COMMISSION OF THE EUROPEAN COMMUNITIES

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COOPERATION AT COMMUNITY LEVEL ON HEALTH RELATED PROBLEMS

Communication from the Commission to the Council

When the Ministers of Health last met in 1978 they agreed that work in the two broad areas of disease prevention and health care costs should be started, the object of which would be to exchange experience and develop ideas for cooperation at Community level. A budget line was established and this work has progressed in the form of studies, expert meetings, symposia etc. (Annex I). A close working relationship has been established with the World Health Organisation, the Council of Europe, other international agencies and competent national authorities.

At the same time the European Parliament has repeatedly raised public health issues by way of resolutions, debates and questions. Specific matters have concerned drugs, tobacco, alcohol, organ transplantation, infectious diseases, dental health, health cards and health policy. The interest of the EP may be summarised as seeking better protection of the individual, both as a citizen and as a patient.

A further expression of concern for such matters was made at the Fontainebleau Summit when the European Council, in setting up an Ad hoc Committee, considered that it was essential that the Community should respond to the expectations of the people of Europe. That these include health was demonstrated most clearly in the results of the 1983 public opinion survey of the Community. Altogether 58% valued health in first place when questioned about their well-being and a total of 81% placed it in the first three of a range of items covering family, relationships, money and leisure.

At the Fontainebleau Summit the European Council also endorsed the work programme set out in the Community's Medium-Term Social Action Plan. In the area of social protection the Council agreed that Member States should examine the means employed to control health costs and arrangements for cooperation in the field of health. The purpose of this communication is to provide the basis for developing such cooperation.

The Commission considers that there are three examples of public health problems, namely drug addiction, smoking, and infectious diseases, for which cooperation between Member States and joint action at Community level would be practicable and should be a priority.

Addiction to illicit drugs

Recent years have seen a marked increase in the use of illicit drugs and in all Member States there is evidence that the number of addicts to heroin in particular has increased. In some towns and cities there are reports of a problem with drug addiction that was not evident a few years ago; in some, the available data suggest a ten-fold increase over the past ten years. Heroin addiction is now being described in epidemic terms. In addition, increasing concern is being expressed about the misuse of pharmaceutical agents, solvent abuse and the availability and use of cocaine.

The epidemiological picture of heroin use has substantially changed. Previously young adults were most affected and generally there was progressive use of a variety of substances culminating in addiction to hard drugs. Now it is observed that heroin is being used by schoolchildren and young adolescents and that it may be among the first of many different substances to be tried. The immediate and long- range health and social consequences of drug usage by these young people are of the utmost concern. There is evidence to suggest that the younger a child is when he or she gets involved with drugs on a regular basis, the more likely he or she is to develop problems related to drug usage. These problems are serious and lead to death, chronic sickness and social dysfunction. Accidental deaths and deaths from related diseases are frequent and serious infectious diseases are common. The associations of drug addiction with crime, prostitution, social and economic deprivation are well recognised although caution is necessary in any generalisation about cause and effect.

A factor underlying the present epidemic of heroin addiction is the increased quantity of the drug on the market in recent years. Reports repeatedly underline a situation where heroin of a higher quality is much more easily available and cheaper than was the case 5 years ago. An indication of the increased amounts in circulation can be gained from official statistics of drug seizures. These have increased markedly but it has to be observed that amounts seized and destroyed form an unknown and possibly a diminishing proportion of the total.

World-wide control of supplies is pursued through UN agencies: within Europe a complementary organisation is the Cooperation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group). However, the increased availability of heroin throughout the Community is evidence that despite the efforts of customs and police services of Member States, containment of addiction to hard drugs through the control of supplies has not been sufficient. Such actions could be made more effective by increased cooperation between customs services within the structure of the customs union. The Commission already supports this cooperation, notably within the framework of the Convention of 7 September 1967 on Mutual Assistance. A further strengthening of the measures against illicit trafficking of drugs would be possible within the framework of the Customs Cooperation Council's International Convention on Mutual Assistance (Nairobi, 9 June 1977). These might be matters for the Ad hoc Committee to address in the framework of their remit to examine measures to combat drug abuse.

