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COMMUNICATION FROM THE COMMISSION

TO THE COUNCIL, THE EUROPEAN PARLIAMENT,
THE ECONOMIC AND SOCIAL COMMITTEE
AND THE COMMITTEE OF THE REGIONS

on the development of public health policy
in the European Community

Executive Summary

The Commission set out a framework for action in the field of public health in its communication of 24 November 1993. This described the strategy to be pursued and measures to be put forward by the Commission to give effect to Article 129 of the EC Treaty. Eight public health programmes have been proposed in the context of this framework. Five are in the course of implementation and the others are being considered by the European Parliament and the Council under the co-decision procedure. There is now a need to consider how far the existing framework remains satisfactory and is able to respond to a number of important developments, such as emerging health threats and increasing pressures on health systems, as well as the enlargement of the Community and the new public health provisions in the Treaty of Amsterdam. Moreover, such a review is particularly urgent as most of the existing programmes will be coming to an end in or about the year 2000 and proposals will have to be put forward in the near future.

This communication first considers a number of developments in health status and health systems in the Community, as well as principles and pre-requisites of public health action at Community level. These considerations lead to the conclusion that, although the principles and underlying philosophy of the 1993 communication on the framework for action in the field of public health remain valid, priorities, structures and methods are all in need of fundamental review and reformulation. Finally, the communication outlines a possible new Community public health policy, based upon three strands of action:

- Improving information for the development of public health,
- Reacting rapidly to threats to health,
- Tackling health determinants through health promotion and disease prevention.

Issues related to enlargement, and to the integration of health requirements in Community policies, would be dealt with by all three strands.

The Commission intends to come forward with concrete proposals on the new policy once the Treaty of Amsterdam has been ratified. In the meantime it is hoped that the ideas presented in this communication will stimulate a broad debate on the future Community public health policy.

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1. Introduction – Purpose and Scope

1. A comprehensive Community strategy on public health has been in place since November 1993. This followed the ratification of the Maastricht Treaty which gave the Community an explicit competence in this field. There are a number of reasons why this strategy is in need of fundamental revision:

- first, the experience gained in implementing the existing public health strategy which has indicated some drawbacks with the current approach;
- second, new developments in health status and health systems which have emerged and which could not have been anticipated in 1993;
- third, the clear requests to the Commission from both the Council and the European Parliament, as well as major actors in the health field, to present proposals for a new public health policy able to respond to the new challenges;
- fourth, the Commission's own commitment to give health policy a higher priority;
- fifth, the new health challenges posed by the enlargement process; and
- finally, the strengthening of public health provisions in the Treaty of Amsterdam.

2. The development of a new policy has become particularly urgent. In order to be in a position to come forward with concrete proposals for new measures as soon as possible after ratification of the Amsterdam Treaty, it is necessary now to set the terms of reference for a debate on the overall direction of policy. Moreover, most of the existing public health programmes will be coming to an end in or about the year 2000. This means that new proposals need to be ready in time so that there is no vacuum in Community policy in this important field.

3. In order to launch the debate, this communication sets out the results of a review of the existing framework and presents a new policy orientation in the field of public health, which puts emphasis on the improvement of health and the need to concentrate on a limited number of priorities, while being sufficiently flexible to respond promptly to new health threats and developments.

2. The State of Health in the European Union

People in the EU are now living longer and leading healthier lifestyles than ever before. A range of indicators ranging from life expectancy, infant mortality and maternal mortality confirm this trend. This must not lead to any complacency. One in five citizens still dies prematurely, often due to preventable diseases. New risks to health, especially communicable diseases, are emerging. There are disturbing inequalities in health status between social classes. And longer life expectancy is itself creating its own problems such as a sharp rise in age-related diseases such as Alzheimer's'.

4. In general terms, the health of the Community population is better than ever before. Year by year, Community citizens are living longer. Since 1970, life expectancy at birth for women in the Community has risen by 5 1/2 years and for men, by almost 5 years. A girl born in 1995 can expect to live well over 80 years, a boy to nearly 74. From 1970 to 1992, the Community's infant mortality more than halved to under 10 per 1000 live births and the differences between Member States decreased. In the same period, maternal mortality fell sharply to 7 per 100,000 live births.

5. The main killer diseases of the last century, such as smallpox, cholera and measles are no longer the threat they were. The development and widespread use of vaccines and antibiotics have contributed to this success, as have improved hygiene, environmental and social conditions. Nevertheless, it would be wrong to conclude from these achievements that no serious health problems remain in the Community.

6. **First**, levels of premature mortality, i.e. death before the age of 65, are still high, accounting for one fifth of all deaths. More than 600,000 people aged between 35 and 64 die every year, particularly from lifestyle-related diseases: four in ten from cancer, three in ten from cardiovascular diseases and nearly one in ten from accidents and suicides. Behaviour patterns developed in childhood and adolescence, such as smoking, limited exercise, poor nutrition, etc., are major risk factors for these diseases in adulthood. Moreover, an estimated 22 million people aged 16 and over report being severely hampered in their daily activities by a 'chronic physical or mental health problem'.

