



Implications of European Public Health

PUBLIC HEALTH IN EUROPE
THE IRISH CONNECTION

A REPORT



THE INSTITUTE OF
PUBLIC HEALTH IN IRELAND

Implications of European public health

The Institute of Public Health in Ireland

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Introduction

The Institute of Public Health in Ireland was established in 1998 by the Department of Health and Children in the Republic of Ireland and the Department of Health and Social Services in Northern Ireland. It was set up to promote cooperation in public health between Northern Ireland and the Republic of Ireland. This report outlines work undertaken¹ by the Institute of Public Health to improve knowledge about developments in European public health, and strengthen links for public health across Ireland.

The aim is to encourage those involved in public health in Ireland, North and South, to contribute to the development and implementation of the proposed EU programme of community action in the field of public health. This proposal was presented by the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions in 2000.

This work is timely because the programme will be voted on in Parliament in 2001 and the setting up of the new Directorate of Public Health and Consumer Protection offers an important opportunity to increase interest in public health and integrate health more fully into the work of the Commission.

A focus group and workshops were held to identify priority areas to strengthen links for public health in Ireland, and strengthen links with European action. Recommendations for this process are set out in the report.

The Institute is very grateful to the members of the focus group, the seminar speakers and all the participants for their attendance and input.

¹ This work included a focus group meeting and a seminar. Focus group participants are listed in Appendix 1.

Executive summary

The Institute of Public Health has conducted a process to explore public health developments in Europe and Ireland. This has identified four critical areas that need to be addressed to strengthen links within Ireland and with Europe in the area of public health.

These areas are:

- Improving the collection and dissemination of health information and knowledge
- The strategic development of public health policy in Ireland, North and South
- Clarifying and defining responsibilities, roles and structures in Ireland and Europe
- Integrating health into other policy areas in Ireland and in Europe

Public health participants engaged in the Institute's work made recommendations in each of these areas. These are summarised here and outlined in more detail in the report.

Improving the collection and dissemination of health information and knowledge

- there is a requirement to have an information audit on the current availability of health information and data sets
- additional data is required in areas where deficits exist, particularly in the area of health determinants and inequalities in health
- standardisation of data items, data collection, data management, data analysis and reporting procedures North and South and within Europe is required
- information systems should incorporate components for the analysis, reporting and communication of information.

The strategic development of public health policy in Ireland, North and South

- public health must be defined on a multidisciplinary and multisectoral basis
- the process of consultation in public health policy development is crucial

- structures that allow for easy, effective communication to take place at local, regional, national and international level need to be established
- structures and consultative processes need to be adequately resourced in financial and personnel terms
- all health strategies and policies should have as a core aim the reduction of social and health inequalities.

Clarifying and defining responsibilities, roles and structures in Ireland and Europe

- some confusion about roles and responsibilities currently exists thus an audit of roles, responsibilities and structures for public health could clarify the situation
- as health issues are not considered important by many outside the health sector responsibilities must be allocated across Government departments and commitment to the health agenda obtained at senior level
- a forum for health is a useful mechanism by which collaboration for health can be achieved.

Integrating health into other policy areas in Ireland and in Europe

- a wider awareness of influences on health is important in promoting public health considerations within a wider agenda
- cross sectoral working is essential for effective public health
- all relevant policies must be health proofed. Health impact assessment is one tool for this
- strategic budgeting and ring fencing of money is critical in ensuring health integration into other policy areas
- strong and determined leadership is needed to secure political support for this integration.

The challenge for public health in Ireland and in Europe is to take forward these issues and make progress under each heading.

Chapter 1. The EU programme – a summary

The European Commission proposal sets out the Community's broad health strategy for the years 2001-2006. It outlines how the Community is working to develop a public health programme and achieve a coherent and effective approach to health issues across a range of relevant policy areas which impact on health.

The programme was developed giving consideration to:

- the expectation of the public that the Community should act to ensure that their health is protected
- the strengthening of the EU's obligations in relation to public health in recent years, especially through successive changes to the Treaty
- the emergence of new health challenges and priorities, especially related to enlargement of the EU, increased demands on health services and demographic change
- the experience of implementing the current public health actions within the framework put in place in 1993
- the views of the other Community Institutions, especially the European Parliament and the Council, that a new approach is necessary to address future challenges
- the extensive consultations on the Commission's Communication of April 1998 on the development of public health policy in the European Community which confirmed the need for a more ambitious Community health strategy
- the Treaty objectives on public health set out in Articles 3(p) and 152 which are central to this strategy.

The programme contains **two components**. The **first component** is entitled the EU Public Health Programme and **contains three strands**.

These are:

Strand 1 - Improving health information and knowledge

A comprehensive health information system will be put in place which will provide policy makers, health professionals and the general public with the key health data and information that they need.

Within this strand there are two main areas:

- Developing and operating a health monitoring system
- Developing and using mechanisms for analysis, advice, reporting, information and consultation on health issues.

Strand 2 - Responding rapidly to health threats

An effective rapid response capability will be put in place to deal with the threats to public health, for example, arising from communicable diseases. The integration of the EU based on the principle of free movement increases the need for vigilance.

Within this strand there are two main areas:

- Enhancing the capacity to tackle communicable diseases
- Strengthening the capacity to tackle other health threats.

Strand 3 - Addressing health determinants

The programme will help to improve the health status of the population and reduce premature deaths in the EU by tackling the underlying causes of ill health, through effective health promotion and disease prevention measures.

Within this strand there are three main areas:

- Developing strategies and measures on lifestyle-related health determinants
- Developing strategies and measures on socio-economic health determinants
- Developing strategies and measures on health determinants related to the environment.

The **second component** relates to health in other policy areas.

In this component the proposal states that the EU's competence in health is not confined to specific public health actions. There is a specific requirement that "a high level of human health protection shall be ensured in the definition and implementation of *all*

community policies and activities". This will ensure that proposals in other key areas of Community activity, eg internal market, social affairs, agriculture, research and development, should actively promote health protection. The new health strategy includes a number of specific measures to give effect to this, including

- the development of health impact assessment (an assessment of all policies and practice across different sectors of how they will impact upon health)
- better coordination between projects and policies
- wider consultation on policy.

Chapter 2. "Public Health in Europe – The Irish Connection". Seminar, November 2000.

In November 2000 the Institute of Public Health held a seminar for invited participants to provide information about developments in public health in Europe. Workshops considered four themes which had arisen in the focus group work. The Institute is indebted to the focus group participants because their work identified these four crucial areas.

Plenary presentations and workshop reports are now set out on the following pages.

Plenary presentations

Commissioner David Byrne

EU Public Health Programme 2001 - 2006

I am very pleased to be able to attend this seminar on "The Irish Connection" which will cover in depth the wide range of issues related to public health in Europe and the contribution which this island can make – and indeed is already making – to developing European Community policy and to putting it into practice.

I was very happy to accept this invitation, not least because the newly founded Institute of Public Health in Ireland represents a unique initiative bringing together health researchers, a policy perspective and practitioners. Bringing them together in a joint effort – as your motto says – to "Work for the health of the people of the island of Ireland". At the outset I would like to wish Dr Jane Wilde and her team, the very best, in working to place public health at the centre of public policy, throughout the island.

Of course at European level, there has been at least one clear "Irish connection" in implementing the Community's work in this field – public health has been the particular domain of Irish Commissioners since Maastricht entered into force! But whether this is down to example, experience or endurance – I will leave you to decide for yourselves!

Our seminar is a timely initiative. It reflects the fact that health issues are increasingly occupying a central place on the policy agenda. This is true both for this island and for Europe as a whole. Now, more than ever, health and the development of health care, have to be seen as matters of fundamental concern to all our citizens – locally, regionally and internationally. Of course, it has been clear for some time that communicable diseases, food-borne infections and the health effects of pollution do not respect national borders. Protecting the public from these hazards, and promoting healthy alternative outcomes requires close and sustained international cooperation. And cooperation between the peoples of Europe and across its borders is no longer the

domain of exotic diplomacy as in the past, but a very real part of everyday life for our citizens. And this is something which is driven home to me, every working day in my role as the first designated European Commissioner for Public Health.

Let me take up a topical example to make a point. In recent days there has been tremendous concern across the continent about the evolution of BSE. There are very real public health concerns regarding the risk of variant CJD, that arise from the management by the public authorities of BSE. Only the dangerously complacent or naïve could assume that we have safely put the BSE crisis behind us. Once more we are reminded that BSE is not an historic event but a real and present danger. Clearly, we need to look at these developments and draw the appropriate lessons.

First, the increased incidence of BSE in France is in large part due to the introduction of random testing by the French authorities. This follows from a Commission decision requiring all Member States to introduce such testing from 1 January 2001. All Member States should follow the French example.

Second, the utter necessity for the implementation of rigid controls on BSE cannot be over-emphasised. The fact is that there is a battery of controls provided by legislation. If these controls are respected and implemented, the risk to the public is reduced to a minimum. Third, we must have total transparency in our approach towards BSE. The consumer reaction to BSE has been variously described as a psychosis, irrational or driven by panic. A lack of clarity and transparency in addressing the issue has contributed hugely to this unfortunate situation.

Finally, we must not overlook the huge process in recent years, in the past year in particular, in putting in place a framework to tackle BSE. In the process, we have also begun the task of ensuring that EU systems are in place to avoid similar tragedies in the future. The foremost of which is the proposal adopted by the Commission last week, on the establishment of a European Food Authority. This represents a quantitative step forward in the protection of our citizen's health and well being.

Now I didn't come here to preach about BSE. But it provides very concrete lessons on why we need to develop regional and European cooperation in key public health areas. And from the handling of BSE we can also see the parallels for our theme today. Namely the vital roles played by a number of elements which are the building blocks of a coherent public health policy. Elements like – transparent governance, vigilant research, scientifically reliable data, rapid reaction capability for crises, effective preventive measures, adequate resources and targeted long term policies.

In the public health domain, these requirements are reinforced by a number of evolving international trends. Trends such as the movement of health professionals, shopping around by patients for treatments, the international nature of medical research, and the global health information explosion. These trends flow in the wake of the increasing numbers of empowered patients who demand to be accepted as equal partners by health professionals. And who have simple expectations from their health providers - nothing but the best! Whatever the cost.

But these trends do not provide comfort to public policy makers who are faced with a number of critical challenges in the years ahead. Any list of principal challenges facing today's public health decision-makers across Europe would include

- the ageing of the European population
- rising health expenditure
- the rapid development and introduction of new technologies
- and the impact of enlargement.

The emergence of the new European Public Health Strategy and Framework Programme takes place against the background of these challenges. And across Europe, whether in the European Parliament, the Council or in stakeholder fora like the Institute of Public Health in Ireland, the shape and destiny of this new approach are currently being discussed, reviewed and fine tuned. Of course, I cannot speak for the other institutions who will deliver their judgement in the weeks ahead. And I expect to hear your analysis of these proposals following your own reflections at this seminar. But I would like to summarise for you the background to this policy from the Commission's point of view.

The European Community has from the outset had a strong interest in protecting health. But it was not until the 1993 Treaty of Maastricht that the Community was given a specific competence in public health. After Maastricht, we developed a series of disease orientated public health action programmes. These are on cancer, AIDS and other communicable diseases, pollution-related diseases, rare diseases, and accidents and injuries, as well as on health promotion and health monitoring. In addition to these programmes, an EC communicable diseases surveillance network was set up and vital initiatives in areas such as blood safety have been elaborated.

In addition, I must mention our important work on tobacco control. This includes a break-through directive on introducing controls on tobacco advertising and sponsorship. As you know, this initiative was recently challenged successfully in the European Court of Justice. And I would like to take this opportunity to confirm that I remain fully committed to the aims of the advertising Directive, and to tell you here today, that I will soon be bringing forward proposals for a new directive which will tackle advertising and sponsorship issues within the clear lines set out by the Court.

But as you are aware, my determination to make an impact on smoking reduction is also evident in the far-reaching draft directive on the manufacturing, presentation and sale of tobacco products which is currently before the European Parliament and Council.

These proposals on content, product information, health warnings, additives, and misleading descriptors will fundamentally tip the balance in favour of our citizen's health.

At the global level, I am about to sign an Agreement with Dr Brundtland setting out how our future cooperation with the World Health Organisation – including preparing a new convention on tobacco controls – will ensure that the work we are doing in Europe is copper-fastened on the world stage.

Now since the Amsterdam Treaty, our mandate has been reinforced and extended. It stipulates that Community actions should be "directed towards improving public health,

preventing human illness and diseases, and obviating sources of danger to human health". This is undeniably a very broad remit, which covers virtually the whole gamut of health issues. But the Treaty does however, underline the key role of each Member State with regard to the health of its own population. And so, in view of this new dispensation, the Commission decided that the time was right for a new, more comprehensive approach to health. A policy capable of mapping out the journey from the concerns and challenges of our citizens today, to a greater state of well being for more of our citizens, for longer, in tomorrow's Europe.

In the light of these challenges, we launched a broad debate about the Community's future public health policy. Encouragingly, the preparatory debate produced a large degree of consensus about the way forward between stakeholders. And the new health policy proposals which I put forward for adoption by the Commission in May, build upon this consensus. The package consists of two main elements:

- A proposal for a new public health programme which will replace the eight programmes currently in force, and
- A Communication on the Community's overall health strategy.

Let me say a few words about both of these.

The proposed new six year 300 Million Euros public health programme concentrates on three key areas:

First, improving health information. Here we want to develop a comprehensive and authoritative information system for the general public, health professionals and health authorities. This will provide reliable and up to date information on key health-related topics which will be disseminated using the Internet, with links to national web sites.

Of necessity and in response to some of the concerns raised in the course of this seminar, let me say that to make a real contribution, the scope of this information system must be very wide. It will include information about trends in population health status, which can be disaggregated into major groups, as well as about factors influencing

health – smoking and diet, for example. It will contain data and analyses about health systems – for instance on their expenditure and how resources are used – and also about specific interventions.

For the general public a particular emphasis will be placed on providing information of use to people travelling to another Member State. And for doctors and other health professionals we want to provide the latest findings on health technology assessments and clinical guidelines.

And the Commission will provide a new health monitoring structure. This will provide a focal point – linked to national public health institutes – placed in the Commission's DG SANCO, a focal point at the heart of all these networks of information which will monitor, analyse and communicate the lessons learned from these processes. It will also serve to disseminate this analysis to the widest possible audience. Learning from our mistakes, and replicating our successes.

A second area will be responding to major health threats. Here we intend to develop a rapid reaction capability combining effective monitoring mechanisms with the ability to intervene swiftly to identify and evaluate problems and risks, and to take the necessary action in response. The aim is to enable the Community to act effectively to counter serious threats both from communicable diseases and other health risks, particularly if they affect people in a number of countries.

Finally, tackling health determinants – the underlying factors which influence health. The programme will aim to contribute to reducing premature deaths and illness in the EU from major diseases, such as cancer and heart disease, as well as the burden of mental illness. To do this it will focus on key lifestyle factors, such as smoking, alcohol, nutrition and drug dependence. In addition it will address the major social, economic and environmental causes of illness.

A specific focus will be on what the Community can do in tackling health inequalities, which I know is a major concern of the Institute of Public Health in Ireland. And I look

forward to working with you to develop our thinking on how to tackle this crucial issue effectively not only on this island, but also across Europe.

As well as pursuing these goals, the programme will also underpin the development of legislative measures in other areas of public health specified in the Treaty. These are in the veterinary and phytosanitary fields, and in relation to standards of safety and quality of organs and substances of human origin, and blood and blood derivatives. I do not need to remind anyone here about the significant problems that need to be overcome in relation to providing a safe and effective blood supply. Experts from this island have already made a major contribution to developing our policy in this respect.

But the new programme is still in the pipeline and it has to be jointly agreed by the European Parliament and the Council probably early in 2001. It will therefore take some time before it can come into effect. To ensure that essential public health work can continue in the meantime, the Commission has therefore also proposed to extend the existing public health programmes until the new programme begins.

Now the second part of the Health package, is the Commission's Communication on the Community's health strategy. This is the first time that the Commission has set out an overall approach to health across the different policy areas. The aim is to ensure that the impact of our public health programme is reinforced by policies and actions in other areas which have an effect on health and health systems. This means that the work undertaken on for example the internal market, social affairs, and research must actively promote health protection and can contribute to health improvement. Our aim is to mainstream health requirements.

More broadly, it implies that the Community must pursue an approach to health that is fully consistent and coherent. Upstream in the policy process this will mean targeting key policy proposals which have a particular relevance to health. Our aim is to demonstrate how health considerations have been taken into account and to show clearly the health impact that we expect from the proposal. Furthermore, we will work

to ensure that the coordination mechanisms within the Commission will be strengthened when policy is in genesis.

And finally, we will place a greater emphasis on health impact assessment and to develop and refine methodologies and criteria so that we can assess the health impact of specific policies and actions with greater confidence.

