has to be applied to health. However, it should not be abused in a resistant and negative way as a bludgeon to defend the vested interests of certain industries for example. Rather, it should be used in a positive way as a dynamic concept to attain the objective set in the treaty. These include "a contribution to the attainment of a high level of health". Second, it is essential not to focus on identifying areas that have to be protected at all costs but to concentrate on those issues in which Community initiatives and cooperation between Member States could contribute to better health.

The way forward

European Health Policy has never been the object of an overall master plan or strategy. If one would have tried to establish it, one would have probably failed because of difficulty in achieving agreement within the

Commission and with the Member States. Diverging interests exist not only between the Commission and Member States but also within the Commission. The health competence and power is dispersed in a large number of directorates with different priorities and tasks, health often not being the central one.

Health policy therefore has been progressed more on the "muddling through" basis, helped quite often by the need to react to new problems or even scandals and crisis. Examples for this are the Commission handling of the BSE crises, where health considerations clearly took second place to those for commercial agriculture, as stated by the European Parliament; the blood scandals; the appearance of a new health threat some years ago, AIDS; the present need to fight bio-terrorism; and of course, possibly most important of all, the European Court of Justice jurisdiction on internal market and competition law, which really revolutionised health policy and still is a matter of great concern.

Indeed through the various judgements of the past, Kohll-Decker being the most well-known, (and more are expected), the European Court of Justice has established itself as a new and very influential player in the health arena. National governments were at first slow to recognise the impact on the EU of these judgements, as this was accompanied by a relative lack of interest. Finally though they did wake up, and in a ministerial seminar in Malaga in February 2003, what has since been called the "Malaga Process – The Europe of Health" began, and the ministers came amongst others to the following conclusion:

"Doing nothing is not a viable option. Health care policy should be directed by politicians and it does not seem that allowing the Courts to draw up health care policy is the proper thing to do for the health of the patients in Europe."

How true, but just saying this is not enough, even for health ministers. They have to do something, take decisions, show the way forward. Up to now being faced with the usual obstacles they have as yet failed to tackle them sufficiently.

The new Strategy

A lot of progress, indeed tremendous progress, has been made since the first Health Council in 1977. Despite the lack of sufficient political commitment we now seem to be in a position, where a new

"Health ministers have to do something, take decisions, show the way forward. Up to now being faced with the usual obstacles they have as yet failed to tackle them sufficiently"

“Despite the lack of sufficient political commitment we now seem to be in a position, where a new overall Health Strategy seems feasible”

overall Health Strategy seems feasible. A lot has been achieved:

A new overall *Health Action Programme* has started, and the calls for proposals have been made. It replaces the eight existing mainly disease-oriented programs and contains a number of cross-cutting themes, even on patient mobility and the cooperation of health care systems.

A *EU Health information system* which could finally lead to really valid and comparable data and not just statistical data with limited value is slowly being established.

A *European Centre for Disease Prevention and Control* especially for communicable diseases is going to be created. The Commission has prepared the necessary regulation. In the long run it should include all diseases and become some kind of European Health Institute, a possible partner for similar big institutions in other parts of the world.

The 6th Research Framework Programme contains health as a priority for its policy-oriented research. This could provide the necessary research input for developing health policy. A European Health survey could be a vision for the future.

In the Malaga process *four areas have been identified that could be the topic for EU initiatives*: highly specialised reference centres, sharing spare capacity for patients from countries with waiting lists, facilitating care in neighbouring regions especially near the border, and providing care for persons who have long periods of residence in other countries.

The Commission has established a ‘*High Level Reflection Group*’ on “*Patient Mobility and Health Care Delivery*” whose members are not only the Health ministers but also the main stakeholders, including patients. Recommendations are expected by the end of this year.

All these activities are quite encouraging and a big step forward, but even if they produce tangible results, these would be of limited value if not bound together by an overall Health Strategy of the EU, one which all the directorates of the Commission as well as the member states would commit themselves politically, legally and even financially.

For political will to be transformed into reality adequate instruments are needed. I am convinced that the ‘Open method of coordination’ could become this tool for

health just as it has for other policy areas. It can be expected that this method will be embodied in the new constitutional treaty that is presently prepared by the convention, giving it the same constitutional status as that for the existing classic instruments.

The main elements of the open method of coordination such as the identification of common objectives and targets, the agreement of valid outcome indicators, the exchange of information, views, expertise, and even ‘best practice’ could well lead to guidelines and recommendations that could be applied in the member states if they themselves choose to do so. As usual member states, especially in health, are looking with suspicion at this new tool, fearing it could lead to creeping harmonisation, undermine Member States responsibilities and lead to Commission interference far beyond what the treaty allows. I do not think, that these fears are justified, but as they exist, they have to be taken seriously into account.

It is absolutely essential that this new method is accepted and used as an instrument of member state cooperation, that is, supported by the Commission but not led or determined by her. That means that any ‘naming and shaming’ is quite out of question and would destroy its application for health. The precise nature, content and form will not be specified in the Treaty, it will be guided by the nature and problems of the issue involved. Health is and will remain a matter of mixed competence and responsibility. Nobody will take it from the member states. Applying the open method of coordination will permit them to keep it. Moreover it will provide them with much needed instruments for meaningful European cooperation.

Commissioner Byrne has announced recently that by the end of the year 2003 the Commission will present a new communication about the role of the EU in health policy leading finally to an overall strategy. If this is prepared in a cooperative manner together with the Member States as well as with the different stake holders, if their fears and suspicions are shown to be unjustified, then I am quite optimistic for Europe. We have come a long way from Maastricht, but we have not come far enough. However if we continue with a little more trust in each other, then we are on the right track for success. The European citizen and patient expect it. We have to deliver, we have the means, what is still lacking, is the political will.

Comment on EU health policy by Hans Stein

Walter Holland

*Visiting Professor at LSE Health and Social Care,
London School of Economics and Political Science*

The valedictory article by Dr Stein on the future of EU health policy is characteristic of Hans Stein's style and method of operation. I have known him since September 1976 when we first met at a WHO Europe Nordic Council symposium on health policy at a remote hotel about 5 kilometres from Kuopio in Finland. There was little to do in our spare time in the middle of a Finnish forest except to have saunas, drink and most importantly play chess. Hans' skills in the latter epitomised his approach to life: jovial, exuberant and humorous but painstakingly careful, and always with a clear strategy, so mostly he won.

During the 1980s the European Community (as it then was) began to develop a Health Services Research Programme, and we continued to meet in Brussels, Luxembourg and in Ispira, Italy. I will not dwell on the many battles we fought, usually as allies to establish a research culture, as well as to improve the research grants mechanisms and the research done in the EU. As a researcher I have had many dealings with senior civil servants, particularly in the UK. In my experience senior central government civil servants are rarely attuned either to promote challenging research or to take heed of research findings. Hans Stein was one of the rare individuals who cared about research and it was no surprise that he developed friendship and close working relations with Cliff Graham, a British Under Secretary, who displayed similar characteristics. The latter died prematurely, but Stein and Graham's cooperation laid firm foundations for effective development of EU health policy based on evidence.

The development of EU Health Policy

Stein's description of the achievements in the development of EU health policy and

his vision of the future reflect his optimistic nature. His plea for a clear Health Policy Strategy for the EU is obviously a crucial component to the development both of EU structures as well as to the improvements in health of the population. But a cautionary note needs to be introduced. As Stein himself comments in the EU visionary words often hide inaction.

I have had involvement with a number of European structures since 1964 when I first served as a British observer in Coal, Iron and Steel committees on research. In my experience over the past decades the factors that promoted successful collaboration between countries and effected worthwhile improvements in both health services policy and their outcomes as well as health research were dependant on two things: a clear, agreed goal and the methods to be used in achieving it, and a strong expert, capable, sympathetic administration in the EC(EU) to facilitate joint action. These conditions were not often achieved, success was more likely if the aims were modest and clearly defined, if the politicians did not feel threatened and if there was clear support from member countries' professional associations.

To develop an effective Health Strategy for Europe, and by this I mean that the health of the population improves, is a mammoth task. As Stein emphasises, this entails the development of coherent, coordinated policies in not only health and health services, but also agriculture, employment, trade, transport, and environment. The formulation of EU policies in each of these areas needs not only to take health into account but actually devise and implement policies that improve health rather than only improving for example, trade or protecting a particular client group. My experience at single nation level does not encourage optimism.

