

EUROPEAN PARLIAMENT

DIRECTORATE GENERAL FOR RESEARCH

Working Document

EUROPEAN UNION HEALTH POLICY ON THE EVE OF THE MILLENNIUM

Public Health and Consumer Protection Series

SACO 102 EN

This study is available in the following languages:

EN (original language)

An executive summary (SACO 102a) is available in all official EU languages from December 1998.

The opinions expressed in this document are the sole responsibility of the author and do not necessarily represent the official position of the European Parliament.

Reproduction and translation for non-commercial purposes are authorized, provided the source is acknowledged and the publisher is given prior notice and sent a copy.

Publisher: European Parliament
L-2929 Luxembourg

Author: Lyndsay Mountford

Editor: Graham R. Chambers
Directorate General for Research
Division for Policies on Social Affairs, Women, Health and Culture,
Tel.: (00352) 4300 23957
Fax: (00352) 4300 27720

E-mail: gchambers@europarl.eu.int

Internet: <http://www.europarl.eu.int>

Manuscript completed in September 1998.

EUROPEAN PARLIAMENT

DIRECTORATE GENERAL FOR RESEARCH

Working Document

EUROPEAN UNION HEALTH POLICY ON THE EVE OF THE MILLENIUM.

A BACKGROUND STUDY FOR THE

PUBLIC HEARING ON HEALTH POLICY

28 OCTOBER 1998

Public Health and Consumer Protection Series

SACO 102 EN

9-1998

ACKNOWLEDGEMENTS

A large number of people gave willingly of time and thought to this study, particularly the fifty-five people I interviewed during the summer of 1998. I hope that this report does justice to the quality of analysis which they contributed.

I owe particular thanks to the South East Institute of Public Health in the UK. Dr Declan O'Neil helped to set up a structure for this study which proved robust to the demands both of working at speed and across a wide range of issues simultaneously. Dr June Crown, Director, reviewed the final report and her comments were especially helpful in providing shape and emphasis to its recommendations. Responsibility for the interviewing and the comments and conclusions set out in this report is, however, entirely mine.

*Lyndsay Mountford
Luxembourg
September 1998*

Possible conflicts of interest:

LM is a freelance health economist living and working in Luxembourg, on special leave from the UK Department of Health. Her particular expertise and interest is in health services planning. She was formerly senior health economist at the European Investment Bank.

TABLE OF CONTENTS

Foreword		vii
Executive Summary		ix
Chapter One:	Introduction and Background	1
Chapter Two	The Cost-Effectiveness of the Existing Programmes	7
Chapter Three:	Strategic Options and Objectives	25
Chapter Four:	The Future Organisation of the Commission	37
Chapter Five:	Conclusions and Recommendations	43
Appendices:	Specifications for this Study	45
	Setting Priorities in Research: A Case study	47
	Assessing Payback from Research and Development	49
	Bibliography	51

Foreword

This study was requested by the European Parliament's Committee on Environment, Consumer Protection and Public Health as a basic input document for the Public Hearing on Health Policy organised by that Committee on the 28th October 1998. Owing to the fact that the go-ahead for the study was only received in April, the deadline was extremely tight and the work had to be carried out over the summer period. Despite this, the result is a very solid piece of analysis.

The title "European Union Health Policy on the eve of the Millennium" was chosen because of the significance of the timing of this study and of the Public Hearing.

Health policy has been gaining in significance at European level for some time now. The realisation that the creation of the Single Market left some significant holes with regard to health and consumer protection was emphasised by a series of problems with food hygiene and resultant health problems, salmonella in eggs and poultry, listeria in dairy products and cook-chill products, the use of growth-promoters and prophylactic antibiotics in animal-rearing and last, but certainly not least, Bovine Spongiform Encephalopathy.

The European Parliament and in particular its Environment Committee have been instrumental in placing health high on the political agenda and in obtaining the changes to the provisions on health in the Amsterdam Treaty. In addition to the changes in the text, health is now a matter for co-decision between Council and Parliament. Not least, in its reaction to the BSE crisis Parliament has set the agenda for the European Union. Its Enquiry Committees into BSE and the subsequent "suspended censure" of the Commission have led to far-reaching changes in the organisation and the relative importance of consumer health protection.

This has highlighted the question of how health is dealt with overall at EU level and in particular has led to questions about the efficacy and appropriateness of the existing public health policy and structure. There is overall a feeling that the existing public health architecture is no longer adequate to the demands which are placed upon it.

1999 will see the election of a new European Parliament. The Commission itself is gearing up for structural change in the year 2000 to meet the challenges posed by future enlargement. The Common Agricultural Policy is coming under unprecedented scrutiny. The whole question of environmental and health audit of policies at national and international level is being raised as never before. The question essentially is how to ensure that the public health in its broadest sense is incorporated in other policy areas as more than just a gesture or cosmetic addition.

Subsidiarity demands that we execute policy at the most appropriate level and that health policy at European union level deliver "European added value". Furthermore the organisation and funding of health care systems is undergoing change and scrutiny as never before in all member states. Recent judgements at the Court of Justice concerning reimbursements to patients who have gone to other member states for medical treatment are a symptom of a growing phenomenon - likely to grow further as the single currency comes into being.

Although the organisation of health care is recognised as something which should be carried out at national, or indeed regional level, there is no doubt that much can be gained from comparison and exchange of experience between member states.

The study, which addresses controversial issues, was requested by the European Parliament's Committee on Environment, Consumer Protection and Public Health as a background document to inform and to stimulate wide-ranging debate on current and future EU health policy.

The Public Hearing on Health Policy comes at a very opportune moment, indeed a defining moment in the history of the European Union. This study attempts to inform the debate which will take place not only during the Public Hearing, but probably for a long time afterwards.

EXECUTIVE SUMMARY

The Purpose, Terms Of Reference And Methodology Of The Study

- E.1 This report sets out the findings of a study of European Union Health Policy. The study was commissioned by the Environment, Consumer Protection and Public Health Committee of the European Parliament and was conducted between July and September 1998. The Committee required an issues paper which would inform its Public Hearing on EU health Policy on 28th October 1998.
- E.2 The study covers three main sets of issues. It assesses the cost-effectiveness of the existing programmes, whether Member States' interests are properly represented and whether the programmes give sufficient attention to the question of subsidiarity. It concentrated on the four programmes contained in the current (1993) framework which have been implemented to date: Cancer, AIDS and Communicable Diseases, Drug abuse and Health Promotion, along with the Health Monitoring programme which has just started. All have followed a common implementation pattern which consists of establishing or strengthening European-wide networks or collaborations and funding projects submitted by researchers.
- E.3 In view of the impracticability of scrutinising all the networks and projects within the existing timeframe, the study set out to explore the design of the programmes with reference to current best practice in the management of research. This is to be found in an increasingly proactive, strategic approach which defines clear operational objectives and outputs, identifies the gaps in the coverage of existing research and attempts to generate user-relevant end-results with clear policy implications. The study scrutinised the existing programmes for these elements. Specifically it looked at how "European value-added" has been defined and whether projects had been selected to deliver it. It also sought to identify what procedures exist for scrutinising research bids for value for money. It considered the role of Networks in policy development and their effectiveness as tools of implementing policy.
- E.4 A second set of strategic questions related to how EU policy should develop in the future, particularly in the light of Agenda 2000 and possible enlargement of the EU. A specific question was whether a disease-based approach was appropriate.
- E.5 Finally, the study was invited to consider future organisation of the health policy functions of the EU within the Commission, with particular reference to DGXXIV.
- E.6 In view of timescale and timing constraints, the study relied heavily on efficient and flexible information-gathering methods, namely semi-structured interviews and a brief literature search in each subject area. The interviews, totalling 55, covered Europe-wide international organisations and networks, including international specialists in each of the subject areas represented in the EU programmes. These were supplemented by interviews with representatives of Member States from the official programme committees, particularly from the UK and Finland. The report was reviewed in draft by

several specialist public health practitioners and/or representatives of member states who were acquainted with the EU health programmes, but had not been involved in the interviews.

Results of the Scrutiny of Programmes

E.7 The study identified a number of EU-sponsored projects which are particularly good examples of work which can be done most effectively at international level. These include:

- the European Prospective Investigation into Cancer and Nutrition (EPIC) run by the International Agency for Research in Cancer.
- the promotion and upgrading of Cancer Registries.
- communicable disease surveillance networks.
- the epidemiology of substance abuse undertaken by the European Centre for Drugs and Drug Addiction, and
- the collection of international statistics of incidence of HIV and AIDS undertaken by the European Centre for the Epidemiological Monitoring of Aids.

The inherent international value-added of these projects derives from:

- the importance to their findings of sample size
- the ability to construct and test hypotheses arising from the geographical diversity of the EU and the explanatory power of comparative analyses
- standardisation of data.

E.8 In addition, the projects are characterised by good strategic understanding of their role in each particular field and a reliance on high quality technical expertise for design and implementation.

E.9 It seems likely that a wider range of disease-based, population-based, risk-based and policy-related studies might also yield value from treatment at international level and that not all possibilities are being exploited. An appropriate response by the EU through its funding programmes, would be to promote highly focused activities which are selected according to the definitions of value added set out above. The addition of cost data, and explicit cost-effectiveness or cost-benefit criteria would help to prioritise these projects in an approach akin to optimising a portfolio of investments. Burden of disease would be an important determinant of status, but existing coverage by other international work, and "rarity" must also feature as determinants of EU value-added.

E.10 Most projects financed under the existing programmes do not appear to be selected against these technical criteria of "international or European value-added". Instead, the Commission uses "number of collaborators" as a key test. The result is that the

programmes have probably generated process benefits where collaborations have been long lasting and successful, but seem to include many projects which could have been carried out at national level.

- E.11 A number of very specific criticisms are common to each of the programmes. They include a lack of strategic planning; the absence of detailed and operationalised objectives; a selection process which lacks the rigour of peer review and is heavily concentrated in the hands of the Commission; uncertain methods of dissemination of project reports. There is considerable confusion about the distinction between pure research and action oriented study, and hence about the respective roles of DGV/F and DGXXII. The rigidity of the programmes is particularly striking: the competences of the Commission are set out in the facilitating legal instrument and then implemented as set out. There appears to be little room for policy development which is separated out into a distinct unit of DGV/F. Read across between programmes and policy development within DGV/F appears to be somewhat ad hoc and haphazard.
- E.12 Direct Health Education was seen as a particularly inappropriate activity at European level, precisely because of the geographical and cultural diversity of Member States' populations.

Future Development of EU Health Policy

- E.13 In addition to its current funding activities, the EU is active in other policy areas which have a direct bearing on health. Classically these involve the so-called "lifestyle issues", which implicate in particular the disincentives to healthy diet contained in the Common Agricultural Policy. These include incentives to tobacco production, incentives to production of foods high in animal fat, and destruction of surpluses of fruit and vegetables, known to be important protectors against a range of illnesses including cancer. Other relevant sectors include a range of environmental issues concerned with waste products, water quality, land use, air quality, energy sources, transport and global environmental changes. The main thrust of EU health policy in future, and its main health promotion activity, should be the development of multidisciplinary working in these areas involving suitably qualified health professionals and incorporating health impact assessment into policy. This should include the development of environmental health indicators. The purpose of health impact assessment would be to enable the effects of policies on health to be made explicit and to enable costs and trade-offs to be evaluated.
- E.14 The EU does not have legal competence to be directive over questions concerning the organisation and delivery of health services and medical care. This does not, however, inhibit it from issuing market-related directives which can and do have extensive implications for the costs and organisation of Member States' health care systems. Nor does it refrain from promoting co-operation between Member States and research into high technology curative medicine through DGXII's Biomed programme.
- E.15 The study encountered strong views on both sides of the debate about whether and how far the EU should develop studies of health care systems. Public health practitioners tended to stress the difficulty of ensuring that health care issues did not hijack the

prevention/promotion agenda. On the other side, many expressed doubts about the real relevance and cost-effectiveness of health promotion. Many commentators were sympathetic to the notion that knowledge of health care systems, and of the impact of changes to which many health care systems are now subject, is rudimentary and would benefit greatly from comparative international study. Some regarded it as important that the impact of EU market-related directives on health systems was clearly analysed and debated with Member States by a part of the Commission responsible for promoting, protecting and co-ordinating Member States' interests in this area.

- E.16 The EU coexists, sometimes uneasily, with other influential international health care institutions. In an attempt to assert its authority in health it has sometimes appeared to want to "go it alone". Many of those interviewed saw the need for increased international collaboration which would draw on and support the expertise of institutions such as the OECD and WHO. The EU has a comparative advantage in European health policy through its access to funding and, drawing on Member States expertise, policy-oriented study. Other organisations can offer high levels of technical expertise, in addition to the specific country knowledge of both the WHO and World Bank in Central and Eastern European countries. Collaborations need to be subject to clear statements of respective roles in the development of future international health policies.
- E.17 There is no obvious reason why Enlargement should cause the basic structure of EU health policy described above to be altered. Enlargement might alter the prioritisation of disease-based topics, but is more likely to enhance the need for health to be integrated with environmental issues. It might exacerbate an implicit sense that EU health policy should be geared particularly to populations with lower health status and/or poorer access to health services. This is extremely difficult to do through a public health (rather than an aid) programme and the desirability and implications of having a more regionally-sensitive EU health policy need to be debated. Health inequalities ought to be dealt with as part of policy developments which focus on relative social and economic deprivation as an explanatory factor of health inequalities. The response, however, is multi-faceted and again serves to emphasise the importance of integrated EU policies.
- E.18 A variety of Networks have been set up under the existing programmes. These involve project-based collaborations, collaborations of executive members of Member States' health systems, and networks of non-statutory organisations. The composition of networks has tended to reflect their role, from executive actions (e.g. in disease surveillance) to advisory, to lobbying. Quite how the voluntary networks relate to Member States statutory health systems and policy development or to the voluntary sector in Member States is not always clear; nor is it always obvious how far the networks constitute an additional level of European bureaucracy which is centred and focused on Brussels rather than effecting successful partnerships with Member States. Part of the strategic development of a focused public health programme must involve a clear view of what settings/arenas should be targeted and what alliances and partnerships should be promoted. A more focused alternative would be to develop direct interfaces between DGV/F and member states' representatives, and part of the future development of the EU Public Health Unit should be the acquisition of country-specific

expertise. Health promotion defined as health education and an outreaching style of advocacy should give way to a new "internal" advocacy which aims to promote the development of high quality policy through the funded programmes and the position of public health in the Commission.