The final part of the package was the announcement that we shall be setting up a new body: the European Health Forum. I am conscious that there are demands from many quarters that policy-making at Community level should be more open, transparent and responsive. This new Forum will help to address this. It will bring together representatives of the public health community – voluntary bodies, health professionals, academics and patients' organisations – to discuss Community health issues and priorities. In this way all those with an interest will have the opportunity to make an input into the shaping and nature of the Health Forum about to be launched and I am sure many of you will have an interest in contributing to and following its progress.

Ladies and Gentlemen, our seminar today is about public health in Europe and the Irish connection. Health as a distinct policy issue for the European Community has had a relatively short history. Tackling the shared health concerns of our citizens irrespective of boundaries and the dictates of geography, is a challenge which we must work together to meet throughout Europe, from the Baltic to the Burren and from Budapest to Ballymena. But in the work of this Institute, we can take heart that common interests can find common solutions. In connecting with this positive Irish example, I hope that we can find a way to an inclusive European health policy that meets the needs of all our citizens in the new enlarged Europe of tomorrow.

Dr Richard Alderslade

Developing WHO policies for public health with special reference to tackling inequalities

Introduction

The European Region of the World Health Organization contains 870 million people, within 51 countries from Greenland to the Pacific coast of the Russian Federation. The Region contains the current member countries of the European Union and, with one exception, all of the applicant countries. It is a region of great contrasts, containing, as well as some very highly developed countries, also some very poor countries, struggling with the processes and consequences of democratic, social and economic transition.

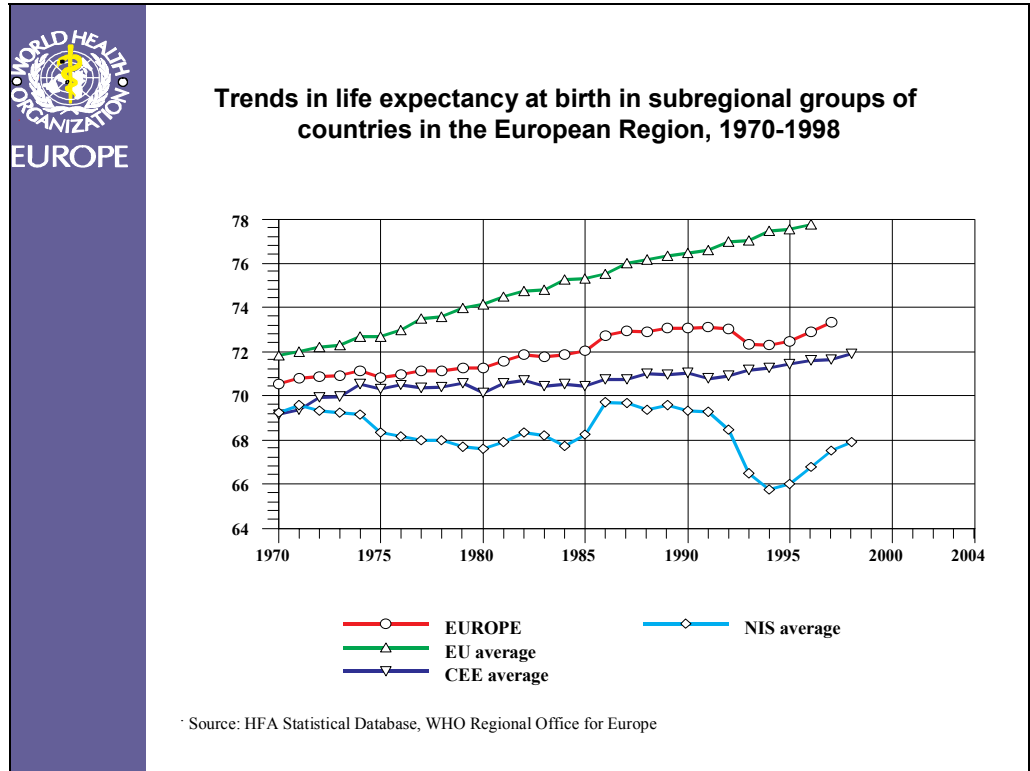
Current health experience in Europe

I have been asked to speak on public health policy with reference to inequalities. I shall start by looking at health experience. Across Europe from east to west, there are great differences in life expectancy and other fundamental health indicators, with very serious problems in the newly independent states (NIS) which emerged from the former USSR.

I would like at this point to review some of these health indicators briefly in a series of slides².

² CCEE stands for countries of Central and Eastern Europe

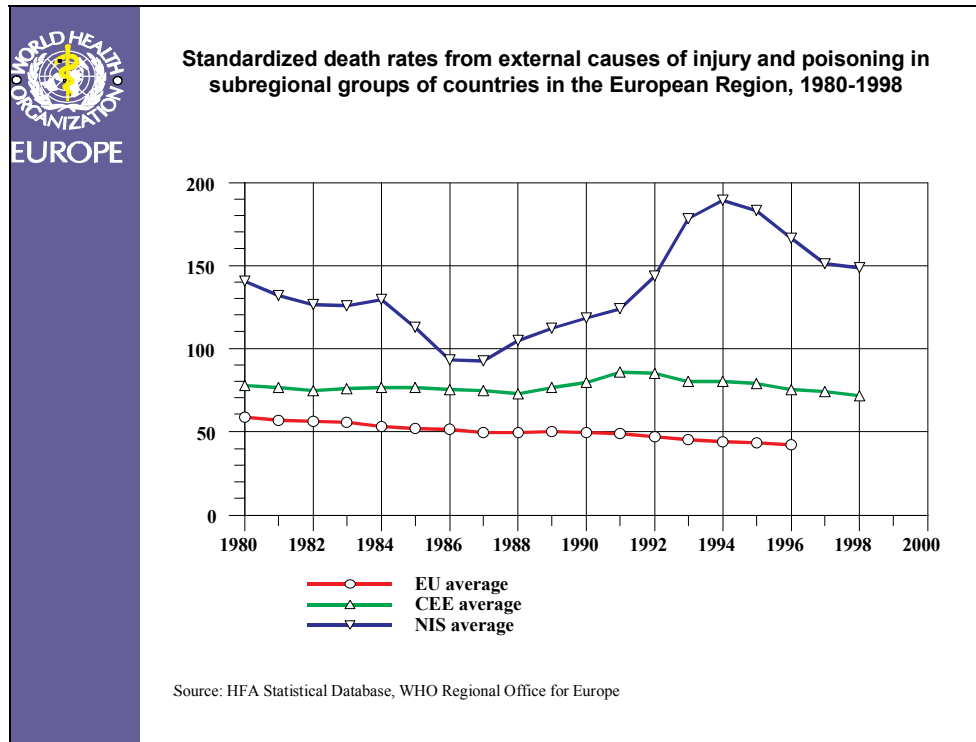
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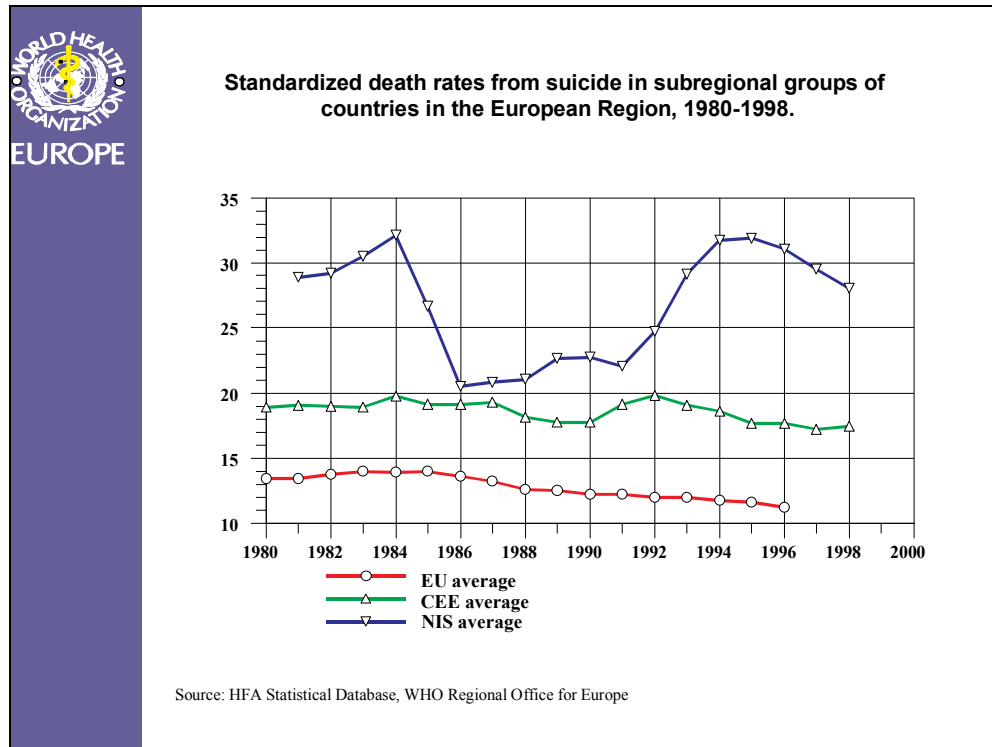
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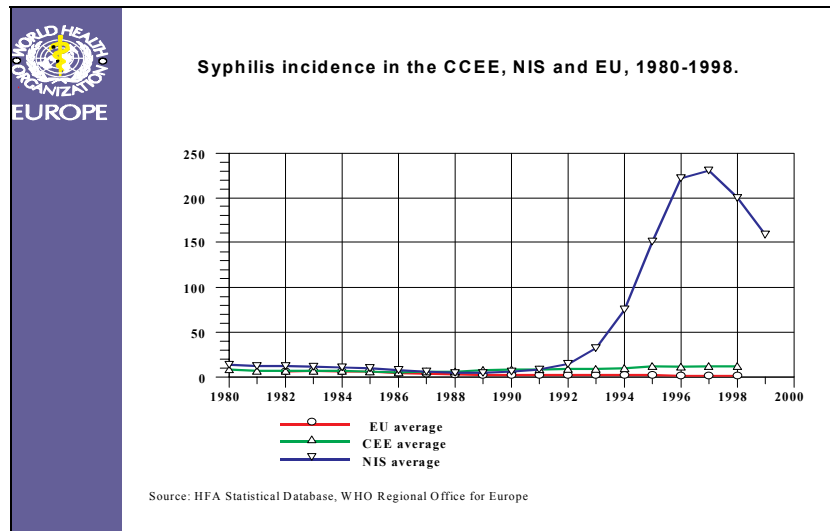
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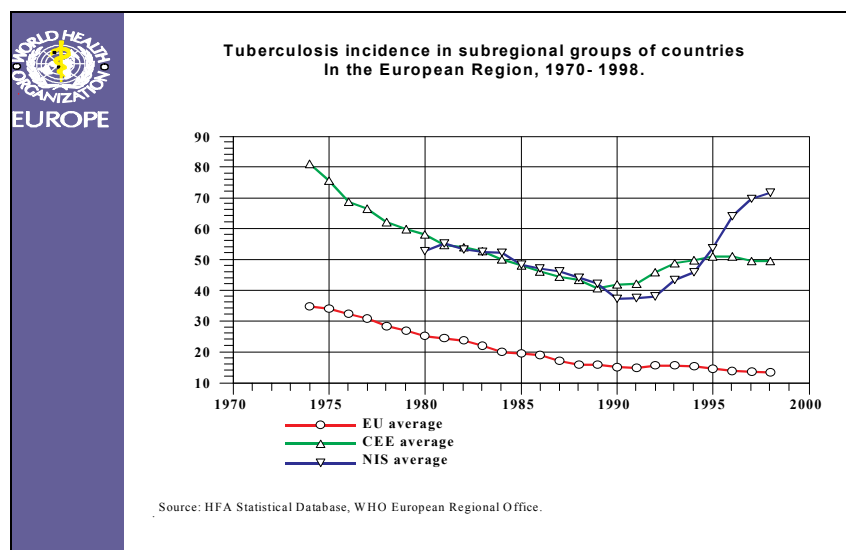
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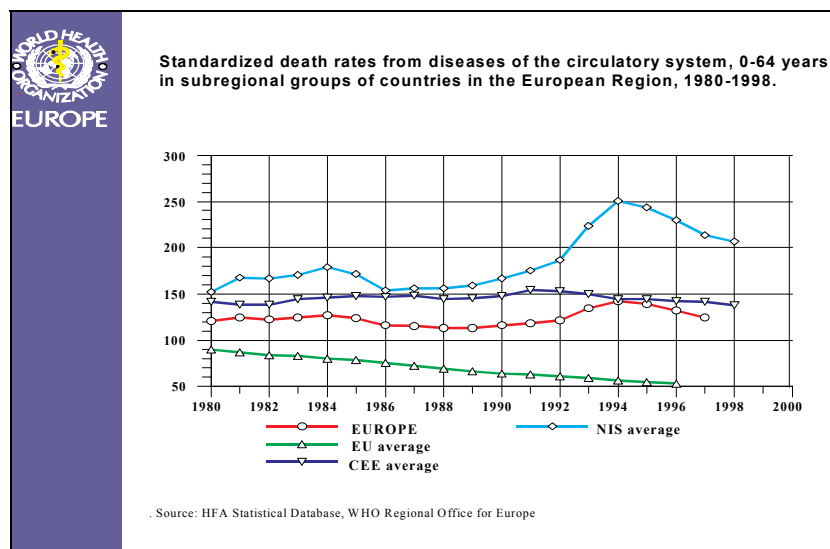
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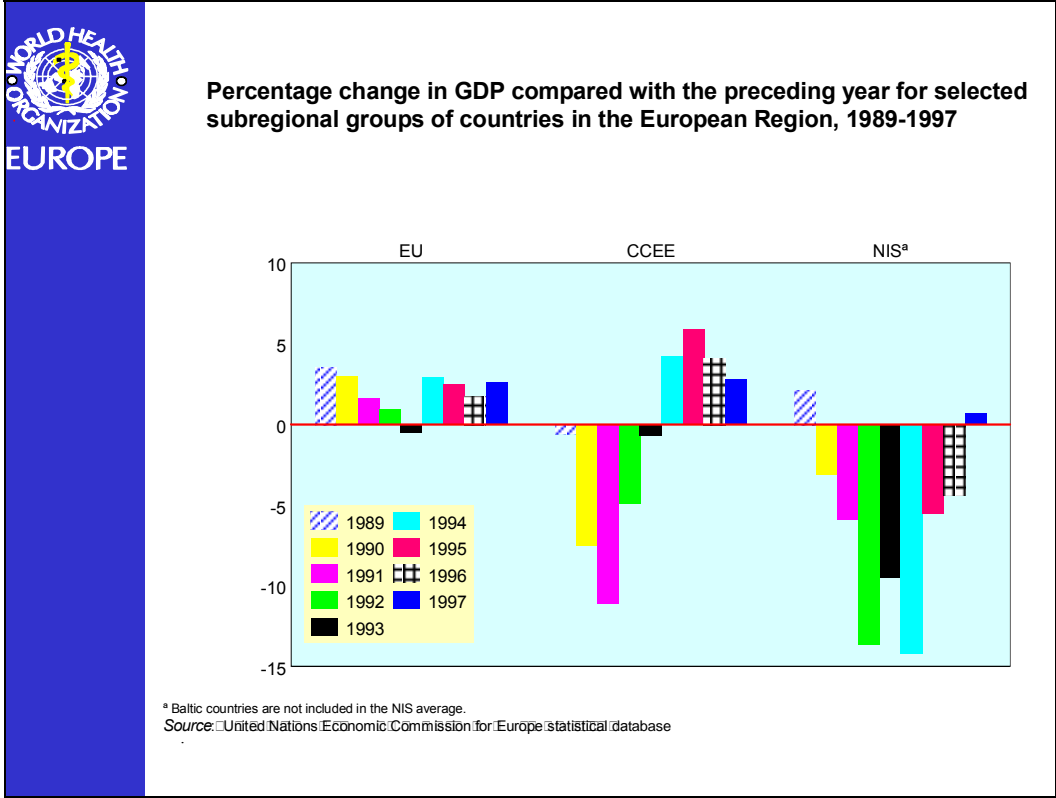
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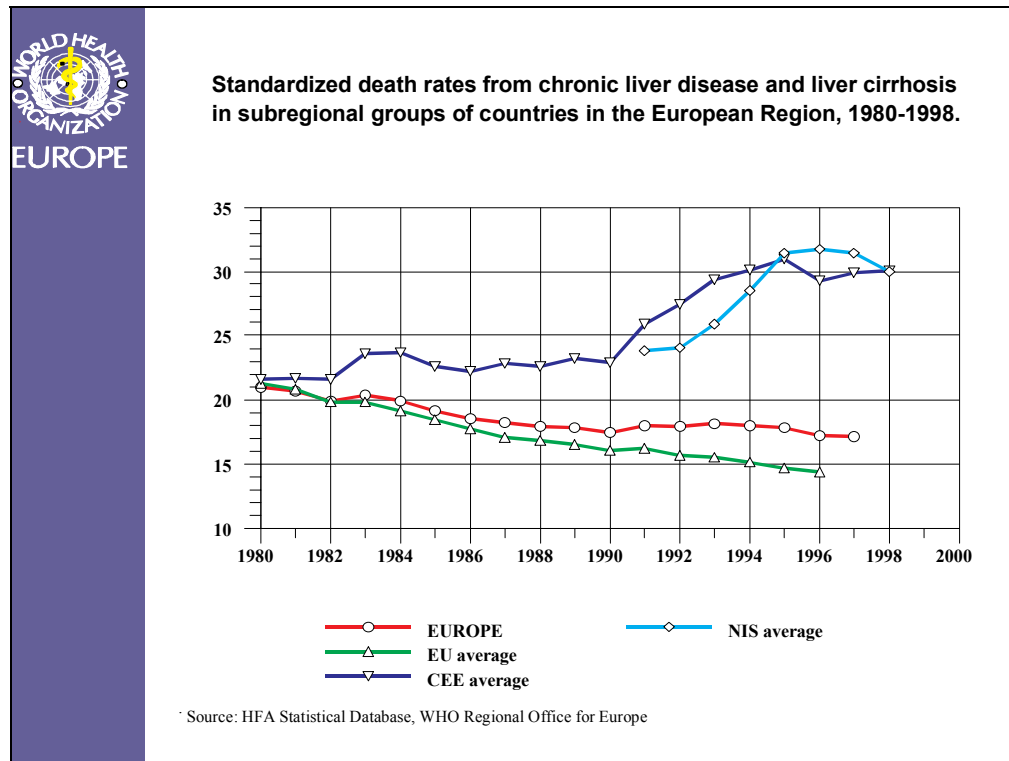
Although it is difficult to be certain, the precipitous reductions in life expectancy and health experience observed in the NIS during the period of political, social and

economic transition are perhaps unprecedented in history. They have been associated with the profound falls in production, economic output and incomes that have characterised this period. Happily there are some more recent signs that this process is stabilising somewhat, although the “East-West” health divide remains in Europe, on a scale difficult to think of in other than human rights terms. My next slide illustrates these economic aspects in terms of percentage change in GDP over the decade.

