HEALTH IN EUROPE: A STRATEGIC APPROACH
DISCUSSION DOCUMENT FOR A HEALTH STRATEGY

QUESTIONS

Within the three broad elements of the Strategy, **addressing core issues**, **mainstreaming health,** and **global health:**

1. How should we prioritise between and within all these areas to focus on those which add real value at the EU level? In which areas is action at the EU level indispensable, and in which is it desirable? For example, is there a means to use the Healthy Life Years indicator or other outcome measurements to give weight to areas on which the EU should concentrate?

Prevention should be a priority (indispensable action): the adoption of healthy lifestyle (nutrition, physical activity, no smoking, low alcohol consumption) reduces premature illness and death for major chronic disease, including CVD (CHD and stroke), cancer, diabetes, COPD.

Prevention leads to an increased proportion of the population at low risk (favourable levels of five readily measured traits, currently designated as major risk factors: no smoking, no diabetes, cholesterol < 200mg/dl without use of medication, BMI<25, blood pressure less than 120/80 mmHg without use of medication); instead of focusing only on high risk and sick individuals, a strategic choice would be shifting the attention toward low risk population increase; this will add a real value at the European level. Presently, low-risk group only constitutes about 5%-10% of the population in MS. Improving this proportion would be a desirable goal in order to reduce premature illness and death, to control health care costs in older people and to improve quality of life.

Reduction in premature mortality and morbidity, DALYs, risk factor distribution and increase in proportion of low-risk population would be good indicators.

2. What should we realistically aim to achieve in practice in these areas of work? What broad objectives should we set for the short term and long term – 5 years and 10 years?

Objectives to be achieved within short term (5 years)

- presently diabetes, obesity, smoking in women are increasing in many MS; to stop this trend would be a desirable aim to be achieved in 5 years.

Objectives to be achieved within long term (10-years)

- to increase proportion of low-risk population

- to reduce smoking habit, diabetes and obesity

- to reduce morbidity and mortality (among young people) of major chronic disease such as CVD (CHD and stroke), cancer, diabetes and COPD. If we could make most CVD events occurring in later years, the duration of treatment would be decreased and the quality of life increased.

3. Are there issues where legislation would be appropriate? What other non-legislative instruments should be used – for example, a process similar to the Open Method of Coordination? How can we make better use of Impact Assessment?

To sustain prevention, it is necessary that Europe strongly encourages the Ministries of Health, Education, Sports, Environment, Agriculture and Industry to take common and agreed actions toward achieving common preventive goals: for example, the Ministry of Industry should encourage salt reduction in preparation of food (bread) and in preserved food (soup); the Ministries of Sport and Education should increase hours of physical activity at all levels of education (from primary school to University).

Legislation at European level would be appropriate within food industry (preparation and labelling); legislation at European level for smoking restriction in public places to support those countries where smoking is still allowed would be also appropriate.

4. How can different approaches be used and combined, for example approaches to different health determinants, lifecycle approaches, and strategies on key settings (education, the workplace, health care settings)?

To ensure good information and provide education activities on healthy lifestyles at all levels (schools, workplace, university, GPs, health professionals, nurses, citizens).

The intervention should be multi-setting, multi-partner and act at multiple levels.

Education in schools, offices and faculty through website, press, courses, TV, radio, advertisement etc.

All health and policy strategies should put prevention as one of the top priorities: enough and safe places for physical activity (sidewalk, cycle paths, swimming pools, etc.); synergies with architects and the building industry (how to design and construct a physical activity-promoting city); restaurants promoting healthy menu etc.

In terms of the **implementation** of the Strategy:

5. How can we ensure that progress is made and that objectives are met? For example, should indicators or milestones be used? What measures or indicators could show real short term change, within the early years of the Strategy?

A surveillance system based on standardized procedures and methods is the most appropriate way for collecting and monitoring indicators (incidence, prevalence, survival rate, DALY, risk factors distribution and proportion of low-risk population) through population-based registers, hospital-based registers and health examination and health interview surveys.

6. How do we ensure that the Strategy adds value to actions at Member State level? How can the responsibility for implementation be shared between the EU and Member States?

Prevention strategy is cost-effective. A comprehensive national public health policy for improving lifestyle from early life is demonstrated to be an important strategic action for controlling health care costs also in older ages and at the end of life.

7. How could methods for involving stakeholders be improved? How can we create innovative partnerships with stakeholders?

Planning and implementing common actions involving different Ministries.

Further comments:

8. Do you have any **further comments**?

No.

Responses to the questions above can be sent to the following mailbox, which will be open until **12 February 2007** :

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The adoption of the new Strategy is planned for summer 2007.