V l e 5 N be 4, Wi´e 1999/2000

eurohealth

An increasingly important aspect of policy making within the European Union is the role of sub-national institutions in the policy process. Nowhere is this more the case than in the United Kingdom, where the devolution process is creating new centres of decision making in the health policy field. This issue of *eurohealth* includes an article by the new Scottish Minister for Health and Community Care on the aims of the current Executive in health policy and ser

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EDITORIAL

Would the Commissioner for health please stand up?

Paul Belcher

Senior Editorial Adviser, eurohealth

A casual observer of EU affairs since the new European Commission took office last year might be forgiven for thinking that David Byrne has swapped his appointed role as Health and Consumer Protection Commissioner to become 'Commissioner for Food Safety', as he now appears typecast by the European media. Whether this is a result of the need to deal with recent food related scandals, or evidence of a longer-term policy shift away from the broader EU health agenda, is now a serious cause for concern.

To be fair, few could have predicted the whirlwind of food scandals that engulfed the new Commissioner as soon as he took office. The European Parliament must also accept its share of the blame for reinforcing the current high political profile of food safety, by failing to raise wider health policy issues during its questioning of Mr Byrne in the hearings held prior to his appointment – apart from the notable few such as John Bowis MEP, former UK Health Minister, who also writes in this issue of *eurohealth*.

Food safety is, of course, a major public health issue. However, the Commission should not lose sight of the fact that this is one part of a much wider EU Treaty obligation to ensure a high level of human health protection and integrate health considerations into all EU policy areas. The high political priority given by the new Commission to press ahead with the White Paper on Food Safety and create a European Food Authority stands in contrast to the absence of proposals, now long overdue, to implement Article 152 on Public Health.

Readers will recall that in April 1998 the Commission published its ideas on the way forward for EU public health activities. There followed a process of consultation with the other EU institutions and interested parties, which was finalised before the previous Commission left office, and it demonstrated overwhelming support for the Commission's general approach to future policy. However, we are still awaiting the second stage of the process and the publication of concrete policy proposals.

As the Commissioner points out in this issue of *eurohealth*, the resignation of the last Commission was a reason for the initial delay. However, there is now palpable annoyance among some Member State administrations, particularly EU Presidency countries, as well as other interested groups who were involved in the consultation process in 1998–99, that proposals have still not been put forward. Now, as Mr Byrne notes, the delay has led to the inevitable discussion of 'interim measures' to keep afloat those health programmes which are coming to an end. Even these interim measures, which have yet to be decided, may themselves have to pass through a lengthy process of agreement and, as a result, there is great uncertainty over the future of some of the valuable projects and health networks funded by the programmes.

The Commissioner announces in this issue of *eurohealth* that his package of proposals can be expected sometime in the next six months during the Portuguese Presidency of the European Union. But why will it have taken so long to deliver these health proposals and are there any conclusions to be learned from this for the future? For many, the Commission resignation last year and the subsequent focus on food safety scandals are not valid excuses for the lack of activity on wider health policy development. It may have more to do with political priority setting within the new Commission. Indeed, the demonstration of how political will and concrete action can be employed in the field of food safety stands in contrast to the infrequent and vague policy statements on the future direction of EU health policy - let alone the complete absence of any detailed policy proposals. Some observers suggest that the reason may lie in the failure of the much heralded joining together of Consumer Policy (previously DGXXIV) and Public Health (previously DGV) within the Commission. There are reports that far from being a marriage made in heaven, this has been a bed of nails from day one and that the partners are barely on speaking terms. As a consequence, have wider health interests been marginalised by food and consumer concerns within the new Directorate-General for Health and Consumer Protection?

Encouragingly, Mr Byrne has already stated publicly that wider health issues do need greater attention. At a conference on 'Building Healthier Hearts' held in Dublin on 5th November last year, he recognised that much of his time was indeed being taken-up with food safety issues. He said that while they are important, "they should not serve to distract our attention from wider health issues". The Commissioner will find much support for these sentiments among the wider European health policy community. However, the time has now come for words to be translated into concrete action by ensuring the timely publication of visionary health policy proposals that interpret Article 152 to the full and maximise the 'added value' which the EU can make to national efforts to *improve* and not just protect public health.

During first the six months of the year 2000, the Portuguese presidency of the European Union will play an important role in the area of public health.

First of all, we are making all efforts to ensure the continuity of proposals launched under the previous Finnish presidency. These will certainly contribute to the implementation of a global strategy for health for the fifteen countries that constitute the Union.

Since becoming Minister of Health in Portugal eight weeks ago, I have been conscious of the importance of this presidency for Health in the European Union. Working towards that objective, we have decided to organise initiatives that will be developed in the forthcoming six months. I am completely confident that they will all be highly beneficial for the successful exercise of my mandate, as they will be for all of my fellow Ministers of Health in the other fourteen Member States.

The recent changes to the Treaty of the European Union have been of great value, first by establishing a Community public health competence (Treaty of Maastricht), and then by introducing a clearer legal basis for the action of the Community in terms of health policy (Treaty of Amsterdam). These changes make the horizontal charac-

The European Community's future strategy in the field of public health

David Byrne, European Commissioner of Health and Consumer Protection, here elaborates on his and the Commission's role in public health, and the priorities for building on the work of the previous Commission and developing future policy in its public health strategy.

From the outset, the new Commission has put health high on its agenda. For the first time a health portfolio has been created. A new Directorate General has been established bringing together public health, consumer protection, animal and plant health, inspection and scientific advice. This significant development responds to the new health provisions contained in the Amsterdam Treaty, which widen the scope of Community action in this area.

The Community's current public health actions are based on the strategy set out in the Commission's framework for action in the field of public health, published in November 1993. In this context, eight action programmes were introduced and are in the process of implementation. Other activities undertaken included a strategy and measures on tobacco and smoking; a strategy and a Council recommendation on blood safety; the organisation and coordination of surveillance and control of communicable diseases at Com-munity level and regular reporting on health status and on the integration of health requirements in other policies.

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Following the conclusion of the Amsterdam Treaty, which strengthened the health provisions of the EC Treaty, and with the prospect of future enlargement, a stock-taking exercise concerning the objectives and administration of the programmes and the overall coherence of policy took place, involving stakeholders inside and outside the Commission. There was consensus towards developing a new policy which ought to be highly effective, well-structured, in tune with the strategic needs of the Member States and flexible enough to respond to new developments. The new policy had also to address the issue of limited resources and the heavy administration burden posed by the current action programmes.

The Commission's communication of April 1998 on the development of public health policy set out the results of the review and suggested a number of priorities and options for the future. It proposed a broader, coherent approach to tackling health issues at Community level, involving:

– one overall public health programme with actions in several key fields: health information, rapid response and tackling health determinants, which should pay due attention to issues related to enlargement and to the interaction with other health-related policies;
– large-scale, sustainable actions, involving all Member States, which would have a strong link to policy development and, eventually, the preparation of legislation;
– taking full advantage of the range of legislative possibilities offered by the Treaty.

The Communication stimulated a wide debate on how the Community's public health policy should develop. For example, the German Presidency organised a major conference (in Potsdam, January 1999); the European Parliament commissioned an expert study and held a public hearing (in Brussels, October 1998); and many NGOs, professional organisations and other bodies wrote to the Commission giving their views, or organised events at which the communication and the future of health policy in the EC was discussed. The overwhelming majority of opinions and comments received, and in particular those of the Parliament, the Council and the other Community institutions, indicated support for the Commission's ideas and approach as set out in the Communication.

The resignation of the Commission in March 1999 has inevitably delayed the process of developing specific proposals. However, it is clear that developing new proposals for action in public health based on Article 152 of the Treaty, and a general communication on the Community's health

strategy, are priorities for the new Commission. While these would reflect the debate on the Community's future policy in this field launched by the Commission's communication, they must also take account of the recent developments concerning the place and weight accorded to health in the new Commission and in public perception, as well as the lessons learnt from recent health-related crises.

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Although the details of the communication have yet to be confirmed, my intention is that it would have a number of aims. First, to describe major trends and developments in health. Thu re/ yeoutas the gal basthis Community'acentis h-relatts

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"The Council of the European Union ... Recognises that mental health is an indivisible part of health ... Invites the Member States to develop and implement action to promote mental health and prevent mental illness ... Invites the Commission to consider ... the need to draw up a proposal for a Council Recommendation on the promotion of mental health." This extract from the unanimously adopted Resolution of the Health Council meeting of 18th November in Brussels shows just how far we have come since the Treaty of Amsterdam gave the European Union competence for health promotion; since the Finnish Government decided to make mental health a priority for their 1999 Presidency; and since the Conference in Tampere, Finland on the Promotion of Mental Health and Social Inclusion, on 10th to 13th October, 1999. This brought together the Council, Parliament and Commission, together with Finnish NGOs, the WHO and representatives of mental health practitioners, planners, service users and families came together from 10th to 13th October in Tampere, Finland for the first EU Conference on the Promotion of Mental Health and Social Inclusion.

I was privileged to represent the European Parliament and speak in the opening session alongside the Health Council's Finnish President, Eva Biaudet and EU Health Commissioner David Byrne. Eva Biaudet and I both challenged the Commissioner to put mental health firmly and highly on his agenda and pledged our support for him if he were to do so.

Ag i g b de

We know, from a great deal of research but notably from the trio of reports from the World Bank, WHO and Harvard University in 1993, 1995 and 1996, that mental disorder is the fastest growing cause of disability and of the global burden of disease. We know too that five of the ten leading causes of disability are psychiatric and that the burden is set to rise from the current 10.5% to some 15% by 2020, at which point it will overtake cardiovascular disease. In Britain we know that we lose more people through suicide than we do through road accidents, that we lose some 92 million working days a year from mental illness and that the direct health, social care and benefit cost to the nation is about £20 billion, before you take account of the cost to individuals of lost earnings and to the country of lost wealth creation.

To me, even more important are the statistics that show just how many of us are mentally ill at any one time (one in seven), how many will be during our lives (one in three) and the fact that one in three of us who visit our GP have some form of psychosocial disorder but only one in six of us has that diagnosed. In the words of the National Lottery advertisers, 'It could be You' – or me, or my wife or son or daughter or a close friend - and it almost certainly will be one of those. And, if it is, then shouldn't we all want there to be in place a caring, humane, close-to-home facility, where we can be restored to health or, if that is not possible, then that we will be cared for with love and with dignity and without stigma. That must be our driving emotion and also our cool logic in pressing forward the need for mental health to be promoted as an integral part of EU policy.