Looking to the future

I believe that one should be more modest in one's aspirations for the EU over the next few years. The development of a valid,

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timely accurate EU health information system, which is designed to be flexible to answer problems from both researchers and policy makers relevant to the development of health improvement on a cross-sectoral basis should be the first step. This will require adequate staffing by trained analysts and should incorporate a training function for analysts for member states thus upgrading their skills and ensuring that it is used appropriately. A second imperative is the development of a capacity to investigate health issues and problems as they arise within the EU and in individual member states.

This entails the development of a cadre of individuals trained in various health sciences, appropriately led by a professional, which can serve both the EU as a whole and its individual constituents. This cadre should also be able to review, compare and analyse findings, solutions and problems in

current practice in order that appropriate models can be tested and developed on the basis of evidence. The third strand, the European Centre for Disease, has already been started, and it is to be hoped that it is to be allowed to both investigate disease outbreaks and be responsible for ensuring that adequate methods of control and prevention are implemented at country level.

My vision of the future is thus more limited but unless these crucial first steps are taken I cannot foresee that a Health Strategy can be more than fine phrases. If the EU and its members are able to achieve an effective structure and function in these areas I can foresee that the dream of a proper strategy for the improvement of health of the people of Europe will be achieved. As Stein says this requires political leadership and recognition that the empowers and staff of the EU require strengthening.

A tribute to Hans Stein

Baldur Wagner

*Former State Secretary of the German Health
Ministry*

Among the many interesting and high calibre people I had the honour to meet during my professional career Hans Stein will always be linked in a very special way with Europe. During the eight years I was State Secretary of the German Health Ministry, I watched Hans Stein looking after the field of European health policy not only in an exemplary manner but also investing a lot of his lifeblood. He truly believes in Europe and health as part of Europe.

But that is not the main reason why he got my deep respect and in the end even my friendship: he offered resistance to ideas and developments he didn't believe in; he showed character. So it was inevitable that we both ran into conflict somehow. I admit I was a little bit upset in the beginning; but only for a short time, because his basic attitude not just to say "yes" to orders and instructions immediately also had advantages. It gave me in the final analysis the assurance that the decisions we made about German positions were well considered and reasonable.

As already stated, in the beginning our cooperation was not free of problems and this was also difficult or at least quite irksome for Hans Stein. I seemed to be the first and only superior who demanded entrance into his prerogative "Europe" and who wanted to share his advance in knowledge and contacts. It seemed to me he was not used to it at all. After some resistance he accepted it, and this he did excellently showing his true class.

Nevertheless, even when he held and fought to keep his own views, he was able and open to compromise. As I for many years represented Germany at the top political level at meetings with the Commission and at the official and unofficial Council meetings, Europe started to fascinate me too. Hans Stein realised that, and began to acknowledge and support this. He learned that as long as he kept me well informed about European developments he could be sure to have all the room to manoeuvre he wanted and needed. This was without losing even a millimetre of his own influence. At the end of the day Hans Stein did an excellent job, and if I had questions concerning European health policy, and there are still many unanswered yet, Hans Stein would honestly be one of the very first people that I would ask.

Tribute to Hans Stein

Ilona Kickbusch

Professor and Head of the Division of Global Health, Epidemiology and Public Health, Yale University, USA

Is there such a thing as a pragmatic idealist? Yes, and his name is Hans Stein. What I have always admired most about Hans is his deep commitment to the European ideal while keeping his feet firmly on the ground if not in the quagmire of European health policy. He is probably furthest away from what anyone would expect a German bureaucrat or for that matter a Eurocrat to be: witty, quick, and incredibly well informed. He has always shown an impeccable sense of timing and helped push European health policy initiatives with great tenacity. He was always helpful in keeping the dialogue between the WHO

and the EU alive and during my tenure at WHO was always ready to give very helpful and sensible advice. Right now he seems to be busier than ever, which on the one hand indicates how out of date the European approach to retirement is. On the other hand it frees Hans to make the type of independent creative contributions to European health development that are not always possible when you are within the constraints of a national Ministry. So I wish for him and for Europe that he maintains his extraordinary energy level. European health policy debates need his experience. And all of us who are involved need him too, because a meeting in which Hans is involved will not only always be challenging, it will also be fun.

Hans Stein

A personal C.V.

Born 5.12.1937 Germany, happily married, one child, living in Bonn and still a little sad that it is no longer the German capital. Since 2003 a pensioner but delighted to be able to travel and thereby experience a growing and changing Europe.

School education: 1943 to 1948 in East and West Germany, 1949–1953 in India (Breeks Memorial School, Ooty), where attempt made to turn him into a Christian gentleman, and also where he played and became addicted to cricket! 1954 to 1956 spent at the German School Cairo, Egypt (Abitur).

University education: Law at Geneva, Innsbruck and Munich. In his spare time for many years editor and publisher of a student newspaper 'Profil' and also a travel guide on the whole of Europe and beyond.

Civil Service Career: 1966 to 1970 Home Office (Interior Ministry) in Bonn, based in section on "Foreigners law", and had first contacts with Brussels related to free movement regulation. 1970–2002 based at the Ministry of Health undertaking various tasks including, general planning and policy, health services research, health monitoring, German – German Cooperation on health matters, health targets, and EU health policy.

Other Highlights: Close contact with Brussels ever since 1970; permanent German member on Council Health Group; member of Commission Health Programme Committees; High Level Health Committee; member and elected chairman of EU Health Research Advisory Committee; responsibility for health under four German presidencies; lecturer in different schools of public health; numerous publications in journals, books etc.

From health targets to health targeting



Marshall Marinker

“Key questions raised were not about the management of targets but about their politics.”

Health targeting confronts us with what Charles Handy describes as paradoxes, paired and contrasted goods that constitute balanced choices in conflict with one another.¹ Handy suggests that paradoxes cannot be settled by feats of intellectual dispute. They must be managed in practice. Any examination of the brief history of health targeting reveals very many examples of such paradoxes: the paradox of the pursuit of health and the provision of health services; of reducing the risks of disease and addressing the determinants of health; of global and local health governance; of libertarian and collectivist values; of evidence and experience.

Health Targets in Europe: Polity, Progress and Promise² was produced with the intention of taking stock, of allowing a number of distinguished commentators to reflect on what has been achieved in Europe, on the lessons learned from health targeting, and on how to incorporate these lessons into future policies and their implementation. As editor, I also had an ulterior and more ambitious hope that this collection of essays would reveal some sort of European school of thought about the role of health targeting; that beyond the immediate, technical and tactical characteristics of health targets (‘specific, quantifiable and measurable’), there would be revealed a radical and effective strategy for grounding health policy in the broadest field of public policy.

Among the many paradoxes that confronted me, three were of particular salience: the paradox of theory and practice; the paradox of European and other traditions; the paradox of health policy as science and art.

Theory and practice

If the book was to be of practical use, a guide to future action, then it had to be grounded in the real world. Therefore the driving engine of the book is provided by the eight reports of work in progress, accounts of national and regional implementation.

In most of the countries reported, the thrust has been to achieve quantified outcomes in relation to well recognised risk factors. But in Finland, for example, such targets found little favour. Here policy was concerned with a qualitative approach to the processes of health governance; and the focus was on the determinants of health rather than on the risk factors for disease.

As a global aim, as a meta-target, ‘health’ has long been construed as more than the avoidance of illness and disease, however desirable such avoidance. Does health targeting in Europe reflect this larger vision? In our book the key questions raised by most of our writers are not about the management of targets but about their politics. These political questions concern the moral worth, the cultural appropriateness, the social contexts, and the budgetary priority of health targets.

Theory and practice most often do not have a linear sequential relationship, the one preceding the other. Neither do evidence and practice, though we constantly protest that they should. The accounts in this book reveal that they are the interactive products of what Schön describes as the work of reflective practitioners.³ It is in the problems of implementing targets that the nature of their philosophy is most clearly revealed.

European and other traditions

A number of the writers search for a peculiar and special something European about

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health targeting. The search for this elusive 'something', proved problematic. The quest was rooted in the rather romantic notion that health policy in Europe would somehow reflect the salient values of the great innovators like Rudolph Virchow and all those other European thinkers and activists, my own heroes in the history of health as politics.