7. **Second**, new risks to health are emerging, for example, from new diseases such as new variant Creutzfeldt-Jacob Disease (CJD), avian flu and Ebola haemorrhagic fever, the spread of food-borne infections, the resurgence of old infectious diseases, notably tuberculosis, and the growing problem of resistance to antibiotics. AIDS is a continuing concern. The increase in travel and in population mobility will aggravate these problems.

8. **Third**, there are wide variations and inequalities in health status both among Member States' populations and among the different population groups in each country. A striking example related to age and gender is that within the 15 to 34 age group, the mortality rate from traffic accidents is three times higher for men than for women. Possibly the most important health inequality relates to socio-economic position. People in lower socio-economic classes have significantly increased health risks throughout their lives. The result is that mortality and morbidity rates are significantly higher for people in the lowest socio-economic classes. In the UK, for example, a baby born today to parents of one of the highest socio-economic classes can expect to live five years longer than a baby in a lower class.

9. **Fourth**, a consequence of the lengthening life expectancy in the Community is the increase in the number of persons suffering from diseases and conditions related to old age, in particular cancers, cardiovascular diseases, physical disabilities and mental disorders, such as Alzheimer's disease and other neuro-degenerative disorders. It has been estimated that by the year 2000, 8 million people in the Community will be affected by Alzheimer's. Increases in the numbers affected by diseases such as this will have important consequences for social and health care and treatment services.

3. The Public Health Challenges facing the Member States

Health care systems in the Member States are subject to conflicting pressures. Rising costs due to demographic factors, new technologies and increased public expectations are pulling in one direction. System reforms, greater efficiencies and increased competition are pulling in another. Member States must manage these conflicting pressures without losing sight of the importance of health to people's wellbeing and the economic importance of the health systems.

3.1 Health care costs

10. Over the last three decades, health care spending in the Community has roughly doubled as a proportion of GDP and now ranges from 5% to 10% in different Member States. This is considerably less than in the United States (over 14%). In response, Member States have been undertaking a wide range of structural reforms and cost containment measures to improve the efficiency and effectiveness of their health systems. The need to contain rising healthcare spending and to optimise cost-effectiveness in this sector has been underlined by the general constraints on public expenditure. Several factors, affecting both the supply of and the demand for health services, have contributed to the rise in health expenditure. The main ones are discussed below.

3.2 Demographic Trends

11. As a result of the falling birth-rates and lengthening life expectancy, the Community population is ageing. By 2020, there will be 40% more people aged 75 and above than in 1990. This is likely to increase demand for health services and will also necessitate changes to their organisation and structure.

12. With more people living into their 80s and 90s, there will be increased pressure on health care and particularly on social care. It has been estimated that, over the next 30 years, health care expenditure will rise by at least 1-3% of GDP as a result of demographic changes alone¹. The problem will be made more serious by the decline in family size and the increasing number of small and single parent households, which is likely to reduce the contribution traditionally made by family members to the care of the elderly. Health and social services will need to respond to these changes. The question of how to pay for the increasing costs is made more difficult because the total dependency ratio (the ratio of dependants to workers) is likely to rise from its current levels.

3.3 Technological and other supply-driven developments

13. Supply management factors are at least as important in determining overall healthcare costs as demand factors. In recent decades, new medical developments have been introduced at unprecedented rates, and their impact is a major factor in rising costs. Innovative medicinal products, for example, generally cost far more than

¹ Franco, T. Munzi, Ageing and fiscal policies in the EU, *European Economy* 1997:4

existing drugs. Yet, many current therapies have not been proven to be beneficial to health and cost-effective. This points to the need for greater emphasis on evaluation of health interventions. Computerisation and networking, including healthcare telematics, may help reduce health costs particularly in relation to the management of health care.

3.4 Changes in health systems

14. Member States face a number of common problems related to the financing, organisation and management of their health systems. There is an increasing concern to raise overall standards, while at the same time to control health costs and secure the best value for money. In parallel, health systems, like other areas of the economy, are affected by the globalisation of trade and industry and the pressures of competition, as well as the development of the Community internal market. The various initiatives in the field of managed care and the growth of evidence-based medicine, quality assurance and health technology assessment are all responses to these developments.

3.5 Citizens' expectations and concerns

15. Health services have to reflect present and projected national and local needs and respond to popular demands, priorities and concerns. In this context an encouraging trend in Member States is the growing attention being paid to public opinion in the planning and provision of services. Besides being able to express their views on service developments, citizens are also increasingly involved in priority setting.

16. Although the legitimate aspirations of the public have to be respected and addressed by governments and health authorities, growing public involvement can produce further pressure on services and budgets, since people are reluctant to accept any rationing of services or cuts in their levels. A recent Eurobarometer survey showed that only 5% of the Community population are ready to see lower public spending on health care. By contrast 50% wanted higher spending.² In general, satisfaction with health systems is linked with the level of expenditure.

17. One further, significant development which policy must take into account is the impact of modern food preparation and farming practices. The introduction of new techniques, such as genetically modified foods and food irradiation, problems related to 'natural' foods and the increased availability of 'fast' foods give rise to public concern and to demands for policy responses.