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The Treaty of Amsterdam takes us forward in two ways: it gives a real jurisdiction for mental health promotion and education and illness prevention; it also provides for all EU policies to take account of their effect on health, including of course mental health. We should– ochho betabre tolookd forward to thedrevlop men- and mopl men-

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There is also a degree of sensitivity to be overcome where any EU action on health is concerned. In this area it is Germany, I am told, who is the strongest upholder of the principle of subsidiarity. The Treaties, we are firmly told, do not cover health, which is entirely a matter for member states. And that is true – well fairly true. In fact public health has been a competence of the EU for some time and so has health and safety at work and so, following a recent judgement, has the right of European citizens to benefit from health provision in whichever member state they find themselves. But the actual system of health service provision is and remains entirely a matter for each country and its government and parliament.

Amsterdam does not give the EU power to direct health across the Union, but it does encourage it to research and share best practice, to promote education on steps to good health and away from poor health. So it will be right for the Commission to enable member states and the Parliament to find a range of good practice in prevention, promotion and provision but not to go the next step and say what each country must provide. It will therefore have to be done by example and by showing what works. The exact border between health provision and health promotion is a little blurred; for example when one is in the area of post-treatment care and rehabilitation and measures to prevent relapse, clearly the two are interdependent.

The Ta e e C fe e ce

Tampere was an excellent coming together of practical experience and academic thought. We started from the quartet of base points

- acknowledging the social and economic causes of mental ill health as well as the physical and neurological ones
- accepting that many if not most mental health problems can be cured or stabilised
- welcoming recently published evidence that health promotion works and that many mental disorders can be prevented
- realising that we have a long way to go in developing acceptable outcome and cost effectiveness measurements and indicators, without which it is difficult to convince finance ministers and budget committees of the wisdom of investing in health promotion

There were three areas that the conference felt merited priority action: children and young people, the workplace and elderly people.

Changes in society have made the world a less secure and stable place for many children. Families break up; parenting skills are no longer handed down the generations; the parent's job and housing mobility removes children from the wider family circle; crime, delinquency, truancy and unemployment inhabit too many estates. It is hardly surprising that child behavioural and psychiatric problems multiply.

At work, firms that take a health at work policy as a matter of course, look bemused when you ask to see their mental health at work policy. People with a problem conceal it, lest it should undermine their job or chance of promotion. Employees, who are caring for a disabled relative, struggle to cope with both and end up coping with neither, for the lack of a flexible policy for carers at work. And when the temporary or permanent end of work comes, through redundancy or retirement, nobody helps the person prepare for the suddenness of the change or to make best use of the new availability of time; and we wonder why people become depressed.

The lengthening of our life years is a bonus but also a challenge. Many of us will become not ill but frail of body or mind. We have a remarkable generation of 80 and 90 year olds, particularly women, who found and took positions of responsibility during the war. There is perhaps a lesson in this that a sense of purpose and of being needed and valued in our later years is

Health policy in the EU
A basic guide

Graham Chambers

This is my second attempt[1] to take you through the labyrinth of the European Union's modus operandi and lead you out at the other side, compos mentis. Both our tasks are simplified because of the most recent changes to the ways in which the EU works, the Treaties of Maastricht in 1992 and Amsterdam in 1998. The fallout from the 1999 'implosion' of the Santer Commission and nomination of the Prodi Commission resulted in considerable changes in the Commission and in its relations with the Parliament.

"There are fears that consumer protection will predominate over health policy in the new department, given the current preoccupation with food hygiene and the almost theological arguments over the safety of British beef."

The European Union does not have a 'government' made up of Members of the European Parliament. Rather, there is an institutional triangle in which (very approximately), the Commission proposes, and Council and the Parliament scrutinise and jointly legislate.

The relative weight of the three main players changes and there is a permanent institutional 'tension' between them. There is a fourth player in the centre of the triangle The Court of Justice, which is the guardian and ultimate interpreter and arbiter of the Treaties.

There are other EU Institutions. The Court of Auditors scrutinises EU expenditure. The Economic and Social Committee and the new 'Committee of the Regions' (which has a health mandate) are consultative bodies, without legislative power. The three principal players are:

The European Commission

Headed by a 'college' of 20 Commissioners, including President Romano Prodi, the Commission is charged with implementing the Treaties. This means running detailed policy, where it exists (e.g. the CAP) or developing policy, where the Treaties grant the power to do so (e.g. the Single Market.)

The Commission employs about 20,000 in Brussels and in Luxembourg. It is divided into departments headed by a Director General. Each Commissioner is responsible for one or more departments.

Health was previously one directorate within the Directorate General (DG) for Employment and Social Affairs as a result of its historical development from health and safety measures in the European Coal and Steel Treaty and Euratom, which were the forerunners of the Common Market (EEC) and the European Union.

Consumer protection questions were originally handled by a unit within DGXI (Environment) and then by a separate, so-called 'horizontal' unit outside of any DG. This lasted until a new DG (XXIV) was created in 1993. The BSE crisis, which revealed many inadequacies in the Commission's structure, triggered large-scale reforms in which health was amalgamated with DGXXIV in a new Health and Consumer Protection Department. The numbering of DGs having been dropped in favour of departmental names.

There are fears that consumer protection will predominate over health policy in the new department, given the current preoccupation with food hygiene and the almost theological arguments over the safety of British beef.

The Council of Ministers

The composition of the Council of Ministers varies according to the policy area. The Health Council is composed of national ministers of health or their equivalents. As well as the permanent Council secretariat in Brussels, all Member States have permanent representations in Brussels, which regularly meet outside of ministerial meetings.

The European Parliament

The Parliament is the only directly elected European body. It was created as a counterweight to institutional power at a European level. Its Members were initially appointed by Member States from their own Parliaments, but direct elections had always been envisaged and in 1979 the first elections took place (the first elections to an international parliament ever).

Parliament now comprises 626 Members, the number from each Member State is calculated in weighted proportion to its population, but the members sit according to political affiliation and not nationality. They belong to 'political groups', which range from nascent European political parties, at one extreme, to loose 'technical coordination' groups of small parties at the other.

Parliament's Secretariat employs about 4000, divided into seven Directorates General. The total includes the Political

1. The first article 'Inside the Labyrinth' appeared in *eurohealth*, September 1996.

and environmental and transport measures have a considerable impact on the health of the public.

The Maastricht Treaty article 129 gave a specific legal basis and competence in the field of public health, though subject to conditions of subsidiarity. It stated that:

"the EU shall contribute towards ensuring a high level of human health protection by encouraging cooperation between member states and, if necessary, lending support to their action. Action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education. Health protection requirements shall form a constituent part of ... other policies."

The Treaty of Amsterdam, introduced on May 1st 1999, whilst not introducing an EU health policy, nonetheless takes a number of steps in that direction. Article 3(p) sets out an overall objective of "to raise the

The information obtained varied greatly in extent and nature. The Democratic Unionist Party (DUP) simply stated that it was "committed to looking after your interests in a caring health service, responsive to local needs. We are pledged to provide health care free for all."[2] In contrast, the Ulster Unionist Party (UUP) presented a detailed paper from its health committee that addressed a wide range of issues relating to the health service.[3] Their report was unusual in that, for many issues, it spelt out the pros and cons of different approaches and recognised the need for both further research and for trade-offs between competing objectives. This may reflect the fact that their health spokesperson has been a long serving member of the health committee in the House of Commons, the lower house of the UK parliament.

Few parties had clearly identified health, as opposed to health care, policies although many had policies that would be of significant importance for population health under other headings, such as education, rural affairs, or community development. For example, the Women's Coalition argued for an integrated transport policy and the eradication of poverty.[4] The Alliance Party proposed a series of specific

health care than the rest of the United Kingdom. Successive governments have justified this on account of their more dispersed populations and higher levels of deprivation and ill health. There were few concrete suggestions to tackle the perceived lack of funding. The Alliance Party advocated hypothecated alcohol and tobacco taxation but the Assembly will not have tax raising powers.

Although the distribution of hospital services has received enormous media attention in Northern Ireland as a result of policies by the (non-elected) health boards to rationalise services, this issue was barely mentioned. An exception was the UUP health committee report which noted that it was "difficult to argue against the case for rationalisation of specialist services", although it also argued for development of complementary local services and good transport provision.

Several parties had identified issues of particular concern to them, such as the quality of care in facilities providing long term care for the elderly (UUP), clinical research training (UUP), general practice fundholding (Alliance), and responsiveness of services to local communities (Popular Unionist Party),[7] although few of these issues had been developed into explicit policies.

A f idable´ a k ahead

If the new system of devolved government works as planned, the executive and the assembly will face a formidable task if they are to develop policies that will address the health needs of their population. It would, however, be wrong to assume that there is a health policy vacuum in Northern Ireland. Since 1974 Northern Ireland government departments, while headed by ministers appointed from within the United Kingdom government, have developed a range of innovative policies, reflecting local circumstances. Bodies such as the Northern Ireland Health Promotion Agency and the Cancer Registry have been established. The Department of Health and Social Services has developed a regional health strategy,[8] similar to the English Health of the Nation and Our Healthier Nation strategies, in which a series of key areas are identified (Table 2) and targets for health improvement are set. They have also undertaken a series of seminars for Assembly Members to raise their awareness of the health challenges facing Northern Ireland. Unfortunately, the almost exclusive focus on constitutional and security issues seems to have prevented the Northern Ireland political parties from taking fully on board what has already been done and what more is needed to bring the health of their population closer to that of the rest of Europe.

As many politicians in central and eastern Europe have learned, the move from political opposition to government is far from easy. It would seem that, at least in health policy, Northern Ireland's politicians still have some way to go.

P´ c i´

Just as this edition was going to press, agreement was reached among the political parties to form an executive. Sinn Fein nominated Bairbre de Brun as Minister of Health and this was accepted by the Assembly.

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The health of the public in Northern Ireland

Etta Campbell

"it is the differences that exist in life expectancy within Northern Ireland that currently cause the deepest concern and call for concerted and sustained action"

The people of Northern Ireland are healthier than they have ever been and on a global scale they are healthier than many other populations. However, in comparison with other European countries our health could be much improved and within the Northern Ireland population there are significant inequalities in health.[1]

Comparisons within Europe show that Northern Ireland is not faring as well as other countries. The life expectation of males at birth in Sweden for example is about three years better than Northern Ireland. In France women can expect to live almost five years longer than women in Northern Ireland (see Figure 1). These differences pose interesting hypotheses for epidemiologists and set challenging objectives for policy makers. Many life years could be gained if we could fully explain these differences.

