



15TH European
Conference
on Public
Health

The Future
of Public Health
in the Unified
Europe

Conference proceedings

Anna Alanko, Hannamaria Kuusio & Ilmo Keskimäki (eds.)



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CONTENTS

1	Introduction _____	3
	<i>Ilmo Keskimäki</i>	
2	15th European Conference on Public Health: Notes from the local organisers _____	5
	<i>Hannamaria Kuusio</i>	

PLENARY PRESENTATIONS

3	How do we respond to European and global health inequalities? A view from within the WHO Commission on Social Determinants of health _____	8
	<i>Denny Vågerö</i>	
4	De-centralization, Re-centralization, and the Likely Future Structure of European Health Systems _____	9
	<i>Richard Saltman</i>	
5	Policy, polity, research and the music of the SPHERES: The SPHERE Project and some of its implications _____	10
	<i>Aileen Clarke</i>	
6	Future challenges in health promotion _____	11
	<i>Pekka Puska</i>	
7	The future of public health in a unified Europe? _____	12
	<i>Martin McKee</i>	

ACTIVITIES OF THE EUPHA SECTIONS

8	Public health, practice and policy _____	14
	<i>Natasha Azzopardi Muscat</i>	
9	Public Health Epidemiology _____	16
	<i>Giuseppe la Torre</i>	
10	Health Promotion _____	17
	<i>Heiko Waller</i>	
11	Injury prevention and safety promotion _____	19
	<i>Johan Lund</i>	
12	Public Mental Health _____	21
	<i>Jutta Lindert & Gunnar Tellnes</i>	
13	Social Security and Health _____	22
	<i>Kristina Alexanderson, Peter Donceel & Sören Brage</i>	
14	Health services research and quality of care – a summary of events that presented research in the field of health services research _____	24
	<i>Tit Albrecht</i>	
15	Infectious Disease Control _____	26
	<i>Dieuwke Vos & Ruth Gelletlie</i>	
16	Chronic Diseases _____	28
	<i>Iveta Nagyova</i>	
17	Public Health Economics _____	30
	<i>Maarten Postma</i>	
18	Children and Adolescent Public Health _____	32
	<i>Auke Wieggersma</i>	
19	Migrant Health _____	34
	<i>Walter Devillé</i>	
20	Food and Nutrition – Lessons learned from the workshop on Healthy Nutrition and the Educational Environment _____	37
	<i>Enni Mertanen</i>	
21	Public Health Ethics _____	39
	<i>Els Maeckelberghe</i>	
22	Public Health Genomics – National Task Forces of the Public Health Genomics European Network: shaping the future of Genomics and the Populations' Health in the Unified Europe _____	40
	<i>Angela Brand</i>	

WORKSHOPS

23 Health in All EU policies _____	44
<i>Eeva Ollila</i>	
24 Health inequity as a challenge in the WHO European region _____	45
<i>Eero Lahtinen</i>	
25 Health Shocks in Eastern Europe – Why Did They Take Place and Have They Been Overcome? _____	48
<i>Hannele Palosuo</i>	
26 Northern dimension partnership in public health & social well-being _____	51
<i>Mikko Vienonen</i>	
27 Health Inequities in Roma Minority Populations: Program and Research Findings _____	54
<i>Dineke Zeegers Paget</i>	
28 Results from SPHERE: a European collaborative study _____	55
<i>Mark McCarthy</i>	
29 Working towards comparable European health system information – The working party on health systems of DG Sanco: the current state of health system indicators development in Europe _____	58
<i>Dionne Sofia Kringos & Walter Devillé</i>	
30 Public Health Programme of the Community – Report on the workshop planned and conducted in collaboration with Health and consumer Protection (DG SANCO) and Public Health Executive Agency (PHEA) _____	61
<i>Vaida Bankauskaite, Guy Dargent, Daniel Mann, Cinthia Menel Lemos, Katarina Solovievova, Ann Thuvander & Stephan van den Broucke</i>	
31 Regional health indicators and the ISARE project – making a difference _____	65
<i>André Ochoa & John Wilkinson</i>	
32 Results from three years of ‘building bridges between research and practice’ at the local and regional level in the Academic Collaborative Centre Tilburg, The Netherlands _____	66
<i>Henk Garretsen & Hans van Oers</i>	
33 Health impact assessment in new member states and accession countries _____	68
<i>Gabriel Gulis</i>	
34 EUnetHTA – European network for HTA _____	69
<i>Kristian Lampe</i>	
35 Utilisation of medicines and primary care. A challenge to public health _____	70
<i>Pietro Folino Gallo, S. Montilla & R.A. Verheij</i>	

HEALTH PROMOTION – COMMUNITY INTERVENTIONS

Community interventions – do they work? _____	74
<i>Antti Uutela</i>	
What constitutes evidence in community interventions? _____	75
<i>Arja Aro</i>	
Economic consequences of community interventions _____	77
<i>Urpo Kiiskinen</i>	
Workplace Health Promotion: Does it make a difference? _____	78
<i>Ása Ásgeirsdóttir</i>	

FUTURE OF THE ORGANISER

Reorganisation of EUPHA _____	82
<i>Walter Ricciardi</i>	
About the editors _____	84

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1 Introduction

The 15th European Conference on Public Health was held on October 11–13, 2007 in Helsinki, Finland. This publication is published in order to remind the Conference participants, European public health community and other readers about the achievements of the Conference in terms of the exchange of ideas, knowledge and experiences. Of course, the publication will not give a comprehensive report on the content of the Conference, but the purpose is rather to highlight the main themes and topics that surfaced during the three days of the Conference.

In the 15 years of its history the European Conference on Public Health has develop from a small conference of 216 participants to a major European public health event which is gathering around 1000 public health experts every year. From the small Conference beginnings has developed an excellent opportunity to learn about what is going on in European public health.

The overall theme of the 15th European Conference on Public Health was “The Future of Public Health in the Unified Europe”. For the organisers, the theme pointed up the starting point for the Conference organisation, which was stated in the first announcement of the Conference as follows: “We live in a unified Europe, interdependent and dependent on global trends. No matter how divergent or convergent our opinions and convictions are, we face the same public health challenges and together we will shape the future of the populations’ health”.

Considering the early foundations of the Conference, launched as a major part of the activities of the European Public Health Association (EUPHA), I am convinced that the Conference theme expressed rather well the ideals of the Societies who convened in Paris fifteen years ago to found the European Public Health Association as an umbrella organisation for their joint activities. In the beginning of the 1990s, historical

changes in Europe had created a great opportunity for establishing concrete and progressive European-wide collaboration in the field of public health.

As mentioned, the European Conference on Public Health has been a success story. While its participation has grown and the scope of the Conference has widened, it can now be considered to cover broadly all fields of public health. The Helsinki Conference also experienced its share of the success. The Conference received once again more abstracts than in previous years. In my mind the quality of the abstracts and presentations have developed, which gave us good grounds to increase the number of parallel sessions and poster presentation in comparison to earlier years.

Another sign of the success story is that the Conference has gained many partners who are willing to contribute to the Conference program. As in earlier years several European projects considered the Conference as a good opportunity to report their results to the public health audience. The same judgement has been made by organisations collaborating with EUPHA in the organisation of the Conference. In the Helsinki Conference, EUPHA continued the excellent collaboration of several years with the European Commission, including DG SANCO, the Public Health Executive Agency (PHEA) and DG Research, and WHO and its Regional Office for Europe including the WHO European Observatory for Health Systems and Policies.

The structure of the programme in the 2008 European Conference on Public Health in Helsinki followed the pattern of earlier Conferences. The plenary presentations focused on the different aspects of the main theme of the Conference. The main body of the programme, giving a snapshot of European public health in 2007, consisted of parallel sessions and workshops that were based on abstracts and workshop proposals submitted for the Conference. The third pillar was satellite semi-

nars, expert meetings and training events organised in the context of the Conference by EUPHA sections and collaborators. The Conference offered abundant choices for the participants to define their own EUPHA Conference according to their interests.

Like the Conference participants, the editors of this publication have also had some choices to make. First, we wanted to remind the readers about the theme of the Conference by giving short summaries of the plenary presentations. The Conference was successful in recruiting renowned speakers to reflect on the future of European public health in terms of key issues in the topic, such as the future of research, health care sys-

tems, and health promotion. The next part of the publication comes from the EUPHA Sections, which were asked to describe the work and achievements of the Conference from their point of view, thus signalling European progress in their own field of public health. In the Conference, workshops are organised according to evaluated proposals from the members of EUPHA and wider European public health community. The workshop section gives summaries of these workshops. And finally we wanted to cast a brief glance towards the future of the main organiser of the Conference, the European Public Health Association (EUPHA), which is in the middle of a reorganisation.

HANNAMARIA KUUSIO

Conference Manager

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Helsinki, Finland

2 15th European Conference on Public Health: Notes from the local organisers

The 15th European Conference on Public Health organised in Helsinki, Finland, on October 11–13, 2007, gathered altogether 959 registered participants from 52 countries. The venue, the Finlandia Hall, offered an excellent working environment for the Conference. The largest conference delegations came from Finland (180), the Netherlands (109), Sweden (68) and the United Kingdom (65). According to the delegate survey and other feedback received during the conference, participants have been mainly satisfied with the scientific programme and practical arrangements of the conference.

Local organising committee

The European Public Health Association had mandated the 2007 conference organisation to its Finnish member association the Society for Social Medicine which organised the Conference in collaboration with three major Finnish public health research institutes: the National Research and Development Centre for Welfare and Health (STAKES), the National Public Health Institute (KTL) and the Finnish Institute of Occupational Health (TTL). In addition, the Local Organising Committee included representation from major public health institutes, universities non-governmental organisations, and the City of Helsinki.

Programme

The core of the Conference programme was based on submitted single presentation and workshop abstracts. The number of abstracts totalled 675, coming from 52 different countries. Most of the submitted abstracts were offered for oral presentations (464). The EUPHA International Scientific Committee accepted 186 abstracts for oral presentations and 300 poster abstracts for the Helsinki conference, which is a record for EUPHA conferences. Altogether, the Conference accom-

modated 66 sessions in 11 parallel tracks. In addition to the accepted presentations, the Conference offered 12 extra and early bird meetings. These meetings were organised in collaboration with EUPHA Sections and EUPHA partners and collaborators, such as the EU Public Health Executive Agency, the WHO Regional Office for Europe, the WHO European Observatory for Health Systems and Policies, and the US Centres of Disease Control and Prevention.

The Conference offered a platform for an abundant choice of satellite seminars, expert meetings and training events. Pre-conference events included a health service research training seminar "Comparative research designs in the study of health care systems". An expert workshop evaluated population-based approaches in health promotion. Of the EUPHA Sections, the Social Security and Health and Migrant Health Sections organised full-day pre-conference seminars. The seminar of the Migrant Health Section focused on methodological issues in migrant research and introduced the latest results from Nordic migration research. The EUPHA Sections on Mental Health and Injury Prevention & Safety Promotion organised a joint seminar exploring the psychological impacts of unintentional and intentional injuries and violence.

On Thursday morning, the Conference hosted a Round Table on Vaccination Policies in the Unified Europe; "Ensuring timely access to public health interventions for European citizens" organised jointly with Sanofi Pasteur MSD.

EUPHA prizes

The best EUPHA abstract prize was awarded by the International Scientific Committee this year to two abstracts: to Dr. Peter Schröder-Bäck from Germany for his abstract "Comparing regional health management of measles, breast cancer and diabetes (type II)" and

to Dr. Sheikh Muazzam Nasrullah from Pakistan for his abstract "Assessment of health and safety problems of carpet weaving children in 3 districts of Punjab, Pakistan".

During the Conferences the participants were able to vote the Best Poster Prize for 3 posters, The Prize was awarded in the closing ceremony of the Conference to Dr Damjana Podkrajsek from Slovenia from the Institute of Public Health in Celje for the poster "To sem jaz – This is me!". The Ferenc Bojan Memorial Abstract-prize went to Dr. Mindaugas Stankunas for the abstract

"Unemployment and suicidal intents: results from a cross-sectional study in Lithuania".

On behalf of the local team, we would like to thank everyone so much for their support and contributions to the recent 15th European Public Health Conference in Helsinki, the first such congress to be held in Finland. Special thanks to the keynote speakers, workshop chairs, chairs, EUPHA Section Presidents, authors, the scientific committee and finally, last but not least, a warm thank you to all the participants

PLENARY PRESENTATIONS

DENNY VÅGERÖ

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3 How do we respond to European and global health inequalities? A view from within the WHO Commission on Social Determinants of health

Between 1950 and 2000, average life expectancy on Earth increased by about twenty years, while at the same time the global population doubled. Global economic growth has helped to improve global health on average, but in important parts of the world this is no longer the case. Segments of the world population are falling increasingly behind. In fact global, regional and national inequalities in life expectancy have persisted or grown during the last 10 to 15 years. Europe is also part of the problem. In Europe, differences in life expectancy between countries have been widening, as they have also between groups within most European countries.

Can we (and do we want to) manage things so that all peoples and all countries can share whatever is achieved as part of progress? A whole network of

international organisations, including the international academic community, are engaged in monitoring global trends, global problems and global crises, based on the assumption that problems must be solved by joint action and with the participation of all. The UN system and the World Health Organisation are key actors in this. Both need to be reformed to fulfill their roles. One of the key strategies for improving health is to focus on the social determinants of health, that is, on the circumstances in which people grow, live, work and age. Thus, social and economic policies may be as important as the provision of medical services for health and development. The Commission on Social Determinants of Health, set up by WHO in 2005 will deliver its final report and recommendations in the spring of 2008. The conclusions we have drawn so far will be reported and discussed.

This abstract has been previously published in the *European Journal of Public Health* (EJPH) 2007 Supplement 1

RICHARD SALTMAN

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4 De-centralization, Re-centralization, and the Likely Future Structure of European Health Systems

De-centralization has long been viewed in Europe as a cornerstone of good health policymaking. It has been considered essential in promoting such key health system outcomes as greater responsiveness to local needs, better management of provider institutions, and greater fiscal efficiency. Yet recent policy decisions in Nordic countries including Norway, Denmark, and Sweden, as well as in Central Europe in countries like Poland, suggest that a counter-trend toward re-centralization is underway. Political and fiscal responsibilities

are being re-allocated from regional to national government, and administrative responsibilities are being placed in substantially larger regional bodies.

This presentation explored the shifting balance between de-centralization and re-centralization across European health care systems. It examined the various types of changes underway, the factors that appear to be driving those changes, and the likely implications for health policy and public health in the future.

This abstract has been previously published in the *European Journal of Public Health* (EJPH) 2007 Supplement 1

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5 Policy, polity, research and the music of the SPHERES: The SPHERE Project and some of its implications

In the SPHERE project (Strengthening Public Health in Europe), partners mapped research evidence and described mechanisms for funding and supporting research across Europe. SPHERE showed that Europe is a major global contributor of public health research, and SPHERE now provides a rich resource of knowledge about public health research in Europe. Maintaining and improving public health is vital for the health and wealth of the citizens of Europe. We know that public health research has supported measurable health improvement for European citizens in many ways. But how do these advances happen? SPHERE also demonstrated some worrying issues. Desirable links between ministries of health and public health research funding and training organisations do not necessarily exist either at national level or at international level.

Put yourself in the position of a busy policy maker. Votes, elections and strategies to maintain your popu-

larity must be high on your agenda. NGOs, lobbyists, industry, your own voters and advisors and professionals vie with each other to get “ear time.” How can you possibly listen to researchers or implement change? Some good short nuggets of practicable advice (interventions that work) may be what you want. But how do you know whom you can trust, when all researchers do is tell you what the problems are, and that more research is needed? Drawing on the findings of SPHERE, it is clear that a new kind of approach to organising public health and health care knowledge systems at national and international level may be needed to stimulate new approaches (policy-friendly, policy-aware, researchers and research friendly, research-aware policy makers). This talk will draw on the findings of the SPHERE project and, looking at the chances of harmony between the policy and research worlds; it will ask the question “when will we hear the music of the spheres?”

PEKKA PUSKA

Director General, National Public Health Institute (KTL),
Helsinki, Finland

6 Future challenges in health promotion

Although forecasting the future is difficult, it is easy to see many future challenges for health promotion. With increases in the material standard of living, immaterial values – such as health, the environment and quality of life – become increasingly important and of increasing public interest. At the same time inequalities in health have become a great challenge. Globally the poorest countries of the world are very deprived, and within most populations there are substantial health differences between SES groups.

As to health problems, globalization means that infectious diseases can spread across borders easier and quicker than ever. At the same time, the world is preparing responses to biothreats more than ever. Since public health is in most countries overwhelmingly dependent on chronic diseases, their prevention through risk-related lifestyles in the population is also increasingly linked with global influences.

A major challenge is to emphasize the basic role of national governments for public health – in the situation where public expenditures are tight and the role of governments often somewhat diminished. The private sector has an increasing impact on public health. Marketing often supports unhealthy consumption patterns; at the same time the private sector can increasingly base their business on health aspects. The role of the civil sector, including that of the NGO's, is increasing, which is basically supportive of positive health developments.

Traditionally national health policies are much occupied with questions on how health services are organized to people. However, people are increasingly making their own choices concerning the enhancement of their health options. This coincides with technological development. People search the internet for health information while innovative and increasingly personal-

ized IT solutions are developed and marketed in the health field.

Because health promotion and disease prevention in the population largely targets general lifestyles, attention is drawn to the determinants of lifestyles. WHO has appointed a high-level Commission on Health Determinants. Its report next year will most certainly increase the international attention on these aspects. At the same time as successful health promotion must understand the broad determinants of health, successful practical health promotion must pay particular attention to determinants of change.

During the last few years numerous national and international programmes and plans have been prepared in the field of health promotion and disease prevention. In the future, more attention will undoubtedly be paid to the question of implementation, i.e. how to implement the many good plans. In addition to doing the right things, it is important to do enough – i.e. the “dose of intervention”; practical resources and organizations will be central. Successful actions should combine strong, dedicated leadership with broad partnership and collaboration.

Discussion on health promotion challenges usually deal with the needed health policy actions or, involves health in all policies, as was the health theme of Finland's EU Presidency. This is because of the emphasis on promotion of healthy physical and social environments. “Make the healthy choice the easy one” is the common slogan. Attention to political decisions means attention to political decision-making, i.e. how to influence it. Although national arguments and evidence-based planning have important roles, ultimately mobilizing people is the key to social change, including healthy political policies and healthy developments in the private sector.

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MARTIN MCKEE

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7 The future of public health in a unified Europe?

The theme of this conference is the future of public health in a unified Europe. For the past 17 years, the words “unified Europe” have signified a closing of the gap between East and West. I will argue that it is now time to move beyond this view. The population of Europe can be divided in many ways. Most obviously, we include different nationalities, but also different genders, income levels, ethnicities, religions, age groups, health statuses, and family structures, among many other factors that can be used to divide us. The European post-war settlement has been based on a system of solidarity that redistributes our common resources among these groups, a model that is markedly different from that of the USA. For example, both social insurance and tax-funded health systems are based on the principle that the wealthy, young, and healthy should support the poor, old, and ill. Perhaps because of the shared hardship in the 1940s, this model has had a high level of acceptance. Will this be the case in the future, as memories of those times fade? Will future generations be more individualistic, especially when asked to help those who, because of their skin colour or religious dress, are visibly different from them?

The warning signs are already apparent, most obviously in countries that are facing large scale inward

migration for the first time. Will our children be willing to pay for our generation, especially when they realise that that we have paid for our wellbeing by transferring the cost to our children, through unfunded pension schemes and complex financial instruments such as private finance schemes? Will the rich countries of Europe still be willing to pay to close the gap with the poor ones, as they did for Spain, Portugal and Greece, but may be more reluctant to do if the EU expands further eastward? And even if there is little further expansion, how will they support the EU’s immediate neighbours? In short, will we return to the situation described by Benjamin Disraeli, a 19th century British Prime Minister, who observed “Two nations between whom there is no intercourse and no sympathy; who are as ignorant of each other’s habits, thoughts, and feelings, as if they were dwellers in different zones, or inhabitants of different planets. The rich and the poor.”

This paper is a warning of the cost to us all of allowing this to happen. As John Donne reminds us “No man is an island, entire of itself...any man’s death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee.”

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**ACTIVITIES OF
THE EUPHA SECTIONS**

NATASHA AZZOPARDI MUSCAT

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8 Public health, practice and policy

During the Helsinki meeting the EUPHA Section on Public Health Policy and Practice was involved in the organization of two workshops reflecting the key conference theme, as they made reference to the European dimension of public health, more specifically the role of the European Union in health and health systems policies.

Scientific programme activities

The EUPHA reflection on the plenary presentation by Prof Vägerö on Socio-economic determinants of health firmly emphasized that it will not be possible for major health improvements to take place in Europe and outside Europe unless our attention is clearly focused on the reduction of health inequalities. EUPHA can play a role in assisting to keep the topic of socio-economic determinants of health and reduction of health inequalities firmly on the European agenda in the years to come.

The workshop, jointly organized along with the EUPHA Section on Health Services, sought to provide an overview of the current developments in European Union policies with respect to health services. The representative from the European Commission, DG SANCO, outlined the scope of the Commission's work in the area of health services and presented the main feedback results from the consultation process, which took place during 2006. The representative from the European observatory on health systems and policies shared the processes and outcomes from the impact assessment carried out on the cross border services initiative. The impact assessment brought together independent experts in four different workshops to examine the main areas on which the initiative could impact and provide solutions to minimize or avert negative impacts and support and build on possible positive impacts. The representative from the EUPHA Section on Public Health Policy and Practice focused specifically on some of the

problems and benefits that would be experienced by small member states and remote communities. The representative from the Section on Health Services discussed the equity, quality and sustainability impacts on countries with several bordering neighbours. The fruitful discussion that ensued highlighted the fact that several stakeholders remain unconvinced of the additional benefits of European legislation in this field. The tensions between the responsibilities of member states and the European Union were discussed. It was agreed that cross-border health services do provide several benefits if carefully planned and organized. The free market approach to "shopping around" for health care across Europe was seen as something that could be dangerous in the long-term for patients and system sustainability. It was however agreed that once the European Court of Justice had bestowed certain rights to European patients, member states would need to find mechanisms to implement these rights appropriately and a minimalist overarching EU legislation would provide a common platform for all member states within which to work.

The Section collaborated with the Finnish Research and Development Centre for Welfare and Health (STAKES) in organizing a workshop on Health in all Policies: Challenges and Potentials. Specifically, a presentation on health and the strategic objectives of the EU was delivered. The presentation put forward a framework for analyzing whether EU policies are synergistic and compatible with public health priorities. It was postulated that in policy areas such as environment and social policy, health objectives have traditionally been mainstreamed in EU policies and activities. There are areas such as regional policy and research where health is rapidly rising up the agenda, notably seen in the application of structural funds and health being included as a main area in the Research frame-

work programme FP7. On the other hand, there are policy areas where the EU objectives at times do run counter to public health objectives and priorities. Areas identified include alcohol and food policies, pharmaceutical policies and economic policies, such as the convergence criteria or the rules on State Aid that make it increasingly difficult to increase public funding in the health sector.

There were several other workshops and sessions that tackled policy and practice issues. Results from the SPHERE project were presented in a dedicated workshop as well as a plenary presentation. There were innovative workshops that discussed issues such as public-private partnerships and the policy process that is driving new service developments such as the introduction of the HPV vaccine. The presentations for the EU-funded project on Policy Impact Assessment of Public Health Reporting also yielded interesting and applicable information. The feedback obtained from these sessions was very positive and it appears that such sessions are welcomed by the EUPHA participants and should be promoted in future conferences.