3.6 Employment

18. The relationship between employment and health goes beyond the impact of unemployment on health status. The health sector is an important employer, consumer of goods and a leading player in research and development. It thus makes a key contribution to socio-economic development. According to the 1996 Labour Force Survey, more than 10% of those in employment were employed in health. Health is one of the fastest growing sectors in the 1990s, expanding on average at just under 3%

² Eurobarometer 44.3 carried out early in 1996.

a year. A further issue is that unemployment reduces the total funds available for health care. This is because in many countries a significant proportion of the finances for health and social protection systems is linked to income-related contributions. It is therefore important when considering health system reforms and cost containment measures, to take into account the possible effects on health and safety issues as well as on the broader economy.

4. The Challenge of Enlargement and the International Dimension

The health situation in the countries of central and eastern Europe compares poorly with the situation in the existing EU. In general, there is lower life expectancy and poorer health status in these countries. They have fewer resources to improve this situation. Enlargement will also have implications for the health systems in the existing Member States, especially due to free movement. There will be a need to assist the applicant countries to adapt to Community policy in this field. Co-operation on health issues with international organisations, such as the WHO, is also necessary to address threats to health at the global level.

4.1 Enlargement

19. The development of public health policy has to take into account the consequences of the enlargement of the Community towards Central and Eastern Europe. The health problems of these countries are substantially different from, and often more intractable than, those of existing Member States. Their main health status indicators compare poorly with Member States'. As is normal for lower-income countries with less-developed health systems, they also face potentially serious problems with communicable diseases. In addition, the candidate countries, with the exception of Cyprus, have fewer resources to spend on health. Their health systems are in need of significant reform to improve their overall effectiveness, as well as requiring a number of specific changes to bring them in line with the relevant Community legislation. The future policy must tackle the problems and priorities of the candidate countries and find ways of providing Community support.

20 A further issue is the possible consequences of enlargement for the health status and systems of the existing Member States. In particular, the free circulation of products, notably certain pharmaceuticals and blood products and medical devices, raises issues relating to safety and quality control as well as pricing.

21. The Commission is already giving support to the candidate countries to ensure that they are in a position to implement the European Community's health-related legislation (the *acquis*), using mechanisms such as the PHARE programme and structural instruments. In addition, the Community's public health programmes are being opened for the participation of candidate countries which will assist them in the process of adaptation to the Community policy in this field. Information will be needed about the trends in health and health determinants in the candidate countries and about the possible effects of accession on their and existing Member States' health systems.

4.2 The International Dimension

22. Public health policy and actions must respond to changes in the international dimension. Health issues play an important role in the Community's relations with third countries, its development co-operation and humanitarian aid activities. Health problems in third countries, can have an effect on the health of the Community population. It is therefore necessary to strengthen the initiatives aiming at global epidemiological surveillance and mechanisms to respond rapidly to health threats and to help developing countries to improve their health systems. Currently, a number of health-related activities are taking place, for example, within the context of the Agreement on the European Economic Area, Euro-Mediterranean Co-operation and within the G7 framework. Moreover, co-operation on global surveillance of and response to communicable diseases is being considered by the EU-US Task Force. Their results will feed into the Community's public health policy.

23. Furthermore, in many areas under consideration here, international bodies, notably the World Health Organization, the World Bank, the United Nations Population Fund (UNFPA), the Council of Europe and the Organisation for Economic Co-operation and Development (OECD) are active within their respective remits. There are several important areas where co-operation with WHO is taking place, for example, on health information and health monitoring systems and on communicable diseases. WHO is currently updating its International Health Regulations and Health For All objectives which should be ready by the year 2000. These are likely to influence Member States' health agendas, and will be taken into account in Community policy. The World Bank has an important role in supporting health service development in Central and Eastern Europe. There is also increasing co-operation with UNFPA in implementing the action programme of the International Conference on Population Development (Cairo 1994). OECD has produced documentation and a database on health care and on health costs. The Council of Europe is carrying out work in several areas related to public health, including pharmaceuticals, drugs and bio-ethical issues.

5. The Community's Role in Public Health

The Community's role in public health has increased over time and especially with the ratification of the Maastricht Treaty. It gave the Community a particular role in promoting health protection and disease prevention. Eight distinct health programmes and a range of other activities have been developed in response. These activities vary from programmes on cancer, on AIDS and on combating drug dependence, to reports on the state of health in the EU and to recommendations on blood safety. In addition, many other Community policies also impact on health. Developments in the last two years, such as the emergence of new communicable diseases, have contributed to a new and greater awareness of the importance of health policy at Community level.

5.1 The existing legal base

24. The European Community has dealt with health issues for four decades. Both the Treaty on the European Coal and Steel Community and the Euratom Treaty referred to health and contained several provisions, for example, relating to restricting free movement of goods on health grounds and to the health and safety of workers. The Single European Act introduced further areas of health-related work such as a large-scale research programme and the development of health and safety at work legislation. However, it was only with the Maastricht Treaty, with its new public health provisions, that the Community had the opportunity to develop a coherent public health strategy. Article 3(o), gave the Community a new objective of making 'a contribution to the attainment of a high level of health protection' which is applicable to all Community policies. Article 129 of the Treaty then sets out a framework for Community public health activities in pursuit of this objective.