- E.19 The EU should not so much seek to increase its funding budgets as to spend existing budgets more selectively and to greater effect. An increase in administrative budgets is essential to achieve the enhancement of existing expertise.

Future Organisation of Health Policy in the Commission

- E.20 Health policy must be located in Brussels rather than Luxembourg to stand any chance of integration with other policy areas.¹
- E.21 Establishing health as a separate DG, though often mooted as a desirable objective, seems unlikely to be justified in terms of budgets. More pertinently, it constrains health, an archetypally cross-cutting agenda, within a classically vertical structure. There is insufficient overlap with DGXXIV to justify a merger between the traditional public health business of DGV/F and Consumer Affairs. Much of DGXXIV's business can be dealt with in a self-contained way and without strategic health oversight. The same is true of DGXI although there is a much greater overlap of subject matter and a need to have health expertise working alongside the environmentalists.
- E.22 One option which would call on the best exercise of modern management techniques, is for core public health issues to be retained in the current structure, but for DGV /F to be much more closely integrated with the Social Affairs directorates of DGV. This should in turn expand their remit to include the new social agenda of public health epidemiology and of health inequalities. A "Lifestyles" unit would be incorporated within Consumer Affairs and an "Environmental Health" Unit within DGXI. Both devolved units would draw on specialist, outposted public health staff from DGV. This assumes that the existing Committee structure in Parliament would continue unchanged, which may not be the case after the 1999 elections. The main problem with such an arrangement is that it is extremely difficult to manage successfully.
- E.23 A less ambitious version of this option would locate public health with social affairs, but would use existing arrangements for inter-service consultation with other DGs. A special Operational Unit would be responsible for health security and control, covering issues such as communicable diseases, vaccines and immediate environmental threats.
- E.24 This option stresses the importance of visionary and effective leadership and a large enough cadre of well-qualified and influential public health experts able to make an impact across the range of relevant EU policies. This will in turn require a revolution in Commission recruitment practices.

¹ However, a Decision of 8th April 1965 states that " The Directorate for Health Protection **shall** be located in Luxembourg."(OJ 152 13/7/67) - (Selected Instruments taken from the Treaties, Book 1 p783) This Decision was re-confirmed by the Edinburgh Summit of December 1992.

CHAPTER ONE

INTRODUCTION AND BACKGROUND

The Origin, Purpose and Output of the Study

- 1.1 This study of European Union Health Policy was commissioned by DGIV the Research Directorate-General of the European Parliament in response to a request by the Parliamentary Committee on Environment, Consumer Protection and Public Health. The Committee wanted a wide ranging review which would look critically at current health policy, and at its future direction and development, in a report which would inform and contribute to a Public Hearing of the Committee in October 1998.
- 1.2 The study had to be conducted within an extremely short timeframe, over a major holiday period and within a constrained budget. In view of the difficulties of drawing definitive conclusions under such difficult working conditions, and in the light of what seemed likely to be most helpful to the Public Hearing, it was agreed that the study should result in an *issues paper*. The main purposes of the paper would be to provide a clear structure for discussion and to draw together key issues and main strands of professional thinking under a number of headings suggested by the terms of reference.
- 1.3 The study focused on professional, technical and managerial questions about what would constitute an appropriate and effective European-level contribution to public health and how this might be organised within a future Commission. It was not principally about what legal Treaty-based competences have hitherto determined – some would argue constrained – the development of European Union health policy to date, nor is this report always constrained by what is politically realistic or achievable in the short term. It defers in some measure to the political and organisational difficulties inherent in any reform of the Commission which would put health into a driving seat: but the acquisition of relevant professional skills within the Commission, however difficult to achieve, is presented as a *sine qua non* of further successful development of EU health policy.

The Terms of Reference

- 1.4 The terms of reference of the study are set out at Appendix 1. The following sets out how the individual points were grouped since this established the structure of the study (the selection of literature, the choice of interviewees and the structure of the interviews) and the organisation of this report. There appeared to be three main headings.

The Cost-Effectiveness of the Existing Programmes

("are the programmes themselves effective? Can they be made more effective? Is the EU taxpayer getting value for money (VFM) and are budgets appropriate to do the job?")

- 1.5 Of the eight programmes allowed for in the 1993 Framework document, five have been implemented namely Cancer, AIDS and Communicable Diseases, Drugs, Health Promotion and Health Monitoring. A further three, Accidents and Injuries, Rare Diseases and Pollution-related Diseases are in preparation but have not yet formally started. Some (Health Monitoring, Communicable Diseases and Health Promotion) are of very recent implementation, although have been under preparation for some time. Others, namely Cancer, HIV/AIDS and Drug Abuse are the continuation of past, longer running programmes. For the latter no real attempt has been made in what follows to separate out one project cycle from a previous one.
- 1.6 The implementation of each programme has followed a common pattern, namely:
- the identification of broad headings of activities under which to fund projects submitted by organisations from Member States
 - the establishment and part-funding of European-wide networks
- 1.7 This component of the study promised to be the most difficult. There are immense methodological difficulties in assessing the VFM of health inputs, in particular the difficulty of measuring their impact objectively and quantitatively. These difficulties are compounded at European level because the EU Public Health programmes tend to duplicate those of member states. Separating out the impact of international from national activities was likely to be extremely difficult. The study was not resourced to carry out scrutiny of individual projects, which is in any case being undertaken comprehensively as part of mid-term evaluations of each programme.
- 1.8 A more fruitful approach seemed to be to assess the *design* of the programmes and of their implementation:
- whether there has been any overall strategic management of the programme budgets which has resulted in a clear definition of European value-added and has prioritised projects so as to maximise the impact of the available budgets. What systems exist to trace the output of projects, to control the quality of project results and to disseminate findings? How do policy-related projects feed back into policy development?
 - how it is decided what European networks to establish, how these networks interface with national statutory and other agencies and how they are expected to impact on national health policies? What systems exist to manage their impact and activities?
- 1.9 This approach proved to be extremely fruitful. The findings of this part of the study strongly inform the strategic policy questions outlined below. They are set out in Chapter 2.

Strategic Options and Objectives

- 1.10 There was a set of strategic questions about what European health policy should consist of and how components of it should be selected. This has a backward-looking element: "is the division of EU health policy into disease-specific programmes sensible and efficient?" and also a prospective element: "what are EU Health policy options from the year 2000 in the light of the Amsterdam Treaty and Agenda 2000?"
- 1.11 These questions invite discussion about how priorities can be set other than in disease-specific terms and whether alternative approaches should be incorporated into EU health policy. They turned out to be inseparable from the issue of "European value added". - what constitutes the distinctive contribution which can be made to health policy at European level over and above that which can be achieved by member states individually - and what *role* the EU should play in relation to Member States ("whether the programmes are correctly structured in the light of subsidiarity and add value to Member States' Health Policies"). Whether future policy options should be amended as a result of Enlargement clearly belongs here. This section of the report also deals explicitly with "settings, mechanisms and alliances" which emerged during the study as an important for policy and implementation, and with future budgets. These issues are dealt with in Chapter 3.

Organisation of the Commission to Deliver Future Policy Objectives

- 1.12 A final set of questions concerned how the Commission should be organised and managed in future in relation to:
- existing interfaces between Directorates having explicit health policy responsibilities ("what is the relationship between the Commission's DG5 Directorate for Public Health and the recently enlarged DG24 responsible for consumer health protection? Does this need to be changed?")
 - the management of internal relationships with Directorates responsible for policies with health implications ("the study should examine ways in which effect on public health can be incorporated as a basic consideration into all other policy areas of the EU")
 - the management of external interfaces, both with member states ("are the roles of the Commission/Member States well balanced in these programmes?") and with other international organisations in the health field ("what is and what should be the relationship in health policy between the EU and organisations such as WHO, OECD and the Council of Europe?").

The last set of questions also relate to that of "EU value added", as opposed to "international value added", and to a strategic approach to implementation. They are dealt with as a conclusion to Chapter 3, and the remaining organisational questions in Chapter 4.

Methodology

- 1.13 The tight deadlines for this study meant that it was necessary to gather information as fast and efficiently as possible. It relied heavily on face-to-face, semi-structured interviews, and to a lesser extent on telephone interviews, supplemented by a selection

of key papers from the literature. The study took up ten man-weeks, of which six were devoted to set up and interviewing and the remaining four weeks divided more or less equally between assimilation of results and report writing.

- 1.14 The interviews covered the following Europe-wide groups:
- representatives of the policy division of DGV of the European Commission (DGV F/1)
 - representatives of international public health networks operating in Brussels, many funded by the Commission
 - representatives working in the individual programme areas from both the Geneva and Copenhagen offices of the World Health Organisation
 - representatives of other international organisations, including (but not exclusively) OECD and the Council of Europe
- 1.15 The DGV/F officers responsible for running the individual programmes constitute an important omission from this list. It was the decision of the two heads of unit concerned not to allow their staff to comply with this study pending formal authorisation from the Commission. This was not forthcoming until three weeks into the study period, by which time most DGV/F programme officers were on holiday and the Luxembourg-based phase of the study was practically complete. Consequently, the study had to be conducted largely without the benefit of input from those actually responsible for administering the EU programmes. They may justifiably feel that some of the difficulties which they confront in the management of the programmes are under-represented in this report.
- 1.16 In addition to Europe-wide institutions and personnel, there were consultations with national representatives and other experts in each of the programme areas. The UK and Finland featured prominently in this exercise. The choice of countries was entirely pragmatic: two was the limit of what could be achieved in the time; both countries have well organised public health systems and it appeared that linkages, or the lack of them, might be tracked easily; one had just held, and the other is just about to hold, the Presidency of the European Union; one could easily be combined with a holiday location to facilitate conduct of the study. Neither country is necessarily representative.
- 1.17 The interviews were conducted on the basis of confidentiality and non-attribution of individual comment. A total of 55 interviews were conducted. However, the sample size is very small for each subject area. A full list of interviewees has not therefore been included with this report, although a list of interviewees has been provided to DGIV of the Parliament as a confidential annex.
- 1.18 For similar reasons, quantitative analyses of the results are not possible. The study was not a formal survey, but should be seen more as a journalistic reporting exercise and the results treated with appropriate caution. The main test of the study is not its methodological rigour, for which there was neither time nor funding, but whether it has addressed the right questions and conveyed answers which achieve sufficient consensus. Several reviewers, either with public health expertise and/or with specific knowledge and experience of EU health policy, commented on this report in draft.

1.19 The literature search concentrated on four main areas:

- the general literature on prioritisation and the specific priority-setting exercises of some member states
- general policy comment, of which there is quite a lot from relatively few sources, on:
 - the conduct and development of EU Health Policy
 - the impact of EU law on Member States' health systems
 - the impact of EU policies on health determination
- comment, of which there seems to be relatively little, on the individual programmes
- a relatively small selection of literature on the prioritisation of research projects and how to secure value for money from research, drawing particularly on the recent experience of the UK Research and Development Directorate

1.20 This study was not permitted access to "internal documents" of DGV/F.

1.21 A vast amount of other literature – well beyond the scope and timescale of this study to assimilate in its findings – was collected en route, and is also included in the bibliography for reference purposes.

CHAPTER TWO

THE COST-EFFECTIVENESS OF THE EXISTING PROGRAMMES

Key Questions

Definition of "European Value-Added"

- 2.1 Cost-effectiveness, commonly described as "value for money" (VFM), is a technical term describing efficient resource allocation. It implies obtaining maximum output from the allocation of given resources, or the expenditure of minimum resources to achieve a given target. At European level, the term is intimately bound up with "subsidiarity" – a political concept – and that of "European value added". A defining principle is that European Union health policy should consist only of actions delivering output which cannot be achieved by Member States acting individually, or which deliver economies of scale. Otherwise, it risks duplication, displacement of activity to a level which is politically inappropriate and economically inefficient, and contravention of national priorities and activities. Key questions for each of the programmes were: *what type of projects deliver European value-added and how far have these been undertaken by each of the programmes?*
- 2.2 In some cases, member states have already acted to exploit international value-added in bilateral or multilateral arrangements which sometimes go well beyond the geographical boundaries of the EU. In such cases it is reasonable to ask whether the EU has a role, and also whether an emphasis on EU-wide activity is detrimental to existing arrangements or inhibiting to the development of wider international collaboration.
- 2.3 Finally, where existing fields are well covered by other international organisations, it is also necessary to ask whether the EU needs to set up its own activities, or whether it is more efficient to act *in support* of other agencies. This particularly applies to the activities of the World Health Organisation. Some comment on this question is contained in the scrutiny of individual programmes, although the bulk of the discussion is left for Chapter 3.