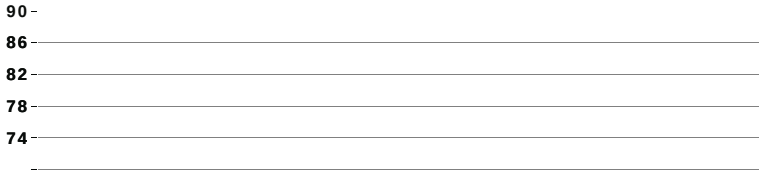
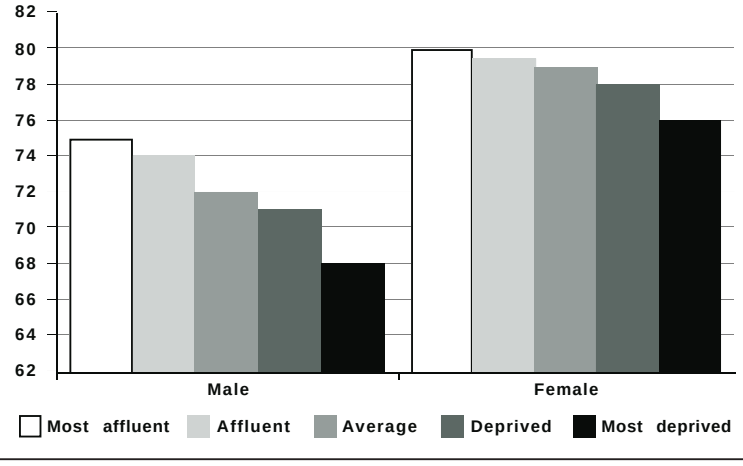


Figure 2

LIFE EXPECTANCY WITHIN NORTHERN IRELAND BY DEPRIVATION (c. 1990)



Inequality in health

However, it is the differences that exist in life expectancy within Northern Ireland that currently cause the deepest concern and call for concerted and sustained action. People who live in affluent areas have a much better life expectancy than those who live in the most deprived areas (see Figure 2). If these inequalities could be addressed, approximately 2,000 lives could be saved each year. Inequalities in health can be depicted in almost every health index which is available to us. Infant mortality rates are 50% higher in the most deprived group compared to the least deprived. These differences are carried through into childhood with higher rates of death due to accidents. Children living in areas of greatest deprivation are 15 times more likely than the most affluent to die as a result of a house fire and seven times more likely to die as a result of being hit by a vehicle.

Inequalities in health are very much in evidence right through into adulthood. Significant differences in health exist between Northern Ireland's electoral wards. Poverty and social exclusion rob a significant proportion of our people of their full potential for health and in turn place a huge demand on our health services.

Cardiovascular disease, including coronary heart disease and stroke, is the single

biggest killer in Northern Ireland.[2] One in three men and one in four women die from coronary heart disease.

Although deaths from heart disease have been falling since the early 1980s, Northern Ireland lags behind other countries in Europe where the death rates are dramatically lower (see Figure 3). With an ageing population we can expect heart disease to remain a major problem for some considerable time. In addition more people than ever are now surviving their first heart attack and are living with heart disease. The incidence of chronic heart disease such as heart failure and atrial fibrillation is increasing.

Breast cancer is the most common cause of death from cancer among women in Northern Ireland.[3] The death rate from breast cancer in Northern Ireland is one of the highest in Europe. Provisional figures from the Cancer Registry suggest that at long last the death rates from breast cancer may be falling.

Northern Ireland has one of the highest rates of colorectal cancer in Western Europe with about 600 new cases every year. The number of colorectal cancers is falling among women but not men. Diet must remain a priority if any reduction in colorectal cancer is to be realised. On average, people in Northern Ireland eat fewer than three portions of fruit and vegetables each day, much less than the current recommendation of five portions.

Mental illness is one of the most common forms of ill health in Northern Ireland. It is responsible for enormous costs to the individual and to society. Many working days are lost as a consequence of mental illness. Using the General Health Questionnaire the Northern Ireland population is at an increased risk of mental illness when compared to other UK regions.[4]

Ri k fac f ill-hea h

Smoking is a common risk factor for many of the major diseases. Whilst there has been some reduction in the numbers of people who smoke the number of smokers in the population is still high at 28%.

These trends in disease and the risk factors for disease suggest that heart disease, stroke, cancer and diabetes will remain as major causes of premature death and morbidity well into the next century. The distribution of the risk factors for these diseases across the social divide within our society suggest that the inequalities in health will remain and grow even wider in the foreseeable future even if concerted action is taken now.

Sig f h e

Faced with these figures it would be all too easy to give in to despair. However there are some signs of hope. Since 1986 the Regional Strategy[5] for the Department of Health and Social Services in Northern Ireland has been based on the principles of Health for All. Whilst this strategy did not have the impact that we might wish, it did intthis s-1.2uTw Health and Social Sere.75 0.89f43440 -icTD TDI-18.197 -1.281 TD 0.0

where these would be of mutual advantage;

- Assisting border areas in overcoming the special development problems arising from their relative isolation.

Official endorsement for the CAWT process has been given at a national level by both ministers of health and by the departments of health in Northern Ireland and the Republic of Ireland.

Area of activity

CAWT has sponsored joint working across a range of service areas. These include acute services, primary care, accident and pre hospital care, learning disability, family and child care, mental health, health promotion and public health. CAWT has been operating a two track approach, concentrating on operational (across the fence, good neighbour) cooperation in the provision of services to the local resident populations, and in addition developing, with the assistance of funds from the EU Special Support Programme for Peace and Reconciliation, foundation projects for the further enhancement and longer term development of key service areas. CAWT has, in addition, developed a Secretariat to support and enhance ongoing cooperation and to develop a strategic direction for its future. In 1997 it published its Strategic Plan for the period 1997–2001 and is at present developing a CAWT web page for wider dissemination of its work and experience to date.

Achievement

Outlined below are key elements of the

cancer audit across the four Board areas. It is anticipated that this audit will last a total of three years and will have strategic significance in the context of future planning for breast cancer services.

Primary care

Primary care cooperation across the border has been developed in the following areas:

– Joint practice organisation.
– Joint service developments.
– Community pharmacy.
– Clinical practice.
– Facilities development, i.e. cross border joint resource centres.
– Initial work in the area of cross border health actions zones.

Work undertaken within practice organisation has recently been nominated for a major UK award in primary care practices, i.e. the Primary Care Management Award 1999.

"The future for cross border cooperation between Member States within the context of wider European policy is crucial for the development of the Union in a way that is relevant and important for ordinary people."

The work underway within the primary care project has particular strategic importance in the context of the primary care groups envisaged in the reorganised Northern Ireland health services outlined in 'Fit for the Future'. It also dovetails with the blueprint for the development of general practice in the Republic of Ireland and the strategic approach being followed by all the Boards for the development of primary care services.

Ambulance services

The work undertaken within the joint ambulance training and developments project began between the Northern Ireland Ambulance Service and the NEHB initially, with the NWHB joining later in the project. This project focused on operational improvements between the ambulance services north and south of the border. In this regard it concentrated on the development of joint training packages, the piloting of a Geographic Information System (GIS), the development of a joint communication system, and the testing of all of the above developments within the context of a cross border major incident exercise in May 1999.

This project has also had particular strategic importance because of the current Review of the Northern Ireland Ambulance Services and the recent Review of the Republic of Ireland Ambulance Services. It also has relevance for the current Review of Acute Services, and importantly in relation to the identification of cross border accident and emergency services as an area for development within the context of the Good Friday Agreement.

Cooperation between specific social care groups

Projects to enhance operational good practice within the areas of family and child care, learning disability and mental health have been undertaken in a number of areas. These include the following:

1. Family and child care:
– Improved accident prevention strategies for children;
– Protection of disabled children;
– Improved parenting skills on a cross border, cross community basis;
– Prototyping and Evaluation of youth intervention strategies;
– Drug awareness training.

2. Learning disability:
– Piloting evaluation of different types of flexi care working schemes in marginalised areas;
– Development of protocols and training for the protection of vulnerable adults within care settings.

3. Mental health:
– Development of a cross border resource centre;
– Community based research into suicide prevention strategies;
– Development and piloting of cross border training for mental health staff in cognitive therapy, and piloting supported employment model of training for those with mental health problems.

Health promotion and public health

A range of health promotion strategies has been carried out under the auspices of CAWT since 1992. These include major health promotion activities in the areas of childhood accident prevention, drug awareness strategies, smoking cessation strategies, mental health promotion, suicide pre-

ventative strategies, examinations of compliance by elderly persons in use of medication.

A g a e f achie e e´

Since its inception CAWT has been successful in a programme of real achievement:

1. Beginning the process of strategic, epidemiological and operational planning for a transborder region.

2. Establishing formalised cross border cooperation within the health and social care sectors in the border region.

3. Improving service for the CAWT population.

4. In achieving operational cooperation across the range of areas outlined above, there have been significant improvements in service cooperation, and the development of new and innovative approaches to common issues and problems. In addition there has been a pilot provision of new localised services on a cross border basis for resident populations who heretofore would have been required to travel to the main centres of Dublin and Belfast for such services.

5. Working in collaboration with other agencies and bodies to establish the special needs of the population in the border region.

6. Placing health sector coordination on the agenda with both Departments north and south.

C e´ ´ íie i a cha gi g lí ical e i e´

CAWT will continue to build on operational cooperation and to enhance service provision to its client population by means of strategic partnerships and alliances. Difficulties posed by back to back planning at national policy-making level and the very different natures of employment, namely in relation to terms and conditions, registration etc., are seen as positive challenges which, in cooperation with national and European bodies, can be overcome in an innovative and energetic way by CAWT and other cross border public bodies.

The re-introduction of an executive into Northern Ireland and its potential for making its own stand-alone legislation and policies provide a major opportunity for coordination of policy making on the island. If supported by both UK and Irish governments and with a focus on joint cooperation, much of this new legislation and policy could significantly impact on the problems in the border region, in particular on the difficulties created by the different funding and management systems in the two jurisdictions. The fact that cooperation between the ministers of health in both Northern Ireland and the Republic of Ireland over a number of years is well established is a firm foundation for future development.

"In achieving operational cooperation … there have been significant improvements in service cooperation, and the development of new and innovative approaches to common issues and problems."

F´ e De el e´

The Good Friday Agreement recognises certain areas of cooperation in health as being worthy of future development. These are:

1. Accident and Emergency Services.

2. Cancer Services.

With the groundwork undertaken by CAWT, opportunities exist for a more organisational approach to planning for health and social services in the border region. To date much of the work undertaken by CAWT has been funded through European funds. It is anticipated that national governments will recognise:

– The special needs of the border region;

– The need to border proof their national policies;

– The need to focus in a special way on encouraging and promoting cross border cooperation in key public service areas within the border region, which has a dispersed, isolated and marginalised population.