25. The Article's main provisions are as follows:

- The Community shall contribute towards ensuring a high level of human health protection by encouraging co-operation between the Member States and, if necessary, lending support to their action.
- Community action on health protection should be focused on the prevention of diseases.
- Community activities in the field of public health should concentrate particularly on the major health 'scourges', including drug dependence.
- In these areas, the Community is to co-operate with other organisations active in the field.

26. The Article provides for the adoption of incentive measures, excluding any harmonisation of Member States' legislation, and recommendations. Finally, it stipulates that health protection requirements shall form a constituent part of other Community policies.

27. In addition to Article 129, there are several other health-related Treaty Articles (e.g. Articles 39 and 43 – agricultural policy, Article 75c – transport safety, Articles 100 and 100a - approximation of laws related to the single market, Article 129a - consumer protection, Article 130f - research, Article 130r – environment, etc.). The Court of Justice has confirmed³ that the objective set for the Community in Article 3 (o) of the Treaty to contribute to attaining a high level of human health protection applies to all areas of Community policy which have an impact on health.

28. Just after the Maastricht Treaty came into force, the Commission presented a communication on the framework for action in the field of public health. This described current health challenges, health status and trends within the Member States. It stressed tackling the determinants of health and the underlying causes of disease, and outlined criteria for deciding the priorities for Community action. The philosophy of this communication and the arguments expressed remain valid today.

³ Cf. Case C-180/96R, United Kingdom v. Commission, ECR 1996, I-3903

5.2 The Community's role

29. The 1993 communication set out some criteria to ensure that Community public health actions fully respect the principles of subsidiarity, proportionality and transparency and that the work undertaken provides added value to Member States' activities. It is essential that these criteria continue to be met in the definition and implementation of actions.

5.3 The development of Community public health activities since Maastricht

Action programmes

30. On the basis of the analysis in the 1993 communication, the Commission proposed the development of eight public health action programmes. Of these, five have been adopted. The action programmes on AIDS and other communicable diseases, cancer, drug dependence and health promotion⁴ have been underway since 1996; the fifth programme, on health monitoring was adopted in June 1997⁵. The drug dependence programme is linked with other political and legislative measures, including the establishment of the European Monitoring Centre for Drugs and Drug Addiction. A co-ordinated approach to combating demand for and supply of drugs has been agreed with the Member States and is laid down in a European Union action plan to combat drugs.⁶ For the remaining three programmes, on pollution-related diseases, injury prevention and rare diseases,⁷ the Commission put forward proposals during 1997 for decisions of the European Parliament and the Council. These are still under discussion.

31. These programmes support many projects which cover *inter alia* the following areas: the exchange of information and personnel, training, pilot projects, information campaigns, networking of organisations and experts. In addition work is being undertaken on developing guidelines and practical recommendations in several areas, including cancer screening, osteoporosis, healthy diet and youth drinking. The programmes aim to provide Community added value by undertaking activities which cannot be undertaken satisfactorily by individual Member States, or where joint implementation has advantages, or which complement their activities.

Initiatives in other areas

32. In addition to the action programmes, work has been carried out in other areas related to the 1993 framework. First, the Commission has proposed the establishment of a European Community network for the control and surveillance of communicable diseases⁸. Second, new initiatives have been taken on smoking, such as a communication on the present and proposed Community role in combating tobacco

⁴ OJ L 95 of 16.4.96, p 16, OJ L 95 of 16.4.96, p. 9, OJ L 19 of 22.1.97, p. 25, OJ L95 of 16.4.96, p. 1

⁵ OJ L193 of 22.7.97, p 1

⁶ COM (94) 234 final of 23.6.1994

⁷ COM (97) 266 final of 4.6.97, COM(97)178 final of 14.5.97, COM(97) 225 final of 26.5.97

⁸ COM (96) 78 final of 7.3.96

consumption,⁹ and the adoption of a Council common position on tobacco advertising. Third, a strategy has been agreed on blood safety and self-sufficiency, including a Commission proposal for a Council recommendation on the suitability of donors of blood and plasma and the testing of donations.¹⁰ Fourth, a comprehensive review has been undertaken on non-ionising radiation, and Commission proposals for Council recommendations are being prepared. Fifth, a number of reports are produced regularly, notably on health status in the Community,¹¹ and on TSEs, including information on reported cases of CJD in the Community. Annual reports are being prepared on health requirements in other policies¹². A wide range of Community policies have an impact on health and even have a health-related Treaty objective. These reports provide an overview of the actions being undertaken in the context of these policies. For example, the Commission has presented a second modified proposal for a 5th Framework Programme for Research and Technological Development (1998 – 2002). One of the priorities of this proposal is to focus Community research policy on specific themes such as, in the area of health, the relationship between health, environment and food, the control of viral diseases, and the ageing population. Equally, the Commission's Joint Research Centre contributes to the fight against cancer.