Regulatory and restrictive measures to control supply cannot however succeed in controlling drug abuse on their own and matching efforts to limit demand are necessary. Indeed current thinking is placing increased emphasis on primary prevention and on those activities concerned with the prevention of the onset and regularization of drug abuse by youth. Control of demand calls for a different form of cooperation which must be the responsibility of the health and education authorities. The objective is to develop prevention strategies based on educational programmes aimed at the professions, the public - especially parents of young children - and the children themselves. The broader aim is to create a climate of non-drug use. From an epidemiological perspective it can be theorized that the drug addict entices others to use drugs and hence contributes to the increase in drug usage. The term "heroin epidemic" is frequently used and indicates an acceptance of this concept. Comparing heroin usage to the spread of an infectious epidemic identifies the spatial dimension of the problem, and the need for a common commitment to establishing a norm of non-drug use by children and young adults based upon individual choice and responsibility. To this end various actions can be envisaged at the macro level - that is directed towards whole populations - and at the micro level dealing with defined sub-groups both of those at risk and of the caring professions.

At a macro level there is a need for better coordination of information campaigns that not only communicate, in a straight forward manner, the adverse effects of drugs but also introduce what is known about the motivations for drug use and ways to counter these motivating factors. For this the concerted role of the media is of central importance both for the dissemination of information and to avoid covert pro-drug messages. The needs of the health and education professions for input during training and for current awareness of the continuing evolution of drug related problems must also be met.

At a micro level actions should address collaboration between parents and staff in schools and between parents, staff and young people in other community settings and agencies. The focus of such actions would be to create a climate in which children and young people are discouraged from drug taking by their peer group as well as from parents, schools and the community, reinforced by the media. At Community level action should serve to support and improve existing national programmes and could take the form of a series of pilot or demonstration projects, with interchange and comparison between different settings in Member States.

Also at the micro level are the specific needs of health professionals engaged on the treatment of established drug addicts and the needs of the social workers engaged in the rehabilitation of the "social casualties", including those with criminal convictions. The present situation is one of immense diversity of practice, fragmentation and isolation leading to frequent expressions of hopelessness or therapeutic nihilism.

Whilst the treatment and management of the drug addict is one of the most difficult problems in both medical and social terms, it is made worse by incomplete knowledge and misunderstanding of the different approaches in Member States. Thus there needs to be greater opportunity for meeting and exchange of the personnel involved in particular for the appraisal of different treatment regimes and patient management policies. This would allow the caring professions to make a more informed contribution to policy making and community-based actions.

Finally at both macro and micro levels there is the need for better information. This is necessary to monitor trends in drug use, to evaluate the effectiveness of actions and to provide the basis for community

awareness. Various sources of data exist but these have, in general, not been satisfactorily developed or utilised. Actions at either level require data for planning, conduct and evaluation which are not at present available.

Drug abuse is an old problem for which there is no solution, only a policy of containment and watchfulness. Actions aimed at reducing demand will have a latent period measured in years before any effect is apparent. Cooperation at Community level will need to be ongoing and responsive to the needs of Member States in order to achieve success.

Diseases due to smoking

The scientific evidence is that most cases of lung cancer and chronic bronchitis are caused by cigarette smoking and that cigarette smoking is associated with increased coronary heart disease and a number of other cancers. Furthermore there is some evidence that children of parents who smoke have more chest illnesses and that the risk of lung cancer is increased in the non-smoking wives of husbands who smoke.

The size of the problem has been quantified in various ways. One calculation published recently gives an estimated 11 fold increase in deaths from lung cancer in cigarette smoking men when compared to non-smokers and almost a doubling of the overall risk of death. In the European Community it is projected that in all Member States, with the exception of the UK, the lung cancer death rate will continue to increase over the next 10 years. In total more than one million deaths from lung cancer are to be expected before the year 2000.

Patterns of cigarette smoking have changed considerably in the last 10 years and vary between Member States. In general the habit has decreased in males of professional or managerial status, is increasing in women, and remains high and unchanging in young adults. There has been a marked decline in total consumption in one Member State and similar declines in other countries, eg. Norway, Sweden and the US, providing good evidence for the effectiveness of anti-smoking measures. Studies of the mortality of doctors provide good evidence of the considerable benefits from giving up smoking in terms of reduced mortality.

