



COMMISSION OF THE EUROPEAN COMMUNITIES  
HEALTH & CONSUMER PROTECTION DIRECTORATE-GENERAL

Directorate C - Public Health and Risk Assessment

v.26

**NON PAPER**

## **Partnerships for Health in Europe**

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# Partnerships for Health in Europe

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## SUMMARY

Good Health is a state of physical and mental well-being that allows individuals to live their lives to the full. A population in Good health – people living long, full, productive and healthy lives – is an integral part of a thriving modern society and a cornerstone of a well performing economy.

Achieving this means successfully tackling important health challenges facing the EU, from the health consequences of an ageing population to very high levels of lifestyle related diseases linked with obesity or tobacco consumption and increasing infection rates of serious communicable diseases such as HIV/AIDS and the threat of new diseases such as SARS.

Meeting these common challenges is a shared responsibility. Citizens' health is to a great extent determined by individual choices on what people eat, smoke, drink and do. As responsible for national health systems and healthcare, Member States share the challenge of providing high-quality health services within limited budgets. Achieving good health across the EU requires co-operation between Member States and EU action to complement national efforts to improve population health, minimise the current wide health inequalities and reduce the burden of disease by tackling the factors that determine health.

### **Putting Health at the centre of EU policy-making**

Achieving good health for citizens throughout Europe and ensuring that all Community policies contribute to health are shared values enshrined in the EU Treaty. The new Constitution, once ratified, further reinforces the EU health mandate by providing for Community law for setting high standards of quality and safety for medical products and devices and for monitoring and combating cross-border health threats. The role of the EU in facilitating Member States' co-operation on health measures was emphasised in recommendations agreed by EU Health Ministers and stakeholders last December and is now enshrined in the new Constitution.

But achieving good health is not an issue for Health Ministers and health specialists alone. Health is closely intertwined with economic growth and sustainable development. The European Commission has therefore committed itself to integrating health into the Lisbon agenda as a driver of competitiveness and sustainable development. A structural indicator to monitor the evolution of "healthy life years" and check it against economic development is in the pipeline. And after the European Council of March 2004 encouraged national governments to strengthen health reforms as a means to improve macro-economics, Finance Ministers are increasingly turning their attention to health.

The time has come for **health to be put at the centre of EU policy making**. Positioning health as a driver of economic development is part of this process. With an enlarged EU of 25 Member States there are even clearer health and economic inequalities that must be urgently addressed.

There is evidence that investing in health brings substantial benefits for economic development. Health expenditure is, however, too often viewed as a short-term cost, not as a long-term investment, and is only now starting to gain recognition as a key driver of economic growth.

The EU spends an ever increasing share of its GDP on health<sup>1</sup>, yet still loses over € 100 billion through the disease burden of lung afflictions<sup>2</sup>; € 135 billion to cardiovascular diseases<sup>3</sup> including 8 million disability adjusted life years lost<sup>4</sup>, and over 500 million work days in work-related health problems and accidents<sup>5</sup>. The disease burden translates not only into long-term growth in healthcare expenditure, but also into heavy social costs ranging from sick leave, replacement at work and lower productivity to early retirement.

Each health euro better spent could make a net saving both for individual well-being and for EU economic competitiveness. With such a heavy disease burden, **improving health must become an economic priority**. Without long-term investment in health, healthcare and social costs will continue to rise and the economy will suffer. It is not a question of just investing more on health. What matters is that health systems are effective and cost efficient – in other words, that money is well spent.

The health sector is driven by scientific and technological progress. Everybody wants and expects access to the latest and best treatment. But new health technology and drugs come at a price and must be used efficiently. Employing more expensive therapies when less expensive, equally effective alternatives exist is a waste of taxpayers' money and a net loss for the economy. It is therefore important that technology is properly assessed. This is an area that can greatly benefit from economies of scale and synergies between Member States. The European Commission can offer real added-value in co-ordinating health technology assessment across the EU – and this is the reason why EU health Ministers have recently asked the Commission to step up work in this area.

Spending well also means investing in tackling issues such as smoking and obesity now to save in massive healthcare costs in the future. While more research on cost-effectiveness of prevention is needed, measures such as awareness-raising on healthy lifestyles, screening and legislation cost relatively little and can trigger important savings. When smoking leads to 1 in every 3 cancers<sup>6</sup> and causes 90% of all lung cancers<sup>7</sup>, the potential benefits of prevention can be very high indeed. The EU is well positioned to bring together national expertise and to disseminate best practice. In addition, the new Constitution specifically provides for EU measures to protect health by addressing tobacco and alcohol consumption.

Against this background, **investing in health needs to become a long-term economic priority** geared towards growth and sustainable development. The Commission has already stressed the need for greater investment in health as a precondition for economic prosperity in its Communication on the financial perspectives 2007 - 2013<sup>8</sup>. The Commission has also committed itself to working with the Member States to ensure that Community financial

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<sup>1</sup> 8,6% of GDP in EU-15 ("Health Statistics, Key data on health" 2002) and 5.8% in new Member States (Health Policy and EU enlargement, European Observatory in Health systems and policy series 2004, quoting WHO data).

<sup>2</sup> European Lung White Book, European Respiratory Society (ERS) and the European Lung Foundation (ELF), November 2003

<sup>3</sup> Eurohealth volume 9, Spring 2003

<sup>4</sup> The Social situation in the EU 2003, European Commission, original source: British Heart Foundation – coronary heart disease statistics.

<sup>5</sup> The Social situation in the EU 2003, European Commission

<sup>6</sup> Securing good health for the whole population, Derek Wanless, February 2004.

<sup>7</sup> Lung Health in Europe: facts and figures, the European Lung Foundation 2003.

<sup>8</sup> Building our common Future": Policy challenges and Budgetary means of the Enlarged Union 2007-2013, COM (2004) 101 final of 10.2.2004.

instruments such as the Structural Funds are increasingly mobilized for investment in health (in particular in the new Member States). But we need to do more.

We need to discuss not just what health costs the economy but also what health contributes to the economy. This calls for a paradigm shift from seeing health expenditure as a cost to effective health policies as an investment. People only think of health when they are ill and then it is too often too late.

One must bear in mind that health threats for example from infectious diseases do not stop at national borders and may have very heavy consequences for the population and the economy of the EU as a whole. Europe needs to build on the lessons learned with SARS and develop EU-wide resource planning and capacity to **provide better protection at lower cost against major threats to public health**, from influenza or other pandemics and bioterrorism. HIV/AIDS is another area where the EU and the Member States must urgently work together to prevent a health catastrophe in the near future. The European Centre for Disease Prevention and Control will have a key role in the prevention of such health threats.

Europe increasingly suffers from lifestyle related diseases triggered by an unbalanced diet, physical inactivity, and tobacco or alcohol consumption. This is another area of shared concern where EU action can offer added value. The EU is already at the forefront of tackling smoking with a range of actions to control the contents of cigarettes, to regulate advertising and publicity across the EU and to raise awareness. If the EU is to help **enable good health for all**, it must address the behavioural, social and environmental factors that determine health. This means we need to **promote health through all Community policies**. This involves understanding better how different policies including transport, environment, regional and social measures can affect health. Health impact assessment is an effective means to both mainstream health and evaluate how other policies affect health.

Improving health is not a short-term activity. Health promotion and disease prevention rarely produce evident short term results – it may take years – or even decades – for results to become clear. This is the reason why we need to put health at the centre of strategic EU policy-making and develop a focused European health strategy. The question is: **how are we going to do all this in practice?**

### **Mobilising different actors: partnerships for health**

Putting health at the centre of EU-policy making is a shared responsibility. Different actors must work together if we are to succeed in achieving good Health across the EU.

Citizens' health is to a great extent determined by individual choices on what people eat, smoke, drink and do. These choices are based on factors ranging from knowledge and information to socio-economic determinants. While Member States are primarily responsible for promoting health and providing access to healthcare, citizens also have responsibility for promoting their own health.

There is much scope for co-operation, consultation and exchange of knowledge. This is underlined in the new Constitution, which provides for EU action to encourage co-operation between the Member States to improve the complementarity of their health systems. Citizens expect effective solutions to the health challenges facing Europe. That means that the EU and the Member States must cooperate effectively respecting the varying distributions of responsibility under the Treaty, but harvesting in each case the benefits of EU-wide **partnerships** for delivering the best solutions. The European Commission is committed to

achieving synergies with national authorities, stakeholders and international organisations and in fostering co-operation between the Member States.

Openness and civil society participation, two core principles of good Governance now enshrined in the new Constitution, are key to EU health policy-making. Stakeholders' participation in health-related Community initiatives from an early stage is already a reality. The Commission now plans to build on concrete achievements such as the EU Health Forum to create mechanisms to work ever more closely with all those involved in health. We also plan to help citizens make informed choices about their health and to promote their participation in decision-making by fostering partnerships. Supporting networking of patients' organisations and setting up an EU Health portal (an Internet based gateway to health information) are some of the means to this end.