This romantic Europe is not to be pedantically defined by cartographic frontiers, but is infinitely extended by the minds of European thinkers. In this sense Europe becomes not so much a geographical as an historical identity, as an idea constructed from its paradoxes. The English social commentator Will Hutton in his seminal work 'The World We're In' claims that the European view is that a vigorous public realm is fundamental to the good society, that it is characterised by a belief in the social contract, in just capitalism, the public realm, equity and qualified property rights.⁴

Certainly the thrust of the health targeting agenda sits comfortably with much of this rather self-congratulatory picture. Yet Hutton's European exceptionalism is perhaps also misleading; it over-simplifies the world-wide challenges to health targeting. The pursuit of health in the modern world can no longer be only a parochial or a continental concern. Health targeting today, with all its emphasis on local ownership, is none the less the brain child of a world organisation.

We define ourselves too readily not by what we are, but by what we are not. Hutton represents the USA as Europe's defining 'other'. Yet his argument falters before the unsurprising evidence of the vast moral overlap between these two domains; before the evidence that North America's moral tradition has deep European roots; that our shared concerns for health and care stem not from party or geo-political posturing, but from the global challenges to human health.

Yet this reveals another paradox: the need for international and national health governance on the one hand, and on the other hand the strong imperative of local involvement and ownership of the policies. In all aspects of Europeanism, the law, employment, education, as well as health, there is wide diversity, and so a determination to respect the principle of subsidiarity. As 21st Century Europe widens its geographical and cultural boundaries, the challenge will be to match European values of

welfare, justice, inclusivity and so on, with respect for a wide variety of niche traditions.

Health policy as science and art

Much of the rhetoric of health targeting suggests that there is a logical march from the collection of evidence of need, to the implementation of targets designed to respond to that need. It is argued that these needs and outcomes are validated by sheer force of data. Yet in truth no such public health imperatives exist in this innocent and pure form. Health data can never be morally or politically neutral. All data, not least health data, are socially constructed. Data are harvested by individuals and organisations in relation to a prior purpose, that is to say with a priori political agendas however benign. In the case of public health professionals, one can detect a creative tension between the statistical Puritanism of epidemiology on the one hand, and a passionate political advocacy for social fairness on the other. Given the inherent uncertainties of science, and the vagaries of human nature, all involved in health targeting must find themselves impelled beyond the evidence.

Consequently health targeting, traditionally grounded in the rigours of epidemiological and demographic evidence of need, driven by the technical processes of management, proves to be only achievable in practice by managing the paradox of public health, that it is driven both by statistical evidence and moral imperative, and that it is at once both science and art.

Next steps

In May 2003, a group of experts in health targeting in Europe were invited to a workshop held in Madrid. They were asked to consider the underlying values in health policy, and the principles that should underpin the generation and implementation of health targets. The words which we use so freely in championing our values – 'equity', 'solidarity', 'choice', 'democracy', 'rights', 'evidence', 'efficiency' and so on – came under close scrutiny.

The principles of governance were revisited. For example, experience suggested that it was not enough simply to advocate 'public involvement'. In order deeply to embed health changes, citizens must become 'actively engaged'. The successful pursuit of health targets makes new demands on a participative citizenry, and that we must therefore experiment with a variety of new ways of achieving active, critical and

"Health data can never be morally or politically neutral"

“The focus seems to be shifting from the attainment of specific health targets to the implementation of health targeting as an instrument of very broad public policy”

informed partnerships with people.

Out of these deliberations we propose to construct a consensus instrument (to which we give the working title “Madrid Framework”) that will permit us to look at the implementation of current health targets in a variety of European settings. In the course of 2003/2004 we plan to hold ‘implementation workshops’ in Wales, Spain, Germany, Hungary, and other locations still to be decided. In the course of these workshops we will apply the ‘Framework’ in order to deepen and modify our understanding of the underlying values in health policy, and to construct guidelines for the holding of ‘constructive conversations’ about implementation - what is being attempted, why and how. We want to construct audits not for judging, but for learning and developing.

Conclusion

The focus seems to be shifting from the attainment of specific health targets to the implementation of health targeting as an instrument of very broad public policy; to a recognition that the pursuit of health is not a cost but an investment; to the view that public health may be a better metaphor for public wealth than a country’s GDP, and that personal health is an expression of personal freedom.⁵

The success of health targeting in enhancing the health of people and populations may lie in something more enduring than

the record of actually hitting pre-determined targets. It may more securely lie in the lessons learned from the experience of implementing health targets. These lessons include the place of health polity in the broader field of public endeavour, the possibilities for democratic participation, for cross sectoral cooperation, and for a wider societal ownership of the underlying values of fairness and inclusivity in health.

The acts of health targeting help us to redefine the relationship between those whose health is to be affected, and those elected and trained to bring about the necessary changes. The challenges of implementation enable new questions to be asked about the intentions of health policy, the values of all the stakeholders, and the role of health governance in democratising our health choices.

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5th European Conference on Health Economics Announced September 8th–11th 2004

LSE Health and Social Care at the London School of Economics and Political Science is hosting the 5th European Conference on Health Economics. The conference will be held at the LSE site in central London. It will be opened by Professor Julian Le Grand at a reception on the evening of Wednesday September 8th, and will close with a reception at lunchtime on Saturday, 11th September 2004.

The conference will be open to presentations from all areas of health economics, including (but not limited to) financing and resource allocation, economic evaluation, econometrics in health economics, incentives in health care, equity in health and health care, outcomes evaluation, pharmaceutical economics, social care and mental health economics.

In addition, one of the conference streams will be organised by the European Health Policy Group (EHPG), a forum that encourages multidisciplinary discussion (for example, between economists and political scientists) in comparing health sector reform in different European countries. The specific theme for that stream will be regulation in health care. If you are interested in presenting within the EHPG stream, please contact the new coordinator of the EHPG, Gwyn Bevan, at gwyn.bevan@chi.nhs.uk

Further information, call for abstracts and registration form available at the conference website

www.lse.ac.uk/Depts/lsehsc/ECH2004/welcome.htm

www.lse.ac.uk/Depts/lsehsc/ECH2004/ECH2004RegistrationForms.pdf

The state of men's health in Europe



Alan White



Keith Cash

We have known for some time that men have a shorter life expectancy than women. In fact it is now so well known that it has, perhaps, ceased to be a surprise or even a cause for concern. However, a new report on the state of men's health across the 15 countries of the EU, as well as Norway and Switzerland¹ brings home the depth and scale of the problem. The awareness that across the 17 countries of this study there are 190,500,000 men and of these 50% will be dead before they are 75 as compared to 25% of women is an opportunity to reflect on this figure and to ask ourselves several questions. First, should this fact be taken so complacently? Second, what are the causes of this inequality? Third, what are the implications for the health of men and fourth, what can be done about the situation?

This study commissioned by the European Men's Health Forum² has brought together key international data on a wide range of disease conditions as well as lifestyle and demographic data for men across Western Europe and has highlighted that men's health varies considerably between countries and between different ages. By also focusing on the statistics for men in comparison to women the report has demonstrated that men are at a universal disadvantage across all the major disease states such that there can now be no doubt that health is gendered and that, as such,

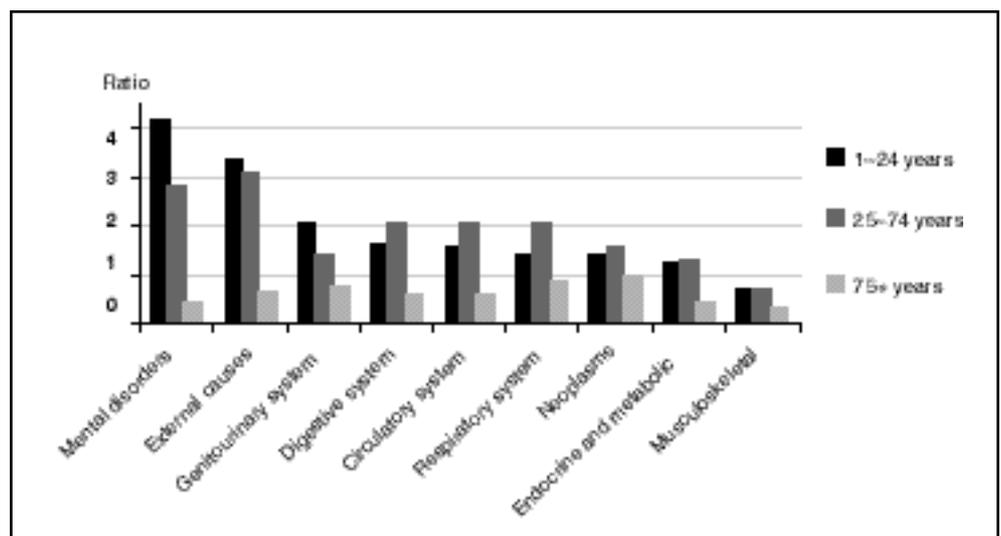
health policy, health strategy and health care provision must reflect the differing needs of men and women.