Slide 8



Associated lifestyle factors such as alcohol and tobacco consumption have also played a major role in these life expectancy figures.



A contaminated environment has also been important. The sorry state of the health system has also played a role in the degradation of health experience, although probably a small one.

The precise quantitative contribution of all of these factors remains uncertain, although the social and economic factors have plainly been of the first importance.

So far, I have focussed on differences between countries. However, within countries too, epidemiological analysis has indicated marked differences in mortality and morbidity experience between social classes and strata. To take a western European example within the United Kingdom, a child born today in the upper social class can expect to live for five years longer than a child born in the lower social class, and the childhood mortality rate for under 15's from injury and poisoning shows a five-fold difference between these social classes

The multiple determinants of health

We know then that socio-economic status and advantage are powerful determinants of health. The promotion of public health must therefore be taken forward in the context of the political, social, economic and institutional context of individual societies and the life circumstances in which countries find themselves, and in which their people actually live. Understanding these factors is fundamental to analysing the many differences in population health experience across and within societies.

Multisectoral public health policy

Investment in health represents an essential prerequisite for development as well as one of its most important consequences. And the relationship and balance between health and political, social, economic and institutional circumstance necessitates an integrated view of sustainable social development and a holistic approach to health policy. Public health policy must therefore place responsibility and accountability for health improvement across all sectors and actors within society.

Health contributes to, and results from, sustainable development. This requires a multi-sectoral approach to the development of policy and activities to achieve improvements in health, in which all the necessary political, economic, social and institutional components are considered together. And this approach must be effective at all levels within society, supra-nationally, nationally, regionally and locally.

Such an approach is much easier to define and describe than to deliver. Creating the political, administrative and managerial dimensions of public health policy, and securing the necessary commitment and accountability from multiple actors at the various levels, are difficult challenges to us all. Many who need to be convinced may not see the relevance of their activities to health, or may not wish to take responsibility and be accountable for their health consequences.

Furthermore, even if commitment can be secured, the actual development of collaborative and effective multi-actor policies and actions for health, and joint action

plans for their delivery, pose formidable organizational, managerial and budgetary problems.

Strategic health policy

For all these reasons, a strategic framework for health improvement within society is vital, providing a sense of common direction and purpose to attract individual and organizational loyalty and action. Within the European Region of WHO, the Health for All framework provides such a comprehensive framework for health improvement. The policy was first introduced in 1984, was updated in 1991, and has now been revised, alongside the adoption of the new global health for all strategy adopted by the World Health Assembly in 1998. The new European Regional Policy was adopted by the Regional Committee in 1998 and has been published as HEALTH21 - health for all in the 21st century.

The process of drafting the new policy was an inclusive one, involving an iterative process of consultation with scientific, policy and national interests, drawing in experience from the Regional Office's technical programmes at regional, national, and local levels.

Based upon Health for All (HFA) principles, the development of national framework strategies is strongly promoted by WHO, augmented also by regional and local strategies. Indeed there is now much interest in decentralised local strategies, which build on the commitment and involvement of the institutions of local governance, civil society and the private sector, and which can also facilitate the construction of collaborative networks and settings for health, eg healthy cities, healthy schools, etc.

At the core of Health for All at all levels is our belief that the quality of human life should stand high in each societal list of priorities, with health being seen much more clearly as a key political goal. We place great emphasis on the critical links between health outcomes and the processes of economic growth. Increasingly, investments in health will be valued and considered in the balance with all other investment decision-making criteria. Health outcomes will be seen as benchmarks in measuring progress

towards the reduction of poverty, the promotion of social cohesion and the elimination of discrimination.

HEALTH21, the WHO regional health for all policy has one constant goal which is to achieve full health potential for all.

It has two main aims:

- To promote and protect people's health throughout their lives, and
- To reduce the incidence of the main diseases and injuries, and alleviate the suffering they cause.

Three basic values form the ethical foundation of HEALTH21:

- Health as a fundamental human right
- Equity in health and solidarity in action between all countries and their inhabitants, and
- Participation and accountability of individuals, groups, institutions and communities for continued health development.

Four main strategies for action have been chosen to ensure that scientific, economic, social and political sustainability drive the implementation of HEALTH21.

- Multi-sectoral strategies to tackle health determinants, employing health impact assessments in policy development, implementation and evaluation
- Health outcome driven programmes and investments for health development and clinical care
- Integrated family and community orientated primary health care, supported by a flexible and responsive hospital system, and
- A participatory health development process that involves partners for health at home, school and work, and that is based upon joint decision making, implementation and accountability.

Twenty one targets for health have been set to inform the needs of the whole European Region and suggest necessary actions, supported by a range of indicators agreed and monitored at the European level. All these elements of HFA together constitute an inspirational framework for developing health policies in the countries of the European Region.

The implementation of policy

WHO's aim is to produce broad societal movements for health through unifying policies, innovative partnerships, and good management. For its part the WHO Regional Office for Europe should give strong support by playing the following five main roles.

- Acting as a "health conscience"
- Functioning as an information centre on health and health development
- Promoting the Health for All Policy throughout the Region
- Promoting up-to-date evidence based tools for countries to turn policies into action
- Working as a catalyst for action.

One issue is worthy of emphasis. Public health leadership is essential, to create and disseminate understanding of population health experience and its determinants, as well as to create and manage the implementation of strategies for health improvement. This process has been defined as "public health management". An understanding of the issues and the strategy by politicians, professionals and people themselves, and their commitment to its implementation, are crucial to success.

Certain policy and management tools are required. One tool is health impact assessments, whereby the potential health effects of wide-ranging policy proposals can be modelled and considered explicitly and transparently within the policy-making and decision-taking process. Our policy will promote the development and use of such assessments.

Another vital tool is health or health improvement programming, whereby agreed collaborative strategies for health improvement are focused around known disease entities and problems. Health improvement programmes should be seen as one of the main policy instruments to achieve health improvement both nationally and locally.

The new geopolitical environment

I have spoken positively about WHO's mandate and role in public health improvement within Europe, but also since the political and economic transformation of central and eastern Europe, there has been the growing interest of other intergovernmental organizations (IGOs) in health policy issues. They have reassessed the health sector giving it new emphasis in their programmes.

One example has been the World Bank's 1993 World Development Report, "Investing in Health", which focused international attention on the potential for achieving health gain and reducing the burden of disease, thereby ensuring healthier and more productive lives, particularly for the poor.

Now the EU's public health mandate has been reaffirmed and strengthened in Article 152 of the Amsterdam Treaty. The recent Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the development of a public health policy for the European Union is of the utmost importance. Additional very important factors are health challenges posed by, and the health dimensions of, the enlargement process.

WHO warmly welcomes this commitment for health by other agencies, and explicitly the developing mandate and public health activities of the European Union.

Healthcare as a public health issue

The time is opportune to reassert the case that health is not a resource hungry consumption item but a necessity without which there can be no development. There is an urgent need to reposition health politically by putting health into the core of social and economic development, so that public policy links together determinants of health,

human development and sustainable economic development. There needs to be a conscious reassertion of this health agenda.

Public health policy within the European Region

Taking health forward will require good evidence and good people. As is now argued for medical practice, policy must be based on the best available evidence, and there must be a systematic health intelligence function to ensure that evidence is collated, ordered, and used. The complex interface between research and policy making is becoming better understood, but certainly here the task is challenging and unfinished.

Public health leadership is essential to analyse and disseminate understanding of population health experience and its determinants, as well as to create and manage strategies for health improvement. Economists, sociologists, and other scientists, must join with public health experts to form a pool of “public health managers” sharing perspectives and analyses in a way which can reveal fresh insights and possibilities for intervention.

Such leadership builds alliances of political, administrative, professional and public support. These “public health managers” must be skilled at managing across boundaries, between professions, institutions and agencies, or population groups, and helping people cope with uncertainty. This will require rethinking the way strategies are built and negotiated at different levels, and how multi-partner actions and alliances, are nurtured. New forms of accountability and governance will be required. Adaptable organizational structures will be needed.

Such a leadership role will be about change. It will be much more demanding than roles expected of earlier generations, and the educational requirements are substantial. It is here, above all, with the promotion of such educational institutions and opportunities within Europe, that the success of HFA can be created and ensured.

Dr Paul McKeown

Information for Wellbeing and Health in Ireland and Europe

Commissioner Byrne, Dr Wilde, Colleagues, Ladies and Gentlemen, I would like to thank the Institute for inviting me to speak today. I am going to discuss information for health and wellbeing and the evidence that public health needs to be effective.

What is public health?

Public health is the discipline concerned with improving health. So what is it? My favourite definition is that of the US National Institute of Medicine:

Public health is what **we, as a society do collectively** to **ensure the conditions** in which people can be **healthy**.

It has been described as consisting of three elements:

- **COLLECTIVE ENDEAVOUR:** public health is an activity for society, operated through the institutions of the state – a societal response. Here, public health is defined as a series of government policies. We are where we are today because of a series of policies that were chosen in the past, and likewise the policies we choose today will dictate where we end up
- **ENSURING THE CONDITIONS FOR HEALTH:** it is not direct cure or care; it operates at a remove from these areas
- **DEFINING HEALTH:** as not merely the absence of disease, but an acknowledgement that the experience of life is greater than merely being “not sick”.

Closing the Circle

- Information for health must come from somewhere. What path does health information take? And how can it be used to improve health?
- The information starts with the public, the reason we all come to work

- Information is collected and is used to provide knowledge to inform policy which should ideally be used to drive improvement
- Closing the circle is important to ensure that information is being put to the best use.

Describing Health

Describing health is the first step in its improvement.

Traditionally mortality and morbidity data have been used to describe health but in fact these measures relate to illness and disease, however they are considered by many to be a proxy for health.

It is now being realised that a range of factors influence health and contribute to wellbeing.

Wellbeing is an important element of health, in fact, health is increasingly being considered a by-product of wellbeing.

The Solid Facts

A substantial body of research has now identified the principal socio-economic determinants of health and wellbeing. Each of these pieces of evidence has potential policy implications.

1 Health follows a social gradient

- Poor people have twice the risk of serious illness and premature death as the well off
- Deprivation is relative – The Whitehall II study showed that lower rank civil servants had poorer health than higher ranks despite the fact that the lower ranks could not truly be described as deprived.

2 Stress is a predictor of ill health

- Low self-esteem, anxiety, insecurity, social isolation, lack of control over work and home life produce stress with resulting depression, increased blood lipids and disordered glucose tolerance.

3 Future health depends on early life influences

- Parental deprivation (characterised by poverty, poor diet, smoking, substance abuse) can lead to poor foetal growth and impaired cardiovascular and respiratory development
- Mental exhaustion and depression lead to reduced stimulation and poor emotional attachment increasing the likelihood of truancy, delinquency, crime, unemployment, and low-status, low-control jobs. And this ultimately leads to reduced cognitive functioning in old age.

4 Social exclusion affects the poor and is a powerful predictor of ill health

- Emigrants, ethnic minorities, refugees, people with disabilities and those from institutions are especially at risk often through exclusion from employment opportunities.

5 Work and health are closely linked

- Stress at work (generally related to social status) contributes to large differences in health and premature mortality particularly due to cardiovascular disease.

6 Unemployment and premature death are inextricably linked

- Moreover, job insecurity increases the likelihood of depression, anxiety and heart disease.

7 Social support supports health

- Strong social support contributes to health by providing people with emotional and practical resources

- Societies with higher levels of income inequality tend to have less social cohesion, more violent crime and higher death rates. There is evidence which demonstrates that levels of heart disease are inversely proportional to levels of social cohesion.

8 Addiction is associated with and increases health and social inequalities

- Substance misuse is (depending on the substance) powerfully associated with death and disability from accidents, heart disease, cancer and mental ill health.

9 Food and health are very closely bound

- Shortage of food leads to malnutrition while
- Food excesses contribute to cardiovascular disease, diabetes, cancer, obesity and dental caries.

10 Transport influences health

- Cycling, walking and using public transport promote health by providing exercise, reducing fatal accidents, increasing social contacts and reducing air pollution.

Important Initiatives - WHO

What other initiatives are giving us pointers about the kind of information we should be collecting?

The HEALTH21 Programme, the WHO Europe Health for All Policy Framework

Aims at:

- protection and promotion of health and
- reduction in disease and injury and alleviation of suffering.

HEALTH21 is characterised by Target Setting and much work is being done in relation to definitions of inequality and in performance management of health systems.

HEALTH21 has highlighted the need for improved information gathering systems and better quality information.

Important Initiatives – EU

The EU's role in public health is to complement the work of the member states and to deal with issues beyond the capacity of the individual states.

Amongst the issues which drive the need for high quality information are:

- The requirements for Consumer Protection
- The requirements of the Treaty of Amsterdam
 - health protection in all legislation
- The requirements of the EU Public Health Strategy which is built on 3 pillars
 - A comprehensive health information system
 - Mechanisms to make timely responses to major health threats
 - Addressing health determinants
- And the demands of Enlargement.

These will all require improved quality of information and enhanced information gathering systems.

Important Initiatives - UK

Initiatives closer to home include:

The appointment in 1997 by the incoming Labour Government of ***a Minister of Public Health.***

The Independent Inquiry into Inequalities in Health chaired by Sir Donald Acheson which recommended amongst other things that

- All government policies with health implications be evaluated in terms of impact on health inequalities.

An evaluation Group advising the Acheson Group looking into inequalities noted that they:

“could see no reason why fiscal, social, economic or educational policies should not be subject to the same type of systematic collection and examination of evidence as is applied to medical interventions .”

In effect, this was a call for evidence-based policy-making.

Subsequently, a comprehensive Government wide public health strategy for England, ***Saving Lives: Our Healthier Nation*** was launched:

- In which Government is being given responsibility for creating the conditions for health and
- Individuals/local agencies are acting to improve the health of local communities eg through Health Action Zones.

An NHS Information Strategy for healthcare in the UK is currently being developed.

In Scotland the Scottish Executive has published a health strategy ***Working Together for a Healthier Scotland***.

Following on from this ***Towards a Healthier Scotland***, a White Paper on Health for Scotland has been published which plans to improve life circumstances by:

- improving lifestyles with
- targeting of specific disease categories.

Their objectives will be:

- to map and monitor outcomes and determinants
- to identify and develop better ways to measure disadvantage and
- to measure inequalities.

In Northern Ireland **A strategy for improving health and wellbeing** "Well into 2000" **identifies:**

- tackling social exclusion
- incorporation of principles of social justice in all policies and strategies for health and wellbeing
- tackling inequalities
- redirecting public policies towards the promotion of good health and wellbeing as being vital components of health protection and promotion.