The Strategic Management of Research Budgets to Deliver Value for Money

- 2.4 What price is worth paying for "European value-added" is for judgement in individual projects and will depend both on cost and on the expected magnitude of the impact. In the past, health research has been predominantly researcher-led, with individual research bids scrutinised as purely self-contained proposals for internal consistency and methodological coherence. This is the model adopted by the EU for funding project bids under each of the programme budgets. Organisations and collaborations are invited to bid under very broad headings such as "data collection and research" or "training and quality control" which themselves address general and unquantified objectives such as

"improving the quality of life" or "reducing mortality and morbidity". The adoption of this model means that the Commission exercises very little control over the type and content of projects submitted, the relative priority of the subjects addressed, or their operational relevance.

- 2.5 There is however increasing interest in – and a growing international literature on – the strategic management of research programmes and on the need to justify research in terms of the benefits which it delivers to health, health policy or health practices. The value of research is no longer automatically taken as given.
- 2.6 This movement has long acknowledged that much research is duplicative and of variable quality. It has given rise to the international Cochrane Collaborations which undertake *meta analyses* of existing studies. These compare, contrast, categorise and quality-control existing studies and draw policy conclusions from them.
- 2.7 There is also now an increasing emphasis on *evidence-based* practice and policy which has enhanced interest in the potential contribution research can make. This is spawning a more proactive approach to the management of research programmes characterised by an explicit assessment of research needs and often involving quite elaborate processes to identify, define and prioritise research projects.

A practical example of this approach is summarised in Appendix 2 of this report.

- 2.8 Most recent methodological developments in research management include the explicit use of cost-benefit techniques at individual research project level to assess the *payback* on research expenditures.
- 2.9 Finally, there has also been a growing understanding that the existence of research findings alone is not sufficient to ensure changes in policy and practice. The process of dissemination is more complex and less predictable than has often been assumed. Part of the new proactivity in research management includes attempts to ensure not only that research results are available to decision makers, but are also interpreted and made operationally relevant to them.
- 2.10 Consequently, a second set of questions was: *how does the EU prioritise project bids under each of the programme budgets, does this deliver VFM and would the adoption of a more proactive, strategic approach described above improve the effectiveness and cost-effectiveness of the programmes?*

Implementation and the Use of Networks

- 2.11 A final set of questions about the effectiveness of policy concerns the use of networks as an implementation tool for the public health programmes of the EU. DGV/F funds a variety of different networks for a variety of purposes, including networks of NGOs who have high political priority within the Commission as a whole. The study attempted to scrutinise:

-what different types of networks have been set up, for what purposes?

-are these networks effective? What is an "optimal number" of networks?

-how do the networks relate to the statutory public health authorities in member states, to other national non-governmental organisation (NGOs)? and

- how do they contribute a European dimension to the development of policy within member states, or otherwise impact on national populations?

- 2.12 Perhaps inevitably, this element of the study suffered most from time constraints. A number of representatives from European health networks were interviewed, but represent such a small sample of experience that firm conclusions are scarcely justified. The questions do, however, seem to be of such importance for future implementation of policy that they are rehearsed in more detail below, and some speculative conclusions drawn as a prompt to further discussion.

Results

- 2.13 The results are reported in relation to each of the five programmes currently being implemented by DGV/F, namely:

Cancer

AIDS and Communicable Diseases

Drug Abuse

Health Promotion

Health Monitoring

However, simple classification in this way is not straightforward and comments overlap programmes: each programme contains an element of health promotion (particularly health education) and of data collection (health monitoring). Europe against Cancer incorporates a tobacco policy which, as a generic influence on health, is equivalent to the alcohol and nutrition elements dealt with by the Health Promotion team.

Cancer

- 2.14 A general classification of activities in the field of cancer cover the following main disciplines:

- (i) Epidemiology: incidence of cancer, mortality and outcomes data
- (ii) Causes of human cancer
- (iii) Mechanisms by which cancers develop
- (iv) Primary prevention of cancer
- (v) Secondary prevention particularly through screening programmes
- (vi) Diagnosis and therapy
- (vii) Palliative care

2.15 The study identified the following topics within these classical domains which can best be done at international level:

- (i) Generation of comparative incidence, mortality and survival data, country by country, which leads to the generation of testable hypotheses about causation and comparative quality of treatment.

The European-sponsored Cancer Registries project is therefore regarded as important for further research into the causes of cancer and the improvement of treatment programmes.

- (ii) large scale epidemiological studies into the causes of cancer which can utilise very large sample sizes provide a heterogeneous background with which to test hypotheses about causality.

The part EU-funded European Prospective Investigation into Nutrition and Cancer (EPIC) study, co-ordinated by the WHO's International Agency for Research into Cancer (IARC) which involves approximately 450,000 patients from nine European countries, was described as "the envy of the US research community". The European Union funds approximately 3 MECU out of total costs of 8 MECU per annum. The study is expected to have far reaching implications for determining the interaction of nutrition with genetic factors in the development of many different types of cancers.

- (iii) the generation of critical sample size in studies of rare cancers, for example the IARC study of the influence of passive smoking on the development of lung cancer
- (iv) selective use of large scale clinical trials to test treatment interventions for individual cancers and international standard setting for the development of trial protocols
- (v) quality assurance protocols, drawing on comparative practice, in:
 - secondary prevention through development of screening protocols
 - treatment regimes, by comparing different treatment regimes with outcomes data

2.16 An area thought to be particularly difficult to deal with at a European level is direct health education which is widely regarded as a culturally specific activity requiring to be done at national level. This was a view repeated again and again, both by experts in specific fields such as Cancer and by health promotion agencies. The implication is, for example, that the EU should not run "Europe against Cancer" weeks. Several commentators noted the excellence of the European Code against Cancer, but wondered if it was superfluous to national efforts.

2.17 Whilst the European programme is seen as sponsoring epidemiological projects in Cancer prevention which were described as "amongst the most imaginative and exciting underway today", questions are raised about

- whether the Cancer programme is effectively exploiting all possibilities of obtaining European value-added
- the appropriateness and cost-effectiveness of many of the projects which are funded.

2.18 There are a number of relevant points:

-projects are not selected according to technical, output-based, definitions of European value-added (for example the value of statistical sample size and explanatory importance of comparative analyses referred to above). The definition of European value-added deployed refers solely to the number of collaborators, at best a process benefit. The result is that many projects which do not appear to deliver European value-added at all, but which could be satisfactorily conducted at national level, are financed under the programme. The need to achieve equity of funding between member states is also seen as being an important determinant of prioritisation leading to what one commentator described as "horse-trading" in bids. The standard of project bids is described as "disappointing".

-there is no strategic management of the available budgets to determine funding priorities in relation to existing research and gaps in knowledge, and to maximise the impact of the available funding. The funding headings under which project bids are invited are seen as being far too wide, and the expertise of the specialist advisory committee on cancer is widely perceived to be seriously under-utilised.

-there is considerable confusion about the respective roles of DGXII (Biomed) and DGV/F in funding research, with some organisations describing how they submit the same project to both. It is equally unclear what expertise DGXII has in developing research priorities for health or what the goals of DGXII are when prioritising health-related research bids.

2.19 The process of individual project scrutiny is also widely criticised. The process does not follow the normal pattern of peer group review, project descriptions are said to contain insufficient material on which to base sound judgements and the projects do not appear to have to specify well-defined and measurable outputs. The process of prioritisation is said to be determined largely by Commission staff.

2.20 There is no strategic management of individual project/research areas. This point has several components:

-projects are funded on an annual basis, but assured continuity of funding would sometimes be more appropriate

-there is no overall strategic direction for some projects and researchers are left wondering how to develop the area of work further and build from one project to another

-there is some difficulty transferring projects in a second phase from Biomed, where some originate, to DGV/F programmes

-there is for the most part no effective reporting of the output of projects and dissemination is left largely to the researchers. It is left to the evaluation process to discover whether the projects have achieved any impact or not

-crucially, feedback of policy-related research into the further development of EU health policy appears to be negligible. Several projects look as though they ought to feed into policy analysis and development, whereas there are no mechanisms for the dynamic development of policy under the legal frameworks which establish each programme.

- 2.21 It proved an interesting detour to investigate the possible effect of European Cancer Policy in the UK. The UK is in the process of reorganising its cancer treatment services in response to evidence that outcomes are poorer than in many other European countries and hence the quality of treatment less good. The hypothesis which this study pursued was that the upgrading of cancer registries and the production of comparative data on survival rates had been an important ingredient in the development of UK policy.
- 2.22 However, contributors to the Calman-Hine report, which set out the need for the reorganisation of cancer services in the UK, felt that European policy had not had a significant effect, either in prompting the report, or in guiding its conclusions. At the time the international data had not been of sufficient quality to be convincing enough, and a range of studies and comment, particularly by the UK media, had already highlighted wide variations in quality of treatment of cancer around the UK. This is not to deny the role of international cancer registry data, and continuing efforts to improve its quality, the need for which receives acknowledgement and endorsement in the Calman-Hine report. It does, however, show the importance of caution in making inferences about the impact of the EU, particularly in areas which mimic national priorities and where there are already well developed national systems.

Aids and Communicable Diseases

- 2.23 The AIDS component of this programme accounts for well over half of the programme budget. However, the relatively recent addition of communicable diseases is seen by commentators as the main success story of this programme, and as meriting a shift in the composition of the budget to reflect the relative value to be obtained from the two elements.
- 2.24 International communicable diseases surveillance networks pre-date the EU programme, which has co-sponsored these networks to improve them (and which has just approved measures to make communicable disease networks the subject of legal requirement). The EU has provided an important forum for regular meetings. This has resulted in more frequent bilateral contacts which have in turn facilitated a speedier response to emerging communicable health threats "because we know exactly who to call".
- 2.25 The key advantage of international co-operation in disease surveillance is the enhanced ability to collate individual cases in order to identify a point source of infection quickly. It is difficult to make deductions on a national basis involving small or single numbers of cases of infection, but, for example, six cases of salmonella within Europe as a whole, involving visitors to the same hotel, would provide a basis for immediate and targeted investigation. All interviewees were able to cite examples where European collaboration had resulted in the speedy identification of sources of infection, and all were convinced that bigger outbreaks of infection, particularly of Legionnaires' Disease, were being effectively pre-empted by European collaboration.

2.26 About ten diseases are now covered by what are described as "useful networks". These include ENTERNET and Legionella surveillance, both financed by DGXXII, and EURO TB financed by DGV.

2.27 International surveillance takes up scarce time and effort in national resource centres and there was a perceived need by Member States to value the collaboration against its costs. A piece of work has been commissioned as part of the EU Communicable Diseases programme to identify where effort should be targeted to maximum advantage. An extended list of ten criteria of "capacity to provide European value-added" was used in this exercise, as follows:

- data/information exchange which provides earlier warning of threats to health (TTH)
- data/information exchange which results in earlier detection of TTH through pooling data
- data/information exchange which leads to the recognition of TTH which would not be recognised at national level
- data/information exchange which leads to recognition of TTH which require international co-ordinated action
- data/information exchange which allows generation of hypotheses from a wider knowledge base
- data/information exchange which improves the evaluation of programmes at national level (at least one interviewer was able to cite national benefit from pooling of international public health experience)
- data/information exchange which helps in the pooling of knowledge and resources
- data/information exchange which helps to raise standards at national level
- data/information exchange which helps develop European-wide surveillance and prevention activities

2.28 The output of this exercise (which was based on consensus methods rather than, for example, formal cost-benefit analyses) indicated the following top ten communicable disease priorities:

- outbreaks of gastro-enteritis/food poisoning
- CJD/other slow virus infections
- serious imported diseases
- legionellosis
- antimicrobial resistance
- tuberculosis (including non-respiratory disease)
- meningococcal disease
- travel advice
- vaccination/immunisation
- influenza

This work ought to be an important lead into the further development of policy in the area of communicable diseases (although a copy of the report could not immediately be located in DGV/F).

- 2.29 The EU had wanted to establish a European Communicable Diseases Surveillance Centre. It appears that no cost data informed this debate, but Member States argued that such an approach was likely to be bureaucratic and inefficient, and would deflect scarce skills from national administrations, thereby strongly exhibiting diseconomies of scale. Again, there are no formal data giving indications of the marginal costs of the current collaborations or the cost savings association with the estimated reduction in disease. However, there is a general perception that marginal costs are low compared with the benefits generated.
- 2.30 The management of this programme is somewhat different from other programmes. National representatives, namely the heads of national surveillance centres, have formed the Charter Group, in effect an ad hoc expert committee which is being funded by the EU for one year. An informal sub-group has also been set up to scrutinise project bids for both AIDS and Communicable Diseases before passing recommendations to the Management Committee. Apart from the process and output benefits deriving from professional contact and collaboration, this committee has been proactive in commissioning strategic studies, such as that described above, to inform the development of future policy and practice. Accordingly, this programme has achieved, albeit informally, a level of strategic direction which is not evident in others. One commentator described the activities of the Charter Group as "a good example of what should have happened previously, but didn't."
- 2.31 Although apparently often criticised for its cost, there is a remarkable consensus amongst those consulted that the EPIET training programme in interventional epidemiology training represents a high quality investment which will result in an international network of skilled people with a common, internationally-derived knowledge base. It is expected to have a high payback in the longer term.
- 2.32 There is a traditional link between the epidemiology of infectious diseases and the market place because of the enhanced risk of contamination through movement of people and products. However, it was noted that the EU has no inherent "epidemiological coherence". EU co-operation has not inhibited the development of networking beyond the current boundaries of the EU. For example, the *ENTERNET* network, which deals with outbreaks of gastro-enteritis/food poisoning was cited as one network which had extended beyond the EU, and involved collaborations with the United States. Legionella collaborations are already said to involve 21 countries.
- 2.33 An important problem is seen to be tensions between collaborations which are appropriate for research purposes and collaborations which are action-oriented, with similar problems existing over the respective roles of DGXII (Biomed) and DGV/F (public health). A specific problem, referred to in other programmes, is the difficulty of shifting funding between DGXII and DGV/F when the results of research are required to be implemented. This is particularly important in communicable diseases where the distinction between research and action-oriented projects is even less clear than in other

subject areas. A further problem is the difficulty of developing a long term policy for ongoing networks which are financed on a year-by year basis.