The cause of death between countries varies considerably suggesting that there are specific health concerns that each country should focus on. For instance 11% of male deaths in Belgium are due to lung cancer as compared to 4% in Sweden. Austria saw 47.6% of their men die of cardio-vascular disease as compared to 27.7% of men from France. Prostate cancer was the cause of 5.3% of deaths in Sweden as compared to 2.2% in Greece, with nearly 3% of male deaths in Portugal the result of cancer of the stomach but only 1% of male deaths in Denmark.

When the ratios of male to female deaths are compared across all the major disease states it is only over the age of 75 that the female rate exceeds that of men (see Figure 1) and for all the major cancers the male incidence rate was higher.

There are large differences between the life expectancy of men across Europe ranging from 73.0 years for men in Ireland to 77.5 years in Sweden but no country comes close to the life expectancy of women, with France having the largest gap (7.5 years) between the two genders. In 8 of the countries under study, men are not expected to reach in 2020 the level women were enjoying in 1980.

Figure 1³
The ratio of male deaths to females for selected health conditions, by age bracket



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Figure 2 Median age specific death rates for men and women due to ischaemic heart disease for all the countries

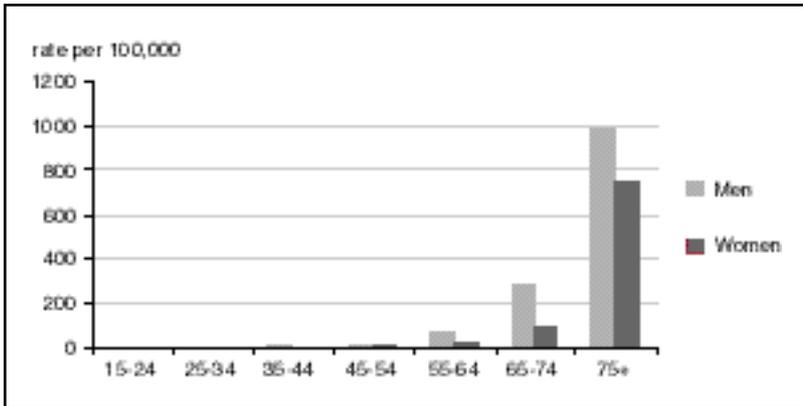


Figure 3 Median age specific death rates for men and women due to cancer of the colon, for all the countries

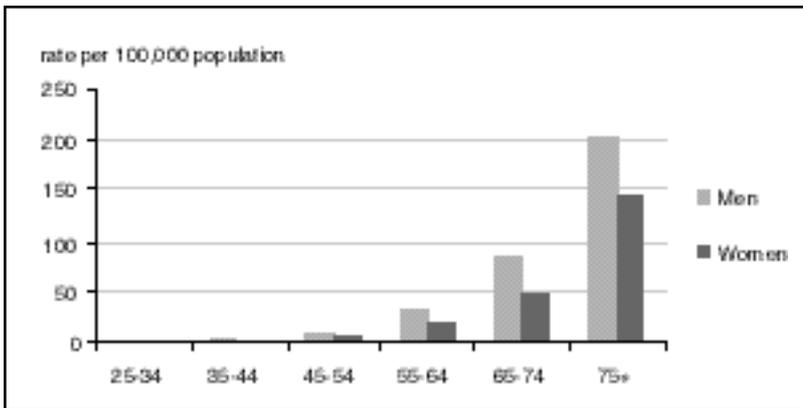


Figure 4 Median age specific death rates for men and women due to accidents and external causes, for all the countries

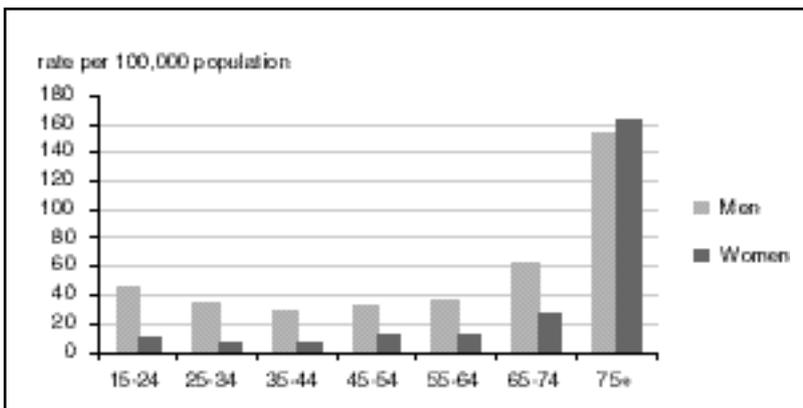
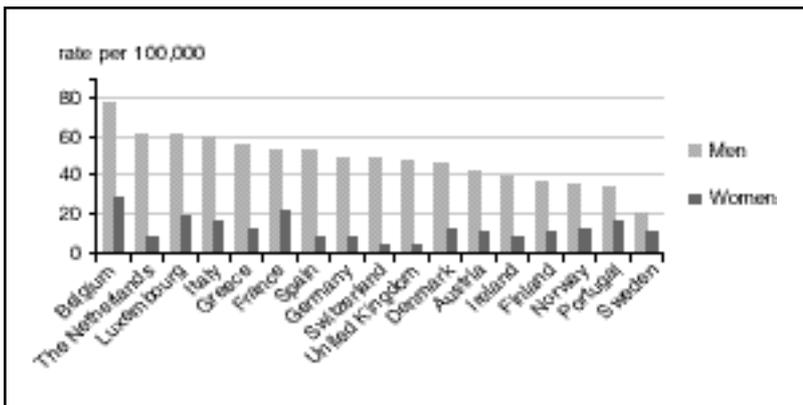


Figure 5 Age standardised death rate for men and women due to cancer of the lungs and bronchus, for all the countries



The data

Ischaemic heart disease

When compared to women it can be seen that overall death rates due to ischaemic heart disease are much higher for men across all the countries (See Figure 2). The figures between the men and the women also suggest that there is a much smaller difference in death rates for women between countries as opposed to the relatively large differences for men. In the age group 45–54 there is an over 14-fold difference between the men and women in Finland.

Cancers of the digestive system

Cancers of the stomach, colon, rectum, rectosigmoid junction and anus primarily affect men over the age of 65. Men having similar median death rates for all the countries to women in the younger age brackets but there are marked differences above the age of 55 where men appear to be much more at risk of dying of these cancers than women (see Figure 3).

Accidents and deaths due to external causes

The median death rates for men and women due to accidents and external causes of death show two trends: one is in relation to the increased risk of younger and older men, but also the excess of male mortality over women until the 75+ age group where the rate of death of women exceeds that of men (see Figure 4).

These charts show the pattern with respect to deaths, when the age standardised rates for incidence are examined similar trends emerge. For example there is an increase in the number of women smoking but incidence for lung cancer still shows a substantially greater rate of new cases of cancer in men than in women (see Figure 5), with a 12-fold difference between men and women in the United Kingdom.

The rate of incidence for cancer of the stomach again shows an almost two-fold difference between men and women across all the countries. The difference between men and women is not so great, but it still exists across all the countries in relation to the incidence of cancer of the colon and rectum.

Suicide and self inflicted injury

There are substantial national differences in suicide rates, ranging from 0.6% of total deaths in Greece to 3.9% in Finland. Substantial increases in death rate from suicide and self harm are seen in the over 65 year age group in the majority of countries.

Men show a consistently higher rate of suicide than females.

Chronic liver disease and cirrhosis

There is a wide variation in the number of deaths related to chronic liver disease and cirrhosis between the countries in the study but overall the death rate is declining. Again men show a consistently higher death rate than women

Diabetes mellitus

Diabetes is a growing public health issue, as it is associated with coronary heart disease, blindness, hypertension and sexual dysfunction. Although the incidence is increasing the death rate is decreasing but there are wide variations in the death rate between the countries of the study. Men show consistently higher death rates due to diabetes than women.

Mental disorders

Men appear to have more disorders related to substance misuse than females, who have more neuro-psychiatric and depressive disorders. Men generally have a higher death rate associated with mental illness until reaching the 75+ age group when there are more female than male deaths. There seems to be little comparative European data on mental health.