Actions to promote non-smoking take a variety of forms. Clearly, as with drug abuse, personal health education to limit demand is essential. But to be most effective this must be supported by other kinds of measures. Again it is a task of creating a climate of non-smoking, rather than a climate of acceptance or tolerance which encourages young people to experiment and copy. The sort of measures that can be taken are shown in Annex II with an indication of those already introduced in Member States.

In the past few years all Member States have taken some action and some are now beginning to develop a series or programme of actions. The future aim should be to begin to coordinate these actions in order to avoid conflicting interests and confusion in the minds of young people, more and more of whom now travel extensively in the Community for study and vacational purposes. The objective should be to reduce current levels of smoking in adults and to discourage children and young people from taking up the habit.

Experience shows that this is not unrealistic. The level of smoking in male professional groups is now less than half of other groups. Where concerted programmes have been aimed at young people the rate of smoking has been reduced to the extent that future non-smoking generations can be envisaged. Furthermore such changes have been achieved by influencing personal choice and responsibility as opposed to restriction. Cooperation at Community level should support actions of Member States in the areas referred to in Annex II. Cooperation would need to recognise that Member States have not all reached the same stage of progress against smoking and will not, therefore, be able to advance at the same rate. Community cooperation would provide the impetus, and agreement on common objectives and policies would help overcome many of the difficulties.

Infectious disease control

Both drug abuse and smoking related disease are increasing problems. By contrast infectious disease is considered to have declined to a level of minor importance. As a broad generalisation this is true but only in an historical perspective. Recent years have seen a number of instances when public and professional concern has been voiced. While the past 10 years has seen the eradication of smallpox resulting from a coordinated world-wide

action, it has also seen continuing problems in Member States from tuberculosis, measles, rubella and pertussis for example, an increasing incidence of gastro-intestinal and sexually transmitted infections, newly identified problems such as Legionnaires' Disease and Acquired Immune Deficiency Syndrome, and potential problems arising from increased travel and tourism. There is current research interest in the possible role of transmissible agents in some neurological and neoplastic diseases and considerable research investment in the production of new vaccines.

Immunisation against the common diseases of childhood is a long established policy in all Member States and Annex III displays existing practices. There is considerable variation between what is required, recommended and available. Present policies are least well formulated and implemented for the newer programmes for rubella and measles. As a result uptake is variable and effectiveness diminished.

The importance of the prevention of both of these diseases is well recognised. Rubella in early pregnancy substantially increases the risk of congenital malformation. Measles is not always a minor ailment and data from one Member State show that 9% of cases develop ear infections, 7% respiratory complications and 0.3% encephalitis. These complications frequently lead to hospital admission.

Recognising the importance of measles in both medical and economic terms, the US established in 1978 the goal of eliminating indigenous transmission of the infection. Achieving and maintaining high levels of immunisation in schoolchildren was the primary component of the elimination strategy. This has been so successful that by autumn 1981, 97% of school entrants had proof of immunity. As a result by 1982 only some seventeen hundred cases of measles were reported, less than 3% of the 1977 total. Significantly, of 199 cases imported in 1982 only 19 led to any secondary transmission. Following the US initiative Canada, Sweden and Finland have declared similar intentions. The position in the Community is that overall the incidence of measles remains relatively high while immunisation rates are low.

In 1982 a meeting of officials responsible for infectious diseases organised by the WHO Regional Office for Europe reported that there is little coordinated prevention policy among the countries in the Region owing

to wide differences in the legislative and infection control measures used, and to the fact that no attempt has been made so far to assess the importance of the various control measures. They endorsed an earlier meeting in 1981 which highlighted the overall importance, and most importantly, the economic cost of infections.

Cooperation at Community level should seek to implement and augment WHO initiatives which would assist the Regional Office to encourage development in other European Countries. There is a need in the Community for a network of national and regional centres with rapid exchange of information, commonly agreed definitions and reporting procedures, standardisation of materials and testing, and joint training and research projects. Surveillance of long-term trends would be valuable to identify areas requiring special attention and research. Immunisation will continue to be the central focus of infectious diseases control and a common approach to childhood infections as well as widespread epidemics and rare diseases of special significance should be the aim.

Towards cooperation

Three priority areas for cooperation at Community level have been identified. The premise is that such cooperation would lead to greater effectiveness and that this benefit could be achieved at a lower cost. Duplication and conflict might be avoided; acceptability might be improved. Moreover many other areas of common interest could be identified turning what might initially appear as a series of specific problems into a more general concern about public health in the Community. This implies that any mechanism of cooperation should be flexible enough to be able to address other issues as appropriate within a general frame of reference and priorities.