Aims of Strategies

A central concept underpinning all these strategies is that health is a fundamental human right.

They seek to produce:

- Improvement in health and wellbeing
- Reduction of inequalities

and are characterised by being

- Driven by Government based policies and
- Implemented through community based action.

Irish Initiatives and Influences

Currently there is an important drive for improved health information in Ireland that includes:

- Public Opinion: increased expectations and demands for greater accountability
- Financial Drivers: value for money and demonstrable benefit
- ICT advances: rapid information exchange
- Evidence based practice: applying best evidence to individual cases
- Governance: particularly in terms of risk management and accountability
- Current Health Strategy - Shaping a Healthier Future: aims for improved health and social gain through systems based upon accountability, equity of access and quality of service

- Health Board annual service plans and annual reports: form the foundation for a statement of intent based on identification of need
- Departments of Public Health: a strengthening in public health capacity
- Health Surveys
- Small Area Research using District Electoral Divisions (DEDs) eg Small Area Health Research Unit (SARHU)
- National Health Information Strategy: a strategy to guide the development of the ways in which we capture and use information to improve health.

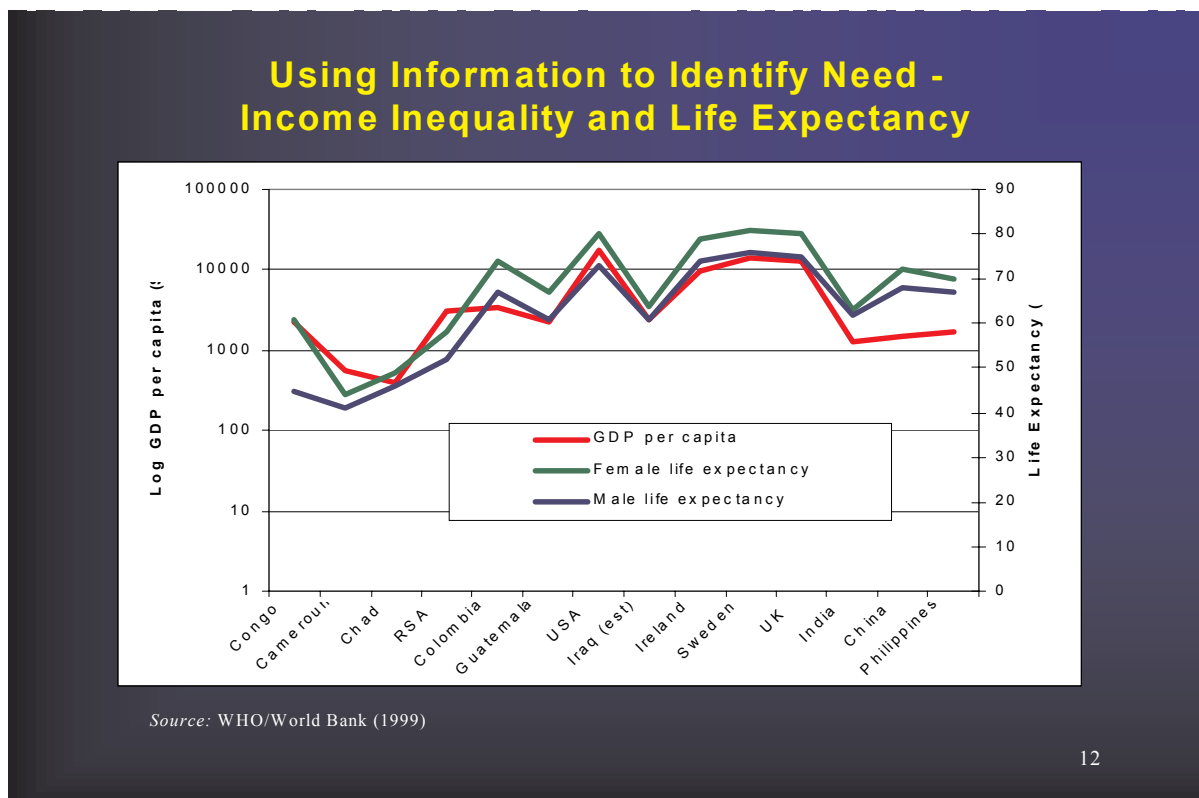
Where should we be looking to gather information that will allow us to identify and prioritise those areas requiring policies for change?

The following are given as examples of relevant information which should be useful in influencing policy change.

Income Inequality and Life Expectancy

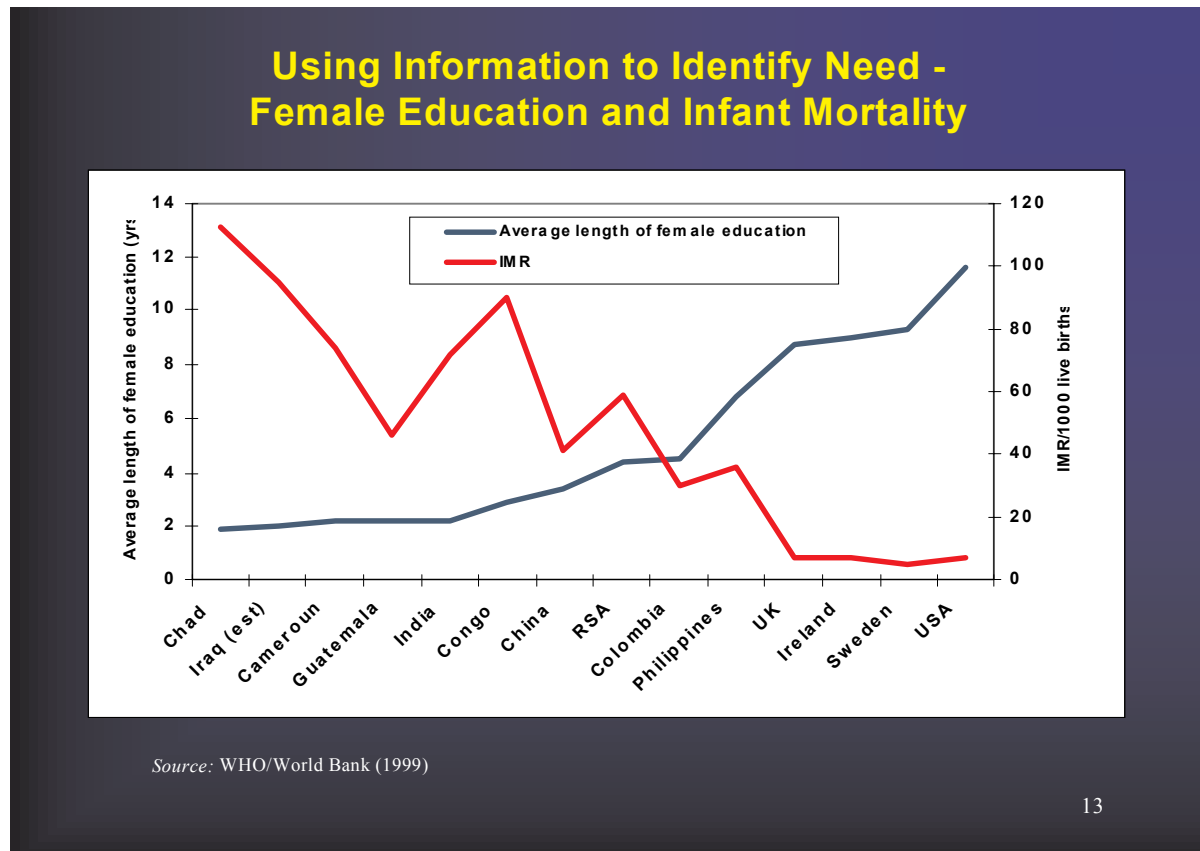
As noted before, income inequality and health are linked.

This graph looks at GDP per capita and life expectancy in various countries. There is close correlation between the two.



Female Education and Infant Mortality Rate (IMR)

This graph looks at length of female education and IMR. They are inversely proportional. The longer girls stay in school, the less likely are their subsequent children to die in the first year of life. These figures relate to nations but the same pattern is seen within western nations when comparing better and worse off sectors of society.



General Practitioner (GP) location Dublin

When the odds of finding a surgery in a deprived area are calculated, it becomes clear that the odds fall with increasing deprivation so that the most deprived areas have one third the likelihood of having a surgery as the better off District Electoral Divisions (DEDs).

This situation has come about largely as an unintended spin-off from what was called the 5-year rule. Under this rule, it was necessary to remain in practice in an area for 5 years to become eligible for a General Medical Service (GMS) patient list. With no

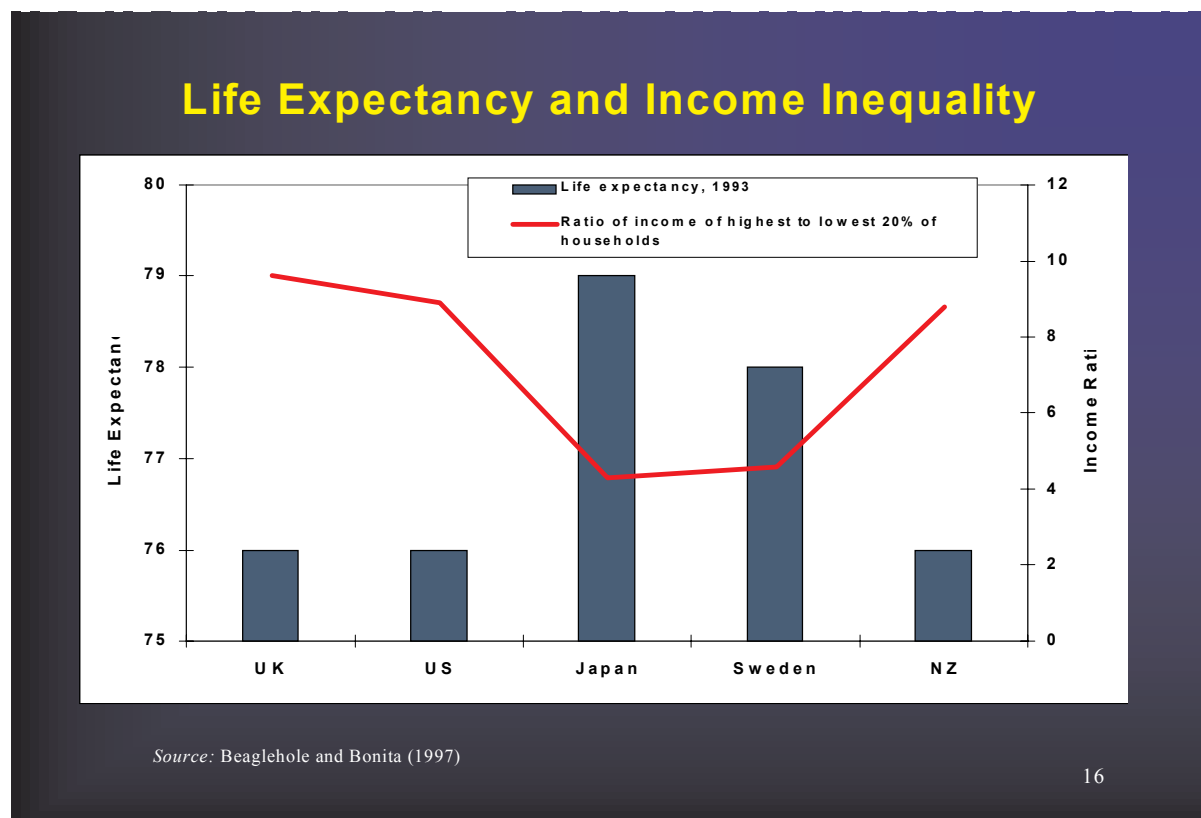
income from a list GPs had to generate money and most did this through private work. Since there are fewer fee-paying patients in deprived areas many GPs established themselves in better off areas.

This is an interesting example of a policy having unintended repercussions and a very good example of what can happen when the free market is allowed to dictate health service provision.

Life expectancy and income inequality

Subtle differences in health experience exist between the wealthiest nations and these can give important clues about which national policies are likely to be more effective.

The following graphs relate to differences between 5 wealthy countries, UK, US, Japan, Sweden and New Zealand.



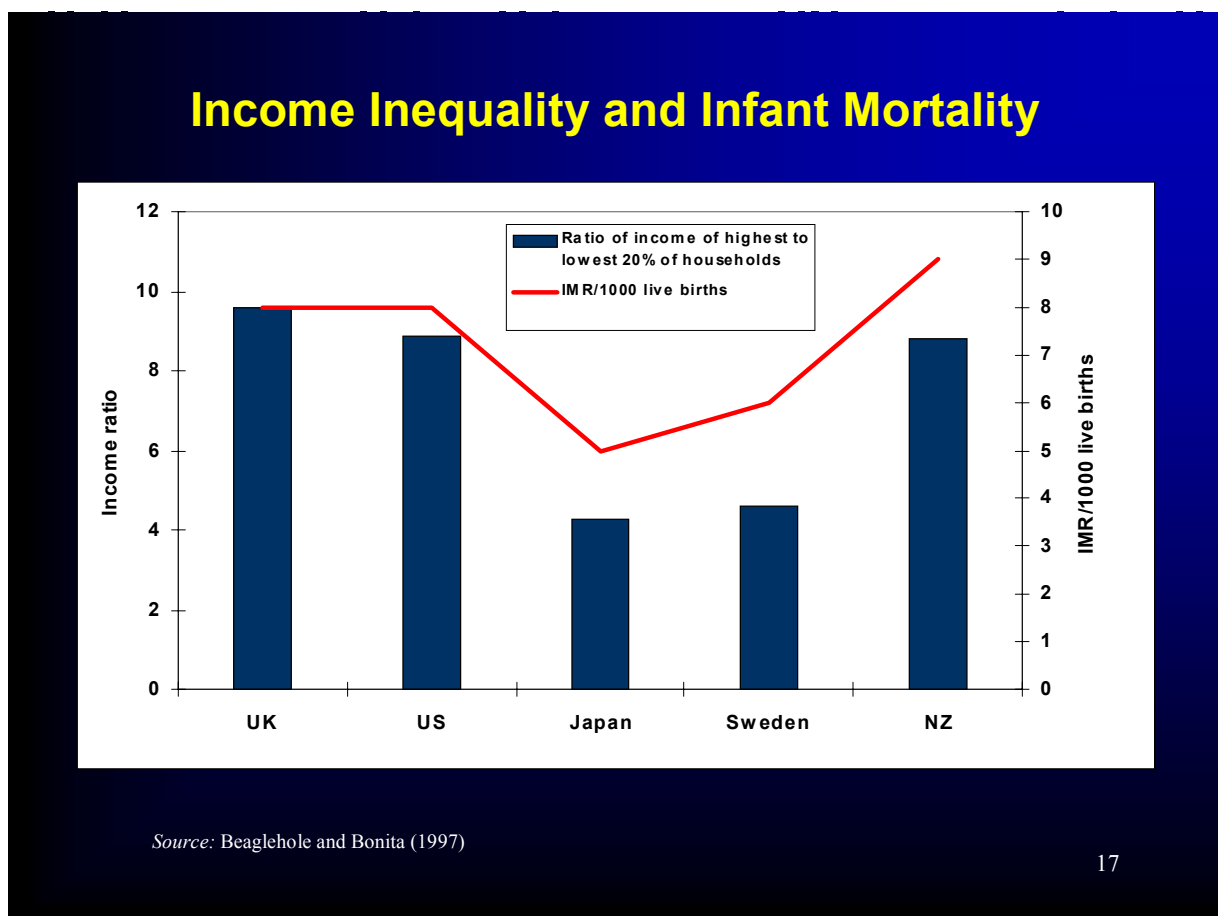
Income ratio is the ratio of the highest to the lowest 20% of households (numbers close to 10 indicating more **unequal** income distribution and numbers below 5 indicating more **equal** income distribution).

Life expectancy and income inequality are inversely proportional – the less the income inequality, the greater the life expectancy.

Income inequality and infant mortality

Again, even between wealthy countries, considerable differences in health experience exist.