EU Health policy must be based on solid grounds: facts, data and scientific evidence. Health authorities, Citizens and health professionals need reliable information. These are the reasons why the European Commission is committed to **providing a strong knowledge base for European action**. This would entail developing EU-wide analysis of health data to provide objective, comparable, and timely information on which to base more effective health policies at national and EU levels.

While healthcare and health systems are the individual responsibility of each Member State, there is much to be gained from enhanced cooperation between health systems. There are many areas where synergies and savings can be achieved such as exploiting European centres of expertise and exchanging knowledge on issues such as quality improvement or clinical excellence. The European Commission is also looking at issues such as the use of spare capacity in some regions to help overstretched capacity elsewhere.

In the long term, such co-operation would provide a solid evidence base for healthcare management and enhance the effectiveness and efficiency of healthcare systems across Europe. The Commission is well positioned to facilitate Member States' co-operation and is driving forward this process through the new High level Group on Health services and medical care which brings together senior officials from EU Health Ministries.

Finally, health is increasingly acquiring a global dimension. Co-operation with the WHO and other organisations active in health already plays a fundamental role in our work. Enhancing the EU's **international role on health** is an important priority. The European Commission remains fully committed to working in close partnership with international organisations with the aim of pursuing higher health standards both within EU border and beyond and to find shared solutions to common problems.

Health is central to quality of life, productivity and economic growth. Without a healthy population, fulfilling the Lisbon goal - to become the most competitive and dynamic knowledge-based economy - will remain an empty dream. The time has come to put health where it belongs: at the centre of EU policy-making. The stakes are high and time is short.

The current document shows where we are, what has been achieved, and what we think should be done next. But it is important that stakeholders also express their views about what should be done in the future. Are the priority issues put forward the right ones? Are there other important issues that the EU should address?

The services of the European Commission count on national governments, stakeholders, international organisations, health professionals and citizens to help develop and implement an effective European health strategy.

## PART I: WHERE WE ARE

### 1. GOOD HEALTH AND HEALTH CHALLENGES IN EUROPE

People in the European Union (EU) are living longer and in general enjoying better health than ever before<sup>9</sup>. The possibility for people to live active and fulfilling lives well beyond retirement age is one of the greatest achievements of public health. However, Europeans still face major challenges to health. These include the rise of chronic physical diseases and other changes in the disease pattern, the importance of mental illness, the increased longevity of the population, the profound influence of new behaviours and consumer choices, citizens' rising expectations for health information and healthcare, and the integration of EU markets for consumer products and services.

#### 1.1. The evolving disease pattern

The traditional scourges of infectious diseases have been replaced by a rise in non-communicable diseases that are often chronic. For example, many cancers and cardiovascular diseases are caused by tobacco use and obesity; changes in lifestyles and consumer markets are thus important. Much of the spread of allergies and diabetes, as well as the high rates of traffic accidents among young men, can be traced back to environmental and socio-economic factors which determine health.

The increase of asthma and allergies throughout Europe over the last few decades illustrates the impact of the environment on health. On average, 10% of European children suffer from asthma. Environmental tobacco smoke and air pollution are major health threats, increasing the risk of lung cancer in non-smokers by 20-30%.<sup>10</sup> An estimate of mortality due to long-term exposure in 124 European cities linked 60,000 annual deaths with long-term exposure to particulate air pollution exceeding a certain level<sup>11</sup>.

Socio-economic factors are linked to expanding diseases such as HIV/AIDS. The increase in newly diagnosed HIV infections in Europe is particularly worrying: more than 500,000 people in the EU are currently living with HIV/AIDS and over 6,000 people a year are dying from it<sup>12</sup>. The situation is alarming in some new Member States such as Estonia and Latvia, and in neighbouring countries in Eastern Europe and Central Asia, where approximately 2 million people suffer from HIV/AIDS. Together with other sexually transmitted diseases, HIV/AIDS is closely linked to social problems, such as poverty and social exclusion.

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<sup>9</sup> Data derived mainly from "Key data on health 2002", Eurostat 2003, "The health status of the European Union - narrowing the health gap", Commission 2003, and the WHO Health For All database (HFA), 2004. References and supporting material are available at [http://europa.eu.int/comm/health/ph\\_overview/strategy/health\\_strategy\\_en.htm](http://europa.eu.int/comm/health/ph_overview/strategy/health_strategy_en.htm).

<sup>10</sup> "Europe's environment: the third assessment", European Environment Agency, Copenhagen 2003, quoted in COM(2003)338.

<sup>11</sup> COM(2003)338 final of 11.6.2003

<sup>12</sup> Source: UNAIDS/WHO data base, 'estimates' for 2001: <http://www.who.int/hiv/pub/epidemiology/pubfacts/en/>

Often underestimated is the weight of mental illness. Up to one quarter of the population suffers from some sort of mental disorder at any given time<sup>13</sup>. Depression is the most common disorder in Europe with a lifetime prevalence of 14.4%<sup>14</sup>. Mental disorders are also closely inter-linked with other illnesses: depressed patients are three times more likely to ignore medical advice; up to 33% of cancer patients and half of HIV/AIDS and tuberculosis patients develop depression<sup>15</sup>.

In addition, there are new threats to health. Infectious agents such as human prion diseases and the virus causing severe acute respiratory syndrome (SARS), can have a great impact on how people live and create major social and economic difficulties. The outbreak of avian influenza is a reminder of how new problems can arise anywhere and pose a threat to Europe. The terrorist attacks on 11 September 2001 in New York and on 12 March 2004 in Madrid and other events have also underlined the potential gravity of man-made threats to the health of the European population. This is the reason why the new Constitution, once ratified, reinforces the EU health mandate in this area by providing for Community law for monitoring, early-warning and combating cross-border health threats.

National health systems are striving to cope with the changing pattern of disease, increased patient expectations, new treatment options, financing difficulties, and the globalizing healthcare market. EU policies aiming to protect and improve health in the Union must adapt to the new circumstances. An important factor in the changing patterns of disease comes from the ageing population. The proportion of people aged over 80 years is expected to increase by 44% between 2010 and 2030, totalling 8.1 million people in EU-15<sup>16</sup>. Their specific needs call for new policy responses to tackle an increasing proportion of age related conditions such as Alzheimers or other conditions related to the deterioration of the musculo-skeletal problems such as hip fractures.

The main burden of disease stems from a few non-communicable diseases which represent about 75% of the burden of disease<sup>17</sup> in disability adjusted life years (DALY)<sup>18</sup>. Mental illnesses alone represent 20% of the total burden of disease in Europe in terms of DALYs<sup>19</sup>. Mental disorders are responsible for a quarter of disability benefits in EU-15<sup>20</sup>.

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<sup>13</sup> The World health Report 2001: "Mental Health, new understanding, new Hope", WHO, 2001

<sup>14</sup> Proportion of people who undergo a depression at least once. Final Report ESEMeD/MHEDEA-2000 project supported from the VI. Framework Programme for research, 2003.

<sup>15</sup> WHO: Investing in Mental Health, 2003

<sup>16</sup> The Social situation in the European Union, European Commission, 2003.

<sup>17</sup> The European health report 2002, WHO Europe, 2002. Figures refer to the WHO Europe Region.

<sup>18</sup> The DALY expresses years of life lost to premature death and years lived with a disability of specified severity and duration. One DALY is thus one lost year of healthy life.

<sup>19</sup> The World health Report 2001: "Mental Health, new understanding, new Hope", WHO, 2001

<sup>20</sup> The Social situation in the EU, European Commission, 2003

Cardiovascular disease and cancer are the next largest contributors to the disease burden. Diseases of the circulatory systems including cardiovascular diseases represent 42% of mortality in EU-15, followed by cancer at 25%<sup>21</sup>. However, there has been encouraging progress in tackling these diseases through prevention and treatment. In some countries overall death rates from many cancers are falling. The EU death rate from cancer fell by 7.9% from 1987 to 1997, reflecting among other things the decline in smoking and new methods of treatment. For cardiovascular disease, the overall EU-15 death rate has halved from 1970 to 2000<sup>22</sup>.

	<b>Amongst the best</b>	<b>Amongst the worse</b>
Life expectancy at birth/males	77.4: Sweden 76.1: Malta Cyprus	72.7: Portugal 64.8: Latvia
<b>Lung cancer</b> (incidence rate p/ 100,000 males)	21: Sweden 32: Finland	85: Netherlands 102: Hungary
<b>Tuberculosis</b> (incidence per 100,000 people)	6.4: Italy 6.7: Greece	45.2: Portugal 86 : Lithuania
<b>Ischaemic heart disease</b> (mortality 100,000 females)	29: France 47: Portugal	120: Ireland 115: Finland 226: Slovak Republic
Suicides (death rate by 100,000 males)	4.9: Greece 7.5: Portugal	31.4: Finland 44.4: Hungary

Sources: "The new EU of 25 compared to EU-15, Eurostat March 2004; "Health at a Glance, OECD indicators 2003; "Health Statistics, Key data on health" 2002.