5.4 Experience with the implementation of the 1993 framework of action

33. From the outset the Commission envisaged that the public health framework would need to be reviewed in the light of experience and trends in health in the Community. This review should not merely be in terms of how well the action programmes have worked, but should also consider how far they have contributed to the Treaty objective. Other issues for assessment are whether the priorities, structure and balance of the framework have proved effective and whether they are appropriate for the future.

34. In 1993, the Commission decided against proposing one overall public health programme. One reason for this was concern that this would risk serious delays in implementing the new legal provisions arising from differences between the Member States over the priorities to be addressed. Instead the Commission decided to put forward proposals for eight separate action programmes. While this approach has avoided some of the pitfalls anticipated with one programme, it has given rise to unforeseen problems:

- It has led to a considerable administrative burden owing to the fact that each programme has its own 'mixed' committee and complex rules and structure;
- It has limited flexibility, making it difficult to respond to developments which are not covered by the present programmes or to changes in the Community's or Member States' priorities;

⁹ COM (96) 609 final of 18.12.96

¹⁰ COM (97) 605 final of 17.11.97

¹¹ COM (95) 357 final of 19.7.95 and COM (97) 224 final of 22.5.97.

¹² COM (95) 196 final of 29.5.95, COM (96) 407 final of 4.9.96 and COM (98) 34 final of 27.1.98.

- The available budget for each programme is relatively small, raising concerns about whether potential Community added value is being maximised ;
- Since each programme develops its own independent strategy and workplan, co-ordination between the programmes is difficult to achieve in practice and there is a risk of duplication and overlap of activities.

35. Another problem related to the implementation of the programmes is their focus on projects submitted for consideration by organisations in the field. This has two consequences: first, funds have been spread among a substantial number of projects, some not of relevance to all Member States. Greater impact might have been achieved if fewer, larger-scale, sustainable actions had been supported. Second, the reliance on organisations submitting projects reflecting what they wish to do makes it difficult to ensure that the programmes' policy aims, and those of national strategies, are attained.

5.5 New developments at Community Level

36. In the last two years, several developments have contributed to a new awareness of the importance of health policy at Community level and to a rethinking of its activities in the field of health. During this period, there has been growing interest in Member States in developing joint activities at Community level to support them in coping with the health challenges they face, which were outlined above.

37. The BSE crisis has demonstrated the need for a more integrated approach to health-related policy. To improve its capacity to respond to the various issues raised by the crisis, the Commission decided to re-organise and strengthen its services dealing with consumer policy and health protection and to establish a new system of scientific committees. A central aim of this restructuring was to separate the procurement of scientific advice, and the function of inspection, from the process of preparing legislative instruments.¹³ As part of their remit, the new committees will be able to provide expert advice on matters related to public health.

38. The extension of the legal basis of the Community's public health activities in the Amsterdam Treaty reflects the evolving consensus on the importance of Community action in this field. Although the new Treaty has not yet been ratified, it is necessary to refer briefly to its public health provisions here, since they revise Article 129 (which becomes Article 152 in the new Treaty). It is the Commission's intention to make maximum use of the possibilities offered by the new Treaty. However, their precise effect will require detailed consideration.

39. The main changes are as follows.

- The provisions on the health impact of other policies have been moved to the beginning of the Article and they stress that a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.
- Some changes have been introduced into the section dealing with the aims of Community actions, which encompass actions "directed towards improving public

¹³ cf. Commission communication on consumer health and food safety, COM(97)183 of 30.4.97

health”, as well as actions directed at “preventing human illness” and “obviating sources of danger to human health”.

- Actions in the drugs field are to focus on “reducing drugs-related health damage”.
- Two additions are made to Paragraph 4, dealing with decision-making:
 - Paragraph 4(a) states that the Community can adopt “measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives”. This should be read in connection with the second sentence of paragraph 5, which says that these measures “shall not affect national provisions on the donation or medical use of organs and blood”. Paragraph 4(a) also stresses that Member States can adopt or maintain more stringent protective measures if they wish.
 - Paragraph 4(b) brings into the scope of this Article (and therefore the co-decision procedure) “measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health”.
- Paragraph 4(c) preserves the existing wording regarding incentive measures, i.e. it excludes “any harmonisation of the laws and regulations of the Member States”.

6. A Future Community Public Health Policy

The Community’s role in public health has to evolve to deal with new challenges, changed circumstances and the greater role envisaged for public health in the draft Amsterdam Treaty. Drawing from these factors and the experience of the existing framework, the Commission considers that future policy should comprise three strands of action:

- *Improving information for the development of public health,*
- *Reacting rapidly to threats to health,*
- *Tackling health determinants through health promotion and disease prevention.*

These three strands would also enable the Community to respond effectively to the challenges of enlargement, and to the issues of health requirements in other policies.

40. A number of events, such as the outbreaks of certain infectious diseases, have raised the profile of public health at Community level, but a new public health policy cannot be based on short-term considerations and one-off events, however important. Instead, it should have a long-term perspective, with a set of clear priorities and appropriate implementation instruments.