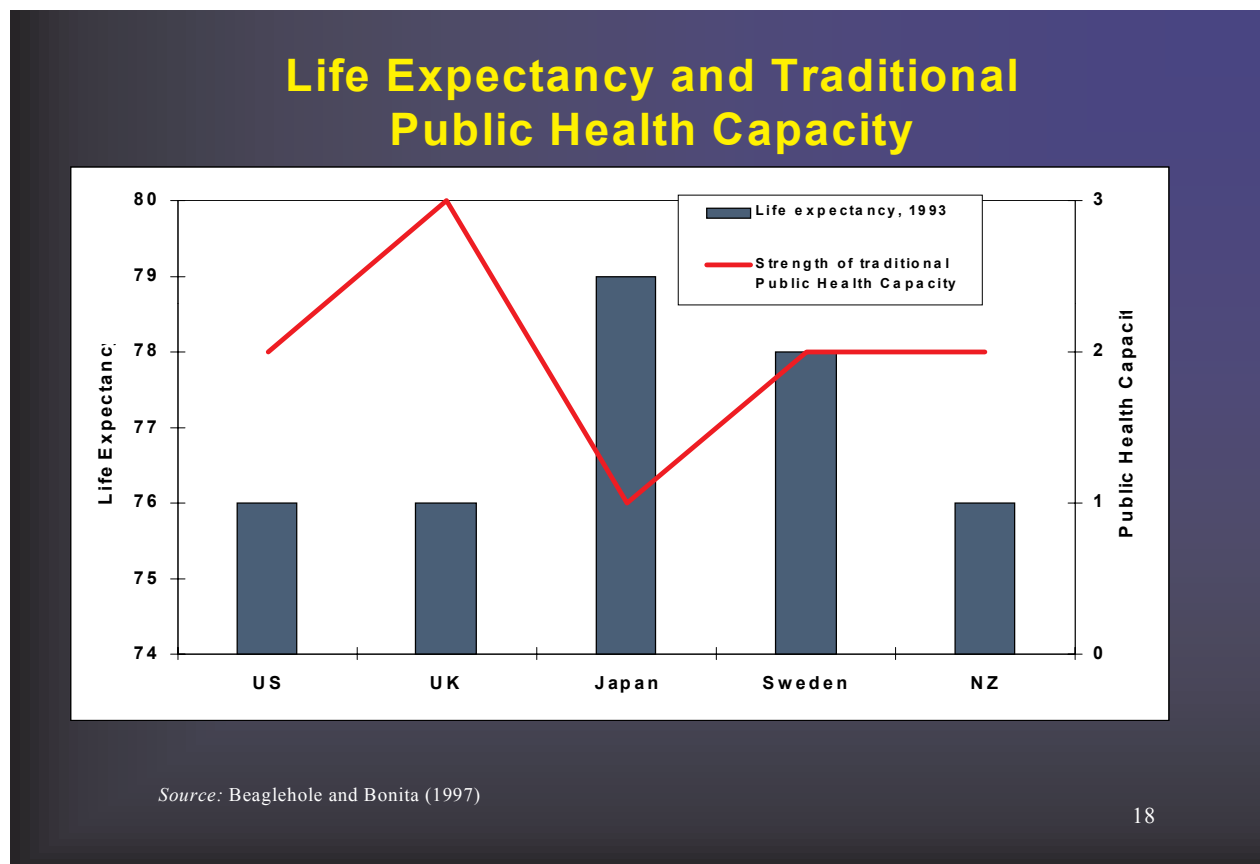
Here, income inequality and infant mortality are directly proportional - the greater the income inequality, the greater the IMR.



Life expectancy and traditional public health capacity

Life expectancy and the extent of traditional public health capacity are inversely proportional.

In this diagram, traditional public health capacity for each of the 5 countries is ranked from 0-3. The public health capacities considered include research, the science base, level of public health education and training and the strength of professional organisations.



Those countries with what is being arbitrarily described as a stronger traditional public health function appear, in general, to have shorter life expectancy.

Before anyone sets off for the local job centre, it is worth remembering that traditional public health capacity has been more concerned in the past with the back end of things, epidemiology and research rather than the front end of getting research into policy and practice and its likely that Japan and Sweden have been rather more successful in these areas.

EU Public Health Monitoring

Part of the enhanced EU capacity to respond to threats and to assist member states in making valid comparisons internally and externally has been in the development of health monitoring. This process recognises that information beyond that traditionally gathered will be necessary to fully describe health.

The aims of the Health monitoring programme are

- Preventing Disease
- Protecting Health

And its objectives are:

- To measure health status, trends and determinants throughout the EU
- To facilitate planning, monitoring and evaluation of Community programmes and actions
- To identify new priority areas for public health
- To provide comparative information on health to Member States to support national policies.

EU Health Indicators

An important element of describing health is to ensure that data should be largely person-based rather than event based. Part of this process involves the development of health monitoring indicators. These indicators are an attempt to ensure standardisation in the information being collected, so that comparisons, be they local, regional, national or EU-wide are meaningful.

This process isn't yet complete but typical indicators to be chosen are likely to include:

<p>1. DEMOGRAPHIC AND SOCIO-ECONOMIC INDICATORS</p>	<p>Total population</p> <p>Birth data</p> <p style="padding-left: 40px;">Migration data</p> <p style="padding-left: 40px;">Projections</p> <p>Educational attainment</p> <p>Population by occupational class</p> <p>Ethnic origin</p> <p>Population by income level</p>
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<p>2. HEALTH STATUS INDICATORS</p>	<p>Mortality</p> <p>Life Expectancy</p> <p>Inequalities in mortality</p> <p>Cause Specific Mortality</p> <hr style="border-top: 1px dashed black;"/> <p>Morbidity</p> <p>Diseases of major importance</p> <p style="padding-left: 40px;">Circulatory diseases</p> <p style="padding-left: 40px;">Cancer</p> <p style="padding-left: 40px;">Accidents</p> <p style="padding-left: 40px;">Mental conditions</p> <p>Diseases with potential for prevention</p> <hr style="border-top: 1px dashed black;"/> <p>Generic Health Status</p> <p>Self assessment surveys</p> <p>Mental health</p> <p>Quality of life</p>
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3. DETERMINANTS OF HEALTH INDICATORS	Personal	Body Mass Index Birth weight Blood Pressure, cholesterol
	Biological	Coping ability Autonomy
	Behaviour	Substance use Nutrition
	Living/working	Physical environment air, housing, water, sewage, accidents Working conditions Social networks

4. HEALTH SYSTEMS	Prevention Protection Promotion
Healthcare Resources	Buildings Manpower
Healthcare Finance	Health care expenditure
Healthcare Utilisation	Hospital and GP activity data
Quality Indicators	Quality Indicators

The use of indicators in measuring outcome as well as process is an important step in increasing the effectiveness and efficiency of health systems.

Future for Information for Health

The following are key areas that will contribute to better information for health in the future:

- National Health Information Strategy
- Greater intersectoral action to tackle the determinants of health
- More health impact assessment which is a means of evidence based policy making for improvement in health. It involves the assessment and improvement of the health consequences of projects and policies particularly in the non-health sector
- Other national requirements
 - Expanded use of GP data
 - More electronic transfer of data
 - Geocoding of data
 - Unique identifier
 - Private health data
- Increased output from the National Surveillance bodies
 - National Disease Surveillance Centre (NDSC), Food Safety Authority of Ireland (FSAI), National Cancer Registries (NCRs)
- Upcoming Health Strategy
- National and EU legislation
- Closer links with international organisations.

Conclusions

- Information for health is about more than healthcare or even health itself
- We need information about what factors make for societal wellbeing
- We need to decide what sort of society we want and
- Having decided this, we need to put policies in place, based on the soundest evidence, to improve societal wellbeing. We need to develop an evidence based policy capacity
- We already have a lot of evidence about which policies are likely to be beneficial therefore these need to be put into practice

- Promotion and protection of health will depend on a strategic approach, only then are we likely to improve health and to reduce avoidable, premature mortality, unnecessary morbidity and health and social inequalities
- We can learn much by cooperating closely with our immediate and European neighbours in these areas
- Careful monitoring of this process will be necessary to ensure that we are producing the changes we want.

Dr Pat Wall

Responding Rapidly to Public Health Threats – Can Ireland Cope?

Responding rapidly to public health threats is one of the strands that the Commission has identified as being central to its proposed programme for public health.

In this presentation I want to outline the threats as I see them and I also want to pose the question "Can Ireland cope with the ever expanding number of threats to public health and can it respond rapidly?" What are the main threats?

A main area which impacts on public health is the area of communicable disease which includes vaccine preventable diseases, hospital acquired infections (anti-biotic resistant pathogens), blood borne viruses, food and water borne disease.

Environmental factors eg stress and lifestyle issues such as smoking, alcohol and drug misuse are also critical influences on public health. Smoking related illness contributes to more than 6,000 premature deaths in the Republic of Ireland each year.

In terms of diet which is a major contributing factor to cardiovascular disease we eat too much of the wrong food.

The single market and increased opportunities for travel also poses threats permitting people and products and consequently germs, to move freely.

Two areas where enormous progress is being made, transport and communications, also bring concerns about the impact on the public's health of these developments. Traffic congestion has become a major threat and we are currently not coping very well at solving this problem. It contributes to environmental pollution, road traffic accidents and driver stress. In the case of technological development increased and faster communication leads to greater pressures both at work and at home which undoubtedly leads to greater stress and is consequently a threat to public health. Children are

benefiting from technological developments and spending increased time in front of computer screen at the cost of less time spent involved in healthy physical pursuits and team games.

These areas may be summarised by reference to this slide.

What Public Health Threats ?

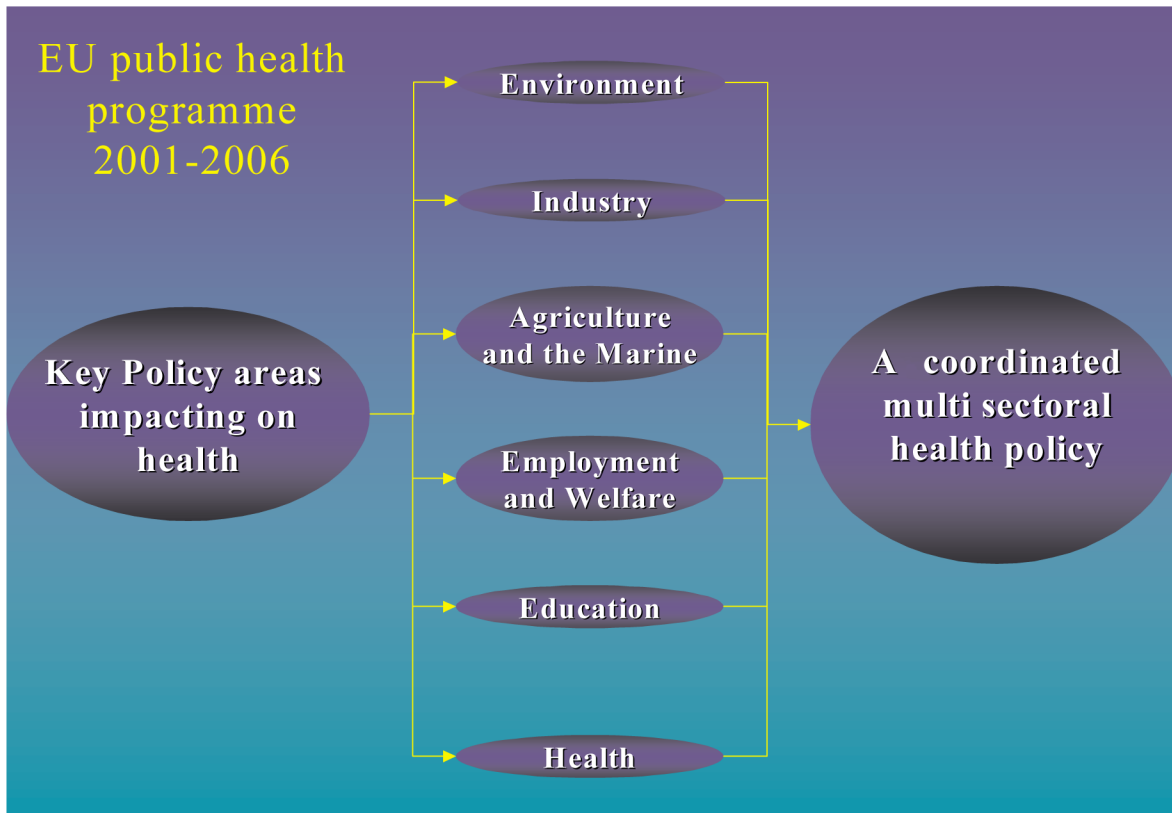
The slide is titled "What Public Health Threats ?" and is divided into four quadrants, each with a title and an image:

- Communicable Disease:** An aerial view of a residential neighborhood with houses and trees.
- Single Market:** An orange and white airplane flying over a blue sky, with a man and a woman in swimwear floating in the water below.
- Environmental:** A person wearing a blue apron and a respirator mask, holding a spray nozzle, next to a hand holding a mobile phone.
- Lifestyle:** A McDonald's restaurant with a drive-thru, a cigarette, and a hand holding a mobile phone.

Responding to threats

In considering these threats and the new EU Public Health Programme we must consider the key policy areas which impact on health and the requirement for coordination so that effective multi sectoral health policies are developed.

The key areas are identified in this slide.



Having identified the key areas we must ensure that relevant policies are developed within each of these areas. Some policy documents are already in existence and of value such as the National Health Promotion Strategy, the National Environmental Health Action Plan and the Cardiovascular Disease Strategy but these documents will not be effective unless a range of players are brought on board and participate. Many policy decisions taken outside the realms of the health service impact on the determinants of morbidity. Therefore a multi sectoral approach is required if the health of the nation is to be improved. Some of the relevant players in the public health arena are listed on this slide.

Some of the Players:

Government Departments
Environmental Protection Agency
Road Safety Authority
Health and Safety Authority
Tobacco Control Agency
National Disease Surveillance Centre
Health Promotion Unit
Food Safety Authority & FSPB
National Cancer Registry
Small Area Statistics Unit TCD
Eurocat - Congenital Defects
Proposed National Centre for Toxicology

Health Boards **Public Health, Environmental Health**
Local Authorities **HPU**

The challenge for us on this island is to respond in a coordinated, structured manner with each agency planning its own role, not on its own, but in a coordinated context. This ability will not come about by accident, we must embark on action that will facilitate the establishment of structures that enable us to respond effectively and speedily to the latest and newest threat to public health. We have experience to learn from and we must use available evidence, use what we know works best in setting in place response mechanisms that work. There is a role for the Institute of Public Health in assisting the development of this response mechanism on an all Ireland basis.

Ms Karen Meehan

Addressing Health Determinants through Health Promotion and Disease Prevention

To effectively address health determinants we have to know what they are and also have a sense of what people experience them to be.

Within the third dimension of the EU Programme they are being described as:
Environmental, Socio Economic and Lifestyle.

To my mind this is somewhat bald. Other people's definitions include these three but add:

policy climate, quality of health care and fixed factors of genetics, gender and ageing.

Many writers on health determinants split up the economic and social and, in looking at the latter, focus on the issue of social capital. In preparing for today I asked colleagues at Derry Well Woman what they felt determined their well being.

What is interesting about this is:

- a people have a clear sense of what is affecting/determining their health
- b how reflective of the professional themes these specific issues are
- c the dimensions of our wellbeing that they reflect - physical, emotional and spiritual.

To my mind there are two challenges for us in addressing health determinants:

- 1 To marry professional and ordinary people's views of determinants because it is only by doing so that our work will be relevant and meaningful to people and that we will get a sense of specific actions to tackle big themes
- 2 To remember that there are three inter-related dimensions to our wellbeing.

How then do we address the determinants and how does health promotion contribute?

The Ottawa Charter defines Health Promotion as:

“A process, the purpose of which is to strengthen skills and capabilities of individuals, groups or communities to act individually or collectively or to exert control over the determinants of health”.

The unusual thing is I know many people working in health projects in the voluntary and community sector aren't aware of this definition of health promotion.

Up until a month ago I was one of them. When I read this I thought what a powerful thing health promotion can be - it is not just giving information but rather it is about getting to the heart of the matter, the cause of the problem and getting there through a process of empowerment.

I like this definition because, by focusing on change and determinants, it legitimises:

- 1 a range of interventions that sometimes get bad press, particularly interventions from people motivated to change from a personal experience eg
 - Support groups, leading to a pressure group to improve quality of care
 - Counselling (in which an individual identifies their own issue and changes their own life)

- 2 people motivated by a sense of social justice and fairness who challenge and campaign on issues like
 - Low pay
 - Gay rights
 - The environment
 - Women's issues.

As a starting point in addressing health determinants I think we should encourage agencies to become health promoting and to adopt this statement making it widely known.

It is important to do this because it puts a lot of health work into context by giving it a goal - people know their target or bottom line and will think about the relevance of particular determinants to their specific context. It also tells them that process is important.

Before looking at some specific determinants and ways of addressing them I want to make a few points from the definition about the way of working that should be relevant whatever determinant we're addressing.

The definition talks about a process – it doesn't say what process or how to ensure it is sound.

I think the process could be community development - some basic principles tie in with Health For All therefore, as an approach, it provides a mechanism for making Health For All alive. That Boards and Trusts are now having community development departments or units is to be welcomed.

The process should be based on listening and acting on what we've heard. This is important if our work is to be relevant, but it is also challenging as it requires:

- a mechanism for feeding back what we've heard eg users forums, and also
- b marrying our priorities with those of the groups with whom we're working.