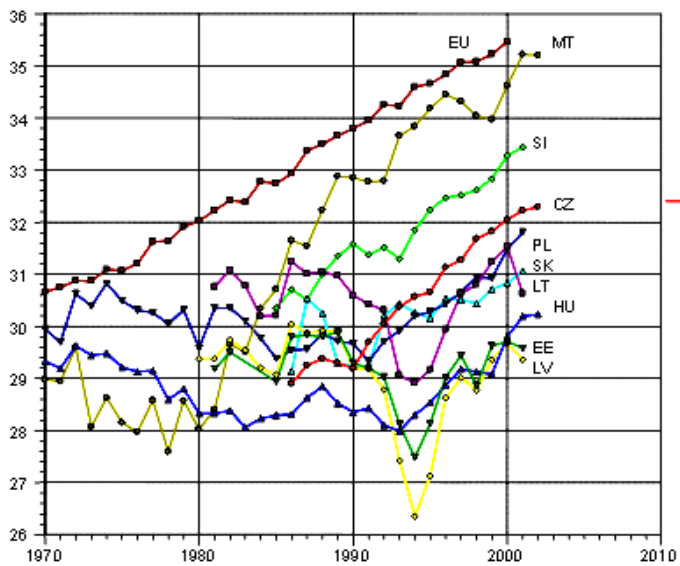
But, despite these encouraging trends, there is enormous scope for improvement. This can be seen clearly by looking at the **differences in morbidity and mortality rates** for different conditions within the EU. Incidence rates for women from ischaemic heart disease are almost 8 times higher in the Slovak Republic (and four times higher in Finland) than in France<sup>23</sup>. Mortality for men from lung cancer is 5 times higher in Hungary and 4 times higher in the Netherlands than in Sweden. Tuberculosis is 17 times higher in Lithuania and 7 times higher in Portugal than in Italy<sup>24</sup>. Traffic accidents claim over three times as many lives in Greece as in the UK<sup>25</sup>.

## 1.2. Inequalities in health and the European health gap

EU-wide and national figures on health status and disease burden hide major differences between population groups within countries. Social class, employment status, as well as living and working conditions all affect health. It is well known that those who have least access to economic and social resources tend to have the worst health.

Premature deaths from most causes are much more common among the poor than the rich and there is evidence that the gap between rich and poor is widening. This issue assumes even greater significance in the enlarged EU as health inequalities between the best-off and the worst off become wider.

<sup>21</sup> The Social situation in the EU, European Commission, 2003  
<sup>22</sup> WHO HFA database (from 102.5 p/ 1 million people in 1970 to 45.8 in 2000)  
<sup>23</sup> "Health at a Glance, OECD indicators 2003  
<sup>24</sup> idem  
<sup>25</sup> The Social Situation in the European Union, European Commission, 2003.



Life expectancy in years at age 45 in the new Member States and the EU15 average. Source: WHO HFA database, 2004.

Most of the new Member States and the remaining candidate countries lag behind the EU-15 average for **life expectancy** and other key health indicators. This has major implications for the economic development of these countries. The increasing incidence of tuberculosis and hepatitis, are particular problems in some of them. There have also been outbreaks of syphilis and other sexually transmitted diseases in a number of Member States since the late 1990s. A projection

of trends in life expectancy suggests that at current rates of improvement the gap will not close until about 2030. This will have consequences on the population's well-being and on the economy as a whole.

While the budget devoted to health varies from one new EU Member State to the next, they all spend less than the EU-15 average (8.6% of GDP in EU-15, 5.8% in the new Member States<sup>26</sup>). Low investment in health limits the capacity of their health services to address major health problems and of their surveillance and response structures to tackle disease outbreaks or problems with blood and tissues.

In addition, the enlarged Union now has frontiers with countries where health status is much worse than inside the EU. This means a further risk of spread of communicable diseases, such as HIV/AIDS and tuberculosis. The Commission Communication<sup>27</sup> on the Wider Europe identified public health as a key issue for future cross border co-operation.

Growing inequality in health is closely linked to poor housing and education, unemployment and social exclusion. Addressing health inequalities effectively requires input from many policy areas.

## 2. TAKING STOCK OF EU ACTION ON HEALTH

The mandate of the European Community in the field of public health has evolved through two Treaties that entered into force in 1995 and 1999.

<sup>26</sup> Health policy and European Union enlargement, European Observatory on Health Systems and Policies series 2004; Key data on Health 2002 European Commission

<sup>27</sup> COM (2003) 603

Article 152 of the Treaty establishing the European Community obliges the EU to ensure a high level of human health protection in all EU policies. Community action complements national policies and aims at improving public health, preventing human illness, and obviating sources of danger, such as the fight against the major health scourges. The EU can set high standards of quality and safety of organs and substances of human origin, blood and blood derivatives, and adopt incentive measures. But any harmonisation of the laws and regulations of the Member States is excluded.

The new Constitution agreed by the European Council of 17-18 June 2004, once ratified, further reinforces the EU health mandate. First, the new Constitution provides for Community law for setting high standards of quality and safety for medical products and devices and for monitoring, early warning and combating cross-border health threats. Second, the Constitution provides for specific EU measures to address tobacco and alcohol consumption. Third, the Constitution underlines that EU action should encourage co-operation between Member States to improve the complementarity of their health systems.

The Treaty calls on the Community to encourage and support cooperation between the Member States who need to coordinate their policies and programmes. As the scope of legislative activities is limited, there is a strong case for partnership arrangements between multiple stakeholders, ranging from Member States to non-governmental organisations and economic operators. Partnerships have been developed within the EU Health Forum<sup>28</sup>, which brings together organisations in the broad health area to advise the Commission on health policy, and many projects are being funded under the public health programme<sup>29</sup>.

## 2.1. Overview of actions and policies in public health

Over the last 5 years significant initiatives have been taken in addressing major health issues at EU level. These include the completion of the eight public health programmes running between 1996-2002<sup>30</sup>, the creation of the new public health programme for 2003-2008<sup>31</sup>, work on developing a health information system, actions against tobacco, policy initiatives on alcohol and nutrition, legislation on the quality and safety requirements for blood, tissues and cells, communicable diseases surveillance, control and early warning, work on health security, and creating the EU Health Forum together with non-governmental stakeholders.

These actions have been supported first by enhanced cooperation with the WHO and other international organisations and second by working closely with other policy sectors. For example, initiatives with the information society sector have led to quality criteria for health related websites<sup>32</sup> and promoted health telematics and best practice in electronic health services. Research projects have been launched to understand better the development of determinants and their implications for health. Action in the field of pharmaceuticals has brought together industrial concerns with public health issues within the High level group on Innovation and provision of medicines – the so-called “G10 Medicines” process – which

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<sup>28</sup> Created in 2001, the Forum brings together umbrella organisations representing stakeholders in the health sector to ensure that European health policy is open, transparent and responds to public concerns.

<sup>29</sup> Decision 1786/2002/EC of the European Parliament and the Council

<sup>30</sup> [http://europa.eu.int/comm/health/index\\_en.htm](http://europa.eu.int/comm/health/index_en.htm)

<sup>31</sup> OJ L 271, 9.10.2003

<sup>32</sup> COM(2002) 667

presented in 2002 a series of recommendations on developing a competitive pharmaceutical industry, while improving patients' benefits and strengthening the EU science base<sup>33</sup>.

## 2.2. Health information and knowledge

EU health information has been developed systematically through the health monitoring programme (1997-2002) and the injury prevention programme (1999-2002). Major information and knowledge related projects were also implemented under other public health programmes. This work led to a range of key reports that mapped health information resources, defined indicators within a systematic framework, and reported on methodologies and health issues. Major efforts have also been made to improve the comparability of health data from the Member States and to share data through a computer platform (Euphin<sup>34</sup>).

Building on these results, a short list of health indicators for the EU has been agreed upon. These indicators will provide an overview of health status, determinants of health and health systems and show their evolution. A network of health information authorities and a series of working groups have been established on lifestyle and other health determinants, mental health, injuries and accidents, mortality and morbidity, rare diseases, chronic and major diseases, health systems and environmental health. A structural indicator to monitor the evolution of "healthy life years" and check it against economic development is currently being developed.

## 2.3. Countering health threats

The EU has taken steps to establish an effective capacity to counter threats to health, which cannot be tackled effectively at the national level alone. Actions have been taken on control of communicable diseases, health security and preparedness, to create a framework for the safety of blood, tissues and organs, and on rare diseases. Projects have been funded under the programmes on AIDS and other communicable diseases and on rare diseases.