41. No formal policy proposals can be made before the ratification of the new Treaty, but it is appropriate to consider at this stage what the main strands of a Community health policy could be and how they might build upon current Community action. In doing so, the Commission is aware of the need for an extensive debate in which the other Institutions and other interested parties can join. It intends to present its

proposals in the light of the results of this debate as soon as possible after the Treaty of Amsterdam comes into force.

42. As emphasised above, the principles and philosophy of the 1993 communication on public health, remain valid. However the developments outlined above require a substantial rethinking of the present approach. A Community public health policy should have several characteristics. It should make the best use of the limited resources available at Community level. It should emphasise the improvement of health and health gain and concentrate on a limited number of priorities. It should be sufficiently flexible to respond promptly to new health threats and developments. Most importantly, the policy should take up the concerns of Community citizens and be credible and convincing so that they are aware that effective arrangements exist at Community level to attain a high level of health protection.

43. On the basis of the above analysis, the Commission considers that future policy should comprise three strands of action:

- *Improving information for the development of public health,*
- *Reacting rapidly to threats to health,*
- *Tackling health determinants through health promotion and disease prevention.*

These three strands would enable the Community to respond effectively to the challenges of enlargement, and to the issues of health requirements in other policies.

6.1: Strand 1: Improving information for the development of public health

44. In order to improve the Community's ability to carry out effective and durable actions in the field of public health, a sound health information system and infrastructure for policy analysis and development is essential. The Community action programme on health monitoring represents a first step by defining common health-related indicators; collecting and exchanging data by means of electronic communications developed in the Interchange of Data between Administrations (IDA) scheme¹⁴; and a capability for undertaking inquiries and analyses. This will also lead to a better-validated database and an improved analytical capacity to inform public health policy development at Community and Member State level.

45. Building on the activities and outputs of this programme, a structured and comprehensive Community system for collecting, analysing and disseminating information should be developed. The system would also be used for evaluations and appraisals, to make comparisons between Member States, with accession countries and other countries, and develop future scenarios and a forecasting capacity. This strand would have two complementary focuses: first, trends in health status and health determinants; and second, developments concerning health systems.

Health Status

46. Areas to be dealt with could include:

¹⁴ Council Decision 95/468/EC; OJ L269, 11.11.95, p.23

- Trends and patterns of demography, morbidity and mortality, and of major health determinants. Analyses could cover different conditions, including physical and mental illness, specific population groups, such as children and the elderly, trends in health-related knowledge, attitudes and behaviour, and gender-specific issues.
- Inequalities in health, covering variations between population groups of the determinants of health, morbidity and mortality, and assessment of interventions to reduce them. Analyses would also cover issues of access to health services, their use and health outcomes.
- Other topics would be the interaction between health status and socio-economic factors such as social exclusion, migration and employment, and between health status and environment.

Health Systems

47. The following areas could be covered:

- The impact of trends in health status and health determinants on health services and interventions and health expenditure, such as changes in patterns of prescribing pharmaceuticals, and the consequences of demographic trends, notably the ageing of the population.
- Developments in health systems, including reforms, distribution of resources and cost containment measures and their consequences, including their impact on health status.
- Trends in health systems' costs and financing, including the role of state and private insurance.
- The health sector as a productive factor in society, including its role as a major employer. Studies might be made e.g. on the impact of market mechanisms, measurement of needs for services; costs and expenditure calculation and control; competition between private and public provision and trends in managed care.
- Priorities in health, including priority-setting mechanisms, as well as public attitudes and concerns about health and the effectiveness of health systems.

48. A major emphasis within the information strand covering both health status and health systems would be placed on best practice in health care, i.e. the current best evidence as regards the safety, efficacy, effectiveness and cost-effectiveness of different approaches to health promotion, prevention, diagnosis and treatment; for instance the cost-effectiveness of screening programmes, health education programmes, emergency services and new pharmaceutical products. The work would aim to promote and bring together activities in the Member States in the fields of evidence-based medicine, quality assurance and improvement, appropriateness of interventions, and health technology assessment. Co-ordination of work in these fields would be supported and set on a formal footing in order to pool the expertise of the centres in the Member States, to gather and exchange information, stimulate international studies, and improve the dissemination of findings.

49. Another cross-cutting theme would be the impact of developments in the Community and of Community policies and actions, including social protection of

migrant workers and people moving within the Community; the utilisation of research findings; the application of technology, the use made of structural funds; the completion of the single market and the introduction of a single currency; and the consequences of the application of other Community legislation, in areas such as health and safety, pharmaceuticals and medical devices, free movement of health professionals and competition. Moreover, specific attention would have to be paid to obtaining information and providing analysis and guidance relevant for the enlargement process.

50. To be fully effective such a Community system and its components should ultimately be based on appropriate networks to which Member States would be committed to contribute in respect of the collection, processing and transmission of data, and in relation to taking into account the results of the analyses and evaluations. Moreover, reporting on the follow-up to any recommendations that might be adopted would be essential.