AIDS

- 2.34 The inclusion of AIDS in the 1993 Commission Framework is widely seen as a political insertion, rather than one with clear health objectives or deliverable benefits from international collaboration. The incidence of AIDS varies widely throughout the European Union both between and within Member States and in epidemiological terms is a relatively low national priority for many, including the pre-accession countries.
- 2.35 In the absence of any clear view of what European value-added could be obtained from dealing in this area, there is also widespread doubt about what the programme has been able to achieve. An exception to this is EU support for the European Centre for the Epidemiological Monitoring of Aids in Paris. This Centre gathers data on the incidence of HIV and AIDS and is seen as being an important source of comparative international data on the varying epidemiologies of AIDS and on the investigation of high risk behaviour. However, some criticism is made of the decision to site this surveillance project in the AIDS programme, much of which is concerned with health promotion, since the same national experts could not always cover both aspects of surveillance and health promotion satisfactorily.
- 2.36 Another highly specific example of beneficial exchange of data is that some countries have been able to observe in others the impact and evaluation of triple-drug therapies for AIDS.
- 2.37 Specific criticisms of the AIDS programme are:
- the difficulty of identifying the output productivity of international collaboration: the incidence of the disease is such that countries do not necessarily constitute an appropriate geographical definition of incidence
 - the absence of any strategic, well-defined, operationalised output objectives against which to inform the letting of project bids and the use and dissemination of results. The list of headings which have dictated the AIDS Programme was determined by Commission officials who are seen as having been trying to meet political objectives, did not have technical expertise in this field, and did not deploy the assistance of an expert committee.
 - the absence of a transparent system of project prioritisation including an effective peer-group review process for project scrutiny.
 - poor handling of technical expertise: the process of project prioritisation is seen as being "closely guarded" by the Commission. Someone referred to the "devaluation of representation of Member States".
 - a plethora of small scale, heterogeneous projects which do not have EU-wide applications. Very few projects are thought to have created models or blueprints for Community-wide action
 - an over-dependence on NGO networks and collaborations which are seen both as having high-jacked the priority-setting agenda and as diluting the academic rigour of research projects

-the inappropriateness of direct health promotion across a wide range of heterogeneous cultures, which also incorporate differing incidences of the disease and risk behaviour

-the absence of feedback and analysis of completed project reports and of how any policy findings will be implemented, either in member states, or as feedback into the development of European Policy

2.38 The situation is perceived to be improving somewhat with the increased use of tenders as a device for commissioning work. Examples of tenders (for both elements of the Programme) include:

-evaluation of current testing policies for HIV. This will produce a paper which will allow Member States to compare their legislative regimes and testing practice (whether this is mandatory and what kinds of rules and regulations govern testing procedures)

-comparing and evaluating vaccination policies across Member States

-production of a database for all institutes dealing with communicable disease surveillance and control

-comparison of hospital-acquired infection policies across Member States

Drugs

2.39 There are three main aspects of drugs policies, namely control, prevention and treatment. These are not independent since control of availability of banned substances is an importance element of prevention, and methods of treatment may impact on control. National legislation and international controls on the movement of illegal substances are governed by UN Conventions derived from the UN International Drug Control Programme, the UN Commission on Narcotic Drugs and the International Narcotics Control Board. Prevention, or "demand reduction policies" form a central plank of EU public health policy. Treatment for narcotic dependencies is strictly not an EU competence, and is in any case seen as the most difficult end of the debate about how far the EU should extend its interest into health services.

2.40 This was the only programme where it was possible to obtain an internal DGV/F view, a coherent account of the control and prevention aims of the programme and its twenty Europe-wide networks, set up in response to Treaty obligations. External commentators noted the orderliness of the administration of this programme, but were more inclined to question its premises, objectives and effectiveness: the inclusion of drugs in the public health programmes is also seen as a political insertion, although the embryonic state of epidemiology in this area means that accurate "burden of disease" estimates are difficult to come by.

2.41 The most commonly made general comment on the EU Drugs programme concerns the difficulty of implementing common policies given the heterogeneity of attitudes towards substance abuse across the Member States of the Union. This heterogeneity of attitudes governs the availability of banned substances "on the street". A tentative view is that prevention policies are unlikely to be effective where control is not rigorously enforced.

- 2.42 A prerequisite of the development of prevention policies is the establishment of a basic epidemiology of substance abuse. Classical epidemiological methods are difficult to apply in this area because of problems of identifying and determining denominator populations, namely what is actually meant by a "drug user". A central plank of the EU Drugs programme has been the establishment of the European Monitoring Centre for Drugs and Drugs Addiction (EMCDDA) with a central epidemiological function. This is attempting to classify and map the incidence of drug-related mortality using ICD 10 classifications. In addition, it is investigating the health consequences of drugs and whether these differ in different countries. These aspects of the work of the EMCDDA are described by other international technical experts as among the best epidemiological work anywhere, including in the United States.
- 2.43 There is some disquiet among Member States about an apparent ambiguity of the EMCDDA remit and responsibilities. DGV/F is not seen to be always in the lead and there are queries about the accountability and transparency of the Centre's activities. It has been criticised for being too lavishly funded, although other commentators dismiss these fears, describing the EMCDDA epidemiological unit budget as tiny and its work as highly cost-effective.
- 2.44 Those Member States consulted took the view that relatively little is known about drug demand reduction and were keenly awaiting the outcome of work in this area at EU level. In the UK, there is a ready-made transmission mechanism for disseminating EU-generated advice, from the national representatives on the management committee to the Drug Action teams which have been set up at local level involving Health Authorities, the Probation Service, Local Authorities and Chief Constables.
- 2.45 A more fundamental question, however, is what is the specific contribution which can be made to demand prevention by investigation at EU level. Perhaps the most interesting comment on research into the reduction of demand for drugs, is that it needs to be dealt with as a "dependency issue", alongside, for example, alcohol and tobacco. Whether there are generic aspects to dependency, or whether dependency needs to be dealt with in the context of specific cultural and social conditions, and hence dealt with more or less exclusively at national level, is a question which does not appear to have been asked.
- 2.46 Treatment for drug dependency is a particularly difficult area for Member States, given the very different drug regimes which can be found within the EU. This is, however, an area where comparative analysis of alternative national policies can yield important conclusions. Work is currently being undertaken by the World Health Organisation on the cost-effectiveness of alternative treatment regimes. EU collaboration with and sponsorship of this work would, perhaps be a more indirect, and less threatening way to approach the issue.

Health Promotion

- 2.47 The health promotion programme is one of several examples of a non-disease-specific programme within the 1993 health framework. It is one of the most recent programmes, having begun formally in 1996, although some activities which would fall naturally

within its remit, for example the Health Promoting Schools Project, pre-date the current programme. It is concerned principally with the behavioural/lifestyle determinants of health, particularly nutrition and alcohol, and hence with health education and influencing lifestyles. Tobacco, seen by most commentators as the most important behavioural influence on mortality and morbidity, is dealt with under the Cancer programme. Like the other programmes, the Health Promotion programme creates and supports networks and finances researcher-led project proposals. All the other programmes also include elements of health education.

2.48 Direct health promotion, narrowly defined to mean health education and influencing lifestyles is almost unanimously seen as the most difficult and controversial aspect of the EU health programmes. To be effective, direct health promotion must be:

- relevant to the highly localised health needs and priorities of populations
- sensitive to cultural differences, including regional and intra-national variations and the needs of population minorities
- specific to local health service organisation and other national and local mechanisms of communication

2.49 There was a remarkable consensus that health promotion, in this narrow sense of health education should not, and could not be the domain of a supra-national body. However, there is an acceptance that there may be very specific, generic lessons still to be learned about health education from carefully defined and focused research (akin to the identification of the importance of health education for children). Several commentators remarked on the widely differing concepts of health promotion between Member States and the difficulty of communicating these concepts across language barriers, although comment was also made on the value of exchanging experiences.

2.50 There are more immediate criticisms of the establishment and management of the programme which echo some of those made of other programmes:

-there has been particular difficulty about defining the subject matter of this programme and prioritising its activities, with the Commission "wanting to get everything in". In addition to the generic determinants of health, the programme has spread itself thinly across a number of ad hoc disease-specific areas (e.g. osteoporosis) and has proved vulnerable to raids on its budget for political gestures (e.g. Alzheimer's disease) and other problems perceived to require a quick response (child abuse). Crisis responses and political gestures should be able to tap into a separate source of funding

-there is a perception that the programme committee has been sidelined, both in terms of their possible contribution to strategic thinking and their contribution to prioritising projects. Similar complaints to those recorded in other programmes concern the lack of time and opportunity for scrutiny, lack of effective documentation of projects, prior selection by the Commission and a sense of some candidates being "on the inside track". At the beginning of the programme, work was said to have "been commissioned all over the place, cutting across and duplicating the work others were doing with no links or planning, largely through the NGO route". The quality of some of the organisations which have been funded is questioned.

-the establishment of networks has been undertaken exclusively by the Commission although it was said that many Member States were uneasy about some of the networks which were established.

- 2.51 It was difficult within the timescale of this study, to explore in detail a) what an appropriate definition of "health promotion" might be and b) what activities would in consequence fall under this programme. The main message is that the programme needs to go back to these basic questions: to develop definitions which are widely accepted by member states, to define subject areas where there is clear value-added resulting from international co-operation and research, and agendas which are closely linked to national initiatives. It appears that these are subjects high on the agenda of the recently-established European Network of Health Promoting Agencies. Several commentators spoke of the Health Promotion programme as being an obvious site for the development of work on health inequalities. It is also an embryonic site for the development of health impact assessments. These subjects are discussed further in Chapter 3.

Health Monitoring

- 2.52 Health monitoring is the most recently implemented programme. It is widely seen as an important and prospectively valuable tool, but its implementation appears to have been a particular source of difficulty to international collaborators and member states alike. Key points are:

-there is arguably a critical role for the EU in the collation of relevant, operational data. The "information picture" is described as being "like a jigsaw with different organisations holding different pieces". The WHO has traditionally collected data on mortality. The OECD has collected data on health services although the data is provided voluntarily and much work needs to be done on standardisation.¹ Both cover different groupings of countries. Eurostat is running surveys of its own, for example, on accidents, and concentrating hard on comparability and standards of collection.

-putting these pieces together to determine what is an operationally relevant and useful data set requires a strategic overview of member states' requirements. Everyone interviewed felt that progress was being made, largely as a result of the input of one or two member states with spare resources to apply to the problems. Getting the Commission to focus on what health indicators were needed was described in various terms, all implying an uphill struggle.

-inviting project bids for the development of data systems is widely seen as completely inappropriate. Health monitoring is classically an area for collaborative working and carefully tendered projects.

- 2.53 A logical progression in the development of a system of data collection would have been:

-identification of data set

¹ The health services database (OECD/CREDES) does not form part of OECD's remit and has been created and maintained through the efforts of one OECD Director. It seems that there is a risk that the database may not survive the retirement of the Director responsible.

- definition of terms and collection standards
- transfer arrangements

Instead, the EU has already established the Interchange of Data between Administrations (IDA) project, which divides into the HSSCD electronic network for the exchange of information on communicable diseases, and the HIEMS (Health Indicators Exchange and Monitoring System). It is extremely difficult to know how electronic data exchange could be developed, or justified, ahead of having identified the relevant data set and, depending on how extensive this is, the most cost-effective means of transferring it. Several commentators queried the VFM of HIEMS.

Remaining Programmes

- 2.54 Three programmes remain to be implemented, namely accidents and injuries, pollution-related diseases and rare diseases. Generally, the study did not seek comment on these remaining programmes, but one commentator noted that two of them, accidents and pollution-related diseases have no EU relevance as set up. This is discussed further in Chapter 3.

The Use of Networks in the Public Health Programmes

- 2.55 An important element of the EU health programmes has been the creation of networks. These have taken several different forms:

- (i) Professional collaborations set up for the purposes of gaining project funding

Some of these are well known to be constructs, but many interviewees spoke of enhanced co-operation between colleagues in member states as a result of these collaborations, and the importance of this to morale and to information exchange.

- (ii) Collaboration between representatives of Members States' Executive arms of government

An example of this is the collaboration of disease surveillance centres, described in very positive terms earlier in this report. Another more recent example, yet to yield results, is the statistical divisions of health departments under the health monitoring programme

- (iii) Collaborations involving "non-departmental public bodies" having particular responsibility for development of policy in member states

The Health Education Authority in the UK is an example of this kind of body. It has an well-defined policy remit in the UK.

- (iv) Collaborations of Non-Government Organisations

The Commission has a general commitment to supporting NGOs, which are seen as

a growing sector of national life and important contributors to employment creation and "close to people" in Member States. The former is statistically true the latter perhaps more contentious.

2.56 Scrutiny of the Networks established by the EU is probably well overdue, but has unfortunately been beyond the scope of this study to explore in any detail. There are a number of questions:

-are Networks used to compensate for the lack of geographical-based competence in DGV? Should more direct, bilateral relationships be developed?

-do networks have well-defined roles in relation to member states' policies and operate through explicit mechanisms to execute or influence those policies?