Sexually transmitted disease

There has been a general and substantial reduction in the degree of sexually transmitted diseases but there is now a growing concern that this trend is being reversed.

HIV/AIDS

Overall the incidence rates for AIDS have gone down in all countries except Portugal but what is emerging is that though the number of AIDS cases in the homosexual male population are declining transmission by heterosexual contact is increasing with the main impact being on the 25 to 44 age group. The death rates for AIDS for men have declined substantially in all countries except for Portugal. The incidence of HIV seemed to be in decline until the late 1990s but now seems to be on the increase again.

Prostate cancer

Prostate cancer is becoming more common than lung cancer amongst men and is now the second most important cause of deaths through malignancy in men resulting in over 3% of all male deaths in these countries. Sweden has the highest proportion of total male deaths due to prostate cancer, while Greece has the lowest. Deaths from

prostate cancer occur primarily in the over 65 age bracket but there are still a significant number of deaths in the younger age groups.

Testicular cancer

Although there is not a large death rate from testicular cancer it has great relevance to men as it is a cancer of young men with an almost 100% survival rate if it is caught early enough. The death rate for testicular cancer is decreasing across all the countries in this study with Switzerland having the highest death certification rates and Spain the lowest. However though the death rate is decreasing there is a rising incidence of testicular cancer.

Opening up the debate

This study did not focus on why men were more susceptible to all the major diseases and had such a high degree of premature death but it is to this investigation, once the messages of this study have been dwelt on, that we must turn our attention. We need to open the debate and engage in more discussion and research into the reasons why men are so much more likely to suffer premature death.

There are three possible reasons that would seem to warrant the most urgent consideration:

1. Men are more vulnerable to the diseases.
2. Men's lifestyles, for example alcohol consumption and smoking, lay them more open to risk,
3. Men are delaying seeking help

The vulnerability of men

A key finding from the report is that men seem to be at greater risk of developing nearly all the major diseases that can affect both sexes. There is a complex sociological argument on the difference between sex and gender with the term sex relating to the biological status of the individual and gender being the way a man or women is affected by social determinants.

The study seems to suggest that it is necessary to look both at the biological entity of man as well as the role masculinity has to play within the health of men. The role of men's 'nature' as well as 'nurture' has to be explored. We have a well rehearsed argument with regard to cardiovascular disease (see for instance Sattar)⁴ but we need to further this debate to see if, as Kramer states, men are more 'fragile' than women or if being a man is in itself a 'disease'.^{5,6}

"Health policy should target men as a specific population group"

"men seem to be at greater risk of developing nearly all the major diseases that can affect both sexes"

“We must focus now on determining what aspects of men’s health beliefs and behaviour militate against help seeking”

Men’s lifestyles

Certainly for some illnesses the destructive nature of men’s addictive and risky behaviour are evident: the number of men who develop lung cancer reflects the high level of male smoking, the greater mortality from liver disease and cirrhosis results from alcohol, and more men are overweight than women and have a tendency to deposit fat around their abdomen leading them to the greater risk of developing cardiovascular disease and diabetes to name but three obvious examples. There are also links to smoking and diet that help explain men’s increased risk of cancer of the stomach. Indeed the figures for mortality due to mental health disorders highlight a greater vulnerability to addictive disorders.

With 60% of deaths in the age group 1–24 being from external causes young men’s risk taking can also be seen as an element of men’s lifestyle that has a negative impact on their health, for instance deaths as a result of road traffic accidents and accidents at work. Further research is needed to determine why the men from the different countries had such differing health outcomes and whether this is due to variations in lifestyle and legislation.

Delayed help seeking

This would also appear to be a key factor in men’s greater death rate and ties in with the socially imposed model of the man as a person who is independent, in control and strong. If there is an increased risk to men, and the higher incident rates certainly suggest this to be the case, then any delay in responding to symptoms or avoiding routine medical check ups will add to the possibility of an early death. We must focus now on determining what aspects of men’s health beliefs and behaviour militate against help seeking to find ways to ensure that men gain early and effective care. This involves the investigation of men’s decision making processes with regard to their health.

Coupled with this is the need to investigate men’s actual usage of health services across Europe. If the supposition is that men have a problem with seeking help and guidance and this delay has a negative impact on their health then we need to have data on this. Comparative studies need to be undertaken both between men and women and between men from the different countries.

- The findings of the report suggest that public health strategies in European countries need to address the respective

health needs of both men and women rather than rely on a ‘one policy fits all’ approach.

- Health policy should be formulated that is gender sensitive and should target men as a specific population group.
- Gender must become ‘mainstream’ and influence the provision and delivery of health services.
- Research must ensure that gender is considered as a possible variable and included where appropriate.
- Health indicators should be collected that are disaggregated for both gender and country to enable a more sensitive understanding of health needs; this is especially true for data on morbidity.
- There is a need to foster collaboration and coordination between European countries to facilitate the dissemination and implementation of example of good practice.

Conclusion

- Even though health is improving for many conditions there are still marked inequalities that exist, both between countries and between men and women.
- There are clear gender-related differences in population health needs.
- National public health strategies should address these needs by promoting gender sensitive policies.
- This report provides an essential cornerstone from which to launch additional research projects.

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Health effects of extreme weather events

The severe health effects of extreme weather events were recently seen during the summer heatwave across Europe, with much attention focused on the situation in France. Vulnerable groups to heat stress can include older people, those with cardiovascular or respiratory disease and young children. A report recently released by the French Ministry of Health and written by independent experts came to the conclusion that as many as 15,000 deaths in August were due to the heatwave. A key issue identified in the report is the need to work more closely with meteorologists to improve early warning systems. Provisional figures released by other national authorities indicate that there were more than 1,300 excess deaths in Portugal, and 4,715 in Italy, while excess mortality was also reported in Germany, Spain and the UK.

The report on excess mortality due to the heatwave in France is available in French only at www.sante.govw.fr/htm/actu/surmort_canicule/sommaire.htm

At the World Climate Change Conference held in October in Moscow, the WHO Regional Office for Europe presented data on the health effects of extreme weather events. As well as discussing the heatwave they noted that flooding remains the most common natural disaster in Europe. In 2002 15 major floods killed about 250 people and affected about 1 million others. The WHO also indicated that the health effects of floods include symptoms of post-traumatic distress, rare outbreaks of infectious disease and an increased incidence of respiratory or diarrhoeal diseases. A programme on global change and health is currently conducting research on temperature-related illnesses and developing strategies for intervention and a ministerial conference on the Environment and Health will be held in Budapest in June 2004.

Further information on this programme, together with information on the conference can be found at www.who.dk/eprise/main/WHO/Progs/GCH/Home

World Congress of Public Health 2004

Sustaining public health in a changing world: Vision to Action

19–22 April 2004, Brighton Centre and Hilton Brighton Metropole Hotel, Brighton UK

Incorporating the 12th Annual Public Health Forum and the 10th International Congress of the World Federation of Public Health Associations, this event will be organised by the UK Public Health Association.

As public health faces up to new challenges, the question arises: is public health in a crisis? The Congress will present an opportunity for members of public health associations, public health agencies, teaching institutions, international agencies and NGO's from all regions of the world, to reflect upon and discuss these and other questions for public health through keynote lectures, country reports, leadership workshops and through participants own submitted papers and poster sessions.

In the last decade, public health in Europe has gone through a phase of dramatic growth and development. In particular, the European Union has developed an increasingly important role in influencing the health of its citizens through a range of policies, including public health, social affairs and the development of the European Single Market.

It now faces a further phase of dramatic change and development with the accession countries on the threshold of joining the EU taking its membership from 15 to 25 European states. Enlargement of the EU will require new European policy responses to meet future public health challenges, such as communicable disease in a larger Europe, and the heightened disparities in health and health system status between Member States.

Europe has become one of the major forces in adapting to the new social, environmental and economic challenges facing the world and the EU's growing health role will be explored through a specific European strand of the Congress. This Congress will be a major opportunity for an exchange of experiences between North and South and East and West; for learning from each other; for reviewing progress in global programmes and international partnerships, and for initiating new ones.

The four day congress will include:

- Plenary sessions, including the WFPHA Leavell Lecture
- Parallel sessions of submitted papers and commissioned workshops and symposia
- Leadership Forum
- Poster and stand exhibitions
- Social functions
- Satellite events

Further information is available at the conference website www.phaworld-congress.com

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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.