At the last meeting of Ministers of Health in 1978 a proposal for an Advisory Committee on Public Health was discussed and it was agreed to place this matter on the agenda of a subsequent meeting. The Commission was invited to consider to what extent such a Committee was necessary and whether existing committees might not serve the purpose.

Numerous committees have a health related interest although no committee is concerned with health per se. The Committee of Senior Officials on Public Health exists to oversee the application of Directives on the mutual recognition of medical and allied diplomas. There are advisory committees on the training of the health professions. There is an advisory committee on health and safety at work. Expert committees on food, cosmetology, pesticides and toxicology consider various matters which may affect health. Technical progress committees and programme management committees exist for defined tasks arising from Community instruments. Outside of the Community institutions various groupings are to be found. A Hospitals Committee of the EEC exists in a semi official capacity drawing financial support from hospital organisations in Member States. The Chief Medical Officers meet to exchange views. Professional interests are represented in a variety of ways.

The Council, in adopting the Second Programme of Action on Safety and Health at Work in February 1984, requested the Commission to prepare annually, after consulting Member States, a forward outline of the work it intends to carry out for its implementation. This has led to the formation of a group of Senior Officials of Member States with responsibilities in the field who meet with Commission officials to determine priorities and actions to be undertaken. An implementation plan of work is established and this document is made available to all interested parties. For instance, a different procedure for cooperation exists in the field of education where a Committee of representatives of Member States has the task, with the Commission, of coordinating the implementation of the various action programmes. This Committee is also charged with the preparation of matters for meetings of Ministers including future developments in the field.

The Commission considers that a similar form of mechanism has now become necessary to further cooperation in the field of public health and to give substance to the recent conclusions of the Social Affairs Council and the Fountainbleau Summit.

Conclusions

Public health is not specifically referred to in the Treaties with the exception of Chapter 3 of the Euratom Treaty which makes reference to the protection of the health of the general public from the dangers of ionising radiation. Public health has in the past found no expression in Community policies and actions unless subsumed under other names. In a debate in 1983 on a question to the Council(1), it was asked if the time was not now ripe to develop and launch a European health policy in accordance with the wishes expressed by the Parliament. The Council reply indicated awareness of the resolutions of the Parliament, the importance of public health questions and a willingness to consider every initiative or proposal from the Commission.

Following this debate and in answer to the point that no proposals had been made which would justify a further meeting of Health Ministers, proposals for a Directive relating to the protection of dialysis patients by minimising the exposure to aluminium(2) (June 1983), a Recommendation concerning the adoption of a European Health Card(3) (December 1983) and a Resolution on a programme of action on toxicology for health protection(4) (May 1984) have been presented to the Council.

In the selection of these topics, and in the identification of the three problem areas discussed in this Communication, particular weight was attached to the priorities identified by the Parliament. To the extent that these reflect the priorities common to the responsible authorities in Member States this is justified. In any event, there is a need to arrange for a continuing dialogue between Member States and the Commission to establish new priorities and areas for cooperation in health matters which would complement other areas of social policy and give expression to the concept of a People's Europe.

To this end Council is asked to continue its examination of the three proposals for Community instruments referred to above, to consider what actions should be mounted on the three topics discussed in this Communication, to identify any other priorities for cooperation at Community level and to decide on the ways and means for effecting this cooperation.

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(1) OJ, Annex 1-303 (Session EP 12-16.9.1983)
(2) OJ No. C 202, 29.7.1983, p. 5
(3) OJ No. C 21, 28.1.1984, p. 7
(4) OJ No. C 156, 16.6.1984, p. 6