If I were to begin by making the Ottawa Charter definition of health promotion widely known, the second thing I'd do is to stress the value to groups of having an ethos or a value base based on Health for All or community development, and of being committed to making it come alive within their organisation.

In terms of addressing specific determinants I want to focus on five areas – money, social capital, lifestyle factors, ageing and quality of healthcare.

As with the dimensions of our wellbeing the determinants to our wellbeing are inter-related. There is no agreed hierarchy but most would agree with the Chief Medical

Officer for Northern Ireland when she says *“the most significant gains in public health are in tackling social and economic factors”*.

I’m not going to look specifically at environment, but general points about process apply here also.

MONEY

We all know that the poorer we are the sicker we’ll be and the sooner we’ll die. We know that inequalities in health status linked to social class are growing.

We’re aware of evidence that the scale of income differences within a society is one of the most powerful determinants of health standards and that - beyond a certain standard of living - it isn’t the richest countries which enjoy the best overall health status - but the most egalitarian.

We know these facts about the links between money and ill health - perhaps if we want to impact more effectively on this determinant then others must know and, more importantly, understand it too. We must understand that poverty affects health status because it excludes people, reduces self esteem and effects the ability to access care and services.

If people understand and appreciate the link between poverty and ill health then it may be easier to engage them in supporting initiatives tackling the causes and effects of poverty. There are many good, but often uncoordinated, programmes and agencies working on this agenda.

I think a useful starting point would be to provide a definition to which people can subscribe and stress the fact that *“A booming economy is not the same as a booming society”*.

There is cause for optimism in terms of impacting on this agenda eg

- the work being done on the National Anti Poverty Strategy
- the focus on poverty in the Western Health & Social Services Board's Health Action Zone bid
- a strong voluntary sector in Northern Ireland focussing on neighbourhood based health work.

Finally, in terms of addressing poverty I would like to make two points:

- Ireland boasts a necklace of poverty around its border counties and the particular health and social care of these populations should be in our minds when developing health projects
- In describing areas and neighbourhoods which experience high levels of unemployment and poverty we should do so in a way which respects the dignity of those who live in these communities.

SOCIAL CAPITAL

For whatever reason - social factors as a determinant are acknowledged and the term social capital is increasingly appearing in health journals.

There are many definitions of social capital, but for the most part it is concerned with levels of social and civic trust; coordination and cooperation for mutual benefit and it is strong when we have a sense of our role within society and a pride in it.

One of the things that fractures social capital is exclusion. Exclusion is bad for the health of a society in general and not just for those groups or individuals experiencing exclusion.

In Ireland the injection of EU funding has given interest groups the opportunity to work in areas where exclusion traditionally exists ie gay community, ethnic minorities, travelling community, disabled and people living in rural areas.

The current hiatus in European funding to the voluntary sector is concerning given their capacity to engage with excluded groups.

There are 2 groups particularly who experience exclusion that I want to mention:

1 Refugees

If we want to be socially cohesive then we must acknowledge the body of work to be done in their integration. This is highlighted in a Northern Ireland context in Belfast Law Centre's recently published report "**Sanctuary In a Cell**".

2 Those whose physical well being has been compromised.

Many who experience chronic, or quality of life, threatening illness experience exclusion as a consequence and actually want information on how to promote the health of the other dimensions of their wellbeing and to be included in a drive towards better health. On this subject I remember a conversation with a woman living with a cancer diagnosis and her saying "*I don't want the rest of my life to be determined by just the tumor and the doctor. I want to have a role in it*". In some ways to exclude sick people promotes the notion that sickness = failure. There are many good models of empowering, holistic programmes e.g. Slanu, Tipping the Scales, Arc Centre, Tara, Aisling and Derry Well Woman. Many of these employ simple techniques and approaches that people experience as health enhancing eg meditation and laughter.

In Northern Ireland the establishment of a Civic Forum should build social capital by allowing all of our voices to be heard. The reality will depend on whether our representatives want to give or receive opinion. The whole issue of exclusion is topical in Northern Ireland with public bodies now working hard to meet obligations under Equality legislation.

LIFESTYLE FACTORS

In terms of lifestyle I think messages are clear around:

- Eating
- Smoking/Drinking/Drugs
- Exercise
- Unprotected sex.

Impacting on this determinant is dependant on individual action so, to impact more effectively, we need to hear why people don't act in accordance with the messages being given.

The reasons may include:

- 1 They don't believe the message because it is inconsistent with their life's experience. To my mind this disbelief would be reduced if those responsible for health promotion put the impact of behaviours in the context of other determinants of wellbeing
- 2 Peer/family pressure
- 3 Can't be bothered because to change is too hard. As health workers it is my belief that we should respect some people's choice to ignore health messages
- 4 Sometimes messages are delivered in a way that sound elitist. Where possible health promotion messages should be written in consultation with those at whom they are targeted (as is happening currently with all cervical smear literature). It is also worth bearing in mind that the average reading age in the population is 10 years.

In terms of lifestyle there are two factors which I think are often ignored but which are of significance in terms of our wellbeing and they are *sleep* and *play*. Sleep and insomnia are big issues for many people - sick or not. We need to work with people to give information on do-able sleeping tips.

With regards to play, Pat Keanes wrote an excellent article in the Observer in October advocating the benefits of a play culture to both individual's and society's wellbeing. I'll just quote one sentence from the article:

"Don't take play to mean anything idle, frivolous or wasteful. Play, as philosophers understood it – is the experience of being an active, creative and fully autonomous person".

QUALITY OF HEALTH CARE

This usually refers to technological and medical advances influencing physical care delivered in a secondary setting, and this is vital. There are, of course, other dimensions of our wellbeing which require care irrespective of the setting. A person's experience of the quality of care they receive may vary vastly from the professional dealing with them who may have forgotten that there are more dimensions to wellbeing than the physical component. In this I am reminded of hearing a woman conclude that her cancer care was poor. A judgement influenced by her having been given her diagnosis in a four bedded room where strangers heard before her loved ones.

I believe that most effective care is often mirrored by most effective partnerships. We now see the validity and power of partnerships being recognised through work of multi-discipline teams in a secondary care setting as will occur with the implementation of the Campbell Report recommendations, and, also, in a primary care setting through initiatives like Healthy Cities, Healthy Action Zones and area based partnerships.

In terms of encouraging partnership and sharing responsibility it is useful to remember that some legitimate players may feel threatened by the idea ie those who traditionally thought they had sole control over one dimension of life ie

Clergy - spiritual

Doctor – physical.

Other key players of course are:

- Counsellors and politicians – we must push for Policies that are ethical and promote equity
- A range of public health players
- Education and Library boards
- Complementary therapists, counsellors
- People with personal experience of a life circumstance: here there is a well of untapped knowledge
- Families who are critical for sick people in their giving of support, acceptance and unconditional love. I recently was speaking with a colleague who was developing a

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programme for people who had an eating disorder and she spoke about the need for them to have unconditional love and that only their families could provide this. I thought it was wonderful to hear someone say that love should be a component of a health programme.

In terms of formal Partnerships - training is essential - WEA in Northern Ireland addressed this. We've many funding led partnerships which aren't as effective as they may be.

I started by making a few general points and want to finish by making another few:

- 1 According to research done by Derry Well Woman in 1994 many people pick up health promotion messages from media, magazines etc. We could try and influence this
- 2 It is important to promote the notion of health as a positive concept and move the emphasis from medical advances, which most of us can't engage in, to wellbeing, which we can. This will of course be empowering because we have a role to play
- 3 Shift the focus of targets in health care from morbidity and mortality to determinants
- 4 Acknowledge the great personal courage required of individuals or groups to take action and challenge a determinant acknowledging and being honest about the fact that sometimes their action/challenge won't change the one thing for which it was initiated
 - ⇒ sometimes they'll still get sick
 - ⇒ sometimes policies won't be changed
- 5 I spoke at the beginning about the importance of listening. When you establish a mechanism to listen, to give people space to talk and find their own answers, there will always be change. Change to big social and policy factors which are affecting a

community's wellbeing or change to hidden things which are determining an individual's wellbeing.

At a previous Institute of Public Health in Ireland conference someone quoted Nelson Mandela as saying "*you must be the change you want to see in the world*". I thought this a wonderful statement placing an onus of responsibility on each of us as individuals and telling us that if we have the courage to accept that responsibility we have the power to effect change.

Dr Jim Kiely

Connecting to European Public Health – Republic of Ireland perspective

I would like to thank the organisers of the conference The Institute of Public Health for their foresight in identifying the subject "Public Health in Europe" as a major topic for discussion and debate at this time and for the energy, commitment and imagination which has gone into developing the programme of keynote speakers and workshops. The publication of the briefing document which Owen Metcalfe put together is a useful backdrop to the conference and is an important contribution in terms of identifying the major issues relevant to the European Commission Programme on Community Action in the field of public health.

On behalf of the Minister of Health and Children, Mr Micheál Martin and the Secretary General of the Department of Health and Children, Mr Michael Kelly, I would like to particularly add a very warm welcome to our distinguished guests Mr David Byrne, EU Commissioner, Dr Richard Alderslade, of the WHO and Dr Elizabeth Mitchell, from the Department of Health and Social Services and Public Safety in Belfast.

The topic I have been asked to talk about is a particularly interesting one and in fact one could spend a lot of time, if not all the 20 minutes, not so much addressing the topic but in asking what precisely does it mean. In this context it is relevant to ask:

What is Europe?

What is public health? - Therefore European public health and how can we possibly connect with it?

Do we here, in this part of the island, actually have a perspective on it that is intellectually sound and based on any coherent set of values or is it simply a matter of the Department of Health and Children on behalf of the Southern Government attending meetings with the various European organisations, putting the flag on the table and waiting?

Firstly though, just to take a few moments to put a frame of reference around this topic which essentially asks about our connection with, participation in and most importantly our commitment to the welfare of the broader community within which we live as a nation. Let me identify a few indicators of our history and track record in this regard.

- 1932 – Ten years after independence Ireland, through President Eamonn de Valera, assumed the presidency of the League of Nations, the first real post independence indication of our membership and commitment to the broader family of nations
- 1949 – We were a founder member of the Council of Europe
- 1956 – Ireland joined the United Nations and by extension its specialist agencies such as the WHO. Within a very short period, under the then Minister for External Affairs, Mr Frank Aiken, Ireland proposed and worked towards the achievement of a total ban on the proliferation of nuclear weapons. In an era when the cold war was at its height, this concern with health promotion and disease prevention activity was of the highest order
- 1960 – Ireland began a 40 year, and still surviving, policy of contributing personnel and resources to peace keeping and humanitarian assistance around the world beginning with what was to become a tragic commitment to the Belgian Congo, now Zaire, and extending over the years through Cyprus, various parts of the Middle East and many other countries up to and including the latest commitment to East Timor 18 months ago. While it seems ironic that a country might count the activities of its military and security personnel as its major contribution to the international community over the years, I think it is widely and generously accepted as a unique contribution
- 1973 - Accession to the European Community
- 1996 –Mary Robinson's appointment as Commissioner for Human Rights at the UN is a major achievement

- 2000 – Ireland was elected to the United Nations Security Council where it can pursue its policy and commitment to the maintenance of peace around the world.

All of these milestones represent a long history of engagement with international organisations dedicated to social progress, economic, health and political development and constitute a record of which we can be justly proud.

With our history and experience of interaction with, and contribution to, the international community let me scale that down and just hone in on the topic which is the subject of this talk ie European Public Health and our engagement with it. Let me go back to the original question, - what is Europe? For the purpose of this discussion I got an answer contained in a booklet published during our presidency of the Council of Europe that is - "Europe is more than you think". This answer emerges because for WHO Europe, it is 51 States comprising an area ranging from Reykjavik in the north west Atlantic to Vladivostok on the western Pacific coast of the Russian Federation, from Siberia in the North to the steppes of central Asia on the South, encompassing more than half of the world's land mass and a fifth of its population.

For the European Union it comprises not only the fifteen Member States of the Union but, as the framework document which is the subject of much discussion today describes, it includes the applicant countries for membership of the EU as well as EFTA countries. Using mechanisms already developed within the EU such as the European / Mediterranean partnership it can bring in North African countries bordering the Mediterranean, the trans Atlantic agenda which encompasses relationships between the US and North America, and partnership and cooperation with Russia.

For the Council of Europe it comprehends 41 Member States and rising.

So that is Europe, a collection of developed, developing and seriously underdeveloped countries with governance structures ranging from highly sophisticated law based systems to less than perfect systems of democratic Government. Health experiences throughout range from some of the best in the world to some of the worst in the world.

So it's an undifferentiated mishmash of 51 national Governments within which there are countless autonomous and semi autonomous regions all with complete or some control over health and health policy. It consists of three mandated international organisations, WHO, European Union and Council of Europe, countless specialist UN and other agencies such as the World Bank, and the International Monetary Fund (IMF) who have connections to health and at last count over 50 non Governmental organisations seeking audience at the Regional Committee of WHO. All of the above have an intense proprietorial interest in what for the purpose of this conversation is referred to as European public health but which in light of the above complexity is an entity which cannot possibly exist.

However, it does seem to me that from our perspective, based on our long history of participation in international organisations and our efforts to improve human welfare, and from our own domestic experience over the last decade in reorientating our own concepts of health services, it is possible to construct an entity called European public health to which you could give allegiance and connect with in a meaningful and relevant way. These principles, it seems to me, could include the following:

- 1 The promulgation of a mission which is clear and is directed at the attainment by all people of the highest possible level of health
- 2 A strategy which places health in its broadest political, social, economic, legal and ethical context
- 3 A value base which is solid and takes its inspiration from the best ethical traditions of equity, solidarity and respect for human rights as expressed in a broad commitment to the attainment of what the WHO in 1978 called health for all
- 4 Implementation of interventions of proven effectiveness in achieving detailed objectives which might fall out of the mission statement set out above.

It will be hard to quibble with a perspective on public health which revolves around these particular notions. It might be useful then in the light of the principles outlined

above to examine in broad outline, the commitments and mandates of those major European organisations with a particular interest in health.

WHO Euro: Health 21

This is the policy framework which the European regional office of WHO developed through consultation with the Member States over the last few years and which was endorsed at last year's Regional Health Committee and which provides a policy framework for Member States to use in developing or refining health policy over the next number of years. It is interesting that while the "Health for all by the year 2000", document which was published in 1978 gave a span of 22 years for the achievement of that objective, by calling this document Health 21, WHO Euro have very prudently extended the time frame to 100 years encompassing as it does the whole of the 21st Century. The basic principle underlying this document it appears to me is:

A constant goal of trying to achieve full health potential for all.

Its main aims seem to be:

- a) to promote and protect people's health throughout their lives and
- b) to reduce the incidence of the main diseases and injuries prevalent in Europe and to alleviate the suffering they cause.

Its basic values appear to be the recognition that health is a fundamental human right, equity in health is a fundamental human right, and that equity in health and a solidarity in action between, and in, all countries and their inhabitants is something to which we should aspire.

It identified four main strategies for action to ensure that scientific, economic, social and political sustainability for the implementation of Health 21 revolve around multi sectoral strategies to tackle determinants, health outcome driven programmes, investments for health development and clinical care, integrated family and community orientated primary health care and participative health development processes that involve all relevant partners.

It seems to me that there is little we can quibble with in this. For the purpose of the argument being developed it would seem that this perspective squares up pretty well with the model developed at the outset.

European Union

Again examining the documents, not only the latest communication from the Commission on public health, but also previous documents, it appears that the EU is mandated to accept that human health is a centrally important human and social resource and should be promoted and enhanced by all means at the disposal of the various institutions of the European Union.

Its key objectives are:

- 1 Contributing towards ensuring the attainment of a high level of health protection
- 2 Improving public health
- 3 Preventing human illness and disease and
- 4 Obviating sources of dangers to human health.

It sees the community's role in public health as that of complementing the efforts of Member States, to add value to their actions and in particular to deal with issues that Member States cannot handle on their own.

Again these would seem to be aims or objectives which are consistent with the highest medical standards, are socially responsible and are aimed at the promotion of the welfare of citizens of that part of Europe contained within the European Union.

The Council of Europe

This organisation of 41 States has a very broad agenda relating to the protection of human rights, promoting social rights and social cohesion, legal cooperation, education youth culture and sport, local Government and the environment, democratic stability and finally health. The general aims of the Council of Europe are:

- 1 To protect human rights and the rule of law
- 2 To help consolidate democratic stability in Europe while backing political, legislative and constitutional reform
- 3 To seek solutions to problems facing European societies including discrimination against minorities, xenophobia and the misuse of drugs
- 4 To enhance Europe's cultural heritage in all its diversity.