The EU network for the epidemiological surveillance and control of communicable diseases<sup>35</sup> is a key mechanism for cooperation. It has led to the creation of dedicated surveillance networks, training in field epidemiology and a publication forum, Eurosurveillance. The early warning and response system<sup>36</sup> ensures mutual information and consultation on measures taken (or planned) to deal with outbreaks of disease. The **European Centre for Disease Prevention and Control** (see II.1.3)<sup>37</sup>, which will come into operation in 2005, will continue development of disease surveillance, strengthen reaction capacity and build up expertise.

Special actions have been designed to tackle influenza and SARS. An EU influenza pandemic preparedness and response plan was presented in 2004 and joint EU measures on

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<sup>33</sup> COM(2003) 383

<sup>34</sup> <http://europa.eu.int/comm/enterprise/ida/index.htm>

<sup>35</sup> OJ L 268, 3.10.1998

<sup>36</sup> OJ L 021, 26.1.2000

<sup>37</sup> COM(2003) 441

SARS proved their worth in the global outbreak of this new communicable disease in March 2003<sup>38</sup>.

The events in September 2001 prompted the EU to reinforce action on bio-terrorism. The Commission reviewed<sup>39</sup> with the Member States the existing protection systems in order to minimise health threats to EU citizens. A dedicated rapid alert system has been in operation since June 2002.

Since 1999, the EU has worked on the Treaty obligation to ensure the quality and safety of blood, tissues, cells, and organs through a legislative framework. In 2003, a directive set high common standards for blood safety<sup>40</sup> throughout the EU. It applies to blood and blood components intended to be used for human transfusion, for manufacturing into medicinal products, or incorporation into medical devices. Another directive<sup>41</sup> adopted in 2004 established quality and safety standards for human tissues and cells used in therapy.

## 2.4. Addressing health determinants

Health determinants have been addressed both through EU legislation and through projects funded under the programmes on health promotion, prevention of drug dependence, cancer and pollution-related diseases.

Comprehensive action has been taken to counter health damage caused by tobacco products. This includes legislation, participation in global tobacco control initiatives, support to networking and EU-wide information campaigns. The EU has been at the forefront of tackling tobacco with legislation to control the contents of cigarettes and to regulate advertising and publicity with the tobacco products<sup>42</sup> and advertising<sup>43</sup> directives. The EU also made a major contribution in the negotiations to put in place the world's first international health treaty, the Framework Convention on Tobacco Control. Adopted at the World Health Organisation General Assembly in May 2003, this convention aims at combating tobacco use worldwide and addressing its negative impact on health.

The EU has also responded to alcohol-related harm through a set of measures that includes a recommendation<sup>44</sup> on drinking of alcohol by young people. In response, the public health organisations and economic operators have increased their efforts. Public health aspects of drug use were addressed in the recommendation<sup>45</sup> on the prevention and reduction of health related harm associated with drug dependence.

Initiatives on nutrition and physical activity included actions to improve available information and to disseminate best practices. A network of expert institutes was established in 2003 to support measures to promote varied and healthy diets, to combat obesity and encourage physical activity. This work is closely related to actions on heart

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<sup>38</sup> [http://europa.eu.int/comm/health/ph\\_threats/com/sars/sars\\_en.htm](http://europa.eu.int/comm/health/ph_threats/com/sars/sars_en.htm)

<sup>39</sup> COM(2003) 320

<sup>40</sup> OJ L 33, 8.2.2003

<sup>41</sup> OJ L 102 7.4.2004

<sup>42</sup> OJ L 194, 18.7.2001

<sup>43</sup> OJ L 152, 20.06.2003

<sup>44</sup> OJ L 161, 16.6.2001

<sup>45</sup> OJ L 165, 03/07/2003

disease, such as the European Heart Health Initiative. Economic operators are showing interest and taking steps to contribute.

Actions on sexual and reproductive health have aimed at the prevention of sexually transmitted diseases. Projects have sought to define best practices to address sexual education and to prevent teenage pregnancies.

Combating stigma was a starting point for the work on mental health that has also included the development of prevention and coping methods for depression and stress. The first report<sup>46</sup> that covers mental health issues in all EU countries was published in 2003. The Council has adopted three sets of conclusions, most recently in 2003<sup>47</sup>.

The Commission Communication<sup>48</sup> on a European environment and health strategy suggested an integrated approach focusing on the most vulnerable groups in society. The strategy aims to develop understanding of the links between environmental factors and priority diseases, respiratory diseases, childhood cancer and neuro-developmental disorders. An Action Plan on Health and Environment was recently adopted<sup>49</sup>.

Several projects have addressed social determinants of health, in close co-operation with social and employment policy. They have covered issues relating to health inequalities, social exclusion, employment status and conditions and housing.

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<sup>46</sup> Eurobarometer 58.0, March 2003

<sup>47</sup> OJ C 141 , 17.06.2003

<sup>48</sup> COM(2003) 338

<sup>49</sup> COM(2004)416/3 of 4.6.2004

## PART II: THE WAY AHEAD: GOOD HEALTH FOR ALL

### 1. PUTTING HEALTH AT THE CENTRE OF EU POLICY

Overall goal: To contribute towards the improvement of the physical and mental health of EU citizens, and to promote greater equality in health throughout the European Union.

The European Union will pursue this goal by putting health at the centre of EU policy-making. This means promoting health, preventing diseases, countering potential threats to health, addressing the concerns of its citizens and their expectations for a high level of health protection in a coordinated and coherent way.

To address the important health challenges described in part I of this document, health must be put at the centre of EU policy making. Achieving a high level of health and well being for citizens throughout Europe and ensuring that all Community policies contribute to health are shared values enshrined in the EU Treaty. But health is a complex area, closely intertwined, first of all, with economic growth and sustainable development. A wide range of other issues impact on health, from unexpected disease outbreaks (threats), lifestyles, the environment and social aspects. The only effective way to tackle the health agenda is to put health at the very centre of EU policy-making.

#### 1.1. Positioning health as a driver for economic development

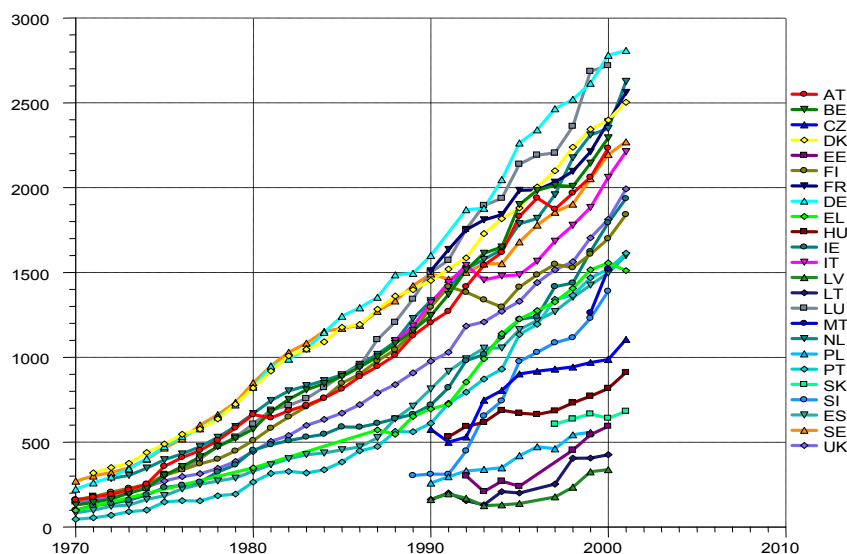
Objective: To promote health as a driver of economic growth, sustainable development and quality of life, and to contribute to promoting the optimal use of resources in health.

Considering the links between health and economic growth is the first step in putting health at the centre of policy-making. Economic progress and longer, healthier, more productive human lives go hand in hand. Education, innovation, and increased productivity are based on long-lasting good health. Studies of the World Health Organisation (WHO) have shown clearly that investing in health brings substantial benefits for economic development and that a population in good health is a key productivity factor.

The EU-15 spends over € 1,700 per/capita on health annually and on average 8.6% of its GDP<sup>50</sup>. In EU-25 investment in health ranges from 10.8% of GDP in Germany to 5.5% in Estonia and 5.7% in Slovakia<sup>51</sup>, with an average of 7,76%.

<sup>50</sup> Health Statistics, Key data on health, European Commission, 2002

<sup>51</sup> Figures refer to 2001. The World Health Report 2004, Changing History, WHO



Total health expenditure in PPP\$ per capita. Source: HFA database, 2004.

Health is a key driver for economic development and has a strong impact on growth and cohesion. First, because the health sector is an important employer (10% on average across the EU and higher in some regions)<sup>52</sup>, it drives demand for goods and services from local suppliers and is a major investor in high technology and R&D. Second, because health is a productive investment: a healthy population translates into a more productive workforce and triggers economic growth.

On the other side of the equation, a population in ill health impacts negatively on the economy. The burden of ill health translates not only into high healthcare costs, but also into heavy social costs ranging from sick leave, replacement at work, lower productivity and absenteeism to early retirement. Without long-term investment in health, healthcare and social costs will continue to rise, the pressure on budgets will increase and the economy will suffer.