ANNEXE I

1) LISTE DES ETUDES EN SANTE PUBLIQUE

Titre	Date finale	Résultat
DROGUE		
Méthodologie commune à appliquer dans la recherche des motivations et des comportements dans la consommation abusive des médicaments; description et évaluation des programmes d'éducation pour la santé sur les médicaments	décembre 1981	rapport final
Analyse critique de la documentation spécialisée (résultats d'études, de recherche, d'enquêtes, etc.) concernant l'évolution de la consommation de drogues dans les pays de la Communauté (B, F, NL, L, D) et les mesures préventives et thérapeutiques prises (voir aussi Résolution du Parlement européen du 14 mai 82 sur la lutte contre la drogue). (3 contrats)	février 1981 décembre 1981 janvier 1984	rapport final
Analyse critique de la situation actuelle de la toxicomanie - consommation et abus des drogues licites et illicites - dans les pays de la Communauté européenne	octobre 1982	rapport final
Analyse comparative des politiques de lutte contre la toxicomanie dans les pays membres du point de vue de l'articulation des différentes modalités d'intervention et de leurs supports législatifs (1ère tranche)	octobre 1982	rapport
Analyse comparative des politiques de lutte contre la toxicomanie dans les pays membres du point de vue de l'articulation des différentes modalités d'intervention et de leurs supports législatifs (2ème tranche)	octobre 1984	rapport en cours
TABAGISME		
Analyse des stratégies actuelles ou envisageables de la lutte antitabagique dans les pays de la Communauté européenne (1ère tranche)	septembre 1980	Publication EUR 8031 FR
Analyse des stratégies actuelles ou envisageables de la lutte antitabagique dans les pays de la Communauté européenne (2ème tranche)	octobre 1981	

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Titre	Date finale	Résultat
TABAGISME (suite)		
Données et informations de base sur le tabagisme dans les Etats membres de la Communauté européenne pour la période comprise entre 1960 et 1980 (1ère tranche)	octobre 1980	Publication EUR 7907 DE
Données et informations de base sur le tabagisme dans les Etats membres de la Communauté européenne pour la période comprise entre 1960 et 1980 (2ème tranche)	octobre 1982	
Statistiques relatives à la consommation de tabac dans la Communauté économique européenne - Analyse et examen critique	septembre 1984	rapport en cours
VACCINATION		
Etude comparative des aspects médico-légaux des complications post-vaccinales dans les Etats membres de la Communauté européenne	septembre 1979	Publication EUR 7019 FR
NUTRITION		
L'éducation nutritionnelle à l'école dans les pays de la Communauté européenne	octobre 1980	Publication EUR 7331 FR
Mise au point d'un modèle de formation destiné à l'éducation nutritionnelle	octobre 1981	rapport final
Définition d'une méthodologie de l'évaluation appliquée à l'éducation sanitaire	octobre 1981	rapport final
Enquête sur la restauration scolaire dans les Etats membres de la Communauté européenne	août 1983	rapport final
Principes et bases d'initiatives communautaires en éducation sanitaire dans le domaine de la nutrition	septembre 1984	rapport en cours
ALCOOL		
Analyse critique des facteurs déterminants en matière de consommation de boissons alcoolisées, tenant particulièrement compte des aspects relatifs à l'éducation pour la santé et à la publicité	juillet 1983	rapport final
REDUCTION COUT DE SANTE		
Préparation d'instruments standardisés de décisions et d'évaluation en santé publique et dans le domaine médico-social (1ère tranche)	octobre 1983	rapport

Titre	Date finale	Résultat
REDUCTION COUT DE SANTE (suite)		
Préparation d'instruments standardisés de décisions et d'évaluation en santé publique et dans le domaine médico-social (2ème tranche)	octobre 1984	rapport en cours
Problèmes liés à l'évolution de la démographie médicale dans les années à venir dans les pays de la Communauté européenne	octobre 1984	rapport en cours
Statut du personnel paramédical dans les Etats membres de la Communauté européenne	octobre 1984	rapport en cours
L'organisation, le financement et le coût des soins de santé dans la Communauté européenne	1979	Série politique sociale - 1979 nr. 36
Consommation pharmaceutique-tendances des dépenses-principales mesures prises et objectifs sous-jacents des interventions publiques dans ce domaine	1978	Série politique sociale - 1978 nr. 38
Approche micro-économique des problèmes relatifs aux coûts de l'hospitalisation	1979	Série politique sociale - 1979 nr. 39
Les soins de santé primaire dans les Etats membres de la Communauté européenne	1980	Doc. V/476/80
Evolution des dépenses pour les soins de santé pendant la période 1970-1976	-	rapport
Technologie médicale de pointe, utilisant des équipements couteux dans les Etats membres de la Communauté européenne, législation, politique et coûts	1982	Doc. V/943/82
Rapport concernant la deuxième phase de l'étude de la technologie médicale	1984	Doc. V/482/84
L'expérience de douze pays européens en matière de contrôle du coût des soins de santé (1977-1983)	1983	Doc. V/1934/83
DIVERS		
Education sanitaire en hygiène dentaire et paradentaire	décembre 1984	rapport en cours
Rôle et développement des dispensaires de gériatrie	décembre 1984	rapport en cours
Personnes âgées et consommation de médicaments - Situation dans les Etats membres	décembre 1984	rapport en cours