These general aims and objectives find expression in the health activities of the Council in many ways but in particular through its advocacy for the rights of the population in their contact with the health care system. This includes the promulgation of the Convention on Human Rights and Biomedicine 1997; a range of activities relating to health and health service provision for minority groups (ie prisoners and immigrants) and includes specific reference to equality of access to health services, health promotion and quality standards in areas such as organ transplantation. Again we have a certain consistency with the principles and objectives set out above.

So what does all this mean, well it seems to me that we have three major organisations in Europe with commitment and a mandate to improve the health of the European population.

- 1 The WHO whose major strength appears to be the range and extent of its membership and the concentration of technical expertise at its disposal to provide

supports, advice and information to allow Member States to use the best evidence based policy development available

- 2 The European Union which is in the early stages of development of its public health mandate but which has the capacity to be the powerhouse driving the political, social and economic development of that part of Europe within its area, which of course is soon to be dramatically expanded
- 3 The Council of Europe which one might describe as the conscience of Europe providing the ethical framework within which all European States and all international organisations might put forward their agendas.

But it is clear that the activities and efforts of these three organisations are to say the least not coherent with each other. The synergies for progress and development which are inherent in the strengths of all three organisations are not being availed of and an enormous amount of work needs to be done to ensure that this happens. Were this to be done in a structured, organised manner then we might have the outline of what everybody can give allegiance to as a European concept of public health which drives in the direction which the missions, objectives, strategies and mandates of all these organisations suggest we should go. I would suggest what is required is a willingness in the coming period to review systematically partnerships for health between these organisations. The aim would be to provide a more focused strategy for the development and maintenance of partnerships and for ensuring a dialogue between the organisations concerning both policy development and implementation. So far as non Governmental organisations are concerned the aim would be to create opportunities for a far more regular and informal dialogue. It seems to me also that there are some guiding principles for the development of such a cooperation strategy and they would be a high level joint political commitment to partnership. This is absolutely necessary of course but not sufficient for common goals and strategies must be sought by negotiation and re negotiation.

Differences between partners must be recognised and respected.

The level and content of collaboration needs to be made explicit.

There must be some mechanism for the management of joint activities.

While it is obvious that many collaborative enterprises do exist between the various organisations, I think it is equally understood that this needs to be put on a more structured, strategic footing. Initial contact has to be made between these organisations at the highest level to ensure all those working in partnership have a practical vision of health improvement based on explicit values. It is then and only then that I think that the entity called European public health which is referred to in today's programme can exist and we look forward to significant progress on this front in the years to come.

Dr Elizabeth Mitchell

Connecting to European Public Health – Northern Ireland perspective

Firstly I would like to thank the Institute of Public Health, and Owen Metcalfe in particular, for bringing all the participants together today to discuss this topic which I feel will have increasing importance and relevance for us all. It is particularly useful to bring people with a wide range of experience together to allow cross-fertilisation of ideas.

There is a big difference between the Department of Health Social Services and Public Safety (DHSSPS) in the North and the Department of Health & Children (DHC) in the South in that we have been much less involved in European and International affairs than the Department of Health & Children and indeed even than our own Department of Agriculture & Rural Development. Traditionally, the Westminster Health Department has taken the lead but with devolution things are starting to change. We will therefore have a lot to learn from Dr Kiely and his colleagues.

This Westminster lead and other factors have meant that we have tended to be inward looking for the last 30 years and in my talk I am going to focus on what has been happening recently in Northern Ireland and what our Minister has been doing about developing a new Public Health Strategy. I also would like to tell you about the recently published Programme for Government and how this should help us develop our European links and then I would like to finish with a few ideas about how we can strengthen our links with Europe and on some opportunities which we may be able to realise.

Our Executive Committee recently published its draft Programme for Government and this contained a chapter on developing North/South, East/West and International relationships, including a section on Europe.

- The main focus is on developing effective links with European Union Institutions and throughout Europe
- It acknowledges the unique level of support that we have received in Northern Ireland especially through the Peace and Reconciliation Fund
- The Executive are planning to open an office in Brussels early next year to ensure that Northern Ireland interests are represented as European Union policy is being developed. Although public health was not identified as one of the key areas perhaps it is something that we could aim to change
- They also announced plans to develop a regular forum on European Union issues
- Another point was to seek opportunities to exchange policies with other regions
- The final objective was to help build and develop knowledge and expertise of European interest across all sectors so as to build capacity.

This final point I think is of particular relevance to ourselves.

The Programme for Government also contains a chapter entitled “Working for a Healthier People”. One of the top priorities for our Department was to get public health into the Programme for Government. We are pleased that the Executive has included a new Public Health Strategy as one of its main cross-cutting issues in the chapter Working for a Healthier People.

The Executive Committee agreed in July that our Minister should take forward a Public Health Strategy. Minister De Brún wanted to ensure that she hears from as many people as possible in developing the strategy and wrote to over 600 organisations and individuals, and placed advertisements inviting views on what should be in a public health strategy. She also re-established the Ministerial Group on Public Health with

representatives from each Government Department to help develop the strategy. This Group has met on 4 occasions since August.

In developing the Public Health Strategy we were inspired by Health 21, WHO European Region document and also influenced by the developing EU Public Health Framework. We have also looked at other country's public health strategies including the new Swedish Public Health Strategy which has an emphasis on inequalities.

The strategy has also been developed in the context of other policy initiatives in Northern Ireland including:

- Targeting Social Need
- Promoting Social Inclusion
- Equality legislation
- Human Rights legislation.

The major themes that have emerged in the preliminary consultation are:

- Tackling inequalities
- Social inclusion
- Addressing the determinants of health
- Greater emphasis on the very young and the old
- Healthy public policy – the social, economic and physical environment
- Health impact assessment.

In common with the change of emphasis in the EU Public Health Programme for Action, we are trying to shift the emphasis from a number of specific topics and disease oriented programmes to action through other policies and to action on the major determinants of health. For this reason we want to embed the concept of health impact assessment firmly across Government.

Critical to the success of the strategy will be ensuring that it has:

- Wide ownership
- Political commitment
- An intersectoral approach
- Opportunities for partnerships
- A community development approach
- Clear lines of accountability
- An evidence-base
- The necessary information, monitoring and research infrastructure to support the strategy.

During the pre-consultation over 100 responses were received. We also held a workshop with wide representation from different sectors on 20 September to discuss some of the key themes and issues. A consortium is working with the Department on a consultation and public engagement strategy to help disseminate the strategy and to raise awareness of public health issues and encourage responses to the consultation document. We plan to launch the public consultation in 2/3 weeks time and continue the consultation period until 10 April, with the aim of publishing a new strategy by the end of April 2001.

With devolution and the development of the Public Health Strategy we are well placed to look critically at how we can strengthen our links with Europe. We hope we can exchange information on public health policies with other Regions in a more direct way than in the past and in particular we hope that we can develop the North/South Cooperation on Health through the North/South Ministerial Council. Health Promotion is identified as one of the specific areas for cooperation on health and perhaps we should be considering what other aspects of public health could be identified for specific cooperation.

We do of course hope to build on existing strong EU programme links and learn from best practice. One personal example that I have been involved with is the European

Programme for Intervention Epidemiology Training (EPIET). Although primarily a training programme this has brought together experienced practitioners from all the Member States to work on developing common methods and a common language for communicable disease control. Indeed it has given the opportunity for those of us working in the North to get to know our colleagues in the South much better and help to develop our links at a very practical level for example on common training.

Initiatives like this may lead us to develop further cooperation for example, perhaps Dr Brian Smyth and Dr Darina O'Flanagan who are both here today could together develop a surveillance hub in Ireland. This would contribute along with initiatives in other European countries to greater available information. Working together on an issue, sharing expertise and resources, we may be able to achieve much.

What other opportunities are there and how can we realise them? I think the Institute of Public Health has an important role in bringing us together and facilitating action but to take this forward we will need the commitment of the two Departments and, crucially, the enthusiasm of people like yourselves for this to succeed. The Institute can help through its strategic objective of developing public health leadership. At a practical level we hope that we can maximise a number of health related projects in the new EU peace programme. I suppose we have to ask ourselves what we have to offer others. I think that we are doing very exciting things for example through the Institute and through North/South collaboration and perhaps other member states can learn from our experience.

Finally, I want to issue a challenge. In keeping with Strand 1 of the EU Public Health Framework for Action, I think a major challenge for us in this island is to develop our capacity to monitor the health of our population, to analyse the data and provide advice to policy makers to convince them of the impact that their policies have on health. To do this we need data for action. Perhaps to put this higher on the agenda it could be put forward as an area for North/South Cooperation through the North/South Ministerial Council.

Chapter 2. Workshop Summaries

These workshop themes were identified by a focus group, prior to the seminar, as essential areas for strengthening public health in Ireland and in Europe.

Workshop 1. Theme: *Improving Collection and Dissemination of Health Information and Knowledge.*

In this workshop much of the discussion focussed on the National Health Information Strategy which is being developed in the Republic and the new Public Health Strategy which is being developed in Northern Ireland. While most of the discussion was concerned with specific aspects of these initiatives, relationships with the new EU Public Health Programme were also considered.

The current status

The first part of the workshop considered general issues associated with health information. Two main issues emerged:

1 A comprehensive health information audit

Each member of the group cited examples of health information that was available and useful. On the island these included demographic data and vital statistics from the Central Statistics Office (CSO) and the General Registry Office (GRO), cancer incidence, hospital activity data and infectious disease data from the National Disease Surveillance Centre (NDSC). European examples included Eurocat and the European Monitoring Centre for Dependence on Drugs and Alcohol (EMCDDA) data. Lack of knowledge in many areas prevents the development of a comprehensive picture, particularly in regard to data access, utilisation and linkages between collections. More thorough knowledge was needed about what information was currently available, what organisations were involved, and what other agencies considered good practice. This knowledge should be available to policy makers, health professionals and the general public.

2 Agreed procedures to identify and prioritise health information needs

Even with a fuller understanding of what information is available, the group considered it important to develop formal procedures for the identification of gaps and prioritisation of health information needs. The development of agreed procedures is important for greater coordination of information systems in member states of the EU.

The major gaps, particularly the determinants of health

There was considerable agreement that the largest gaps in current Irish and European information systems related to health determinants and inequalities. Examples included the low level of disaggregation possible on the island, the lack of a unique identifier to link individual data collections, and the lack of longitudinal data. Filling such gaps was seen as critical to the success of the third strand (addressing health determinants) of the EU New Public Health Programme. The focus of that strand provides considerable support for concentrating attention on these issues in national health information systems.

Other important gaps included morbidity data and community level data.

Reporting and communication

The value of data lies not in its existence but in its use, particularly the extent to which it contributes to development, monitoring and evaluation of policy.

Analysis, reporting and communication

Health information systems should incorporate components for the analysis, reporting and communication of information. The allocation of adequate resources to these components was seen as very high priority. The focus on 'reporting and communication' in the 'Health Information and Knowledge' strand of the new EU Public Health Programme was seen as providing strong support for efforts to concentrate on this issue.

Web site

A useful vehicle, but not the only one, for analysing, reporting and communicating would be a properly maintained European-wide web site linked to national sites in

member states. An all Ireland web site that incorporated a public health observatory was considered potentially valuable. The establishment of an all-Ireland intra-net was also considered to be very useful.

Filling the gaps and strengthening European Links

In the second part of the workshop attention turned to specific strategies to fill gaps and strengthen European links.

The following points emerged:

Standardisation

Standardisation of data items, data collection, data management, data analysis and reporting procedures was seen as vital to the success of efforts to enhance collaboration. In a community as diverse as Europe, the need to measure local issues and to take these into account when making and interpreting comparisons across groups was also clearly recognised.

Special topic networks

It was noted that a number of international networks focus on specific health topics. These could be supported to undertake agreed work on behalf of member states. Reduction in duplication would be an important consequence. A further benefit would be immediate outcomes from more advanced existing networks. This would strongly bolster support for ongoing European collaboration.

In addition, it would be helpful to have in place procedures that would help to identify the need for new networks.

Political will, resources and formal structures

Improved collection and dissemination will require commitment at top political level. Enhanced capacity requires the allocation of sufficient resources and the establishment of formal structures to oversee and implement action.

Commence with North/South co-operation

There was agreement that opportunities to promote collaboration on the island itself exist and an enhancement of these existing opportunities to promote collaboration would be a useful starting point.

Key recommendations and actions – Workshop 1

At the end of the discussion participants were asked to identify key recommendations and actions that would contribute toward "improving the collection and dissemination of health information and knowledge". They identified:

- A number of specific strategies to strengthen health information and European links. These included:
 - Conducting a comprehensive health information audit including existing health information, agencies involved and thoughts about best practice. The results of such an audit should be updated and made widely available
 - Developing agreed procedures to identify and prioritise information
 - Promoting standardisation for coordination of health information systems
 - Developing and supporting international special topic networks to undertake an agreed workplan

- The development of North/South cooperation on health information provided an opportunity to broaden the scope of health information activities on the island, as a first stage of wider participation in European public health

- The need to develop the political will and resources for these activities

- The development of formal mechanisms to help build partnerships and strengthen links were seen as critical to the process

- The largest gap, in current Irish and European information systems, is in information about health determinants and inequalities. Filling this gap was seen as critical to the success of the third strand (addressing determinants of health) of the new EU public health programme

- The requirement that health information systems should incorporate, as vital elements, components that include the analysis, reporting and communicating of information. A European wide health information web site linked to national web sites was seen as a useful vehicle for such components.

Workshop 2. Theme: *The Strategic Development of Public Health Policy in Ireland, North and South.*

Current Initiatives

The discussion commenced by considering how public health policy is currently developed in both jurisdictions. The Public Health Strategy being developed in Northern Ireland and the review of the Public Health Function underway in the Republic were referred to as extremely important developments. At the moment in the Republic, public health policy is encompassed in broader health strategy but it was suggested that a specific public health policy would be useful. The current review could be important in progressing this. The Ministerial Group on Public Health in Northern Ireland was referred to as an important policy making group and the National Anti Poverty Strategy (NAPS) was considered an important policy document for health in the South.

Strategic development

The groups then discussed requirements for strategic development in public health. It was stated that for those involved in policy development there is a requirement to be clear about objectives and aware of the necessity to prioritise actions. The key role that public health has to play in tackling inequalities was emphasised.

The following key issues emerged during the discussion:

Consultation

The process of consultation in policy development is crucial. If policy is to be effective, wide support is required and consultative processes are key to achieving this support. Consultation must be across the board and true consultation means a well resourced, fair and accessible process where those consulted feel a real sense of ownership.

Information

It is important to establish evidence to support policy. This requires relevant information. In recent times more information is available but information gaps still exist. Comparisons are not always possible therefore efforts should be made to ensure

that collection and dissemination methods and instruments are standardised and comparable on the island and also within Europe. (See also report from workshop 1).

Structures

It is important that structures exist which allow for exchange of information and experience and for collaboration. A formal high level group needs to be established to oversee developments. Issues for exchange include consultative processes used, how policies are health proofed, how health impact assessment is used and the use of tools to target inequalities.

Networks, formal and informal, are useful mechanisms for consultation, developing consensus and they can also be useful for implementation.

Resources

Public health must be adequately resourced and treated seriously at the highest government level. The European Programme was described as a good programme but the resources allocated were not seen as being adequate to do it justice.

European support for public health at national level

In this part of the discussion opportunities for Europe to support national policies were considered.

Article 152 of the Treaty of Amsterdam is important and having an impact on health strategy development in terms of research, information and the determinants of health.

Public health at national level can be supported by European public health policy as EU directives are binding and obligatory. The principle of subsidiarity must however be taken into account.

Dialogue between Member States and the Commission is essential for more effective legislation and strategy development.

Judgements of the European Court have the potential to support public health.

The World Health Organisation is a body that provides support through technical reports, guidelines, target setting, reporting requirements and expert advice.

The OECD and World Bank are useful in highlighting issues and providing benchmarks in certain areas.

Ireland's input into European policy

Opportunities for Ireland to contribute to European policy were discussed.

Ireland can help set the agenda and contribute to what happens in European policy making through existing representative pathways. These include, the Commissioner and staff, MEPs, European civil servants in DG Sanco and other relevant directorates, Irish Ministers, Government departments and civil servants who sit on committees or working parties (this form of representation has been more accessible to the South than the North as UK representation has traditionally focussed on London).

Other options for input include participation in expert committees and through public demonstration.

At WHO level opportunities exist through executive structures and expert groups.

Key recommendations and actions – Workshop 2

Participants were asked to identify key recommendations and actions that would assist strategic development of public health, North and South, and help those on this island strengthen links with Europe. The following recommendations were put forward:

- Information must be collected and available that is comparable between North and South and also comparable with European information systems. This step could greatly strengthen links, North and South, and with Europe
- Visible structures should be established that allow for easy, effective communication to take place between North and South and with Europe. These structures could include forums or advisory councils. Communication can be in person or electronically. Communication can also be on specific issues
- Any policy developed will be more effective if it is underpinned by genuine, widespread consultation. This takes time, effort, organisation and resources
- All relevant policies must be health proofed. Health impact assessment is a tool but to be effective it must be properly resourced
- All health strategies and policies should have as a core aim (be proofed for) the reduction of social and health inequalities.