Public Health Policy

David J. Hunter

Blackwell Publishers, 2003

ISBN 0-7456-2646-7

Hardback £50.00

Paperback £15.00

Mounting public disquiet over a range of crises, such as foot and mouth, BSE and other food safety issues, public transport, pollution, obesity and the environment have fuelled a renewed interest in public health policy in the UK. Yet, health policy remains pre-occupied with health-care services. Providing an overview of the key debates relating to public health policy in the UK, this volume explains that, while they are important, health-care services are not the principal determinants of health. Why then, do they absorb the bulk of resources and attention of policy-makers? The reasons for the extraordinary difficulties encountered in putting health before health care are multiple and complex.

Contents: Include the relationship between health and health care, healthcare management and the powerful interests at work which prevent policy aspiration from becoming reality, attempts in the UK since 1992 to pay greater attention to health issues, and examples from Europe and Canada, where a similar policy imbalance exists.

Understanding the Financing of Welfare. What Welfare Costs and How to Pay for it

Howard Glennerster

Policy Press, 2003

ISBN 1-8613-4405-8

256 pages. Paperback £17.99

How can society pay for high quality public welfare services such as health, education, social care and social security? This book presents the case for public social services, looks at the role of taxation, the limits of markets in meeting human needs, and compares the ways in which different areas of social welfare including health and social care are funded in the UK and other developed economies. Professor Ian Shaw from the University of Nottingham has said that the book "makes the complex subject of financing welfare accessible to all those studying and working in the field."

Contents: Meeting basic human needs. Market failure and government failure. How to pay for social programmes? Financing healthcare. Financing social care. Financing education. Financing income security. Financing housing. Rationing scarce resources. Do public services have a future?

Public Health for the 21st Century. New Perspectives on Policy, Participation and Practice

*Judy Orme, Jane Powell,
Pat Taylor, Tony Harrison and
Melanie Gray*

McGraw-Hill, 2003

ISBN 0-3352-1193-3

Softback £19.99

This book explores the meaning of the 'new' public health within current debates, and the policy changes that are reshaping the context for public health. It moves away from public health medicine to a multi-disciplinary approach to public health concerns. It presents a case for this multi-disciplinary and asks how public health professionals can move towards an evidence-informed public health practice.

Contents: Part One: Policy for 21st century public health – Public health policy, Public health meets modernisation, Public health: a vision for the future. Part Two: Participation and partnerships in 21st century public health – Who are the partners in public health? Capacity and capability in public health, Public health and primary care, Protecting the public's health, Lay contribution to public health, community development and networking for health. Part Three: Major contemporary themes in public health – New directions in tackling inequalities in health, Neighbourhood renewal and regeneration, Implementing sustainable futures in cities, Globalisation and health. Part Four: Evidence and evaluation in 21st century public health, Evidence-based multidisciplinary public health, Health economics and public health, Frameworks for measuring community health and well being, Health impact: its estimation, assessment and analysis.

Patients, Power and Responsibility

John Spiers

Radcliffe Medical Press, 2003

ISBN 1-8577-5924-9

272 pages. Paperback £27.95

This stimulating and challenging work proposes radical, practical and politically persuasive steps by which patients can take charge of their own health care. It explores how to place consumers in charge to facilitate good patient care. The key is the patient as fundholder, with economic power decentralised to the self-responsible individual. The book provides a coherent account of how customer/supply, and demand/supply relationships work and can be related to healthcare; it identifies and describes the principles of good medical care, and the approaches that can be taken to offer a credible and realistic agenda for change.

This book is essential reading for policy makers and shapers, healthcare managers, and all those with an interest in the role of patients in healthcare.

International Alliance for Patient Organisations (IAPO)

www.patientsorganizations.org

The IAPO is a global alliance of almost 100 national, regional and local patient organisations. The website includes a global directory of patient organisations, which can be searched using various criteria, including location, disease area, and IAPO membership status. The site also has a patients exchange where individuals running or working in patients' organisations around the world can come together to exchange views, share resources, give advice and support and discuss common issues. It also provides free access to an online patients network magazine. Available in English.

International Network for Health Policy & Reform

www.healthpolicymonitor.org

The International Network Health Policy & Reform, a clearinghouse project of the Bertelsmann Foundation's Health Program was initiated in September 2002. The centrepiece of the network's website is a comprehensive health policy database which consists primarily of information provided in half-yearly surveys by expert partners from around the world. The results of the first survey, conducted in March 2003, are now online. The site contains reports on health policy ideas and ongoing reforms from 15 industrialised countries. Database search results can be retrieved and sorted by countries, issues, years, process stages (from idea to implementation and evaluation), and actors or stakeholders. The database search engine enables anyone interested to inquire into health policy developments, and to generate individual reports, assembling various search topics. Other features comprise information on the network partner institutions, country statistics, updates, as well as news & notes on recent or upcoming publications, events and conferences. The website is available in both English and German.

WHO Macroeconomics and Health Web Site

www.who.int/macrohealth

This website provides detailed information on WHO macro-economics and health work, the latest action in countries, news and links with related sites, and links to the Commission on Macroeconomics in Health Report and its Working Group Reports. Published documents and reports can be downloaded from the site. To ensure that the website becomes a forum for sharing ideas, information and news, readers are encouraged to submit their views and work on macro-economic and health issues.

World Health Organisation Health Impact Assessment website

www.who.int/hia

The World Health Organisation Health Impact Assessment (HIA) website is intended to provide user-friendly access to international examples of HIA practice and key documents, tools and methods, evaluations, links with individual-nation HIA websites, and highlight relevant HIA work within WHO, Regional Offices and Collaborating Centres. The website also provides an opportunity to send in examples of HIA (case studies, completed HIA, toolkits etc).

The Italian Presidency

www.ueitalia2003.it

News and information on the Italian Presidency

Health Technology Assessment International

www.htai.org

HTAi is the new international society focused on health technology assessment, taking over from its predecessor the International Society for Technology Assessment in Health Care. The website provides the latest HTA related news, information on conferences, links to national and regional HTA agencies and groups and information on the Society's journal, the International Journal of Technology Assessment in Health Care.

SBU – The Swedish Council on Technology Assessment in Health Care

www.sbu.se/admin/index.asp

SBU is Europe's longest established health technology assessment group. It's main task is to assess technologies to help promote the rational utilisation of health care resources. It undertakes extensive dissemination of appraisal findings through a variety of sources. The website provides access to information on current projects, reports, a newsletter, links to other organisations and information on it's successful Ambassador Programme. These Ambassadors operate in 25 countries in Sweden providing face-to-face information to professionals on HTA findings. The website is available in English and Swedish.

WAY OPEN FOR GRAPHIC HEALTH WARNINGS ON CIGARETTE PACKS

The Commission has adopted a Decision opening the way for Member States to use pictures as part of the obligatory health warnings on tobacco products from 1 October 2004. It also lays down the conditions under which they may be used. The Commission Decision is a follow-up to the 2001 Tobacco Products Directive which already makes it obligatory to enlarge the size of health warnings on tobacco packages: from 30 September 2003, they have to take the form of large black on white text covering at least 30% of the front of the cigarette pack and 40% of the back.

Article 5 (3) of the Tobacco Products Directive gave the European Commission the power to adopt rules allowing, but not obliging, Member States to introduce picture warnings. The Decision requires that the European Commission create a central database of health warnings illustrated with colour photographs or other illustrations. Member States wishing to use picture warnings must use images and text from the Commission's database. This avoids problems with the free movement of tobacco products in the EU: picture warnings put on cigarette packs in one Member State will be valid throughout the EU. It also means that Member States contemplating a switch to picture warnings will not need to go to the expense of developing them themselves. Although no Member State will be obliged to introduce picture warnings, they will not be allowed to restrict the import of cigarettes from EU Member States where such warnings have been introduced. The Decision also permits the promotion of helpline numbers or addresses.

More information is available at www.europa.eu.int/comm/health/ph_determinants/life_style/Tobacco/tobacco_en.htm

EU AMONG FIRST TO SIGN CONVENTION ON TOBACCO CONTROL

Following the adoption of the Framework Convention on Tobacco Control (FCTC), by all 192 Member States of the World Health Organisation in May, Health and Consumer Protection Commissioner David Byrne and the Greek Council Presidency were among the first signatories of the FCTC on behalf of the European Union. Before the signing ceremony held in Geneva in June outgoing WHO Director General Gro Harlem Brundtland presented the special WHO Director-General's World No Tobacco Day Award to David Byrne for his "remarkable contribution towards European and global tobacco control"

Commenting afterwards Commissioner Byrne said: "With the FCTC, the tide has turned decisively in the battle to empower our citizens to

live healthy lives, free from the scourge of tobacco. It is important to get the first 40 ratifications of the FCTC as soon as possible to implement this useful tool and to reverse the rising death-toll which now claims nearly five million lives every year. Armed with this Convention we can move forward to make tobacco control a cornerstone of health and development. The Convention is testimony to the solidarity of an alliance of 192 countries who have decided to put the health of their citizens first."