Section outlook

An active discussion on the Section, its existence and future activities took place during the annual Section meeting. The need for this Section was questioned in

view of the fact that the reorganization of EUPHA requires policy and practice to permeate throughout the work of all the Sections. It was finally decided that EUPHA at present is predominantly focused on research, and there is still a need for this Section in order to keep the policy and practice focus on the agenda so as to further stimulate EUPHA activities in this area. Overall the meeting participants felt that more needs to be done to attract practitioners to participate in the EUPHA meetings. It was agreed that the practice stream should not be "marginalised" or developed in parallel but there should be a policy / practice dimension throughout the sessions and the workshops as this will allow cross-fertilisation of ideas between researchers and policymakers / practitioners. It was felt that EUPHA conferences should be promoted amongst senior people within Ministries as well as practitioners working in the field to further develop EUPHA's role and relevance as a policy partner at European and global level. It was also proposed that an extra meeting at which persons from the Governing council and the Sections should be able to attend as well as EUPHA activists should be held in Lisbon to analyse the current strengths and weaknesses of EUPHA in relation to the development of the policy and practice elements with proposals for future opportunities and developments to be made.

GIUSEPPE LA TORRE

Assistant Professor of Hygiene

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9 Public Health Epidemiology

At the 15th EUPHA conference in Helsinki the Section on Public Health Epidemiology organised a workshop entitled “The Role of Public Health Epidemiology in the Health Technology Assessment”. This was chaired by Paolo Villari, Alastair Leyland and Giuseppe La Torre.

The key idea that inspired the workshop was that health systems in developed nations have to contend with the growing spread of chronic diseases whilst the provision of a high quality, efficacious and efficient service remains the principal aim. The specific aim of the workshop was to give an overview of the framework of Health Technology Assessment (HTA) and how HTA has changed over time (Renaldo Battista) as well as the possible relationship between HTA and Epidemiology (Walter Holland).

The primary objectives of public health are the improvement of community health, the reduction of population health risk factors, and the improvement of health care provision. But an emerging problem in public health is the limited nature of resources, which contrasts with the diffusion of new technologies and the growth of health needs due to population aging and uptake of less healthy lifestyles.

Public health interventions are designed to control, prevent and reduce health problems, such as obesity, sexually transmitted diseases, and road and domestic injuries, and also to decrease the burden of chronic-degenerative and infectious diseases. This means that epidemiology has a fundamental role in giving the process the appropriate methodological approach. As such the link and the relationship between Public Health Epidemiology and HTA would appear to be a good tool to provide answers not only regarding the burden of disease in a certain population and the efficacy and effectiveness of health technology, but also concerning the social and organisational impact of a technology, seen in a broader sense, and so is a prerequisite for economic evaluations and systematic reviews. The relationship between Public Health Epidemiology and HTA could, for example, encompass issues such as vaccinations, disease screenings, health promotion and educational campaigns.

Renaldo Battista, in his presentation “Health Technology Assessment and Public Health: a time for convergence”, pointed out that HTA is a field of application of several disciplines at the core of Public Health Science. Whereas the development paths of HTA and public health are distinct, a shared interest in knowledge translation underscores the need to bolster convergence between them. Different scenarios of convergence are examined at the conceptual, disciplinary, methodological, and organizational levels. The future of health systems and population health will both benefit from greater harmonization between public health and HTA.

“Public Health Epidemiology in Health Technology Assessment: risks and opportunities” was the theme tackled by Walter Holland. Formal evaluations of procedures and equipment have become the norm in most health services, particularly for pharmaceutical agents. However, they should also be applied to the assessment of methodologies used on populations for health promotion and disease prevention. There are examples of HTA for the evaluation of screening, e.g. for breast cancer, in France and in the UK. In Sweden, formal HTAs have been applied to polio vaccination and water fluoridation. However, in most countries HTA has largely been concerned with individual clinical care rather than population (public health) subjects.

The discussion dealt with historical examples of HTA for health improvement, for example the assessment of measures to reduce maternal mortality, the introduction of the Clean Air Act in the UK in 1956, and the banning of smoking in public places. Part of the reason for the neglect of HTA for measures to improve health rather than just for the treatment of disease is the complexity of the necessary measures, the politically charged nature of possible interventions, the lack of charisma of public health and the belief that most measures make “common sense”. Suggestions as to how epidemiology can provide the necessary framework for HTA for health improvement and disease prevention were given as well as possible topics (and approaches) that would broaden the application of HTA from its narrow disease-treatment perspective.

HEIKO WALLER

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10 Health Promotion

Health promotion topics played a prominent part in the scientific programme of the annual conference in Helsinki: 2 tracks with 12 health promotion workshops including 55 presentations were presented. In addition, 35 posters were shown with health promotion topics. Workshops and posters documented the broad scope of health promotion topics in Europe: Family and health, recreation and mental health, injury prevention, alcohol and drug prevention, healthy nutrition in schools and kindergarten, obesity prevention, capacity building in health promotion etc. The presentations mostly focussed on target groups or target problems of health promotion, and to a lesser extent on health promotion settings. In the following I will give some examples to illustrate the broad scope of health promotion topics:

The workshop “Family and Health” chaired by Mika Pyykkö and myself contained the following 6 presentations with the following titles:

- “The long arm of the family – Are parental and grandparental earnings related to developmental health in late adolescence?”
- “Differences in child self-reported and parent-assessed health of fourth grade school children (age 9–10)”
- “Childhood residential stability and health in adolescence: findings from West of Scotland Twenty-07-Study”
- “Adolescents’ psychological well-being and its association with parenting processes”
- “Family affluence among 11-year-olds: international study of agreement between children’s and parent’s reports”
- “Family influence on individual consultation behaviour is as important as in 1987”

Whereas the above presentations were mainly focussing on sociological and methodological aspects of health promotion, the papers in the following workshop (chaired by Eva Roos and myself) mainly dealt with practical aspects of health promotion. The titles of the papers were:

- “School environment and eating school lunch among

10–11 years old children in Finland in 2006”

- “High-risk strategy in smoking cessation is feasible on a population-based level. The Inter99 study”
- “Age-related functionality and driving in Piemonte Region, Italy: the “Over 65” project”
- “Factors influencing attitudes of mass media on tobacco control”
- “Health literacy – is there a social gradient in Switzerland?”
- “Transnational empirical research into healthy lifestyle determinants of families in Hungary, Poland, Czech Republic and Slovakia (2005–2007)”

The section workshop was organized together with Prof. Davies from the European Region of the International Union of Health Promotion and Education (IUHPE) and was dedicated to the topic of capacity building in health promotion. The workshop was chaired by John Davies and myself and contained the following presentations:

- “Education and training development in Public Health: the PHETICE Project”
- “Theory and practice with the Hungarian BSc of Health Promotion and Recreation”
- “Annual health promotion summer course Strategies for Health in Europe”
- “Oral health promotion capacity building in Belgrade”

Thus the workshop presented 4 different examples of capacity building: The paper from Serbia concentrated on the further education of paediatric dentists in a dental health promotion strategy called “Better smile”. The paper from Hungary described the development and implementation of a new curriculum for a health promotion course at Bachelor’s level. The contribution from Germany focused on capacity building within a health promotion summer course organized for many years and together with many European countries. The contribution from the United Kingdom was a summary of the PHETICE project of the EU and shall be outlined here in more detail: The PHETICE Project (PHETICE stands for Public Health Training in the Context of an Enlarging Europe) has been funded by the EC (DG SANCO) to build on the experiences and investments from exist-

ing European public health training programmes, and to identify commonalities and synergies. The enlargement of the EU reflected a need for mobility among public health professionals based in Bologna process in higher education. Therefore there is a need to build on well-defined and agreed generic and specialist competencies in public health.

PHETICE's work is focussed on integrating educational institutions from new member states and candidate countries into existing European training programmes in public health. Reference has been made to the efforts to create a common understanding of the core competencies of professionals within public health specialist areas using the PHETICE model, European professional and academic standards to enable uniform quality processes and joint degrees, innovative methods for public health training that integrate areas of inequality, health monitoring and best practice, guidelines for public health specialist training in Europe, and access to evidence-based education and information for European public health workers and specialists.

The posters concerning health promotion showed – as did the workshops – a broad picture of European health promotion activities in research and in practice, mainly concentrating on target groups (school children, adolescents, families, elderly etc) or target problems (smoking, alcohol consumption, obesity, sleep problems, violence, STD, injuries etc) but rarely on settings of health promotion (like schools, hospitals, workplaces, communities etc). Health promotion topics taking explicitly a gender, social economic or ethnic perspective were present but also rare. As one example the study "Health promotion in multi-ethnic communities" of Larsen from Denmark can be mentioned:

Ethnographic fieldwork is conducted among residents in a Danish socially deprived and multi-ethnic community of approximately 700 individuals. The analysis is based on a discourse analysis of how individuals act upon and counteract health promotion activities and experience being part of that community. Ana-

lytical findings are juxtaposed with a theoretical investigation of health promoting policies and concepts. Preliminary results suggest that people who engage in formal social networks aimed at developing communities are characterized by a certain set of social categories. They share particular cultural values that are compatible with empowerment discourses. However there is a large group of residents, mainly immigrants, who do not engage in community activities, but engage in their own informal networks practicing other values....In empowering communities, a narrow focus of the community as one entity entails the risk of overlooking social and cultural diversity. Further I argue that staying healthy can not be seen as a direct result of being engaged in social networks. Rather it depends on the values, norms and political traditions imbedded in those networks.

The annual meeting of the EUPHA Section on Health Promotion was focused on future co-operation between IUHPE (International Union of Health Promotion and Education) and EUPHA. From IUHPE the former president of the European Region of IUHPE John Davies and his successor Mika Pyykkö joined the meeting, from EUPHA the acting president John-Paul Vader and the manager Dineke Zeegers.

The colleagues from IUHPE informed the audience about the structure, members and activities of IUHPE. The next conference of IUHPE/EURO will be in 2008 in Turin. The following proposals for a closer co-operation between IUHPE and EUPHA were suggested: mutual invitation of Section presidents, creating joint working groups, organizing a joint workshop in Turin, organizing joint conferences between the annual conferences addressing strategic health promotion topics like "advocacy in health promotion", "health in all policies" or "capacity building in health promotion". Common tasks were also networking and establishing better links to WHO etc.

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11 Injury prevention and safety promotion

Injuries (including both accidental [unintentional] and violence) are a major threat to life and health in many parts of the world. In the World Health Organization (WHO) European Region, injuries are the third leading cause of death. The region has some of the highest and lowest injury mortality rates in the world. Furthermore, the burden unequally distributes both between and within countries.

Therefore, the WHO and the European Commission have recognised injury prevention and safety promotion as a major priority and have developed policy frameworks, action plans and public health programmes in order to strengthen injury and violence prevention activities within the region. This has led to the European Commission's initiative to have a Communication on "Action for a Safer Europe" which is adopted by the European Parliament and to the WHO European Region's Resolution on Injury Prevention in the Region (RC55/R9).

The EUPHA Section on Injury Prevention and Safety Promotion was established during the conference in Montreux in November 2006. During the Helsinki conference, the section arranged a pre-conference, three workshops and a Section meeting.

Pre-conference: "Impact of intentional and unintentional injuries on physical and mental health"

This pre-conference was arranged together with the Section on Public Mental Health. In the first morning session, definitions and concepts of injuries were presented, both on accidental (unintentional) injury and on violence and self-inflicted injury. It was stated that due to the public health perspective, self-inflicted injuries are included in the definition of violence.

The second morning session gave an overview of how to measure the short-term impact of accidental injuries. It was stated that there is no best or right measure: the closest to the truth would be a combination of measures that are available and take into consideration existing biases (e.g. hospital admission rates differing across Europe). Such measures are severity measures, length of stay and surveys. At the European

Community level, shortlist indicators have been created called European Community Health Indicators (ECHI). Indicators for accidental injuries, violence and suicide can be found online at: (http://ec.europa.eu/health/ph_information/dissemination/echi/echi_en.htm).

In the first afternoon session, it was discussed how to measure the long-term impact on mental health of accidental injuries and violence. In the second session, a presentation on violence against men and its effects on their health, scope and measurement was given.

As a conclusion it was stated that prevention on this combined topic would be of interest and perhaps a potential theme for next year, particularly in children and youth. Also it was wished to include more of the European dimension, with harmonisation of data, and streamlining to common indicators for consequences of injuries and violence linked with mental health.

Certain presentations from the pre-conference are available upon request by sending an email to: msen-goelge@hotmail.com.

Workshop on Community based interventions – what works and why?

Community based intervention is a promising concept for injury prevention. In one study significant reductions both in targeted injury types and on overall injury rated in the community was reported. The interventions were directed towards the whole population, not only high-risk groups or individuals. Primary health care, hospitals, local authorities, media, and organisations (voluntary, private and public) were involved in the interventions.

Whereas the plausibility and importance of multifaceted interventions and a long-term program view tend to be supported by empirical evidence, the principle of community involvement is less convincing. Little research links program effectiveness to community member involvement or to coalitions. Furthermore, the community focus principle is often applied without adherence to the underlying assumption, i.e. that community members have a sense of community, and most programs are implemented in large, diverse geographically defined communities. The principle of population outcomes assumes a certain degree of community ho-

mogeneity, with the risk of being widely and evenly distributed through the whole population despite the fact that risks in geographically defined populations tend to be distributed in pockets of heightened prevalence.

Workshop on Burden of injuries in Europe

In the Netherlands, information on the burden of injuries (in particular the costs of injuries) and cost-effectiveness analyses turned out to be extremely valuable for policy makers to base their decisions upon. It worked for determining the priorities within the large domain of health care issues, for determining priorities within the domain of injuries, but it also had effect on determining the most effective preventive measures.

At the moment, quite simple and frequently asked questions about injuries – “How many bicycle accidents are there in the EU?” – cannot readily be answered, or at least not with sufficient validity. The implementation of the proposed concept for EU level injury indicators, specifically from the IDB (Injury Data Base), would provide for an EU level injury surveillance and injury reporting to international standards – and also substantially complete the ECHI list (European Community Health Indicators).

There is a dramatic health gap due to fatal injuries between eastern and western parts of Europe in the age group 20–64 years. The divergence goes deeper within the eastern part of the European Union, and is much more apparent between the Baltic States and the other central and eastern European EU new member states. In central and eastern parts of the European Union (CEE) alcohol was responsible for 38% of all deaths from injuries in the male population aged 20–64. In the Baltic States this proportion was 48%, and in the EU-15 at the level of 29%. In the female population this proportion was 29% in CEE countries, 42% in the Baltic States and 19% in the EU15. The unusual jumps in sudden deaths due to injuries in a time of peace in eastern Europe is without precedence in modern history. The phenomenon concerns mostly the weakest, the lowest educated, those with no profession and lonely people. A proximate cause leading to a very high level of injuries is alcohol.

Workshop on Child and adolescent safety in light of different environments

This workshop started with a multi-country study on childhood injury patterns in the home, and related evidence-based strategies for prevention were highlighted. Thereafter, a prospective study on school injuries was presented, highlighting the determinant role of environmental factors in injury genesis. The third presentation

addressed children perceiving safety and presented the results of a survey on the fears experienced and coping strategies adopted by young adolescents in their neighbourhood. Children are important informants about the relative safety experienced in their neighbourhood. Many, though not all, young adolescents experience fears of various kinds, but several of them have developed strategies to cope with those fears. There is a strong association between the type of fear experienced, coping strategy (amount and kind) and gender as well as with family and household characteristics. Finally, the traffic environment was addressed through an analysis of new road safety education for children that has been built around the concept of learning for sustainable development.

Section meeting

The Section presidency proposed to make a two-year plan for Section activities. Some of the proposed activities were:

- Policy making/advocacy (for example J. Lund offered to send a message to all of the European PH Associations to ask if injury prevention and safety promotion is part of their plan of action and do they have injury representatives in their organisation. The section agreed this would be a good advocacy action.)
- Health gap (injuries) between East and West (J. Lund volunteered as co-ordinator)
- Ranking of injury within other PH problems to be used for advocacy
- Knowledge transfer with PH professionals
- Having a voice at EUPHA via conferences: trainings, pre-conferences, workshops, plenaries
- Adolescents and risk-taking (U. Löwe as coordinator)
- Terrorism, in collaboration with other sections, create a statement

A participant stated it is important to determine what is the uniqueness and role of our Section, particularly the added value. Responses were: clear link with other PH professionals; we share similar target sections as PH and use similar networks; we represent all of Europe; we are able to do policy work at the EU and the European level.

The Section agreed that a newsletter twice a year is sufficient. A mapping exercise identified the following Sections with which injury would have a link: child and adolescents, migrant health, public health economics, health promotion, public health practice and policy.

The Section agreed to establish working groups to work on specific injury matters; J. Lund (johan.lund@fnh.no) volunteered to co-ordinate East and West Injury Gap and U. Löwe (Ursula.loewe@kfv.at) Adolescents and Risk-taking.

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12 Public Mental Health

We were very pleased that we were able – one year after the funding of the Section on Mental Health – to offer several section activities at the Helsinki Conference in October 2007. We organized a 1) pre-conference together with the EUPHA Section on Injury Prevention; 2) a workshop on outdoor recreation and mental health; 3) an early bird meeting on gender differences in public mental health and last but not least the annual meeting of the Section.

Pre-conference on Impact of Intentional and Unintentional Injuries on Physical and Mental Health

The pre-conference was held on Wednesday, 10th October between 9.00–18.00 and it included six presentations. The scope of injuries and the epidemics of violence were presented with facts and figures from Europe. Some important issues were addressed, like the need for comparability of data on injuries and violence. The overview was followed by an introduction on possible mental health effects of violence and injuries, both short-term and long-term. Mental health effects can vary by gender and there is a clear need to obtain precise knowledge on gender-based differential exposure and effects of violence.

The pre-conference was the first organized jointly by two EUPHA Sections. The landmark pre-conference was regarded as a success and attracted more than 60 participants. However, the time was too short, and some participants would like to have another pre-conference on mental health effects of violence, including suicide.

Workshop on Outdoor Recreation and mental health promotion

The workshop on outdoor recreation and Public Mental Health was well attended and was important in identifying well-established ways for mental health promotion. The workshop shed new light on our understanding of the links between outdoor recreation and mental health.

Early Bird Meeting on Gender Differences in Public Mental Health

It is internationally observed that women are diagnosed with higher symptom levels of poor mental health than men. The results and instruments of assessing mental health in a gender sensitive way were discussed and the participants agreed the need to further discuss this issue in the year to come.

Annual Meeting of the Section on Public Mental Health

The meeting discussed further themes of the Section. Mental Health is ubiquitous in public health and the role of mental health for health should be strengthened in the future. All participants agreed that the section should continue providing a platform for the exchange of information, experience and research in the field of Public Mental Health epidemiology and encourage and promote European joint and multicentric research activities. For next year's annual EUPHA-conference in Lisbon, workshops with a variety of themes e.g. gender-based differences in mental health, migrants' mental health and mentally healthy ageing were proposed.

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13 Social Security and Health

The Section arranged this year a full-day pre-conference meeting, a workshop, and a Section meeting. Moreover, there were three parallel sessions covering the study areas of the Section, namely sickness absence.

Workshop

The Section on Social Security and Health arranged a workshop during the EUPHA conference in Helsinki. The theme of the workshop was "The implementation of the 'International Classification of Functioning, Disability and Health' (ICF) in disability assessment". Chairing the workshop was Prof. Peter Donceel, Department of Public Health, Katholieke Universiteit Leuven.

The background for the workshop is the increasing interest shown across European countries in the International Classification of Functioning, Disability, and Health (ICF), adopted by the WHO in 2001, and its potential use in clinical medicine, public health and social security. The ICF introduces both a universal conceptual framework and a detailed classification system. As a result the ICF offers an interesting and useful tool in the field of social security and disability evaluation. In the latter field, progress has been made towards European standards, but there are still major obstacles. The definitions, criteria and procedures for the evaluation of disability and work incapacity substantially differ among European countries. This poses a major difficulty for comparative analyses and data exchange between different national schemes.

Three researchers from the working group on ICF in the European Union of Medicine in Assurance and Social Security (EUMASS), and one researcher from the ICF Research Branch of the WHO presented their work. The various aspects of the development of an ICF core set (an adapted short version) for disability evaluation in social security were illustrated.

First, fundamental concepts of the ICF were discussed with their implications for disability assessment. Secondly, since the detailed classification system of the ICF is too inconvenient for use in daily practice, core sets are proposed as a practical alternative. An adjusted method to develop core sets was presented. Thirdly, the results of a European core for the assessment of long-term disability were presented. The final contribution discussed the need and the methodology for the validation of core sets in practice. This contribution also introduced the audience to the very comprehensive work on ICF core sets for use in rehabilitation medicine that has been carried out by the ICF Research Branch.

In the discussion that followed, the importance of environmental factors for work disability was stressed. In conclusion, the work with ICF in social security is promising, and the core set now being proposed will be subject to validity testing.

Moreover, there were also three other sessions at the conference with presentations of studies in the area of sickness absence, disability pension, and return to work. The quality of presentations and discussions was high and the room was more than full. We also had a well-attended Section meeting during the conference.

Pre-Conference Meeting

The Section on Social Security and Health arranged a pre-conference meeting at the EUPHA-conference in Helsinki, October 10, 2007. This was the fifth pre-conference meeting arranged by the Section. Around 40 people attended the whole-day meeting.

The theme for the meeting was "Economic theories and methods in sickness absence research". The participants were given an update on economic research by three economists: Patrik Hesselius, Astrid Grasdal, and Anders Norlund, covering important fields like economic models and methods, the associations be-

tween unemployment and sickness absence, and cost analysis of sickness absence. Examples on economic research were also given by Fiona Ford, and Arnstein Mykletun on the Pathways to Work-policy in UK, and on economic incentives in relation to disability pensions.

The meeting also contained group discussions where the participants were invited to share experience of the economic aspects and variables in their own research.

It was concluded that pre-conference meetings are very important for the Section since it gives researchers in a rather narrow field the opportunity to meet, be updated, and to exchange ideas. It might also serve as a starting point for closer research collaboration. The choice of theme was given much support, since this is a field of research that is rarely covered at the EUPHA conferences.

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14 Health services research and quality of care – a summary of events that presented research in the field of health services research

Introduction

In the EUPHA conference in Helsinki, we had a fruitful programme related to activities in health services research across Europe and several of those were directly linked to the Health Services Research Section.

Comparative research designs in the study of health care systems

The first topic dealt with during the EUPHA conference in Helsinki was dedicated to the comparative research designs in the study of health care systems. It was jointly organised by the EUPHA Health Services Research Section and the Academy of Finland Research Programme on Health Services Research (TERTTU). The main topic is of utmost importance given the present intense interest in studying different health systems. The interest of policymakers and scientists in the field is continuously growing, often without enough methodological background and co-ordination. Similarly, interpretation of outcomes is based too often on personal preferences with stress given to details or to extracted partial solutions, without noting the context in which these solutions exist. Finally, this work is commonly associated with oversimplification of the basic sets of questions or it is a result of focused interests in specific solutions. This pre-conference seminar was supposed to bring additional insight into interesting scientific methods related to the comparative research across health care systems. Organised in two half-day sessions, it provided the following content¹:

- Cross-national evaluations of health care systems and their reforms (R. Saltman)
- International comparative health systems research (P. P. Groenewegen)
- Comparison of cost and outcomes between hospital districts (U. Häkkinen)
- Rapid evaluations of health policy reforms (K. Blum, Z. Or)

Through the presentations of the methodological approaches, it was shown how to approach the study of

health care systems and their comparisons. In the second half, practical implementations of these approaches were shown through the examples of a national study and by an international network dedicated to studies of health system reforms.