-should the EU have a role in promoting advocacy of public health issues in member states through Networks?

-how many of the networks merely represent the creation of an informal European bureaucracy which is largely self-serving and has relatively little influence on member states policies or "the man in the street"?

-is sufficient use made of existing national bodies in specific areas of competence? Why are new "European" bodies being created, and what is their relevance to member states when national charities and other organisations are already doing the same work?

-how are networks managed? Do they have clear objectives and output targets and how is their performance monitored?

-what is the appropriate relationship of accountability between the funding agency (DGV/F) and the network it funds? How is impartiality of advice and action secured when networks rely on Commission funding for their continuing existence?

2.57 At least one member state expressed the view that European networks were "of little interest" given that the areas were well covered by national bodies, although as has also been pointed out, this is not necessarily true of all Member States. Another spoke of the need for "soundly-based policies, not the development of vested interests" and noted that "the development of NGO constituencies should not be at the expense of agencies running national initiatives".

Conclusions

2.58 EU health policy has evolved through a succession of Treaties, over a number of years. It is well beyond the competence of this study to comment on whether that process might have happened differently. Arguably what has been done so far through the specific programmes has been "safe" in that it has both mimicked and been confined to, uncontentious priorities many of which duplicate member states' own concerns. It has also been highly static, in the sense that activities have been determined in advance by the legal instruments establishing the programmes, and ongoing policy development has been minimal.

2.59 The EU public health activities set up by the 1993 Framework documents include several vertical subject groupings, particularly in the disease-specific areas of drugs,

cancer and AIDS/infectious diseases. The implementation of these programmes is thought to have yielded some outstanding examples of the value added to be derived from international co-operation and to have resulted in the promotion of epidemiological work of the highest quality. Some of this is believed to have observable benefits in disease reduction. These projects have exploited the true opportunities for the generation of international value-added derived from:

- pooled data/very large sample size
- the heterogeneity of member states' natural environments
- analyses of comparative practice
- standardisation of data

2.60 Characteristic of these activities is that they are generally:

- developed under expert guidance and strongly collaborative with external expertise
- have strong central design
- are focused and well directed within a strategic view of what is required and what can be achieved by the international dimension
- particularly effective where they require or build on executive and operational functions in member states and other international institutions

2.61 Other researcher-led projects funded by the EU do not appear to meet any test or criteria for international value-added. For these the EU is an additional form of funding of projects which could be satisfactorily conducted at national level, but which member states attempt to exploit to their own national advantage. The study even found some anecdotal evidence of second-rate projects which had been unsuccessful in obtaining research funding within member states, trying to obtain EU funding instead. Direct health education/promotion activities are seen as unsuitable at international level precisely because of the cultural heterogeneity of member states which provides such a clear comparative advantage in other areas of study and activity.

2.62 These projects seem to be prioritised without a clear view of their output benefits, of their strategic contribution to the state of knowledge or their likely operational impact. Programme committees appear to be confused about the overall strategic intentions of the programmes and consequently also about the value of the projects which they fund. Prioritisation and selection of project bids is said to be undertaken principally by Commission staff according to principles which are not clearly communicated to programme committees. The normal peer-review process is not applied and a minimum of information about project content is communicated to programme committees. There were many criticisms about the actual conduct of meetings, and for some member states there is a real question about how much scarce time and effort to devote to the EU dimension of policy. The process has been described as "utterly disempowering" and in consequence as "not worth bothering with, because there are more important things to get on with".

- 2.63 The projects do not appear to have been prioritised according to value-for money criteria: there is no ex- ante appraisal of expected costs and benefits, nor alternative ways of proceeding. This partly reflects the administrative burden of dealing with a large number of small projects, but is true even of the largest of them.
- 2.64 The requirement to establish collaborative working across all member states does not of itself define "European value-added". It is widely recognised, and documented elsewhere that at least some of these collaborations are merely constructs, put together solely for the purpose of obtaining funding. However, other working collaborations are seen as having generated important process benefits, although how far these extend beyond the involvement of the immediate participants is difficult to judge.
- 2.65 There is considerable confusion within management committees about the respective roles of DGXXII (Biomed) and DGV, uncertainty about who should be exercising strategic management of health research in DGXXII, and no information about whether and how they do this and how it relates to the DGV health programmes.
- 2.66 The static nature of the implementation of the programmes is reflected in the vertical structures of DGV/F in which policy development is contained in a separate unit from the administration of the programmes. The read across between the administration of the programmes and the development of policy appears to be ad hoc and haphazard. Some issues which should properly be dealt with horizontally, are separated into vertical programmes. The recent reorganisation of DGV/F does not address these issues.
- 2.67 There is little effective feedback of the results of projects. Interviewees brought to the attention of the study a number of project reports, one of which was being peer reviewed, some of which have potentially important implications for the further development of European public health policy. However, DGV/F has no systematic information retrieval system (i.e. library), several important reports could not be found, that there is no standard reporting or interpretation of project outcomes for management committees, and no automatic requirement for reports to appear in peer-reviewed journals where they at least stand some chance of being picked up by the wider research community.
- 2.68 The absence of effective information management in DGV/F includes a notable absence of basic public health references and journals.
- 2.69 Two commentators noted the vested interests which EU policy can create and the importance of bringing some projects to an end which have clearly fulfilled or outlived their function. The Health Promoting Schools Project was given as an example of the latter.

CHAPTER THREE

STRATEGIC OPTIONS AND OBJECTIVES

Some definitions of health policy.

"The science and art of preventing disease, prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service, the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health." *Winslow, 1923*

"The art and science of preventing disease, promoting health, and prolonging life through organised efforts of society." *Acheson Report, 1987*

"What we, as a society, do collectively to assure the conditions in which people can be healthy". *US Institute of Medicine, 1988*

- 3.1 The European Union engages in three distinctive types of activity. One is *funding*: whether of research or other types of inquiry or health-related activity. A second is that the EU establishes *incentive structures* which may have important health implications in policy areas outside health. A final activity is the promulgation of legally-binding *directives* which may have implications for health. These also tend to occur in non-health policy areas, although their implications for health policy and services may be extensive.
- 3.2 This chapter of the report addresses the question *Where do we go from here?*, and in doing so tries to relate the three distinctive activities above to different elements of health policy. It considers methods of setting funding and activity priorities in areas of health, and some of the conceptual difficulties and conflicting objectives associated with such priority setting. It separates out priority-setting in health services from priority-setting in public health, since the problems and approaches are somewhat different and distinctions are not always carefully made. It looks at the traditional role of a disease-based approach to priority-setting in public health and then sets out other population target groups. Drawing on the above analyses of the individual programmes, it argues that priority-setting of funding programmes at supra-national level should rely on a somewhat different approach to that at national level, and should aim to exploit distinctive opportunities in a highly selective, "portfolio approach". It argues that these opportunities could in principle be exploited across a range of disease-based programmes but could also incorporate a variety of other policy areas and target groups. It rehearses a possible approach to ranking priority interventions, using a traditional economic cost-benefit framework.
- 3.3 This section also develops a much wider definition of public health, taking into account risk factors and the development of policies which address the underlying determinants

of health. It incorporates a discussion of the growing awareness of social and cultural factors as explanatory variables of health status and inequalities. It promotes the extension of activity at EU level into health-determining policy areas as the future core of EU health policy, using the tool of health impact assessment to inform policy development, and considers how this might be used to develop "health-friendly" policies and directives.

- 3.4 A separate section develops the question which proved to be the most controversial and resulted in the most polarised views, namely whether EU activity should eventually extend, in whatever form, into health care delivery.
- 3.5 A further question at supra-national level is "who should do what?" and the discussion of policy content is rounded off by comment on the possible roles of the EU and other players in the international health market.
- 3.6 Finally, there is the unanswerable question, *how much should all this cost?* at which this report makes a slightly unfashionable pitch.

Priority-Setting

Priority Setting in Health Services

- 3.7 *Explicit* priority setting in health services is an exercise fraught with conceptual and practical difficulties. Health budgets are in general determined at three different levels: the establishment of the national budget, the establishment of regional and institutional (e.g. hospital) budgets; and the medical expenditures which result from the decisions of individual doctors in consultation with their patients. Priority setting in insurance-based systems has traditionally focussed on what packages of care should be covered by the insurance system. Taxation-based systems have greater leverage for direct control of national expenditures through the imposition of national budgets, and have traditionally relied on *implicit* methods of priority setting, particularly queuing (waiting lists) dilution of services and displacement of costs to other budgets (for example to education or prison services).
- 3.8 Explicit and systematic methods of priority-setting in health services have to consider:
- what services should be offered?
 - who should be treated, in what order?

They run into the fundamental problem of what are the objectives of health service delivery. Methods based on a utilitarian, efficiency objective – maximising the health of the population – would deliver services to those most able to benefit from them at lowest cost. This approach, immortalised by the Oregon experiment in the United States, ranks interventions on the basis of measures such as cost per quality-adjusted life year (QALY). However, it compromises important ethical principles. It ignores the natural priority which health systems tend to give to life-threatening conditions and to life-saving interventions. It discriminates against treatment of elderly people and minority

groups. It appears to compromise deeply-held principles about the value of the individual, idealised in the ethical responsibilities of doctor to patient, which are too important to be subsumed within a community-based approach. It probably does not compromise the principle of "equity of access for equal need" but this is itself a largely unoperational maxim which fails to provide comment on the relative priority which should be associated with different types of interventions, for example, hip replacement and heart transplant.

3.9 Apart from the conceptual difficulties of prioritizing services, national health care systems also have to prioritize across a variety of quite different targets:

- different population groups (women, the elderly, children's services)
- primary and secondary care
- acute and community institutions
- equity of geographical provision

3.10 The latter is a particularly intransigent target. For example, different localities have different relative priorities: perhaps cancer services take a larger proportion of budgets in one, reflecting incidence of disease, compared with mental illness in another, leading to differential access rates for cancer patients in each locality.

3.11 Finally, there is an important problem of operationalising generalised priority targets. Health care systems tend to have relatively high levels of fixed costs, based on historical patterns of service provision, tied up in both plant and clinical manpower. They also often have incentive systems which support the high-technology, institutional, innovative end of medicine. Managing disinvestments in services is unlikely to be achievable in the short term, and controlling innovation in service delivery requires regulatory systems which, at least in their current stage of development, the medical profession is well able to bypass.

Priority-Setting in Public Health

Diseases and Populations

3.12 Whilst access to health services is a hotly-debated and highly sensitive area which has tended to defeat attempts at explicit priority-setting, priority-setting methods in disease prevention and health promotion relying on a utilitarian, that is "burden of disease" approach have been less contentious as a basis for decisions about resource allocation.

3.13 There are alternative means of defining burden of disease which may give rise to different ranking. Nonetheless, these disease-based definitions remain an important method of defining the principal causes of mortality and morbidity, and are an essential tool of classification for epidemiological research. Coincidentally, there is currently an increased interest in a disease-based approach to the planning and execution of health services.

3.14 There are other aspects of priority-setting which complement a disease-based approach. These include the identification of target population groups, use of which may highlight different causes of mortality and morbidity from those which would be identified by global indicators of incidence of disease. This complementary approach might point to the need for specific strategies. For example, four common age-related groupings are children, women of child-bearing age, adults and older people.

-children continue to be important as a group particularly in developing countries because of the very substantial burden, measured in terms of disability-free years of life lost, which childhood mortality imposes; but children are also an important target group for health education.

-women of child-bearing age are usually identified as a separate group because of the tremendous global variation in maternal mortality and the fact that the majority of these deaths are preventable.

-deaths in adults are important for several reasons. Adults make up about one-half of the population and about 70% of all deaths occur in adults, of which about 50% occur before the age of 60. These death rates show enormous regional variation and are associated not with communicable diseases, nor exclusively with non-communicable diseases, but also extensively with injuries and accidents.

-finally, the ageing of populations world-wide has important implications for the cost of social provision and health budgets.

3.15 Increasing attention is being paid to "socially-excluded" population groups given the now incontrovertible evidence that socio-economic status is an important explanatory variable of variations in health status.

Risk factors and the determinants of health

3.16 A disease-based approach alone is too restrictive but must incorporate the risk factors which contribute to disease. Health determination has traditionally been seen as an interplay between genetic factors, environment, including social and psychological factors, and so-called "lifestyle" i.e. behavioural factors. There is also a growing understanding of how far health-determining behaviour is itself a response to social, cultural and economic conditions and incentives. Some of the "leading edge" arguments about the development of public health are about how epidemiology should develop a multidisciplinary approach to these social and cultural questions.

3.17 Lifestyle factors considered to be of particular importance are tobacco, nutrition including consumption of alcohol and physical exercise. To this list could be added the high risk activity of private transport.

3.18 Many threats to human health are environmental. Environmental impacts on health include:

- industrial and household waste
- fresh and marine water quality

- land use and agricultural development
- biological, chemical and radioactive wastes in food
- air quality including industrial waste/emissions
- energy sources.
- ionising radiation.
- domestic and industrial accidents and injuries.
- global environmental changes, especially stratospheric ozone depletion and global warming

3.19 A change in approach to national and international environment planning was heralded by the Rio Earth Summit of June 1992. The Rio Declaration and Agenda 21 emphasise the importance of investment in improvements to people's health and environment as a prerequisite for sustainable development. Many commentators, including the OECD and the WHO at international level, argue for the development of "environmental health indicators" and the concept of "environmental epidemiology" has been developed. As with lifestyle factors, the forces and incentives influencing environmental degradation are seen to be as important as direct regulation itself. This approach also emphasises the development of intersectoral collaboration. Three main issues are:

- the need to integrate health into environmental impact assessment procedures.
- the need for effective and efficient environmental health information systems.
- the need to improve knowledge of environment-health linkages.