The sums involved are very large indeed. In EU-15 the annual financial burden of respiratory diseases has been estimated at €102 billion<sup>53</sup>; the direct and indirect costs of cardiovascular diseases at €135 billion<sup>54</sup>; and treating asthma patients at €17.7 billion<sup>55</sup>.

The social costs of ill-health are particularly worrying. Health problems and accidents at work caused 500 million lost workdays in EU-15 in 1998/99<sup>56</sup>, and over 8 million disability adjusted life years are lost due to cardiovascular diseases<sup>57</sup>. In the UK alone, obesity

<sup>52</sup> Employment in Europe 2002, data source Eurostat

<sup>53</sup> European Lung White Book, European Respiratory Society (ERS) and the European Lung Foundation (ELF), November 2003

<sup>54</sup> Eurohealth volume 9, Spring 2003

<sup>55</sup> Lung health in Europe - facts & figures November 2003

<sup>56</sup> The Social situation in the EU 2003, European Commission

<sup>57</sup> The Social situation in the EU 2003, European Commission, original source: British Heart Foundation – coronary heart disease statistics.

accounted for 18 million days of sickness absence and 30,000 premature deaths in 1998<sup>58</sup>. In the EU almost 10% of the disability adjusted life years are lost due to poor nutrition (4.5%), obesity (3.7%) or inactivity (1.4%)<sup>59</sup>. The cost of mental health problems in developed countries is estimated to be between 3% and 4% of GNP<sup>60</sup>. Workers suffering from depression are 70% more 'expensive' in terms of their medical costs<sup>61</sup> and 20% less productive<sup>62</sup>. In Germany alone it is estimated that in 2002 18 million working days were lost due to depression, costing employers €1.59 billion<sup>63</sup>. In Finland mental health problems are estimated to account for 2.4% of GDP in total, 80% of which is due to loss of productivity<sup>64</sup>.

With such high costs of illness, improving the population's health must become an economic priority. This is the reason why the European Council of March 2004 encouraged national governments to strengthen health reforms as a means to improve the macro-economic situation.

Member States' health budgets vary widely across the EU. But what matters as much as the total budget is how effectively it is spent and the outcome in health gains.

Health relies heavily on R&D and high technology. The pharmaceutical sector alone invests billions of euros every year. The development and introduction of new technologies, such as medical devices and pharmaceutical, has led both to the development of a vibrant health technology sector and to a significant rise in health expenditure. It is particularly important to ensure that new technologies are properly assessed to ensure cost-efficiency. The rational use of medicines and diagnostics also requires more information on added therapeutic value. Cost-efficiency is an area where co-operation between EU health systems can lead to synergies and cost savings. This is the reason why EU Health Ministers have asked the Commission to strengthen co-ordination in this area.

Europe also needs to invest in tackling issues such as smoking, alcohol consumption and obesity now to avoid massive treatment costs in the future. The specific mention of the first two issues in the new Constitution is an indication of their importance in relation to health threat costs. Tobacco smoking alone is the cause behind 1 in every 3 cancers<sup>65</sup> and of 90% of all lung cancers. It is estimated that 50% of all deaths in Europe from intentional and unintentional injuries are attributed to alcohol consumption<sup>66</sup>. In England alone, 17 million working days per year are lost due to alcohol consumption and the loss of productivity caused by alcohol is estimated at £ 6.4 billion<sup>67</sup>.

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<sup>58</sup> Source: Eurohealth Vol 9 N1 Spring 2003 quoting from the UK National Audit Office.

<sup>59</sup> The Social situation in the EU 2003, European Commission, original source: determinants of the burden of disease in the European Union. Stockholm, National Institute of Public Health, 1997.

<sup>60</sup> WHO: Investing in Mental Health, 2003

<sup>61</sup> Leutzinger et al., 2000

<sup>62</sup> Goetzel et al., 2002

<sup>63</sup> Depression and sickleave in Germany (Source: Gesundheitsreport der Technikerkrankenkasse, Hamburg 2002).

<sup>64</sup> Lehtinen, V: Mielenterveyspalvelut. (Mental health services), in Heikkilä, M and Parpo A (Eds.): Sosiaali- ja terveydenhuollon palvelukatsaus 2002. (Social and health services in Finland in 2002) Helsinki: Stakes, Reports 268/2002 pp. 106-28.

<sup>65</sup> Securing good health for the whole population, Derek Wanless, February 2004

<sup>66</sup> Murray and Lopes A.D., "Mortality by cause for 8 regions of the world, Global Burden of Disease", Lancet, 1997. Figures refer to WHO Europe region.

<sup>67</sup> The Cabinet's Office, Prime Minister's Strategy Unit, Internal Analytical report, 2003

While more research on cost-effectiveness of prevention is needed, it is clear that certain measures, such as awareness-raising on healthy lifestyles, screening programmes and legislation (e.g. tobacco control) require relatively little investment and can trigger important savings. Health promotion through taxation, e.g. excise on tobacco, is both life saving and a revenue generator.

Co-operation on the cost efficiency assessment of technology and of prevention measures are useful ways to promote health while keeping expenditure under control. Another means is sharing capacity. Together with the Member States, the European Commission is looking at issues such as the use of spare capacity in one region to help overstretched capacity elsewhere. Setting up networks of centres of reference focusing on specialised treatment is another example of possible action.

When considering investment in health, there is also a need to take into account the specific needs and potential of rising numbers of elderly people. The crucial point is to keep people as healthy as possible through prevention and health promotion so that they can live longer, healthier and productive lives.

Ageing also affects the health professionals, who are growing older and fewer. The health and social work sector employs approximately 10% of the EU-15 active population and generated over 2 million jobs between 1995 and 2001. Employment in Health can play a particularly important role in stimulating regional employment and economic growth. But between 1995 and 2000 the number of doctors aged over 45 increased by 57% while the number of doctors below this age increased by only 20%<sup>68</sup>. An increasing proportion of nurses is aged over 45. Addressing this situation requires investment in providing access to medical studies and promoting health professions.

The European Commission has committed itself in its 2004 Spring report to the European Council to integrating health into the Lisbon agenda as a driver of competitiveness and sustainable development<sup>69</sup>. The Commission stressed the need for greater investment in health and presented health as precondition for economic prosperity in its recent Communication on the financial perspectives 2007-2013<sup>70</sup>. It has also committed itself<sup>71</sup> to working with the Member States to ensure that Community financial instruments are increasingly used to support health. Efforts in these areas need to be continued and further stepped up.

Finally, health policy must be built on solid grounds: data and scientific evidence. At EU level, however, there is no fully systematic and comparable data on key economic aspects of health and healthcare despite the advances in the System of Health Accounts promoted by OECD in collaboration with Eurostat. As mentioned in section I.2.2., a structural indicator to monitor the evolution of “healthy life years” is in preparation in the context of the mid-term review of the Lisbon process.

## **Actions proposed**

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<sup>68</sup> The Social situation in the EU, European Commission 2003.

<sup>69</sup> Report to the Spring European Council on “Delivering Lisbon, COM(2004) 29 of 21 January 2004.

<sup>70</sup> Communication "Building our common Future": Policy challenges and Budgetary means of the Enlarged Union 2007-2013, [COM\(2004\) 101 final](#) of 10.2.2004.

<sup>71</sup> Communication “Follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union” [COM\(2004\) 301 final](#) of 20.4.2004

- Gain better understanding (and evidence) of health's impact on economic growth and sustainable development, disseminate evidence and provide guidance to Member States on the economic implications of health and illness (through external studies and policy reports)
- Assist Member States in improving the cost efficiency of health care systems (through exchange of good practice and knowledge and making better use of available capacity)
- Assess the economic and health benefits of health measures and interventions, ranging from health policies and legislation to prevention and use of health technologies.
- Promote the rational use of medicines (through an action plan)
- Gain better understanding of the impact of longevity on health status, well-being and health systems, as well as its economic and social implications, and promote the health of the elderly population.

## 1.2. Bridging the health gap

Objective: To make measurable progress in bridging the health gap between the Member States in the enlarged EU.