Health services research is a set of methodologies and a science, which is reflected in the large proportion of research carried out within the public health community in Europe. The Section on Health Services Research (SHSR) was directly involved in co-organising two workshops during the EUPHA conference in Helsinki. The content of these workshops show the research interests and the policy orientation of the health services research community. One of them was dedicated to the process of health system indicators development in Europe.²

The workshop on the development of health system indicators was jointly organised by the Section on Health Services Research and DG SANCO Working Party on Health Systems. The issue of developing health system indicators in Europe is a long-standing task, which has only recently started to show tangible outcomes across the different member states. It needs to be said that there are two important issues – one is the number of international organisations seeking to standardise and harmonise health reporting across their member states and the second issue is the fact that this gives rise to a multitude of requests, often divergent and sometimes overlapping only to a certain degree. Eurostat and DG SANCO have launched an inclusive process, which builds on the existing experience and, due to a growing overlap of membership across different organisations, tries to minimise the differences. Certainly, two dimensions are important in this respect. One of them is in the richness of the diversified interests, since the OECD has traditionally been focused on performance indicators and on hospital care, while Eurostat is rapidly picking up the main issues related to the infrastructure, mortality, morbidity and human resources. The other issue is the complexity of harmonising definitions in an organisation such as the WHO, where the world di-

mension needs to be taken into account as no system can exist that would ignore the need for comparability across different continents. All these efforts are now directed in a way where inclusiveness and allocation of the many tasks involved would be rational. Activities running within the OECD for three consecutive years regarding the quality of care are certainly an important contribution to health system indicators, as the present level of insight in this respect is very limited. Eurostat built the development of its health interview survey mechanism through the rich experience of the WHO in developing EURO-HIS. Gradual integration of the various reporting requirements will not be exclusive of the specific interests and missions of the individual international organisations. A significant step towards a more prescriptive and regulated system will be made once the Regulation on health statistics is adopted in the European Parliament. This will mean that for the first time as many as 27 countries will be reporting to an international body under a legal obligation.

The second workshop was co-organised by the SHSR and by the Section on Public Health Practice.³ Its main goal was to organise an open and constructive debate around the issue of the future policy developments for health services at a European level. The European Union has started to implement the different principles and freedoms across the different sectors. This process has been modified by various issues. The definition of the European Commission's competencies with respect to health care has been challenged several times. The important cases in front of the European Court of Justice, such as Kohll, Decker, Peerboom, challenged the previous views on this issue. The response of the Commission arrived in 2003 in the form of a draft directive on services (also known as the Bolkenstein directive after the then Commissioner for the Internal Market). Ever since then intense debate has been going on around the previous draft and then also around the envisaged proposal of a directive that would regulate also the area of health services. It became evident that the separate treatment and perspective on health care will not stand the test of legal issues and also of the growing interest of opening, at least some, aspects of market mechanisms in health care. This is certainly seen as laden with the different challenges and opportunities. On the one hand, health

care systems need to take into account the fact that their citizens already now possess certain rights, which entitle them to travel to other countries for care. Opportunities for patients to choose their providers and for the latter to become more competitive and open to foreign users are imminent. On the other hand, this may pose different threats to health systems ranging from their diversity in reimbursement practices, country sizes and levels of economic development to the differences in actual health resources, both financial as well as human. This will potentially make planning of services in individual countries more complex and much more unreliable as there will always be a certain number of patients who may decide to seek care elsewhere. To what level these processes still need to be regulated or not at all, remains an important topic for future discussions. Small member states may face pressures to close down most of their specialised services as there will often be enough provision of services elsewhere to accommodate their needs, too. The same is true of the remote communities in the bordering areas. Planning of health services will obviously not be only an issue for the national governments but also increasingly at international levels, requiring bilateral and multilateral solutions. Also the equity and sustainability of health services in the bordering regions may become challenged as there may be differences in access for different populations. These differences may not be based solely on economic grounds, but also relate to the level of education and ability to actively speak foreign languages, which often remain a barrier in such situations. On a positive note, these challenges may provide possibilities for sharing capacities, cross-border exchange of professionals and patients, including more diverse professional and scientific co-operation.

Health services research is a scientific discipline in public health, which faces a multitude of challenges arising from different factors: continued and ongoing health reforms, opening of borders with interest in looking at transplanting efficient foreign solutions, advancing technologies, problems with human resource planning, etc. Some of these challenges have been addressed in Helsinki, but many still remain and may become interesting topics for fruitful discussions and exploration at future EUPHA conferences.

NOTES

- 1) 15th European Conference on Public Health: Abstract book 2. Pre-conferences, Early bird meetings, Extra meetings. EUPHA 2007; 23–24.
- 2) Brand H, Albrecht T. 3.9. Workshop: The Working Party on Health Systems of DG SANCO: The current state of health system indicators development in Europe. In: Keskimäki I (ed.), Vader J-P (ed.), Zeegers Paget D (ed.) 15th EUPHA Conference – The future of public health in the Unified Europe, Helsinki, 11–

13 October 2007. Eur J Pub Health 2007; 17(Suppl 2):65-66.

- 3) Azzopardi Muscat N; Albrecht T. 6.3. Workshop: Future policy developments for health services at a European level. In: Keskimäki I (ed.), Vader J-P (ed.), Zeegers Paget D (ed.) 15th EUPHA Conference – The future of public health in the Unified Europe, Helsinki, 11–13 October 2007. Eur J Pub Health 2007; 17(Suppl 2): 118-119.

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15 Infectious Disease Control

The Section on Infectious Disease Control at the EUPHA conference in Helsinki provided once again a stimulating and diverse programme. The Section organized two workshops and a breakfast meeting with abstracts from invited speakers, while the rest of the Section consisted of sessions constructed from the best submitted abstracts. All the sessions were well attended and the excellent presentations generated lively discussion between the speakers and their audience.

The Section on Infectious Disease Control started with a pre-conference Round Table discussion 'Vaccination policies in the Unified Europe; ensuring timely access to public health interventions for European citizens', organized by Sanofi Pasteur MSD together with EUPHA. The presentations and the ensuing discussion were web-cast live from Helsinki.

The first of the Section workshops focused on research methodologies in communicable disease control with emphasis on the acute aspects of managing outbreaks. The workshop explored the suitability of several methodologies, focusing on recent research: these included the use of Delphi studies to gain consensus among experts, the development of a qualitative instrument to improve scientific advice, and the use of mathematical models for preparedness.

The use of advanced information technology in infectious disease control was the theme of the second Section workshop. This highlighted some of the innovative information technology tools that are now being used in communicable disease control and several of the tools demonstrated at the workshop generated widespread interest.

The submitted abstract sessions, while focusing on infectious diseases control, were designed to encourage participation from members of other EUPHA Sections. One looked at the decision-making around the introduction of the new Human Papilloma Vaccine

in several European countries and asked whether the process was politically or scientifically driven. Another focused on measuring social mixing patterns and modelling their impact for the spread of infectious diseases, clearly an important public health issue for Europe in the twenty-first century. Several very interesting presentations on the cost-effectiveness of different vaccination programmes formed a third workshop.

The Section organized a very well-attended breakfast meeting which highlighted the importance of collaboration between clinical microbiologists and their colleagues in public health, and explored several current initiatives. The meeting, which was organized together with European Centre for Disease Control (ECDC) and ESCMID (the European Society of Clinical Microbiology and Infectious Diseases), was very well attended in spite of the early start, and different approaches to the development of collaboration between microbiology and infectious disease control professionals were illustrated. Afterwards, while enjoying a light breakfast, attendees discussed new opportunities for co-operation.

The ICD section is growing rapidly and currently has more than 500 members. At the Annual General Meeting (AGM), Ruth Gelletie, president of the Section, reported on its activities over the past year. One of the more important achievements had been the establishment of the Section board. New rules and a mission statement were agreed by the Section board in February 2007.

During the AGM Chakib Kara-Zaitri demonstrated the new Section website to the members. The website can be accessed through www.EUPHA.org (select EUPHA sections, then infectious disease control) or <http://portal.in-fact.com>. The website is interactive and provides a password protected area for members to network with each other and for example to discuss and develop research proposals and seek partners, and

publicise courses, conferences and other activities.

During the AGM members were asked to propose new activities for the 2008 ICD Section business plan. Ideas for workshops, collaboration and training were discussed by the members and these will be taken forward by the section board. At the end of the AGM members agreed that the section was going from strength to strength and that with the new website, networking between members would be greatly facilitated.

The conference was once again an excellent opportunity for infectious disease control professionals to network and share knowledge, and to meet with colleagues working in other branches of public health. In 2008 the Section looks forward to continuing to grow, building on the foundations that have been laid in earlier years.

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16 Chronic Diseases

The 2007 EUPHA conference in Helsinki was very successful for the EUPHA section on Chronic Diseases (ESCD). During the first year of its existence as the regular EUPHA section it was able to prepare a varied and interesting programme for the 2007 EUPHA conference. The section organised two workshops out of which one was carried out in co-operation with the Task Force on Major and Chronic Diseases of DG SANCO. Three other sessions were devoted to chronic diseases based on best submitted abstracts from all over the Europe. In addition, a track of poster presentations included nineteen posters.

Workshops

The conference programme started with the *joint workshop* of the ESCD and the Morbidity and Mortality Working Party / Task Force on Major and Chronic Diseases (MMWP/TFMCD) of DG SANCO (http://ec.europa.eu/health/ph_information/implementation/wp/morbidity/task-force_chronic_en.htm). The Task Force on Major and Chronic Diseases is one of the implementing structures of the EU Public Health Programme 2003–08. The workshop aimed to tackle the incomparability of morbidity data at the European level and introduced the development of the accurate health information system concerning the health status of the population in order to improve the health of European citizens. The workshop focused on the first axis of the matrix, presenting some of the major building blocks of the EU Health Information System on morbidity and mortality. In particular, recommendations for implementing population-based registries for stroke and Acute Myocardial Infarction/Acute Coronary Syndrome were presented, as well as activities aimed at harmonizing coding practices of cancer registries.

The *second ESCD workshop* dealt with psychosocial determinants of health and quality of life in the

elderly. The workshop highlighted the importance of raising awareness of the health consequences of the increasing elderly population with special emphasis on preventing chronic diseases and chronic conditions as well as managing physical disability, depression and social isolation. Within this workshop three multicentre projects focussed on prevention of chronic diseases, health promotion and improvements in quality of life in the elderly were presented.

Parallel sessions

The *parallel session 'Socio-economic Inequalities in Chronic Diseases'* analyzed the associations between socioeconomic inequalities and trends in several chronic conditions, such as self-reported depressiveness, coronary heart disease, stroke, lung cancer, cervical cancer and graft survival after kidney transplantation. This session confirmed the persistence of socio-economic disparities in chronic diseases, it however also showed that tailored interventions and policy programmes, resulting for example in increased participation in screening programmes or having equal access to healthcare services, may eliminate these disparities.

The *parallel session 'Psychosocial Variables and Chronic Diseases Control'* elaborated on the role of personality traits in predicting mortality as well as the effects of social support, occupation and culture on psychological well-being. The studies demonstrated that personality factors such as 'hostility', 'antisocial personality' and 'coronary heart disease-prone' personality predicted all-cause mortality. In contrast, the 'cancer-prone' personality, 'rational' personality and 'Type A behaviour' were not significantly associated with mortality. With regard to improvements in psychological well-being adjustment to disease and social support yielded to have positive effects, but the significance of the aspect of social networks on psychological well-be-

ing differs according to the gender and the culture of origin. Furthermore, the studies confirmed the beneficial effect of meeting the occupation needs on psychological well-being in persons suffering from dementia. The studies also show that prevention of such chronic diseases as low back pain may benefit from improving work organization and integrating health promotion and stress management into the more traditional occupational health and safety measures.

The *parallel session 'Cardiovascular Diseases'* dealt with risk factors for cardiovascular disease, trends in acute myocardial infarction case fatality, effects of the Mediterranean diet on cardiovascular disease and the utility of interventions for improving compliance with cardiac medication. With regard to risk factors the studies demonstrated that blood pressure in late adolescence is an important independent risk factor for coronary heart disease and stroke before 55 years of age. Therefore attention to pre-adult blood pressure as a determinant of cardiovascular disease in middle-age onwards should be warranted in future research. The study on the trends in short-term case fatality after a first acute myocardial infarction event and the socio-economic and geographic inequalities from Scotland provided evidence for socioeconomic inequalities in short-term case fatality and that these socioeconomic gradients are more pronounced at younger ages. The study dealing with a systematic review of the scientific literature on the Mediterranean diet supported the assumption about the protective effects of this diet on cardiovascular diseases. Similarly the outcomes of a study aimed at improving compliance with cardiac medication supported the utility of interventions in preventing coronary heart disease. Finally, a study on screening programmes to identify people at risk for ischemic heart disease showed that screening for risk of ischemic heart disease combined with immediate health counselling was not associated with an increase in anxiety, depression and somatisation. On the contrary, it seemed to have a positive effect, which could be due to professional counselling.

Annual meeting of the EUPHA section on Chronic Diseases

During the annual meeting of the ESCD the section's president introduced the mission and aims of the section as well as its brief history. The ESCD started its existence in 2005 as 'proposed section' and it was established as a 'regular section' at the 14th EUPHA conference in Montreux, Switzerland in 2006. Within this context interesting are the EUPHA database statistics

on the number of persons indicating interest in chronic diseases. In 2005 only 35 people expressed their interest in chronic diseases, in 2006 this number raised to 61 and in 2007 it reached 204 persons. Similarly interesting are the developments in activities of the section. While in 2006 the oral presentations reporting on chronic diseases were included into a track on 'Chronic Diseases and Care for the Elderly', in 2007 the increased number of accepted abstracts enabled to create an independent track on 'Chronic Diseases'. The poster presentation track entitled 'Controlling Epidemics of Chronic Diseases' included 19 posters from 13 European countries. With regard to workshops, in 2006 the section did not succeed in organising a workshop, however in 2007 it organised 2 successful workshops. During the section's annual meeting also plans for the 2008 EUPHA conference in Lisbon took place. The topics for planned workshops included news on health information system on morbidity and mortality in chronic diseases and e-health in general as well as trends in chronic disease care and in particular the patient's self-management. The conference participants also elaborated on more active involvement of the section members during the year, e.g. regular exchange of information using the EUPHA mailman system, development of the section's web-site, plans for common projects. Finally, the selection of the section's vice-president took place. The new section's vice-president became Dr. Coen van Gool from the Netherlands.

Conclusions

All activities organised by the ESCD were of great interest for the conference participants. The sessions within the track as well as the workshops attracted many listeners. On average they were attended by more than 60 persons; and actually during some presentations there was not enough space in the rooms so some people were even sitting on the floor. The presentations within the sessions and workshops were of very good quality and provoked vivid and stimulating discussions. In addition, the workshops served as a kind of advertisement for the ESCD, because some of the conference participants heard about the existence of the section during the workshops for the first time and after the workshops they asked for more details and wanted to become members of the section. All in all, the increase of section's activities, the growing number of oral presentations in parallel sessions as well as the number of posters indicate that the epidemics of chronic diseases generates an increasing interest in the scientific public health community.

MAARTEN POSTMA

Professor, University of Groningen Research Institute of Pharmacy (GRIP),
Groningen, the Netherlands

17 Public Health Economics

The EUPHA Section on PHE organised 2 workshops during the recent Helsinki 2007 conference. This reflected a doubling compared to the previous year. With its increasing number of members – now up to 230 – the Section is establishing its position within EUPHA, after having been founded in 2006. In addition to the two workshops, the Section participated in a pre-conference activity "Round Table Conference on Vaccination Policies in the Unified Europe". Both workshops were very well attended, but the section meeting had a low participation, warranting extra attention for the next year's conference.

Collaboration exists with the EUPHA Section on Infectious Disease Control and a closer collaboration in the future is envisaged by both Sections. For 2008, the public health economics of infectious diseases will again be high on the agenda of the Section on PHE, while the building and strengthening of a network within EUPHA for other disease areas – in particular, cardiovascular and oncology – will be continued.

Both the president and the vice-president of the Section (Prof Maarten Postma and Dr Göran Henrikson, respectively) will push forward with the above challenges in 2008.

The 1st workshop on the second conference day (chair: Dr G Henrikson, vice president of the PHE-section; organiser: Prof MJ Postma president of the PHE-section) was entitled "Public Health Economics of Universal Strategies to Promote Health and Prevent Disease". In the workshop we presented the broad spectrum covered by PHE in relation to various aspects of promoting health and preventing disease. This broad spectrum will be illustrated with topics in health promotion (smoking and physical activity), food fortification and vaccination.

Lars Hagberg started off the workshop by summarizing the issues in cost-effectiveness analysis of

interventions on promoting physical activity. During the discussions afterwards, it came out that the most important determinants of cost-effectiveness are adherence to new habits, the experience and value of time spent on physical activity and selection of the target group.

Anne Prenzler, Thomas Mittendorf & Matthias Graf von den Schulenburg estimated smoking-related production losses and direct health-care costs in Germany and related this to the acceptable costs of a tobacco prevention programme in schools. It was shown that smoking has a strong financial effect on the economy.

Janneke Jentink, Nienke de Vrie-Hoekstra & Lolkje de Jong – van den Berg analyzed potential folic acid food fortification in the Netherlands regarding its cost-effectiveness. As a public health strategy, the Dutch Health Council have advised against folic acid fortification. The lecture showed that the strategy does have a high potential for cost savings or at least to be highly cost-effective. During subsequent discussion, the results appeared to be robust for additional aspects brought into consideration.

In the final lecture of the workshop Ardine de Wit, Mirjam Kretzschmar, Marie-Jose Manges et al. compared the cost-effectiveness of universal Hepatitis B vaccination against risk-based strategies in the Netherlands. It came out that both universal adolescent (12 years) and infant vaccination would be very cost-effective strategies despite the relatively low endemicity in the Netherlands, with cost-effectiveness ratios below €0,000 per QALY gained. The lecture was very timely as universal vaccination is currently being discussed in the Dutch Health Council as an addition to the National Immunization Program.

The second workshop of the Section was entitled "Cost-effectiveness of Vaccination Programmes: issues, solutions and examples" (Chair: Prof WJ Edmunds, Health Protection Agency UK; Organizer: Prof

MJ Postma president of the PHE-section). It focused on various aspects that make economic evaluation of vaccines rather unique: the sensitivity of results to time horizon and discounting, inclusion of herd immunity effects and measuring quality of life in infants and small children. All these aspects pose challenges to public health economics, both regarding methodology and practical impacts on National Immunization Programs. All lectures during the session were on behalf of the POLYMOD project.

Philippe Beutels introduced the topic by highlighting the specifics of health economics in vaccination policies. Next to the issues listed above, he focused a.o. on the model choice. Regarding this model choice, Beutels advised to generally always consider a dynamic epidemiological model that takes account of the indirect effects of vaccination (in particular, herd immunity) to adequately estimate cost-effectiveness of a program. Yet, dynamic models are more complicated and more data-requiring than static models, and should therefore only be used when necessary. Furthermore, he noticed that with the long time-span that is often used in the evaluation of vaccines, the impact of the discount rate may be huge, and this impact should always be analyzed in sensitivity analysis.

Mark Jit, Philippe Beutels, Edmunds et al. presented the cost-effectiveness of rotavirus vaccination using cohort models for 5 European countries (England, Belgium, the Netherlands, France & Finland). Cost-effectiveness varied over these countries, primarily determined by seroprevalence and vaccine price. For example, rotavirus vaccination was estimated to be cost-effective in Finland.

Benoit Derveaux and Mark Jit considered the very timely topic of HPV-vaccination. This vaccine has already received positive recommendations in many European countries. In the presentation Derveaux presented two mathematical models to evaluate the effects of vaccination: (i) a multiple static cohort model for France, and (ii) a dynamic model of HPV vaccination in the UK. From these examples, differences between

the two types of models for the HPV vaccine were discussed. Static models do seem to be able to provide a valid preliminary assessment of the economic value of HPV vaccination. However, for further analysis – e.g. incorporating boys into the vaccination – dynamic models should be used.

Albert-Jan Van Hoek, Alessia Melegaro, Nigel Gay, Edmunds et al. presented an analysis of Herpes Zoster (HZ) vaccination in England and Wales. It was presented by the first author – who was recently “transferred” from the Netherlands to the UK. He showed that introduction of the vaccine will significantly reduce the burden of HZ, but cost-effectiveness is highly dependent on various specific model parameters. In particular, these parameters refer to vaccine price, duration of protection and the specific QALY weight inserted into the analysis.

Alessia Melegaro and Edmunds ended this workshop from the POLYMOD project with a talk on the potential impact of herd immunity after varicella vaccination. A deterministic realistic age-structured model was applied to adequately simulate the impact of varicella vaccination on HZ. This model builds on work at the Modelling Unit of the Health Protection Agency that extends already over many years now. They concluded that varicella vaccination might well not be a cost-effective intervention if the impact on zoster is included.

The workshop was lively, very well attended and gave rise to lots of discussions. It was highly informative and therefore went over time by 10 minutes, causing a delay in the start of the plenary closing ceremony, for which we apologize. Finally, we note that the workshop extended on precisely the issues introduced in the pre-conference Round Table on Vaccination.

The Sections’ Round Table discussion can be downloaded from the website www.euphahelsinki2007.fi. The session was chaired by the presidents of the PHE and “Infectious Disease Control” sections, and it concentrated on various timely issues such as pneumococcal vaccination. Its proceedings will be submitted to the European Journal of Public Health.

AUKE WIEGERSMA

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University Medical Center Groningen, Netherlands

18 Children and Adolescent Public Health

The goal of our Helsinki pre-conference “The Electronic Child Record – an International Perspective” was to acquaint participants with how the various flows of (electronic) information related to mental and physical well-being of children can be combined and used for specific purposes. Furthermore, the pre-conference aimed at giving an insight into the methods used by different European countries to this end. Ultimately, this is to result in an international co-operative effort to streamline this information, not only with the purpose of integrating these data on a national scale, but also to make possible comparative international studies of (threats to) children’s wellbeing, opening an opportunity for the development of new effective, preventive activities.

The example used was child abuse, where in the primary and/or secondary prevention of child maltreatment, data have to be obtained not only from medical organisations but also from institutions as diverse as police, social welfare, schools, etc. These data have to be interchangeable and comparable, thus needing indicators that are generally and internationally defined and agreed upon. Much work has already been done in this respect by Michael Rigby e.a. in the EU-project Child Health Indicators for Life and Development (CHILD) and the indicators developed during this project can adequately be used in a future Electronic Child (Health) Record (EC(H)R). Moreover, the information-gathering process has to have ironclad authorisation procedures in place, to prevent workers from different organisations accessing private or irrelevant data.

For several years now, France has had a successful EU e-practice project ‘SESAM-Vitale’ which involves smartcard-oriented business companies, health professionals, insured patients and the French health insurance system. Currently, it encompasses over 230–000 health professionals and more than 50 million patients,

processing over 900 million health claims a year. The VITALE health insurance national card is based on de facto and de jure existing standards for interoperability with other smartcard applications. Also, it is a potential medium for carrying information required for the announced electronic European Health Insurance Card (eEHIC).

During the pre-conference this project was presented by members of Pjisk, a Dutch advisory committee that focuses on integrating information related to the well-being and healthy development of children and adolescents and aims to implement an integral (pilot) ECR in The Netherlands – for several reasons the national Electronic Child Health Record that was to be implemented in January 2008 was cancelled. Members of the French project have been contacted to see how we can work together to develop a EC(H)R on a European scale and in advance of that a pre-conference abstract has been submitted for the next EUPHA conference in Lisbon 2008. There we will present the progress made and in the mean time we will of course keep the members that indicated an interest in these developments informed. Other members, interested in this development are invited to send an email to me, so they can be included in the project’s email-list. We aim to form an international working group to apply for a EU grant in order to develop an integral EC(H)R for Europe, using the indicators developed by CHILD.

During the annual meeting several topics were discussed, and the general conclusion was that the Section would have to adopt one or more overall themes and provide a platform to discuss these projects. For the annual meeting and section, workshop(s) should be used. At the moment we are discussing the possibility of creating an in-depth overview of preventive health care services for children and adolescents in the European countries: the exact nature and content of these

services is far from clear and knowledge of the various approaches together with an indication of their effectiveness would be of great value for the development of evidence-based preventive interventions.