The FCTC includes international rules on smoking prevention and treatment, advertising and promotion, labelling, illicit trade, taxation and product regulation.

More information is available at www.who.int/gb/ctc

WHO REGIONAL OFFICE FOR EUROPE LAUNCHES HEALTH EVIDENCE NETWORK

On September 8, the WHO Regional Office for Europe, at the 53rd session of the WHO Regional Committee for Europe, launched its new project: the Health Evidence Network (HEN), developed to support decision-makers in taking evidence-based decisions on public health matters. The project is intended to provide a framework for pooling and disseminating information on public health, meeting the specific needs of Member States.

Commenting at the launch, WHO Regional Director for Europe, Dr Marc Danzon, said "Information is more than ever a priority for the Regional Office. It is one of WHO's basic missions and a vital service that countries expect of us. Our ambition is to provide each country in the Region with analysis and information that are useful to,

and usable by, decision-makers in the Member States".

HEN is intended to provide rapid access to databases, publications and experts in evidence-based public health; and rapidly respond to questions from decision-makers. Responses will be based on careful reviews of both scientific evidence and other relevant information, and should highlight what is and is not known, current debate and policy options for different topics.

HEN it is argued differs from other similar projects as it begins with decision-makers' questions about policies, then collects and analyses relevant evidence and finally presents it in a form tailored to the needs of decision-makers. Experts are commissioned to compile and update responses taking local context across countries into account.

Examples of questions tackled by the Health Evidence Network and more information on the project can be viewed at www.euro.who.int/hen

53RD WHO REGIONAL COMMITTEE FOR EUROPE CLOSURES WITH CALL FOR STRONG ACTION AGAINST MENTAL DISORDERS AND TO IMPROVE YOUNG PEOPLE'S HEALTH

The 53rd annual session of the World Health Organization Regional Committee for Europe ended in Vienna on 12 September.

Twenty-nine ministers of health and over 300 policy-makers from the 52 countries in the WHO European Region attended the event. This year's session paid particular attention to mental health and young people's health.

Country representatives expressed concern about the gap between understanding what needs to be done and then taking action. To narrow this gap, the WHO Regional Office for Europe will hold two conferences: the Fourth Ministerial Conference on Environment and Health (in Budapest, Hungary, 23-25 June 2004) and a Ministerial Conference on Mental Health in Europe (in Helsinki, Finland, January 2005). The Regional Committee asked the Regional Office to provide detailed evidence-based analysis to support the work of these conferences.

Dr Lee Jong-wook, WHO Director-General, also addressed the Regional Committee stating that "inequalities in development have reduced life expectancy to 40 years in some countries but have raised it to about 80 years in others". He also stressed that "the 25th anniversary of the Declaration of Alma-Ata on primary health care provides an opportune moment to recall that good health is for all".

In his report to the Regional Committee, Dr Marc Danzon, WHO Regional Director for Europe, stressed four recent WHO achievements: the successful struggle against severe acute respiratory syndrome (SARS), the adoption of the Framework Convention on Tobacco Control (FCTC), the increased awareness of AIDS in countries of the European Region and the greater financial investment in them from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Focus on mental health

Mental health was a cross-cutting theme of discussions. Four main

concerns were identified: premature deaths, the need to avoid stigmatisation, the assessment of the current situation in countries and the particular problems of children and adolescents.

Mental health is an essential part of public health. Factors triggering mental health problems include changes in socioeconomic conditions, armed conflict, poverty and the growing gap between rich and poor even in the developed world.

Country representatives suggested that mental health be incorporated into all public health programmes. Some suggested topics for the programme of the 2005 ministerial conference were depression and its direct and indirect consequences, stress in the workplace and at

school, alcohol abuse and the prevention of suicide.

The health of children and adolescents

Investing in the health of young people is of great benefit not only to individuals but to society as a whole. Children under the age of 5 comprise 10% of the world's population but bear over 40% of the global burden of disease due to environmental factors. The Member States asked the Regional Office to prepare a regional strategy to orchestrate efforts to protect and promote children's and adolescents' health, and welcomed the children's environment and health action plan for Europe that is expected to be adopted at the ministerial conference in Budapest in June 2004.

More information on the Regional Committee session including working documents and final resolutions, is available on the Regional Office web site www.euro.who.int/rc

COMMISSION WANTS EU ROLE IN STRENGTHENING GLOBAL HEALTH THREAT DEFENCES

The European Commission has called for the EU to play a central role in World Health Organisation negotiations to reinforce international rules on the control of infectious diseases and other health threats. The WHO has proposed a major overhaul of its International Health Regulations (IHR) and seeks to begin dialogue on this early in 2004. The Commission adopted a Communication in which it fully supports the WHO's proposals. The reinforced system of international cooperation on infectious diseases proposed by the WHO is similar to the system that already exists within the EU. The Commission also endorsed WHO

proposals for international cooperation on all major public health events of international concern: for example, natural disease outbreaks and deliberate release of chemical or biological pathogens (bio-terrorism), as well as food safety threats. At present the IHR covers only three diseases: cholera, plague and yellow fever. The Commission envisages developing a common EU negotiating position on those aspects of the IHR which fall within the EU's competence. The WHO aims to have the revised IHR adopted in 2005, and to implement these regulations soon after, under the framework of the Global Alert Network on health threats

Further information on EU cooperation against health threats is available at http://europa.eu.int/comm/health/ph_threats/threats_en.htm

COMMISSION PLAN TO STRENGTHEN EUROPE'S DEFENCES AGAINST HEALTH THREATS

On 23 July, the European Commission adopted a proposal to create a European Centre for Disease Prevention and Control in recognition of the threat posed by communicable diseases to citizens' health, most recently highlighted by the Severe Acute Respiratory Syndrome (SARS) outbreak.

The new centre it is hoped will mobilise and significantly reinforce co-operation between the existing national centres for disease control. It will have a small core staff and an extended network of contacts in Member States' public health institutes and academia. After approval by the European Parliament and the Council, the ECDC could be operational as an independent European agency in 2005.

The key tasks of the new centre will be to undertake

- Epidemiological surveillance and laboratory networking
- Provide early warning and response
- Provide scientific opinions

For further information on the proposal to create a European Centre for Disease Prevention and Control see:

http://europa.eu.int/comm/health/ph_overview/strategy/ecdc/ecdc_en.htm

- Provide technical assistance for Member States, EEA/EFTA States and Candidate countries
- Improve preparedness against health emergencies
- Communicate information on health threats
- Provide a rapid and effective response to health threats
- Support national public health institutes

Health and Consumer Protection Commissioner David Byrne said: "If communicable diseases do not respect national borders, then neither should preventive and control measures. SARS was a 'wake-up call' for Europe to get better prepared and to substantially enforce cooperation at an EU-level.

"The EU and Member States had a system in place to monitor the spread of the SARS virus but no system for advising on, let alone deciding, EU-wide measures to contain it. In today's Europe, where millions of people cross national borders each

day, we need rapid, coordinated action at EU-level to protect our citizens.

"The European Centre for Disease Prevention and Control will make this possible. By pooling Europe's scientific expertise and reinforcing our rapid alert systems the ECDC will help the EU and its Member States to respond more quickly and effectively to disease outbreaks to be better prepared against epidemics and bioterrorist attacks."

EU: NEW LABELLING RULES ON FOOD INGREDIENTS ADOPTED

An amendment to the EU Food Labelling Directive has been adopted by the Council and European Parliament.

With some limited exceptions, consumers once the Directive is implemented will be fully informed of the complete contents of foods. Exceptions will not apply to ingredients liable to cause allergic reactions listed in the Directive, thus enabling consumers with allergies to identify any possible hazardous ingredients that may be present in a food.

The new Directive abolishes the '25% rule' that currently means that it is not obligatory to label components of compound ingredients that make up less than 25% of the final food product.