In simple terms CAWT has proven that practical cooperation across the border can enhance service provision, create economies of scale and enhance peace and reconciliation through collaborative working. The future for cross border cooperation between Member States within the context of wider European policy is crucial for the development of the Union in a way that is relevant and important for ordinary people. Continued and coordinated European, national and local commitment to the needs of this border region can only produce increasingly significant and longer term benefits for the population.

Health care across borders:

The scope for North-South 7 0 0 7 402-mros MSouO.05 0

Sha ed ble b´ i di id al l´i

The Good Friday Agreement and the constitutional changes that have arisen from it offer scope for a reassessment of the provision of acute health care in Northern Ireland. Provision of hospital services in its border regions has long been contentious with the current pattern based largely on historical factors. Health authorities, in this rural region with its very low population density, have sought, since at least the mid 1960s, to concentrate facilities on fewer sites. It has, however, been difficult to introduce change in the face of widespread public and professional opposition, based largely on concerns about poor transport links.

Although the border areas of both Northern Ireland and the Republic of Ireland face the same problems, proposed solutions have been limited to only one country. A common response, based on cross-border cooperation, has received no serious consideration. This is especially surprising in view of both the long tradition of free movement across the border – facilitated by the existence, since Irish independence in 1921, of a common travel area within which passports are not required – and, until relatively recently, the use of a common currency. Furthermore, the medical professions in the two countries have strong links. The Irish Royal Colleges, which predate independence, draw members from both parts of the island.

On the other hand, formal contact between official bodies in Northern Ireland and the Republic has been extremely limited and, at least in Northern Ireland, highly contentious, extending only to matters such as fisheries and the cross-border rail link. In addition, cooperation on health care has been complicated by different financing and delivery systems.

The political settlement in Northern Ireland has been accompanied by a growing recognition, on both sides of the border, that cooperation can bring important benefits. This process is being encouraged by substantial funds, in particular from the two governments and the European Union.

Most readers of Eurohealth will be familiar with the provisions for free movement of patients within the European Union so these will not be repeated here. In addition, however, the UK and the Republic of Ireland have a separate agreement enabling each other's citizens to obtain care in the other state without requiring an E111 form.

In 1992, health boards on either side of the border, signed an agreement (the Ballyconnell Agreement) to "improve the health and social well being of the resident populations and to exploit opportunities for cooperation, joint working and sharing of resources". This led to the establishment of Cooperation and Working Together for Health Gain and Social Well Being in Border Areas (CAWT), which has developed work in areas such as mental health, prevention of childhood accidents, drug education and information technology. In addition, the border health boards are sharing experiences in primary care, supported by funds linked to the Northern Ireland peace process.

The Good Friday Agreement, ratified by referendum in May 1998, provides for a North/South Ministerial Council, "to develop consultation, cooperation and action within the island of Ireland –including through implementation on an all-island and cross-border basis, on matters of mutual interest within the competence of the Administrations, North and South."* This has included social security and social welfare. 'Health' seems to have been something of an afterthought, specifying inclusion of "accident and emergency services and other related cross border issues". It seems likely, however, that emerging cross-border structures will ultimately provide a basis for cooperation on other health-related issues,[1] building on recent developments

in cross-border cooperation on communicable disease control and cancer registration, although much will depend on the attitude of a Northern Ireland executive.

The c e f c -b de c e á i

Although the purchaser-provider split in Northern Ireland enabled health boards and trusts to agree contracts with bodies in the Republic, this has had little practical effect. Some outpatient services are provided in Derry and Omagh, in Northern Ireland, for residents of the Republic and health boards in both countries have purchased some elective procedures, such as cardiac bypasses and orthopaedic procedures, from each other.

Nevertheless, there is likely to be an underestimate of the scale of cross-border flows, as there is no effective system to measure them. There is, however, a widespread impression that patients from Donegal, in the Republic of Ireland travel to Derry, in Northern Ireland – many may use addresses of friends or relatives there when doing so.

Last year I examined perceptions of cross-border care in a survey of managers and general practitioners in a border area of Northern Ireland, supplemented by information from government bodies and health boards in both countries.[2] Respondents saw cross border flows as predominantly into Northern Ireland. Few general practitioners were aware of proposals to increase cross border cooperation in health care, although most saw advantages outweighing disadvantages, citing benefits such as shorter waiting lists, easier access, and better services. Another perceived benefit was the ability to support local hospitals that are currently not viable but which could become so if they served both sidets-
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tributions from three of the five topic areas, fiscal policy, foodstuffs and pharmaceuticals, thus introducing a comparative element into the debate.

The c a á i e di e i

One of the advantages of carrying out a project in several topic areas at once is the

The regulation of pharmaceutical products

The analysis in this area draws heavily on work presented at the seminar that was held in the course of the project.[1,2]

"it is unclear whether standards are likely to rise or fall in the future as a result of harmonisation."

The ad ha i á i

The background to the EU-level system is that the regulation of pharmaceuticals has a long history, and was already well developed in the Member States before effective harmonisation took place. Thus, apart from the possible economic advantages of an enlarged single market, the EU system could benefit public health by providing a higher quality of regulation than would otherwise continue to be provided at Member State level, in accordance with Article 100a of the Single European Act that specified 'a high level of health protection'. However, it is also possible that a harmonisation process could lead to a reduction in standards, rather than a rise.

The European Community's first Directive on medical products regulation (EEC/65/65) was published in 1965. Common standards for specific toxicological and pharmacological tests were subsequently issued in 1975, when the Committee for Proprietary Medicinal Products (CPMP) was set up to provide expert scientific advice. At the same time, a Community-wide mutual recognition system (the CPMP procedure) was introduced. This was not completely successful in achieving harmonisation, especially because Member States frequently tended to seek arbitration, and it was replaced in 1985 by the multi-state procedure. A concertation procedure was also introduced for biotechnology and 'high technology' products in 1987.

A major change occurred on 1st January 1995, when CPMP opinions became binding on the Member States. At the same time, the European Medicines Evaluation Agency (EMEA) was established to administer the new procedures, with expert advice from the CPMP. The process of harmonisation has thereby been greatly strengthened. A further major change occurred in January 1998, when national authorisation routes effectively ended.

The c e´ í á i

The situation now is that the regulatory authorities are still based at national level, and that they compete for regulatory work and the fees from industry that support it; the expectation is that only about five of them will survive, which has implications for the future of the European toxicological science base. There is also a requirement for rapid evaluation: a strict time frame (typically 210 days) may be all that is available to review an application that runs to thousands of pages and that took the company many months to compile, and it is difficult to maintain high quality in these circumstances.

This and other features of the system mean that the industry and the agencies have a relation of cooperation rather than the opposition that is traditionally associated with the regulatory process. This situation is evaluated differently by different participants (apart from in the industry where it is uniformly welcomed), and places a heavy responsibility on the peer review process. While it is generally agreed that the scientific standard is high, it is unclear whether standards are likely to rise or fall in the future as a result of harmonisation.

Two other issues deserve to be highlighted. First, there is widely agreed to be excessive secrecy, which is usually justified in terms of the need to maintain commercial confidentiality. If the latter is indeed necessary, it is unclear why the public and the regulators should be expected to trust pharmaceutical companies that apparently cannot trust each other.

Secondly, the EU regulatory system pays no attention to the question of need: perhaps three drugs each year have something substantially new to offer, whereas a large number of apparently new products are merely versions of already available drugs. Not only are these rarely advantageous therapeutically; the proliferation of 'me-too' versions has sometimes resulted in the belated discovery that they caused problems, as was the case with bromfenac and mibefradil. There is now a case for moving from an essentially economic system of product regulation towards a system that has the rational use of pharmaceutical agents as its basic aim, as occurs in certain non-EU countries (2). This would mean reconsidering the position of the regulatory system within the Commission: pharmaceuticals are currently the responsibility of DG III (Industry), but health could be given a larger role.

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Regulating the market in medical devices

Unlike pharmaceuticals, the market in medical devices has been largely unregulated in most Member States. As this very broad and heterogeneous term embraces implantable items such as heart valves and artificial hip joints, as well as a wide variety of non-implantable equipment24.262nts, as well aso(ge8TD 0,s, s)Tj -aquan1D (t25.341ial hipdiac1.455 5.341ion-impla

A haha a d e

At best the system has been haphazard, either treating devices as pharmaceutical products, or covering some categories but not others, for example contact lenses but not intra-ocular lenses, or condoms but not intra-uterine contraceptive devices.

The situation has therefore arisen that a large number of essentially similar products exist, but some of them are inferior in design and/or manufacture. There has been no requirement to record which product is used, for example, for insertion of an artificial joint, and no follow up of adverse incidents. There have been examples of medical devices that have caused harm to patients, which in some cases have been serious, including the Shiley heart valve. A recent example was a type of artificial hip in the UK which was discovered to deteriorate over time, and required a large number of people (many of them elderly) to undergo replacement of the joint; the product had no advantage over the standard type of hip prosthesis (hundreds of different types exist). It also proved difficult to discover who had received this particular implant so that they could be contacted about the need for further surgery.

T a d effec i e eg lá i

In 1993, a Directive concerning medical devices (93/42/EEC) was agreed, and this came into force in all the Member States in 1998. Its main provisions are the requirement for all medical devices to carry the CE mark, and provision for post-marketing vigilance. Eligibility for a CE mark depends on safety, effectiveness, absence of side effects and satisfactory performance in use, as well as on manufacturing quality. The vigilance procedure should make it possible to have earlier warning of adverse events. However, there is a problem in linking the data on individual patients, because of data protection legislation. It seems strange that protecting the identity of patients is legally regarded as having priority over protecting their health.

Many devices have already been removed from the market, and progressive raising of standards in this area is likely to result from the Directive. The resulting benefit of this legislative initiative may be quite large, but this cannot be quantified, as the data on previous harm from medical devices is inadequate - another consequence of the previously anarchic situation. In addition, although there is a literature on aspects of medical devices, for example from a legal viewpoint, no work appears to have been done that could be used to assess the public health impact of changes in legislation and practice. This is an area that requires further research.

A e i g he eg lá i i lace

In practice, serious health consequences that are known to result from exposure to dangerous chemicals are uncommon, apart from a few specific instances, notably asbestos. This could be because the regulatory system is functioning effectively, because there is limited potential for most chemicals to cause serious illness at exposure levels that actually occur and/or because there is under-recognition of such effects.

The regulatory method used is risk assessment, and a great deal of attention has been paid to the methodology; however, it is an

expensive and laborious process. The system is not only concerned with the question of approval, but also with such things as labelling, packaging etc. Labelling has been harmonised, and includes symbols of danger, risk phrases and safety phrases.