Apart from that, new plans were made regarding the development of national EU Teach courses. EU Teach (EUropean Training in Effective Adolescent Care and Health) is a teaching course developed in Lausanne, Switzerland and is designed to make health professionals aware of the special needs of adolescents in terms of health care – be it preventive or curative. Following the Summer School in Lausanne, The Netherlands took its first steps to create a Dutch EU Teach course for (para)medical professionals as well as medical students, working together with HanzeConnect, an institute that develops post-HBO courses and training sessions. For further discussion of the progress made in the various countries that are also in the process of developing courses for national use and to exchange information regarding the (solution of) problems encountered during these activities, a pre-conference ab-

stract was submitted for the next EUPHA conference in Lisbon. The abstract was planned in consultation with the Lausanne group.

Apart from these Section-oriented activities we visited the annual meeting of the EUPHA Section on Food and Nutrition, discussing the possibility of working together on the development of a DIPEX website on obesity in children. In January 2008 a meeting is scheduled with the Oxford group that runs the DIPEX website (www.dipex.org) to see how we can put in a EU-grant for the development of such a website together with other countries.

With the section on Injury Prevention and Safety Promotion, a pre-conference abstract was submitted regarding injury prevention in children and adolescence, with an emphasis on alcohol abuse related injuries in adolescence.

These 'intersectional' activities reflect the increasing tendency of EUPHA Sections to co-operate, resulting in, we are confident, even more interesting pre-conferences, workshops and annual meetings.

WALTER DEVILLÉ

EUPHA section president – Migrant Health
Netherlands Institute for Health Services Research (NIVEL)

19 Migrant Health

The pre-conference presented research in the Northern European countries, the problem of assessing acculturation in migrant health research, and the study of the quality of health care dealing with ethnic minorities.

National public health policy in Finland up to 2015 outlines multiculturalism as one of the major challenges for social and health sector development (Council of State 2001, 2004). Major migrant groups in Finland are originally from Sweden, Russia, and Estonia and are specific migrant groups compared to other countries. An important group of non-Western origin are refugees from Somalia. An important aspect in dealing with clients from other cultures in a multicultural society is cultural and transnational competence. A framework for assessing ethno-cultural discordant health care was used in psychiatric health care. A multicultural society requires making multicultural adjustments to the service system to fulfil the needs of new citizens. Even though the Nordic countries use the principle of equity in their health systems, exactly which health care system model should be followed is still open to discussion: choices typically focus on development of tailored programmes, development of a health system that copes with the migrant population, or a model whereby the migrant groups have to adjust to the system. Further discussion centres on whether these models are mutually exclusive or might exist simultaneously within one country or one health system.

Acculturation, adaptation, integration, assimilation, segregation: the debate is very prominent in our Western societies and also affects (public) health, as well as the use of health care by immigrant populations. Research focus and models seem specific to each discipline and are not consistent even between various research projects in the same discipline. Clearly there is insufficient dialogue between disciplines. Measure-

ments are seldom standardized and results difficult to interpret. Longitudinal research in Finland on Russian and Estonian immigrants showed that socio-cultural adaptation predicted socio-economic and psychological adaptation. The process of acculturation requires longitudinal research and information of the pre-migrant status. There is a need for cross-cultural comparisons between different countries.

Studying ethnic variations in quality of care in the UK show that despite similar processes of care, outcomes in some ethnic groups may not be as good compared to other groups. Whereas in areas with large migrant populations, health services are trying to deal with the needs of their diverse population, migrant women in areas with small proportions of migrants face difficulties due to the conflicting expectations of proper maternity health care. Evidence gathered to support health policy should include the experiences of migrants or minority populations to improve the quality of care. High quality health care should be able to deal in one way or another with the heterogeneity of its target population. How to organize this remains subject to debate: either by specific services, mainstream services with support for specific populations or by other alternatives.

Workshop “Monitoring the Health Status of Migrants within Europe: development of indicators – the SANCO MEHO project”

The main objective of this project is to develop indicators to monitor the health status of immigrant/ethnic minority groups in Europe. Therefore existing health related databases and surveys are used. Furthermore, a European network of epidemiological observatories on migrants' health is being established. This network will generate a European overview of comparable and exchangeable socio-demographic and health profile data of immigrant/ethnic minority groups for selected

health problems. Specific attention is being paid to the conceptual, methodological, ethical and practical issue of identifying immigrants and ethnic minorities in health databases and to the assessment of valid comparisons between these groups within countries and between countries. Also the Roma population in Central and Eastern Europe are included in the project. Five critical health areas for which ethnic-specific health data are available are addressed: mortality, cardiovascular diseases and diabetes, infectious diseases, cancer, self-perceived health and health care use. The status of the mapping exercises of the research networks on mortality, CVD and diabetes, self-perceived health and cancer were presented at the workshop.

The first results re-affirmed the great heterogeneity according to cause of death, e.g. between different types of injuries. Common patterns among different countries were observed for cancer mortality, with a generalized tendency towards lower mortality among migrants, but gradual convergence with native levels. Population-based studies on cancer among migrants are available mostly from northern European countries. For many large European countries and many migrant populations, hardly any data are available. The ways in which European cancer registries do or do not collect data about migrant status or ethnicity differ considerably; most are based on nationality or place of birth. Only a few collect information on ethnicity, languages or other variables. And that's not only the case for cancer but also for registries in many fields, often based on national or regional policies. The comparability of data will be hampered by the different definitions used for the identification of immigrants.

Oral sessions “Morbidity, mortality and migration” and “Ethnic minorities and health care use

On mortality, data were presented from Slovakia, where it was clearly demonstrated how the regional data for the Roma population had an independent and stronger effect on infant mortality compared to socioeconomic indicators. Immigrants from the former Soviet Union in Israel have lower mortality figures compared to their home country, but higher mortality for specific causes compared to the host country. In Germany, analyses of the Childhood Cancer Registry indicate that migration status has no effect on survival after cancer therapy, while in the UK, ethnic inequalities in cancer mortality remained static or even worsened for many groups and specific cancers. The level of risk factors for cardiovascular diseases in German Turkish migrants converge in the second generation with those of native Germans: migration is seen as a “health transition”. Lifestyle factors may be better or worse in immigrants compared to native populations and Denmark showed that immi-

grants perceive less of a link between those factors and good health. Finally, data from the Netherlands showed that surveillance for hepatitis B should include high-risk groups like migrants coming from high endemic countries.

Universal access to health care, as in the NHS in England, minimizes disparities in health care. But as many factors determine health and health needs, and those factors differ between various ethnic groups, it is crucial in research and health planning to consider the unique character of each group. Migrant health (care) cannot ignore heterogeneity within cultural diversity. While the need for mental health care is perceived by Turkish immigrants in the Netherlands, they are not satisfied with the services provided. Non-western migrants receive less antidepressant treatment for depression by their GP for instance. Generally non-western immigrants in the Netherlands report that mental health services do not meet their needs.

Meeting of the EUPHA Section on Migrant Health

The Section meeting was attended by around twenty-five participants. Some senior researchers in the field of migrant health from various European countries were present.

- The Chair reported on developments in Europe: the Council of Europe Explanatory Memorandum: Adapting Health Care Services To Cultural Diversity In Multicultural Europe (2006; www.coe.int > health > health services > social cohesion > recommendations 2006 > recommendation (2006) 18 > Explanatory Memorandum). He summarized also the Recommendations from the Conference Migration and Health in Europe Lissabon, 27–28 September 2007 (Conference under EC Portugal's Presidency) where a few members of the Section presented several issues, such as access to health care (www.hmelisbon2007.com > conclusions) .
- Prof. Per-Olof Östergren presented the plan of the 2nd Conference on Migrant Health in Europe, 22–24 May 2008, Malmö, Sweden (www.migranthealth.se). The Section on Migrant Health will organize and coordinate the Scientific Committee (SC). The chairs of the tracks will come from the Committee. The SC will have to look for Master Lecturers. There will be 6 tracks: “Health as a human right”, “Sexual and reproductive health”, “Health systems and policies”, “Mental health”, “Occupational health” and “Life style and chronic diseases”.
- European research and policy networks: an overview and some details were provided on the following EU projects: MEHO (*Migrant and Ethnic Health Observatory: development of indicators*)(DG SANCO project, started in 2006) ; EUGATE (*European Best Practic-*

es for Improving Access, Quality and Appropriateness of Migrant Health Care) (DG SANCO project, in October 2007 still in negotiation with SANCO); HOME (*Health and Social Care for Migrants and Ethnic Minorities in Europe*) (COST network, started 2007; cooperation with EUPHA section's network) (http://www.cost.esf.org/index.php?id=233&action_number=IS0603) ; MIGHEALTHNET (DG SANCO and Stavros Niachos Foundation – *Information network on good practice in health care for migrants and minorities in Europe*) (http://mighealth.net/index.php/Main_Page)

Themes for new projects were discussed (e.g. Health Services Models for dealing with migrants and minorities). Also the potential overlap between all these projects and initiatives was seen as problematic and the need for co-ordination and contacts between co-ordina-

tors was expressed. The Section may play a role here. The Public Health Agency in Luxembourg (linked with DG SANCO) will organize a meeting in early 2008.

- Follow-up EUPHA workshop 2006: EU policy related to health care for asylum seekers – how to proceed further? It was suggested to establish a work group on the rights to health care of asylum seekers and/or undocumented migrants.
- Work plan of the section for 2007–2008: how to keep Migrant Health on the public health agenda in between 2 EUPHA meetings? Tasks of the Section? Also the establishment of work groups was suggested regarding acculturation, quality of care, health policies.
- The name of the Section should cover minorities as well: suggestions “Minority Health”, “Minority and Migrant Health” or “Minority Health and Migration”.

ENNI MERTANEN

EUPHA section president – Food and Nutrition
Jyväskylä University of Applied Sciences, Finland

20 Food and Nutrition – Lessons learned from the workshop on Healthy Nutrition and the Educational Environment

The Section on Food and Nutrition organized a workshop on the topic of Healthy Nutrition and Educational Environment at the EUPHA conference in Helsinki. The workshop was chaired by Christopher Birt, who also chaired the session. The audience had the pleasure to listen to his marvellous presentation, where he gave some introductory remarks about the topic. He also defined the educational environment (from kindergarten to universities) and all the actors in different educational environments (from parents to school catering staff and all those in between). Christopher Birt pointed out that healthy nutrition has been increasingly important in different discussions in Europe, but still those decisions with health impacts are often made without thought to health. He gave some very common examples: Educational authors try to save money, and they are coerced to save money, but this leads inevitably to cheap food, which is also high in fat and calories. At the same time obesity and its related problems is increasing among children and young people in Europe. Christopher Birt hoped that the presentations would lead to a good discussion, which turned out to be the case.

During the presentations we learned that the provision of kindergarten food and related policies and practices need to be developed. Modi Mwatsama gave an example from Cheshire and Merseyside, where an intervention study took place. The problems were that the kindergarten did not emphasize nutrition and healthy eating, even though half of them had some kind of food policies. Catering staff had rarely received training on healthy eating. All kindergartens provided fruit and vegetables, but also full fat milk as a daily drink and there were no attempts to reduce saturated fat intake. The common reason for these practices was that the staff thought that children would not eat healthy food.

The next presentation related to Finnish school meals, and was given by Susanna Raulio. She present-

ed results from the national School Health Promotion Study. In Finland a comprehensive, free school meal is served to all pupils in all schools. The meal includes a main course, fresh vegetables, bread and milk or water. The proportion of pupils who ate all meal components were very low, only 35%. Almost all ate the main course, but the vegetables were eaten more among girls and milk and sour milk consumption was higher among the boys. Eighty per cent of pupils ate bread daily with the school meal. Susanna Raulio said that those who did not eat a school meal were more often snacking. Also those who liked to go to school usually had a school meal, but not so for those who were bullied at school. Not eating school meals can give hints about other, sometimes more serious problems.

Tatjana Buzeti presented an encouraging case about the local co-operation involving school catering, healthy eating and local food production. In Slovenia, a food and nutrition policy for 2005–2010 has been adopted by the parliament in 2005. It contains three pillars: food safety, well-balanced and protective nutrition and sustainable food supply. Several actors have been working towards the same goal: health promotion. Tatjana Buzeti reported that if the school food practices have to change, then all parties need to be involved, including the principal, teachers, food organizers and cooks, children and parents. The most important lesson to me was that in Slovenia the new law about outsourcing services or buying food products for public purposes was seen as a way to protect local production and helping to use local products, whilst in Finland it seems that the current set up even hinders buying food stuffs locally.

The last presentation was given by Sylvia Cheater, who talked about an English school food policy. She reported that “as the implementation of the new nutritional standards is rolled out and achieving National Healthy

School status becomes mandatory, public health has an important role in supporting schools". This is possible when new nutritional standards for school food have been introduced through several ongoing local healthy school programs backed by the independent School Food Trust and also supported by the Department of Education and Skills. The main themes to be developed were as follows: the level of knowledge of diet, nutrition and food safety required by teaching staff,

how to influence packed lunches, and where to access information.

To conclude the whole workshop: much work has to be done before the educational environment will also be a healthy environment. The best lesson is that by international network, we can learn much from others and we can notice that the same issues are acute in several parts of Europe.

Els MAECKELBERGHE

EUPHA section president – Public Health Ethics

Lecturer, Health Sciences/Medical Ethics, University Medical Centre Groningen, The Netherlands

21 Public Health Ethics

Welcome

Els Maeckelberghe welcomed the participants for the second meeting of a proposed Section on Public Health Ethics. The suggested agenda was adopted.

Plenary Speaker

It was agreed as appropriate to try to install a plenary speaker on public health ethics as soon as possible at an upcoming EUPHA conference. This would introduce the topic of public health ethics to the wider scientific community and would clarify that public health ethics is not identical with the work of Research Ethics Committees and Institutional Review Boards. Attendees felt it was important to make this clear right from the beginning to avoid misunderstandings of the role of ethics in Public Health and especially in EUPHA.

Among persons that would be ideal candidates to ask to deliver a lecture and to take a leading role in a workshop on ethics would be Ruth Faden (Baltimore), Onora O'Neill (Oxford), Nancy Kass (Baltimore).

Workshop

The participants of the meeting agreed that the Section should as soon as possible contribute to the EUPHA conference with its own workshop. The main aim of this workshop should be to show how ethics and philosophy can contribute to good public health research and practice.

The idea was discussed to make a joint workshop with one or two other sections (e.g. Public Health Genomics, Food and Nutrition, Child and Adolescent Health). In such a proposed workshop, public health researchers could present ethical issues or ethically challenging aspects of their work (e.g. prevention of obesity, informed consent of minors, nutrigenomics, youth and

e-cards, dealing with genetic information) and an ethicist could then give a reply presentation that discusses these aspects from a philosophical point of view. This dialectical structure could help to bring public health practice and research and ethics into dialogue.

Section Inauguration

The proposal will be made to the EUPHA Governing Council to make the Section on Public Health Ethics an official EUPHA Section. The aim of this Section is to provide public health professionals with a cross-sectional forum in which ethical questions can be raised, discussed and scrutinized.

Name of the section

After some discussion, it was agreed that the section's name should be appealing to EUPHA members. EUPHA Section on 'Ethics in Public Health' seemed to be the best candidate.

Miscellaneous

Els Maeckelberghe and Peter Schröder-Bäck reported on a joint editorial in the European Journal of Public Health (forthcoming) that introduces the concept of public health ethics and reports on the plans of a EUPHA Section on this very topic.

A website for the Section shall be established in the near future.

Closing

Els Maeckelberghe was entrusted to pursue the future planning of a plenary talk, workshop and the proposal of the section to the EUPHA Governing Council. She thanked all persons attending the meeting, especially the EUPHA manager for her guidance.

ANGELA BRAND

EUPHA section president – Public Health Genomics
School of Public Health University of Bielefeld, Bielefeld, Germany

22 Public Health Genomics – National Task Forces of the Public Health Genomics European Network: shaping the future of Genomics and the Populations' Health in the Unified Europe

The idea of the unified Europe is built on traditional and moral values, and on effective system of political democracy. This includes the respect of human rights and democratic principles by informing and mobilizing citizens, and influencing decision-makers at all levels within European Societies. Therefore, it would be a serious error of judgement to consider European integration as nothing more than an effort to adapt the economies of the European countries to the challenges of free international trade and globalisation. Integrative approaches like the concept of “health in all policies” fit within the whole rationale of the European Community, and the process of civilisation itself. In addition, a positive vision of the capacity to learn from the experiences of others in order to prepare a better future is of high European added value.

One of the biggest challenges all European health systems currently face is genomics. Genome-based knowledge and technologies will have to be implemented in a responsible manner, having regard to all the evidence, if the goal of improving population health is to be achieved. In the unified Europe this can only be guaranteed by taking an integrated and interdisciplinary European approach.

The international accepted framework of Public Health Genomics (as conceptualised by the “GRaPH-Int Group”, www.graphint.org) assigned Public Health Genomics (PHG), a translational research area, the communication-role between the basic research and the application of genome-based knowledge.

Since 2006 the European Commission (DG SAN-CO) is funding a project “Public Health Genomics European Network” (PHGEN, www.phgen.eu). PHGEN maps the research areas and provides an inventory of PHG-issues and priorities in Europe. For example, it al-

ready identified objectives and activity areas of PHG through a literature review and a peer-review process in a working group entitled “Issues and Priorities of PHG”. The identified objectives were compared with and evaluated against those of Public Health (PH). Almost all traditional PH objectives and activity areas are conceivable in PHG. Objectives such as Health Technology Assessment are a prerequisite and will be strengthened when classical health determinants will be expanded by genome-based indicators. Epidemiology will be asked to develop methods for handling population-based association studies which go far beyond conventional questions of genetic epidemiology. The use of existing databases as well as frameworks for new bio-banks should be assessed with regard to the ethical, legal and social issues (PHELSI). Health promotion and prevention will be expanded by including the possibility of risk stratification. In compliance with health literacy concepts, new ways for communicating risk must be developed when genome-based knowledge is utilised to inform the public and to train the work force. Thus, the integration of genome-based determinants as some of the main health determinants allows new perspectives on conventional PH issues. PHG helps to re-define PH instruments and concepts. It also advocates a new multidisciplinary approach and a multi-level discourse, which will lead to a coherent strategy to improve the populations' health in the unified Europe.

Within PHGEN the bottom-up concept of National Task Forces (NTFs) has been developed to promote and stimulate efforts in all European Member States, Applicant Countries, and EFTA-EEA countries for effective networking in order to reach sustainability of discourse and institutionalisation of public health genomics in the countries. These PHGEN National Task Forces

discuss and explore the situation in their countries, develop suggestions for national strategies and report results back to the PHGEN secretariat. By initialising the NTFs, there are – apart from the NTFs reporting back to PHGEN on all relevant information needed for national situations – further specific objectives of PHGEN to be met, namely to identify national key experts and disseminators and to promote sustainable processes of discussing Public Health Genomics. PHGEN NTF has to engage in interdisciplinary work to guarantee a distinctive Public Health approach. Representatives are esteemed experts and multipliers in the respective country to ensure high quality, standardisation, and sustainability. So far, NTFs have been implemented in eleven European countries (Austria, Belgium, Bulgaria, Czech Republic, Germany, Italy, Netherlands, Norway, Poland, Portugal, Spain).

From the NTFs it can be learned that a growing awareness of the possibilities and shortcomings in our knowledge of genomics and its potential impact on public health has become evident. There are several issues and needs important enough to be raised both at national and European level: for example, the lack of regulatory structures allowing the implementation of genome-based knowledge and technologies in Public Health initiatives, the lack of a regulatory framework for evaluating, validating, and adopting diagnostic and ge-

netic tests, difficulties for the technical validation of the genetic tests by biotech companies, difficulties in the development of genetic tests because of the copyright of the SNPs, the need for a better understanding of the mechanisms of complex diseases, the need for “appropriate” funds for research in this area, the need to update scientific policies to integrate the concept of PHG independently from clinical genetics, and the need to improve the public perception of the area.

Progressively clear lines are emerging by means of which this new knowledge could have an impact on the populations’ health. The increasing importance of genome-based knowledge and technologies requires new strategies in public health. The NTFs assess current shortfalls and gives advice on future implementation. They detect weaknesses both in the awareness and preparedness of the various European health care systems. Stakeholders and experts need to be encouraged to come up with coherent and consistent methods and action plans in order to meet with the current challenges deriving from genomics. PHGEN has the capacity to transfer the conceptual knowledge into research (translational research), policy and practice. In the long run, through the establishment of PHGEN NTFs, the future of genomics and populations’ health will be shaped in the unified Europe.

WORKSHOPS

EEVA OLLILA

Ministerial Advisor, Ministry of Social Affairs and Health,
Helsinki, Finland

23 Health in All EU policies

The workshop was organised to collect current views on the application of the “Health in All Policies” -principle within EU policies. The core thought is, that health is to a large extent constructed by policies outside the health sector, and that it is of utmost importance to assess the implications of all other policies to health and health systems.

The Maastricht and Amsterdam treaties have paved the way for Health in All Policies -thinking, and Health in All Policies was the health theme of the Finnish EU presidency in 2006. The workshop was set up to discover what was the state of the art of Health in All Policies at the time of the conference. The workshop consisted of three presentations.

Natasha Azzopardi Muscat’s presentation title was “Health and the strategic objectives of the EU – Synergy, coherence and compatibility”. She emphasised that while growth and competitiveness are current EU priorities, the health of EU-citizens is also an important objective. Traditionally, the environment and social policy sectors have had goals in common with public health. An emerging issue is, whether policies such as external relations, regional, research and development and gender policy can be seen as complementing health policy. Some policy areas still remain competitive to health; examples are tobacco, alcohol, economic convergence, ageing and also in some respects, pharmaceutical policies. She concluded that public health is now rising up the EU-agenda, as it is perceived as an investment. For public health, this is a unique opportunity to be seized.

Nick Fahy’s title was “Tools, methods and procedures of considering health impacts of EU-policies”. The starting point of his presentation was the fact that the treaties of the European Union have given the Com-

munity a mandate to guarantee a high level of health protection in its policies and actions. The result of this is that, the EU has much to offer in this respect, while the member states are not able to control their health-relevant policies alone. Mr Fahy discussed the European health strategy (that was upcoming at the time of the conference), and paid special attention to how a Health in All Policies-approach is seen as a key priority in the strategy. He concluded by pointing out that investment into health is also a way to support economic growth and sustainable development, so that it is “not just about Europe to health but of health to Europe”.

Meri Koivusalo talked about “Health in health policies – the interface between EU and global activities in health and pharmaceutical policies”. In the light of the broader emphasis on Health in All Policies, she brought up the need to secure sufficient policy space so as to ensure health in health policies. A particular example of this dilemma at European Union level can be found from pharmaceutical policies, which within the European Union are dealt with primarily in the context of industrial policies. She further examined the challenge of articulating health policy priorities in the context of international policies and the WHO intergovernmental working groups on public health, innovation and intellectual property rights. According to her there is a danger that, in the current context of policy-making and expanding international competence, the European Union Member States may also end up having to accept policy stands in health forums, such as the WHO, which favour industry over health and lead to an undermining of health priorities both at national and global level.

The presentations raised lively discussions.

EERO LAHTINEN

Senior Policy Advisor

WHO European Office for Investment for Health and Development, Venice

WHO Regional Office for Europe

24 Health inequity as a challenge in the WHO European region

This workshop started with an introductory note, followed by examples from different types of countries.

Introductory note

Health inequities are defined as avoidable and as unjust systematic differences in health status between different groups in a given society. Recent country health data indicates that there have been improvements in overall health status for many countries in Europe. These differences are due to the conditions in which people live and work, and the structural and socio-political causes of these conditions. Unless these underlying conditions are addressed, we treat people for the short term, and risk “sending them back to the unhealthy conditions that made them sick.”

Inequities in health are becoming a concern in many high- and middle-income countries within the EU. The WHO member states are taking various approaches to address this important issue. Some of these countries have developed cross-governmental policy frameworks to address health inequities. Others are tackling health inequities through policies and interventions to increase health system access for the most socio-economically disadvantaged groups. Meanwhile, there are low-income countries which are facing increasing health inequities, but have limited resources to tackle the issue and must give attention to more urgent priorities.