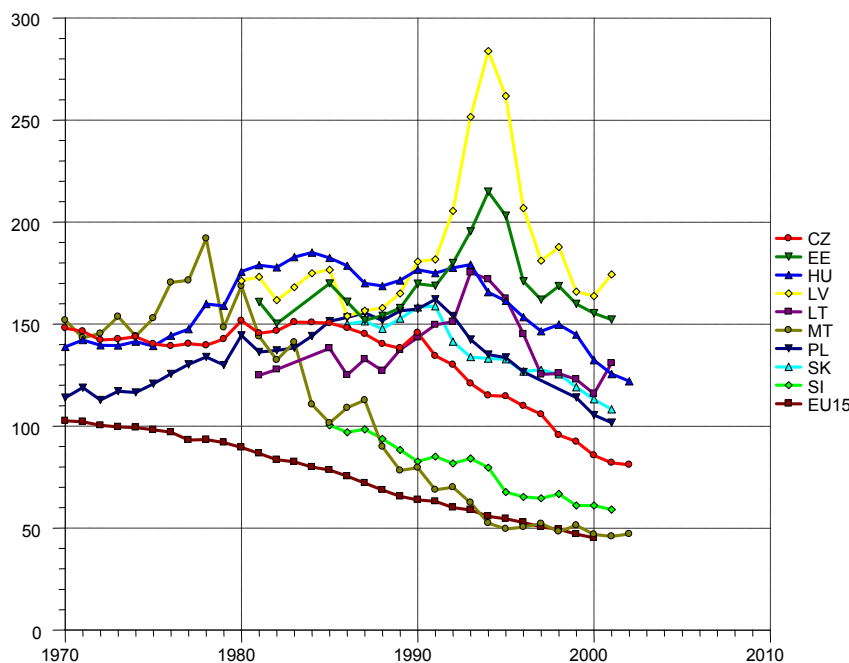
With an enlarged EU of 25 Member States, there are even clearer health and economic inequalities that must be urgently addressed. The economic gap between EU-15 and the new Member States is reflected in a major health gap.

During the pre-accession period, attention has concentrated on transposing EU health legislation. A significant shift in focus is now needed: health problems in new Member States present a major challenge. The future European health strategy should help enable all Member States to attain the highest possible level of health. However, reducing the health gap between Member States will require substantial financial resources.

The health situation in the enlarged EU's new neighbours is even more demanding. The EU must address potential health threats with these countries and help to reduce the gaps in health and wealth.

The public health programme is an important tool to promote health in the new Member States. Its annual work plans can be used to target support for activities in these countries. A part of the annual budget could be expressly reserved for them. In order to ensure the proper use of funds, this financial support should be accompanied with tailor-made information and training. This would improve the countries' public health capabilities and expertise, and help them to develop high-quality projects. Links need to be made to neighbouring countries which can contribute to better health for EU citizens. Consideration should also be given to enabling the programme to support activities in the new neighbour countries.

Cancer, cardiovascular diseases, injuries and key determinants, such as smoking, alcohol, drug use, pollution and social exclusion, need immediate attention in the new Member States. However, the programme's resources are nowhere near adequate to respond to the major health problems in the enlarged Union.



Difference between the new Member States and the EU15 average in mortality from the diseases of circulatory system per million of 0-64 year olds. Source: WHO HFA database, 2004.

By way of comparison, the Community Action Plan Against Cancer<sup>73</sup> 1996-2000 alone had €64 million in 1996-2000 to combat cancer, and the HIV/AIDS and other communicable diseases programme nearly €50 million. Most of the resources were used for practical action and helped to limit the HIV/AIDS epidemic and to reduce cancer mortality in the current Member States.

The EU Structural Funds could play a more significant role in developing health infrastructure and skills in the new Member States and, in particular, to increase their capacity to respond to health threats. While Structural Funds are supporting important work in this area, health is expected to become a more explicit priority area in the programming period 2007-2013.

Until the accession of all candidate countries, pre-accession assistance such as Phare and Twinning should be kept geared up towards supporting investment in health. Participation in all EU relevant programmes, such as the Framework Research Programme, should be encouraged and supported. Finally, cooperation with other international organisations and financial institutions, such as the WHO, the European Investment Bank and the World Bank, should be intensified to strengthen investment in health.

### Actions proposed

- Support the specific health needs of the new Member States by giving a higher priority and a larger share of financing for projects under the annual work plans of the public health programme

<sup>73</sup> The action plan against cancer contained 22 measures, covering data collection, public information, education, training for health-care workers, early detection and screening, quality of care, and research.

- Help mobilize a larger share of the Structural Funds for health-related investment, particularly in the new Member States
- Strengthen cooperation with organisations supporting health development, notably in the new Member States (through joint measures/projects)
- Contribute to effectively tackling the burden of disease and its underlying determinants, and to countering threats to health in the enlarged EU by shifting more resources to these priorities in the public health programme.
- Help reduce health inequalities across the EU (through a dedicated action plan).

### 1.3. Protecting the population against health threats

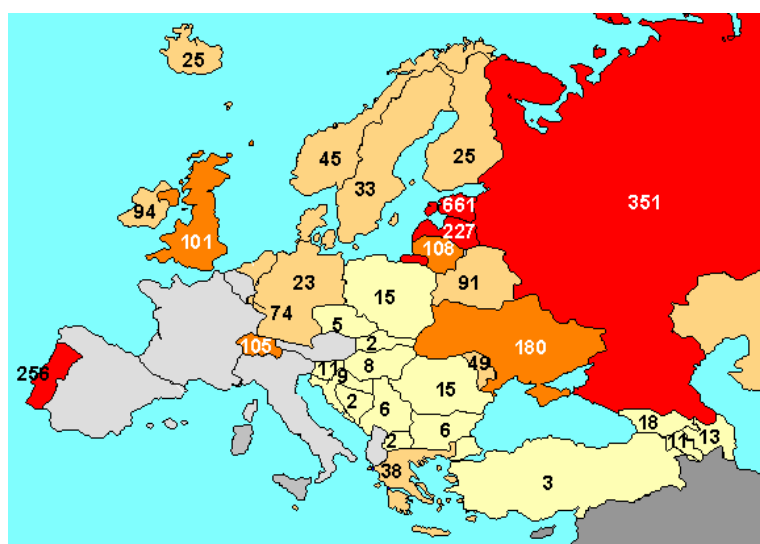
Objective: To protect the health of EU citizens by developing capacity to prevent and react to health threats that cannot be adequately tackled by individual Member States.

Health threats for example from infectious diseases or chemical agents do not stop at national borders and may have very serious consequences for the population and the economy of the EU as a whole. Europe needs to build on the lessons learned with SARS and the avian influenza epidemic and develop EU-wide resource planning and capacity to provide better protection at lower cost against major health threats.

The burden of traditional communicable diseases has diminished. Tetanus, poliomyelitis and diphtheria for example have been practically eradicated. However, significant risks to the health of the European population still remain from food-borne diseases, zoonoses, imported diseases and the growing resistance to antibiotics.

The rapid rise in HIV/AIDS infection rates connected to injecting drug use in some countries, particularly the Baltic States and Russia is worrying. A coordinated EU approach

to addressing the various aspects of HIV/AIDS is required, involving research, surveillance, provision of appropriate pharmaceuticals, education and information. The Northern Dimension Partnership in Public Health and Social Wellbeing provides one important mechanism for action, in addition to the public health programme.



Newly diagnosed HIV infections in Europe. Cases reported in 2002 per million of population. Source: [www.EuroHIV.org](http://www.EuroHIV.org).

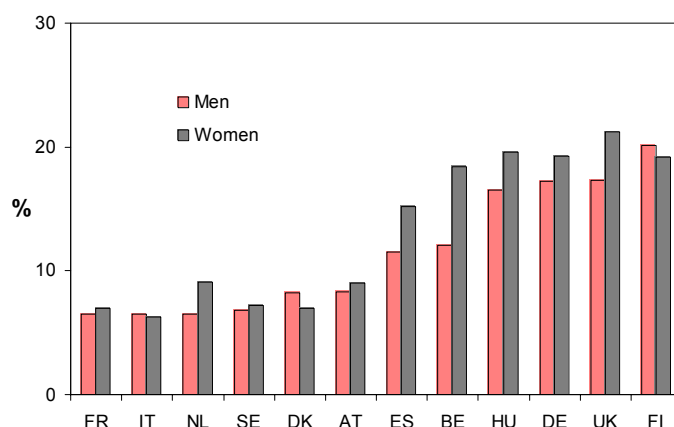
It is crucial, therefore, that the EU reinforces surveillance, alert and response capability to ensure effective coordination of national efforts. The European Centre for Disease Prevention and Control, a new EU agency aimed at addressing health threats across Europe (building on the existing system of surveillance

of infectious diseases), will be a major building block in the EU's capacity as from 2005. The tasks of the Centre include epidemiological surveillance and networking of laboratories, producing scientific opinions, early warning and response, providing technical assistance, and helping in emergencies. The Centre will strengthen the EU's international role in controlling communicable diseases. In 2008, the evaluation of the first years of the Centre will inform on the need to extend and develop its scope and actions.

A new and serious risk to health in Europe comes from deliberate releases of biological, chemical or radiological agents to cause harm, whether from terrorist acts or from other causes. At EU level, current capacity to respond to these is based on the Health Security Committee created in 2001 – which brings together high-level representatives of Health Ministers to co-operate in countering deliberate releases of biological and chemical agents - and the experts on temporary loan to the Commission.

In the areas of communicable disease and deliberate releases, as well as in food safety, the EU has a vital role to play in coordinating efforts and bringing to bear the best expertise and facilities that exist in the EU.