The system is very complex, and will not be described in detail here. A distinction is made between substances that already existed in 1981 and are listed in the EINECS inventory (there are approximately 100,000 of these), and new substances of which there are typically several hundred introduced each decade. To prioritise within the 'existing' substances, the production level is used, e.g. above 1000 tonnes annually (2000 substances). A second type of distinction is between types of product, for example plant protection products (PPP - pesticides used in agriculture), biocides (other uses of pesticides), detergents, explosives, etc. There can be differences in the way these are handled, such as in the case of PPP because of the possibility of residues in food. A third distinction is in the type of toxicity: whether the hazard affects human health or some aspect of the environment. In the former case, a particular group is known as CMR, because they are carcinogenic, mutagenic and/or harmful to reproduction; these have been withdrawn from the market.

The difficulty of banning substances

One consequence of banning is that it is possible for a useful substance to be withdrawn despite absence of an actual risk. This could occur if the potential level of exposure to, for example, a teratogen would have been so low that no harm would have resulted. The converse situation occurs with chemicals that have been approved: there has traditionally been no way of influencing their usage. DG XI has initiated an attempt to encourage sustainable use of PPP, which includes the reduction of quantities used, and substitution of safer products for less safe ones.

The main aim of the regulatory system is to prevent episodes of adverse outcomes occurring. Nevertheless, it is occasionally possible to identify an instance where intervention has made a difference. In early 1997, Germany and Austria reported approximately 1000 cases of children being poisoned by drinking coloured oil from decorative oil lamps. One died, and many had serious respiratory problems that could be long lasting. It is thought that in the EU as a whole, four times that number were affected. The Commission introduced an urgent Directive to ban the use of coloured oil in the lamps, together with other measures, to prevent further cases of poisoning.

azo colours has been contested by Sweden and Finland.

A controversial area is so-called technological justification, which signifies whether or not a substance is needed. This criterion is potentially subject to disagreement between individuals and between Member States. For example, colourants are typically less favoured in the Nordic countries where people are used to paler (un-dyed) food. Clearly a judgement of this type is different when the additive is used for an essentially cosmetic purpose rather than for health protection, as the mascarpone example illustrates.

F d h gie e

Food hygiene has played a prominent role in European affairs in recent years, and continues to do so. Earlier plans aimed at comprehensive deregulation were reversed, and the Commission was re-structured: DG XXIV (consumer affairs) was given responsibilities that had previously belonged to DG III (industry) and DG VI (agriculture), as they were considered to require more orientation towards consumers rather than producers.

-

Member States

To assess the effects of this, Member States' data for the years 1988–97 (provided by DG XXI) were examined. It was clear that the low tax countries had greatly increased the level of excise duty: in Greece it rose six-fold, in Spain and Portugal it trebled, while in Italy and France it merely doubled. On the other hand, most of the high tax countries had rather stable levels, although there are some exceptions to this, notably the UK.

A tax rise is not the same as a price rise: for example, if tax forms half of the price, and it is then doubled, the overall price rise will be 50%. This assumes that the tax rise is passed on to consumers. If this does not happen, the manufacturer loses the corresponding amount of profit.

With astonishing speed, a new map of European food policy is emerging in which food safety now rates as high a political profile as the farm politics of the Common Agricultural Policy (CAP). Besides staring in wonderment as this new terrain is altered as the volcanic eruptions over consumer safety lead to food wars within the EU and between the EU and particularly the USA, there is also an urgent need to subject this new map to proper public policy analysis. What are its new fault-lines? Where will the next eruptions come? Who, if anyone, is in control? Is the political process in charge of public policy? Will the new food agencies at EU and member state level pacify or exacerbate public concerns about food safety?

The European Union is being drawn inexorably into food policy without having any clear overall official policy. As with so many areas, the EU has bolted new initiatives on to the core that is, and is likely to remain, the Common Agricultural Policy (CAP). The reaction in 1996 to the BSE crisis was supposedly going to change this emphasis but in reality it has not. Within days of his appointment, Commissioner David Byrne promised a new European Food Agency and in December 1999, in response to a request by the then Director General of DGXXIV, three academics produced an outline of what a European Food and Public Health Authority could look like.[1] This January the EFA was announced but in a weaker form than the Professors proposed. It will be part of the EC, not free-standing. Excellent though this might be, it is unclear whether such a body could resolve the tensions already manifest within EU food policy and institutions. A number of fissures are key.

P d ce e c e i´e e´

The first is the tension between consumer and producer interests. Although political rhetoric now gives primacy to consumers, producer interests still carry the legacy of a municifent past. Despite supposed subsidy reductions negotiated in 1994 under the last Uruguay Round of the General Agreement on Tariffs and Trade (GATT), the reality is still that about half of all EU expenditure is on farm support. Anti-CAP Member States such as the UK love to portray CAP as the promoter of inefficient farming. The reality is more complex. Born out of a very real experience of hunger and of food chaos in World War II, the CAP set out to bring stability and to ensure that Europeans never suffered hunger again.

Who today remembers that the Netherlands suffered a famine in 1944? Or that the UK's war-time reliance on US lend-lease to feed itself nearly brought it to its knees after the war ended, when the tap of Uncle Sam's food beneficence was (understandably) turned off in the late 1940s to give priority to feeding Germany and to keep it from falling to the USSR? Critics argue that the past rationale for CAP is irrelevant today. But it would be a foolish politician who allowed Europe to stop feeding itself and to put its currencies and affluent consumers onto the roller-coaster of world commodity markets.

The political challenge for CAP negotiations today is not so much whether there is a CAP but what the expenditure is for? The EU is breaking its own commitment to scrutinise all policies for health by ignoring the health impact of CAP.[2] One might have thought that the neo-liberal policy agenda would have latched on to this opportunity to tame CAP. It has for years sought the nirvana of dismantling all subsidies. Neo-liberals like to portray CAP as a trough filled endlessly by conned consumers who as a result pay too much for their food, but the reality is again more complex. Although producer subsidies are high in the EU, as the OECD constantly shows, the price farmers get for their products is a small, and for some commodities a decreasing, proportion of end consumer prices. The food supply chain is lengthening all the time. This means that even when food is cheap, many costs are externalised. Who pays for food poisoning or pollution of land and waterways? A team led by Prof Jules Pretty at Essex University has now calculated for the UK alone, extra environmental costs amount to yeas6ing-leaslic butern0 0 7 Jules Prettand to a-makTD their196 (of land and wate

policy we need more accurate and comprehensive studies.

The e i ´a ce ff d ˛ali

The second fissure in modern EU food policy links directly from this issue of cost. If CAP was set up to (re)build quantity, now its challenge is quality. Since the early 1980s, a wave of scandals has made consumers sceptical about the commitment of industry to quality. Europe's food processors and retailers have been driven by other drivers such as building brands, searching for new products, beating competitors, squeezing primary producers. This, ironically, has generated an opportunity that politicians have so far not grasped. Consumers are sending consistent messages that they want changes in HOW food is produced. So far, the mass market has been dominated by intensive production, but now different messages are coming.

Euromonitor polls, let alone the public mood since the 1996 BSE crisis, show that since the late 1980s Europeans have been prepared to fund farm support but not at any price. They want farming to change, to be more environmentally sound, and now, above all, they want the food supply to be safe. They are right. The safety scandals that used to be associated with the British are now seen to be more systemic. France has been found to have been feeding sewage to animals, and Belgium to have released excessive dioxin in meats. Everywhere there is unease, if not fury, at perceived big business backing for genetic modification (GM) foods but support for the EC to hold firm before a US inspired assault via the World Trade Organisation. Big business is now backing away from GM under consumer pressure. No wonder food safety is now such a priority for the Commission. Intensive farming, not just national incompetence or ministries overzealous in their support for insensitive farmers, is under scrutiny.

The European Parliament, just as much as national Parliaments, has seized the opportunity to admonish and curtail excesses of EC farm support programmes. The humiliation of former President Santer following the publication of the damning European Parliament report on the handling of the BSE crisis in 1996 was a defining moment. Many at the time expressed a more cynical view that M Santer's Japanese-style self-criticism was merely playing to the gallery.[4] It was a clever smokescreen, they argued, to disguise a desire to return to 'business as usual'. That may have been so, but by coming out into the open, the EP-EC tensions over handling of food policy meant that when further scandals happened – a likelihood as certain as night following day – the EC would be on the defensive again.

Hence the alacrity with which David Byrne, Ireland's EC Commissioner for Public Health and Consumer Affairs stepped into his job with promises to make food safety his primary concern. I have little doubt that Mr Byrne means what he says but can he deliver without setting longer-term goals? The short answer is 'no'. He is setting out on the false premise that better controls and management of microbiological contamination is all that EU food policy needs to clean up the food system. This is wrong. The problems are more deep-seated and will take decades to sort out. Sweden, for instance, which had a cataclysmic outbreak of food poisoning in 1952, killing 100 people, set up a programme to eradicate salmonella from its poultry flock. This took decades. In Britain, for instance, which had its salmonella-in-eggs scandal in late 1988, a period when over one in three carcasses sold to the public were contaminated, companies privately admit that they still cannot eradicate contamination. Rates are dropping but to achieve low counts, let alone zero, will take years.

The b ade i e ff d lic

This brings us to the major fault-line in modern EU food policy. While political priority is given to food safety, a real food policy – one the consumer can trust - would be like a good chair, built on four legs: safety, nutrition, environment and social justice. In practice, the approach to safety is crisis management rather than systemic. The approach to nutrition is next to non-existent, bar a reliance upon labelling (which has little proven impact on improving food-related ill-health unless arj 18.197h (i8.19uncr.0

vegetables. This, as a Swedish National Institute of Public Health report has pointed out, is a scandal within such a rich agri-food zone as Europe. [5]

Even if the current concern for food safety were – wrongly – the sole concern for the EU, there would still be one thorny final problem. Which state level is to have responsibility for safety – EC or Member States? This policy hot potato has been served up by the row between the UK and France over beef. The handling of this 'food war' bodes ill for the role of national food agencies. France's new Food Safety Agency, set up in the wake of a national outcry about contaminated blood samples, made a pronouncement that it wanted British beef kept out. Its credibility for putting consumer safety was on the line. The UK, whose Food Standards Agency has only just received legal approval and will not come into existence formally until autumn 2000, received advice from its embryonic agency (mostly drawn from the old Ministry of Agriculture) that the changes made to UK beef slaughtering now meant British beef was safe. Scientists separated by a narrow strip of water apparently came to different conclusions.

The EC meanwhile had been patiently taking the UK through a number of safety procedural hoops begun back in 1996 when the cases of new variant Creutzfeld Jakob's Disease (CJD) were confirmed. At stake here is a tussle over subsidiarity and the

Sustain, the alliance for better food and farming

The labour of Sisyphus

According to legend, Sisyphus, one of the Titans, was condemned forever to push a boulder up a hill. The boulder repeatedly rolled back to the bottom.