Priority-Setting at Supra-National Level

3.20 Although the terms of reference for this study invite comment on whether the EU should continue to opt for a "disease-based approach", in fact only in two of the five existing public health programmes could properly be described as disease-specific. These are Cancer and Communicable Diseases. It was argued above that drug demand should be dealt with as an issue of dependency, along with tobacco and alcohol as one of the "lifestyle" issues of public health. The health promotion programme already deals with several "lifestyle" determinants of health, namely nutrition and alcohol. Forthcoming programmes include accidents and health, which implicitly involve particular age groups, and some of the environmental determinants of health status. There is, therefore, already a matrix approach to public health, incorporating "horizontal elements". Further exploitation of European value-added might be gained if carefully-defined projects involving more disease groups were added *selectively* to those already explicitly dealt with.

3.21 Chapter 2 argued that, in defining European value-added in terms of numbers of collaborators, the EU is measuring European value-added in relation solely to an *input or process benefit*. Instead, the discussion in Chapter 2 attempted to identify output value-added associated with the existing programmes. It described this as the advantages which accrue to:

- pooled data/very large sample size
- the heterogeneity of Member States' natural environments
- analyses or experience of alternative, comparative practice
- standardisation of data

3.22 These criteria may apply to a wide range of health-related activities, including:

- basic epidemiology
- biomedical research into the aetiology of diseases
- meta-analyses of existing research
- risk assessment and communication
- clinical research into the effectiveness of clinical interventions
- communicable disease surveillance
- effectiveness and cost-effectiveness of alternative types of public health policy delivery
- effectiveness and cost-effectiveness of alternative patterns of health care delivery

3.23 The funding element of EU health policy should concentrate on highly specific activities, defined in the first instance by their ability to generate "European value-added" according to the criteria established above. These could involve a wide range of topics, including the study and treatment of diseases, analyses of policy and practice in relation to target population groups, indeed any health-related study where comparative analysis and pooled data are important determinants of the quality of study.

3.24 EU-level project funding would become highly selective, and would tend to involve fewer, larger projects selected from a range of subject (including disease-based) areas. It then becomes more feasible to prioritize in accordance with a "portfolio" approach to investment planning, including more formal techniques for defining and establishing the costs and benefits of the planned investment in research and analysis. An example of a CBA case-study of research is given at Appendix 3. These might be built up in a ranking exercise. Despite the emphasis on the selectivity of investments, and individual project analysis, it would be essential to rely on high quality strategic advice, and a strategic overview of each subject area in order to:

- precisely define the expected European value-added, taking into account work being undertaken elsewhere
- describe the magnitude of the expected benefits

3.25 As a general rule, the importance ("burden") of a disease is likely to affect the priority ranking of disease-based interventions. However, there are two countervailing points to be made. One is that some areas are already relatively well-populated and "awash with money". The point was made that the EU should also consider "less fashionable problems", such as, for example, rheumatic illness which has a dramatic impact on

working days lost. A second is that international collaboration can also deliver advantages in dealing with *rarity*.

- 3.26 The discipline of effecting investment appraisals would help to redress the problem of the current lack of disaggregated cost data with which to inform scrutiny of projects. Where appropriate, it would be possible to undertake explicit option appraisals of the estimated costs of alternative organisational types of EU intervention (e.g. a centralised EU facility versus disaggregated networking with existing national institutions).

Health Determination and the EU Response

- 3.27 The question then arises, what sort of a policy response is appropriate at EU level in the health determining policy areas described above? Many commentators see the core of future EU policy, building on the Amsterdam Treaty, as being internal EU action in these health determining areas. This is not health promotion in the sense of direct health education, or of external advocacy vis-à-vis member states' own health policies, but the EU "putting its own house in order" through the integration of health expertise and health impact assessment into internal EU policy determination. This involves an understanding of the incentives or disincentives to healthy living which are embodied in EU policies and directives in these health-determining sectors. Interest has focused particularly on nutrition and the perverse incentives promoted by the Common Agricultural Policy. The role of the CAP in promoting tobacco production is almost too-often quoted to bear repeating. The perverse incentives of the CAP have already been analysed to great effect in the Swedish Health Impact Assessment of that policy. The essential incoherence of the planned programme of pollution-related diseases is that it is being handled separately from the work which DGXI is taking forward in many areas including, for example, the limitation of emission of known pollutants and carcinogens.
- 3.28 The WHO vision of intersectoral collaboration for health promotion is one in which all sectors collaborate with the health as their main objective: "The new perspective on health developed at the Earth Summit demonstrates that health can only be achieved with input from each sector. Intersectoral action thus means that each sector and each Ministry contributes to health development in a conscious and co-ordinated manner."
- 3.29 Some realism is needed. Human societies, and indeed individuals, have multiple objectives and contain competing groups. Policies usually involve trade-offs; between equity and efficiency; between different groups (e.g. producers and consumers, the old and the young); between growth and health. These trade-offs are potentially limitless. There also needs to be a sensible view of the role and ethics of individual choice. Life is never risk-free. People trade off risk against convenience every time they step into a car. In the words of one interviewee, they "do not always like to be told what to eat". There are inter-temporal trade-offs to be made. In a notorious aside it was once noted that jogging was likely to prolong one's life by approximately the time spent engaged in the exercise!
- 3.30 What is arguably more important is to identify and cost personal and policy trade-offs so that consumers are as fully empowered as possible to make their own choices, and the implications of decisions, many of which will need to be taken at political level, are

fully available to decision makers. In terms of health, this implies attempting to describe, preferably to measure, and ideally to value, the health "opportunity costs" of alternative policies and interventions: what can be gained and what stands to be lost in terms of population health. This requires a means of identifying the health impact of policies, and the application of these techniques to policy development in health-determining areas. There is a need to develop methodologies for effective health impact assessment. The organisational implications of adopting this tool within the Commission are explored further in the following chapter.

European Union Involvement in Health Services Delivery

"Community Action in the field of public health shall truly respect the responsibilities of member states for the organisation and delivery of health services and medical care." (Clause 5, Article 152 of The Amsterdam Treaty.)

- 3.31 Questions about possible EU involvement in health services delivery elicited strong responses and tended to polarise views. This was particularly true of national representatives of Member States who have a line to follow on this question, but members of the public health community felt equally strongly. The latter fear that if the EU were to extend its activities into health services, the public health/disease prevention/health promotion agenda would get squeezed out in much the same way that public health is often the poor relation of high technology medicine at national level. They argue that health services have historically contributed relatively little to the dramatic improvements in health status which have been witnessed this century.
- 3.32 Others argued as strongly that the priority should be the effectiveness and cost-effectiveness of health services: that whilst it may be theoretically the case, for example, that 75% of cancer is preventable, de facto vast amounts of money and clinical effort also have to go into treating the disease in the interim. Only about 10% of cancer treatment is thought to be governed by clinical protocols. Both public preoccupation with treatment, and the often doubtful cost-effectiveness of many prevention activities, were noted by interviewees.
- 3.33 There are a number of points to be made on this issue, many of which would support an extension of the current *analytical activities* of the European Union:
- national health systems have to prioritise across investments in both health services and public health activities. The recent wave of health care reforms, with a new emphasis on "commissioning for health" has tried to reduce the emphasis previously given to health care institutions and instead has promoted the output objectives of health policy, namely improvement in health status. At the same time, there is a new interest in an extended role for clinical institutions in health promotion activities, for example how the budgets and incentive structures of traditional curative institutions such as the hospital could be reformed, perhaps along disease-specific lines, so as to provide incentives for these institutions to promote preventive measures and health education. This is also an increasing preoccupation of primary care. The notion of the "public health manager" incorporates that of an integrated approach to prevention and cure, namely managing and prioritising across the public health/health services interface.

- there is already a "grey area" in the public health activities of the EU, involving both primary prevention (e.g. immunisation practices) and secondary prevention (the development of screening protocols). These are functions performed by member states' health services and study of practice in these areas under the existing EU public health programmes has apparently been uncontentious.

-involvement in comparative study of health services, to explore questions of clinical efficacy and cost-effectiveness is a long way from a prescriptive and directive approach and indeed from "the convergence of national systems". The analyses presented in Chapter 2 note examples of clinical research into curative methods, for example, large scale clinical trials for cancer treatments, which could deliver high levels of European value-added. It also notes the importance of developing a standardised framework for transnational clinical trials.

-the organisation of health care delivery is arguably at a crossroads. A number of member states confront important strategic questions about the traditional organisation of services and the role of primary care and community-based institutions. The role of the hospital as the cornerstone of curative medicine is coming under scrutiny and some health systems are witnessing the development of substitution policies involving community services and hospital-at-home schemes. There is a dearth of studies within member states on effective service planning with which to inform these and other questions and practically nothing on comparative international practice.

3.34 In addition to these points, much discussion has been prompted in the literature of the wide range of EU market-related directives which concern:

- the free movement of professional labour (including doctors)
- professional training and accreditation
- working hours
- the rights of patients to treatment

3.35 These have far-reaching effects on member states' health systems. Some commentators felt that:

- member states do not notice, or anticipate the possible effects of, such directives, because they are generalised and not couched in terms specific to health services.
- there is no forum for a co-ordinated analysis of, and response to, these various directives and this should be provided by the Health Directorate of the Commission.

Agenda 2000: Geographical Equity or a Regional EU Health Policy?

3.36 Whilst a number of people were invited to comment on the possible impact of Enlargement, the exercise produced few really perceptive comments. In principle, the elements of a public health policy as defined and described above, would not be affected by Enlargement, except perhaps in the prioritisation of projects and the enlargement of the heterogeneity of experience which the candidate countries would bring to the "European laboratory".

- 3.37 Evident in the comments of many, however, is a more paternalistic and interventionist view of the EU role which sees EU health policy as an instrument for compensating for variations in the quality of member states' healthcare and public health systems. This feeling has very strong resonances with the debate on health inequalities, it impinges heavily on the "advocacy" and "awareness raising" role which many Networks see themselves as having, and is likely to be exacerbated by the accession of some CEEC countries. It was explicitly referred to in the discussion of the AIDS programme in which the varying incidence of that disease in Europe was already noted.
- 3.38 There should be an explicit debate and scrutiny of this question of regional variations, in conjunction with member states. The tentative view of this report is that issues of variation between member states should be dealt with within the policy responses outlined above, namely:
- as part of the health inequalities agenda
 - in the generation of explanatory studies using comparative country data
 - through, in particular, environmental policy and directives, appropriately informed by health data.
- 3.39 It is also important to guard against biases in EU public health policy. None were explicitly identified by this study, but the level of geographical knowledge across the range of member states within the Commission is very weak and much discussion is driven by the experience of northern European countries, particularly Scandinavia and the UK. There would be benefit in developing country-specific experience and expertise in the Commission, alongside the development of expertise in technical subject areas.

The Respective Roles of the EU and other International Institutions in Health

- 3.40 There are a number of international players in the European "health market". These include both the Geneva and Copenhagen offices of the World Health Organisation, the OECD in Paris, the Council of Europe in Strasbourg and the activities of the World Bank in Eastern Europe. There is a very strong perception from within some of these institutions that the Commission has wanted to "go it alone" and in so doing is either missing out on available expertise and the benefits of collaboration, or is busy reinventing the wheel.
- 3.41 The questions which this section asks are:
- what is the particular expertise and comparative advantage of each institution?
 - do these point to the possibility of purely collaborative working?
 - are there any possible overlaps or outright clashes of interest which need to be addressed and how should these be dealt with?

It considers these questions under both geographical and subject headings – exploring the latter under the themes "leadership", "funding" and "professional expertise".

Leadership

- 3.42 Much international intellectual leadership in developing *strategic frameworks* for the management of health issues has undoubtedly been provided by the World Health Organisation and its regional offices, of which the analyses underpinning Health for All are one notable example. Sometimes, however, the rhetoric of WHO publications and policy documents is deeply removed from the practicalities of day to day management and operational problems and misses important details. One of the key challenges for public health identified in this report is the need to define *operationally relevant* analyses, tools and indicators, drawing on the grassroots experience of practitioners "at the coal face". In principle the EU is well placed to manage the "operationalisation" of analytical work in those subject areas identified as appropriate for international handling, in work which would complement that of the WHO.

Funding

- 3.43 A distinction is commonly drawn between the WHO and the OECD, which have considerable technical expertise in the appraisal and analysis of health issues, but do not have access to extensive funding, and the EU which lacks technical expertise but through programmes including Biomed, can offer very substantial levels of funding. Both the Copenhagen office of the WHO, and the OECD have expressed a desire to extend areas of collaborative working with the EU and the Geneva office also sees the EU as an important financial sponsor of highly worthwhile projects and an important administrative "economy of scale". The response of these organisations to the EU bidding process varies: one uses it extensively, but another will not take part because it is seen as too burdensome on scarce internal administrative resources.

Expertise

- 3.44 These international organisations, to which could be added a large number of other specific UN-related bodies, such as UNAIDS, contain very high technical expertise across a wide range of health care issues. As with all large organisations, the quality of expertise will vary, and it needs to be used discriminatingly. But commentators, both from expert centres and from member states were generally of the view that the EU needed to draw much more heavily on existing expertise at international level.
- 3.45 As well as having subject area expertise, the Copenhagen office of the WHO also has extensive geographical expertise of the CEE countries, including the pre-accession states. Another important and expert player in this area is the World Bank, both as a source of funding and as a source of technical expertise.
- 3.46 Relations between the EU and other international institutions have clearly not been easy, an issue exacerbated by the uncertain role of the Copenhagen office of WHO. International collaboration requires skilful handling, but also needs clear definitions of

the respective interests and roles of the organisations, set out in formal memoranda of understanding.