Lithuania's approach

Prof. *Ramune Kalediene*, Dean of the Faculty of Public Health, Head of the Dept. of Health Management Kaunas University of Medicine

A reduction of socio-economic inequalities in health is a recognized priority in the development of health policies by the Government of Lithuania. However, inequalities in health by education and urban/rural health dispari-

ties have been increasing throughout the last decades.

Since regaining its independence in 1991, the government of Lithuania have enacted a series of reforms relevant to both the national economy and the health system. A solid research database providing information on inequalities in health in Lithuania served as an integral component in formulating national health policy. The ongoing projects provided an opportunity to monitor inequalities in health at the national and regional levels. The major strategic documents of the Lithuanian health care system were largely based on Health for All principles, giving due importance to equity in health, community participation, intersectorality, and balance in health care aspects. However, numerous social and economic constraints, a lack of intersectoral co-operation and political instability resulted in delays and deviations from health policy and have hindered a more structural development and implementation of those strategies aimed at systematically reducing inequalities in health.

A quick translation of national research data into health policy formulation could be considered as one of the successes that might be recommended to other countries of the former Eastern bloc, the identification of potential data being the first step. In order to avoid similar failures, and aiming at a translation of policy into action, stable intersectoral partnerships should be created. Research into health inequalities should be intensified at a regional and municipal level, aimed at strengthening of health information to back up policy formulation and action.

Effective health promotion activities can no longer ignore social contextual factors and have to intervene on as many levels as possible. Collective efforts are necessary to address the health problems of the least privileged. The solution is integrated strategic planning and an implementation of a balanced national health policy involving all sectors of society.

Public Health Reform in Georgia-General Review

Ms *Sofia Lebanidze*, Head of the Department of Health and Management of Emergency Situations, Ministry of Labour, Health and Social Affairs of Georgia

The main directions of state politics in the healthcare sector include ensuring a supply of qualified, equal and accessible medical services for every category of the population. The aim of health system reform is to establish a public health system that integrates the whole healthcare structure, including a healthy and safe physical environment and healthy lifestyles, so as to maintain a positive epidemiological situation and its development.

Public health (impersonal medical services), which includes immunization and other preventive programs and promotion of safe environment, is one of the priorities and the main sphere of state responsibilities.

The restructuring of the Ministry of Labour, Health and Social Affairs (MoLHSA) and affiliated organizations has been done, as part of the structural reform of the Ministry, with the purpose of improving the health infrastructure (including public health organization, epidemiological, health information and analytical services, competitive human resources permanent development etc.). Recently, a new structure – the Centre for Disease Control and Public Health – has been established by means of the uniting of the Public Health Department, which promoted health politics development and implementation in the sphere of public health, with the National Centre for Disease Control and Medical Statistics. The structural transformation led to other substantial changes. A special unit has been formed within the MoLHSA which is responsible for developing the national Public Health Programs, for organizing, managing and monitoring the approved national programs as well as submitting the methodological and instructional proposals for their update. Presentation will be dedicated to the changes of national Public Health Programs and their updated format. It outlines the challenges and future activities that are planned for health promotion and disease prevention.

Georgia is at a stage of development where the main priority is to restructure the health care system. Health inequities are not yet a priority. The government investments in the healthcare sector provide improvements in health for the whole population on the one hand, and on the other, promote a positive economic situation in the country. Therefore, improved health will benefit the labour activities of the population, the active involvement of the population in the labour market, high individual income, prolonged labour activities and high potential for pension deposits, and as a result, decrease the social burden upon the state.

Preparation of a national action plan to reduce health inequalities in Finland

Dr *Seppo Koskinen*, National Public Health Institute, Finland, *Eila Linnanmäki* and *Taru Koivisto*, Ministry of Social Affairs and Health, Finland

There are wide inequalities between population groups in terms of health status, morbidity and mortality in Finland, and evidence of growing inequalities in mortality. Socioeconomic health disparities show a systematic gradient: the higher the socioeconomic position a group has, the better its health. These health inequalities are due to both differences in the living and work environment and to lifestyles and health services. Among men around one-quarter and among women a slightly smaller proportion of the mortality differences between socio-economic groups are due to deaths caused by alcohol, while smoking has a roughly similar kind of effect.

The group of ministers responsible for social policy issues has commissioned the Ministry of Social Affairs and Health to prepare a national action plan to tackle health inequalities in Finland. The action plan aims to identify the policy areas and measures required to achieve the national target to reduce socioeconomic differences in health, which is also a stated aim of the national “Health 2015” programme (2001).

The preparation is the responsibility of the Advisory Board for Public Health, consisting of representatives from several administrative sectors, local government, the health service system, NGOs and professional organisations, and health research institutes.

The action plan will be built around the following seven strands:

- Reinforcing the theme of Health in All Policies (HiAP) and integrating health inequalities into it;
- Strengthening work to reduce health inequalities in municipalities;
- Alcohol and tobacco policies;
- Enhancing equity in services;
- Reducing health inequalities in children and young people and preventing social exclusion;
- Reducing health inequalities in people of working age;
- Developing monitoring systems for health inequalities between population groups.

The proposed measures should be preferably linked to other ongoing processes. The action plan is mainly intended for the next four-year government period, but the perspective for structural changes is of course longer than that. The Government will decide if the proposed measures require legislative measures and related funding.

Determinants of health inequalities are multifaceted and linked with social inequality, the uneven distribution

of available material and cultural resources. Its effects can be felt throughout society and impact a range of policy sectors. Health inequalities are not, however, inevitable. For example, a marked reduction in regional health inequities and in socioeconomic differences in infant mortality in Finland, resulting from determined activities, show that something can be done to prevent health inequities. Political will is needed, as well as concurrent implementation of cross-sectoral measures to

tackle inequalities.

Health inequalities present a major problem for any modern welfare state committed to values of equality. Health disparities also reflect adversely on the average health of the population. If the health of other population groups could be raised to the same level as that enjoyed by people who are now in the best position, the nation as a whole would be in significantly better health.

HANNELE PALOSUO

National Research and Development Centre for Welfare and Health (STAKES), Helsinki, Finland
co-convenor Dr. **SIMO MANNILA**, STAKES, Helsinki, Finland

25 Health Shocks in Eastern Europe – Why Did They Take Place and Have They Been Overcome?

The workshop was organised to shed light on the present situation in public health in Eastern Europe and particularly Russia, having in mind the dramatic rise of mortality connected with the dissolution of the Soviet Union and the profound system change in Eastern Europe in the beginning of the 1990s. The chair of the workshop opened the session by noting that the proportion of oral presentations in the EUPHA Conference by participants from Eastern Europe was rather small in proportion to the scope of public health problems in the area.

Growing inequity in health care

Dr. Sergey Shishkin, Moscow, addressed the challenges that the societal changes have created for the Russian health care system. The sharp fluctuations in the overall high mortality in Russia show a recent decline in 2006, but it remains to be seen whether this positive turn will continue. Infant mortality and maternal mortality have quite sharply declined in the past 10 years; yet the Russian levels remain considerably higher than those of the older EU member states and also those of the new EU member states. There have been positive changes in the economy in Russia between 1999–2006 (increase in real incomes, increase in budget incomes, decrease in unemployment). Also public health funding has increased and has finally exceeded the level of the early 1990s. At the same time, since the mid-1990s, the household expenditures on medical services and drugs have steadily increased. In spite of the free-of-charge health care system, many surveys have revealed that paying for services is very common, especially for dental care and inpatient care. Paying for outpatient care has varied from 12% to 38% according to different surveys.

There is considerable regional variation in public health care funding in the Russian Federation. Free

health care is more accessible in well-to-do regions, and the average share of health expenditure of the household income is higher in the economically less developed regions. Lower-income households pay relatively more for care than higher-income households. There is inequity both in health care funding and in access to health care. Moscow and St. Petersburg are best placed in terms of providing outpatient care and examinations, whereas the countryside and the villages have the least access to care.

In the WHO ranking, Russia has received rather low positions and was placed as 130th for integrated health care system performance in 2000. However, resources in terms of numbers of doctors in Russia are greater than in the EU. It is to be expected that there will be demands for higher efficiency of the health care resource utilisation. Also the growing middle class will probably create pressure for improvements in the quality of health care. Actions have been taken to improve the availability of medication by introducing a system of free drug delivery for targeted populations in 2005. A National Project “Health” is being implemented in 2006–2007, with an effort to invest in primary and tertiary care. For example the salaries of the primary care physicians and nurses have been raised since 2006. The development of the health care system will depend on the investments of the Government, population and business corporations, as well as of public attitudes towards health and health care, and the Government’s capacity to develop health care management and financing institutions.

How do the Russians relate to their health and health care

Dr. Pauliina Aarva (Tampere Finland) described the practices and attitudes concerning health care, as well

as public perceptions on the reasons for high morbidity in Russia, in her presentation "Citizens' views on primary health care in Lipetsk and Tyumen, Russia", which was based on household surveys conducted in 2006 (appr. 1000 respondents in each city). The majority (82%) of the respondents had used the services of a polyclinic, which is the basic primary care unit, during the previous three years, especially those aged 60 or over (96% in Tyumen, 86% in Lipetsk). More people had visited a general practitioner or a specialist during the previous 12 months in the more well-to-do city of Tyumen, compared to Lipetsk.

According to the Constitution of 1993, the provision of health care at state and municipal health institutions shall be free of charge, but a Government Resolution of 1996 allows chargeable health services, which the local authorities define. The question of payment in health care is not entirely clear, and it is not clear what people pay. In this study, half of the respondents reported having paid for health services, and 15% reported unofficial payments for free medical services. Half of the respondents that had used chargeable governmental services were of the opinion that there was no choice other than to pay, a quarter expected to receive better quality for having paid, and almost a quarter considered paying to be customary.

There was considerable dissatisfaction among the respondents with preliminary registrations for primary care, with queues and personnel in the registration, queues to see the doctor and access to specialist treatment. However, high satisfaction with the time doctors gave to a patient, with access to a therapist, the professional skills of the specialist, the comfort of the setting and the location of the polyclinic was quite common. A low level of satisfaction was often more common in the poorer city of Lipetsk compared to the more well-to-do Tyumen.

It was common to attribute the high level of morbidity in Russia to a poor ecological situation (36% of the respondents), whereas only 17% attributed this to unhealthy habits, and 12% to stress. At the same time, the respondents considered stress to be the factor that affected their own health most negatively (38% of the respondents), while only one tenth considered unhealthy habits to be the major cause of that. The most common factors that were perceived to affect positively one's own health were positive emotions and the outdoors.

There seems to be a need for clarification of the payment mechanism in health care, as well as a need for clarification on the role of the polyclinics in health education and counselling. Health information for the population is an issue that needs to be resolved. The ongoing national project "Health" does not tackle health promotion.

Fluctuations in mortality and the role of alcohol

Professor Martin McKee (London) started his presentation "Explanations of the East European Health Crises and Implication for Health Policy" by arguing that most male deaths at working age in the Commonwealth of Independent States (CIS) are avoidable by reducing smoking and use of alcohol, and by stressing the importance of preventing smoking-related diseases in women, as well as pointing to the potential of health services in secondary prevention. One of the striking differences between the EU and Eastern Europe is that while the trends in life expectancy have shown a steady increase in the EU for the past decades, fluctuations in the CIS have been sharp. The gap in life expectancy between the EU and CIS populations has even expanded. The trends in life expectancy at birth and alcohol poisonings in Russia form practically full mirror images, which heavily points to the importance of alcohol in accounting for the fluctuations in life expectancy. Such fluctuations did not occur in smoking. There is no evidence of the role of diet and exercise, the other major health behaviours, in the fluctuations of life expectancy.

Another striking difference between the EU and CIS is the large and fluctuating difference between the male and female life expectancy in CIS, whereas the female-male gap in life expectancy in the EU has slowly but steadily decreased. As the general environment is shared by men and women and it is implausible that women would have benefited much more from the health services compared to men, the use of alcohol, smoking and risk-taking behaviour emerge as likely explanatory factors for the sex difference in life expectancy.

The third peculiarity of the East European health crisis is that the mortality increase affected especially the working-aged population. Those groups that are socially and economically most vulnerable, i.e. children and pensioners, were not affected by the societal crises in the same manner. The main causes of death in the working age are circulatory diseases, injuries and poisonings and cancer. Alcohol is a key driver of injuries, poisonings and violence, and possibly also of heart-related fatalities. Smoking is highly prevalent among men and is rapidly increasing among women. Thus, smoking remains a major public health problem. Smoking causes more deaths from cardiovascular diseases than cancer.

Alcohol has been important in Russian state policy ever since Czarist times, for example for fiscal reasons, but also to keep the population from revolting. Heavy drinking is customary, even 'zapoi' (heavy drinking episodes lasting days) occurs frequently. Heavy drinking

seems to vary strongly by socioeconomic status and employment status. Recent research has revealed the importance of surrogate alcohol in mortality. There are surrogates on the market that contain even 90% alcohol and cost 1/3 the price of vodka. Medicines used as surrogates also have a higher ethanol concentration than vodka. All-cause mortality increases sharply with increasing drinking frequency of surrogates. It has been estimated that even 38% of all deaths in the 25–54-year-old male population in Russia are due to alcohol abuse, i.e. causes directly linked to heavy use of alcohol, such as alcoholic cirrhosis and alcohol poisoning, and also other alcohol abuses such as use of surrogates. Policy measures are obviously needed to tackle alcohol problems. These include higher prices, limitations on availability, restricting sales of surrogate alcohols, new approaches to education and prevention especially among young people, providing effective treatment services, sanctions against serving alcohol to people already drunk and enforcing drink-driving laws. New legislation has been launched in 2006. The challenge is to implement and police the restrictions comprehensively.

Discussion

The presentations described trends in Russia and other CIS countries, but the problems of health policy and health care were mostly discussed in the Russian context. The discussions in the audience tackled for example the role of the growing middle class in Russia, which according to some estimation might increase to encompass 50% of the population by 2025. It was noted that Aarva's results "from the field" were much in line with Shiskin's presentation of the health care system. It was asked whether the Russian population should be even more dissatisfied with their health care and demand better care. Behavioural factors seem to be highly important in explaining mortality fluctuations in Russia, as presented by McKee, but the public opinion seems to attribute morbidity and health problems to ecological factors and does not seem to recognise the role of behavioural factors.

About 120 persons participated in the workshop.

MIKKO VIENONEN

Dr, Co-ordinating Chairman, Expert Group on Social Inclusion, Healthy Lifestyles and Work Ability ("SIHLWA") under Ministry of Social Affairs & Health/ Finland
Northern Dimension Partnership in Health and Social Wellbeing (NDPHS)

26 Northern dimension partnership in public health & social well-being

The workshop on the Northern Dimension Partnership in Public Health & Social Well-being was held on Fri 12 October "European health 2". Mikko A. Vienonen acted as chair. The workshop was organized by the Northern Dimension Partnership in Public Health & Social Well-being (International Secretariat of NDPHS, the Expert Group SIHLWA (Social Inclusion, Healthy Lifestyles & Work Ability) and Expert Group HIV/AIDS). The venue of the workshop was well organized and it was attended by approximately 30 participants.

Introduction: The Northern Dimension Partnership in Public Health and Social Well-being (NDPHS) was established after 3 years of high-level consultation leading to the Oslo Declaration 2003. It aims to promote sustainable development in the Northern Dimension area through improving health and social well-being by means of: 1) intensified co-operation and 2) enhanced co-ordination. 13 countries and 8 international organizations have joined the Partnership. Four years have passed and the network has been able to establish its position as an important actor in public health in the Northern Dimension area. The seminar elucidates the lessons learned (positive and negative) through some of its expert groups, in particular the EG on HIV/AIDS and the EG on social inclusion, healthy lifestyles and work ability "SI-HLWA". NDPHS project-database and project-pipeline are a tool from which several public health organizations, administrators and the scientific community can benefit.

There were 5 speakers in the workshop:

Dr *Viktoras Meižis* spoke about the Northern Dimension Partnership in Public Health and Social Well-being: background, priorities, activities and future perspectives. He said that The Northern Dimension Partnership in Public Health and Social Well-being (NDPHS) was established after 3 years of high level consultation that

led to the Oslo Declaration 2003. It aims to promote sustainable development in the Northern Dimension area through improving health and social well-being by means of: 1) intensified co-operation and 2) enhanced co-ordination. 13 countries (5 Nordic Countries, 3 Baltic States, Canada, France, Germany, Poland and the Russian Federation), and 8 international organizations (BEAC, CBBS, EC, NCM, ILO, IOM, UNAIDS, WHO-EURO) have joined the Partnership.

NDPHS priorities are: 1) Reduction of major communicable diseases and prevention of lifestyle-related non-communicable diseases (including HIV/AIDS and tuberculosis, the use of illicit drugs, cardiovascular diseases and the consequences of socially distressing conditions), and 2) Promotion of healthy and socially rewarding lifestyles (including determinants of health and social well-being, such as sexual behaviour, alcohol consumption, smoking, the use of illicit drugs, people's social and work environments and social skills).

Ms *Outi Karvonen* spoke about the HIV/AIDS epidemic in the Northern Dimension area. She reported that the main role of the EG on HIV/AIDS is to act as the focal point for national inputs from the Partner Countries and Organisations. In this capacity, the EG on HIV/AIDS has the overall objectives to work towards seeing policies for controlling the HIV epidemic included on political agendas, supporting co-ordinated and collaborative efforts to prevent the spread of HIV/AIDS in the Northern Dimension area, and promoting networking and partnership building among relevant stakeholders. EG on HIV/AIDS has responsibilities such as (to mention five)

- Establish and maintain relations within the Partner Countries and Organisations as well as with international and national organisations, and other institutions as appropriate;
- Establishing connections and co-operation with other

NDPHS Expert Groups;

- Facilitating the project proposal processes such as by expediting relevant technical reviews, negotiating specific terms and conditions, and establishing assessment mechanisms, with an emphasis on performance and verifiable results. In this respect, the Expert Group can identify needs and develop initiatives for new projects, identify actors and new partners. EG will not be involved in the execution of identified activities and projects;
- Contributing to the development of national policies that respond to the needs and requirements of Partner Countries; and
- In association with Partners and with assistance from NDPHS Secretariat, supporting efforts to provide technical and other forms of assistance to governmental and national partners in planning, implementing and monitoring programs to scale up HIV/AIDS treatment, care and prevention.

Dr *Mikko Vienonen* spoke about the work for promoting healthy lifestyles (fight against alcohol, tobacco, obesity and other public health threatening lifestyle trends) in the Northern Dimension area (EG on social inclusion, healthy lifestyles and work ability "SIHLWA").

Within the Northern Dimension area, there are significant disparities in health and well-being, including social and economic problems which lead to a high level of mortality, abuse of alcohol and drugs, and the spread of infectious diseases. Thus, one of the main priorities of the Northern Dimension Partnership in Public Health and Social Well-being (NDPHS) is to enhance and promote healthy and socially rewarding lifestyles. The building of public policies to enhance health and social well-being in all relevant sectors needs to take place at all levels of society. Also, the creation of supportive physical and social environments should include the continued reorientation of health systems and social care systems. The opportunities for the development of individuals' basic skills related to health and social life are consistent with the Partnership objectives to empower and mobilise people and communities to take action to enhance their well-being. The main role of the EG on SIHLWA is to assist in co-ordinating and further developing the Partnership's co-operation in the fields of alcohol and binge-drinking, young peoples' lifestyles, and occupational safety and health. In this capacity, the EG on SIHLWA has the overall objective to emphasize support for national, regional or local programmes in its respective fields of co-operation

Dr *Suvi Lehtinen* in the Northern Dimension area. The group exists to promote a broader understanding of the problem by

- preparing an analytical overview (political overview)

of occupational safety and (especially) health service/systems situation, and eventually as a policy paper for the ministerial level, and

- undertaking a systems' development and intervention plan for interested ND region countries on work ability and work-related injuries and diseases, taking into account their impact on enterprises in a selected pilot industry. Issues like obesity, alcohol, tobacco, etc. will be reviewed through rapid assessment procedures and practical interventions will be produced and tested. Results from the selected sector will be generalised for the national level to provide a better understanding of the benefits of a preventive and systematic approach both to productivity and to lower curative health costs.

Mr *Bernd Treichel* spoke about the NDPHS Database and Project Pipeline.

The overall aim of the NDPHS project database is to contribute to the reduction of the serious health and social problems in the Northern Dimension area. This is to be achieved by the preparation of thematic reports, network creation and new project proposals for the purpose of better co-ordinated projects and policy efforts in this area. This co-ordination work will be based on an innovative information/database tool to be created within the framework of this project. It will for the first time combine newly collected information on projects and processes on HIV/AIDS, lifestyle-related diseases, prison health, etc. with existing relevant data, policies, research, best practice, etc. (from other databases). The NDPHS Secretariat acts as the project management office assisted by a full-time project expert. All project partners and the NDPHS Expert Groups are actively involved in the implementation of this project. The tool/reports/networks will be open/accessible to all interested stakeholders. The project will result in a series of policy recommendations, proposals for future project actions to be carried out, and newly created or strengthened networks.

NDPHS project pipeline (currently under development) will be a market place enabling project proponents and project donors/funding agencies to meet. International national, regional and local organisations active in the Northern Dimension region in the area of public health and social well-being will be able to submit their project proposals. These proposals will subsequently be considered by project donors/funding agencies who will be able to take co-ordinated decisions as to which project to fund in accordance with previously agreed funding priorities and criteria. Current public health and social well-being activities include inter alia the areas of primary health care, prison health, occupational safety and health, adolescent's health, alcohol and drugs, HIV/AIDS. The project pipeline will

offer donors an easy-to-use and hands-on solution for reviewing and classifying projects, including the possibility to streamline and improve project application procedures. It is an open information sharing tool. It promotes co-ordination, transparency and the sharing and dissemination of knowledge and information between the project partners and donors in the ND area. The NDPHS project pipeline co-ordinates and harmonizes project initiatives. By providing an overview of all submitted projects it avoids projects of similar nature being duplicated and/or double-funded.

Discussion:

- The audience presented several questions and received answers on the funding, governing bodies and mode of work of the NDPHS.
- The NDPHS database and project pipeline was welcomed as an important step in co-ordinating activities and making it easier to find relevant data. The audience emphasized the importance of good information about the facility.
- The organization of NDPHS was considered a bit “top-heavy”. There are a lot of governing bodies (PAC, CSR) but the “grass-roots”, namely the expert groups and projects seem to be under-funded, and run almost on “volunteer basis”. There should be better funding mechanisms as for instance is the case for NDP Environmental projects and activities. Probably environmental issues are more appealing than health and social well-being, although the human toll of alcohol, tobacco, social exclusion, HI/AIDS is counted in millions whereas so far much less disease and deaths are caused by environment per se.
- The NDPHS received good wishes for success on its future work.

DINEKE ZEEGERS PAGET

Executive director, European Public Health Association – EUPHA

27 Health Inequities in Roma Minority Populations: Program and Research Findings

This workshop explored the inequities in health status between Roma and non-Roma populations documented throughout Europe. It was co-organised by the SOFOS Foundation and EUPHA. The contact persons were Heather Doyle and Dineke Zeegers Paget. The abstracts in this workshop were selected by both organisers and reviewed by the International Scientific Committee of the 2007 EUPHA conference.

The workshop was chaired by Semiha Denktas of the Erasmus University of Rotterdam, the Netherlands and Dineke Zeegers Paget of EUPHA. About 40 persons attended the workshop.

The first speaker in the workshop was Martin McKee of the London School of Hygiene and Tropical Medicine (UK) who gave an overview of the issues for Roma minority populations and presented the activities of the SOFOS foundation-sponsored 'Roma Health Project'.