Jeanette Longfield

Talk to anyone engaged in trying to reform the Common Agricultural Policy (CAP) and they will tell you that Sisyphus had it easy. Despite years of patient research and determined lobbying, the CAP seems as resistant as ever to attempts to change it into an environmentally sustainable system that produces wholesome food and creates high quality jobs while respecting the rights of other living creatures. Today, the CAP remains a juggernaut, piled with mountains of produce for which there is no market, under the wheels of which jobs are destroyed, the environment is damaged and animals suffer.

Admittedly, part of the problem has been – and will continue to be – the fact that the patient and determined lobbyists are often lobbying against each other, allowing politicians to ignore proposals or 'cherry pick' policies that, outside the framework for which they were devised, work less well or not at all. Another is the sheer scale and complexity of the many policies that make up the CAP. It seems appropriate, somehow, that the CAP should attract legends of its own (for example, that only three people have ever understood the CAP: one has died, one has forgotten, and the one that still understands it has gone mad).

Arguably, though, the most fundamental obstacle is that the CAP was designed to solve a problem that we no longer face in Europe – lack of food. Shaped as it was by post-Word War II shortages, the CAP has been spectacularly successful in solving that problem, but the costs have been high. This article will focus on just one of these: diet-related diseases.

"Today, the CAP remains a juggernaut, piled with mountains of produce for which there is no market, under the wheels of which jobs are destroyed, the environment is damaged and animals suffer"

F d a d heal h

Despite popular belief that experts on food and health are in a state of perpetual disagreement, the consensus has been growing for 30 years or more that diets high in fat, sugar and salt, and low in fibre, vitamins and minerals increase the risks of developing cardiovascular disease, a range of cancers, and a number of other fatal or debilitating conditions. This agreement is only now coming to be recognised formally by the EU policy making process, with a group of experts convened by the Health and Consumer Protection Directorate currently developing food based dietary guidelines.

The phrase 'food-based dietary guidelines' may not be the most elegant in the language, but it is critical to avoiding the 'nanny state' accusations that are routinely hurled at any agency trying to improve public health by shifting the balance of the food supply. In practice it means that a dietary guideline of, say, a maximum of 30% of the total energy in the diet from fat, can be met by choosing from a very wide range of foods. In Northern Europe, it is likely that much of this fat will come from dairy and meat products, whereas in Southern Europe a higher proportion will be made up of olive and other vegetable oils. Similarly, a dietary guideline to increase the proportion of complex carbohydrates in the diet will encourage some people to eat more potatoes, others bread, while some will opt for rice and others pasta.

In other words, people's physiological requirement for particular nutrients generally does not vary, but our way of meeting those needs can do, and is fulfilled by a huge range of foods. Thus food-based dietary guidelines that apply across the EU are emphatically not a way of 'Brussels bureaucrats' telling us what to eat.

Ve´ ed i´ e e´

Doubtless this is a distinction that will be lost on leader writers in the popular press. They will be aided and abetted in fuelling popular prejudices by powerful sectors of the food and agribusiness industries that are unable or unwilling to diversify out of

the food sectors that should shrink, and into the food sectors that should grow, according to food-based dietary guidelines. And make no mistake, a CAP based on such guidelines would be radically reshaped and require some serious investment to ease the process of diversification.

"the derisory amounts spent on fruit and vegetables … is spent on destroying fresh produce to keep it off the market and avoid prices falling."

nance of environmentally sustainable production methods, in urban as well as rural areas

- ending payments for grubbing up orchards
- support (funding and training) for marketing schemes (including promotion of regional specialities)
- local or regional support for a wide range of retail outlets for vegetables and fruit (to reduce reliance on supermarkets)
- major media campaigns, supported by local activities, to provide the skills and confidence for people to incorporate vegetables and fruit into their daily diet
- shifting subsidy away from some types of crops (tobacco and sugar beet are obvious candidates) to support sustainable production of vegetables and fruit

Fruit and vegetables are not a major or complex part of the CAP compared to other sectors. Changes in this sector would not, therefore, have an immediately profound or far-reaching impact, particularly if the amounts spent, directly and indirectly, on supporting meat and dairy production were left untouched. However, given the size of the alliance of different interests that could be constructed around this positive agenda, the chances of success are – arguably – reasonable. It might be one small stone that we manage to push to the top of the hill without it rolling back down again.

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Public health and food safety: the case of Salmonella in Denmark[1]

Nils Rosdahl

The main concern of food control is safeguarding of human health dealing with a range of chemical and biological factors. This article addresses primarily Salmonella, but the considerations are relevant to other infectious agents.

The development in Denmark has features comparable to those in other European countries, but there are also unique elements. Denmark has experienced significant changes in the food control system over recent decades, some with potential public health implications.

The ie f he ble

The true incidence of salmonella infections is not known in any country. Several countries have figures for microbiologically confirmed cases, but they probably need to be multiplied by at least a factor ten to give the real incidence.

In 1992, we conducted two telephone interviews asking representative samples of approximately 1,500 Danes about experience of 'stomach trouble' during the preceding three months. Only a limited number of these incidents are related to foods and even fewer to salmonella. The adult respondents recorded a total of 927 incidents of 'stomach trouble' over the combined six months period and for the approximately 750 children in the house-

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1998, the number decreased by 30% and this trend continued in the first part of 1999. Microbiologically confirmed cases of Campylobacter infections are still increasing. In Norway with a population similar to Denmark and in Sweden with a 60% larger population, recorded cases in 1997 were only one fifth of those in Denmark. There might be differences in criteria for performing stool examinations in various countries and there have undoubtedly been changes over time.

As is seen in Figure 2, Salmonella Enteritidis has for most of the time been the predominant serotype, but S. Typhimurium dominated from 1987 to 1990. The changes between serotypes are linked with the food origin of the bacteria.

In the past 15 years Denmark has had three major sources of Salmonella infections.[4] From 1984 to 1988 the main culprit was chicken, followed by pork around 1991 to 1994, while in the second half of the 1990s it is eggs. The estimated sources of human salmonellosis in Denmark in 1995 were eggs with 40–50%, poultry with 15–20%, pork with 10–15% and travel abroad with 10–20%.[4] Beef and other sources only constituted minor proportions.

The multiresistent S.Typhimurium DT104 constituted 6.1% of all S. Typhimurium isolates from humans both in 1995 and 1997.

O ga i á i f́ he Da i h f d c ́ l

Denmark has a long tradition of state-organised control of foods for export, organised through the Ministry of Agriculture. Control of domestically consumed foods was a local government responsibility administered through Ministry of the Interior legislation. In the 1960s, an Institute of Foods was developed, which due to its administrative duties was renamed the National Food Agency.

In 1972, a Ministry of the Environment was created, of which the National Food Agency became a part. When a Ministry of Health was established in 1987, the National Food Agency was moved to that ministry.

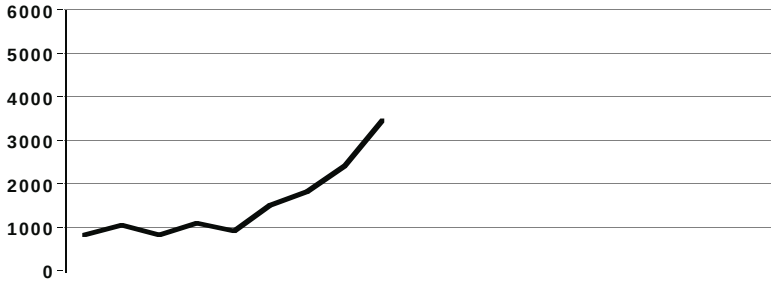
However, the Ministry of Agriculture retained responsibility through its Veterinary Directorate for animal infections and parts of microbiological control of foods. Consequently, local government food control units were professionally accountable both to the Veterinary Directorate and the National Food Agency.

In 1995, a report from the Academy of Technical Sciences[5] recommended unification of the state food control system under a slogan similar to the British 'from plough to plate'.

In a 1996 government reshuffle, the present Ministry of Foods, Agriculture and Fisheries was born. The National Food Agency was merged with the Veterinary Directorate into the Danish Veterinary and Food Administration. The Danish Parliament in 1998 passed a bill consolidating existing food laws into one common food law. According to the law, local government food control units are being transferred to the state and reduced in number.

'The Sal ella c i i'

Denmark experienced an increase in human infections caused by Salmonella from 1985. No single factor can be held responsible. Increased centralisation both in the production sector and in the slaughtering industry has without doubt played a signif-



icant role. Spread of Salmonella within flocks in chicken farms and in pig raising 'factories' has been seen repeatedly. Centralisation of fast food production has also been responsible. The involved industries were slow to recognise publicly these factors and to take appropriate action. For quite a time, the authorities and industries tended to place the responsibility for the increase in human cases on the lack of consumers to adhere to the so-called good old housekeeping practices.

In the early 1990s, it became apparent that something had to be done. In 1993, the Danish Zoonosis Centre at the Danish Veterinary Laboratory was established. It was to follow the development by collecting and collating data from all sources, establishing excellent working relations with the national institute for human microbiology, Statens Serum Institut. In the following years, state financed action plans were developed, aiming at expanding the monitoring system at all levels of the food chain and subsequently imposing certain measures on the industry.

Monitoring schemes carry out some two million investigations annually. The system is based on regular controls of broiler flocks as well routine sampling after slaughter. Egg production is primarily controlled through routine monitoring by serological and microbiological analysis of flocks of layers. If S. Typhimurium or S. Enteridídis are detected in a flock, production is terminated and the flock destroyed. Eggs are not systematically monitored for Salmonella. Screening including 14,800 eggs in 1995 showed one in 1,000 eggs contaminated with Salmonella. In 1998 this figure decreased by a factor of ten. The control of pigs and pork is based on continuous monitoring of all breeding and multiplier pig herds and all herds producing more than 100 pigs annually for slaughter, combined with control after slaughter. Beef is controlled after slaughter and a random sampling in 1996 showed 0.7% positive samples.

An independent expert review concluded in 1997, that the control programme with regard to pigs and pork has substantially reduced the level of Salmonella in pork products and the incidence of human infections related to the consumption of pork.[6] A revised plan from 1997 concerning egg production has been followed by a reduced incidence of human S. Enteritidis infections.

C cl i

Human salmonellosis in Denmark increased for ten years before serious attempts were taken to control the 'epidemic'.

The food industries were late in recognising their responsibility – and obvious self-interests – in providing safe food products. The National food control authorities were slow to initiate measures to safeguard animal products from microbiological contamination.

Monitoring the industry helped identify the major trouble areas, but the initial action plans tended to focus on partial solutions, and the Salmonella problem moved from one food sector to another.