Workshop 3. Theme: *Clarifying and defining responsibilities, roles and structures that are necessary to strengthen links for public health in Ireland and in Europe.*

Introduction

At the outset it was agreed that strengthening links for public health would be useful for all involved in public health. It was suggested that a first step would be to establish links to strengthen public health on the island. If we can achieve this, it could be replicated on a broader basis in Europe.

The main areas discussed are described under a number of headings:

Existing situation

Not everybody is clear about what is already in existence in terms of structures, and who has a role or responsibility in relation to Europe. It was suggested that an audit of roles, responsibilities and structures could clarify the situation.

There was a perception that the information flow from Europe is possible to access but inputting back into Europe is much more difficult.

Roles and responsibilities

Health issues are not considered important by many outside the health sector who have a role to play in influencing health. Wider awareness of influences on health is important in promoting public health considerations with a wider agenda.

This needs commitment across government departments at senior level. The idea of government incentives for inter sectoral and inter departmental collaboration should be considered.

Structures

A structure is required that can clarify existing links, build on them and provide support across the island and with Europe. It needs a mandate from both Governments and

adequate resources. It has to be capable of improving and encouraging collaboration and cooperation on a multisectoral basis and it must be accessible to "grass roots" and "top policy making" levels.

It should promote exchange at a National and European level and allow for two way flows between Ireland and Europe and between practitioners and policy makers. To be effective, it will require dedicated personnel who are responsible for establishing and maintaining links. Personnel must have the time and resources to do the job properly.

The structure must be capable of using up to date information technology including the development and maintenance of a web site.

A monitoring system is also required to ensure that this structure is working properly.

The Institute of Public Health could house such a structure.

Following on from this discussion on structure, the idea of a forum was discussed.

Forum

A forum for health could be a useful mechanism by which collaboration for health could be achieved. A forum must consist of broad representation. How this forum should work and how it should be driven requires a more detailed discussion. Its structure and operation should parallel the process and structure used to construct the proposed European Health Forum.

Cultural differences

In developing links it is important to respect cultural diversity, avoid unnecessary legislation, be inclusive and respect the differences that exist throughout Europe.

Key recommendations and actions – Workshop 3

Participants were asked to identify key recommendations and actions that would facilitate a clarification of responsibilities, roles and structures to strengthen links with Europe.

The following recommendations were put forward:

- A structure must be established which can provide links, ie an overall coordinating body with a clear mandate from governments
- Public health has such broad representation it is important to have shared multisectoral participation with accompanying responsibilities
- Communication is vital. This means communicating, North and South, and on an all island basis with Europe. Communication must exist in many areas such as; information sharing from meetings and conferences; sharing best practice; policy development; use of technology and web site
- It was suggested that a European supported pilot project in Ireland, North and South could explore how links could be established and how joined up working across jurisdictions might take place. Findings could be used to help other countries.

Workshop 4. Theme: *Integrating health into other policy areas in Ireland and in Europe.*

Setting the context

In the initial discussion, participants commented that the morning plenary session was informative and useful. The differences in approach and roles of the WHO and the EU were acknowledged. Good background information on the new EU Public Health Programme had been presented. A good evidence base to support the incorporation of health into other policy areas had been established by the speakers. (See plenary presentations section Chapter 2, page 11).

Focus of discussion

There was agreement amongst participants of the importance of integrating health into other policy areas. The discussion centred around certain criteria. These were:

Creating a better understanding of health

Those working in the public health arena need to encourage a greater understanding of health and how it is achieved. This can be aided by creating a greater awareness of the determinants of health and developing the capacity to influence policy and politicians about this. There needs to be better dissemination of public health information and research. Information, programmes and policies need to be put in accessible language to influence other areas, such as law and economics. Public health messages should be communicated in new and diverse ways. The public health sector has to help people identify how and why health partnerships are relevant. Perhaps public health needs to be described and 'sold' in another way. The term the 'public good' was suggested. There is scope for a greater involvement of civil society in creating and disseminating public health messages.

Leadership

There was strong emphasis on leadership. Strong and determined leadership is needed to secure political support. Leadership is needed at European level to give health and social issues the priority that economic and security issues currently command. Mutual

support between stakeholders, engagement in joint leadership programmes, shared platforms for responsibility, joint ownership and pooled resources could all facilitate leadership.

Partnerships

This issue was considered under two headings:

i Working with other sectors is key to influencing other policy areas

There is now a large body of knowledge on effective partnerships. Experiences of 'joining up' at local level can be applied regionally, nationally and transnationally. Partnerships can help create joint understanding, participation in decision making and facilitate learning to work in different ways. Partnership is needed between action on the ground and high level decision making. There is a need to engage with diverse sectors not obviously associated with public health, such as insurance companies. When working with the private sector, there must be vigilance so that policy is not captured by corporate interests, such as the tobacco industry.

ii Learning from work with other sectors

Other areas such as regeneration and environmental strategies now have political and policy support. Lessons from these areas could be applied to public health, eg environmental impact assessment. Utilising a community development model for health ensures responses based on the needs of communities.

Structures, framework and resources

Structures and resources are needed to integrate health into other policy areas. While there is some integration at local level and some at national and international level, an interface between these levels is also required.

Evidence on the links between socioeconomic status and health status is established but actions to address the links have yet to be comprehensively implemented. The gap between policy and implementation has to be bridged. Funding can play a key role in influencing policy and implementation. As health is determined by influences beyond the health sector, it should be funded from beyond the health sector. The

Cardiovascular Strategy in the Republic of Ireland is having an impact due to the strong policy and implementation framework and the large amount of funding for implementation.

The National Health Forum which has been proposed for Ireland should be mirrored at regional and local level.

Key recommendations and actions – Workshop 4

Participants were asked to identify key recommendations and actions that would facilitate the integration of health into other policy areas in Ireland and in Europe. The following recommendations were put forward:

- All relevant policies impacting on health need to be assessed using transparent health impact assessments. Integration of health into other policies should be audited and reviewed. It was felt that the Institute of Public Health would be in a position to do this in Ireland
- Leadership is needed North and South, from Ministers of Health and in Europe from the Commissioner. There needs to be political accountability at European, national, regional, county and local levels
- New arguments and new ways to present and promote concepts of health and public health are needed
- Coherent legislation for health improvement must be developed across sectors
- Capacity building needs to take place at all levels and across sectors on the broader determinants of health and public health issues
- Sharing costs, information and training can reduce barriers and build trust so that messages and policies can be developed
- Strategic budgeting and ring fencing of money is critical in ensuring health integration into other policy areas. Funding allocation can be made dependent on engagement in, and use of, a framework for health integration
- All stakeholders need to have a sense of ownership of the public health agenda. The involvement of civil society is crucial in developing a common agenda
- There needs to be a balance between international vision and local autonomy.

Chapter 3. Information on European Union and European Agencies.

This chapter is a response to the request from seminar participants to have basic information about the European Union and European Organisations in public health.

Understanding the structures and processes of the EU

The Institutions of the European Union:

The European "government" is not made up solely of Members of the European Parliament. Instead, there is a triangle of institutions in which (roughly), the Commission proposes, the Parliament scrutinises, and the Council of Ministers (increasingly jointly with the Parliament) disposes. There is a fourth member in the centre of this triangle – The Court of Justice, which is the guardian and ultimate interpreter and arbiter of the Treaties.

The European Commission (Brussels/Luxembourg)

The Commission is the most powerful of the EU institutions. It is the civil service of the EU, and is headed up by 20 EU Commissioners, including Commission President Romano Prodi, appointed by Member States.

The Commission is charged with implementing the Treaties, which means:

- implementing specific policy (eg The Common Agricultural Policy)
- implementing Directives and Regulations and Decisions, and if necessary bringing legal action through the Court of Justice against member states that do not comply
- issuing regulations of its own accord, developing policy and drawing up draft legislation where the Treaties grant the power to do so (eg the European Single Market). Draft legislation is then put before the Council and Parliament for codecision and laws are issued in the form of Directives, Regulations or Decisions.

The Commission's bureaucracy is sub-divided into 23 different Directorates General or DGs, each headed by a Director General.

The Organisation of the Health Function of the Commission

Prior to the current Commission headed by Romano Prodi, the health function was fragmented throughout the bureaucracy, and this remained the case even though public health had become a formal competency.

Now, for the first time, and as an illustration of its increasing profile, health has its own specific Directorate-General. The Directorate-General for Public Health and Consumer Protection is headed by Irishman, Commissioner David Byrne.

The European Parliament (Strasbourg)

The Parliament is the only directly elected European body. Direct elections first took place in 1979, and initially the Parliament had largely an advisory role. Its powers have since been strengthened and it now has legislative power and is able to approve some of the EU's expenditure.

The main role of the Parliament is to scrutinise the executive – the Commission and the Council – which it does through its 20 subject committees, each covering a policy area. Health comes under the powerful Committee on Environment, Consumer Protection and Health. Health and Safety at Work is dealt with by the Committee for Social Affairs and Employment. A separate committee for health has been suggested and seems attractive on the surface, but health probably benefits from the weight and power of the Environment Committee.

The Council of Ministers (Brussels/Luxembourg)

The composition of the Council of Ministers varies according to the policy area, so there is a Social Affairs Council, an Agriculture Council and now a Health Council, composed of the health ministers of each of the member states. The Council of Ministers represents the governments of the 15 member states and is able to amend, accept or reject draft legislation. The Council has its own secretariat in Brussels.

The Court of Justice (Luxembourg)

The Court of Justice draws its judiciary from all the member states. European law takes precedence over national law, and individuals, companies, governments or the Commission can bring cases before the court.

Other EU Bodies

These include the *Court of Auditors* which scrutinises EU expenditure, the *Economic and Social Committee* and the new *Committee of the Regions*. The last two have a health mandate, but are consultative committees without legislative or executive power.

The "Eurosphere"

The "Eurosphere" is the informal name given to the large lobbying network that has built up in Brussels around the EU. There are health pressure groups, not least the European Public Health Alliance though these are vastly over-shadowed in funding terms by industry lobbies.

Addresses

European Commission
DGV/F – Public Health
Euroform Building
Rue Robert Stumper
L-2929 Luxembourg

Tel: +352-4301 32 719
Fax: +352-4301 34 511

European Parliament
Rue Wiertz 60
1040 Brussels

Tel: +32-2-284 25 01
Fax: +32-2-284 90 14

General Secretariat of the Council
Rue de la Loi 175
1048 Brussels

Tel: +32-2-285 66 28
Fax: +32-2-285 78 22

Economic and Social Committee
Rue Ravenstein 2
1000 Brussels

Tel: +32-2-546 95 10
Fax: +32-2-513 48 93

Public Health Organisations

Association of Schools of Public Health in the European Region (ASPHER)	
<p>Rue du Val d'Osne F,14, 94415 Saint-Maurice Cedex, France Tel: + 33-1-43 96 64 59 Fax: + 33-1-43 96 64 63 email: aspher@aspher.ensp.fr website: www.ensp.fr/aspher</p>	
Founded:	1966
Members:	57
Categories of members:	Educational Institutions
Financed by:	Members, contracts
Areas of interest:	Public Health, Health Promotion, Healthcare services, Consumer interests, Research, Environment
Main activities:	Promotion of European dimension in public health training
Major publications:	Monthly newspaper, annual report, website

European Network of Health Promotion Agencies (ENHPA)	
<p>6 Rue Phillippe le Bon, B-1000 Brussels, Belgium Tel: + 32-2 235 0320 Fax: + 32-2 235 0339 email: enhp.liaison@village.uunet.be website: www.enhpa.org</p>	
Founded:	1996
Members:	15 EU countries, plus Iceland, Norway and Liechtenstein
Categories of members:	National Health Promotion Agencies
Financed by:	Commission, members
Areas of interest:	Public Health, Health Promotion, Environment, Transport, Social Welfare
Main activities:	<ul style="list-style-type: none"> • Public Health policy and strategy development: Identify opportunities to advocate health promotion and inform decision making in EU institutions including health in other EU policies • Coordination and collaboration: Facilitate collaboration between Member States, with countries from Eastern and Central Europe and other health networks • Communication and dissemination: Provide up to date information on health promotion/public health to members and EU institutions and facilitate exchange of information, expertise and examples of good practice between policy makers at EU level and health promotion experts.
Major publications:	ENHPA News (quarterly newsletter), Closing the health gap briefing pack, reports on specific health related topics.

European Public Health Alliance (EPHA)	
33 Rue de Pascale, 1040 Brussels, Belgium Tel: + 32-2 230 3056 Fax: + 32-2 230 3880 email: epha@epha.org website: www.epha.org	
<p>Founded:</p> <p>Members:</p> <p>Categories of members:</p> <p>Financed by:</p> <p>Areas of interest:</p> <p>Main activities:</p> <p>Major Publications:</p>	<p>1993</p> <p>Over 75 local, regional, national, European and international non-governmental and other not-for-profit organisations that actively protect and promote the public health interests of all people living in Europe.</p> <p>NGOs, Government Agencies, Educational Institutions, Individuals</p> <p>Commission, membership and publication subscription fees</p> <p>Public Health, Health Promotion, Healthcare Services, Consumer interests, Research, Regional development, Environment, Transport, Social Welfare</p> <p>EPHA plays a major role in the development and strategy of European health policy by:</p> <ul style="list-style-type: none"> • monitoring the policy making process within the EU institutions and maximising the flow of information concerning health promotion and public health policy developments amongst all interested players including: Commission officials, MEPs, member state and candidate country ministries, NGOs and citizens • promoting greater awareness amongst European citizens and non-governmental organisations about policy developments and programme initiatives that effect the health of EU citizens so that they can contribute to the policy making process and take practical action to take part in appropriate programmes • supporting collaboration at a European level between non-governmental organisations and other not-for-profit organisations active in the member states and the candidate countries in health promotion and public health. <p>European Public Health Update (bi-monthly magazine in English, French and German), EPHA membership newsletter, EPHA membership directory, annual review, Health Forum Intergroup minutes, position papers, briefings and press releases</p>

European Public Health Association (EUPHA)	
Eupha Secretariat, Admiral Helfrichlaan 1, 3527 KV Utrecht, The Netherlands Tel: + 31-70 30 300 45 Fax: + 31-70 30 300 45 email: eupha@knoware.nl website: www.nivel.nl/eupha/	
Founded:	1992
Members:	25
Categories of members:	NGOs, Institutions/individuals/Government agencies can become associate members or benefactors.
Financed by:	Members, sponsorship, project money, profits from their revenue
Areas of interest:	Public Health, Health Promotion, Healthcare services, Research
Main activities:	Annual conferences; Exchange of information; Publication of EUHPER journal
Major Publications:	European Journal of Public Health (quarterly journal)

International Union for Health Promotion and Education, European Region (IUHPE)	
Campus Univeritario de Cartuja, Ap Correos 2070, Granada 18080, Spain Tel: + 34-958 16 10 44 Fax: + 34-958 16 11 42 email: iuhpe@easp.es website: www.easp.es	
Founded:	1951
Members:	350 members approx. in the European Region
Categories of members:	NGOs, Government agencies, Private companies, Educational Institutions, Individuals
Financed by:	Members, donations, EASP (IUHPE's hosting office in Spain)
Areas of interest:	Public Health, Health Promotion, Healthcare services, Consumer interests, Research, Regional development, Environment, Social welfare
Main activities:	Liaison; Networking; Consultancy; Information; Training; Research; Conferences and meetings
Major Publications:	Euronews, European Bulletin on Health Promotion (European office)

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Website: www.who.int/regions/weu

WHO European Centre for Health Policy

c/o Ministère des Affaires Sociales, de la Santé Publique et de l'Environnement
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Fax: +32-2 210 50 37
Email: pascale.dejond@health.fgov.be

NB: A larger directory of European organisations representing the interests of public health is available from the ENHPA (address above).

Appendix 1

Focus Group Meeting, 6 October 2000

Participants:

Ms Linda Barclay, Director of Planning, Health Promotion Agency Northern Ireland

Dr Rosaleen Corcoran, Director of Public Health, North Eastern Health Board

Mr Denis Doherty, Chief Executive Officer, Midland Health Board

Mr Niall Fitzduff, Director, Rural Community Network

Prof Bernadette Herity, Emeritus Professor of Public Health Medicine, University College Dublin

Ms Mary Ellen McCann, Director, Ballymun Youth Action Project

Ms Bidy O'Neill, Health Promotion Officer, South Eastern Health Board

Dr Anne Marie Telford, Director of Public Health, Southern Health and Social Services Board

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Mr Owen Metcalfe, Associate Director

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