The new rules will also extend to alcoholic beverages if they contain an ingredient on the allergen list, for example sulphite in wines. Sulphites are used in many foods, including some wines, beer and cider and can potentially cause severe adverse reactions, e.g. asthma attacks, in some of those susceptible to allergies.

The Directive will be published in the EU's Official Journal in late 2003, and if all goes according to plan, it could have an impact on the supermarket shelves by 2005.

NEW PUBLICATION: HEALTH SYSTEMS CONFRONT POVERTY

A new publication from the WHO Regional Office for Europe examines 12 initiatives that 10 Member States, Croatia, France, Germany, Hungary, Italy, Kyrgyzstan, Poland, the Republic of Moldova, the Russian Federation and the United Kingdom, have undertaken to address the issue of poverty and health.

According to the accompanying press release the study edited by Erio Ziglio, Rogerio Barbosa, Yves Charpak, and Steve Turner, documents WHO's preliminary findings on how health systems can help to

alleviate poverty, and reaches three main conclusions: that these systems can take effective action to improve the health of the poor, that they can sometimes represent an additional barrier for the poor and that more knowledge, training and capacity building in this area are urgently needed.

It is hoped that the information presented will contribute to WHO's efforts to help countries across the length and breadth of Europe improve health and increase equity by tackling poverty and its effects on health.

The report is available on line at www.euro.who.int/document/e80225.pdf

MAJOR REFORM OF IRISH HEALTH CARE SYSTEM ANNOUNCED

On 18 June the most extensive reform programme for 30 years in the Irish Health System was announced. Key reforms include the abolition or merger of many existing agencies, reorganisation of the Department of Health and Children and the establishment of a Health Services Executive, the first body to manage the health service as a single national entity.

Launching the programme, the Minister for Health and Children, Micheál Martin and the Minister for Finance, Charlie McCreevy, said that "the central aim of the reform programme is ultimately about providing an improved level of patient care for the increasing number of citizens availing of the Irish Health Service each year."

The Ministers drew particular attention to the significantly increased level of investment in the health service since 1997, which is now at record levels and is equivalent to over €2000 for every man, woman and child in the country and said "it is essential that we achieve greater value-for-money for a service which accounts for over a quarter of all public spending in the interests of not alone the patient but of every taxpayer in the country."

In a further speech to the Dáil (Parliament) on 27 June Minister Martin also noted that "[the existing]

health board structures are over 30 years old and the wide health system has also seen the addition of a large range of specialist agencies during that period - often to give focus and to protect particular policy developments. The result is that there are now 58 agencies operating in the public health system. It is obvious that this is simply not sustainable. This multiplicity has resulted in a complex and fragmented system which has itself become an obstacle to achieving improvements." He went on to add that he believes "that the decisions made will reinforce and build on efforts to date in creating a more innovative and participative working culture in the health services, focused on continuous improvement in service quality. This programme is about providing a framework for developing services and maximising the impact of these services on the patient and clients who rely on them."

The main elements of the proposed reform programme are:

Major rationalisation of existing health service agencies to reduce fragmentation. This includes the abolition of the existing health board/authority structures.

Reorganisation of the Department of Health and Children, to ensure improved policy development and oversight.

Establishment of a Health Services Executive which will be the first ever body charged with managing the health service as a single national entity.

Establishment of three core areas within the Health Service Executive - a National Hospitals Office, a Primary, Community and Continuing Care Directorate and a National Shared Services Centre.

Establishment of four Regional Health Offices within the Health Service Executive to deliver regional and local services.

Immediate establishment of an interim National Hospitals Office with the priority being the reform of the hospitals sector.

Establishment of a Health Information and Quality Authority to ensure that quality of care is promoted throughout the system.

Move to devolving responsibility for care budgets to the people actually in charge of delivering that care.

Complete modernisation of supporting processes (service planning; management reporting etc.) to improve planning and delivery of services, including maximising the impact of public funding.

Further information on the Health Service Reform Programme is available online at www.doh.ie/publications/hsreform.htm

WHO EXTERNAL REVIEW OF NICE TECHNOLOGY APPRAISAL PROGRAMME IN ENGLAND AND WALES

An independent WHO-conducted international review of the National Institute of Clinical Excellence (For England and Wales) Technology Appraisal Programme undertaken at the request of NICE has recently been published. The review team concluded that within a short time frame of just four years NICE "has a well-deserved reputation for innovation and methodological developments that represent an important model for technology appraisals internationally...Achievements that are particularly valuable include: the transparency surrounding the

process of technology assessment; the intensive participation of different stakeholders and the inclusiveness of the approaches taken; the commitment to using the best available evidence for decision-making; the commitment of the technical and management staff; and the dedication of the appraisal team and the Appraisal Committee members. All of these form the cornerstones of an organization that continues to invest in quality development."

Furthermore the report notes that NICE appraisals are viewed by many as an international benchmark

for appraisal. The committee however concentrated on areas of controversy and made a number of recommendations to strengthen the technology appraisal process further. These include a recommendation that more explicit information on the criteria for decision making, including the specific weighting given to clinical evidence, economic evidence and other factors such as equity considerations should be made public.

The report can be downloaded at www.who.dk/Document/E81254.pdf

News in Brief

Forthcoming Conference: Mental Health of migrants and refugees: what are the answers of the care system in Europe?

A conference organised by the Association Françoise and Eugène Minkowski for the mental health of migrants and refugees under the sponsorship of the French Ministry for Social Affairs and the International Organisation for Migrations (IOM) will take place in Paris on 27 and 28 November. The conference languages will be English and French.

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Reaching the Poor with Effective Health, Nutrition, and Population Services: What Works, What Doesn't, and Why.

The World Bank, in cooperation with the Gates Foundation and the Dutch and Swedish Governments, is hosting a conference on this topic from 18–20 February 2004 in Washington D.C.

Further information is available at: www.worldbank.org/wbi/healthandpopulation/Brochure/main.htm

Long-term care for older people in Ireland

A review of the nursing home subvention scheme by Dr Eamon O'Shea at the National University of Ireland at Galway has recently been completed for the Department of Health and Children. The report includes extensive analysis of the current state and future need for long term care for older people in Ireland.

The 144 page report is available on-line at www.doh.ie/pdfdocs/nhsubv.pdf

New Report on Illness, Disability and Social Inclusion

This new report by Stefanos Grammenos, published by the European Foundation for Work and

Living Conditions, examines issues in the development of policies and the delivery of services to promote the social inclusion of people with a chronic physical or mental illness or disability. It reviews the nature and scale of the problems facing different groups and identifies policy initiatives in employment, education, housing, transport and other areas which facilitate social and economic integration. Published to coincide with the European Year of People with Disabilities, the report aims to fuel the debate and increase policy focus on people with a chronic illness or disability, particularly those of working age.

The full 168 page report is available on-line at www.eurofound.eu.int/publications/EF0335.htm

European Parliament – Policy seminar on social inclusion and health across Europe

On June 24, the European Network for Public Health, Health Promotion and Disease Prevention organised a seminar on Social Inclusion and Health across Europe. Catherine Stihler MEP hosted this event, which aimed to mobilise and involve public health organisations in the National Action Plans (NAPs) on Social Inclusion.

David Byrne receives Honorary Fellowship from Royal College of Physicians

The Royal College of Physicians (RCP) in London elected Health and Consumer Protection Commissioner, David Byrne, to an Honorary Fellowship in July. This is the highest honour that the RCP can

bestow on a non-medically qualified person. The President of the Royal College, Carol Black, presented the Honorary FRCP diploma to David Byrne in a special admission ceremony in St. Andrews Place, Regent's Park, London. Commissioner Byrne said: "As a new fellow of the Royal College of Physicians, I will be happy to work towards creating a genuine Europe of Health and to place a positive concept of health at the heart of European policymaking. Moreover, the economic benefits of a healthy population need to be better appreciated especially as a driver of economic growth and prosperity."

Making Services Work for Poor People – World Development Report 2004

The World Bank published its annual World Development Report on 21 September 2003. The report focuses on why government services fail poor people and how they can be improved. Drawing on successful examples from around the globe, the report recommends putting poor people at the centre of the provision of basic services such as health, education, water and electricity.

The report is available at <http://econ.worldbank.org/wdr/wdr2004/>

Review of Health and Social Care in Wales Published

A 103 page review of Health and Social Care in Wales commissioned by the National Assembly in Wales has now been published.

The review is available on-line at www.wales.gov.uk/subieconomics/content/hsc/review-e.pdf

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