Denmark has, however, reacted to the problems, which is unfortunately not the case in some other countries. Recent developments look positive, but fluctuations have occurred earlier, and Campylobactor infections are still increasing

Health services have ingtely not thecais mansumptn, The Nationath sTc ul esn sok has, however, reacted6t5s0t

health service managers are judged by several hundred performance indicators, there is a potential for calcification, with 41 indicators and 200 public sector agreements.

David Hunter added: "It is easy to have too many outcome-orientated targets and for managers to manipulate the data to give the Government what they want, even if the reality is that it creates all kinds of other distortions in the system locally."

D e ´a gé i g k?

Several delegates were even sceptical about putting too much value on targets at all. Nick Bosanquet, from Imperial College, London, commented that target setting is "a fairly harmless activity by middle level bureaucrats in international agencies." But he added later that they are still a good idea, provided they were limited in number. Smoking and traffic accidents are good target areas.

The poorest health record is in the capital, said Ib Haurum, of the City of Copenhagen Health Administration. In an example of how local health drives can be put into effect, he said the city instituted public health initiatives in schools and the workplace, and support services for alcoholics were set up. The plan was based on the WHO European Healthy City Project and was refined to reflect local public opinion as to target choice. Five-year targets were set in 1994 and have now been met. Health indicators are beginning to improve, although Copenhagen remains behind other cities in Europe. Public enthusiasm is encouraging health planners to set new targets.

N ´h Rhi e We´ halia: li k- i g´ ´he i a ce del

Germany is often seen as having a model dominated by health insurance funds, financing acute care at the expense of health promotion; and this was the case until recently, but in some of the Länder this is changing.

Giving details of introducing targets in the North Rhine Westphalia in 1995, Dr Weihrauch said they had come about through a conference initiated four years earlier. The meeting drew in state and local politicians, health professionals, health insurers, welfare organisations and others. Greater rationality in healthcare, more transparency for patients, and better evaluation of treatments is the result – as well as closer cooperation between professional groups.

De l ed i S ai

Spain has autonomous, regionally run health services, but these are required by federal law to have 'integrated' health services and targets. Some regions have set 100 targets, the average is 45. Juan Cabases, an economist from Navarra, pointed to the Basque Country as one of the most advanced regions in targeting. Services are organised on internal market lines, with providers and purchasers of healthcare. Targeting is effective because purchasers take it into account when they draw up contracts. This helps to ensure they are hit – a model borrowed from earlier developments in Wales. Other lessons are that 'health' targets should be backed by 'healthcare' targets: and progress should be assessed on quality as well as quantity.

It was argued by one delegate that the Spanish model, where money follows the target, is a form of rationing in a cash-limited system. Non-targeted conditions will get less. But this also can also be used as a way of sparking public interest, which can be crucial to the whole exercise.

"It is easy to have too many outcome-orientated targets and for managers to manipulate the data to give the Government what they want, even if the reality is that it creates all kinds of other distortions in the system locally."

The Da i h a e

Denmark provides a startling example of what can happen if you institute good healthcare but fail to set long-term health goals and monitor effectiveness. Allan Krasnik, of the University of Copenhagen, recounted how his country had been seen as a model in health terms. So deep-rooted was the feeling that WHO public health initiatives were deemed relevant only to "Africans and nurses – certainly not for medical interventions in our part of the world".

Self-satisfaction, he said, was rudely shattered in 1993 when Danes realised that they were not among the world leaders in health, having dropped from fifth to seventeenth place in the OECD league of life expectancy, with 6,000 excess deaths a year.

Whe e h ld´ he´a gé i g d i ec e f ?

Targets need to be realistic and distinguish between those that are high and low level. In Poland, a high level target might be cutting blood cholesterol levels in the population and, by contrast, seeing that stroke patients are properly diagnosed is a low-level target about which doctors and managers should liaise.

Distinguishing between types of target is also important because of accountability. There have been cases in which health authorities have been charged with reducing accidents. Hardly appropriate!

Ultimately though, the meeting concluded different rationales are at play when it comes to targeting – the political and the technical. It is the combining of these that gives rise to a process of health targeting, at the end of which there is the requirement for decision-making about the allocation of resources. This is a political act, and politicians are confronted by the realities of scarcity and the difficult requirement that they might have to be explicit about both prioritisation and rationing.

The United States is the only major industrialised country that has failed to provide basic health care cover for all its citizens. Indeed, between 1989 and 1997 the number of Americans with no health insurance cover increased by over 10 million, to an estimated 45 million.[1] By the time of the 2000 presidential election it is likely to have increased by a further 500,000.

Traditionally, those without cover were the most disadvantaged, in particular the poor, the unemployed, and non-whites. These groups have continued to be affected, and the largest absolute increases in the uninsured have been among black and Hispanic populations and those in poor or middle income families. However, since the early 1990s they have increasingly been joined by others who, in previous years, might not have considered themselves to be at risk of losing cover. Downsizing by employers has created a large pool of people in their late 50s and early 60s who, while no longer employed, are too young for Medicare cover.[2] Many small employers do not offer health insurance cover, so that 80% of the uninsured are now actually in employment or in families of someone who is.[3] Indeed, some of the increases in the numbers of uninsured have been in north-eastern states that have achieved greatest economic growth. Although cross-sectional studies will capture many people who are experiencing a short period of uninsurance, with one in four Americans uninsured for at least one spell in a two year period, there remains a large number of people whose chance of coverage continually recedes.

with growing evidence that they are facing obstacles to uptake of services.[8] These failings are attracting growing public attention, with the American Academy of Paediatricians launching its own proposals for universal child coverage.

Although it may be argued that the system does ultimately provide some forms of acute care for the uninsured, this care is often of poor quality and typically is received late in the course of the disease, when complications are more likely.[9] It is also increasingly difficult to find as providers are forced to eliminate internal cross-subsidies between different categories of patients. Furthermore, while the uninsured might receive treatment in emergencies, they are substantially less likely to receive preventive services despite their greater need.[10]

At state level, some legislatures have attempted local solutions, such as expansion of Medicaid and various insurance reforms (such as low-cost plans, subsidies, risk pooling, open enrolment, continuity of coverage requirements, and community ratings). However few have succeeded in increasing health insurance coverage and those that have worked have achieved only limited impacts.[11]

In these circumstances, in which those on middle incomes are increasingly insecure, there is a high level of support for change.[12] Despite the failure of President Clinton's 1994 proposals, a majority of voters nonetheless favour covering the currently uninsured and particularly children and those with low incomes. This is reflected in the decisions of both leading Democratic candidates, Gore and Bradley, to make access to health care a central issue of their campaigns. In this paper we examine the various plans, asking whether they have any greater chance of success than the failed Clinton plan. In particular, will they resonate with the American electorate, especially given that many of those most disadvantaged by the existing system either do not have a vote, being children, or are among the approximately 50% of adults who, while eligible, choose not to vote?

The Cli´ ef h´he failed

Clinton's health initiative to provide health insurance for all Americans was sent to Congress in 1994 as an effort to provide 'universal coverage', following promises made during his bid for the presidency in1992. He ran on a strong programme to develop comprehensive health reform, which contrasted strongly with Bush's laissez-faire attitude. Health care reform had been seen as a way of winning middle-class votes from the Republicans. The plan seemed to be a compromise between marketists and medicalists, falling between market tendencies and governmental involvement in health care.[13] It was designed to produce 'competition within a set national budget' and relied on five basic elements:

- the creation of 'regional health alliances' to organise and regulate the regional health insurance market;
- quality and regulatory standards for health insurers and managed-care plans, determining the price at which products could be sold through the health alliances, which products each health plan must include, and the level of deductible and co-payments to be charged;
- employers were to make premium payments to the alliances on behalf of their employees, with the promise of federal subsidies for the smallest companies (employers of low wage earners);
- consumer choice for health plans on the basis of price to encourage cost-containment;
- regulation of the rate at which alliance premiums could rise, with a national cap forming the budget under which competition would operate.

The plan is said to have failed for a number of reasons. These include lack of coalition building or attempts to achieve public support, unanticipated crises both at home and abroad that distracted government attention from reform, a loss of presidential credibility as control of congress appeared to slip away, pressures from small businesses (many of which felt threatened by the reform), and aggressive lobbying by the health care industry, particularly medium and small insurance companies which would have been forced out of business by the legislation.

Although many in the industry did favour the reforms in principle, they were unwilling to make any form of sacriftheD (u6insurance compa)Tj 15.373 0 TD (-)

duced at arguably the worst possible time. The president faced the legacy of 12 years of Republican rule that had created a massive federal budget deficit and an accentuation of the traditional climate of distrust of the role of government in American life. The policy was constrained by the g possible

expanding existing structures like the Children's Health Insurance Programme and Medicaid to cover more families and individuals. As yet Gore has not announced how he plans to finance the proposal, an omission underlined by Bradley, but claims that it should not involve a tax increase. The key attraction of this plan to the American public is its provision for small businesses to come together to negotiate lower rates for their workers' coverage and in providing a 25% tax benefits for the health insurance policies they offer.[18] Small businesses proved to be a powerful lobbying force in the debate about the Clinton plan.

The incremental nature of the plan has attracted favourable comment, with some arguing that the boldness of Clinton's plan contributed to its failure.[19] On the other hand, Gore's proposals are seen by some as over cautious, with some commentators calculating that a more ambitious plan would yield considerable economies of scale.[2]

Recently Gore has seized on a comment by Bradley that he felt so strongly about health care reform that he would even be prepared to raise taxes. Bradley has stressed that he does not see such a move being necessary but it is now clear that Gore is seeking to make health care reform a major issue in differentiating the two Democrat contenders.[21]

The Re blica ' la

In contrast to the two leading Democrat contenders, Republican hopefuls have had little to say on health care reform. We have been unable to find any reference to proposals by George W Bush. John McCain has been slightly more active but proposals have been limited. He has argued for federal support for health care provided to illegal immigrants that is currently funded by states, no doubt reflecting the high cost to states bordering Mexico, such as Arizona, which Senator McCain represents.[22] He has also supported extension of a programme that tackles the shortage of health facilities in rural areas.[23] Finally, drawing on his personal experiences after adopting a Bangladeshi child with a severe cleft palate, he has put forward a bill that would prevent Health Maintenance Organisations from refusing to fund reconstructive surgery on children with severe deformities, as is increasing the case in the US.[24]the Pnab0 9.25 2bse4

Some clues about a possible Republican approach emerge from ideas pursued by the present House Republican leaders who, in September 1999 passed their own health plan, subsequently vetoed by the President. This would have been much less wide ranging than that put forward by Bradley or even by Gore. It envisaged tax breaks for people buying health coverage as well as a provision to allow opting

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ers committed to universal coverage using existing programmes.