2) SEMINAIRES ET REUNIONS ORGANISES DANS LE CADRE DES DECISIONS DES MINISTRES DE LA SANTE

Séminaires	Dates et Lieux
Séminaire sur les risques médico-sociaux dans la consommation d'alcool	novembre 1977 Luxembourg
Symposium sur la nutrition, la technologie des produits alimentaires et l'information nutritionnelle (Session "Education Nutritionnelle en collaboration avec la DG III - Bruxelles)	mars 1980 Londres
Séminaire "Le rôle du médecin en éducation pour la santé"	juillet 1980 Luxembourg
Séminaire International d'Education pour la Santé "Elaboration d'une politique pour la santé : processus et structures" (en collaboration avec la Bundeszentrale für gesundheitliche Aufklärung- Cologne)	juin 1981 Bergneustadt (Allemagne)
1er Symposium sur le cancer du poumon en Europe-Session consacrée à l'éducation sanitaire sur le thème : "Comment réduire l'usage du tabac" (en collaboration avec la Société Européenne de Pneumologie)	septembre 1982 Knokke (Belgique)
Séminaire "Les problèmes liés à la consommation d'alcool dans la Communauté européenne"	mars 1983 Luxembourg
Symposium international "Tabac et Cancer" (en collaboration avec "The European Organisation for Cooperation in Cancer Prevention - Bruxelles)	mars 1983 Bruxelles
Séminaire sur la prévention et le traitement de la pharmacodépendance (en collaboration avec l'O. M. S.)	septembre 1983 Bruxelles
Séminaires européens sur les politiques de santé	
1er Séminaire : Allocation de ressources et soins de santé aux personnes âgées	décembre 1978 Luxembourg
2ème Séminaire : La santé publique et les premières années de la vie (en collaboration avec l'INSERM - Le Vésinet)	octobre 1979 Ispra (Italie)
3ème Séminaire : Evaluation et politique de santé mentale	mars 1980 Luxembourg
4ème Séminaire : Evaluation de modèles de services de santé européens, en particulier les modèles scandinaves	décembre 1981 Luxembourg

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Séminaires	Dates et Lieux
Séminaires européens sur les politiques de santé (suite)	
5ème Séminaire : Evaluation des services de médecine du travail par des méthodes épidémiologiques	décembre 1983 Luxembourg
6ème Séminaire : Le contrôle du cancer	décembre 1983 Luxembourg
Séminaire Ethique du secret médical et dossiers sanitaires	décembre 1980 Luxembourg
Groupe de travail sur la création de centres anticancéreux et sur l'élaboration de programmes de lutte anticancéreuse dans la collectivité en Europe (en collaboration avec l'OMS)	octobre 1981 Luxembourg
Orientations dans les domaines de la santé et du bien être social des personnes âgées	octobre 1982 Luxembourg

Groupe de Travail de Médecine Sociale et d'Epidémiologie des Communautés européennes	plusieurs réunions de 1974 à 1984 à Bruxelles

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Réunions d'experts	Dates Lieu : Luxembourg
DROGUE	
Les problèmes de la drogue dans la Communauté européenne	novembre 1981
Lutte contre la toxicomanie	juin 1982
TABAGISME - NUTRITION	
Education sanitaire : tabagisme - nutrition	mai 1979 septembre 1979 octobre 1980
Motivation et comportement (importance des motivation, comportement des fumeurs et habitudes alimentaires)	juillet 1979
Methodologie commune permettant de comparer les résultats et d'apprécier l'efficacité des campagnes d'éducation sanitaire	septembre 1979 novembre 1979
L'éducation nutritionnelle à l'école dans les Etats membres de la Communauté européenne	octobre 1981 octobre 1982 septembre 1983
VACCINATIONS	
Lutte contre les maladies transmissibles (problème des vaccinations)	mai 1978
Sensibilité des enfants à la tuberculine	septembre 1982 février 1983
ASSISTANCE SANITAIRE	
Assistance sanitaire réciproque en cas de catastrophe, d'accidents majeurs et de maladies exceptionnellement graves	décembre 1979 mai 1980 novembre 1980 février 1981 juillet 1981
CARTE SANITAIRE	
Carte sanitaire d'urgence pour personnes à risque	juillet 1979