51. A Community system of this kind would offer several major advantages: the data collected would be comparable, comprehensive, up-to-date and of high quality; the information would be validated; and the outputs of the system would be linked to the development and implementation of policy. It would therefore be different from the various information and reporting systems that now exist, such as those created by WHO and OECD.

6.2: *Strand 2: Reacting rapidly to threats to health*

52. A second strand should be the creation of a Community surveillance, early warning, and rapid reaction capability. There have been recent examples of outbreaks of disease such as plague, haemorrhagic fevers and avian flu which have required urgent consultations and action at Community level. This strand of action would involve having a capability which would be available to deal with future outbreaks. It would enable quick and appropriate responses to be given to threats to health which might arise at any time. This would involve co-ordination mechanisms at Community level. Actions to be undertaken would include surveillance, swift analysis and investigation of specific problems or issues, including site visits, if appropriate. The aim would be first to identify the hazards and evaluate the likely consequences in health and other policy terms; and, second, to determine whether and, if so, what action was needed to manage health risks and to communicate information to health authorities and more widely, as appropriate.

53. In 1996, the Commission put forward a proposal for a European network for communicable disease surveillance and control¹⁵. It will provide a framework which will enable the Community and Member States to take a co-ordinated approach to surveillance and control of outbreaks. For the network to function effectively requires the Member States to make a commitment that the relevant surveillance and response organisations and authorities in their countries will co-operate fully in the operation of the network. The proposal is currently being discussed by the Council and the European Parliament, and it is hoped that it will be adopted in the near future. This

¹⁵ see footnote 11

network could provide a model for further Community mechanisms. In addition, the Commission's proposal for a rare diseases programme,¹⁶ which is currently under consideration, includes actions on handling clusters of cases of rare diseases which could be carried forward in this broader context.

54. The subject matter of this strand of action could be further extended to cover, besides communicable and rare diseases, health requirements in food safety issues, phytosanitary and veterinary matters, zoonoses, blood and organ safety, environmental hazards, risks to health from chemical substances and poisoning, and adverse effects of medicinal products and devices. In addition, there might be a role in helping to provide a rapid response to concerns about the health claims of new products or procedures. This strand would also allow appropriate responses to the challenges faced by the accession states.

55. In a number of these areas, such as food safety issues and veterinary matters, there are already Community early warning and rapid reaction systems in place. Therefore, any further work that might be developed on these areas within this strand would have to link up with these systems and take them fully into account.

56. The work undertaken should make use of the best advice, including that of the experts working with the Community under the scientific advisory committee structure, as well as expertise in international organisations and third countries. The task is to provide information and advice within a very short time scale. Most important, these activities must have the full backing and co-operation of the relevant authorities in the Member States.

6.3: Strand 3: Tackling health determinants through health promotion and disease prevention

57. While Article 129 of the Maastricht Treaty emphasises the prevention of disease, particularly the major health scourges, the Amsterdam Treaty stresses that Community action shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. In the light of this, policy in this strand should aim at improving health determinants through health promotion as well as effective actions on disease prevention.

58. Health promotion aims at enabling people to increase control over the determinants of health and thereby to improve their health. It encompasses actions aimed at strengthening individuals' skills and capabilities and those directed at changing social, economic and environmental conditions so that they are conducive to individual and public health. Disease prevention is equally important. It includes many activities, such as vaccination, safety precautions and rules, screening and testing of target populations.

59. Reflecting the weight given to prevention in Article 129, six of the eight public health programmes proposed are concerned with prevention of diseases and injuries.

¹⁶ COM(97)225 final of 26.5.97

60. The new policy must make provision for tackling health determinants, both through broad health promotion activities and by specific disease prevention actions, and should be underpinned by inter-sectoral action and the possibilities for instruments offered by the Treaty, not only in the health field but also in other sectors. The precise contents of this strand, such as the determinants to be addressed, the disease-specific actions to be taken and the health promotion priorities, needs further consideration. The basic issue is how far the existing actions reflect trends in health and changes in the pattern of disease.

61. Among the questions to be considered are the following:

- how greater emphasis can be given to addressing conditions which are becoming ever more important as a result of the ageing population, notably Alzheimer's disease and other mental disorders;
- how work on nutrition and obesity can be strengthened;
- whether more stress should be put on cardiovascular diseases;
- how the new Treaty provision on reducing drugs-related health damage should be implemented;
- whether there should be a greater focus on the health of specific population groups, such as the socially excluded, young people and children, or women;
- how access to health information and health advisory services can be assured for Community citizens as they move to other Member States for work, study or leisure, and how to reinforce partnerships with education and training institutions; and
- how strategies should be adapted to take the specific problems of accession countries into account.

62. Leaving aside the detailed contents of this strand of action, two conclusions can be drawn about its structure and objectives. First, there seems little benefit in continuing to split promotion and prevention actions into a number of separate programmes. Bringing actions together in a coherent manner and thoroughly evaluating them within a single framework would make better use of resources. Secondly, the existing balance between actions on disease prevention and on health promotion, and the resources devoted to them, will need to be modified.