The Size of Future Health Budgets

3.47 The implication of the discussion in Chapter 2 is not so much that the EU health budget lacks money but that it needs to spend what it has in a much more selective and focused way. Some of the most effective projects identified in the current programmes are being carried out at minimal cost. Meanwhile, a theme which will be developed in Chapter 4 is that health needs to compete within the Commission on the basis of high quality technical expertise. These two conclusions prompt the following comments on budget setting:

-budget setting and priority setting need to be undertaken simultaneously as part of a straightforward budget appraisal, portfolio-management process. Simplistically framed, the question is where, down a list of costed and prioritised interventions, does Parliament want to draw the line?

-the breadth of coverage of a public health unit will have to be considerably expanded, in terms of numbers and skills, to ensure any degree of effectiveness within the Commission. A sufficient increase in the influence of the public health unit can only be achieved by expanding administrative budgets.

CHAPTER FOUR

THE FUTURE ORGANISATION OF THE COMMISSION

4.1 Health is archetypally a cross-cutting issue. This has been understood for a long time, but the preceding chapters of this report have attempted to describe the extent to which epidemiology and health policy are now being seen as:

- bedded in social and cultural contexts
- subject to a variety of thematic approaches
- integral to policy determination across a range of sectors and issues

4.2 This contrasts sharply with what one member of the Commission has distinctively described as the "ghetto-isation" of public health.

4.3 This report has argued that the distinctive contribution to be made to the health of European populations by the EU is in:

- a funding portfolio of highly selective activities, across a range of disease-based and other public health policy areas, which exploit the distinctive output benefits of the international setting and are prioritised in line with a cost-benefit framework
- the development of expertise in health impact assessment across a range of policy areas
- a facility to expand these activities into the comparative study of health care delivery and health technology assessment, along with the development of a unit which would scrutinise EU directives and, in conjunction with member states, analyse their impact on healthcare systems

4.4 The following sections of this final chapter consider the following points:

- how should health be organised in the Commission, particularly in relation to other DGs, including DG XXIV?
- what expertise should a future health directorate seek to employ and what implications does this have for Commission recruitment policies?

These are "leading edge" questions in the sense that member states are themselves feeling for integrated solutions to cross-cutting issues. They need considerably more attention than this short study was able to devote to them. Accordingly, the following comments are somewhat speculative, but are offered as a prompt to further discussion. The following explores five options. It is taken for granted in the discussion which follows that it is not sustainable to keep health policy in Luxembourg, but that it must be geographically contiguous to the other policy areas it is trying to influence.

*Possible Organisational Solutions***Option 1: A new DG for Health**

4.5 One option which has been proposed in the past is that health should have its own Commissioner and a Directorate General all to itself. There are, however, several problems with this proposal.

it seems unlikely that health, which is so often seen as being of low political profile, could yet command the political status to achieve this solution

this report has argued that the health budgets needed to perform the tasks outlined are unlikely to be massive: that money needs to be spent selectively to be effective, rather than in large amounts

4.6 The most serious objection, however, is that this approach confines public health in a unitary framework which does not adequately recognise its wide-ranging remit. It underlines and confirms the vertical structures of the Commission, in which traditional sectoral boundaries are heavily emphasised and territorialism can flourish without limit. These act to the extreme detriment of the cross-cutting agendas. The forward-looking agenda of more radical member states is to identify and develop structures which break down the traditional sectoral boundaries in favour of holistic, thematic and intersectoral approaches to health policy.

4.7 A second option, which this study was asked to explore specifically in relation to DGXXIV, is a merger of DGs. The Commission contains three DGs with explicit responsibility for health: DGV (public health), DGXI (environmental health) and DGXXIV (consumer health). The contiguity of these three areas is reflected in the Committee structure, one Parliamentary Committee covering all three areas.

Option 2: Possible merger with DGXXIV

4.8 DGXXIV deals with consumer protection and works principally with a network of European consumer agencies. One of the features of the BSE crisis was that consumer organisations orchestrated and articulated comment on government policy. In response to the BSE crisis, the remit of DGXXIV was expanded. Scientific advice was separated from policy making, in order to preserve its integrity, impartiality and transparency, and as a result DGXXIV now also has responsibility for managing a number of scientific committees, namely:

multi-disciplinary scientific committee

scientific committee on cosmetology

scientific committee on pesticides

scientific veterinary committee

scientific committee for toxicity and ecotoxicity of chemical compounds

scientific committee for animal nutrition

scientific committee for food

- 4.9 DGXXIV is seen as dynamic and reforming and as having the drive to push the health agenda were they to receive it. Other than this there is not that much overlap between the health and the consumer affairs agendas, in terms either of objectives or subject matter. Key points appear to be:

although the issue of product safety has been instrumental in raising the profile of health in the Commission, and is likely to drive its development in the future, consumer protection represents a relatively small set of health and health determining issues. It excludes, for example, the whole range of environmental and social issues. It is concerned with the protection of individual consumers, unlike public health whose denominator is population health

whilst consumer protection does impact on health and on safety, these issues can be dealt with by regulation in an entirely self-contained way. This is also true of food policy: some linkages need to be made between food safety and infectious diseases, but at least two member states consulted by this study are in the process of establishing stand-alone food safety agencies outside their health ministries

research methods are quite dissimilar

Option 3: Possible merger with DGXI

- 4.10 In the light of the analysis in the preceding chapter, a more serious option for the development of joint agendas, should be health and environment. The following are some key points:

there is a large overlap of subject matter. As discussed above, traditional environmental concerns are seen as important and ongoing determinants of health. There is a strong perception that, despite the excellent work done by environmentalists, an integrated agenda is needed incorporating health expertise. A growing international literature is devoted to technical tools which incorporate environmental and health indicators.

environment is the other main cross-cutting issue, and DGXI is also struggling – as yet unconvincingly – to integrate across the Commission.

research methods of the two disciplines are very similar, reflecting the similarity of subject matter

- 4.11 However, as with consumer protection, environmental concerns are but one component of health policy. An important tactical question is also whether the addition of health and the combined weight of two cross-cutting agendas would facilitate the integration process, or whether this would unite external vested interests, and/or collapse under the weight of managing the internal integration of health and environment

Option 4: The "Disaggregated Option"

- 4.12 This option would involve:

the retention of a public health division, based in DGV in Brussels, strongly integrated with the social policy divisions - which would themselves evolve a more explicit health-policy role, progressing in particular the health inequalities agenda - and exercising strategic oversight of health policy

a task-force approach to the determinants of health with "so-called "lifestyle determinants" of health located with Consumer Affairs Directorate and the environmental determinants of health integrated with the Environment Directorate.

the "matrix" management of expertise, with cadres of "core" staff in DGV and "outposted" staff working in other Directorates in multidisciplinary teams on thematic and cross-cutting issues identified under the programmes

- 4.13 This approach reflects a cross-cutting organisation and would provide the basis for further integration of health with other relevant sectors. It would draw heavily on modern organisational approaches to workforce management and would require the development of a modern set of operational and managerial skills. Old style, hierarchical command and control methods of management would have to give way to influencing, co-ordinating and high level communication skills.
- 4.14 The main argument against this approach is the difficult of making it work, particularly of effectively managing and providing strategic direction to outposted staff.

Option 5

- 4.15 Option 5 is a somewhat less ambitious, arguably more workable version of Option 4. Under this Option health would remain with DGV in Brussels, integrated with the Social Policy Divisions, deploying the existing arrangements for inter-service consultation with all those DGs whose policies have a direct impact on the health of EU populations. An Operational Unit would deal specifically with health security and control, covering communicable diseases, vaccines and immediate environmental threats. As much as organisation and structure, this option stresses the importance of:

visionary leadership in promoting the health agenda across the Commission

a sufficient cadre of staff of relevantly-qualified and influential staff to respond effectively to the demands of inter-service consultation

The Importance of Relevant Public Health Expertise

- 4.16 One of the most commonly volunteered comments concerned the Commission's lack of technical public health expertise. There are two reasons for arguing that this situation should change. To consolidate its rising political status, but in the absence of large budgets, health will have to compete in the Commission principally on the basis of operational skills and quality of technical expertise. This might be characterised as "internal advocacy". In addition, the field of health and health care contains some of the finest minds, occupying positions of considerable prestige. Engaging, managing and harnessing this expertise effectively, to develop a high quality policy response, requires skills which are commensurate.
- 4.17 Specifically, the preceding chapters of this report suggest that a future public health unit of the Commission will need to be able to perform the following tasks:

- develop in collaboration with member states a vision for Community health policy and market that vision effectively within the Community structures
- undertake a collaborative and complementary role vis a vis other international institutions, rather than compete with them
- provide a supporting, facilitating and consensus building role, drawing on and managing the experience and expertise of representatives from member states and other specialist institutions, rather than imposing views or circumventing discussion
- work through devolved structures and promote the development of more effective interfaces between existing components of member states' health systems, rather than building centralised health infrastructures
- understand the geographical diversity of individual member states' health policies and systems
- communicate effectively with health experts from other international bodies and academic institutions
- identify and manage high quality technical advice effectively and in a strategic way
- manage a high quality portfolio of highly selective and cost-effective investments across a range of technical health subjects
- undertake or commission economic scrutinies of the portfolio on behalf of member states and advisory committees, interpret the output of funded work and assist with the dissemination of results to international institutions and to relevant member states' health departments
- develop methodologies for health impact assessment
- carry out or commission health impact assessment in other areas of policy
- develop flexible and effective working collaborations with colleagues in other Directorates-General

4.18 These tasks require managerial, operational and technical skills of a very high order. It is the contention of this report that without them there is little point trying to upgrade the status of the EU health programme.

Recruitment Policy

4.19 Developing the relevant expertise would, in other contexts, be a relatively straightforward managerial task. In the context of the Commission, however, it will require a revolution in procedures, although recent deviations from customary practice have been achieved by DGXXIV, and some precedents set.

4.20 Key points are:

- the need to define specific tasks and identify the specific expertise required
- the capacity to identify a range of personal skills and qualities relevant to the multidisciplinary, cross-cutting, managerial and handling tasks in hand
- a willingness to ignore "quota" issues, except where these are inherently important to ensure the universality and objectivity of health policy development

4.21 These qualities contrast sharply with the recruitment exercise currently being run by the Commission for qualified health personnel, which appears to involve:

- poor or non-existent job descriptions
- minimal selection criteria
- scrutiny of bids based not exclusively on CV but also on somewhat less relevant criteria

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

Objectives of EU Health Policy

- 5.1 It may seem odd to end a report with a discussion of objectives. However, very many commentators on EU policy spoke of the need to start by analysing principles which would define the distinctive contribution which the EU can make to the promotion of health and then to develop its role, objectives and activities in relation to these principles. Earlier chapters have attempted to set out the principles. The purpose of this last section is to briefly draw several general themes out of what has emerged and to consider how these principles fit within general aims.
- 5.2 It is possible to discern in the comments of some of those more closely involved with EU policy, a paternalistic view which sees the main objective of EU health policy as being to influence the health policies of member states. It may be worth stressing that this is very much **not** the spirit of Article 152 of the Amsterdam Treaty. The latter emphasises both the centrality of *Community* policies and activities as the focus of EU health policy, and the need for *complementarity* of EU policies with those of national policies. Consistent with the wording of that Treaty, this report has argued that complementarity is secured by careful attention to "European value added" in the EU's funding activities and that a wide range of carefully-selected EU-level activities are capable of generating and making available to member states important results and lessons for the development of policy and good practice. A point to pursue is that mechanisms, partnerships and alliances should be targeted principally at the learning, dissemination and take-up of these lessons.
- 5.3 Also consistent with the Amsterdam Treaty is the contention of this report that the core of EU public health activity should be action in the health-determining areas of Commission policies. This was described earlier as a shift from "external" to "internal" advocacy.
- 5.4 These shifts of emphasis have implications for the sometimes uneasy relationship between the Commission and member states. The Commission sees itself in a variety of roles vis-à-vis member states, including protector, victim and protagonist. One person spoke instead about the need for the Commission to see itself as a *resource*. It seemed from this study that this was very much the spirit in which member states would like to approach the Commission and its health work.

Summary of Recommendations

5.5 Specific recommendations which have appeared in this report are

- i) The core of the EU's future efforts in public health should be the integration of health impact assessment into health-determining areas of EU policy
- ii) This should be supplemented by highly selective funding of projects and research which deliver European value-added and have been assessed for cost-effectiveness.
- iii) These could include disease-based, population-based and risk-based approaches, as well as comparative analyses of policy and practice. There would be merit in undertaking selective comparative analysis of health-care systems
- iv) Projects should have clear, policy-oriented objectives and clearly identified methods of dissemination and take up.
- v) Direct health education should not be undertaken at EU level.
- vi) More consideration should be given to the development of a regionally-based health policy, in which priorities would be developed to deal with particular regional problems
- vii) Collaboration with other international organisations needs to be improved and extended.
- viii) A future public health unit should be located in Brussels.(or at least should be in the same place as its Directorate-General). Several options exist for organising the health unit in the future, none of them ideal. The most workable option would be to integrate health with social policy and to exploit existing arrangements for inter-service working with other Directorates-General.
- ix) The key to the future success of health policy lies in visionary leadership and the development of an extensive cadre of well-qualified staff in support. This should include the development of country-specific expertise.
- x) Administrative budgets need to be increased to support an enlarged cadre of well-qualified staff. Funding programmes need to make better use of existing budgets in the first instance.