A more substantial emergency response capacity needs to be developed. The aim of this would be to ensure the transmission of alerts, the handling of information flows in emergencies, consultations on counter-measures, provision of advice and referral to experts. It would ensure support for the operation of assistance teams and that key vaccines, anti-virals and other public health medicines are available. This would combine with the surveillance and risk assessments undertaken by the Centre. This must be backed by appropriate links between the Member States, the Global Health Security Network (senior representatives of the G7+ member countries who coordinate the work of the Global Health Security Initiative) and the WHO. The development of the legal framework on blood, tissues and cells has paved the way for similar measures on organs. The challenge is to enact the implementing rules and to keep them up to date.



Prevalence of obesity, latest available data. Source [www.heartats.org](http://www.heartats.org)

### **Actions proposed**

- Reinforce surveillance, alert and response capability against health threats by setting up the European Centre for Disease Prevention and Control, by reinforcing systems to handle public health threats requiring a rapid response, and by creating links with relevant actors

- Effectively fight HIV/AIDS and other communicable diseases in the EU and neighbouring countries by developing co-ordinated approaches
- Reinforce the EU's preparedness and response capacity in public health in relation to deliberate releases of chemical, biological or radiological agents (starting by evaluating existing capacity)
- Secure the quality and safety of organs used for medical purposes in the EU (through an action plan) and fully implement legislation on blood, tissues and cells.

#### 1.4. Enabling Good health and promoting health through all policies

Objectives: To increase healthy life and reduce the burden of disease by addressing behavioural, social and environmental factors which determine health and by mobilizing instruments in different policy areas

Europe increasingly suffers from lifestyle related diseases triggered by an unbalanced diet, physical inactivity, and tobacco or alcohol consumption. This means that citizens' health is, to a great extent, determined by individual choices on what people eat, smoke, drink and do. These choices are based on a number of factors ranging from knowledge and information to socio-economic determinants. Citizens therefore have responsibility for promoting their own health. Lifestyle determinants combine with physiological risk factors, such as hypertension and a high level of blood lipids to produce cardiovascular diseases and cancers.

European citizens want access to reliable, authoritative, and user friendly information about health issues to help them make the right choices. When they fall ill and become patients, they want to be partners in managing their health and have prompt access to high quality care. Citizens increasingly judge their governments by their access to health and healthcare. Health is never out of daily headlines. Citizens expect effective solutions to the health challenges facing Europe.

EU action needs to promote daily living and working environments that support health and make the healthy choice the easier choice. Common approaches in the EU can be explored for unhealthy products, such as tobacco.

Environmental conditions and socio-economic factors also play a key role in determining health. Environmental and socio-economic factors, such as poverty and low education, have a role in causing or aggravating disease. If the EU is to help enable good health, it must address the behavioural, social and environmental factors that determine health. This means we need to **promote health through all Community policies**. Protecting and improving health is not a matter for health policy alone: many policy areas affect health.

In taking an approach involving other policies, a key question is to understand exactly the impact of particular actions on health. The public health programme can support projects to refine methods and to carry out case studies on EU policies, legislation and actions.

Impact assessments<sup>74</sup> of EU policy proposals can be used to ensure proper attention to their impact on health. These assessments will be carried out on all major initiatives as a way to improve the quality and coherence of the EU policy-making. However, impact assessments are not used uniformly in the EU and there is a need to improve their methodologies. Better resources, skilled staff and broader awareness are essential missing elements in many Member States and at EU level. A feedback and benchmarking mechanism could be used to measure progress in the use of impact assessments.

Population-based prevention can be a particularly cost-effective and affordable way of improving public health. The EU can play a major role in supporting and complementing national efforts. Two examples indicate the magnitude of problems and the potential for prevention. Tobacco kills over 650,000 people in the EU every year<sup>75</sup>. Motor vehicle accidents are the most common cause of death in age groups from 1 year to 29 years.<sup>76</sup> Health gains from acting on smoking, obesity and physical inactivity can significantly reduce the disease burden. Suicide (in 90% of cases connected with psychiatric disorders) is often an underestimated problem: in 2001 in Germany there were more deaths by suicide (11,163) than from traffic accidents (7,089), illegal drugs (722), and AIDS (518) put together<sup>77</sup>. A Europe wide project has already provided evidence that preventive measures can lead to significant reductions<sup>78</sup>.

Evidence on the effectiveness of interventions, guidelines on prevention and treatment would support Member States actions. EU-wide initiatives can help to put the focus on particular determinants or diseases. The piloting of innovative strategies in different Member States can shed light on the transferability of social innovations.

The action plan on environment and health is a good example of a coordinated approach to a major public health issue. Different Commission services are also co-operating to mobilize regional policy and the Structural Funds to promote health. Further coordinated action plans linking health with other policy areas should be developed to exploit synergies and focus efforts. They would bring together various policy interests at EU level and different partners in the Member States.

Evaluating health risks related to the environment, consumer products and emerging technologies are important functions to serve EU citizens. For example, an advance assessment of nano technologies is vital. The independent scientific committees of the Commission have played a valuable role in carrying out such assessments, as was the case with many cosmetics. The EU's research programme is an important tool in creating a European scientific knowledge base.

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<sup>74</sup> COM(2002) 276

<sup>75</sup> Peto, Lopez et al. This is an epidemiological estimate derived from a statistical model that incorporates factors such as lung-cancer mortality in each country and knowledge about the phase of the smoking epidemic, plus use of a reference population.

<sup>76</sup> Health Statistics, Key data on health, European Commission, 2002

<sup>77</sup> Source: Statistisches Bundesamt, Fachserie 12 / Reihe 4 "Gesundheitswesen, Todesursachen in Deutschland 2002", Wiesbaden 2004

<sup>78</sup> European alliance against depression, preceded by Bündnis gegen Depression. Project succeeded in reducing the number of suicides and suicide attempts by 26 % in two years.

## **Actions proposed**

- Set up cross-policy initiatives to tackle specific health determinants and major diseases, starting with HIV/AIDS (through joint action plans and multi-stakeholder approaches)
- Develop strategic approaches to promote health and prevent disease (involving networks of professionals, institutes and non-governmental organisations)
- Analyse possible common approaches to key health determinants, in particular on tobacco and alcohol
- Ensure that all relevant Commission proposals contribute to health/do not have a negative impact on health (through the creation of an effective system of health impact assessment)
- Mainstream health in all policies by enhancing cross-policy cooperation, (including disseminating information on successful cross-policy initiatives and by setting up an expert network)
- Strengthen the EU's scientific expertise (by setting up a system of scientific advice building on the scientific committees for the risk assessment of environment, consumer products and new technologies)

## **2. POOLING EUROPE'S CAPACITY: PARTNERSHIPS FOR HEALTH**

Putting health at the centre of EU-policy making is a shared responsibility.

Different actors must work together to implement a health strategy across the EU. There is much scope for co-operation, consultation and exchange of knowledge for the benefit of all parties concerned. Synergies with and between Member States, stakeholders and international organisations can and should be achieved. The EU is well positioned to bring together the different players and help them achieve synergies.

EU policy actions must be based on solid ground: this requires comprehensive Europe-wide information and comparable EU data. The EU can offer added value by bringing together information and experience from a wide range of different sources.

### **2.1. Creating partnerships for citizens' health**

**Objective:** To create partnerships to help European citizens make well-informed choices about their health, and to promote their active participation in the health decision-making process.

European citizens expect to be well-informed about health issues that concern them and their families and to see their opinions and priorities reflected in policy. When they fall ill and become patients, they do not see themselves as mere recipients of health care; they want to be partners in managing their health and to have full access to information and high quality care. Putting health at the centre of EU-policy making is a shared responsibility. Different actors must work together if we are to succeed on implementing a health strategy

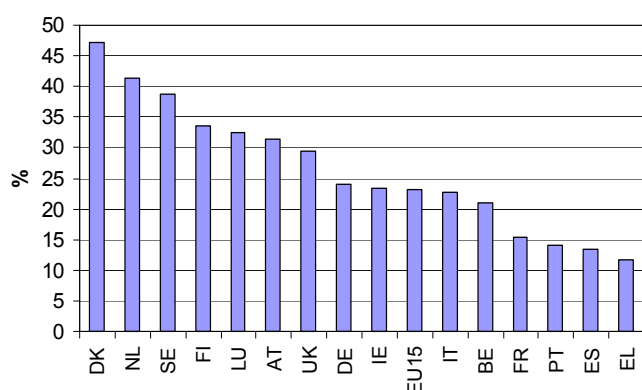
across the EU. There is much scope for co-operation, consultation and exchange of knowledge.

Following its “European Governance” White Paper in 2001<sup>79</sup>, the European Commission has committed itself to five “good governance” principles: **openness** (to communicate on its activities in a user-friendly manner), **participation** (for example by promoting stronger interaction with national and European organisations from an early stage in policy-making) and also **accountability, effectiveness and coherence**.