63. Consideration must also be given to a number of questions arising from the practical experience of implementing the existing framework:

- should activities be primarily aimed at the general public, specific target groups, health professionals or specialist organisations?
- should projects be mainly solicited through open calls for proposals, or by using specific calls for tender, in particular in response to policy considerations?
- should the emphasis be on large-scale activities involving all Member States, or on small, region- or locally based activities?
- should more emphasis be given to long-term sustainable projects likely to result in the setting up of lasting structures?

64. One conclusion already emerging is that more weight should be placed on actions that support the development and implementation of policy, including those related to devising and testing intervention strategies and methodologies. Such work would need to be informed by the results from the Community health information system. Research findings on e.g. best practice and effectiveness of interventions, disease causation and the impact of determinants on health need to be speedily disseminated so that they can feed into this strand. Co-ordination between health research projects and promotion and prevention will thus be required. Similarly, work will be needed analysing the impact of other policy areas on health-related behaviour and attitudes.

6.4 The impact of Community policies on health

65. The Commission has developed a set of procedures in response to the Treaty obligation that 'health protection requirements shall form a constituent part of the Community's other policies'. These include measures to ensure that the Commission services in charge of public health are consulted on all health-related proposals; the setting up of the Interservice Group on Health to provide a forum for discussing major health-related issues among Directorate Generals, and the preparation of annual reports on the integration of health requirements in Community policies.

66. It has not however proved easy to implement the Treaty obligation to keep a 'health watch' on all areas of Community policy, or to develop and apply an adequate methodology. The new Treaty Article underlines that a high level of human health protection shall be ensured in the *definition and implementation* of all Community policies and activities. The action strands described would enable the Treaty requirement to be complied with more effectively in several complementary ways:

- Community policies and large-scale multi-annual programmes, such as research, structural funds, education, training and youth, transport policy, food policy, agricultural policy, competition and industrial policy, which can have a significant long-term impact on health determinants, health status and health systems could utilise the information base developed under the information system. This could involve an appraisal of the policy or action before its adoption. During implementation, a policy or action could be closely monitored; and afterwards its impact could be the object of an in-depth and, if appropriate, independent evaluation.
- Specific measures and actions relating to fast-emerging risks to health would fall within the remit of the rapid reaction mechanisms. Issues in this field could include legislative instruments on public health aspects of food safety, veterinary and phytosanitary measures, etc.
- Particular measures and actions influencing knowledge, attitudes and behaviour, such as developments relating to tobacco, alcohol, drugs, nutrition and advertising would be scrutinised and assessed within the health determinants strand.

67. The precise instruments to be created to carry out the various activities identified will require further consideration. It may be necessary, for example, to develop sets of criteria and specific methodologies, such as appraisal guidelines and checklists,

against which developments in any health-related policy could be measured. Such instruments could also be used to assess the impact of public health activities.

7. The Way Forward

68. The Commission considers that there must be debate both on the ideas for a future policy presented in this document, and on how the policy should be put into effect. A central issue is the nature of the legal mechanisms to be used to ensure that the policy effectively combines incentive and legislative measures provided for in the new Treaty. Provisions must be made for the transition from the present programmes and legal instruments to a new policy. Several factors make this a very complex issue: the existing public health programmes each have their own legal decisions and expire at different dates; three draft action programmes have not yet been adopted; the Community resources available to public health actions are attached to the existing action programmes; actions under the existing and proposed programmes that would continue under the new policy will have to be re-grouped and allocated funding which reflects their relative importance; finally, the proposed network on the surveillance and control of communicable diseases will have its own legal basis.

69. There are two possible ways to formalise the new policy. One would be to adopt a single 'framework instrument' providing for the subsequent adoption of separate ones for each strand. This would have the advantage of creating a single financial envelope and of apportioning funding between the strands, but the disadvantage of requiring two layers of decision-making and administrative structures. The other option would be to adopt a separate legal instrument for each strand with no overall instrument. This would need an implicit consensus on the funds to be allocated to each.

70. Whichever option is chosen, there must be some flexibility in tackling unforeseen problems and in allocating resources between the strands of action. There should also be scope for the introduction of binding provisions governing, for example, the collection of data, once the networks and other structures envisaged have been developed and are fully in place. Moreover, in the areas singled out by Article 152 and other health-related articles in the Treaty of Amsterdam for harmonisation measures, the Community would be able to adopt binding instruments regardless of the programme structure or funding mechanism.

71. The work programme(s) agreed in the different strands of action could vary year on year, as appropriate. This kind of approach would enable the overall aims, scope and structure of the Community programmes to be clearly set out, within defined limits, while introducing some element of flexibility over their content.

8. Conclusion

72. This communication does not put forward formal proposals for a new Community public health policy. Instead its aim is to give an overview of issues that must be addressed in determining the future direction of the policy. The Commission has concluded that in order to build on what has been achieved, while taking proper account of the trends in health and the changing situation in the Community, a new public health policy is required. The Commission intends to come forward with concrete proposals for the new policy in due course once the Treaty of Amsterdam has been ratified. In the meantime it is hoped that the ideas presented in this communication will stimulate a broad debate on the way that Community public health policy should go forward into the next millennium.

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