The second speaker was Henna Huttu of the Provincial State Office of Oulu (Finland) who presented her abstract on Roma living conditions and health in Finland. Finland has set up a national advisory board of Roma affairs already in 1956 and four regional boards between 1996–1998. The presentation also focused on co-operation between the local Roma communities and the Finnish government. This included following some rules (cleanliness was one of them) combined with certain freedoms for the community. Even though this is an innovative approach, the Roma population in Finland still faces poor health, poor levels of education and social problems. The audience was interested in the co-operation, but somewhat disappointed with the outcome. Henna stated that the advisory boards are still learning and still progressing.

The third speaker was Laura Cacciani of the Lazio Region's public health institute in Rome (Italy). She presented an intervention project in several Roma 'camps' in Rome. The intervention was to inform the Roma population about access to health care (when and how).

The information was set out in brochures, with little language (but in more than one language) and a lot of pictures. The information was distributed in the 'camps' and the project was seen as useful both for the Roma population as well as for the health care workers (to become aware of the problem). The audience had some questions on the top-down process of the intervention (the brochures were created by the institute and the project workers were not from the target group) but was favourable to the intervention. One comment was that these type of brochures could be easily used in other countries (little text, lots of pictures).

The fourth speaker was Zuzana Skodova of the University of PJ Safarik in Kosice (Slovakia). She focused on gathering research data on specific health problems comparing Roma population to the general population. The study showed that low socio-economic status was more of an influence than ethnicity. The study showed as well that gathering data from the Roma population may prove difficult, as identification as 'Roma' may have negative consequences.

As there was still some time, the chairpersons then invited Kveta Rimarova also of the University of PJ Safarik in Kosice (Slovakia) to give a short presentation on her activities in the MEHO project (Migrant and Ethnic Health Observatory Project) funded by the European Commission. In this project, which started early in 2007, one work package will examine the health of the Roma people in CEE. The objectives are to:

- Define the most important criteria identifying Roma health;
- Update existing databases with available information on Roma health issues in CEE;
- Collect and analyse data on the health of Roma in comparison with the indigenous population.

During the closing plenary session, Prof. Martin McKee again addressed the issue of health inequities in the Roma population.

MARK McCARTHY

Professor, University College London, UK

28 Results from SPHERE: a European collaborative study

SPHERE (Strengthening Public Health Research in Europe) is a collaboration supported by the Sixth Framework Research Programme of the European Commission. SPHERE has three work themes: bibliometric studies of scientific publications in public health; inquiries at national, European and international levels on priorities and arrangements for public health research; and coordination, implications and dissemination of the work. The Workshop at Helsinki was the third of a series at EUPHA annual conferences, where the work and outputs of SPHERE are being described and discussed. This workshop included presentations from members within the SPHERE team, and also an external opinion from the European Commission.

Gabrielle Harvey: Overview and findings

Bibliometric research was undertaken by seven partners, and a scientific report has been published in the *European Journal of Public Health*.¹ The main findings from the work packages included:

- The annual number of public health research publications in EUPHA has been rising and over the 10 years between 1995–2005 it has averaged 7000 papers per year compared to a global total of 20000 for the field of public health;
- There were more papers on environmental health and infectious disease control in central and eastern European countries, while health services and management research and genetic epidemiology and health promotion were more frequent in northern and western countries;
- The highest rates of public health research output per capita are from Nordic countries and the UK, while most new member states, along with Portugal, have the fewest publications;
- Most publications are in English; and
- Public health social science literature is less likely than biomedical sciences to be published in jour-

nals or identified through medical science literature searches.

The major findings from the work packages on public health research priorities and arrangements were:

- There are wide differences in national structures for supporting public health research; ministries of science support biomedical research while ministries of health support public health research. However there is insufficient dialogues between these ministries at national level;
- The representation of health sciences at European level is much stronger for biomedical and clinical research than for public health research;
- Despite the substantial output from European public health researchers, national ministries of health have little knowledge of European health research policy and do not exchange information on each other's research programmes;
- The priorities of NGOs and national associations generally reflect their own areas of interest. There is a gap in information on public health research infrastructures, training and capacities.
- USA, Canada and Australia all have public health research programmes at federal level, and support state and regional research. But structures and priorities differ, and – as in Europe – biomedical and clinical research receive more government and commercial support than public health research.

Hans Stein: European Institutions

Policy related public health research is growing in scope and influence on both a national and international level. There are frequent calls for “evidence-based” health policy and a growing interest in the research community to provide this. The gap between policy and decision-making and public health research needs to be bridged.

Two approaches were used to identify European level stakeholders' views of support for public health

research: an analysis of official legal and policy documents; and formal written and oral interviews with representatives of international institutions, researchers and experts from different Member States. The oral interviews provided a broad range of views, quite often differing from the 'official' position, while written interviews were of less value because of low response rates and a repetition of official views available in formal institutional documents.

The analysis of documents showed the tremendous changes that have taken place in the last years, and also the potential for new approaches including changes to promote partnership between research and policy. However, the gap between research and policy still remains, as they have different interests and priorities, stakeholders, instruments, organisational structures, funding and resources.

This work package recommends that:

- The European Commission should not seek to integrate the two independent areas of public health research and policy;
- But to strengthen co-operation between the two areas through existing structures on the policy, programme and project level, and through greater national collaboration;
- To improve links between the two policy areas by using knowledge transfer structures and other networks; and
- Propose establishing a European research – health policy conference or platform.

Marianne Takki: Evidence-based policy making at the EU level – a myth or reality?

The European Commission has been working in two broad ways: strategic and policy initiatives, which include consulting with the European Health Strategy, a Directive on Health Services and a Pharmaceutical Forum; and stakeholder dialogue that includes consulting with the EU Health Policy Forum (on which EUPHA is a representative), conferences, and consumer dialogue and platforms.

The EU has several mechanisms to support health. The main funding area for The European Commission's Directorate for Health is the Public Health Programme, while the Public Health Portal is the means for electronic information and support. Other mechanisms include DG Research's 7th Framework Programme, the Structural Funds, collaborations with other policy fields (including WHO, Council of Europe, OECD, World Bank and WHO Observatory), as well as co-operation with non-EU countries and other stakeholders.

There is a need to undertake 1) more research in general policy and health politics, 2) fundamental, translational and applied research, 3) research with long-term objectives and 4) research on policy decisions to guide the policy making processes of the future.

European evidence-based policy-making needs all types of research and there needs to be improved co-operation between researchers and policy makers. The national level research needs to be better brought to the EU level while the research community should collaborate more to position itself as a genuine stakeholder in EU-level debates.

Walter Ricciardi: Implications for EUPHA

The EUPHA member organisations represent both research-active participants, and users of public health research findings. SPHERE sought to identify perceptions of research priorities at national and international levels, barriers to undertaking better research, evidence on the implementation of research findings and uptake by policy-makers. Information was collected on current methods of commissioning public health research at national and local levels in member states.

There is a marked heterogeneity between countries across Europe, and different research priorities in different European Regions. Considerable variation exists in public health research funding processes and development across the European Region. Most responses mentioned the common barriers to undertaking research, which were lack of infrastructure, lack of technological equipment and lack of research personnel and administrative staff. It was also shown that research findings in public health are published primarily for the research community and often do not reach policy makers and practitioners.

Working to reduce the knowledge gap between public health research and policy/practice needs to be prioritised. There is also a need to disseminate results from existing collaborative research and build capacity through exchange. There is a strong need for international collaboration among public health associations and for south east Europe, a regional collaboration could be the start for the development of public health research.

One of the goals of EUPHA is to provide a platform for the exchange of information, experience and research so this should be more actively promoted. EUPHA and national public health associations need to better co-operate to find solutions for these issues. The integration of Europe as a political, social and economic unity will strengthen public health collaboration and funding across borders in Europe.

Discussion

The four presentations were followed by a discussion, which raised the following points.

- Younger researchers should become aware of the policy implications of their research early in their careers, and be able to answer questions such as: Who wants to know? and What is the best way of communicating with that audience?
- The Danish National Institute for Public Health produces a weekly public health media message which enables researchers to understand the interest in their research. The European Commission website also has health news daily. Should / could EUPHA provide

a research input to the Commission, which would also make a more visible profile for EUPHA?

- Policy makers want evidence of interventions, and journals seek policy implications. But too little research addresses this.
- How can EUPHA better include non-EU countries – perhaps by comparing east / west differences?
- Summits and conferences / workshops are important for maintaining international profiles in public health research.

NOTE

- 1) McCarthy & Clarke eds: Public health research literatures in Europe. EJPH 2007 Supplement 1: 1–49

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With acknowledgement of the contributions made by *Gaetan Lafortune, Bernhard Gibis, Tit Albrecht, Helmut Brand, and Ales Bourek.*

29 Working towards comparable European health system information – The working party on health systems of DG Sanco: the current state of health system indicators development in Europe

Achieving a high-level of health status for European citizens means helping the citizens and governments to understand how to behave appropriately in today's environment with regards to health and to assure the provision of best possible health care services. Both goals can be reached with the help of data, information and knowledge management. Comparisons of health system performance have long been of interest to developed countries in Europe and outside Europe. Health systems are striking in their differences and the variations across countries in the range of available indicators on health expenditures, resource use, outputs and outcomes are also striking. Some of the major suppliers in Europe of health system information are progressing in expanding and strengthening the capacity to make meaningful comparisons of health systems and health-system performance across developed countries. Among these suppliers are the Health Systems Working Party of the Directorate General Health and Consumer Protection (DG Sanco) of the European Commission, the Organisation for Economic Co-operation and Development (OECD), and the World Health Organization (WHO).

DG Sanco's Health System Working Party

The European Public Health Programme 2003–2007 is the European Commission's main instrument for implementing the EU health strategy. The programme aims via a number of projects it funds, to improve the level of physical and mental health and well-being of EU citizens and to reduce health inequalities throughout the Community. The programme is set up to develop rapid

reaction capacities to health threats, to tackle major health determinants, and to establish a sustainable EU Health Information and Knowledge system (HIK). The latter should be achieved by producing comparable information on health, health-related behaviour, diseases and health systems. The HIK is based on the development of Europe-wide common agreed indicators with regards to their definition, data collection and use. The system builds on the work of former Community health programmes and aims to be complementary to the activities of Eurostat, as well as the work of other Community agencies, and of WHO and OECD. All projects that are funded by the Public Health Programme in the field of health systems are assigned to the Health System Working Party (HSWP). The HSWP has been set up to facilitate the exchange and comparison of information about important aspects of health systems in the EU member states. The advisory group sets out to reinforce co-operation between member states, and provide certainty over the application of Community law to health services and health care. Currently, the HSWP has about 22 running projects in the areas of health systems performance and health system organisation and structure. Among the major achievements of the HSWP in contributing to a European HIK are the following to be mentioned per topic:

- Health systems: The EUCOMP project has set up a system of standardised descriptions and comparisons of health care systems to create a basis for routine EU health care statistics as the foundation for routine data collection and comparative analysis.
- Public health in the media: The media is a powerful instrument to reach individuals. Therefore, a continu-

- ously enlarging network of broadcasters from all over Europe has been set up that continuously exchanges stories about health and medicines, free of any rights through a web portal (www.healthineurope.tv), documentaries and other mass media.
- **Pharmaceutical care:** The pharmaceutical pricing and reimbursement project has been able to make comprehensive, comparable descriptions of the pharmaceutical systems in 21 EU countries. The EUROMED-STAT project has made a web-based searchable database providing information on licensed medicines in 15 EU countries.
 - **Health technology assessment:** A European health technology assessment network has been set up that covers 27 EU countries, which is developing tools to translate assessments made for countries to other contexts, and translating it into applicable policy advice.
 - **Quality of care:** The EUPHORIC project has made an inventory of existing public health outcome studies. This resulted in a set of 54 validated clinical outcome indicators. The CEEQNET project has developed an administrative health care database to evaluate quality performance in 5 Central and Eastern European countries.
 - **Patient safety:** The safety improvement for patients in Europe project has resulted in a patient safety vocabulary. Based on this, a set of 42 indicators has been developed for use in efforts to improve patient safety.
 - **Health equality:** The EUROTHINE has developed and collected health inequalities indicators and provided benchmark data on health inequalities and their determinants for over 20 European countries. After assessing the evidence of the effectiveness interventions to tackle these health inequalities, the project was able to make recommendations for all participating countries on strategies for reducing health inequalities.
 - **Health impact assessment:** The EU for Health and Wealth project has managed to put HIA on the political agenda of EU policymakers through the Finnish presidency. The methodology has been taken forward by subsequent EU presidencies, and it has even been included as one of the main themes in the newly proposed Health Strategy of the Commission. The WP has also invested in capacity building in Eastern Europe by taking the existing knowledge and experience in HIA from developed countries and using this to strengthen HIA for policymaking in candidate EU countries where HIA has been underdeveloped.
 - **Electronic medical records:** From the eHID project we now know that good epidemiological data can be retrieved from routine electronic patient recording in primary care practices. This has been shown by providing data on four health indicator conditions from primary care practices in 7 seven countries. The project has made recommendations on how issues of comparability and quality of data and confidentiality can be accommodated.
 - **Hospital activity:** The Hospital Data project has developed a methodology for improving the comparability of hospital inpatient and day case activity data across Europe. According to this methodology hospital activity data is currently being collected Europe wide, and efforts are being made to also include acceding EU countries.
 - **Emergency care:** The European Emergency Data Project has developed a comprehensive list of indicators based on the routine collection of Emergency Medical System data which makes it possible to monitor the use of emergency care and the health status of emergency patients across Europe; it provides essential information on the geographical distribution of accidents in Europe, and provides benchmark data for comparing EMS systems.
 - **Cardiac care:** The CARDS project has developed European data standards for three priority modules of a cardiovascular health information system. The data set was primarily based on previously existing data sets in Europe. The standard data have been accepted by the Ministries of Health of all the EU member states in 2004. This was a major success and meant the start of a quality assurance programme to improve cardiac care in Europe.
 - **Cross-border care:** For some time already, Europe has been engaged in quite a number of cross-border projects in the health care sector. The EUREGIO project has identified 37 cross-border structures active in the health sector in Europe. They have identified 45 models of best practice to encourage the exchange of experiences and information between health care actors. On a patient level, the HEALTHACCESS project has investigated in 10 EU countries hampering and facilitating factors for access to cross-border care for patients. One of the problems the project encountered was data deficiencies on overall numbers and expenditure of cross border patients.
 - **Health promotion:** The EUPHID project has recommended the establishment of a European health promotion monitoring system based on a comprehensive health promotion model and the classification systems EUPHID has developed. The classification system consists of sets of indicators on health, health capacities and health promotion opportunities. The HSWP has also greatly invested into increasing the evidence base for health promotion interventions. The *getting evidence into practice* project has developed a consensus-based protocol for health promotion reviews. It has also set up guidelines and

a quality assurance tool to enhance and assess the evidence base for health promotion practices.

Further information about the HSWP is available at www.nivel.eu/EC/WPhealthsystems.

The OECD's health system performance work

OECD countries share some common policy goals: that health care systems should be accessible, of high quality, affordable, responsive and provide good value for money. OECD countries also share common challenges. Health is a large and growing share of OECD economies. Ensuring sustainable financing is more and more challenging, and there is an increasing demand to improve system performance. Remarkable cross-country variations exist in system design, inputs, outputs and outcomes. These variations provide opportunities to learn from experience and share best practices. The OECD focuses on health system issues that are key to developed countries, produces comparisons between European and non-European countries, and applies its expertise in health economics. The OECD has built up, over 20 years, one of the leading databases on health and health systems: the OECD Health Data. It contains more than 1000 statistical series, some of which go back to 1960. It is based on a collaboration with national data correspondents in 30 OECD countries, and co-operation with WHO and Eurostat. Descriptive analysis of key indicators are released every two years in "Health at a Glance". The OECD assesses the performance of health systems against the mentioned (common) policy objectives. An important developmental project for the OECD Health Data is the further elaboration and refinement of the OECD System of Health Accounts, which aims to define global health accounting standards, and which is being undertaken in collaboration with Eurostat, WHO and DG Sanco. Nearly all EU member states and OECD countries have started at least pilot implementation of SHA. Another major priority of the OECD is the work underway to produce internationally comparable data on the quality of health care under the Health Care Quality Indicators Project, funded by DG Sanco, the US and other countries. Examples of the Initial Set of Health Care Quality Indicators are vaccination rates, screening rates for cancers, diabetes care, disease incidence, survival rates from cancers and 30-day mortality following heart attack or stroke. The future priority areas include patient safety, mental health, primary care and prevention, cardiac care and diabetes care. These two major projects are linked directly to the debate about the extent to which the growing expenditures on health services is justified by the health value it helps to create.

Further information about the OECD's health work is available at www.oecd.org/els/health

WHO's perspective on health system indicators

Both the UN Millennium Development Goals, and more directly the Resolution of the last World Health Assembly (WHA60.27) have enforced the importance of strengthening health information systems. The WHO Regional Office for Europe has a longstanding policy to provide indicator-based information for all 53 European member states. This is in part achieved by the maintenance of databases which also comprise health system indicators. One of the main focuses of the WHO European Office with respect to health information is to strengthen the data quality of all databases and the further sophistication of databases to enable more in-depth analysis. This applies to the standardization of data collection, the evaluation of reporting biases and finally the validation of submitted data. The European Health for All database (HFA-DB) is a recognised international source of basic health statistics (mortality, morbidity, health care etc.), and is free of charge. It is constantly updated, based on inputs from a network of information counterparts in 53 member states. WHO also offers a Data Presentation System (DPS), a software tool enabling user-friendly access and analysis of statistical data. It can be used with the HFA-DB and to support countries in developing similar national health indicator databases. New programming will be implemented in 2008. In addition to the HFA-DB the product range has been broadened recently. To give users access to more detailed mortality data by cause of death, age and sex, two separate versions of the mortality database have been developed, each offering data at a different level of aggregation. A new source of information is also the European hospital morbidity database (HMBD) containing hospital discharge data, all accessible via www.who.euro.int.

In line with WHO's normative function, initiatives and continuous efforts are being made towards the development of international definitions, standards and data collection instruments, which are essential prerequisites for improving the international comparability of health and health systems indicators. WHO has worked closely with Eurostat and the OECD on the harmonization of health system parameters and will continue to support any efforts to produce valid inter-country comparisons.

One of the future priorities will be to foster the harmonized development of health and health system indicators in close co-operation with Eurostat and OECD. The challenge, however, is to cover and also include in this process other WHO European member states that are not members of the EU or OECD.

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30 Public Health Programme of the Community – Report on the workshop planned and conducted in collaboration with Health and consumer Protection (DG SANCO) and Public Health Executive Agency (PHEA)

This workshop conducted jointly by DG Sanco and the PHEA had the objective of presenting the new Public Health Programme and the work of the PHEA.

The Second Programme of Community Action in the Field of Health 2008–2013

The Second Programme of Community Action in the Field of Health 2008–2013 came into force on 1 January 2008. The first Programme (2003–2008) financed over 300 projects and other actions following the eight programmes implemented between 1993 and 2002 (Health promotion, Cancer, Drug dependence, AIDS and other communicable diseases, Health monitoring, Rare diseases, Accidents and injuries, Pollution-related diseases).

The Health Programme is the key means to implement health objectives at European level. It is based on Article 152 of the Treaty establishing the European Community and is basically an incentive measure designed to protect and improve human health, while excluding any harmonisation of the laws and regulations of the member states.

The Commission implements the Health Programme via an annual work plan which sets out priority areas and the funding mechanisms. It is assisted by a Committee composed of representatives nominated by the EU member states, which gives its opinion on the work plans, the selection criteria and financing of actions and methods for evaluating the programme. The implementation of the different tasks (projects) of the Health Programme is managed by the Public Health Executive Agency.

Priorities of the new Programme

The Health programme aligns with the overall Community objectives of prosperity, solidarity and security.

In relation to prosperity, population health is seen as a key factor of productivity and growth. Better health policies will lead to EU citizens living longer and in better health, which is important to reduce worker absenteeism and premature retirement. Increasing Healthy Life Years indeed is crucial in attracting people into employment – Europe can hardly afford to have people drop out of the labour market when they are in their fifties. For this reason the new Health Programme provides a strong focus on healthy ageing and also on health's potential to promote growth.

As regards solidarity, achieving the Community goal of a more cohesive Europe requires the reduction of the major inequalities across the EU in terms of life expectancy, health status, and access to high-quality health services. This translates into major differences across the EU, not only in quality of life, but also in productivity, labour participation and age of leaving the labour force on invalidity grounds. Inequalities in health go hand in hand with inequalities in prosperity. A Europe of solidarity cannot neglect these inequalities. In response to this the new Health Programme focuses more on addressing health inequalities, and also provides for action to improve solidarity between health systems, albeit streamlined in the light of budgetary constraints.

Finally, as regards security, recent developments with avian flu and growing concerns about a possible influenza pandemic remind us of the urgent need to step up efforts to protect our citizens against cross-border health threats. Improving security requires de-

veloping European and national capacity to respond to health emergencies in a co-ordinated and efficient manner, while also respecting citizen's rights protection. Citizens and stakeholders expect the Union to ensure a rapid and efficient assistance to member states in responding to a possible pandemic and other serious health threats. The new Health programme therefore continues to stress this issue. Action under this area of the programme will be complementary to the work of the European Centre for Disease Prevention and Control (ECDC).

Programme Objectives

Actions under the Programme will pursue three main objectives:

To improve citizens' health security

A number of serious cross-border health threats with a possible worldwide dimension exist and new ones are emerging. Actions identified to improve the citizen's health security in the new Programme include developing EU and member states' capacity to respond to health threats, for example with emergency health planning and preparedness measures; actions related to patient safety, injuries and accidents, risk assessment and community legislation on blood, tissues and cells.

To promote health, including the reduction of health inequalities the Programme should contribute towards the attainment of a high level of physical and mental health and greater equality in health matters throughout the Community by directing actions towards improving public health, preventing human diseases and disorders, and obviating sources of danger to health with a view to combating morbidity and premature mortality. Actions identified to promote health in the new Programme include actions on health determinants such as nutrition, alcohol, tobacco and drug consumption, as well as social and environmental determinants; measures on the prevention of major diseases and reducing health inequalities across the EU; and increasing healthy life years and promoting healthy ageing.

Health information and knowledge

The Programme, in synergy with other Community initiatives and funding, should contribute to better knowledge of and information on the prevention, diagnosis and control of major diseases. The Programme should also foster appropriate co-ordination and synergies among Community initiatives regarding the collection of comparable data on major diseases, including cancer. Actions identified to improve health information and knowledge in the new Programme include action on health indicators and ways of disseminating information to citizens; focus on Community added-value action to

exchange knowledge in areas such as gender issues, children's health or rare diseases.

Financing mechanisms

Several new financing mechanisms will be proposed within the new Health Programme with the aim of ensuring full stakeholder participation in the Programme to organisations which take forward the health agenda. Among these mechanisms are:

- Co-financing of projects (public or private body or NGO) intended to achieve a Programme objective. This is as in the previous public health programme, although lump-sum financing may be given;
- Co-financing the operational costs of a non-government organisation or a specialised network;
- Joint financing of projects with one or more Member States;
- Joint actions with other Community programmes, which will additionally provide coherence between this instrument and other Community programmes.