EEC COUNTRIES

Country	Advertising	Package information	Levels of harmful substances	Sales to adults	Smoking in public places	Smoking by minors	Mandatory health education
Belgium	◐W	WNTC		⊗	◐		
Denmark	(◐)	(NT)			O		O
France	◐	WNT			◐	⊗	◐
Germany, Fed. Rep.	◐(WNT)	(WNT)				⊗	
Greece					O		O
Ireland	◐W	W					
Italy	●				◐	⊗	
Luxembourg	O	W			O	O	
Netherlands	O	WNT					
United Kingdom	(◐WT)	(WT)	(⊗)			⊗	

Key to symbols

● = total (or effectively total) ban
◐ = "stringent" control measures
O = "moderate" control measures
} see criteria below

⊗ = other control measures (stringent/moderate distinction not applicable)
W = health warning required
N = indication of nicotine level required
T = indication of tar level required
C = indication of carbon monoxide level required
( ) = provisions laid down by voluntary agreement, not by legislation

Examples :
◐W = stringent controls; health warning required
W(◐)= warning required by law; also stringent controls under terms of voluntary agreement

CRITERIA FOR ASSIGNMENT OF SYMBOLS

Advertising
● = a total (or effectively total) ban on advertising of tobacco products (in some cases included in a ban on advertising of all commodities)
◐ = extensive restrictions in several media
O = minor restrictions, or major restrictions in one medium only

Smoking in public places
◐ = a wide range of restrictions clearly dictated by health considerations
O = a limited range of "traditional" restrictions, or an undefined ban "in public places"

Smoking in workplaces
◐ = a range of specific measures to protect workers' health
O = measures which affect workers' health only incidentally, or which concern only a limited category of workers

Mandatory health education
◐ = a broad health education policy (especially if funds are expressly allocated)
O = health education directed at one or more target groups (e.g. pregnant women)

Tableau comparatif des situations nationales

situation fin 1983

	Belgique	Danemark	Allemagne	Grèce	France	Irlande	Italie	Luxembourg	Pays-Bas	Royaume-Uni
Variole	S	A	A	-	S	-	A	S	-	-
Rougeole	R	D	R	O	R	D	R	R	P	R
Rubéole	R	D	R	R	R	R	R	R	P	R
Diphtérie	R	R-P	R- -P	O	O	R-P	O	R- -P	R- -P	R
Tétanos	R	R-P	R- -P	O	O	R-P	O	R- -P	R- -P	R
Coqueluche	R	R-P	R	O	R	R-P	-	R- -P	R- -P	R
Poliomyélite	O	R-P	R- -P	O	O	R-P	O	R- -P	R- -P	P
T.A.B.	OGR	-	-	D	OGR	R	OGR	-	R	R
B.C.G.	R OGR	R-P	R	O	OGR	R	OGR	R	R	R
Grippe	R	R	R	D	R	R	R	R	R	R
Oreillons	R	R	R- -P	R	-	D	-	-	-	-
Rage	R	D	R	R	R	D	R	R	R	R
Hépatite B	R	-	-	D	R	-	R	-	-	-
Choléra	-	-	-	D	-	-	-	-	-	-
Fièvre jaune	-	-	-	D	-	-	-	-	-	-
Leptospirose	-	-	-	-	R	-	-	-	-	-
Brucellose	-	-	-	-	R	-	-	-	-	-

Index des Symboles

S = suspendue

A = abolie

O = obligatoire sauf contre indications médicales prévues par les autorités nationales de la santé

D = disponible sur demande dans les conditions prévues par les règlements nationaux en vigueur

R = recommandée dans les conditions précisées par des dispositions nationales particulières

P = programmes de vaccination disponibles

OGR= obligatoire pour certains groupes à risques sauf contre indications médicales particulières