APPENDICES

SPECIFICATIONS FOR A STUDY ON THE HEALTH POLICY FOR THE EUROPEAN UNION

A study on European Union Health Policy has been requested by the European Parliament's Committee on Environment, Consumer Protection and Public Health.

The Committee will hold a Public Hearing on this subject in October of 1998 and wishes to have a study carried out on the current status of EU Health Policy and future options, in particular in the light of the provisions of the Treaty of Amsterdam.

The deadline for this study is fixed and immutable. It must be completed and remitted in final format to the Directorate-General for Research of the European Parliament no later than September 15th 1998.

The aim of the study is to analyse the current Public Health policy and programmes of the European Union in order to determine:

- a) whether these are correctly structured in the light of subsidiarity and add value to Member States' health policies.
- c) whether the division of EU health policy into "disease specific" programmes is sensible and efficient.
- d) are the programmes themselves effective? Can they be made more effective?
- e) are the roles of the Commission/Member States well-balanced in these programmes?
- f) is the EU taxpayer getting value for money and are budgets appropriate to do the required job?
- g) what is the relationship between the Commission's DG5 Directorate for Public Health and the recently enlarged DG24 responsible for consumer health protection? Does this need to be changed?
- h) what are EU Health policy options from the year 2000 in the light of the Amsterdam Treaty and Agenda 2000.
- i) what is and what should be the relationship in health policy between the EU and organisations such as WHO, OECD and The Council of Europe.

In order to carry out this study, the contractor will be expected to examine the working of the current programmes both at EU and national level (some illustrative examples may suffice here since time is short).

The contractor will be expected to consult with Commission staff responsible for running the programmes and with their national homologues. The contractor should also consult the Commission's own services and if possible any analyses of its Public Health Directorate which may have been carried out internally, and to consult Commission papers on the future of Health Policy. Interviews with officials responsible for the individual programmes should be arranged if possible.

In addition, the contractor will be required to consult European Parliament Resolutions and reports on the subject of health policy and to interview Members of Parliament prominent in health policy matters.

Consultation with interest groups at EU and national level will be expected as will consultation with representatives of Member States regarding the nature of EU Health policy in the light of subsidiarity and

the understanding that health policy excludes harmonisation or centralisation of Member State health care systems.

The study should examine ways in which effect on public health can be incorporated as a basic consideration into all other policy areas of the EU.

The study will require the contractor to operate in both Brussels and Luxembourg. The contractor shall work closely throughout the study with the DGIV Research Administrator responsible for the study, who shall direct the study and edit the final text.

SETTING PRIORITIES IN RESEARCH: A CASE STUDY

Setting priorities for research into the interface between primary and secondary care in the UK NHS.

1. Before 1991, research in the NHS had traditionally been "top down" and investigator led. Proposals were judged largely on scientific merit rather than in relation to health needs. The NHS Research and Development Programme represented a first attempt in Britain to establish a research strategy to support the promotion of health and provision of health care.
2. Broad themes were identified by the NHS Central Research and Development Committee. The following summarises the work of a fourth advisory group set up to identify research and development priorities at the interface between primary and secondary care. This subject was selected as important for study because:
 - the effectiveness of the "gatekeeper" system of GP referrals depends on what happens at the interface between primary and secondary care
 - the balance of care has shifted in recent years, with the proportion of total health expenditure on inpatient care falling in Britain and other European countries
 - there was concern about variations in referral rates by general practitioners to specialist care and the appropriate use of specialist services
 - new methods of commissioning and contracting were likely to influence the type and quality of care provided in general practice
 - Health of the Nation targets for reductions in mortality and morbidity require co-ordination of effort between primary and secondary care
3. A 16-person advisory group was established, representing interests from primary and secondary care and other disciplines including nursing and medicine, purchaser and provider management, research and consumer concerns. Three panels of the group considered the following sub-headings: entry to secondary care; exit from secondary care; shifts in the balance of care. Panels were charged with reviewing existing evidence, considering responses to consultation and identifying key issues to take forward. Consultation involved 242 organisations, of which 139 replied, covering statutory agencies, professional bodies, consumer groups, academic centres and research organisations. In addition, workshops were convened around England to generate informal discussion of problems at the primary-secondary interface and a small group of carers met to advise the advisory Group on some of the issues facing individual users of services. Letters of invitation asked for simple statements of need rather than fully worked up research proposals. These were then translated into subjects suitable for research and considered in relation to the relevant available research evidence.
4. Broad criteria for prioritising research subjects were:

-criteria related to NHS need, namely likely benefit of research to the NHS and patient care; relevance to policy initiatives such as the Health of the Nation and Patient's Charter; burden of disease; costs to the service and to patients; variation in practice

-criteria related to research and development potential, including feasibility of research (availability of existing methodology and resources), likelihood of research being implemented (degree of management commitment to the issue under scrutiny, study design and participants)

Twenty one individual research topics were agreed by the Advisory Group and prioritised according to a system of scoring. The top ten were:

- transfer of information across interface between health care professionals and other agencies
- evaluation of clinical guidelines at the interface
- appropriate access, use and location of diagnostic facilities and new technologies
- impact on referrals and discharge of including patient and carers in decision-making
- appropriateness of inpatient follow up
- evaluation of treatment by referral versus management in primary care
- impact of purchasing arrangement on interface
- aftercare: rehabilitation and community care priority groups
- prescribing across the interface
- models of intermediate care

Research was commissioned in 16 of the priority areas following a call for applications

Source: Jones R, Lamont T and Haines A *BMJ Volume 311 21 October 1995*

ASSESSING PAYBACK FROM RESEARCH AND DEVELOPMENT

A Case Study: Near Patient Testing

The problem:

GPs under pressure from companies to take up Near Patient Testing (NPT). This could result in a substantial increase in service costs, but effectiveness was questionable.

Research process:

The clinical and economic impact of NPT of 6 commonly used tests – 4 biochemical and 2 bacteriological – was assessed from 1989 – 91. 12 group practices were studied in 3 phases including a 4-month baseline observation of current laboratory use for all tests.

Primary outputs:

The study found no need for onsite testing: the important factor was that high quality results reached GPs quickly. Near Patient Testing increased the number of tests performed and only one was found to be cost-effective.

A dissemination package was funded by the Department of Health and the introduction of NPT has probably been curbed. The total cost saving is difficult to estimate since it is not known how far NPT would have spread without the research. The universal introduction of cholesterol testing alone could have increased costs by up to £24m. The research cost £0.1m.

Source: Buxton M and Hanney S *Assessing Payback From Department Of Health Research And Development* Health Economics Research Group, Brunel University Report No. 24

BIBLIOGRAPHY

- Abel Smith B, Figueras J, Holland W, McKee M, Mossialos E (1995) *Choices in Health Policy*
- Beaglehole R and Bonita A (1997) *Public Health at the Crossroads*
- Belcher P "The Role of the European Union in Health Care" *Eurohealth* Vol 4 No 2 Spring 1998
- Birley M, Bos R, Engel C and Furu P A Multi-sectoral Task-based Course: Health Opportunities in Water Resources Development *Education for Health* Vol 9 No 1 1996 71-83
- Ed Briggs D, Corvalen C and Nurminen M (1996) *Linkeage methods for environmental and health analysis*
- British Medical Association (1998) *Health and environmental impact assessment*
- Buxton M and Hanney S (1997) *Assessing Payback from Department of Health Research and Development* Vols 1& 2 Health Economics Research Group Brunel University
- Cassels A (1997) *A guide to sector-wide approaches for health development* WHO/DANIDA/DFID/European Commission
- Calman KC (1998) *The Potential for Health*
- Chollat-Traquet (1996) *Evaluating Tobacco Control Activities* WHO, Geneva
- Council of Europe (1993) *Comparative study on discrimination against persons with HIV or AIDS*
- Council of Europe (1996) *Convention on Human Rights and Biomedicine*
- Downie RS, Tannahill C, Tannahill A (1996) *Health Promotion Models and Values*
- European Commission DGVI/2 *Annual Reports 1996, 1997*
- European Commission (1997) *Promoting the role of Voluntary Organisations and Foundations in Europe*
- European Commission *Community action programme on Health promotion, Information, Education and Training 1997*
- European Commission (1997) *Public Health in Europe*
- European Commission (1993) *Commission communication on the framework for action in the field of public health* COM(93) 559
- European Commission (1997) *Consumer Health and Food Safety* COM(97) 183
- European Commission (1998) *Communication on the development of public health policy in the European Community*
- European Commission (1998) *Partnership for Integration A Strategy for Integrating Environment into EU Policies* Cardiff – June 1998
- European Monitoring Centre for Drugs and Drug Addiction *Annual Reports 1995 and 1996*
- European Organisation for Research and Treatment of Cancer (1997) *Organization Activities and Current Research 1997-98*
- Gellert G "International migration and control of communicable diseases" *Social Science and Medicine* Vol 37 No 12 1993
- *Grimaud O, Weinberg J, Newton L "Establishing Priorities For European Collaboration In Communicable Disease Surveillance" On behalf of the Charter Group, DGV/F European Commission
- International Agency for Research on Cancer/ Europe against Cancer Programme (1992) *Comparative study of anti-smoking legislation in countries of the European Union* IARC Technical Report No 8

- Jones R, Lamont T, Haines A "Setting priorities for research and development in the NHS: a case study on the interface between primary and secondary care" *British Medical Journal* Vol 311 October 1995
- Kari M (1998) *Meeting with EU Social Policy*
- Lacombe D, Therasse P and Meunier F "Obstacles for independent transnational clinical trials in Europe" *International Journal of Pharmaceutical Medicine* 1998 12:133-136
- Ed Manciaux M and Romer C(1991) *Accidents in Childhood and Adolescence* WHO/INSERM
- Ed McMichael A, Haines A, Slooff R, Kovats S (1996) *Climate Change and Human Health* WHO/WMO/UNEP
- McKee M "An Agenda for public health research in Europe" *European Journal of Public Health* 1998: 8: 3-7
- McKee M, Belcher P "The Influence of European Law on National Health Policy" *Journal of European Social Policy* 1996 6 (4) 263-286
- Mossialos E, McKee M, Rathwell T "Health care and the single market" *European Journal of Public Health* 1997 7 235-7
- Mossialos E, Belcher P "Health Priorities for the EU Intergovernmental Conference" *British Medical Journal* 1997 314 1637-38
- Mossialos E and McKee M "The European Union and Health: past, present and future" in Ed Anthony Harrison *Health Care UK 1997/98* Kings Fund, London, pp 224-238, 1997
- Mossialos E, McKee M "The Amsterdam Treaty and the future of European health policy" *Journal of Health Ser Res Policy* 1998 3 65-67
- Netherlands Government Committee (1992) *Choices in Health Care*
- Netherlands Institute for Health Promotion and Disease Prevention (NIGZ) (1997) *School Health Promotion and Cancer Prevention Final Report of a European documentation and evaluation project*
- O'Donnell "Clinical Trials in Europe: New Plans, New Challenges" *Europe In Action* Vol 4 No 2 Feb 1995
- Powels, J (1992) "Changes in disease patterns and related social trends" *Social Science and Medicine*, 35, 337-387
- Power C "Health and Social Inequality in Europe" *British Medical Journal* Vol 308 1994 1153-56
- Riboli E, Kaaks R "The EPIC project: Rationale And Study Design" *International Journal of Epidemiology* Vol. 26 No. 1
- Royal College of Physicians, London (1991) *Preventive Medicine*
- Russel L (1986) *Is Prevention better than Cure?*
- Ed Scally G (1997) *Progress in Public Health*
- Sculpher M, Drummond M and Buxton M (1995) *Economic Evaluation in Health Care Research and Development* HERG Discussion Paper No 12
- Smith G, Blane D and Bartley M "Explanations for socio-economic differentials in mortality: evidence from Britain and elsewhere" *European Journal of Public Health* Vol 4 1994 pp 131-44
- Ed Stavridis S, Mossialos E, Morgan R and Machin H (1997) *New Challenges to the European Union: Policies and Policy-Making*
- Swedish Parliamentary Priorities Commission (1995) *Priorities in health care*
- Ed Townsend P and Davidson N (1982) *The Black Report*
- UNAIDS/WHO (1998) *Report on the global HIV/AIDS epidemic*

- Whitehead M (1988) *The Health Divide*
- Whitehead M (1990) *The Concepts and Principles of Equity and Health* WHO, Copenhagen
- Wisely J, Haines A "Commissioning a national programme of research and development on the interface between primary and secondary care" *British Medical Journal* Vol 311 Oct 1995
- Working Party on Priority Setting in the NHS, United Kingdom (1996) *First Report*; (forthcoming)
Second Report: Experience of Priority Setting in Six Districts
- World Bank (July 1997) *Health Aspects of Environmental Assessment*
- World Health Organisation (1998) *Guidelines for Controlling and Monitoring the Tobacco Epidemic*
- World Health Organisation (1997) *Health and Environment in Sustainable Development*
- World Health Organisation, Geneva (1986) *Intersectoral Action for Health*
- World Health Organisation Copenhagen (1991) *Forty Years of WHO in Europe* European Series No 40
- World Health Organisation Copenhagen (1991) *Targets for health for all*
- WHO European Series No 68 (1996) *Environment and Health 1 Overview and main European issues*
- WHO Regional Publications European Series No 56 (1993/94) *Health in Europe*
- WHO Copenhagen *Comparative Analysis of nutrition policies in WHO European Member States* (June 1998 Draft)
- WHO Centre for Health Development Kobe, Japan (1996) *Urbanization: A Global Health Challenge*
- WHO/Republic and Canton of Geneva (1992) *Motor Vehicle Air Pollution Public Health Impact and Control Measures*