The challe ge ahead

Presidential candidates seeking change must address the needs of the bottom three fifths of the income distribution who face real insecurity from the threat of illness with no money for essential care. However they face a major challenge from powerful anti-government forces.

At first sight Bradley's plan seems to reach many more people than Gore's and it also seems to have attracted considerable support or, at least, limited opposition, although this may change as Gore increasingly attacks it. There are, however, many details yet to be clarified. It may be that the scale of Bradley's proposed premium subsidies for the uninsured are insufficient to provide adequate health care benefits, or that those subsidies may contribute to rising costs in healthcare.

A key question will be how many of the uninsured actually assert their democratic right to vote. Voter participation has declined significantly in recent decades, and is particularly marked amongst lower income Americans. In the 1989 Congressional elections health care (specifically Medicare reform, the uninsured and managed care reform) were perceived as important issues at the polls, but not the most important ones. It is notable however that those who voted for Democratic candidates ranked health care higher than did those who voted for Republican candidates. In a contradictory fashion voters seemed to view health reform as a priority for the next Congress rather than as a voting issue in the election of the time. Whilst voters seem keen for health care reform (particularly of Medicare and managed care) they appear to be less affected in their choice of candidate at the polling station. This may be because although the majority believes that radical health care reform is needed, no-one can agree on how it can best be done.

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Acknowledgement: We are grateful to Richard Saltman for many helpful comments.

Good health is the most precious individual possession. Sadly, too many Scots are deprived of this. Now, as a nation, we have the unparalleled opportunity offered by the new Scottish Parliament to rid Scotland of its reputation as the 'sick man of Europe'.

To achieve a healthier Scotland we need to be bold, imaginative and brave, and practical as well, catching the tide of change within society.

Public health is defined as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society". The "organised efforts of society" are particularly important. Individual responsibility is right and it is essential; but to reach their full potential, individuals need the organised support of the society around them.

This might mean good quality education, a warm and comfortable house, a safe environment, the feeling and reality of being part of a community – to feel included. That is what the Scottish Executive is all about. Better schools and housing, a cleaner environment, safer communities, social inclusion, higher employment and worthwhile jobs.

Ide´if i g l´i

A new childcare strategy; helping parents into work or training. The new community schools programme assisting pupils to increase their educational achievement through the integrated provision of services, including health and social work. The 'Warm Deal' for the elderly ... all of these are the essential ingredients of a long-term solution, creating the conditions in which good health can flourish. Transforming, slowly but surely, life circumstances, hitherto the harbinger of sickness and disease, into a catalyst for better health.

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"previous Governments chose to ignore the most telling cause of poor health: poverty."

lifestyles, the home environment, parenting skills and child care, have a profound impact on patterns of health and disease in later life. Cancer, stroke and heart disease rates, as well as mental health are all affected by childhood health.

Four health demonstration projects announced in the White Paper – backed by £15 million of new resources – will all be under way by spring 2000. They should help make considerable inroads into reducing health inequalities and provide testbeds for bringing together the principles set out in the White Paper, building on best practice from UK and abroad, developing new approaches and providing scope for innovation and new thinking.

'Starting Well' will focus on the promotion of health and protection from harm in the period leading up to birth and throughout the first five years of childhood.

'Healthy Respect' will foster responsible sexual behaviour on the part of Scotland's young people with emphasis on the avoidance of unwanted teenage pregnancies and sexually transmitted diseases.

'The Heart of Scotland' will focus on the prevention of heart disease, recognising that many of the measures likely to be used (for example, healthy diet, exercise and avoidance of tobacco) will help reduce the incidence of cancers and strokes.

'The Cancer Challenge' will add a screening programme for the early detection of colorectal cancer to existing screening programmes (for breast and cervical cancer) and take forward the new measures to combat the cancer-promoting effects of tobacco smoking.

Fluoridating the water supply is also back on the agenda. It is a controversial issue that needs to be tackled in order to bring lasting improvements to child dental health, especially those who are disadvantaged. We await the conclusions of a current review of the safety of fluoridation. The Scottish public will be fully engaged and informed in the debate on this important issue.

We have an unprecedented opportunity to create a healthier Scotland and to drive down health inequalities. All the necessary ingredients are there. A new Parliament. An energetic and committed Executive. I want a committed public health workforce – ministers included – empowered, resourced and energised in order to claim a new future for our people – a prosperous and healthy Scotland.

How a new English health agency can benefit European health development

Clive Needle

Forget the *Millennium Bug*. Is *Millennium Fever (MF)* treatable as a communicable disease? Politicians display the worst symptoms – an inability to pen an article without standing on the threshold of a new age – but it does seem rife throughout much of the media, commerce, sport, and also …… European health policy? Well, M.F. does have an inevitable dynamic and a heady mix of desirable and dangerous elements, so there are some parallels.

Donald Reid's welcome for the bright new English Millennium baby, the Health Development Agency (*eurohealth* 5:3), avoided such clichés but posed some pertinent questions about what will be a demanding infancy. However, although he didn't mention that M word, he excluded the E word too. While the new H.D.A. is being *born* in England, to play a full role it is essential that it *grows up* in Europe. Let me explain why.

The le f a lia e´

Health and Consumer Policy. In the Autumn edition of *eurohealth* its new Chair, Dr. Caroline Jackson, reminded us of the range of issues before it. Very soon it will consider the urgently needed new health framework and a new Directive on blood, as well as the massive high profile body of work on food and consumer safety. Given the parliament's power of co-decision, there will be some big tests of MEPs' priorities on integration, inequalities, impact assessments and interpretation of the Amsterdam Treaty as well as bud-

review praises forthright government economic actions, but fears health inequalities may worsen with relative poverty increasing and growing regional imbalances.

– The renowned Professor David Hunter bemoans the rarity of UK health services seeking to learn from abroad. He

Anglo-French Dispute over British Beef

The dispute between the UK and France arose because of French failure to lift the ban on British beef, despite the fact that EU veterinary experts pronounced that it is safe for human consumption. Germany has also refused to lift its ban, owing to obstruction in the Bundesraat by some Länder.

Exports of British beef were abruptly halted in March 1996 after UK scientists identified a potential link between BSE and CJD (new variant Creutzfeldt-Jakob disease), a disease that can be fatal to humans. This worldwide ban was lifted on August 1, 1999. France, however, informed the European Commission on October 1, 1999 that it would not lift its embargo on British beef, on the basis of advice from its recently established National Food Agency.

The EU's Scientific Steering Committee (SSC) evaluated the evidence presented by France and on October 29 concluded unanimously that there was no need to change their previous opinions on the safety of British beef. On November 16, The European Commission decided to initiate formal legal proceedings against France for not fulfilling its obligations under Commission Decisions 98/256/EC and 99/514/EC relating to the lifting of the embargo.

Commissioner Byrne informed the Council about the proposal for an Action Programme on Public Health, which is currently being developed and about the Fourth Report on the Integration of

A NEW DIRECTORATE GENERAL ON

EU AND US LEADERS MEET TO DISCUSS TRADE ISSUES

During their meeting in October to discuss the agenda for World Trade talks, European Commission President Romano Prodi and US President Bill Clinton agreed to launch a dialogue between EU and US scientists in a bid to defuse damaging trade rows over food safety issues such as genetically modified foods.

MENTAL HEALTH

A European Conference organised by the Finnish presidency on the Promotion of Mental Health and Social Inclusion was held from the 10-13 of October 1999 in Tampere, Finland.

NEWS IN BRIEF

Fi ´ Mee´i g f E - Medí e a ea Heal h Mi í´e

The first meeting of 27 Euro-Mediterranean Health Ministers was held in Montpellier, France on the 2nd and 3rd of December, 1999. The Conference emphasised that health threats, such as communicable diseases, know no borders, and are therefore relevant to both the Northern and Southern dimension of the European Union. Vaccinations are cost-effective means to combat diseases. Equally important are measures outside the actual health sector, such as safe drinking water and safe food. The Euro-Mediterranean ministers adopted the first political declaration on future cooperation in the field of health.

High le el C í´ee Mee´i g Heal h

About thirty high-level civil servants working in the field of health in EU Member States met in Helsinki on 26-27th October to discuss the future of public health programmes in the EU and the impact of other EU policies on health. Representatives of applicant countries were invited to take part in the second day of the meeting, where they discussed their participation in

policy.

EU ba h´halá e i childca e a´icle a d´

The European Commission will adopt proposals for an emergency ban on sales of some oral baby toys softened with chemicals believed to be toxic. Representatives on the EmergencjwieCommittee set up under the General Product Safety Directive, composed of representatives of Member States, unanimously endorsed the Commission's draft decision (approved on 10 November) to ban certain oral baby toys made from polyvinyl chloride PVC) that have been softened with phthalates. Tests have shown that

phthalates (DINP and DEHP) that exceed the levels considered safe by

first time that the Commission has instigated an immediate ban under the General Product Safety Directive. The Decision will wnter into force before the endeof 1999. (1 December)

Ne Di ec´i e ´he ´ec´i f ke á´ik f e l ie á´ he e

The European Parliament and the Council of Ministers have confirmed the full agreement on rules for the protection of workers at risk from explosive atmospheres. The successful result of this conciliation procedure is particularly noteworthy as it is the first legal act in the health and safety area to be adopted under the co-decision procedure as a result of entry into force of the Amsterdam Treaty. (1 December)

Labelli g GMO

EU governments backed the European Commission's proposal to require companies to provide information labels on foods if any ingredjwnt in a product containiemore than 1 percent of genetically modified soya and maize. Although the decision applies only to these two substances, it is likely to set a precedent for other substances. The proposal will probably be followed by a formal Commission proposal. Environmental Groups such as Greenpeace have argued that the thresholdeof 1 percent is too high

opposition in the European Parliament

C fe e ce c ee i g a d ea l dé ec´i f Ca ce

A European Conference on screening and early detection of cancer, sponsored by the "Europe Againit Cancer" Programme and organised by the Austrian Cancer Socjwty of Vjwnna, took place in Vjwnna on the 18-19th of November 1999. The ultimate goal of the Conference was to adopt European guidelines to implement cancer-screening programmes in such a way as to max-

participants at the Conference recommended that the best way to do this wouldebe to offer healthy people only those screening tests that have proved to decrease the incidence of cancer. At present these methods are: pap smear screening for cervical abnormalities starting at the latest by age 30 and notebefore age 20, mammography screening for breast cancer in women aged 50-69, and faecal occult blood screening for colorectal cancer in men and women aged 50-69. The Commission services will examine, on the basis of these precise

recommendation on cancer screening in the EU.