Implementation of the programme

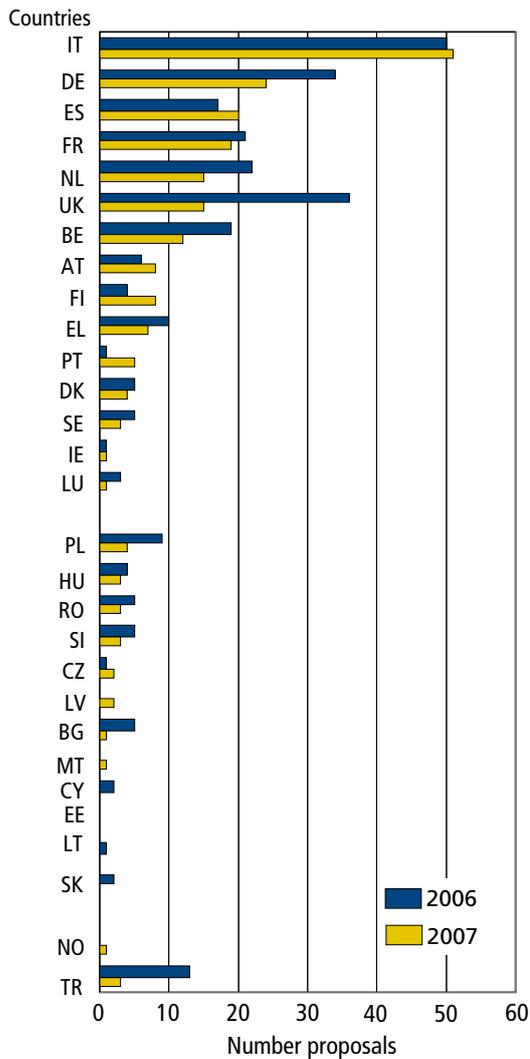
The Health Programme will be implemented through the development of annual work plans. The objective of this consultation is the streamlining and prioritisation of content. Before launching the Call for proposals, the PHEA will establish selection and award criteria for the new financing instruments.

The Public Health Executive Agency

Objective and main tasks of the Agency (PHEA):

The Executive Agency for the Public Health Programme aims to provide an excellent service (consistently high standard of technical and financial management and transparency) in performing the tasks and activities entrusted to it by the European Commission.

The Agency is entrusted with managing all the phases of specific projects funded under the Programme; executing the budget for all operations necessary for the management of the Programme; providing logistical, scientific and technical support for meetings and conferences. The European Commission's Health and Consumer Protection DG (DG SANCO) and PHEA have clearly defined responsibilities. The Commission lays down the European Community policy in Public Health, liaises with Member States and sets out related priorities in the annual work programmes. PHEA launches calls for proposals and tenders, ensures efficiency in the management of awarded projects and tenders and is in charge of disseminating the results. DG SANCO and PHEA collaborate closely in the execution of their tasks through meetings at both managerial and technical levels and through the agency's reporting structure. National Focal Points (NFPs) have been nominated in a number of member states and



participating countries to act as national information relay points on the Health Programme and to provide local support to potential project applicants. The decision to create PHEA was taken by the Commission on 15 December 2004, pursuant to the Council regulation of 19 December 2002, which allows executive agencies to be entrusted with certain tasks in the management of Community programmes.

Call 2007: evaluation criteria:

First of all, it has to be noted that PHEA proposed a change of selection criteria for the Call 2007, on the basis of the statistical analysis and assessment made on the results of the Call 2006. In 2006 the statistical analysis performed on award criteria's use showed poor content and predictive validity. Therefore, PHEA proposed new criteria in 2007.

Call 2007: Evaluation procedure:

The evaluation procedure is made by several steps:

- screening of the proposals to check if there is compliance with the exclusion criteria,
- financial and organisational analysis to check the compliance with the selection criteria,
- evaluation on the basis of the evaluation criteria done by 3 external evaluators and on the basis of the advice on policy issues done by Sanco officials,
- consensus meeting to get a consensus evaluation report and finally,
- evaluation committee that ensures compliance with the published criteria, discusses proposed co-funding for each proposal, excludes potential duplication and decides on the projects' funding based on the indicative available budget and on the consensus evaluation report after ranking of the proposals within each strand.

Call 2007: Results:

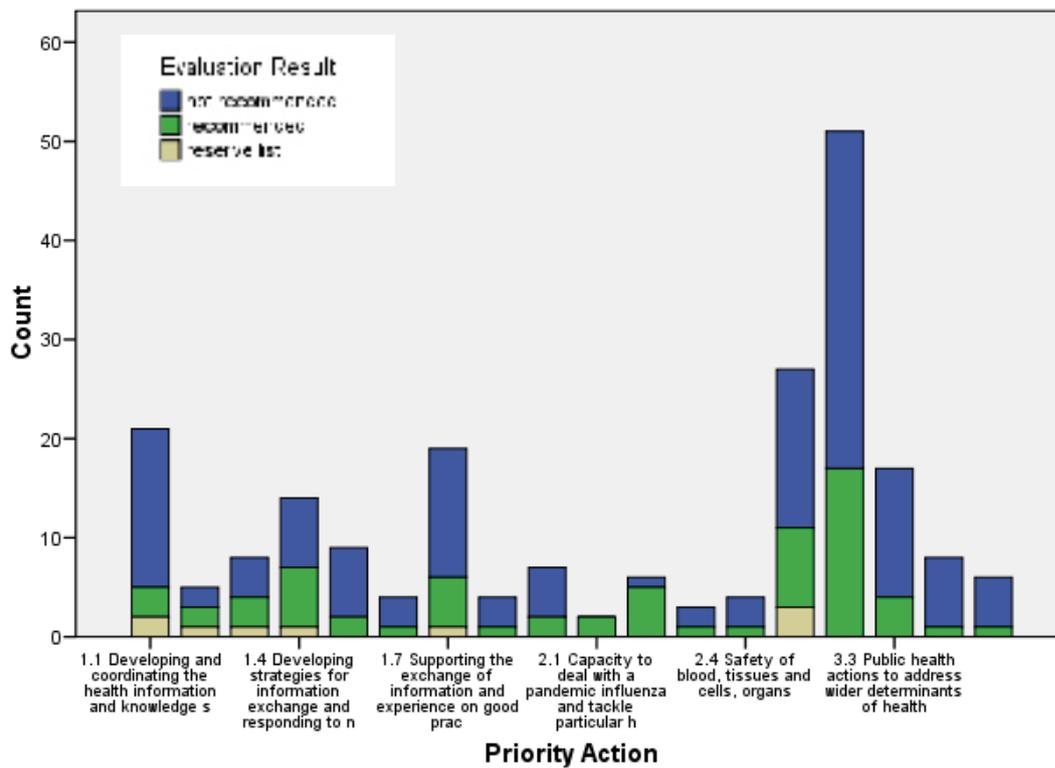
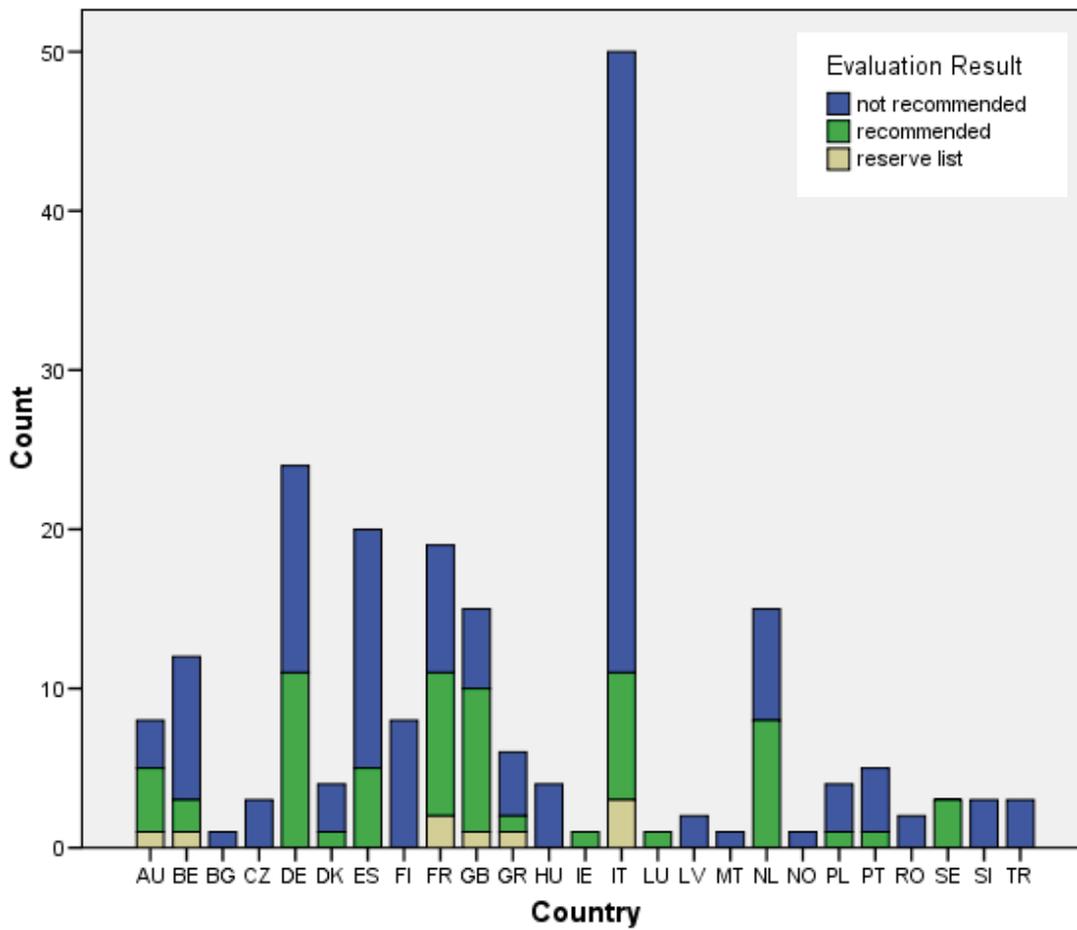
For the health information strand, 93 proposals were received, 88 were evaluated, 23 were recommended for funding and 7 were put on the reserve list. For the health threats strand, 17 proposals were received, 16 were evaluated, 11 were recommended for funding and none was put on the reserve list. Finally, for the health determinants strand, 112 proposals were received, 111 were evaluated, 30 were recommended for funding and 2 were put on the reserve list.

The major facts coming from the evaluation of the Call 2007 were the low number of proposals submitted where the 12 new member states were the main partner and among this group the very low number of proposals selected. This is a major concern with regard to the increasing gap in the health situation between EU 27 MS and 15 MS.

Also, the unbalanced success rate among the different member states is a concern since the writing of a proposal is time- and resource-consuming.

The distribution of proposals among the different priority areas of the work plan clearly indicates the major interest of the applicants: 1.1 developing and co-ordinating the health information system, 1.4 developing strategies for information exchange and responding to non-communicable health threats, 1.7 exchanging information and experience on good practice, 3.1 addictive substance, 3.2 lifestyle determinants and 3.3 wider determinants of health are the most prized priorities.

Finally, the evaluation through statistical analysis of the way the new award criteria were used and the assessment of the consistency of the evaluators showed a quite fair and balanced evaluation process.



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31 Regional health indicators and the ISARE project – making a difference

The workshop was held to discuss the main findings of the three ISARE (Indicateurs de Santé Regionaux d'Europe/Indicators of Regional Health Indicators Project) projects to date which have all now been completed. The three ISARE projects are designed to assess the need for and nature of health indicators at a regional level throughout the European Union. Further details can be found in the conference abstract booklet. The workshop consisted of the following presentations: "Results and Implications of the ISARE project" (Frédéric Imbert, France)
 "Methods of data presentation to gain maximum impact" (John Wilkinson, UK)
 "How can we best communicate health information to enhance the impact on decision-making?" (Olivier Grimaud, France)

In the workshop a number of issues emerged:

- There was a concern raised by a colleague from Iceland about the issue of small numbers, and the point was made that Europe is now a union of small countries, with only six countries with large populations (UK, France, Spain, Germany, Poland, and Italy). Thus for the large countries the issue of regions is critical but for the smaller countries, regionalisation raises other issues.
- There is a need for consideration of presentation style

and format for different audiences. In some cases for example control charts are appropriate but in other circumstances these are not. However, the general understanding and appreciation of graphical presentations is better than may be generally expected.

- There was considerable discussion as to the future of the ISARE project. The presentation had emphasised that the project was now coming to an end. However, delegates felt very strongly that the expertise and work should not be lost and that effort needed to be made to integrate the work into the continuing work of the European Union and that a further project should be supported to assist in this process. The leaders of the project were warmly congratulated by the delegates on the success of the project.

There was discussion about the current prototype database from ISARE which contains unvalidated data. It has already proven to be a useful resource and the EU commission are urged to ensure that this type of tool is available in the future – with validated data.

Discussion took place about the need for communication experts to be involved in the production of public health reports, recognising that communication is a specialist area. It was learned with interest that some of the public health observatories employ their own journalists to assist in communication.

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32 Results from three years of 'building bridges between research and practice' at the local and regional level in the Academic Collaborative Centre Tilburg, The Netherlands

The workshop was briefly introduced by Ien van de Goor, co-ordinator of the Academic Collaborative Centre Public Health Tilburg, the Netherlands. The history and core activities of the collaborative centre were presented followed by four presentations on ongoing projects and a general discussion.

In the academic collaborative centre four partners work closely together: Tilburg University (department of Tranzo), the Dutch national institute on public health and the environment (the RIVM) and two regional public health services (GGD's). The collaborative centre started about four years ago and has detailed its progress at former EUPHA conferences (in 2003, 2004 and 2006). The focus of the collaborative centre is on the building of scientific evidence to support local and regional public health policy and interventions. One way of enhancing the link between science and practice is by involving public health professionals actually as (part-time) researchers (called 'science practitioners') in the research projects.

The results presented in the workshop focussed on the added value that research accompanying public health activities can provide: promoting and supporting evidence-based interventions at the local level and evidence-based local health policy (the two central lines of research in the collaborative centre).

The first presentation "How to reach the promised land of evidence-based public health practice. To a staged approach of intervention research" was presented by Carin Rots. In public health there is a lack of intervention-research. This is at least partly due to the gap between research and practice. In the presentation it was shown that several authors (such as Nutbeam) have recommended useful models for a staged approach to intervention research. These models show

that the development of public health interventions have several distinct phases and that each phase should be accompanied by research that suits the specific stage of development. The content of the evaluation questions changes in the evolution of an intervention, so the research can and should take different forms. This should be rather a process of building evidence step-wise than of performing one single, definite effect-study. Two of the collaborative centre's interventions in the area of children and families at risk that have utilised this staged approach were discussed, focussing on the process of building evidence in a close collaboration between researchers and practitioners.

The second presentation involved a project called "Opportunities for intersectoral health policy to stimulate physical activity in children" by Marie Jeanne Aarts. The first part of this project investigated which factors in the physical environment (buildings like schools and houses, streets and traffic, play grounds, green areas) are facilitating or hindering for the physical activities of children. In the second part of the study, concrete propositions for intersectoral health policy to stimulate physical activity in children are developed and their potential health impact is quantified. The proposed measures are discussed with local public health professionals and civil servants. Small scale implementation will take place and information on success factors and barriers for implementation of these measures will be provided through a feasibility pilot. Finally the quantitative health impact of two potential policy actions will be calculated using a modelling approach such as health impact assessment.

The third and fourth presentations belong to the same project entitled "Development of regional public health status and forecast reports in two Dutch re-

gions". In the Netherlands every four years a National Public Health Status and Forecast Report is published. The national report forms the basis of the Dutch national public health policy. In a regional pilot study it is now being investigated whether such a report can also be developed at the regional level and can contribute to the development of more evidence-based regional and local public health policy.

The third presentation by Marja van Bon described the overall pilot project on regional public health reporting. The goal of this project is to study the suitability of the national model for public health reporting for the regional and local level, given the currently available epidemiological data. In the presentation the products of a regional pilot study were presented: a regional report, a website and local reports with key messages specific to local public health policy in each of the 47 municipalities.

The impact on local health policy and the utility and usefulness of these products for local health policy are being evaluated, which started in the summer of 2007. Eventually a framework for analyses and reports is to be developed and a number of evidence-based and transferable tools for interpretation and prioritization for policy advice will be generated.

From the pilot results it appears that the national model is a suitable basis for providing local health policy advice, given the currently available epidemiological data. Furthermore the study shows that the regional reports, the website and the local key messages contribute to more evidence-based prioritization in local health policy.

The fourth presentation by Emmy van den Heuvel consisted of a demonstration of the website www.regionaalkompas.nl aimed to promote evidence-based local health policy. This last presentation focussed on the development and application of a website aimed at the promotion of the use of epidemiological information, while evidence-based interventions in local public health were central. The local authorities themselves gave input as to the information needed to translate strategic local public health goals into a feasible and evidence-based plan of activities.

This website could only be realized because of the network of organizations involved in the academic collaborative centre. The website integrates in an intelligent way the existing national public health information on the World Wide Web with local and regional information. For this project, the academic workplace also collaborated with the Dutch National Institute for Health Promotion and Disease Prevention (NIGZ).

At this very moment the interest of regional and national organizations in this website is growing rapidly. The challenge now is to claim a role in quality and extend the content to a national level, aligning it with sev-

eral other initiatives on strengthening evidence-based public health policy at the local level.

Following these presentations a very lively discussion with the public developed. The discussion developed around issues such as the specific role of 'science practitioners'. How do "science practitioners" function? Are they best able to combine tasks as a public health professional and as a researcher? What is the risk of them becoming more and more like scientific researchers, when performing a PhD study, instead of keeping in close contact with the public health practice? And how can the research be embedded in public health practice? It was generally agreed that although it might be demanding and requiring specific effort, it is very worthwhile trying to integrate scientific research in the environment of local health policy and public health practice.

The role of science practitioners was further elucidated on. Science practitioners form a concrete link between public health practice and research in that they work both as professional (epidemiologist, health promotion professional or health policy professional) in public health practice but also part-time at the university working on PhD projects. Of course it takes specific qualities to operate as a science practitioner, specifically a combination of interest in research and experience in public health practice. Intensive communication by and between public health professionals will enable the needs of practice to be better translated into research and vice versa, with research results being more easily translated and implemented into public health practice.

Furthermore, it was discussed that the gap between research and practice was also there because of the rigour demanded by 'traditional' research designs – which form the gold standards for evaluating effectiveness, such as RCT designs – match very badly with the dynamics of interventions being carried out in practice. It was concluded that there indeed is a need for developing a different approach towards research that better fits the practice of public health intervention. What is also of specific importance to mention here is that in the Netherlands a special grant program has been established to stimulate scientific research that better fits and fulfils the needs of public health practice. In most other countries as in the Netherlands, until recently it was very difficult to qualify for subsidy with practice-oriented scientific research.

As to the regional public health reporting and the development of the website "regionaal Kompas/regional compass" most people were very positive about the usefulness of such tools in supporting more evidence-based local policy making. Discussion here focussed on the questions of how and to what extent local authorities were actually involved in the development of the public health reports.

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33 Health impact assessment in new member states and accession countries

At the EUPHA conference in Helsinki, I co-chaired with prof. Roza Adany from Hungary a workshop on HIA. We presented preliminary results of the HIA-NMAC project funded by DG-SANCO of EC, which was running from August 2005–Dec 2007. The presentations covered an overview of the project, capacity building issues, case studies on dietary fibre policy, Roma minority policies and local level implementation of HIA in new EU members states.

About 45 participants attended the workshop. All the speakers, coming from Denmark, Hungary and Poland, and the workshop attendees discussed very actively the following issues:

- Need for capacity building – systematic, continuous training both of public health professionals and even more importantly, public policy experts on the basic principles of determinants of health, impact assessment techniques and specifically HIA is very necessary. Single workshops are useful as process initiators, but can not fulfil the role of systematic training.
- There is a need to understand the complexity of broad policy issues before starting an HIA. The case study HIA of dietary fibre policies revealed the complexity of the area by describing most of the channels influencing the production and consumption of dietary fibre.
- Local level implementation requires a long-term negotiation and consultation process with all relevant political players and stakeholders, with no respect to the “EU history of a country”. The barriers and enablement towards HIA use are similar across Europe.
- Legal implementation remains an issue for further research as there are both positive and negative examples where legal provision for HIA has supported use or did not help at all due to lack of personnel and institutional capacities.
- More research is needed on implementation of HIA into practice; there is a gap (as in many areas of public health) between knowledge and practice.

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34 EUnetHTA – European network for HTA

The workshop was chaired by Kristian Lampe, Camilla Palmhøj Nielsen, DACEHTA, Denmark, and Montse Moharra, CAHTA, Spain

EUnetHTA, the European Network for Health Technology Assessment is a project that aims at developing an organisational framework for a sustainable European network for HTA, as well as tools to support collaboration in the field of HTA. The project commenced in the beginning of 2006 and runs until the end of 2008. Fifty-one partner organisations from 31 countries work towards this goal. The work is organised in eight work packages that focus on various aspects of collaboration.

Kristian Lampe presented the efforts of work package 4 (WP4), which is developing a common core structure for HTA. WP4 employs a wide perspective on HTA and takes into account not only the effectiveness and costs of health technologies, but also organisational, ethical, social and legal aspects as well as a more detailed technical description of technologies and their current use. Two models for HTA ("Core Models") are developed within WP4, one for medical and surgical procedures and the other for diagnostic technologies. Furthermore, two health technology assessments are conducted based on these models. The basic idea of the models is to split information contained in HTAs into standardized pieces called "assessment elements". The use of such elements guides the production of HTAs and leads to better structured reporting and hence easier utilization of HTAs across countries. At the time of the workshop the first core model was undergoing validation and public feedback. The results of these will be used in the further development of the deliverables.

Camilla Palmhøj Nielsen presented WP6, which works on the transferability of HTA into health policy.

Over 30 organisations participate in WP6, with the aim of obtaining a systematic overview of the relationship between HTA and health policy making, and of analyzing the common characteristics of such relationships. Furthermore, WP6 aims at demonstrating the concrete use of HTA in policy making, positioning HTA in such contexts in relation to other sources of information and increasing HTA's responsiveness to the demands of HTA consumers. Two main deliverables are a book containing a systematic overview on relevant topics and a sustainable open Forum to exchange views and expectations on HTA with stakeholders.

Montse Moharra presented WP8, which develops systems to support HTA in member states with limited institutionalisation of HTA. The aim of WP8 is to define the minimum components related to the scope, structure, process and visibility of an HTA organisation, as well as to develop tools for information and education support to institutions or healthcare systems that are in the process of evolving towards being an HTA organisation. WP8 has reviewed HTA agencies around the world with regard to their staff, organisation, budget etc. More information has been sought through a survey. The results describe the common characteristics and variations among agencies around the world. These are used to make recommendations for new agencies. WP8 is producing a handbook that provides practical guidance for such efforts.

The audience of the workshop welcomed the presentations with interest. Collaboration among countries in the field of HTA was supported. The approaches will most likely require a lot of training within Europe so that new methodologies can be implemented. Also the interest of the European Union on HTA was noted.

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35 Utilisation of medicines and primary care. A challenge to public health

The European Union is the second most relevant pharmaceutical world market and the pharmaceutical expenditure accounts for a large proportion of health care spending, amounting to more than EUR 100 billion and varying widely between countries: from 9% (Denmark) to nearly 40% (Slovakia) of health expenditure. It is also estimated that two thirds of total pharmaceutical expenditure is paid by public healthcare systems, posing an economic burden and suggesting the need to evaluate *value for money* of medicines.¹

Despite this high level of expenditure and a wide utilisation of medicines with large differences across countries, only a limited amount of information is available on the availability, price, expenditure and utilisation of medicines in European countries.

For all these reasons the European Commission has funded several projects in recent years aimed at providing and collecting data, defining indicators and developing technical issues in order to study—using a multidisciplinary approach and from a public health perspective—the pharmaceutical sector and the impact of medicine utilisation on public health. It is also in this arena that the European Public Health Association (EUPHA) started up a Section in 2002 on the utilisation of medicines. During the 2007 EUPHA Conference the Section “Utilisation of medicines” workshop discussed and presented some data mainly related to the dispensing and reimbursement flow (as collected by the EURO-MED-STAT project) and prescribing data (from GP database as evaluated from the electronic Health Indicator Data project) using diabetes as a test case.

Discrepancies in the availability, price and utilisation of medicines in Europe

The complexity of the pharmaceutical context is exacerbated by the wide differences across European countries as a result of the different organizations of the pharmaceutical care systems and the economic levels of the different countries. These differences are reflected in the different number of licensed medicines, their prices, reimbursement rate, utilisation, expenditure and, finally, their licensed clinical properties.