Openness and civil society participation, now enshrined in the new EU Constitution,<sup>80</sup> are key to EU health policy-making. This is the reason why the Commission is determined to provide stakeholders the opportunity to input from the earliest stage possible in the shaping of the future EU Health strategy. In line with these, the purpose of this document is precisely to put forward for wide consultation proposals for a future strategy.

Health is one of the most sought-after topics on the internet, which demonstrates citizens’ desire for high-quality and accessible information. While national health portals and information sites are the major sources used, there is also a need for reliable international information. Preparatory work for an EU health portal has shown widespread interest in

such a measure, and also the sustained efforts required. A particular issue is how to communicate risks related to environment, consumer products and emerging technologies.



Share of the population that seek information about health from the internet, 2002. Source: Eurobarometer 58.0, March 2003.

EU policy on pharmaceuticals has identified information as an area where patients are not only demanding more but also information more directly relevant to their needs – what treatment options exist, and how they can access them.

The voice of civil society is rapidly gaining importance in health policy debates. The EU Health Forum has proved the value of broadening participation in EU policy consideration.

The transparency of policy making and stakeholders’ participation need strengthening. Involvement of civil society is especially important in those countries where health is not always placed firmly on the political agenda. EU-wide contacts with policy makers and networking of non-governmental organisations can help them in their efforts to make health count in their countries.

### Actions proposed

- Further encourage the participation of citizens in health policy making by

<sup>79</sup> “European Governance, a White Paper”, COM(2001)428 final, 25.7.2001.

<sup>80</sup> Articles I-49, III-193, I-49.

- strengthening the EU Health Forum (including upgrading the annual Open Health Forum, which brings together a wide range of stakeholders under the framework of the Health forum to a European Health Day)
  - regularly assessing citizens' priorities and concerns in the field of health (EU-wide surveys) and shaping policy action accordingly
  - supporting networking of non-governmental health and patients' organisations at EU level, ensuring the participation of organisations from all Member States.
- Provide citizens with high quality information on health by
    - setting up an EU health portal (an Internet based gateway to health information) producing user-friendly publications and developing campaigns
    - improving communication with patients on pharmaceuticals and treatment options by setting up public-private partnerships.

## 2.2. Facilitating Member States' cooperation between health systems

Objective: To support the dialogue between those responsible for the development of national health systems and coordination in healthcare in the interest of patients.

Health services are provided within a context of limited resources, widening scope of intervention, increasing demand, and an integrating and interconnecting market. This provides opportunities for collaboration to the benefit of individual patients and professionals and of systems as a whole, but it requires a coherent approach. The Commission therefore convened a high level process of reflection on patient mobility and healthcare developments in the EU to provide a forum for developing a shared European vision in this area whilst respecting national responsibility for health systems. At its final meeting in December 2003, the reflection process agreed a wide-ranging report including nineteen recommendations for action.

In its communication<sup>81</sup> responding to this report, the Commission has set out proposals to follow up these recommendations in four main areas: European cooperation to enable better use of resources; information for patients, professionals and providers; the European contribution to accessible, high quality and financially sustainable healthcare; and responding to enlargement with investment in health infrastructure. Alongside this communication, another<sup>82</sup> proposes extending the open method of coordination to healthcare and long-term care as a framework to support national efforts to further improve health systems. A third communication<sup>83</sup> sets out an “e-Health action plan” for using information and communication technologies to help improve access, quality and effectiveness for health services across the Union.

Developing cooperation between health systems will be a long process but it represents a key part of an overall Europe of health. European cooperation will not only help to improve

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<sup>81</sup> COM(2004) 301

<sup>82</sup> COM(2004) 304.

<sup>83</sup> COM(2004) 356

the quality of life of citizens by helping health systems throughout the Union achieve their objectives. It will also contribute to economic growth and sustainable development for the Union by making better use of the resources invested in health systems.

### **Actions proposed**

- Help improve access, quality and effectiveness of health services by the implementation of the e-Health action plan
- Take forward the recommendations of the patient mobility reflection process (in particular through the High Level Group on Health Services and Medical Care, which brings together senior officials from EU Health Ministries to facilitate cooperation at European level by identifying shared priorities and exchanging best practice)
- Create a European vision for health systems with health objectives shared by the Member States.

### **2.3. Providing a strong knowledge base for European action**

Objective: To put in place the EU health information and knowledge system that will provide objective, comparable, and timely information for the formulation of policies and actions.
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Europe depends on reliable and up to date information about health for taking effective action and introducing sound policies. Eurostat is a major information provider. WHO and OECD have good databases on particular topics. However, there are major problems with the coverage, both geographical and in content, with comparability, and with timeliness of the data. Some countries have well-established information systems on some diseases, but often disparate methods render available data incomparable.

The improved health information and knowledge system starts with the definition of indicators, but covers also collecting, processing and exchanging data as well as analysing and reporting of the results. All categories of data and information need to be covered: demographic and socio-economic factors; health status in terms of health and diseases; determinants of health; resources, output, costs, and financing of health systems.

The system should bring together information from EU sources, international bodies, national and regional administrations, private sources and partners. The existing sources need to be complemented by new data on defined priority issues where gaps exist. Data is lacking for example on obesity, injuries and mental health.

A key feature of the system is the timely availability of good-quality and comparable data and information. This can be achieved by promoting partnerships and preparing necessary legal or incentive instruments for standardised delivery of data and information by Member States.

An essential part of the health information and knowledge system is to improve the dissemination of information. The EU health portal will be a common entry point to health information but it must be complemented by a public health report series for professionals, decision makers and authorities.

The public health programme currently provides the technical and financial resources to develop the system. However, setting up and operating effectively a health information system will require a continuing substantial investment in the long term.

### **Actions proposed**

- Set up a health information and knowledge system by creating a framework for activities under the public health programme. This will include, besides the health portal, a system of EU health indicators, a European health survey system, and dissemination of information and analyses through EU health reports and the internet
- Assess the role of the European Centre for Disease Prevention and Control in relation to health monitoring and information.

### **2.4. Enhancing international cooperation**

Objective: To respond to the globalisation of health by working with international bodies to tackle health problems in Europe and to contribute to health improvement throughout the world.

The health of EU citizens is itself affected by global developments. Whether it is scientific research, spread of information, economic development, global security or migration, major health issues inevitably arise. Health is becoming a key part of international relations and trade agreements; defending health is their key element. This ranges from transparency in disease notification to ensuring the availability of priority medicines and vaccines. The new prominence of health means that the EU has to develop its role and working methods at global level.

International initiatives on improving access to pharmaceuticals, tackling AIDS, malaria and tuberculosis, the WHO Framework Convention on Tobacco Control and the developing work on nutrition are examples of how protecting health globally is directly linked to the EU. The outbreak of SARS underlined the need for synergies between the EU Early Warning and Response System and the WHO Global Outbreak Alert and Response Network.

The exchange of letters between the Commission and WHO<sup>84</sup> in 2000 has led to expanding cooperation between the two bodies. Strategic partnership agreements being prepared in a number of areas, including development assistance and public health, set out the details of practical cooperation. The European Centre for Disease Prevention and Control will work closely with the WHO on global issues. The International Health Regulations are intended to mobilise countries quickly against serious threats. Their revision seeks to combat global epidemics more effectively.

As well as participating at the global level, it is also important that the EU's actions in Europe are properly informed by the work of international agencies. The OECD, the European Observatory on Health Systems and Policies, and the WHO's Health Evidence Network can provide valuable input for EU policy development. The Commission has been

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<sup>84</sup> OJ C 1, 4.1.2001

working with the Observatory over years, benefiting from its expertise and analyses on health systems and policies. The OECD carries out work in similar fields, in particular on economic aspects of health. Actions proposed on health as a driver of economic development would benefit substantially from reinforced partnerships. The Council of Europe has a long tradition of working on ethical aspects of health policy and has developed considerable expertise in several key areas, including issues concerning blood, organs, tissues and cells.

### **Actions proposed**

- Strengthen co-operation with the World Health Organisation by agreeing on a joint framework for long-term collaboration in areas of common interest
- Strengthen and formalise co-operation with the European Observatory on Health Systems and Policies
- Play a major role in the revision of the International Health Regulations aimed at reinforcing the global system of cooperation against health threats
- Reinforce the existing partnerships with other international organisations, in particular with the OECD and the Council of Europe.

### **3. STATUS AND INSTRUMENTS**

This document puts forward a number of proposals for future action for consultation with organisations active in health. Stakeholders input will be fully taken into account in the future shaping of a European Health Strategy – a Commission policy document presenting such a strategy is envisaged sometime in 2005.

The main Community instruments foreseen for implementing the strategy are the existing public health programme for 2003-2008 and the executive agency for its implementation (currently under preparation) and the European Centre for Disease Prevention and Control. Resources (in particular from the public health programme) may need to be re-directed in the light of the strategy to secure their feasibility. Once the current public health programme expires in 2008, its successor programme will be closely co-ordinated with the actions foreseen in the strategy.