As an example 100 cardiovascular medicines (active ingredients) are licensed in Finland and 218 in Belgium, only 91 medicines are commonly available in Finland and Belgium, while 127 are exclusively available in Belgium. Similar differences are common for other classes of medicines and other countries.² Price discriminations exist across countries and in some cases prices are paradoxically higher in less affluent countries.³ Also reimbursement rates may largely differ between countries and medicines reimbursed in a country may not be reimbursed in others.

Utilisation of medicines differs widely, also in neighbour countries: Belgium and the Netherlands are the countries with the highest and the lowest consumption of antibiotics, respectively; Denmark and Norway have, respectively, the lowest and highest consumption of lipid lowering medicines, and so on.

These elements warranted the development of a European database of medicines in order to increase the level of transparency, measure differences and identify areas for improvements in the quality of pharmaceutical care and enhance the efficiency of the national pharmaceutical systems.⁴

The EURO-MED-STAT database, funded by the European Commission DG-SANCO under its Public Health Programme, is available on the web and contains information on the number of licensed medicines, their price and reimbursement, level of utilisation and expenditure.⁵ Unlike the EMEA database, the EURO-MED-STAT database provides information on price and reimbursement of licensed medicines and it also makes available statistics on the number of licensed medicines across EU countries, on utilisation and expenditure according to the ATC/DDD methodology.

The electronic prescribing database

The use of GP electronic medical records offers the opportunity, at no extra cost, to analyse epidemiological purposes and international comparisons data collected through routine operational activity on prescribing treatments. Furthermore, studies and research on prescription and utilization of medicines often does not include the reasons for prescribing, which are instead available in most of the primary care databases.

Some European projects have investigated the availability of a GP database, their usefulness, data recording and handling and also formulated recommendations on the harmonization of data collection, analysis and interpretation.

The EC DG-SANCO sponsored project *electronic Health Indicator Data* (eHID) aims to identify, collect and disseminate information on best practice in recording diagnostic data in the form of electronic medical records (EMR) during operational routines in primary care and to provide data on four health indicators: incidence and prevalence of diabetes, prevalence of ischaemic heart disease, and the burden of mental illness. The project provided an inventory of the EU countries that have networks that routinely collect diagnosis and prescription data in a systematically computerised way.⁶

Moreover the completeness of the data from a GP database allows us to better understand the complexity of primary care, providing helpful information on health needs. A pilot study of GP prescribing in Italy quantified the complexity of the primary care setting and the reasons for prescribing.⁷ Data collected during the last quarter of 2005 showed that three classes of diseases account for more than half of all prescriptions: the circulatory diseases (33% of all prescriptions), respiratory diseases (12%) and endocrine and metabolic disease. Medicines for the cardiovascular system and the alimentary tract and metabolism (Class C and A of the ATC code, respectively) accounted for more than 50% of all the prescribed medicines, whilst anticancer medicines (Class L) accounted for less than 1% of prescriptions in primary care reflecting the treatment of these patients mainly in secondary and tertiary care. The

study also evidenced the frequency of comorbidities, 26% of patients received medicines for more than six different diseases.

Diabetes as a test case for pooling data from different GP databases

The use of GP databases in comparative research would enable a comparison of treatments for specific diseases in different countries, such as diabetes care in Sweden and the Netherlands. In both countries levels of drug utilization are low and the prevalence of diabetes is increasing in countries.

Swedish and Dutch data from 2005 were derived from respective primary care databases (SPCRD and LINH) providing patient and GP level data on clinical diagnoses and pharmaceutical treatment. The data, elaborated through multilevel analyses, showed differences and similarities in treatment guidelines between the two countries. The main results also demonstrate the differences in prescribing treatments: in Sweden diabetes is more frequently treated with insulin than the Netherlands and women are less predisposed to receive lipid-lowering drugs in both countries, while in the Netherlands women are more liable to receive antihypertensives.

The availability of information from GP database also permits an evaluation of clinical parameters in different populations, as in the case of a study that compared levels of both glucose and blood pressure in a type-2 diabetes population in Sweden and the USA. Several results emerged by extracting data from GP databases and applying successive logistic regressions by age, gender, BMI, number of antihyperglycaemic drugs, insulin dependence, and treatment with different antihypertensive drugs: glucose control was better, but blood pressure control worse, among the Swedes. Furthermore dissimilarities in diet, physical activity, alcohol intake, and differences in screening may contribute to condition physician attitudes and patients treatment compliance.

Conclusion

The workshop at the EUPHA Conference in Helsinki highlighted that the availability of public, comparable information may increase transparency in the pharmaceutical sector. More information will allow benchmarking of expenditure on and utilisation of medicines across European countries as well as aid in measuring the quality of care.

It would also be possible to identify improvement areas in the quality of pharmaceutical care and therapeutic outcomes, thereby increasing benefits and reducing the risks for patients, as well as enhancing the efficiency of the national pharmaceutical systems.

Acknowledgement

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HEALTH PROMOTION – COMMUNITY INTERVENTIONS

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Community interventions – do they work?

The development of public health in Finland has been a key objective and national-level plan in the field of community interventions in health promotion since the 1970s. The starting point has been the North Karelia Project, which addressed to the prevention of cardiovascular disease among the residents of this province of Eastern Finland. The project has shown that high rates of heart disease are not inevitable; community-based projects can reduce rates dramatically. At present, musculoskeletal problems and mental health problems, mostly depression, are increasing and taking a heavy toll on societies. These are the challenges that European societies and communities are facing. Do we know enough about the proper study designs of economic consequences of community interventions? What is the role of communities, environments and contexts such as the workplace? A special workshop involving state-of-the-art scientists from Finland, Denmark, Australia and elsewhere discussed these questions at the Finlandia Hall on Wednesday, 10th Oc-

tober 2008 chaired by Antti Uutela from the National Public Health Institute in Finland (KTL). These questions were addressed from various perspectives: Arja Aro, professor of Public Health from the University of Southern Denmark described in her presentation how rigorous research evidence can be used to plan and apply health promotion interventions in communities. Urpo Kiiskinen from KTL discussed these challenges from the economic perspective. Ása G. Ásgeirsdóttir from the Administration of Occupational Health and Safety in Iceland identified which work-related factors are causing health problems and thus long-term sickness absence and disability. Pilvikki Absetz from KTL identified the main theoretical and practical elements in the successful Good Old Age in the Lahti Region type 2 diabetes prevention study. Brian Oldenburg (Monash University, Melbourne, VIC, Australia) reviewed how important environmental health promotion activities are in order to achieve good results.

What constitutes evidence in community interventions?

Complex community interventions in health promotion provide challenges for evidence-based research and practice. This is due to the fact that health promotion work uses existing strategies, initiatives, structures and channels, and is done in a participatory, empowering and ownership-based manner¹. The purpose of the presentation was to describe how rigorous research evidence can be used to plan and apply health promotion interventions in communities. In community-based health promotion, research evidence on health determinants informs about what needs to be done. Evidence on the effectiveness of interventions informs what can be done in certain settings. However, what is actually done in practice depends on political and social factors, and how it is done depends on the resources, structures and stakeholders involved². Non-research documents as well as local stakeholders such as different professionals, though also lay people, have a lot of implicit know-how on setting-based implementation, which can prove fruitful in intervention planning, implementation and evaluation. In health promotion, taking the context into account ranges from changing policies and environment to mobilizing and engaging local and regional resources to enable people to improve their health. This strong contextual approach in health promotion has often led to arguments that health promotion is so different from clinical medicine that strict, controlled research designs – mainstream in clinical medicine – cannot be used to gather evidence in health promotion³.

Examples were given from the evidence-based medicine evidence hierarchy and criteria, where systematic reviews and randomised clinical trials form the highest level of evidence, and where other study designs are rated as lower forms of evidence, and e.g. expert opinion is positioned as the lowest level of evidence. However, also good quality, practical decision-making in clinical medicine is able to adapt research evidence and guidelines to the individual patient and

his/her situation⁴. The terms patient-centred care and collaborative care describe how patient preferences are taken into account e.g. by personalized identification, prioritisation of health problems, the collaborative selection of appropriate treatment, and goal setting. This kind of contextualising of individual treatment is similar to the contextual-setting approach of health promotion⁵.

The health promotion field has developed protocols, tools and criteria to systematize the research evidence, practical know-how and lay knowledge, e.g. within Cochrane Collaboration⁶, NICE⁷, and GEP EU-project⁸. Further, suggestions have been published to adapt trials for complex community settings⁹, to enhance the use of process evaluation in interventions¹⁰, and also to think creatively about how to standardise not intervention components but rather the function and process, and e.g. define intervention integrity as evidence of fit with the theory or principles of the hypothesised change process¹¹.

In conclusion, evidence-based community interventions build on good quality research evidence whenever feasible, and apply and combine that knowledge with contextual community needs, values, information, skills and politics. In doing this, health promotion is not different from clinical medicine in treating patients by adapting treatment and applying guidelines so that they fit the patient's preferences, needs and environment.

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Economic consequences of community interventions

Health promoting interventions that reduce the risk of diseases and disabilities as well as influence the health choices of citizens are seen as an important opportunity to increase public health. A significant proportion of public health problems could be prevented by increasing physical activity and reducing cigarette smoking, alcohol abuse and obesity in the population. Generally, community health promotion strategies are believed to be a cost-effective way of improving population health and wellbeing. Moreover, it is hoped that the wider adoption of health promotion would help to contain continuously increasing health care costs. However, it appears that the economic evaluations of such actions are rather scattered.

Purpose

The purpose of this study is to demonstrate the economic consequences of health promoting strategies targeted at reducing the incidence of cardiovascular disease, type 2 diabetes, fractures due to osteoporosis, and home and leisure time accidents. In particular, we concentrate on measures aimed to promote physical activity, healthy diet and weight management, smoking cessation, and prevent alcohol abuse as well as falls and fractures.

Methods and data

Results and conclusions are drawn on the basis of a comprehensive review of the literature. Evidence on effectiveness is mainly based on the review of published reviews and meta-analyses whereas evidence from economic evaluations relies on original research reports. The cost-effectiveness results were extracted from original research by selecting the most general measure of cost-effectiveness reported in any particular study, preferably cost per quality adjusted life years (QALY) gained. All cost were converted to euros by using purchasing power parities and inflated to 2005 price level with the consumer price index.

Main findings

The review shows that the need for good quality cost-effectiveness studies is immense in many areas of health promotion. A clear exception is smoking cessation, where economic evidence is solid and covers a wide range of interventions. However, individual studies show that cost-effective strategies can also be found in all areas subject to the review and some of them are potentially cost saving if properly targeted. For instance the cost-effectiveness of measures to increase physical activity are in range of 2000 – 17 000 €/QALY whereas diet and weight management based strategies fall in the range of 7000 – 30 000 €/QALY. Smoking prevention and cessation programs are an even more cost-effective public health strategy. Policy level intervention such as taxation, restrictions on the availability of unhealthy goods and voluntary arrangements with industry are potentially very cost-effective.

Conclusions and discussion

There are still some gaps in the effectiveness evidence of health promotion interventions and the transferability of results of economic evaluations from one setting to another is challenging due to the lack of transparency and use of non-standard methods. Nevertheless it seems fairly reasonable to conclude that many health promotion activities are cost-effective compared to treatments and technologies currently used in publicly funded health care systems. Net savings in health care costs may not be typically expected, and even when savings outweigh the initial cost it should be kept in mind that in most cases the costs of the program has to be met immediately while the savings occur over a very long period of time. Hence, the budget impact and other decision criteria such as equity concerns and overall feasibility etc. must be taken into account in addition to economic efficiency. Moreover, it seems obvious that many studies on community interventions may not reasonably conform to gold-standard methods applied to assess evidence for effectiveness and cost-effectiveness of health care technologies. Guidelines should be agreed upon in order to utilize “softer evidence” in evaluations of such programs.

Workplace Health Promotion: Does it make a difference?

It is a well known fact that ill health is costly. In Iceland, for example, disability incidence is growing despite a low unemployment rate and generally good public health¹. It is important to identify which work-related factors are causing health problems and thus long-term sickness absence and disability, so that professionals in the field of health promotion are familiar with the risks, health status and habits of their target groups.

According to the Luxembourg Declaration of 1997, Workplace Health Promotion (WHP) requires the “combined efforts of employers, employees and society to improve the health and well-being of people at work. This should be achieved through a combination of: improving the work organisation and the working environment, promoting active participation and encouraging personal development”².

Workplace Health Promotion is often celebrated only few days a year within workplaces through isolated activities, such as offering a “health day” or by taking part in a singular activity throughout the year. In order for WHP to be successful, however, a long-term approach is needed. Furthermore it is vital to identify and locate the drivers for improvement of health and whether it is the personal motivation of the individuals or an outside motivation from the workplace or the society.

The greatest motivation among employers for workplace health promotion is often to reduce costs related to healthcare and sickness absence, and to increase productivity. Healthy employees are seen as happy employees and more productive. Studies show, however, that there is not a linear relationship between work satisfaction and productivity³.

It has been shown that implementing WHP is an easier task when the necessary knowledge, skills and incentives are available, rather than when working conditions are bad, where there is a lack of support and resources (financial and manpower), such as in small

and medium sized enterprises and rural areas⁴. Furthermore, health promotion is not a top priority in workplaces with great mental and physical demands, lack of control, flexibility and when it is considered “easy” to replace an employee. It is important, therefore, for professionals involved in workplace health promotion to ask: Are we only reaching those who are motivated? Are we only enforcing a behaviour that already exists? Furthermore, it is important to identify the obstacles and facilitating factors and to find ways to reach those who typically are harder to reach.

In order to identify needs in terms of workplace health promotion in small and medium sized enterprises, focus groups comprised of different specialists and WHP enthusiasts were conducted in Iceland, Ireland and Italy in 2007. Participants emphasized the importance of developing guidelines, checklists and other tools and training material regarding stress and mental health. Also, active involvement was emphasized for all stakeholders in local communities: employers, managers, health care specialists, occupational health and safety specialists and health enthusiasts.

Assessment methods in WHP include evaluation of processes, impact and effectiveness of programs. Evaluation of success/effectiveness of WHP programs is, furthermore, easier when there is a “single risk” (i.e. smoking) that programs target, rather than complex risk factors (i.e. stress and muscular skeletal problems). Research within the field of workplace promotion can encounter obstacles such as selection bias. It is therefore important to use hypothesis and to do pre- and post-evaluation in order to measure difference/success. Furthermore, it is often hard to make assumptions outside the workplace, or between jobs, workplaces or work sectors. It is difficult to differentiate between what is caused by the work and what is caused by individual factors (personality) or by behaviour outside work,

which can alter measurements and results of the research. Many factors are hard to manipulate within the workplace, such as increased attention, which can cause a placebo effect. There are examples, however, of studies showing a positive benefit of WHP⁵.

A prospective intervention research project was conducted focusing on health promotion of employees in preschools in Reykjavik, Iceland (2000 – 2006). Aims of the project were to promote general health and wellbeing of employees and to improve the work environment. Furthermore, the goal was to decrease absenteeism and lower the turnover of labour. Pre-evaluation (survey questionnaires) done in 2000 in 16 preschools (90% response rate) showed substantial mental and physical strain among the employees. An ergonomic/risk evaluation was done and an implementation followed where the focus was on adapting workplaces to employees needs. Furthermore, training in ergonomic techniques, lifting and handling, and psychosocial matters were offered⁶.

Post-evaluation was done in 2002 (88% response rate). Results showed that fewer employees were working in a forward or bent position or requiring kneeling down in their work. Furthermore, the number of complaints about pain from back, knees and ankles had decreased and fewer employees visited their doctor because of back pain. Finally, the number of those who felt mentally exhausted decreased by half and awareness as regards noise levels was improved. The program was transferred to all preschools in the Reykjavik, formally ending in 2006⁷.

The following indicators of effectiveness of health promotion at a company level have been identified⁸.

- Reduced risks (health damage, accidents)

- Decreased sickness absence
- Improvement in health and wellbeing
- Financial: Cost effectiveness, Cost Benefit, Return on Investment (ROI)
- Positive attitudes, Increased knowledge, Increased awareness
- General participation
- Management responsibility and support

Indicators of success of WHP at a societal level include:

- General acknowledgement of the importance of primary prevention activities
- More awareness and training regarding WHP, at all education levels and easy access to training and training funds
- National activities that are highly publicised and established links between Workplace Health Promotion programs and community interventions, especially in rural areas

To conclude, one can say that the reality of WHP is that it has a long way to go before becoming a norm which is well integrated into the strategy of most companies – as part of their mission, goals and priorities. Furthermore, greater understanding in society of the importance of WHP is needed. Evidence shows that Workplace Health Promotion can make a difference when the focus is on real needs/risks within the workplace and when a holistic, multi-level and proactive approach is used by offering flexible services and continuous education. Another key ingredient is respect and understanding of workplace culture and individual differences. Workplace Health Promotion is therefore a long-term process with no quick fixes.

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FUTURE OF THE ORGANISER

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Reorganisation of EUPHA

In recent years, EUPHA has grown from a small organisation to a big and influential public health association in Europe.

This process of growth has been implemented slowly:

- More members were accepted into EUPHA
- The conferences increased in terms of the size of the programme and the number of participants
- The EJPH was further developed
- The role of the EUPHA Sections was expanded
- A permanent EUPHA office was established

The increase in activities had an impact on the organisation of EUPHA and the responsibilities of the different EUPHA bodies. Also, the constitution and by-laws of EUPHA no longer reflected the practical running of EUPHA.

The committee of past presidents of EUPHA organised a discussion on reorganising EUPHA, clarifying both the objectives of EUPHA as well as the structure of EUPHA.

The initial document was presented to and approved by the Governing Council in November 2006.

The document has since been split into two documents:

- one looking at the organisational structure
- one looking at the future activities of EUPHA.

Both documents were discussed on two occasions:

- A meeting of past presidents (extended council) of 3–4 April 2007 in Rome, Italy. For this meeting, the past presidents committee was extended with four Governing Council members:
 - Two representing country members: Nick Salfield (UK) and Finn Kamper Jorgensen (Denmark)
 - Two representing EUPHA sections: Kristina Alexanderson (Sweden) and Natasha Azzopardi Muscat (Malta)
- The June meeting in Helsinki where the past presidents met with the section presidents and the Executive council.

At the inauguration of EUPHA, the activities were set up in the constitution (article 3). The focus of EUPHA was clearly aimed at research, as EUPHA would concentrate on:

- encouraging and furthering effective European joint research, educational policies and other activities in the field of public health;
- circulating a scientific journal, which will among other things state the results achieved by the association;
- the holding of scientific conferences at regular intervals;
- encouraging and furthering the use of knowledge in the field of public health in order to improve the relative situation in Europe;
- encouraging and furthering scientific research in that field;
- using all other appropriate means to achieve the object of the association.

In the future mission of EUPHA adopted in 2003, the role of EUPHA was changed to become the proactive platform for public health professionals in research and practice and be a bridge between these professionals and policymakers. EUPHA should expand its tools and activities to achieve this new mission and become a more visible partner for public health in Europe.

The committee of past presidents emphasized that the excellent reputation as a research association should be protected and that we should go forward slowly with any changes. The committee also agreed to go in the direction of being the proactive bridge between research and policy/practice.

In the June 2006 meeting, the council proposed to create four pillars within EUPHA and two priority areas. The two priority areas are:

- knowledge transfer
- capacity building

These two priority areas should be implemented throughout the structure of EUPHA.

Further to the two priority areas which should be included in all EUPHA activities, the committee of past

presidents proposed to base all EUPHA activities on four pillars:

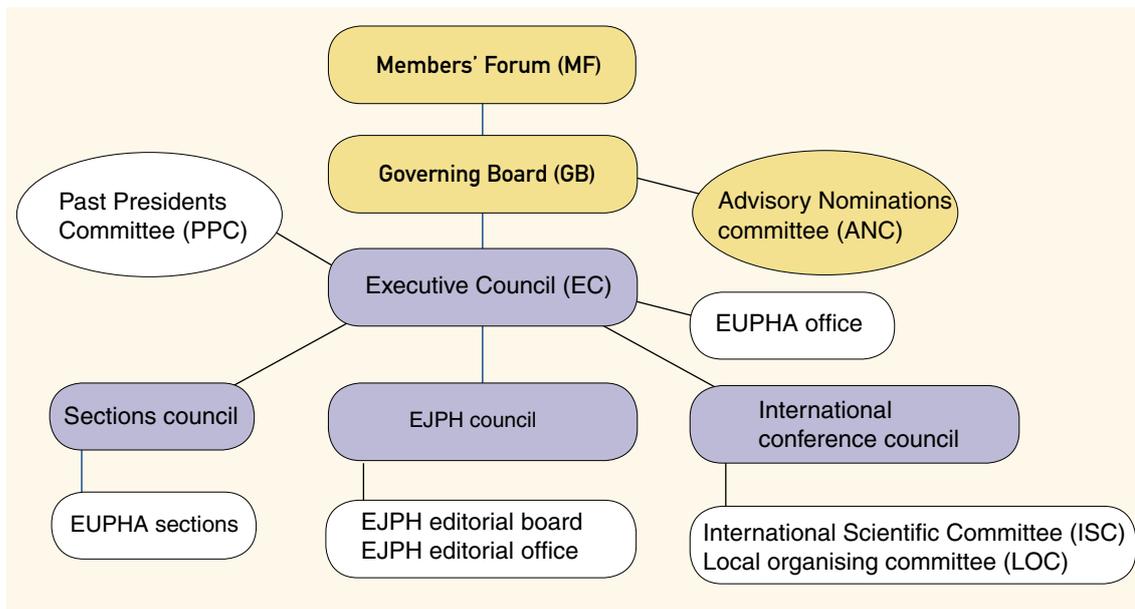
1. Research
2. Policy
3. Practice
4. Training

The idea was not to create specific sections on these pillars, but to automatically include all four pillars in EUPHA's activities. This would mean for instance that each section has to report on all four pillars (activities, plans, etc.) and that each conference should clearly show that these four pillars are represented. Please note that at the moment EUPHA's focus has been more than 80% on the research pillar, even though we see an increase in policy and practice especially at the conferences.

In 2007 during the Annual Meeting in Helsinki the final document on the reorganisation of EUPHA was presented to the Governing Council basing the need for structural changes on a number of considerations:

1. EUPHA is currently re-focussing its activities and the proposed reorganisation is in line with this.
 2. There is currently a gap between the current practice and the constitution.
 3. The reorganisation will better balance EUPHA's governing side with EUPHA's executive side.
- The Governing Council unanimously approved the reorganisation of EUPHA as displayed below.

We are expecting an evolutionary change in the EUPHA structure as we move towards the new vision for EUPHA. Further structural change may be required as part of this process.



After the Helsinki decision the following steps would be:

- Set up four working groups to further elaborate the future activities (deadline June 2008)
- Re-formulate the EUPHA constitution (draft by June 2008)
- By-laws: reformulate the existing by-laws and expand them to include the rules for the different EUPHA bodies in more detail (draft by June 2008).
- In June 2008, the documents will be discussed again in the Executive Council together with the Committee of Past Presidents and the presidents of EUPHA Sections.
- In August, the documents will be sent to the members for approval
- In November 2008, the new constitution of EUPHA will be presented to the Governing Council

The European Public Health Association has two major assets that would be beneficial in the development of the new public health:

- it is a European non-governmental association of public health experts
- it consists of researchers, policymakers and practitioners.

Therefore, EUPHA can be a great boundary spanner, not only between policy, research and practice, but also between the different disciplines. It can easily use its network to collect information from different countries on policy, practice or research.

If our European Public Health community agrees on these principles and statements we can start to make concerted efforts to overcome the health challenges of the present and future.

About the editors

Anna Alanko is the secretary of the Society for Social Medicine in Finland. At the time of the conference worked for the National Research and Development Centre for Welfare and Health (STAKES) as a researcher in the Health Services and Policy Research group, and at present she is the coordinator of the Nordic Centre of Excellence NordWel in the University of Helsinki.

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